

RELIGION IN THE DOCTOR-PATIENT RELATIONSHIP:  
CULTURAL COMPETENCE AND CULTURAL HUMILITY

BY

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## Table of Contents

Abstract	iv
Chapter One Introduction to Religion in the Doctor Patient Relationship	1
Chapter Two The Serpent Handling Community, Beliefs, and Traditions	15
Chapter Three The Problems of Cultural Competence	27
Chapter Four The Promise of Cultural Humility	37
Works Cited	51
Curriculum Vitae	54

## Abstract

Religion has a great impact on the medical decisions of many people, especially the most devout. The intent of this thesis is to explore the role of religion in the doctor-patient relationship, specifically through the case study of the serpent-handlers. This religious sect is found primarily in the Appalachian Mountains and holds religious beliefs that affect their utilization of the medical system. I examine how religious and cultural issues are currently dealt with, through cultural competence. I identify several problems with this approach and suggest an alternative: cultural humility. Through acceptance of the practice of cultural humility, medical providers could better care for patients with diverse religious views.

## Chapter 1: Introduction to Religion in Doctor-Patient Relationships

The field of bioethics is quite broad, encompassing anything that can affect the health care system and the patient's experience within the system. The system is influenced by big picture forces: federal and state government, insurance policies, and hospital administration, to name a few. Patients are unavoidably affected by these forces and by much smaller and more subtle factors. Physicians see a small slice of the patient's life in the exam room; this life is heavily influenced in ways doctors do not always realize by the patient's culture, society, and place within the society. An important factor on this list of influences is religion. The effects of a patient's religion are relatively well discussed within the literature in situations where the religion forbids certain aspects of Western medicine. These include such examples as Jehovah's witnesses refusing blood transfusions and Scientologists refusing psychiatric treatment. There is, however, a lack of scholarship on the cases in which religion subtly influences a patient's disease experience. In some cases, such as the Appalachian serpent handling sects of Christianity, the religion does not forbid the use of modern medicine. The interpretation of the faith does, however, lead to unusual utilization of the health care system. In cases such as this, as well as cases where the patient is influenced in smaller ways by religion, the physician can benefit from acknowledging the role of religion and spirituality. Exploring the case of serpent handlers will expose the importance of religion to patients within the medical system.

The purpose of this thesis is to then determine the best approach to incorporating religion into the doctor-patient relationship. The similar but disparate approaches of cultural competence and cultural humility will be detailed. Cultural competence attempts

to make providers proficient in the basics of diverse cultural backgrounds so that they can understand their patient's experiences, while cultural humility allows the patient to instruct the physician on their cultural and religious views and the effect of those on their medical decisions. The many problems of cultural competence will be addressed, as will the ways in which cultural humility avoids these problems. I will argue in this thesis that the approach of cultural competency is not sufficient and that replacing it with cultural humility will improve the doctor-patient relationship and patient care.

Currently, patient needs concerning religion are addressed through what is termed the practice of cultural competence. With this practice, a physician can learn the basic facts of a culture and then understand the ways in which being a part of that culture has influenced the patient. Ideally, having the basic knowledge of a patient's culture and beliefs would allow physicians to develop a better relationship with their patients. In practice, cultural competency programs often devolve into stereotypes. Generalizations often develop from cultural competency programs because a patient's culture is presented as something that the physician can become an expert in. The approach of cultural humility would better allow patients to instruct physicians on what their experience has been and what their spiritual needs are throughout their illness. Cultural humility suggests that, when it comes to the patient's individual beliefs and experiences, the doctor cedes their expertise and learns from the patient. In this way, physicians avoid stereotyping and learn which cultural factors matter to their patient. Doctors allow the patients to communicate to them the importance of their culture or religion, rather than assuming they know what the patients' experience has been. Cultural humility will allow physicians to better understand the large role that religion plays in the lives of many

patients, and the doctor-patient relationship will be improved. This improved understanding between physicians and patients can be achieved when physicians approach patients' spirituality with humility and respect. An approach of this kind will become increasingly helpful as religious diversity within American society increases.

To accept this approach, we must first explore the ways in which religion plays a large role in the lives of many patients and influences their experience of the medical system. Religion affects not only patient's treatment decisions, such as how much end-of-life treatment to pursue, but also the doctor-patient relationship. Hebert et al. spoke with patients who had recently undergone a life-threatening illness about their opinions on the role of spirituality for them as patients. Patients clearly expressed a desire for physicians to acknowledge this component of their illness: "All participants stressed the importance of physician empathy. Willingness to participate in spiritual discussions with doctors was closely tied to the patient-physician relationship" (Hebert et al., 2001, p. 685). Because patients were likely to rely on religion for help coping with their illness, they hoped that their physicians could "be more sensitive to patients' spiritual needs" (Hebert et al., 2001, p. 685). Religion is also a clear component of health, affecting patient's well-being. Although studies have not determined the precise mechanism by which this occurs, researchers have shown links between religion and mental wellbeing (Bradshaw & Ellison, 2010). A patient's religious affiliation has also been shown to affect their utilization of different aspects of the health care system. Schiller and Levin conducted a review of studies that concerned religion and utilization of the health care system. They describe the complexity of this relationship: "Even if religious orientation does not directly determine the use of health care, it may still be a critical factor insofar

as it contributes to the willingness of individuals to engage in certain health-related practices or hold certain health-related beliefs or attitudes which are causally antecedent to utilization” (Schiller & Levin, 1998, p. 1375).

Religion can be seen as one facet of the broad idea of culture, which is widely recognized as having an effect on patients and on patient care. Patients’ culture can affect everything from how they express their symptoms to their choice of treatment options. Physicians are taught to respect and understand these effects of culture through cross-cultural communication techniques. Juarez et al. explore the effect of Hispanic culture on the expression of pain and the role of religion on that expression (Juarez, Ferrell, & Borneman, 1998). Culture overall and religion specifically were shown, through patient interviews, to have a strong influence on their experience of disease and pain. Patients expressed having been taught to follow God and to trust His will, which affects the way in which they communicate their pain and needs. Instead of describing their pain to nurses and requesting medication, for example, “one person stated, ‘I pray the rosary daily because that makes me feel better’” (Juarez, Ferrell, & Borneman, 1998, p. 267). Patients relied on prayer and relaxation methods when they were in pain, using that to feel calmer. Physicians who were aware of those practices and habits could better understand the patient’s day-to-day status. The authors state that “taking...steps to understand and respect the patients’ cultural beliefs and practices will allow healthcare professionals to provide more effective pain relief as well as better communication among healthcare providers, patients, and family” (Juarez, Ferrell, & Borneman, 1998, p. 268). In many cases, this cultural understanding and awareness would include a religious or spiritual understanding. As exemplified here, religion can have subtle influences on a

patient's experience of disease by providing patients with mechanisms for anxiety control and pain relief outside of the medical system.

There are also several well-known examples of situations in which religion has a large impact on a patient's treatment decisions; one of these cases is Jehovah's Witnesses and the ban on use of blood transfusions. The religious doctrine behind this decision is complex, having changed throughout the twentieth century. Traditionally, Jehovah's Witnesses believe "the Bible prohibits the transfusion of blood and its primary components" (Digby & Brydon, 2006, p. 67). Beliefs vary, however, among individual believers. Some believers find secondary components of blood, clotting factors, for example, to be acceptable. Others will accept transfusions within a circuit, where the blood is not stored. As Digby and Brydon explain, "these grey areas must be explored with the individual members" (2006, p. 67). In situations in which blood transfusions are refused, physicians must decide to respect the patient's religious beliefs and autonomy concerning medical decisions more than their own scientific training and clinical judgment.

The Jehovah's Witness community remains a clear example for the bioethical implications of religion in medicine, the balancing of the patient's convictions and the medical realities. In this case, the effect of the patient's religion on their medical decisions is obvious to the physicians. It does not have to be discovered during a careful history-taking; this preference against blood transfusions will be made clear by the patient. Physicians have no choice but to incorporate this strong preference into their treatment plan for the patient. Less obvious or less well known examples, such as those within the serpent handling community, can have equal effects on the patient's

experience and decision making; physicians must learn to address these influences.

There are many other situations in which a patient's religious preference has a large influence on their experience of disease that are less drastic. Matthews et al. presented one such case in their compilation of stories from eastern North Carolina concerning how African American women in the region understood their experience of breast cancer (Matthews, Lannin, & Mitchell, 1994). A patient named Sharon interpreted her illness with a profoundly religious lens; she was a preacher, and her faith played a large role in her daily life. When she was told of her diagnosis, Sharon informed her physician that she needed time to pray and discern what the Lord wanted her to do in terms of treatment. Later in the progression of her disease, she resolved to "trust God to cure" her disease, ultimately, however, deciding that the Lord told her "a medical doctor was needed to cure a medical problem" and "He could work through the doctors" (Matthews, Lannin, & Mitchell, 1994, p. 798). The reaction of the health care team was initially decidedly negative towards her very visible faith. The story encapsulates the need for physicians to be understanding towards patients' reliance on their faith. Sharon was simply using her Christianity to approach this life-altering event in a way that she could comprehend, but the physicians understood her reaction as a rejection of Western medicine. There often exists this false tension between the religious and medical communities that works against high quality patient care to the detriment of the patient. When physicians are open to understanding a patient's religious perspective, they are better able to bridge this tension. In order to develop a treatment plan that works well for both patient and provider, religious influences must be taken into account.

In this thesis, I argue that cultural humility will lead to an understanding and

acceptance of the religious perspective of patients that can improve the doctor-patient relationship and, consequently, improve patient care. An integral part of this relationship is the building of trust between doctor and patient. For a religious patient, knowing that a physician at the very least respects their religious and spiritual beliefs can be a great help in establishing that trust. If patients feel that the doctor looks down on them for their beliefs, they would, understandably, be less trusting of that physician to understand their point of view. I will argue that the approach of cultural humility, rather than cultural competence, can best achieve a good understanding between doctor and patient in terms of cultural and religious preferences.

In 2007, the *Journal of Clinical Psychology* published a special issue on spirituality and psychotherapy discussing the importance of spirituality within that specific medical specialty. In the introduction, the authors stress the centrality of religion to medicine: “there is a spiritual dimension to human problems and solutions” (Pargament & Saunders, 2007, p. 903). The issue contains an article that discusses making alterations to the recommended treatment for obsessive-compulsive disorder in order to make it culturally acceptable to the Ultra-Orthodox Jewish community. These alterations allow the patients “to accept and actively engage in the treatment,” and the authors state that “psychologists ignore the spiritual dimension of psychotherapy to the detriment of their field and their clients” (Pargament & Saunders, 2007, p. 905-6). Psychology is not a special case; spirituality is important to consider throughout the medical field. Religion helps patients to determine their values and priorities, which will affect their treatment decisions. It is clear that within many different disciplines of medicine, a better understanding of the patient’s religious perspective will lead to better

care for the patient.

The importance of the patient's religious outlook throughout the medical system is supported by interviews and surveys conducted by Hebert et al. concerning spirituality and the patient-physician relationship. This study dealt with patients who had undergone serious and often life-threatening illnesses. While individuals expectedly did have some variations in beliefs, a desire for physicians to be cognizant of these beliefs was almost entirely universal. Patients relied on spirituality for guidance and coping throughout their illness. As such, illness "has been described as a spiritual event. To ignore the spiritual aspect of illness, then, is to ignore a significant dimension of the experience" (Hebert et al., 2001, p. 685). From this point of view, physicians do patients a great disservice by not offering any sort of spiritual aspect to care. Overall, patients desired an expression of understanding and empathy from doctors in a spiritual way, if the patient directed the conversation towards that concern. Patients also recognized that not all physicians would feel comfortable in that situation and suggested that, if that were the case, physicians should refer the patients to the appropriate clergy. The authors suggest that this would markedly improve patient care: "as physicians respectfully explore religiosity/spirituality with those patients who desire it, a deepening of the therapeutic alliance may lead to more effective care" (Hebert et al., 2001, p. 691). An effort to incorporate religion and spirituality, even in subtle ways, can make a significant impact for a religious patient.

In discussing religion and medicine, one must recognize that challenges do exist in bringing those two fields closer together. Levin discusses the barriers to studying the effects of religion on the medical field in "Religion and Health: Is there an association, is it valid, and is it causal?" In general, academic medicine is much more concerned with

interventions that work through known biochemical means and can be supported by rigorous clinical studies. Within this climate, any studies that did attempt to show effects and importance of religion and spirituality received little to no recognition: “ideological and institutional barriers within academic medicine have discouraged the dissemination of positive findings” (Levin, 1994, p. 1475). Not surprisingly, when researchers and doctors are discouraged from discussing religion and spirituality, patients who desire to incorporate those aspects into their care will find the medical system unreceptive. There do exist, however, many patients who would prefer that religion not remain “part of the folklore of discussion on the fringes of the research community” (Levin, 1994, p. 1475). Physicians must be able and willing to make this change.

In a 2008 study, Koffman et al. conducted interviews with cancer patients in the United Kingdom in order to determine what religion meant to them in their experience of life-threatening illness. For many of these patients, religion and spirituality was a central focus rather than something to be marginalized. Patients were better able to understand their cancer by focusing on the belief that God has a plan for their life: “He’s brought me this far and I know He controls cancer, and whatever He decides I’ll go along with it” (Koffman et al., 2008, p. 784). This faith, rather than existing in a separate realm from their physical illnesses, was able to help patients to comprehend and come to terms with cancer. For many patients, religious faith also offers a comforting element that can be absent from the medical field: “[an interviewed patient named] Grace stated that whilst she admitted it was impossible to physically see God there was never a time when she felt alone during her illness. It was under these conditions that she was assured of her safety and well-being in a manner that no doctor or other health care professional was able to

impart to her” (Koffman et al., 2008, p. 785). The authors recommend that physicians begin to adopt this approach and treat patients in a way that acknowledges the influences that religion and spirituality can have in a time of illness: “it is not enough to know how to care for patients with advanced cancer and their symptoms; health and social care professionals also need to care for them sensitively and holistically” (Koffman et al., 2008, p. 788). It is clear that, to effectively treat religious patients, physicians must be able to respectfully acknowledge their beliefs.

Religion and medicine, as science, are often presented as different ways of approaching the world. The two fields are seen as automatic opponents; opposite ends of a spectrum that could never work together. Patients, however, incorporate both fields in their experience. In a 2010 study, Hvidt and la Cour examine how the divide between religion and medicine often exists more in perception than in reality. They attempted to divide the existential orientations of the secular, spiritual, and religious realms in order to determine the differing approaches and purviews of the groups. However, they found that the different categories “overlap in the minds and hearts of most people” (Hvidt & la Cour, 2010, p. 1298). Ultimately, the authors state that “although both the religious/spiritual and the secular existential conceptual traditions focus on meaning-making...the divide between them is artificial and counterproductive for relevant research in the field” (Hvidt & la Cour, 2010, p. 1293). That is, in the end, the barriers between the religious and scientific or medical communities are more easily understood and surmounted than they would first appear to be. Where doctors and patients may assume there is no common ground, understanding can easily be found. Physicians must be open to the idea that a patient’s religious and spiritual sensibilities can have a place

within their medical treatment. By acknowledging the interconnectedness of these fields, doctors will improve patient care.

It also becomes important to consider the views of individual physicians. These views can often differ from those presented by academic medicine as a whole. Stereotypically, however, physicians exemplify some of the same distrust of religion that does pervade the system overall. This generalization is borne out in research done in a 1999 study by Frank et al. concerning the religious characteristics of female physicians in the United States. The authors found that, while some doctors certainly are religious, the group expressed beliefs different from those found in the population as a whole. This conclusion paralleled the discoveries of previous research: “patients are more religious than the healthcare professionals serving them” (Frank et al., 1999, p. 1720). While there certainly are some religious physicians, there are more religious patients. Frank et al. see important implications for this difference as medical technologies continue to advance and raise new ethical issues. Personal backgrounds and beliefs will certainly inform physicians’ opinions on controversial issues, especially as expressing religious or spiritual beliefs remains somewhat taboo within the medical community.

There is further insight to be gained when physicians themselves become the patients, as studied by Klitzman and Daya. These doctors are forced into the patient role by disease and must “face their own mortality and grapple with fundamental existential and spiritual questions” (Klitzman & Daya, 2005, p. 2398). In this role, many physicians found themselves giving more weight to religious and spiritual ideas. It was still hard, however, for them to reconcile this with their medical training and to communicate their new insights with colleagues. Following these experiences, doctors were more aware of

the ways in which religious and spiritual beliefs influenced communication between physicians and patients. Doctors also acknowledged how the importance of communication extends beyond religion to a need for recognition of a patient's overall importance: "when...doctors...look [patients] in the eye, and talk to them with respect, it gives them a sense of their own humanity: they really do matter" (Klitzman & Daya, 2005, p. 2404). It is common for physicians to be wary of the influences of religion and to be uncomfortable with patients making medical decisions on a religious basis. This study makes it clear, however, that religious and spiritual thoughts are common occurrences in the face of life-altering circumstances such as disease, even among scientifically educated physicians. An acknowledgement and incorporation of this religious importance would strengthen the medical community.

These articles make clear the importance of recognition and inclusion of religious beliefs by the medical system in order to fully care for and understand patients. The literature falls short, however, in suggesting ways in which physicians can accomplish this. Cultural competency is advanced as the standard approach for dealing with these issues, but limits physicians and their understanding of patients' experiences in many ways that I will address later in this thesis. The idea of cultural humility, allowing patients to educate physicians on their cultural experiences, has been advanced by some scholars, Linda Hunt in particular. Cultural humility holds immense potential for physicians to improve their understanding of a patient's beliefs and perspective by allowing the patient to instigate and direct discussion concerning their cultural views. Giving patients' control of this discussion will improve the doctor-patient relationship and patient care. Cultural humility should be the standard approach used by physicians in

order to appreciate and respect a patient's religious beliefs and cultural practices in their treatment.

It is clear that religion influences the doctor-patient relationship through its effect on patients' experience of and understanding of disease. The sources discussed above detail the many ways in which religion can influence a patient's experience of medicine, as well as the importance patients place on a physician's understanding of these influences. Religious faith comforts patients and gives meaning to disease in ways that medicine is unable to do. These influences are sometimes incomprehensible to physicians, but a better understanding of them will lead to more respect and trust between doctors and patients, which will lead to better care. Patients have expressed a clear desire for physicians who can at the very least acknowledge the importance of religion and spirituality in the health care environment. In order to understand what exactly needs to be done and how, it is helpful to put ourselves in the position of a group that is mistreated by the medical profession on the basis of their religious beliefs.

One such group is the Appalachian serpent handlers; exploring their stories will give insight into the complexity that lies between religion and medicine. The second chapter will explore this community in detail. In doing so, we will see the various ways in which individuals within the same community interact with the medical field in different ways. By exploring this belief system and society in depth, we can begin to see why believers can often find themselves at odds with the medical field. This case study clearly demonstrates the need for enhanced cross-cultural communication between the medical field and religious patients.

An understanding of religion is currently treated by the medical system as falling into the realm of cultural competency; that approach, however, has many shortfalls. Cultural competency, however well meaning, often becomes an exercise in generalizations and stereotypes by attempting to teach competence in a culture. Such a complex set of values and beliefs cannot be taught in a way that physicians can become proficient in their patient's culture and cultural experience. The third chapter will explore the changing approach of the cultural competency movement. Ultimately I will argue that this approach is not the best way to incorporate religion and culture into the doctor-patient relationship.

The concept of cultural humility will lead to better relationships between physicians and patients than can be achieved through cultural competency programs. When using cultural humility, doctors allow the patients to express their cultural values and the ways in which these affect their medical decisions. This approach requires the physician to acknowledge that the patient is the expert concerning their own experiences and cultural influences, such as religion. In the final chapter, I will detail how the approach of cultural humility will improve the doctor-patient relationship and argue that this model should replace that of cultural competency.

## Chapter 2: The Serpent Handling Community, Beliefs, and Traditions

In order to more clearly see the obstacles that religion can bring into the doctor-patient relationship, it is instructive to attempt to understand the viewpoint of the religious patient. The Appalachian serpent handlers are well placed to give insight on this interaction, given their marginalized religious views and general distaste for modern medicine. Exploring their unique perspective is not limiting; lessons learned from their experiences will be applicable to patients of many religious traditions. As Dr. Bill Leonard explains in his exploration of the beliefs, “serpent handlers open the door to multiple religio-medical issues, a collision of bioethics and sectarian spirituality that may well be larger than the serpent handling tradition itself” (Leonard, 2013, p. 123). In order to appreciate this collision, one must explore the distinctive beliefs of the serpent handlers, as well as their typical place in society, their beliefs concerning healing, and their experiences with the medical field. Following this, conclusions can be drawn as to how the religious patient’s experience of the health care system could be improved.

The serpent-handling sect is a fundamentalist Christian movement that has ties to the mainstream Presbyterian denomination. Their beliefs depart from those of mainstream Christianity in the interpretation of one passage: Mark chapter 6, verse 17 through 20. Here Jesus lists signs that His followers will be able to complete in His name: “And these signs shall follow them that believe; In my name shall they cast out devils; they shall speak with new tongues; They shall take up serpents; and if they drink any deadly thing, it shall not hurt them; they shall lay hands on the sick, and they shall recover. So then after the Lord had spoken unto them, He was received up into heaven, and sat on the right hand of God. And they went forth, and preached everywhere, the

Lord working with them, and confirming the word with signs following” (The Bible, NIV). Serpent handlers interpret the Bible literally; Dennis Covington explores the world of serpent handling as a journalist and quotes Brother Carl: “honey, the Word says what it means and it means what it says” (Covington, 1995, p. 15). These Christians, therefore, interpret this passage literally; they believe Jesus is discussing actually taking up serpents, actually drinking deadly things. Mainstream Christian denominations dismiss this passage as having been added to the Scriptures later and therefore doubt its validity or allow for a looser interpretation.

There are also differences in beliefs within the serpent handling community; Leonard discusses, for example, the opposing beliefs in a Triune God, Father, Son, and Holy Spirit, or Jesus as the only God. The uniting belief is in the signs listed in the final verses of the twentieth chapter of Mark. Serpent handlers call themselves as “Signs Following” believers, referring to these signs. They do not perform these signs as a test of faith or as a way to create their God, but rather to confirm the truth of the Word and to bring the gospel into the world: “As they see it, their serpent handling, poison-drinking pursuits point beyond themselves by ‘confirming the word’ of God for the entire Christian church” (Leonard, 2013, p. 124). Descriptions of these church services include not only the handling of serpents, sometimes a handful, but also impassioned dancing and shouting. This dramatic action serves for the serpent handlers to “authenticate the total trustworthiness of God’s word” (Leonard, 2013, p. 124). There is another important component to this action of handling serpents: the Holy Spirit.

Those who handle serpents will often speak of being under an anointing when they choose to pick up serpents. To be anointed is to have the Holy Spirit on you, which

affords a certain degree of protection for the handler. This anointing is similar to the act of speaking in tongues, which also is instigated by the visiting of the Holy Spirit on the believer. Speaking in tongues is one of the signs that serpent handlers confirm in their worship. Descriptions of being anointed are dramatic and striking: “it feels like oil dripping out of my fingers...it’s full of joy...I feel like I’m walking in another world” says Preacher Liston Pack, and Preacher Robert Grooms explains that “it’s tremendous...I just went plumb out in under the power. But I knew exactly what it was for. God was telling me to take up the serpent” (Leonard, 2013, p. 129-130). These powerful descriptions clearly show that serpent handlers believe in a God who is present and active in their lives and in themselves through the Holy Spirit, as is evidenced by handling serpents and the other signs of Mark 20:16-17. This presence of the Holy Spirit creates for serpent handlers a sacrament of serpent handling that “is alive and can kill you, and every time you gather for worship it is a matter of life and death, an experience of the real presence of Christ made known through the Holy Ghost and the victory over the serpent” (Leonard, 2013, p. 130).

In the case of handling serpents, there is some disagreement among handlers as to how much protection the Holy Spirit gives. Fred Brown and Jeanne McDonald spent time with three serpent handling families to learn about the communities and found that there is a consensus that one should “wait on the Lord,” wait to feel the presence of the Holy Spirit before handling a serpent (Brown and McDonald, 2007, p. 79). Some serpent handlers believe in a “perfect anointing” where the handler is unable to be bitten, but others have been bitten while they felt an anointing and disagree: “Just because the Spirit’s upon you don’t mean you’ll live” (Covington, 1996, p. 195). Others feel that the

anointing will protect the handler from pain, but only while they are anointed (Brown & McDonald, 2007, p. 102). Some describe it as a fragile and transient protection: “You might be anointed when you take up a serpent...but if there’s a witchcraft spirit in the church, it could zap your anointing and you’d be left cold turkey with a serpent in your hand and the spirit of God gone off of you. That’s when you’ll get bit” (Covington, 1996, p. 155). Most believers have indeed been bitten at least once if not repeatedly while handling serpents in church services. Regardless of the specific beliefs concerning the degree of protection of an anointing, serpent handlers all believe that it is an integral part of handling, and believers should wait on the Lord.

Another defining component of the beliefs of serpent handlers is their emphasis on heavenly things above earthly things. This belief is implicit in their statements and decisions concerning healthcare and the bodily dangers of handling serpents. John Brown is quoted by Brown and McDonald to clearly express this: “I’m not worried about *this* life. It is only temporal. *This* life, the Bible says, is a vapor that is here for a little while and then vanishes. And that’s a proven fact. It’s proven every day that we are not here eternally” (Brown & McDonald, 2007, p. 67). The emphasis on heaven is not unique to serpent handlers; mainstream Christians certainly accept the words of Jesus in John chapter 17 saying that His followers are not “of the world” (The Bible, NIV). But this does not necessarily lead to a disregard for bodily safety, which John Brown dismisses as “the flesh talking” (Brown & McDonald, 2007, p. 71). Serpent handlers express an eager desire to leave this world for the next; Brother Carl “talked about the body as ‘fleshy rags’ that he would gladly give up in exchange for a heavenly wardrobe” (Covington, 1996, p. 72). This viewpoint clearly influences the serpent handlers’

decisions regarding medical treatment. This lack of materialism is somewhat strange to our materialistic culture, but it is less surprising considering the place serpent handlers' have historically held within society as part of the impoverished lower class (Brown & McDonald, 2007, p.5).

The beliefs of serpent handlers may appear to contemporary eyes as very archaic, outdated traditions from times long past. But for those who believe in them, the practices serve not only as worship, but also as links to their past. Southern culture overall can be seen as more concerned with the past, for a variety of reasons; this is evident in the way traditions are emphasized. Covington explores this idea when introducing the surroundings of serpent handlers: "The South hasn't disappeared. If anything, it's become more Southern in a last-ditch effort to save itself" (Covington, 1995, xviii). He explores the conflict between the society developed from progress following World War II and the self-sufficiency of the communities in which serpent handling developed. Covington states that "they grew what they ate, bartered what they couldn't grow, and did without those conveniences they couldn't fashion out of the materials at hand" (1995, p. 23). As mainstream society developed and progressed, this way of life became increasingly unsustainable. The old-time religion then, serpent handling, becomes a way to live like one's parents and grandparents did. The serpent handling community to this day places great value on tradition and eschews modernity. They worship "like believers used to do in the old days, before the world with all its deceitfulness and vanities lured them down from the mountains and into the city" (Covington, 1996, p. 63). Their way of worshiping is reminiscent "of another era of oral tradition in American preaching" (Leonard, 2013, p. 128). Serpent handlers embrace tradition and reject the modern world,

in part because they feel out of place with the modern world, but also in order to protect their faith. Brother Byron expresses this sentiment bluntly: “We’re living in a modern time; you can take your modernism and go on to hell!” (Leonard, 2013, p. 129).

Historically, serpent handlers, as a group, value self-sufficiency and tradition. They were also poor; as Lucy Black Ownby told Brown and McDonald, “we lived like there was a depression all the time” (2007, p. 5). As the serpent handling tradition grew and developed, its practitioners were not wealthy people. This fact and the predilection to self-sufficiency make it unsurprising that serpent handlers turned away from mainstream medicine. Health care was simply something else that was out of their means, something they could do without. Physicians were also few and far between in the far reaches of the Appalachians. While faith healing does have a Biblical basis, it likely also arose from the inability to visit a physician and the desire to solve problems within the community. The serpent handling community became a sort of religious haven for those who felt that they did not fit into the larger outside world (Brown & McDonald, 2007, p. 4). As much as they separated themselves from the wider world through their beliefs, traditions and practices, serpent handlers still lived in the same communities with people who did not share their beliefs. Covington evocatively links this clash to the physical appearance of the towns in which he met members of the serpent handling community: “The hills have been shaved off, the trees splintered, the ground blasted and pulverized. It’s a kind of ugliness that can be achieved anywhere, I suppose, but it’s most easily found on the borders where cultures clash, in this instance where the Appalachian hill people have run smack up against contemporary America” (1996, p. 183).

The practice of faith healing is a fascinating component of the serpent handling sect. Serpent handlers are not forbidden by any part of their beliefs from utilizing modern healthcare; practitioners will repeatedly say that that is a decision to be made by the individual. Some people who belong to serpent handling churches do visit physicians. All believers accept that the Lord can and does intervene in their lives and the lives of their neighbors to provide healing and relief of suffering (Brown & McDonald, 2007, p. 153). In literature concerning serpent handlers, there is an abundance of stories and reports detailing these faith healings. The main themes remain similar. The believer has usually been suffering for a considerable amount of time and may or may not have tried modern medicine to no avail. The one suffering will either request prayers or the other believers will feel called to provide them. Hands are often laid on the person being prayed for. In her dissertation on serpent handlers, Mary Lee Daugherty quotes an evocative prayer a preacher named Joe offered up for a woman struggling with a smoking addiction: “Jesus! Heal the affliction in this body, Lord! Glory to God! You’ve got ta move against the powers of Satan, through the name of Jesus!...Thank God. How do ya like that? Obey the Lord, Sister. If ye die, I’ll help dig yer grave” (p. 47). Joe then continues, describing an injury to his leg that “hurt so bad I couldn’ hardly stand it...I come down here [to the church] ‘n’ got into the Spirit of the Lord ‘n’ didn’t seem ta have a pain” (Daugherty, p. 48). That is the defining theme of stories of healings: God can remove all pain and suffering, if He so chooses. This power is central to a strong and reliable deity: “I say this, children – a God that can’t heal, I’m not interested in. If He can’t heal me, He’s not worthy of me” (Daugherty, p. 45).

Serpent handlers do not believe that God must heal all calamities; indeed, this

belief is refuted daily in the continued suffering present on earth. But they do believe that God can relieve all suffering and is all-powerful. Serpent handlers continually express the belief that what God intends to happen is what will come to pass. One believer had an injured finger that some people were encouraging him to cut off; he left that up to God: “I ain’t going to cut it off. If God wants it to fall off, it’ll fall off” (Brown & McDonald, 2007, p. 154). Parents with a sick infant were dismissive of her breathing machine and eventually disconnected it: “That thing right there is not gonna save her if God wants to take her out of here” (Brown & McDonald, 2007, p. 184). Believers assert that regardless of the interventions of modern medicine, regardless of one’s personal actions, God will heal those He wants to heal and allow continued suffering in others. Prayer and worship are viewed as alternatives to visiting a physician, as John Brown explains in conversations with his sick father: “there would be times I’d ask him, I’d say, ‘Pa, if you are sick, aren’t you going to the doctor?’ He’d say, ‘Yeah, I’m going to *my* doctor,’” referring to church (Brown & McDonald, 2007, p. 58). The majority of serpent handlers do take their children to physicians, leaving the decision to refuse treatment for the children themselves to make at eighteen. The strong belief in God’s will extends to matters of the grave: “they all agree that when it is your time to go, God takes you home, no matter the form in which death arrives” (Brown & McDonald, 2007, p. 16).

Often in these communities, death arrives by way of a serpent bite. In these cases, parishioners are not forbidden from seeking medical care. However, there is a pervasive belief that doing so undermines one’s faith in God, which places significant pressure on believers to refuse medical treatment. Covington describes what occurred in one case: “[the serpent] turned on [Mrs. Craig] and bit her four times on the right forearm and

shoulder before it escaped. Asked later if she wanted a doctor, Mrs. Craig said, ‘Anything for ease.’ But someone in the congregation said she would lose her faith if she called a doctor, so Mrs. Craig rejected help, fell into a coma, and died four hours later” (Covington, 1996, p. 149). To the secular world, these actions seem incomprehensible or almost criminal. But within this belief system, Mrs. Craig made a sensible and correct choice. She died sure in her faith, trusting in God, and therefore left the earthly world for heaven. The majority of serpent handlers rely on faith and prayer following a snake bite rather than medicine, though it does remain a personal choice: “Anyone who participates in the serpent handling, we don’t tell them what to do, but we’d rather if they’re going to handle serpents and get bit, just to trust the Lord even if it takes them to the hillside to be buried” (Leonard, 2013, p. 135). Within this belief system, death is not the ultimate failure, to be avoided at almost any costs, as it is in the secular society. Death following a serpent bite is not viewed as a failure of faith or being abandoned by God; it is simply viewed as God’s plan. Seeking medical attention is often viewed as not trusting in God and His plan: “if you get bit, you trust God to deliver you” (Brown & McDonald, 2007, p. 219).

The decision to receive or refuse care, however, is further complicated by the serpent handlers’ familiarity with serpent bites. Most believers who handle serpents do get bitten, often many times. In many cases, the handlers survive these bites with minor long-term effects. Having been bitten often, they assume that another bite, while painful, will most likely not be deadly. Symptoms from snakebite also progress in such a way that by the time the person or their family realizes that this bite is different, it is too late for an antidote to do any good. While many believers do truly want no medical

treatment, some change their minds when they or their family members are in terrible pain from snakebite. But if this decision is made too late in the progression of the poisoning, nothing can be done. More will be said about this and a number of related issues, including decisions in the case of children, in the concluding chapter.

It is clear that the main reason serpent handlers do not often utilize the modern medical system lies in their belief structure, their trust in God and reliance on faith healing. However, when believers do seek medical care, they often feel isolated and looked down upon by the system. The fact that most doctors and other health care providers do not share serpent handlers' beliefs and many are against the beliefs affects the willingness of believers to interact with providers. A member named Gracie sought treatment from physicians for a heart condition and explained that other believers "hit [her] pretty hard...for that" because "a whole lot of them doctors are against serpent handling" (Covington, 1996, p. 181). When believers feel that the medical system not only does not share their beliefs but also is "against" them, they will naturally be unwilling to participate in the system. If believers cannot trust that their beliefs will be respected, they have good reason to avoid modern medical care and rely on the faith healing practices that have sustained them thus far. Linda Smith Coots describes an interaction with the medical system during which she felt that providers "treated us like dirt" upon discovering their religious beliefs (Brown & McDonald, 2007, p. 159). While this may not be true of every instance when serpent handlers seek care, enough believers "feel or experience the alienation of their commitments when they seek institutional-based health care" that they cannot trust they will be respected (Leonard, 2013, p. 135). This distrust can in no way serve as the basis for a functional doctor-patient relationship

and instead serves to drive serpent handlers farther away from the modern medical system.

For serpent handlers, the church and the accompanying culture inform their ideas of sickness and medical care. Their experience of the medical system will be interpreted through this religious lens. Darlene Summerford expresses this belief in her recollection of treatment following multiple serpent bites: “She is thinking about how nice it was to have her hand washed off like that. Her hand was mostly numb, but she could still feel it a little, a gentle anointing, both warm and cold, like something she’d receive in church” (Covington, 1996, p. 34-35). When believers do visit physicians, they experience the treatment as still coming from God: “the doctors gave me antibiotics, but the cure is all due to the Lord. I attribute that mostly to prayer” (Brown & McDonald, 2007, p. 314). This understanding is not something that is going to change or something that can be ignored by medical providers: “until the Spirit offers another revelation, medical communities will have to live the biological and ethical dilemmas raised by a people committed to ‘confirming the word with signs following’” (Leonard, 2013, p. 138). It is certainly not logical to suggest that the only solution is that serpent handlers receive medical care from professionals who share their beliefs. And it is not tenable to accept the situation as it is, with serpent handlers receiving substandard care when they do seek it simply because of their religious affiliation. So, healthcare providers are called to ask, with Dr. Leonard, “While medical practitioners have a right to their interpretations of serpent-handling practices, how are they to respond to individuals whose actions they dismiss? What techniques for responding to serpent handlers or practitioners in other isolated communities of faith might they employ?” (2013, p. 135). The healthcare system

today turns to the approach of cultural competency, which can still result in an isolation of the patient within the system. In order for serpent handlers and other similar communities to utilize and benefit from modern medicine, they must be made respected partners in their healthcare. By following the method of cultural humility, providers can respect and accept their patients regardless of their views on the patients' beliefs.

### Chapter 3: The Problems of Cultural Competence

This exploration of the serpent handling community leaves us with an understanding of religious culture that contrasts sharply with the scientific culture of medicine. Religious communities are based on faith, on believing what cannot be seen, while medicine requires proof and extensive data to support every aspect. Religion is rooted firmly in tradition; religious communities are necessarily focused largely on what has already happened in the past and on making those events relevant to today's world. Science, on the other hand, is necessarily striving to always understand more, to provide more through medicine than has been achieved before. These approaches to understanding and interacting with the world will provide different solutions to the same problems. When religious people enter the health care system as patients, these two dichotomous worldviews must be resolved into a treatment plan palatable to both patients and providers.

The process of developing this plan can, at times, be volatile. Patients may feel that their views are unappreciated or even mocked; providers may feel that patients are rejecting medical facts in favor of wishful thinking. The story of the North Carolinian minister with breast cancer, Sharon, that was explored in the first chapter also offers insight here. Sharon's physicians and nurses could not initially reconcile her desire to pray and discern God's will with the desperate and urgent facts of her medical condition (Matthews et al., 1994). This disconnect resulted in a poor quality of care for Sharon, left her feeling alienated from the medical community, and delayed her receiving life-saving care. This negative attitude towards religion can prevent religious patients from being open with their doctors and undermines the trust that underlies the doctor-patient

relationship.

Medical schools are certainly aware that religion is among the many influential factors that create a patient's culture. The approach of cultural competency has been developed in order to train physicians to be sensitive to and understanding of these cultural differences. In providing guidelines for how this concept should be taught, the American Association of Medical Colleges defined it in this way: "Cultural competence in health care combines the tenets of patient/family-centered care with an understanding of the social and cultural influences that affect the quality of medical services and treatment" (Cultural Competence Education for Medical Students, 2005). The AAMC argues strongly that this should not be a side note to medical education but is of great importance to providing high quality patient care: "With the ever-increasing diversity of the population of the United States and strong evidence of racial and ethnic disparities in health care, it is critically important that health care professionals are educated specifically to address issues of culture in an effective manner" (Cultural Competence Education for Medical Students, 2005). The guide has lofty goals for cultural competency, such as "eliminating racial and ethnic disparities" and contains a "Tool for Assessing Cultural Competence Training" (Cultural Competence Education for Medical Students, 2005). One domain included here urges students to provide "patient/family-centered versus physician-centered care" and the AAMC suggests that the future doctors should be trained to place "emphasis on patients'/families' healing traditions and beliefs" (Cultural Competence Education for Medical Students, 2005).

The University of Texas M.D. Anderson Cancer Center has published a guide that is representative of many cultural competency guidelines (Surbone & Baile, 2011). The

“Pocket Guide of Culturally Competent Communication” states that “cultural competence promotes patient-centered care through sensitive negotiation of therapeutic goals” (Surbone & Baile, 2011). The guide gives several “Pearls of Wisdom” such as “sensitivity to cultural issues enhances trust between patients and doctors” and the suggestion that doctors should “learn about the cultural groups most frequently treated at [their] institution” (Surbone & Baile, 2011). Overall, the message of this guide is that by “respecting cultural diversity” and “[opening their minds] to different ways to promote health and cope with illness” physicians will be able to “avoid...misunderstanding and/or bedside ethical conflicts” (Surbone & Baile, 2011).

Cultural competency goals and curriculum such as those described above are certainly well-meaning, but they can quickly devolve into the pigeon-holing of patients into broad cultural stereotypes. As presented by the AAMC, cultural competence also does nothing to truly give patients and their families decision making power. Rather than suggesting that medical students be taught to incorporate the patient’s beliefs into treatment plan, they suggest that students use their knowledge of the patient’s culture to “enhance patient adherence” to the care plan that physicians develop independently from patients (Cultural Competence Education for Medical Students, 2005). While medical providers certainly do have more expertise than patients in terms of medical treatment, simply using cultural understanding to “enhance patient adherence” limits the provider’s potential connection with the patient. The MD Anderson guide explicitly states that “cultural competence is a set of attitudes, skills and knowledge that can be acquired” (Surbone & Baile, 2011). The idea that shifting and diverse cultures, the members of which do not all share identical beliefs or experiences, as something a physician can

master is almost ludicrous. This vision of cultural competency, while well intentioned, gives the impression that physicians can reach an end point at which they have become culturally competent. When a physician imagines that they are culturally competent, they will have the mistaken impression that they are experts in their patients' culture. This leads to providers interpreting their patient's symptoms and requests through a stereotyped view of what they believe the patient's culture to be. In a 1998 article, Tervalon explains just such a scenario: a physician was in the surgery recovery wing and "noting [a] 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 overexpress 'the pain they are feeling'" (Tervalon, 1998, p. 119). The physician happened to be Hispanic and struggled to convey to her where she had gone wrong. When providers are trained in cultural competency, they will not strive to learn from each individual patient, they will simply apply their prior knowledge of the patient's culture, which will likely amount to a broad generalization of a complex culture.

As with everything else in medicine, practitioners demand empirical evidence to show whether or not cultural competency programs improve patient care. Saha et al. published an article in 2013, which they argued that providers with "high cultural competency" would have better outcomes for minority patients with HIV. The study was based on the fact that minority patients with HIV are less likely to receive antiretrovirals (ARV) than are white patients. The authors suggested that this effect is especially marked when minority patients are cared for by a physician of different ethnicity than themselves. The authors argued that cultural competency skills could bridge this gap by

strengthening providers' relationships with minority patients. Saha et al ultimately argued that their findings showed clearly that high cultural competency scores reduced racial disparities in treatment: "higher scores on our measure among [primary care providers] in HIV care settings were associated with more equitable care and outcomes across racial/ethnic groups... These findings provide empirical support for the assertion that greater provider [cultural competency] may reduce racial/ethnic disparities in health care quality and outcomes" (p. 624, 2013). An editorial written by Malat and published concurrently with the Saha study, however, calls these results into question.

In her critique of Saha's work, Malat argues that he only shows efficacy of a very few types of cultural competency programs: those that carefully guard against generalizations and the provider's own cultural bias. Most cultural competency approaches, unfortunately, do not do this. Malat argues, therefore, that "we importantly learn [from Saha's work] that providers who report more consideration of patients' social context, and who recognize ... their culture, have minority race patients with better outcomes" (p. 607, 2013). By showcasing programs that do manage to avoid generalizations, Saha's study shows the potential in cross-cultural communication to improve the doctor-patient relationship. However, the work cannot be applied to cultural competency programs in general, only to those able to avoid generalizations and account for provider's own bias. Malat also discusses how challenging this is for cultural competency programs to accomplish. She gives many examples of training sessions and workshops she attended in which instructors have a hard time avoiding stereotypes in practice. Students and physicians are told not to generalize, told to approach and respect each patient as an individual, but this advice is hard to heed when cultures are taught as

lists of common traits and behaviors: “the oft-repeated warning that not all patients will conform to these traits may do little to challenge taken-for-granted assumptions” (Malat, p. 606, 2013).

In a 2011 discussion of the changes within the cultural competency approach, Jenks identifies similar problems and challenges. She eloquently restates the main issue that almost all critical researchers point to: the tendency to generalize and “[identify] an essentialized, static notion of culture that is conflated with racial and ethnic categories and seen to exist primarily among exotic ‘Others.’ With this approach, culture can become a ‘list of traits’ associated with various racial and ethnic groups that must be mastered by health providers and applied to patients as necessary” (Jenks, p. 209, 2011). Many medical professionals and educators are aware of this issue and the movement overall has shifted to the idea of open-mindedness: that providers should recognize the individuality of patient’s experiences and beliefs, even within the same culture. This approach is certainly an improvement, but it is rather vague and leaves practitioners without clear instruction. Jenks experienced the disconnect between theory and practice firsthand: “In all of the training sessions...I attended, facilitators and educators made a conscious effort to emphasize that culture cannot be thought of as a bounded object or uniform list of traits and that providers must be careful not to make assumptions about how their patients will think or behave. But in practice, it was often very difficult to discuss culture without reinforcing these ideas” (p. 217, 2011).

Jenks also raises a further issue with cultural competence: the failure of cultural competency training to address the culture of providers, the culture of medicine itself. By ignoring this fact and acting as if providers are coming from a place of normality, a

viewpoint that contains no biases or assumptions, cultural competency can become an exercise in marking patients as different. Jenks argues that “many cultural competence efforts reinforce the assumption that...culture matters most in cases where patients are most different from an unmarked ‘mainstream’” (p. 223, 2011). Cultural competency efforts also do not require the provider to examine their own viewpoint. They are taught and applied as though healthcare providers and the healthcare system as a whole have no culture or biases of their own. This oversight prevents physicians from recognizing ways in which their culture or the culture of medicine could be adversely affecting the patient. Overall, Jenks argues that cultural competence programs must find some way to instruct providers to “recognize that differences exist, welcome more knowledge about these differences, and seek to treat each patient as an individual” without stereotyping that patient or casting them as the abnormal “other” (p. 229, 2011). Focusing cultural competency on open-mindedness is a step in the right direction, but does not solve all of these problems.

It is helpful to pause in an academic discussion of cultural competency and consider how the approach affects actual patients themselves. Returning to our case study from the previous chapter, we can consider how cultural competency would help or hinder a serpent handling patient. Healthcare providers in the areas where serpent handlers are prominent are certainly familiar with their beliefs, at least in general terms. If the serpent handling culture were covered in a cultural competency seminar, the fact that many believers avoid modern medicine would certainly make the list of facts to know. Providers would likely also be told that believers can be fanatical, given that they are unwilling to compromise Biblical beliefs. A physician walking into his or her exam

room knowing that the patient was a serpent handler would likely have negative preconceived ideas about what sort of patient he or she would encounter. These ideas would affect the physician's behavior towards the patient and could affect the treatment options they offer, limiting them to minor interventions, for example, because they believe that is all the patient would accept.

The exploration of this culture in the second chapter helps illuminate how this approach does a disservice to the patient. Serpent handlers do not all hold identical beliefs, especially concerning modern medicine. Some practitioners do avoid all types of modern healthcare. Some, however, are willing to accept most aspects and see God at work through medicine. In terms of children, almost all serpent handlers accept modern medicine. By generalizing about this culture and assuming that they are the experts, physicians would undermine their relationship with serpent handlers. These patients would almost certainly end up receiving substandard care as a result. Not only are many researchers critical of the cultural competency movement, but it also does not help physicians to interact with patients from religious minorities, such as serpent handlers.

Kleinman and Benson address these and further problems in their 2006 article "Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix it." They raise many of the same problems other researchers do: cultural competency leads to the stereotyping of patients and is problematic in many cases. But their main problem is more basic than that: they take issue with the central approach of cultural competency. Physicians are trained to believe that cultural competency will make them experts in a patient's culture and, as anthropologists, the authors cannot accept this or the suggestion that culture can be reduced to a list of memorable traits. They suggest that cultural

competency be viewed as an exercise in ethnography, which, in anthropology, refers to a “description of what life is like in a ‘local world,’ a specific setting in society” (Kleinman & Benson, 2006, p. 1674). With this viewpoint, physicians would be directed to take into account the patient’s perspective and preferences, not merely their generalized cultural views. This approach would encourage doctors to communicate and connect with patients on an individual basis. In the case of serpent handlers, instead of the physician feeling that they know the culture and know what the patient will believe, they would explore specific issues with individual patients to learn what the patient’s actually believed and preferred. The authors suggest that, in order to provide optimal care to their patients, doctors should simply empathize with them: “the clinician ... can empathize with the lived experience of the patient’s illness, and try to understand the illness as the patient understands, feels, perceives, and responds to it” (Kleinman & Benson, 2006, p. 1674). These modifications would certainly improve cultural competency and lead to better communication and relationship between doctors and patients. However, with all these modifications, the approach could hardly be called cultural competency any longer. Kleinman’s suggestions lead us to cultural humility which, I will argue in the final chapter, offers a much better alternative for incorporating patient’s cultural beliefs into their medical care.

Healthcare professionals agree that a patient’s culture is important to their medical care. Currently, the medical system attempts to help physicians and other healthcare providers to understand and incorporate cultural beliefs through cultural competency. This approach tries to teach the main beliefs and values that each culture holds. Often, cultural competency results in the stereotyping of patients based on their

assumed beliefs and alienates them by focusing on their differences. The example of serpent handlers illustrates further the problems that can arise. As Kleinman suggests, the healthcare field must find a way to “set [doctor’s] expert knowledge alongside (not over and above) the patient’s own explanation and viewpoint” (2006, p. 1674).

#### Chapter 4: The Promise of Cultural Humility

It is clear that the medical profession needs a way to compassionately and efficiently communicate with patients who will base all or part of their medical decision-making on religious beliefs. In the previous chapter, the model of cultural competency was explained and the various problems that have plagued its practical application were detailed. Linda Hunt eloquently pinpoints the basis of the problems: “culture is neither a blueprint nor an identity...it is not possible to predict the beliefs and behaviors of individuals based on their race, ethnicity, or national origin” (2001, p. 134). She further argues that cultural competency “may also reinforce the belief that culture can be diagnosed and treated, that exotic or unfamiliar beliefs and behaviors of members of already disempowered subgroups should be controlled and adjusted to resemble norms of the dominant group” (Hunt, 2001, p. 135). In this chapter, we move to a discussion of cultural humility, an alternative that does not attempt to predict beliefs based on ethnicity or to convince members of minority groups to alter their views to those of the dominant medical culture, but leads simply to better understanding between doctor and patient through communication.

Cultural humility shifts attention away from providers learning details of various cultures and instead to providers being trained to recognize their own culture and to develop awareness and respect for diverse patient views. As Hunt explains, “the provider is encouraged to develop a respectful partnership with each patient through patient-focused interviewing, exploring similarities and differences between his own and each patient’s priorities, goals, and capacities” (2001, p.135). Practically, this model asks physicians to do one basic thing: set aside their expertise when it comes to cultural

aspects of disease. Physicians should allow patients to lead this discussion and allow themselves to be taught by each patient what cultural values are important to them. In a 1998 article, Tervalon expresses one of the main bases of cultural humility: “humility is a prerequisite in this process, as the physician relinquishes the role of *expert* to the patient, becoming the *student* of the patient with a conviction and explicit expression of the patient’s potential to be a capable and full partner in the therapeutic alliance” (p. 121). Some patients certainly will have few or no cultural biases that affect their treatment or will prefer to be largely left out of the decision-making process. However, for many patients that have traditionally have been left behind by the medical field —minorities, the impoverished, anyone different — this approach could reconcile them to the field of modern medicine.

Explorations of the model of cultural humility uncover three main components. Cultural humility is based on correcting power imbalances, incorporating the patient’s perspective, and forcing self-reflection by providers. These elements work together to make the patient a part of the decision-making process, rather than a bystander about whom decisions are made. Through these components, providers are able to avoid the issues of stereotyping and focusing on the patient as the “other” that have plagued cultural competency. By allowing the patient to guide discussion of cultural values and to help incorporate those values into the treatment plan, physicians show that they respect those values and are able to respect the individual patient’s beliefs, not a stereotyped version of the culture as a whole.

Tervalon emphasizes the importance of recognizing the power imbalance that exists in doctor-patient relationships: “awakening trainees to the incredible position of power

physicians potentially hold over all patients, particularly the poor, is critical. Especially in the context of race, ethnicity, class, linguistic capability, and sexual orientation, physicians must be taught to repeatedly identify and remedy the inappropriate exploitation of this power imbalance” (1998, p. 120). Physicians can forget the great power they hold over patients, especially those who are largely powerless in society. This power imbalance inherently exists in the doctor-patient relationship, in part simply because of the strong history of paternalism in our medical system. Even without vestiges of paternalism, patients are inherently the weaker party. They are sick, first of all, in some way in body or mind, they are hurting or lacking. They also have deficits of knowledge as compared to physicians. Necessarily, physicians are the medical experts; they glean information from the patient and synthesize a diagnosis in seemingly mysterious ways that imply they know more about the patient than the patient themselves. Combined, all of these factors create a relationship in which the patient can feel largely dependent upon and inferior to the physician.

Cultural humility is able to somewhat reconcile this glaring imbalance. While physicians clearly remain the medical experts, patients assume the role of expert in terms of their culture and their life experience. Physicians can then incorporate the knowledge patients share into their treatment program, making patients equal partners in their own care. Practically, this can be accomplished by adjusting the way in which physicians conduct the patient interview. Cultural humility asks simply that the patient interview focuses on the patient: “patient-focused interviewing uses a less controlling, less authoritative style that signals to the patient that the practitioner values what the patient’s agenda and perspectives are, both biomedical and nonbiomedical” (Tervalon, 1998, p.

120). Through this approach, physicians send a clear signal to patients that their knowledge, their culture, and their experience of their disease is important and valued by the physician.

Relatedly, cultural humility focuses on incorporating the perspective of the patient and not considering them as the “other.” Rather than seeking to understand the basics of a culture in order to make it fit with medicine, the cultural humility model seeks to identify “the presence and importance of differences between [the provider’s] orientation and that of each patient, and to explore compromises that would be acceptable to both” (Tervalon, 1998, p. 136). By focusing on bridging the gap between the provider’s culture and that of the patient rather than simply changing the views of the patient, cultural humility encourages the medical community to respect and incorporate diverse beliefs and cultures. In a 2008 exploration of cultural humility in Rhode Island, Borkan identifies one major difference that fundamentally exists between providers and patients: “biomedicine tends to focus on the pathological processes of disease. Patients, in contrast, often focus on the psychological experience of illness” (p. 361). By acknowledging the power imbalance and exploring the specific ways it is manifested by individual patients, providers are better able to address patients’ concerns.

In practice, physicians can address these concerns through the same approach needed to correct a power imbalance: patient focused interviewing. Borkan explains that in order to understand and respect a patient’s illness experience, providers need to be skilled in “eliciting and listening to patients’ and family members’ stories of their illness experiences, which includes the events, their models and beliefs about causation, their feelings about their disease, their quest for therapy, and their reactions to biomedical

recommendations” (2008, p. 362). When physicians are able to allow patients to guide discussions concerning their symptoms and treatment options, physicians will learn what matters to the patient. From there, the provider and patient together can develop a treatment plan that solves the medical issues and incorporates the patient’s cultural preferences. When patients are treated in this respectful way, trust in the physician will increase and the doctor-patient relationship will be improved. Borkan argues that “culturally appropriate communication that respects the individual’s beliefs, practices, and background, yet allows the health care practitioner to make precise diagnoses” is integral to medical practice (2008, p. 364).

The final main component of the model of cultural humility is self-reflection on the part of the medical provider. When physicians recognize and acknowledge their own cultural biases, they are better able to recognize that the patient’s cultural biases are valid. They are also able to realize that medicine has a culture itself and that this cannot be ignored. As Tervalon explains, cultural humility asks “trainees to identify and examine their own patterns of unintentional and intentional racism, classism, and homophobia” in order that they can correct these biases (1998, p. 120). Physicians need not only be aware of their own personal cultural viewpoints, but they must also acknowledge that the medical field itself has a culture. If this is ignored, the medical system and recommended interventions are treated as the norm and the inarguably correct approach. In truth, “modern biomedicine is influenced by historical, social, economic, political, religious, and scientific events. It has its own language, vocabulary, and concepts. It also has its own values” (Borkan, 2008, p. 363). In short, the medical field itself has cultural biases. Physicians must be trained to recognize this so that when these biases conflict with those

of a patient, doctors are able to recognize what can be compromised upon and what is medically necessary.

When physicians follow the cultural humility model, patient interviews are refocused in order to give priority to patient values. In this way, power imbalances between patient and physician are corrected, patients are not treated as the “other,” and physicians are able to acknowledge the cultural biases of modern medicine. Cultural humility allows physicians to respect and incorporate a patient’s cultural preferences without resorting to stereotyping and generalizations. This model is applicable in many different scenarios. The serpent handling case study presented in chapter two is certainly an example. Serpent handling patients would greatly benefit from physicians who allow them to express their religious views and the ways in which these views influence their medical decisions. When patients express their views, they are able to help physicians to understand the nuances that are not readily explained in the bullet point approach of cultural competency. While the concern may arise that this approach is simply something else to add to our overburdened physicians’ to-do lists, that criticism would be unfair. Cultural humility simply asks providers to adjust their mindset during patient interviews and address the patient’s cultural and religious background with respect. The medical system should not develop physicians who consider themselves too busy to treat patients with respect.

Cultural humility also assists physicians who are practicing in populations that have little or no exposure to modern medicine. Fahey et al. explain their implementation of cultural humility in Northern Guatemala in a 2013 article in [The Journal of Perinatal and Neonatal Nursing](#). The study focused on obstetrics and neonatal emergencies among

indigenous patients in rural areas. Given that these patients typically chose traditional birth methods, which had a higher mortality rate, and the incoming providers were Western doctors and nurses, “Guatemalan health authorities [had] requested that the training include training on cultural humility” (Fahey et al., 2013, p. 36). The alternative to traditional birth assistants, or comadrona, is government constructed community clinics, or CAPs. Expectant mothers avoided these clinics largely because they perceived the clinics as offering a lower quality of care: the clinics lacked traditional elements that these mothers felt necessary to a good birth. To address these cultural needs, the incoming providers “were asked to include elements in the training aimed at improving the cultural fluency of the providers at the CAPs” (Fahey et al., 2013, p. 37).

The developers of the training method, known as PRONTO, emphasize the importance of culture and cultural values during labor and birth. The focus should be placed not on the provider, but on the patient: “placing the patient at the center of each care interaction is a key strategy for improving the quality and safety of care” (Fahey et al., 2013, p. 38). Trainers had to find a way for foreign providers to gain the trust of a population already distanced from medicine and to whom “intercultural care can be a particularly sensitive topic” (Fahey et al., 2013, p. 38). Six training objectives were developed to lead providers to understanding and improved communication with the patients. Three of these objectives express the main facets of cultural humility. Providers are asked to “minimize focus on acquisition of discrete knowledge/facts regarding indigenous cultures but rather focus on changing the approach a provider takes to the entire healthcare encounter”; “focus on the idea that only the individual woman knows what components of cultural background and context are relevant and important to the

healthcare encounter”; and to “introduce and practice patient-focused interviewing” (Fahey et al., 2013, p. 39). This training model defines cultural humility as “the process of integrating the patient’s belief system into the healthcare encounter by allowing the patient to inform the providers about their culture and how their culture may impact the healthcare encounter” (Fahey et al., 2013, p. 39). When providers were trained to understand and incorporate cultural values, patients were more comfortable with the modern medical system. In situations in which cultural factors are essential to patients receiving appropriate and adequate care, cultural humility helps providers to understand their patients’ needs and to fulfill them.

Cultural humility has the potential to revolutionize the modern medical system for many people, especially those who are seen as different and outside societal norms. Cultural humility can clearly be applied to the serpent handlers’ case study from the second chapter. Providers who allow patients who practice serpent handling to explain their own views and values will gain a much deeper understanding of their patient’s perspective. The physician would be better able to understand the decision to reject some kinds of medicine. While this decision likely would still not be entirely accepted by the physicians, a better understanding would allow them to offer alternatives that may be accepted. Basing the doctor-patient relationship in this kind of understanding and trust would likely lead a serpent handling patient to return to the physician in the future if they needed further care. Knowing that the physician had knowledge of and respect for their religious views would allow patients to be more open with providers and would lead to better care. This approach would have similar benefits in the case of Sharon the minister, which was discussed in the first chapter. Sharon was diagnosed with breast cancer and

wanted to pray before receiving treatment. Her physicians had a strong negative reaction and her lifesaving care was delayed. Physicians who understood her religious perspective would have been able to incorporate this initially instead of delaying her care.

Cultural humility also allows physicians to incorporate families into patient care. Family is often central to a patient's life; family members are often almost as directly affected by an illness or injury as the patient themselves. While the patient's wishes will certainly always take precedence, it is important for family members to be considered by providers. Cultural humility will help doctors to become more aware of the concerns and experiences of the family. Their communication and actions can then be altered to address those concerns, which would result in better care for the patient and better peace of mind for the family. Especially in a scenario where the patient is unable to speak for his or herself, utilizing cultural humility techniques would allow physicians to better understand the cultural experiences of the patient and the family. As cultural humility increases trust between patient and provider, it would also increase trust between family and provider.

Cultural humility allows for options for providers and patients to work together. Through rhetoric, doctors can build trust with their patients and develop a relationship that works for the good of the patient. The provider, while still advocating a medically correct course of treatment, can use the patient's own language and hermeneutics, or interpretation of the world, to better communicate with the patient. In the case of the serpent handlers, a physician able to use religious language and understand the patient's framework of theology could present medical interventions in a way that the patient could accept. Without talking them out of their religion, doctors could talk patients into a

medically necessary treatment.

Another option for providers, in the case of serpent handlers, would be a public health initiative based on cultural humility. As discussed in the second chapter, if serpent handlers do decide that they want treatment for a snake bite, the decision often comes too late for the antidote to do any good. By focusing on cultural humility and presenting the information within the serpent handlers' theological frame of reference, doctors could provide education about the different stages of snakebite and when medical help should be called for, if it is desired. Through skilled rhetoric, believers could be persuaded that medical treatment can be had within their frame of belief and could be educated about when that treatment would be necessary. Pediatric care is another case where physicians could act as mediators with the serpent handling community. Because most children are brought to the doctor in these communities, pediatrics offers a chance for doctors to communicate to the parents that they are respected within the medical community. Parents would then be more likely to bring their children back for more treatment or to visit a physician themselves. Cultural humility can only go so far, however, when parents make the decision to refuse treatment for their children on religious grounds. Doctors are often compelled by law to provide certain treatment to children, and this can certainly not be overridden. But cultural humility can help in terms of building trust with the serpent handling community.

As the United States, the South in particular, becomes more religiously diverse, the utilization of cultural humility will become increasingly important. United States census data shows this change clearly: in 1990, 527,000 adults self-reported as Muslim. In 2008, that number had jumped to 1,349,000. Similar increases are seen for Buddhist, Hindu,

and Sikh populations (US Census Bureau, 2012). As we have seen, cultural humility is important even for patients who practice religions that are common in the United States, such as evangelical Christianity. This approach will be even more valuable to those patients whose religions are unfamiliar to their physicians. In a 2007 article, Laird et al. detail the stereotypical ways in which Muslims are discussed in medical literature. A major theme of the articles they explored is that “to be Muslim is to be in particular need of biomedical intervention” and “that being Muslim may obstruct the pursuit of available biomedical resources and worsen the health of the faithful”(p. 2430-1). For a patient whose very way of life is viewed by the medical system as pathological, the chance to express and define their own cultural values to their healthcare provider would be invaluable.

Cultural humility is clearly far superior to cultural competency in terms of establishing trust, empowering patients, and improving the doctor-patient relationship. Importantly, the approach of cultural humility closely matches the approach patients describe. When Hebert et al. interviewed patients on spirituality and the doctor-patient relationship, they placed importance on the same things that cultural humility prioritizes. They expressed a desire for physicians who were “more sensitive to patients’ spiritual needs” (2001, p. 685). It was clear that patients appreciated doctors who were able to show respect for their religious views: “physicians who, through their actions and words, respected patients’ individuality and fostered an environment based on mutual respect and interest were most likely to generate comfort and confidence” (Hebert et al., 2001, p. 688). When patients were given the opportunity to describe how this respect would arise practically, they emphasized what cultural humility suggests: a patient-led discussion of

cultural and religious values. Participants acknowledged that not all patients would have the same needs and understood the value of patients leading the discussion: “participants reported that all barriers to [spiritual] discussion could easily be overcome if physicians allowed spirituality-oriented discussions to evolve from psychosocial inquiry” (Hebert et al., 2001, p. 689). These patients were not asking that physicians also fulfill the role of spiritual advisor, but simply that “physicians respectfully explore religiosity/spirituality with those patients who desire it,” which would lead to “a deepening of the therapeutic alliance” (Hebert et al., 2001, p. 691). It is certainly telling of the efficacy of cultural humility that when patients are asked to describe the way in which they believe physicians should approach cultural and spiritual issues, this is the model they arrive at.

Cultural competency exists in a stark contrast to these values. Patients ask physicians to explore religion through open-ended questioning; cultural competence teaches laundry lists of beliefs. Patients ask physicians to remain respectful and understanding of beliefs; cultural competence implicitly teaches that the most complex aspects of patients can be intellectually mastered. The name of cultural competence itself is misleading of where the movement has ended up. To be “competent” is to be masterful. The word conveys expertise and knowledge. Any patient would be happy to be in the care of a competent physician. In this case, however, cultural competence has become its own opposite: incompetence. It has come to embody many of the flaws that patients perceive in the medical system. Cultural competency creates physicians trained to believe that they know better than patients and results in physicians that are incompetent in caring for the whole person.

In a 2013 article in The New England Journal of Medicine, Arthur Kleinman

explores the importance of patient experience to the provider's caregiving ability. He focuses on his wife's experience of Alzheimer's and what this showed him about the difference in priority for the provider and patient: "we recognized that what mattered most to clinicians — in emotional and moral, not just cognitive, terms — was not necessarily the same as what mattered to us. Those contrasting stakes came to define our journey and that of the clinicians we encountered" (Kleinman, 2013, p. 1377). Kleinman explains that "it was a messy mix of emotions, values, and relationships" at play for himself and his wife and this influenced their experience of her illness (2013, p. 1377). He places the burden on doctors to "bridge this divide" in order that "our difficult journey would have been eased" (Kleinman, 2013, p. 1377). Kleinman identifies the missing piece as basic caregiving; he stresses that "the moral-emotional core of [illness] experiences deserves greater primacy — as does the social suffering that affects everyone, but especially marginalized people already injured by poverty, isolation, and other forms of structural violence" (2013, p. 1377). He is asking physicians to find a way to connect with and understand a patient's illness experiences and cultural values in order to provide better care and ease the difficult journey of illness. Cultural humility is the solution Kleinman is searching for.

By allowing the patient to express what is important to them in their experience of illness, doctors will be able to address those concerns. Kleinman argues that "modern medical practice's greatest challenge may be finding a way to keep caregiving central to health care" (2013, p. 1377). Cultural humility allows physicians to do this. Cultural humility allows physicians to return to the basic elements of caregiving that Kleinman and many others find missing from modern medical care. By allowing

patients to express and define their own cultural experiences and values, physicians will be able to return “to such enduring moral practices of caring as ... the expression of kindness, the enactment of decency, and the commitment to presence — being there for those who need them” (Kleinman, 2013, p. 1377). In other words, cultural humility will return medicine to what it should be: taking care of those in need. As Kleinman states, “ultimately, caregiving is about doing good for others, and doing good in the world, as naive as it may sound, is what medicine is really about” (2013, p. 1377). By adopting cultural humility, physicians can refocus modern medicine on truly doing good for others.

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### EDUCATIONAL BACKGROUND

Master of Arts, Bioethics

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### ACADEMIC MEMBERSHIPS

Alpha Epsilon Delta

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### SCHOLARLY WORK

Synapse conference: poster presentation, 2012

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### ACADEMIC AWARDS AND HONORS

Wake Forest University: Dean's List: 2009, 2011

William K Stamey scholarship, George F Hankins scholarship: 2008-2012

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Peoples Bank: On-call Teller, 2012-present

Benson University Center: Student Manager, 2010-2012