

ETHICS CASE

Cultivating Humility and Diagnostic Openness in Clinical Judgment

Commentary by John R. Stone, MD, PhD

Abstract

In this case, a physician rejects a patient's concerns that tainted water is harming the patient and her community. Stereotypes and biases regarding socioeconomic class and race/ethnicity, constraining diagnostic frameworks, and fixed first impressions could skew the physician's judgment. This paper narratively illustrates how cultivating humility could help the physician truly hear the patient's suggestions. The discussion builds on the multifaceted concept of cultural humility as a lifelong journey that addresses not only stereotypes and biases but also power inequalities and community inequities. Insurgent multiculturalism is a complementary concept. Through epistemic humility—which includes both intellectual and emotional components—and admitting uncertainty, physicians can enhance patients' and families' epistemic authority and health agency.

Case

Dr. K, a resident physician, informs medical student Mary that Mrs. J has returned yet again this week with a persistent rash. Mary is in the third week of a family medicine rotation. Dr. K briefs Mary before they see Mrs. J. "I already told Mrs. J that it is highly unlikely that water contamination is causing her rash. She denies associated symptoms such as headache, fever, or chills. Physical examination shows no signs of malignant or infectious disease processes such as lymphadenopathy [swollen lymph nodes], hepatosplenomegaly [enlarged liver and spleen], nuchal rigidity [neck stiffness], or neurological dysfunction. Additionally, her complete blood count with differential and chemistry panel from her annual visit were within normal limits. I know she denies any exposure to food allergens, new soaps, or lotions, but it must be something like that. It just doesn't make sense that it's from her water."

Mary and Dr. K enter the patient's room. Mrs. J immediately reports that her rash remains. Also, she and neighbors notice reddish tap water. Mrs. J states that her son and neighbors developed similar rashes soon after noticing the reddish water and think the water is responsible. Although Dr. K nods his head, he repeats that her water is an unlikely cause.

Mrs. J replies, “Dr. K, you don’t seem to understand. We know it’s the water. Why can’t you believe our city’s water is harming and poisoning us? You don’t know what’s in my water. You go home to the suburbs with clean water and don’t have to worry about what’s in it. You don’t know our city and what our pipes produce. Our water’s hurting us. What will it take for you to see that?”

Commentary

Dr. K discredits Mrs. J’s suggestion that tainted water is responsible for her rash, but he lacks a clear diagnosis or cause for her condition. Mrs. J says Dr. K excludes tainted water as the cause because he’s ignorant about Mrs. J’s community; rather, he lives in “suburbs with clean water.” Mrs. J asserts that Dr. K is deaf and blind to her concerns.

Is Dr. K prematurely excluding diagnostic possibilities? Lacking a specific diagnosis, why categorically reject her assertion about water if a water contaminant is a possible cause? Dr. K fails to offer plausible reasons. Mrs. J’s comments about the suburbs could mean that socioeconomic class and cultural, racial, or ethnic biases are skewing Dr. K’s professional judgment. Or perhaps Mrs. J thinks Dr. K isn’t invested in assessing the water problem simply because he lives elsewhere. What might indeed influence Dr. K’s judgment? What would help him better respond?

Employing a fictional narrative, the following remarks explain how cultivating humility and related virtues could help Dr. K (and physicians generally) more constructively respond to patients like Mrs. J. But first consider every clinician’s challenge to remain open to diagnostic alternatives.

Premature Diagnostic Closure and Epistemic Humility

News reports reveal continued problems from lead-contaminated water in Flint, Michigan [1]. Our heightened public health awareness suggests Mrs. J could be correct. Thus, we should worry that Dr. K is making an egregious diagnostic error with potentially terrible outcomes for Mrs. J and her community. Perhaps he is committing “premature closure: the tendency to stop considering other possibilities after reaching a diagnosis” [2].

Of course, even the best clinicians can make diagnostic errors despite adhering to best evidence-based practice. One reason is that diverse diseases can present with similar symptoms and signs. Since mistaken diagnoses and related treatment can allow preventable suffering or avoidable death, clinicians should repeatedly consider alternative diagnoses, especially when a problem continues. What helps? A key strategy is for clinicians to cultivate the epistemic humility to accept that their conclusions are always fallible [3]: that what they think they know could be incorrect.

Suppose Dr. K is guilty of premature closure and that humility is an important preventive. The next section shows how humility involves much more than a disposition to appreciate diagnostic fallibility.

Cultural Humility, Insurgent Multiculturalism, and Diagnostic Frameworks

Cultural humility: basics. After the above visit with Mrs. J, suppose Dr. K attended a retreat on “cultural humility” that drew on Melanie Tervalon and Jann Murray-García’s seminal account [4]. The authors’ 1998 essay railed against the idea that competency as an endpoint—a set of skills and knowledge—captured what health professionals need to provide satisfactory cross-cultural care for diverse populations. Quite the contrary, they argued that continuous learning about cultures is necessary to provide everyone quality, respectful, and equitable health care. Cultural variations are too complex for concrete endpoints. Consider differences related to race, ethnicity, national origin, sexual orientation, gender, gender identity, and socioeconomic classes. Thus nothing but a persistent [educational journey](#) will suffice for excellent health care for all. Tervalon and Murray-García explained that such education requires: (1) continual self-reflection based in humility, (2) addressing attitudinal barriers and ingrained stereotypes or biases, (3) recognizing and correcting power differentials, and (4) advocating for communities with disadvantages. And clinicians should continuously pursue growth in addressing these issues.

Conceptual barriers to cultural humility. After presentations and discussions, suppose retreat participants wrote self-reflections with self-critiques, as described by Tervalon and Murray-García [4]. Privately journaling about his attitudes, Dr. K worried that unconscious stereotypes and biases affected his clinical judgment, as reported in the literature [5]. Perhaps Mrs. J’s perceived race/ethnicity, cultural background, or social class biased his decision—what Dr. K suspected Mrs. J meant. Such possibilities assaulted his confidence. Did he wrongly dismiss her claims about the water? Did Dr. K even give Mrs. J a respectful hearing? Was Dr. K failing to ensure Mrs. J’s “epistemic authority” that involves perceiving her “knowledge claims are ... worthy of regard ... and ... responses” [6]?

Insurgent multiculturalism and diagnostic frameworks. Suppose the retreat also introduced Delese Wear’s analysis of “insurgent multiculturalism” [7], which includes critical reconsideration of biomedical paradigms and power dynamics, as does cultural humility [4, 5]. Regarding power, conferees learned that physicians gradually tend to become arrogant and more controlling in patient relationships [8]. Physicians are then likely to speak “to” rather than “with” the ill [9]. Not only does this approach maintain or enhance their power over patients, “speaking to” reduces opportunities for “listening to” patients and families. Furthermore, these power dynamics discourage the latter from voicing concerns. Thus Dr. K wrote in his personal journal that perhaps he was becoming

arrogant. He began to appreciate the need for cultivating and maintaining cultural humility.

Dr. K also started critically examining how ingrained communication and clinical diagnostic frameworks shaped his professional thinking. His training stressed assessing individual patients' problems. Hence perhaps he tended to discount patient or family suggestions about diagnoses with causes that operate at community levels. If his focus was on the individual and diagnostically he was "thinking from the person out" about etiologies, he might overlook broadly acting factors. In short, sometimes perhaps he needed to assess the forest to understand what was affecting the trees.

Dr. K wrote in his journal: "Am I *really* listening to Mrs. J? How *really* open am I to alternatives? Oh.... And am I humble enough to accept such potential defects in my work?" In short, Dr. K realized that Wear's analysis of resurgent multiculturalism could also correct restrictions in his clinical thinking. And having cultural humility meant rebelling against his own restrictive diagnostic paradigms.

Empowering open and bilateral communication. Cultural humility includes efforts to ensure that patients and families can speak and be heard—and to build their power. But conferees agreed with findings that physicians' much greater power and many health care environments discourage free discussion by and with those seeking help [4, 7]. Thus retreat participants explored how to foster "horizontal" and "dialogic" relationships [9] and epistemic humility. If the relationship is horizontal, the ill and loved ones feel able to speak freely on the same level with health professionals. Moreover, although physicians have specialized knowledge, Karen Lebacqz argues that epistemological (knowledge-related) humility includes respecting not only what health conditions mean for patients' lives but also people's wisdom about their medical diagnosis [3]. Expressing epistemic humility should help clinicians value and promote mutual respect and recognition between them and their patients and their patients' families. Then true back-and-forth exchange with clinicians is more likely—the dialogic component of relationships.

Spatial arrangements and health agency. Retreat discussants agreed that clinicians' humility motivates such enhanced communication. The consensus was that following Paulo Freire, humility includes a deep-seated sense of people's equality or nonsuperiority [9]. But discussants also concurred that clinicians' personal humility doesn't alter how health care settings discourage open dialogue with patients and families. Rather, institutional environments often undermine patients' and families' "health agency"—their capacity to express ideas and advocate for their concerns. Hence, retreat personnel concluded that ensuring health agency also requires quiet and private locations with sufficient seating and an atmosphere conducive to conversation. They built on Margaret Urban Walker's argument that adequate ethical consultations need

areas and arrangements conducive to critical discussions with stakeholders—what Walker calls a “moral space” [10].

Dr. K Reflects Further about Humility and Talks with Mary

After the retreat, in free moments, Dr. K occasionally thought about his last interaction with Mrs. J. He realized that the clinic setting inhibited open exchange with Mrs. J and other patients. But yet she spoke assertively. Reflecting on all he learned from the retreat, Dr. J appreciated the challenges Mrs. J overcame when she spoke so firmly about her community’s water. Was he arrogantly dismissing Mrs. J’s suggestions?

Humility’s scope. With some trepidation, Dr. K spoke with Mary, the medical student, about humility and the retreat. Mary asked: “What should professional humility include? How can I learn and sustain it?”

Dr. K recalled Jack Coulehan’s influential thesis that “Humility in medicine manifests itself as unflinching self-awareness; empathic openness to others; and a keen appreciation of, and gratitude for, the privilege of caring for sick persons” [11]. None of these is easy. “I try to emulate Coulehan’s points,” Dr. K continued. “Tervalon and Murray-García’s account of cultural humility [4] supports what Coulehan asserts in its emphasis on cultivating ‘lifelong commitment to self-evaluation and self-critique’ [12]. And Coulehan’s ‘unflinching self-awareness’ obligates us to explore our unconscious biases and stereotypes. Also, Butler and colleagues advise that cultural humility involves continued efforts at ‘being receptive, empathetic, and compassionate to the various ideas, customs, and lifestyles of the patients’ [13]. So just as Tervalon and Murray-García explained in 1998, Mary, we must continue striving for humility in its many elements [4].”

“Okay, is it something like this?” Mary replied. “Without humility, we aren’t really open to everything the patient and family tell us. Cultural and other [stereotypes and biases](#) may obscure or slant what we should be hearing. And being closed to differences might block empathic connection to people’s emotional status and our compassionate responses.”

Humility: internal and external focus. Dr. K answered that Coulehan and Butler et al. [11, 13] should support Mary’s interpretation. “However, an internally-focused humility ignores structural features like inadequate physical surroundings for ‘moral spaces’ and overlooks problematic power inequalities. Tervalon and Murray-García’s broader schema of cultural humility includes addressing such inequities through advocacy and, as they write, ‘developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations’ [12]. So, for physicians, humility as an inner-focused quality is important but radically incomplete. Cultural humility is also expressed through efforts to change external circumstances.”

Dr. K continued that, in Chochinov's words, "Physicians who lack humility talk *at* their patients; physicians who are sufficiently humble talk *with* their patients. Talking or partnering with patients can promote empathic connections" [14]. Dr. K added that "other factors also promote great professional communications and relationships. According to Chochinov, 'Acknowledging medical uncertainty invites dialogue, providing patients a greater voice in the decision-making process' [14]. And admitting uncertainty promotes moral space for two-way conversations."

Uncertainty and epistemic humility. Mary worried that displaying [uncertainty](#) might undermine patients' and families' confidence in their physician's expertise. Dr. K noted that admitting uncertainty or ignorance either to oneself or patients can require courage. However, he recalled Kelly and Panush's admonition that failure of epistemologic humility could encourage mistaken diagnoses [15]. As Marcum observed regarding "intellectual humility," openness to professional error can be crucial for accurate clinical judgment [16]. However, Dr. K added that "intellectual humility seems too narrow because clinicians should be emotionally receptive to and perceptive about people's mood or affect. Thus, Mary, rather than 'intellectual,' the broader concept of 'epistemic' or 'epistemological' humility is more apt—it includes all forms of knowing."

Dr. K continued that comfortably admitting uncertainty helps establish a safe climate for the patient and family to express diverse views [10]. "In Mrs. J's case, perhaps other facts are being withheld that bear on the water concerns. If I said I was wrong to exclude a waterborne cause, maybe other information will emerge. Also, Mary, most patients and families know we don't know everything! So comfortably admitting uncertainty can reinforce our professional legitimacy."

Cultural humility and communities. Dr. K and Mary further discussed Tervalon and Murray-García's arguments about cultural humility and communities [4]. Dr. K reflected on their call for physicians to address potential health inequities such as Mrs. J's community might be experiencing. Dr. K also reviewed an argument that physicians are obligated to address upstream social determinants that promote health inequalities [17]. "In short, Mary, we need to revisit Mrs. J's concerns about the water. We should test her blood for waterborne agents like lead and arrange a phone conversation with Mrs. J. Let's also seek her collaboration in working with public health colleagues. Other suggestions?"

Mary replied that she and some classmates might be interested in working with Mrs. J's community to address the issue. She and Dr. K then discussed possible next steps with student colleagues.

Conclusion

This paper explains how practicing humility and cultivating related traits can help physicians better hear and respond to patient and community problems. Stereotypes

and biases related to economic, cultural, and racial/ethnic differences can unconsciously skew professional judgment. Physician-patient power imbalances and institutional arrangements can undermine patient and family capacities to self-advocate. Clinical diagnostic frameworks, adherence to initial impressions, and aversion to uncertainty limit physicians' openness to alternatives and patient and family knowledge. Cultural humility and insurgent multiculturalism have overlapping and complementary roles in eliminating personal stereotypes and biases, power imbalances, and community inequities. Epistemic humility helps physicians admit uncertainty, open themselves to new information and possibilities, bridge differences, establish safe moral spaces that foster patient and family epistemic authority and health agency, and expand clinical frameworks to consider influences at both individual and community levels.

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