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Discursive Table of Contents—Amanda Calhoun, MD

Interview #1: August 6, 2008

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Audio File 2

Changes in the clinician population at Richmond, working with StirFry, seeking to achieve understanding in the workplace—Race and entitlement—Looking toward the future
Amanda Calhoun, MD
Interviewed by Aliza Simons, ROHO
Interview #1: 08-06-2008

[Begin Audio File 1 08-06-2008.mp3]

01-00:00:00
Aliza Simons: Today is August 6, 2008. I’m here in the Regional Oral History Office main office. My name is Aliza Simons. And this is an interview for the Kaiser Two project, year three on Diversity and Culturally Competent Medical Care. And this is tape number one. And I'm here with:

01-00:31:08
Amanda Calhoun: I’m Doctor Amanda Williams Calhoun of the Department of OB/GYN at Kaiser in Richmond.

01-00:38:04
Simons: Great. So to start out this interview and get us into your personal background, I'd like to ask you how you became interested in a career in medicine.

01-00:49:03
Calhoun: Actually, I came to medicine relatively late. I actually always thought that I was going to do history. But I had a number of good role models around the family—not in my immediate family. But I knew that I wanted to interact with the intimacies of peoples' lives. And I was always a really big story teller and reader. And then I was exposed to medicine through some friends of my parents. And I said, "Maybe this is something that I would like to do." And then had some good internships, and then it sort of came together when I was an undergraduate and I studied American medical history and biochemistry at Harvard. And then decided that I did want to go on and study medicine.

01-01:48:06
Simons: Do you want to tell me about your study of American medical history?

01-01:52:09
Calhoun: Oh, it was awesome. I absolutely loved it. Because I realized that so many people think of medicine as this science that's in this vacuum. But really, medicine interacts with the politics of the day, the culture of the day, historical events, and is really a moving target. So from that standpoint, I thought it was just fascinating. And also, the fact that there's so much more to peoples' health than what's traditionally thought of as biomedical wellness. When you think of the interaction between health and human rights, between health and one's sociopolitical power in the world, it's very different. And there's a lot more that mediates one's health and well-being than just whether they have pneumonia or not. And I think that idea has really stuck with me. And that's actually part of the reason that I ended up coming to Kaiser. Because there really was an emphasis and a focus on wellness, as opposed to sickness.
Simons: Did you have any particular focuses of your study when you were at Harvard?

Calhoun: Well, like I said, I did American medical history, mostly nineteenth century stuff. And I wrote my thesis on the Halstead Radical Mastectomy. Sort of a revision of the revisionist feminist history of Halstead. That he was this horrible, masochistic man cutting off women's breasts. I went to the libraries at John Hopkins and found his original correspondences and so forth with his patients, and sort of made the argument that he actually was really doing what he thought was best for his patients. In brief.

Simons: So you mentioned that was a feminist rethinking. Was there feminism in your background at Harvard?

Calhoun: I grew up in Washington, D.C. and my mom was in the Carter White House. So I sort of grew up with women—I went to an all-girls school—women in power, women can do. And so there wasn't necessarily intentionally feminism. It was sort of more of a de facto feminist perspective. It's sort of what I just fell into, as opposed to being challenged, per se, along the way.

Simons: And what year did you graduate?


Simons: So do you want to talk a little bit more about your own history, in terms of when you left school as an undergrad? When you went to Emory?

Calhoun: Yeah. I did the combined M.D./M.P.H. program at Emory. And I got a lot of slack for leaving but I really wanted to. Because the CDC was there, and honestly, because I wanted to be around more black people. I was a little bit sick of the elitism and ivory tower attitude, that the world begins and ends at Harvard. My dad was a Harvard guy, my brother. And I was ready to do something different.

Simons: Did you go immediately from Harvard to Emory?

Calhoun: I did. And I did with the intention of doing this combined degree. So my M.P.H. is not epidemiology—it’s health policy and management. So it was actually a quarter to a half of business school combined with public health school. And sort of continuing along that same vein, that there's a lot more to peoples' wellness than what's biologically occurring inside their body. That
there's systems problems, that there are economic problems that have to be addressed to help keep people well. Knowing that eventually I wouldn't just practice medicine—not that I don't love practicing medicine, because I really do value the individual patient encounter—but I knew that I had some sort of organizational skills, some management skills that would eventually come to the forefront. And that political bug of having grown up in D.C. is just really hard to shake.

So it was great to be able to do med school and then also do public health school at the same time. So I did that, a combined program—and to be at the CDC, which is sort of the hotbed of public health. And I met my husband and I got married. And that was good too.

01-07:29:06
Simons: In what ways do you feel like that really shaped you and your views and who you are? You mentioned there's a lot more to wellness.

01-07:44:00
Calhoun: You mean my exposure in public health school?

01-07:47:00
Simons: Yeah. And your time at Emory.

01-07:50:00
Calhoun: The time at Emory was very divided. The medical part and the public health part were very divided. But both really had a huge impact on me. Of course, that's why I decided I wanted to become an OB/GYN. But I also worked at Grady, which is the second biggest county hospital in the country. And just seeing what happens when people are completely disenfranchised. And it's not just that you're not going to the doctor. It's why aren't you going to the doctor, why aren't you taking your medication? Is the doctor speaking to you in the language that you can understand? Can you read what's on the bottle? Can your boss give you the time off to go to your appointments? Have you been homeless and contracted HIV? Are you doing sex work to make money for your kids? There's so much more to this story.

And I think building that awareness by directly interacting with people is just a really powerful experience. To sit on the side of a bed of a sixteen year old sex worker with HIV and a huge vulvar abscess and change her dressings, and listen to her story. You can't help but have that shape you. And then a month later be in the classroom and looking at how the president has decided to rework the health care funding for low-income children. And to think how do these two experiences come together. How do they meet? And how's what we do, in terms of policy, in terms of designing healthcare programs, how does that matter? How does that actually translate into peoples' lives and into people claiming their physical and mental well-being? So it was really a powerful and formative experience.
So it seems like you're able to think about healthcare as a system.

And how are you able to bring that with you, to take that with you throughout your career?

Honestly, it just had to go on the back burner a lot when I was doing my specialty training. So when I went and did my specialty training in OB/GYN, you're just working like a dog and learning how to operate and how to take care of people. I didn't really get a chance to give it the time and attention that it needed or deserved. But it still gives a structure to how you interact with people. So even though I might be running around on labor and delivery and going from one room to another, I might think about differently: if I'm going to get this person back into prenatal care after she goes home from this pre-term labor incident, what needs to happen, from a systems standpoint? Or how do I keep this kid who is born to this mom on crack, is there anything I can do to be active in this woman's life or to advocate for her or her family, or should I not advocate for her and her family? It just kind of flowed in the back of my mind, but I didn't actually get to act on it during that period of time.

So do you feel like having that kind of background, that kind of thinking about healthcare as a system, in an integrated system located in the belief that there's a lot more to wellness, in what ways do you think that's helped you? And what ways do you think that's been a challenge?

It's been a challenge because I feel like so many of my colleagues just don't get it. They like to deal with patient is here, has disease X, give medicine, fix X. Or take out tumor and then be better. And doctors are really smart people. But our healthcare system is so broken. And having that sort of disconnect between how peoples' culture, background, socioeconomic status, human rights, personal impairment, how that figures into the story, you're really missing a huge part of it.

So I think it has served me really well. Not to toot my own horn, but I have really high MPS scores. I don't know if you guys know what those are. But I think part of the reason why I do is because I try to listen to peoples' stories more and try to figure out where they are in their lives and what I can do to help them be well. And not try to fit them into my view of wellness. So I think people appreciate that. I think that patients appreciate you talking to them as a human, as opposed to a patient or a subject. And I'm not afraid to show my own humanity, to show my own faults, to share my own experiences. And I know that a lot of my colleagues actually don't intentionally do that, because
they feel like patients want to know answers. They come to you because of your expertise. They don't want to know that: "Oh, yeah, I gave my little Jonnie such and such medication, so that's why I'm prescribing it for you." It's just a different perspective. And I'm not saying that it's right or wrong, but it's what works for me. And I think that patients have the ability to self-select to see if that's the kind of provider that works for them.

Simons: Why do you think, as you say, doctors are so smart but so many just don't get it?

Calhoun: Because you spend so much time training from this sort of myopic perspective. That's the way American medical training works. And most people in my med school class didn't study history as undergraduates. Most of them studied biochemistry. So they went to their high school, they took a lot of AP bio, AP chemistry classes, then they were a bio major, a chem. major, then they went to medical school, then they did their medical training. And that fluffy stuff didn't matter. So once they get into the patient interaction they can be kind, they can be compassionate, but it's still sort of coming from that same perspective. I'm sounding like an arrogant jerk right now. But that's okay.

Simons: [laughter] No, you don’t sound like an arrogant jerk. As somebody who's currently studying a lot of the fluffy stuff, I can really identify. But I'm wondering what exactly it was about your undergraduate work in history that really enabled to be the doctor that you are today.

Calhoun: I'd say that probably my two biggest influences would be, actually, Paul Starr and a guy named Jonathan Mann who was killed on that Swissair flight, I don't know, five years ago, who's the person who really championed the idea that interaction between health and human rights. That the people who will in any society become the least healthy are those who have the lowest realization of human rights and dignity. And it's basically the philosophy of the illness of the marginalized. And it just had such a profound impact on me and such a profound influence on me. Partially, he was just brilliant and I got to spend a lot of time around him.

And then Alan Brant also, and all of his work, in particular, about smoking and how bad behaviors do cluster in the racially, politically disenfranchised. And it really resonated with me. Also, having grown up in a political household, sort of legal household, I didn't come from that intense medical, scientific worldview. That wasn't my world outlook. So it just stuck with me. And everything I saw as an undergraduate volunteering in a homeless shelter, to being a medical student working in an inner-city hospital, to being a resident working at San Francisco General, it all came together and made
sense for me. And I really believe that there's a better way to take care of people. I really believe that we can do better.

And then when I studied, actually, comparative health systems from around the world as a public health student, it really reinforced that there are even some models out there. Even though the government structures are very different and they would have to be supportive of that. But that there are a number of different ways to fix the brokenness of medicine in this country.

Simons: Are there any specific ideas or themes from some of these authors that you mentioned or studying comparative health systems that have really stuck with you and that you feel like you do draw upon for you work everyday? Now not only as an OB/GYN, but also as the new Assistant Director of Women's Health?

Calhoun: In my new role, one of the big things I have to decide is what to measure and what to promote. And so I get to take our delivery of women's health, our delivery of OB/GYN care, and say, “What matters? What matters for keeping people healthy, out of hospitals, from having low birth weight babies? What really matters?” Keeping people alive. Keeping them from coming to the doctor's office and the emergency room every day. I've got to figure out what to measure. And as I think about that, I think about what, then, mediates those measures. It's not just “Okay, I want to figure out how much chlamydia screening we're doing in sixteen to twenty-five year olds.” It's “Well, why the hell are all these sixteen to twenty-five year olds getting chlamydia?” And what's happening in our school systems that these girls aren't getting supported and getting involved in other activities so that they're sitting around having sex with all these boys? Or why is it that this serial, really promiscuous sexual behavior is so appealing in the low-income neighborhoods? I try to think of what else goes with it and where else can we intervene along the way.

So, yes, it makes me think about what I want to measure and then what I want to promote. Do I want to promote, of course, breastfeeding month or domestic violence awareness or HIV screening? And I really think about not just what we can write down on a piece of paper, what fits our national health quality assurance goals, but what really makes people live better, healthier lives. So we'll see. Ask me in a few years. [laughter] We'll see if I'm doing a good job.

Simons: So from Emory, then you went to an internship at UCSF, right? And then how did you eventually join Kaiser Permanente?

Calhoun: When I was at UCSF, I did my internship and my residency, all my specialty training at UCSF. And I sort of went back to—not that Emory's a bad school by any stretch of the imagination—but went back to sort of being at the very
elite training program where almost everybody goes into academics. And I was very torn. Did I want an academic career—

So back on track, so how did I end up at Kaiser? So I was very torn about whether I was going to do a fellowship and do sub-sub specialty training, or whether I was actually going to go and get a job and take care of people. And at first I thought I was going to end up applying in gynecologic oncology, because from a medical perspective, it's what really caught my attention. But in this particular moment I said to myself, "If I do this, then I have to give up all of this other stuff that really, really matters to me." And though, from a technical standpoint, that's what interested me probably the most, I stepped away from it and got really involved in family planning. And then decided not to do a family planning fellowship because I had done my residency at, basically, the best place for family planning in the country. And to just integrate it into my medical practice and really think about birth control, abortion, family planning services, teen services, that sort of thing.

And I knew that Kaiser would be a great place to practice because you really do get a nice solid middle slice of the population. And Kaiser is huge. Isn't it 40 percent market share in northern California? So when you're working at Kaiser you have the potential to recreate yourself and to actually do a lot of health policy sorts of things down the road. So even though I just got this new job, I didn't really think I would have a position like this for another five to ten years. But the opportunity came and it's exactly what I want to be doing, sort of be 50 percent clinical, 50 percent doing health policy management-type stuff.

01-23:52:00
Simons: So how did you get involved in family planning and birth control? Why did that interest you? Did that have to do with your background as a history major at Harvard?

01-24:08:00
Calhoun: A little bit. There are a lot of different pieces of it that drew me. Well, part of it was definitely my reading about sort of the history of birth and the politics around family planning and abortion issues as an undergraduate was very compelling experience. Really knowing what women went through in the fifties, sixties, and seventies to try to obtain terminations.

And then, also, to think about where can we intervene in our society to empower people. I really believe that—with all due respect—that women are the keepers of the culture in our society. That women tend, in general, to be at the heart of the family and tend to really shape what goes on in the raising of children. And so if we're going to impact how people are living their lives and really encourage them to thrive, we want them to be in control of their fertility.
I went as a medical student on a sub-internship here. It's sort of how I fell in love with UCSF. And talking with some of the women in the abortion clinic or in the family planning clinics and listening to their stories. Everyone says, “Okay, abortion's terrible.” But some of the alternatives are much, much worse. And to say to someone that, “Oh, because you go to a Catholic college, you're not allowed to have birth control.” Well, how the hell are you supposed to get your college education? How are you supposed to do that if you're going to be sexually active, which is a normal human function?

And it just really resonated with me. I went to an all-girls school from age eight to eighteen. And so I was very much focused on girls can and never had the idea that okay, well, because I was a girl there was something that I couldn't do. But I realized very quickly when I was an undergraduate, that that was not the norm. That was not the way that most people lived. And then when I went on to get to know homeless girls, girls who were doing sex work, I realized how incredibly disempowered these young women were. And a lot of it was vis-à-vis fertility issues. So it became a really powerful pathway for me to do some of the work that I care about, but within the context of the OB/GYN world.

Simons: In terms of thinking about the different patients' backgrounds and different stories, I'm interested to know about how you came to cultural competency. Was it through listening to these stories? Was it through thinking about different definitions of wellness?

Calhoun: I didn’t even know what cultural competency was. I never heard that term until maybe two years ago. So I can't say that it's something that has been created or that I've been thinking of in the back of my head. It's a concept that just made sense to me. Basically, I learned about it when I came to Kaiser three years ago. And I was introduced to the idea of what I was doing before.

Simons: So you don't think you need the label of culturally competent to practice cultural competency? Or does it help?

Calhoun: I don't know that you need the label, per se. But just to think “Oh, I speak Spanish, I can give culturally competent care to this Latino patient.” Or “I'm black, I can give culturally competent care to this African American girl.” I don't think that that's the case. But I think that some of the perspective that I was bringing reflected the ideas of culturally competent care already. And then as I learned more about culturally competent care and at Kaiser there's a lot of training material and the various brochures.

Simons: The booklets.
Calhoun: Yeah, the booklets. Exactly. I realized that there was a lot more to it. Especially about different cultural groups that I didn't know much about. But I think I felt like I was kind of on the right path. That I was kind of doing that sort of stuff anyway.

Simons: And what year did you come to Kaiser?


Simons: Happy anniversary.

Calhoun: Thank you.

Simons: I'm curious to ask just a little bit more about why you came to Kaiser. Because you were talking about that had a lot to do with your background and your education in medical history.

Calhoun: I knew I'd not want to do one-on-one patient care forever. I have known that since I decided to go to medical school. But I knew that I wanted to have a very solid, good clinical background and be a good doctor. So instead of being in private practice somewhere for five to ten years and then looking for a foray into policy or health systems or something like that, at Kaiser it seemed like the ideal place to sort of reinvent myself while still being within the same system, while still being able to do clinical medicine. I kind of thought that this opportunity was out there, even though it didn't exist at the time. Also, I think that Kaiser is on the right track in terms of really focusing on wellness instead of focusing on sickness. And they're on the right track in terms of being an integrated system, having aggressive IT applications. There are a lot of things about the organization that really made sense to me. And from a healthcare systems perspective, if we're ever going to have universal healthcare in this country, the basics of it, I think, could look somewhat like Kaiser Primary Care. So it seemed like a good place to start my career, even though coming from Harvard and Emory and UCSF it's not what's traditionally done.

Simons: What do you mean by not what's traditionally done?

Calhoun: Most people go and do gynecologic oncology fellowships or go and become professors at another university or that sort of thing.
But being at Kaiser you felt like you were able to most sink your teeth in.

Right. And do what resonated most with me, even though my residency director said that it was a waste of good talent.

A waste of good talent?

A waste of good talent. “I don't know why there's this flurry of residents who want to waste their good talent and go to Kaiser.”

And what did you say to that?

I was like, “I'm very sorry that you feel that way.” I also had just had a baby and had a real shift in my life perspective, that I really wanted to be in an organization that valued physician well-being too. Not just the patient well-being. I know a lot of organizations just abuse their doctors. The lifestyle of an OB/GYN in private practice is absolutely miserable. So it made sense for me from that perspective also.

This is a good time, to talk about physician well-being and change gears. And I want to ask you about some transitions that have happened at Kaiser Richmond. So my understanding is that there have been some important transformations at Kaiser Richmond having to do with physicians and clinicians who are hired, and the kind of diversity in the workforce. The kind of picture that was painted for me by some other folks that I interviewed was one of Kaiser Richmond was a place where a less diverse—ethnically, racially—staff was treating a more diverse population. And that has recently shifted in the last five to ten years to becoming a more diverse staff treating a highly diverse population of Richmond.

A staff that reflects the patient population, that's what we try to be. And I really think we are. And if you look all over northern California Kaiser, you will find no place else for which it's more evident than Kaiser Richmond.

So I'm curious to hear from your perspective, as somebody who came on board very recently, why that's happening at Kaiser Richmond. What role that you've taken in that and how that affects you. What kinds of changes you see. I guess, from your viewpoint, what kind of changes occurred?
Calhoun: It's just awesome. It's truly, truly awesome. When I first started, I was on cloud nine, because I thought it was the best place I could ever imagine working. I was doing what I loved. I was taking care of a really diverse patient population with a big slice of African American women, a good-sized slice of Spanish-speaking women. And there was a staff that actually reflected this patient population and just had such a better understanding of who the patients were and really sort of connected and cared about connecting with their patient population. The old Kaiser doc model is someone who is on their way to retirement, who just wants to be the doc in the box. See the person, go home and leave. But at Kaiser Richmond, I feel like we're so attached to our patients in sort of a mini-private practice way. We're like a very diverse small private practice inside a large organization.

So it's mostly Tracy Flanagan's brainchild-slash-recruiting efforts, I think, that ended up turning the department around. Because when she became chief—was it 2001, I think—everyone there was white, and there was one Asian guy. And that was it. And there was no reflection of the actual patient population. And so they've also been very aggressive with the staff, with the medical assistants, the nurses, and actually recruiting people who live in Richmond to come on board on the staff. And I think that makes a big difference too. But Tracy, having been very well-trained and being a UCSF doc and having made a big splash at other healthcare organizations, was able to really start pulling in good people. And so first she got Nora Salvador. And then having Nora there helped attract Tracy Seo. And then having Nora and Tracy there helped attract Rachel. And having Rachel Hartshorn there helped attract me. And having me there helped attract Carla.

Simons: I'm getting the picture.

Calhoun: It's all about building critical mass. And now we're this amazing rainbow of women of diverse backgrounds, different ages, but who really do reflect the patient population. And I don't think there's any department in northern California Kaiser OB/GYN that so powerfully mirrors the patient population.

Simons: What exactly about this does this do for clinician-patient interactions?

Calhoun: You mean why does it matter, to reflect?

Simons: Yeah. And why does it matter, what do you witness happening with patients?

Calhoun: They're relaxed, is the biggest thing. It's one powerful barrier that's removed. That you don't have to worry about any racist undertones. Sorry, I've been
thinking a lot about presidential politics. [laughter] When you live in a country where there was, in the very recent history, institutionalized racism—so not just individual bias, it was the law of the land. So not just because you hate X, you treat them like shit. You just want to be a good law-abiding citizen, and that's why you behave that way. It was the law. And for some of our patients, this was during their lifetimes. It was during my parents' lifetimes. And so to have it be that fresh and that raw, and to remove the barriers and some of the hurts that come with it.

And maybe I don't even deserve it. I grew up in a very elitist background, and I'm aware that blackness in America is not a monolithic experience. But there is something powerful to be said for being the cultural survivors of institutionalized racism that builds a commonality, that builds an entrée that allows me to connect with my African American patients in a different way.

Simons: Do you think that's true for a lot of people of color on staff?

Calhoun: Yes.

Simons: Because of that kind of, I guess, shared history?

Calhoun: I think the two most powerful are shared history and shared language. I think that a very compassionate provider can make connections and sometimes, I almost feel like I don't deserve the entrée that it gives me. But I try to honor it and I try to do it justice and really respect my patients. And use that to really impact their well-being.

Simons: Have you had experiences where you have really felt like, in your words, you haven't deserved the entrée that that has given you?

Calhoun: At the end of the day, I probably have more in common with the person who's a physician who went to an elite prep school and went to Harvard or whatever. But because of that shared racial heritage, patients will disclose things to me or say things to me. And they'll be like, "Doc Calhoun, I'm just so glad it's you. Because those people just do not understand what it's like out here." And I'll be like, "Mm-hmm. Exactly." I'm like, I don't know. I don't know what it's like to be hustling on the streets. But it's not that far removed from at least a historical perspective, and a not so far removed personal perspective, too. I feel like it gives me a jumpstart, for sure. And there are things like fibroids, for example. You're hard-pressed to find a black woman in America over age fifty who has her uterus, because 50 percent of all black women have fibroids and had heavy periods. And so hysterectomy is a dime a dozen. But patients don't have to worry that there's some racist, masochistic physician who wants
to yank out their uterus. They know that I'm there with you, that I get it. And this is part of my medical cultural history also. And so it allows my patients to not have that anxiety. And to maybe remove some of the judgment that goes along with it.

Simons: What I'm hearing from you is that you're able to use certain aspects of your own personal identity in order to provide more culturally competent care.

Calhoun: Definitely.

Simons: But when you're working with patients who you don't share the same background with, are you able to provide the same quality care?

Calhoun: I think I am. I'm definitely able to provide the same quality care from a technical medical perspective.

Simons: But culturally, in terms of your patients' backgrounds?

Calhoun: Right. I actually don't think it's as good. I always try to find a commonality with my patients and I think that allows me the entrée into that intimate space. So whether it's over having a two year old, or whether it's over having gone to college in Boston, or whether it's over being African American, I try to find some commonality with a patient that then allows them to relax and share more honestly with me. And let me know, really, how I can help them be better.

Simons: So you don't necessarily think that that same kind of quality of care, culturally competent care, can happen between a clinician and a patient of dissimilar racial, ethnic, religious, gender backgrounds?

Calhoun: I think it takes a huge amount of work. I think that it's possible, but it takes a huge, huge amount of work and a personal investment in learning about that individual's culture. And that there's so much diversity, especially in the East Bay, that you can't know everybody. You learn your main groups that you interact with, and then you find whatever else is there to relate to people. And you become a student of the game. You've got to keep asking, and keep learning, and talk to your patients. And try to figure out what does this really mean for you, so that you can help to understand your patients within the context of their cultural backgrounds.
Simons: So do you ever find yourself shying away from seeing patients who are not of the same background?

Calhoun: No, not at all. Because I think that I can pretty much sit down and talk to anybody. But I think that I can come up with something. Am I giving them the best that I have to offer? Maybe not.

Simons: Does that scare you?

Calhoun: It does, but I also think that my 80 to 90 percent is way better than most peoples'. So I'll still usually take it. But I want to keep learning. I want to keep engaging and figuring out how I can give more culturally competent care to groups that I don't know their culture well. So I hope I don't just stop. I hope I don't just give my 80 percent and call it a day. And I hope I don't just say, “Okay, well I'll just deal with the medical issues and put it in a box and take care of that.”

Simons: Instead of hearing about peoples' stories. So I was talking to another clinician who talked about this idea of culturally competent care and learning about tips and tricks about different patients' backgrounds. “Oh, so-and-so is from such-and-such background and so they're going to look at me in a certain way or look down at the floor.” And that was described as not as effective as really asking questions and coming to a deeper cultural understanding. And I'm wondering whether or not you think that that goal, of learning someone else's culture, can you actually ever do that? Are those kinds of tips and tricks useful? What does really good culturally competent care encompass?

Calhoun: The tips and tricks are great and I think it's a launching point. It's something to work with, it's something to start with. But that's not going to tell you about anyone's culture. It's going to tell you how they express certain feelings, certain ideas. But that doesn't teach you their history, that doesn't teach you why they do that. It might keep you from totally sticking your foot in your mouth or doing something really stupid. But that's not going to give you cultural competency. So I think that it's so much work, and I'm not saying that in a bad way. I'm saying that if you're really committed to doing this work, you need to read and read and watch movies—

[break in tape]

Simons: Okay, so please continue.
Oh, god, what was I saying? I was talking about learning culturally competent care, I think. I think the tips, the tricks, learning about peoples' eye contact, their gesticulations, I think that will keep you out of trouble from saying something really stupid, sticking your foot in your mouth. But if you really want to engross yourself in somebody's culture, that you need to go to their house and have dinner. You need to read voraciously. You need to watch movies. You need to have hours of conversation in a coffee shop. And I just don't know that that's realistic. So then, what becomes our surrogate? So then, what is a good shot? What's a good try? And I think that the tips and tricks give you a start, and then you just keep asking questions. You take each patient interaction with someone who's from a very different culture and you make yourself vulnerable, and expose your lack of knowledge about it. And use that knowledge to then serve you in your next interaction.
StirFry, yeah. So we did StirFry, and then we did an all-day seminar with a work group with StirFry. We had another—gosh, what was that woman's name—organizational coach come in to work with us, to teach us how to deal with our issues a little bit more.

What do you mean deal with the issues?

As some of the cultural entitlement issues started bubbling up between staff members, people were getting offended. Peoples' feelings were getting hurt. And there were some times when there's a little bit of loss of professionalism. And we had to learn, as a group, how to be a little bit more respectful of each other. And given that for Rachel Hartshorn, who I know you're going to interview also, this is one of her life's passions. Now that she is the site chief of our department, it's been an incredible experience to watch this department move towards really investing itself in cultural competence and giving people the opportunity to ask the questions that they always wanted to ask but were embarrassed to. To learn more. We have our moment in cultural history at the beginning of every department meeting.

Moment of cultural history?

Yeah. Whether it's lunar new year or black history month or whatever it is. We do something at every department meeting. And I think that the StirFry experience was incredibly powerful. Where people were very honest with each other. And there's a lot of breaking-down of cultural and class barriers. And we were circulating articles in the department about entitlement and class. I can't imagine any other OB/GYN department at Kaiser is doing this. So I feel like we're working in this incredible place where people really care about understanding each other and how that impacts how we function as a unit.

I know this might be kind of difficult and hard to discuss, but I'm wondering what exactly cultural entitlement means to you. And also how did that breaking-down occur? Did that occur through discussion? Did it occur through these workshops? And in talking about them, maybe you could talk about some of the challenges that you, personally, face.

It's like five different questions.

You can answer one.
Calhoun: No, no, no. It's okay. I think that the group became really invested when there was sort of a movement began between some of the physicians of color saying, “We've got to let these white girls know that this is not okay.”

Simons: What's not okay?

Calhoun: This is really hard to nail down.

Simons: Was it just a general feeling?

Calhoun: It's something like the disparaging comments about Richmond patients. The assumptions that are made because someone is African American and getting MediCal and WIC and living in public housing. Whether it's the lack of insight into what it means to walk into Neiman Marcus and be ignored because the assumption is that you don't have the purchasing power to shop here. What it means to be a black professional and have people wonder. Oh, I guess that was affirmative action in the works that got her into such-and-such position. A lot of comments out of the side of peoples' mouths. And we had sort of created enough of a critical mass that we could actually push back and instead of being on the receiving end, start driving the culture. And having Tracy Flanagan actually support it and say, "Oh, my god, I've got a lot to learn too. And I want to be better. I want to be just a better human," I think made a huge difference. Because if you don't have the support up top, then you're dead in the water. And Tim Batchelder, our physician in charge at Richmond, gave us the funds to give everybody a paid day to do this workshop.

So without that support, it couldn't happen. But to have the actual movement begin with the physicians themselves, that this critical mass had begun. And that's why I love Kaiser Richmond. We're really, I think, a special group because we've done this work and have tried really hard to understand each other.

Simons: And do you feel like after these workshops, after these discussions, as a group Kaiser Richmond is able to provide higher quality care, is one way to put it?

Calhoun: Higher quality care, more culturally competent care. Yes, absolutely. And I think that we've just created an environment where people can ask questions. I think physicians inherently are kind of egotistical people. It just comes with the territory.
Simons: Paul Starr has a lot to say about that.

Calhoun: Yeah, he sure does. [laughter] But it's weird when you can really save somebody's life. And then to say, “Oh, but you're a very, very flawed individual even though you have this power.” I think a lot of physicians have a hard time integrating those two concepts. And so to get these people who've trained so hard to be on the top of their field to really know what they're talking about, and to have the technical skill to really save somebody's life, to then step back and say, “Oh, wow, but I'm missing this.” Or, “Oh, but this piece of the puzzle I'm just totally screwing up.” That's a hard shift for people to make.

Simons: Yeah. Especially when that kind of flaw is an extremely sensitive issue to point out, to say, “These privileges that you're entitled to,” that you're not necessarily noticing.

Calhoun: And to wrap your mind around the concept that no one is entirely entitled and no one is entirely disentitled—or nonentitled. I don't know what the right word is. But everyone has some entitlement. And so to not cast off people as saying, “Oh, she's the snotty bitch from Marin.” There's much more to the story than that. So I think going from that antagonistic perspective to saying, “Okay, we all have something to learn here. We can all come to a better understanding, regardless of what our background is.”

Simons: And you feel like that was able to happen?

Calhoun: I think it's on-going work. I think it's something that we're really committed to doing.

Simons: So we should wrap it up. I wanted to ask about placing these kinds of cultural discussions that happen at Kaiser Richmond and these discussions of cultural competent care and placing it more in the broader history of American medicine. Why do you think that this is happening now? Why is this important now? Why is this being discussed?

Calhoun: I think we've screwed it up for long enough. Honestly, so many bad things have had to happen that now becomes the time. I don't know if you have to, but first somebody has to be able to ride the bus. If you can't ride the bus, you can't have this conversation, right? If you can't vote, you can't have this conversation. So that takes us at least to the sixties. And then you have to be able to have people in positions of power for it to matter. So when do you actually have a critical mass of black professionals in the United States? Late
seventies, eighties. And then when do people start realizing that racial health disparities are huge in this country and that race has become almost a surrogate for health. Oh, gosh, I'm trying to remember what year the Surgeon General had the year of healthy people 2000-whatever.


Calhoun: 2010. Decreasing health disparities becomes a national priority. It took a long time to get here. And, I think, at Kaiser it's become very important because Kaiser originally was the working man's insurance. And so when that solid, lower-middle middle class becomes very heavily African American, Spanish-speaking, Southeast Asian, that population then has to be served. And when we realize that we're missing so much and that poor health outcomes are clustering in some of the less common groups, and you realize you've got to do something. That we're just not doing a good enough job. And I'm really proud to work in an organization where it matters. There's so many places around the country. Private practice is the standard of care, and people don't give a crap. And, yes, some of the culturally competent booklets are kind of trite and stereotyped, but at least it's a step in the right direction. And at least it opens up some dialogue.

Simons: So looking to the future of policy, of medicine, as a view of the Assistant Director of Women's Health, what do you see as some steps in the future? What's going to happen? Do you intend to provide more culturally competent care by facilitating more discussion in the department, open that up to ask more questions?

Calhoun: Definitely. That's one of my big agendas for my new role, is to start working with the Office of Diversity. So there's no interaction right now between the Office of Women's Health and the Office of Diversity. None.

Simons: Why?

Calhoun: Just hasn't been. It doesn't exist. So to open up that dialogue and figure out how can we help each other. How are women's health outcomes tied into the outcomes of women of color? And aren't they actually the main drivers in some of less desirable outcomes? And if we can help the women of color, then we're actually going to help our population so much more. It's a huge frontier that's just waiting to be opened. So hopefully I can't start doing some of that work. We'll see.
Simons: Well, that about wraps it up for my questions. Of course, I could ask a million more. But at this point in the interview, if you want to make any sort of last final statement or closing remarks or anything you'd like to add, you can do that.

Calhoun: Oh, wow. I'm really glad that this is part of your Kaiser Project. Because I think it's something that distinguishes the organization. As I said before, most places in private practice, which is the medium through which other health systems deliver their care, it's not even an issue on the table. So if we're thinking about the history of Kaiser as an organization, I'm really glad that this is a part of your study. And I think that we have a lot of work to do. Whenever I think about culturally competent care, I always think about cultural incompetence. Which is how I feel, a lot of the time. And I know that's how a lot of other people feel. But we have to be able to bring humility to it and ask a lot of questions. And if we do, and we figure out really what helps people, really what helps individuals to maximize their physical, mental, and emotional well-being, then we really can be a healthier society.

[End of Interview]