Cultural intimacy: medical education's invisible velvet rope



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Many years ago, while teaching undergraduates, I met with my much older Jewish co-instructor to discuss a grading appeal by a well-heeled student from an historic coastal city who feared his academic performance might impact his prospects for law school. I casually mentioned that the student had a familial connection to a prominent yachting regatta. My colleague responded with two words: *goyim naches.* In Yiddish, *naches* is the sort of untranslatable delight one might derive from one's grandchildren or from being surpassed by one's mentees. Yet *goyim naches*—literally, "Gentiles' delights"—carries a condescending tinge. In Joyce's *Ulysses,* Leopold Bloom's father famously uses the term to describe Irish schoolboys racing through mud. On the lips of my colleague, the words boded ill for the aspiring attorney's grading appeal.

Recently, I was reminded of this episode, and its relevance to medical education, when invited to dine at a private club. Two nearby guests, women of a certain vintage and pedigree, were discussing the appropriate age at which to buy a girl her first steeplechase pony. Fascinating—until one of them asked for my opinion. They might as well have asked my views on the provenance of porcelain and the significance of Oxbridge rowing colors, or how many of my ancestors had signed the Mayflower Compact—which, in essence, and without conscious intent, they were. As the descendant of Eastern European Jewish peasants, I could not have felt less at home in a biber hat and sidelocks at Annie Hall's family table. (If you do not recognize the term biber hat and the reference to Annie Hall, you are experiencing firsthand the exclusionary effects of cultural intimacy—although in a manner, fortunately, that can be quickly corrected with a search of Wikipedia.)

Both of these incidents reveal the hidden power of cultural intimacy. The term, first coined by Harvard anthropologist Michael Herzfeld, is a concept that describes the shared, often elusive cultural norms through which insiders in a particular community, often ethnic or geographic, connect at the expense of outsiders.[1] The concept differs subtly, yet fundamentally, from the more frequently cited concept of "cultural capital," associated with the writings of French sociologist Pierre Bourdieu, which loosely refers to the currency—customs, knowledge, credentials—through which social and economic hierarchies are enforced.[2] Connections to a storied regatta still indicate cultural capital in our society, ranking with a diploma from St. Paul's or a choice pew at Grace Church, but they held no sway with my Orthodox Jewish colleague. In the absence of cultural intimacy, cultural capital may well come up short.

Cultural intimacy differs from both structural and unconscious bias, although the distinctions are easier to recognize in practice than to articulate. Structural biases, including structural racism, are chiefly a feature of institutions. Unconscious bias is chiefly a property of individuals. Cultural intimacy, in contrast, is a property of relationships. The phenomenon emerges when two people discover that they share a cultural vocabulary and, in doing so, experience a degree of mutual recognition. Of course, such recognition may reinforce unconscious preferences and may even contribute to broader patterns of societal inequity. Yet cultural intimacy does not require hostility toward outsiders, nor does it depend upon agreement among insiders. Rather, it reflects a far less dramatic inclination: the comfort of familiarity. Unfortunately, in settings where opportunities are scarce and judgments are subjective, that comfort can prove devastatingly consequential.

To portray cultural intimacy solely as a source of inequity would itself be misleading. Shared cultural reference points often foster trust and can be valuable doors to mentorship. As C. S. Lewis observed in *The Four Loves:* "Friendship is born at that moment when one person says to another: What! You too? I thought I was the only one!" A trainee who discovers they share similar cultural experiences with a faculty member—whether memories of Passover seders or of caroling with a choir on Christmas Eve—may feel more comfortable seeking career advice, admitting to imposter syndrome, and, ultimately, imagining a place for themselves within the profession. Such connections can enrich educational environments. The challenge is that the same forces that foster connection may also influence the allocation of scarce opportunities. Cultural intimacy is not problematic because it creates affinity, but because it limits the opportunities of those excluded, and does so in a manner that is often invisible. An attending who feels an immediate kinship with a resident may genuinely perceive unusual talent, even when shared cultural reference points have helped shape that impression. Indeed, the positive effects of cultural intimacy may be precisely what render the inequitable effects so hard to recognize.

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I fear that healthcare educators have been far too slow to recognize the significance of cultural intimacy as it relates to equity in medical training. Over the past quarter century, the Association of American Medical Colleges (AAMC), the Accreditation Council for Graduate Medical Education (ACGME), and many individual medical schools and hospitals have made enormous strides in recognizing structural barriers to

student opportunity.[3] Most notable have been efforts aimed at dismantling systemic racism and breaking down barriers stemming from economic disadvantages. Lack of cultural capital, although rarely the direct focus of equity initiatives, has received meaningful attention in the scholarly work of Karin Darin.[4]

Unfortunately, in discussions of the relationship between culture and equity in medical training, the emphasis is consistently placed upon those aspects of background that render trainees more familiar with the world of medicine, such as having a physician as a parent. Confronting—and overcoming—these barriers are certainly crucial. But I suspect that addressing traditional forms of cultural capital is only a small part of the equity equation. Even in the absence of barriers stemming from a lack of social capital, some trainees will still find themselves inexplicably disadvantaged. Without recognition of the importance of cultural intimacy as a force in medical education, and further research into its effects, educators will struggle to explain why.

Recognition, however, is only a first step. Before medical educators can hope to address the effects of cultural intimacy, they must first understand them. Future scholarship should strive to clarify the role that shared cultural affinities play in securing the opportunities that shape medical careers. It is theoretically possible that research will reveal only a modest influence. Or, as I suspect, it may reveal a far more significant impact. At present, nobody can say to what degree, when judgments are rendered among similarly qualified candidates, familiarity tips the scales. If cultural intimacy is indeed one of the hidden engines of inequity in medical education, then bringing its role into the sunlight may prove every bit as important as determining how to respond to its effects.

The distinctions among social capital, cultural capital, and cultural intimacy are perhaps best illustrated through a scenario all too familiar to medical students. Imagine three applicants competing for a summer research position. The first applicant's parent happens to know the principal investigator personally; this connection may help secure the applicant an initial interview. Such an advantage reflects the power of social capital. The second applicant, the child of two physicians, arrives highly versed in the customs of the medical world. She knows how to approach faculty and to speak the language of the profession fluently. Her advantages reflect cultural capital. The third applicant, in contrast, is endowed with neither family connections nor professional familiarity. During the interview, however, she discovers that she and the principal investigator are from the same hometown and that their parents are both immigrants from the same country. As a result, conversation becomes easier. The interviewer tells a joke she might not share with an outsider; the interviewee laughs. Mutual recognition emerges—cultural intimacy in action. In practice, these three forms of advantage frequently do overlap. Yet they remain distinct phenomena and the power of the last is all too often overlooked.

While cultural intimacy has received relatively little attention in the medical education literature, scholars have long recognized the tendency of human beings to gravitate toward those who seem most familiar to them.[5] It would be surprising if the same impulse did not shape at least some of the countless judgments rendered in the course of medical training.

Cultural intimacy makes its impact felt at the margins. But in medical education, it is at the margins where decisions of consequence occur. When hiring students for summer research positions, or formulating rankings on residency match lists, very subtle impressions have drastic consequences. Often, multiple candidates are extraordinarily qualified; only one candidate may share a cultural bond with the principal investigator or program director. In many cases, the parties involved never consciously realize the outsized role that this intimacy has played. Even if they did, surmounting such influence may prove impossible. While objective standards can help mitigate the effects of these subtle forces, they are unavoidable in decisions requiring subjective assessments.

In truth, nobody knows how often cultural intimacy alters the course of a medical career. Lived experience suggests that its influence is not negligible, but the magnitude of that influence remains largely unexplored. Future scholarship may help clarify the role that shared cultural affinities play in securing mentors, research opportunities, residency positions, and other gateways to professional advancement. Such knowledge is unlikely to diminish the power of cultural intimacy. It may, however, help illuminate those corners of medical education where its effects are most keenly felt.

Unlike cultural capital, cultural intimacy cannot be acquired readily. With practice and determination, Eliza Doolittle may learn to speak like Henry Higgins. Anyone with sufficient resources is able to

attend the opera, or to summer at Newport, or, with sufficient networking skills, secure membership at the Metropolitan Club. By contrast, the nuances of Yiddish phraseology and the etiquette of gifting Shetland ponies are destined to remain elusive to outsiders. While anyone might obviously choose to study *specific* cultural refinements, mastering them in the aggregate is a task for multiple generations.

Moreover, the specific cultural identities of decision-makers and powerbrokers vary from situation to situation. Fluency in "Ashkenazi Jewish" or "high WASP" will not give a medical student a leg up when her preceptor is Bengali or Vietnamese. Even if all communities were represented equally in seats of authority, which is obviously not yet the case, cultural intimacy would not lead to genuine equity, but rather a haphazard assortment of injustices based upon whether or not, in any given instance, cultural intimacy existed between the parties. In other words, equal representation would ensure, as an average across the countless decisions rendered in medical training, a member of a cultural community will have an equal chance of being favored for shared bonds. For the individual, by contrast, whether one would benefit or be disadvantaged by cultural intimacy in any given situation would reflect merely the luck of the draw.

Of course, all communities are not represented equally in positions of authority. While individuals may increase the likelihood of shared affinities by gravitating toward particular institutions and professional networks, the reality is that most consequential gatekeepers in medical education are not chosen by trainees or students. Prospective medical students and residents do not select their interviewers directly, although they can do so indirectly, to a limited degree, by choosing where to apply. One has little if any say over who conducts one's evaluations. As a result, while cultural intimacy may be influenced by personal choices, whether it ultimately operates to one's benefit in the aggregate is influenced by societal structures.

So, what can medical educators do? The first step is to recognize that, unlike with structural racism or the lack of social capital, cultural intimacy is a force for inequity that no level of commitment can entirely eliminate. Unlike many other sources of inequity in medical education, cultural intimacy resists obvious remedies. Objective scoring systems and diverse selection committees may temper their effects at the margins, but these measures can only go so far. Since cultural intimacy operates not through formal rules but through subtle affinities, eliminating them entirely would require a degree of cultural homogenization that removes all individuality. Few, if any of us, would welcome such sterile uniformity. Instead, we must strive for mitigation. Recognizing the limits of any corrective strategy itself is essential, lest educators promise a degree of impartiality that cannot be realistically achieved. What medical educators can do is to strive for meaningful representation among those in authority for all major cultural communities. In addition, recognition of cultural intimacy should also inspire a measure of humility among educators. The conviction that one applicant is an especially good fit, or that another possesses unusual promise, may at times reflect shared cultural reference points as much as objectively superior qualifications. Such awareness is unlikely to liberate decision-makers from the influence of cultural intimacy. It may, however, encourage them to hesitate before mistaking familiarity for merit. That approach, in turn, may reduce the overall negative effects of cultural intimacy on society. In any given dyad—applicant and interviewer, trainee and preceptor, principal investigator and junior researcher—cultural intimacy will favor some parties over others. To pretend that even the most well-intentioned physician-educators will be able to transcend evolutionary psychology is pollyannaish.[6] To channel psychoanalyst Carl Jung, until one makes the unconscious conscious, it will direct one's choices, and one will term them fate.

Awareness of cultural intimacy may also spare trainees a measure of needless discouragement. In medicine, many consequential decisions are rendered among candidates whose qualifications differ only at the margins. When several outstanding applicants compete for a single opportunity, the decisive factor may sometimes be less a matter of merit than of familiarity—a shared background, a common reference point, or simply an ease of conversation that neither party fully recognizes. Seeing this reality does not diminish the importance of excellence. Rather, doing so offers a more accurate account of how opportunities are often distributed. As Max Weber observed, politics is the strong and slow boring of hard boards; the same might be said of a career in medicine. Not every closed door is evidence that one lacks the qualifications to pass through it. Sometimes the person on the other side

simply recognizes a different knock. Understanding that rejection is not a reflection of one's merits can lead to frustration with injustice; at the same time, this knowledge can prevent the demoralization that comes with taking rejection as an indication of one's own talents, which it often is not.

The best we can hope to do is to acknowledge cultural intimacy as a hidden and pervasive force that likely underpins much of the inequity in medical education outcomes. Doing so is unlikely to change an outcome in any particular circumstance. However, understanding the power of cultural intimacy can go a long way toward preventing demoralization. After all, trainees in medicine will face many velvet ropes across their careers—and many gatekeepers of many backgrounds. If merit alone does not secure passage, moments will arise when merit and cultural intimacy together can do so. Teaching trainees to dream of a world in which everyone will let them cross beyond that rope does not help them in the present. Instead, as medical educators, we should be reminding them that, despite the effects of cultural intimacy, only one gatekeeper has to lift that velvet rope for them to get to where they wish to go.

References

1. Herzfeld M. *Cultural intimacy: social poetics in the nation-state.* New York: Routledge; 1997.
2. Bourdieu P. The forms of capital. In: Richardson JG, editor. *Handbook of theory and research for the sociology of education.* New York: Greenwood Press; 1986:241–58.
3. Martinez-Garcia S, Shinohara MM. Inequity, bias, racism, and physician burnout: staying connected to purpose and identity as an antidote. *Cutis.* 2023;111(3):122–3.
4. Darin K. Cultural capital and performance in medical education. *Journal of Social Sciences.* 2012; 8(3):397–406.
5. Byrne D. *The attraction paradigm.* New York: Academic Press; 1971.
6. Brewer MB. The psychology of prejudice: Ingroup love and outgroup hate? *Journal of Social Issues.* 1999; 55(3):429–44.

Code

It's all available staff, again,
this time to Six West.
Stairways swell.
Men, women in scrubs
go two stairs at a time,
quietly hold the door
for each other.

The patient's room
clots with people and things:
devices on wheels,
medications drawn up,
an intubation kit.
A figure at bedside wails a name
that must be his.
I step back. The roles are filled.
There's no place for me here.

—Phoebe Prioleau, MD

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