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Vigilance as coping, vigilance as injury

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By Michelle Munyikwa

If I were asked for a definition of myself, I would say that I am one who waits; I investigate my surroundings, I interpret everything in terms of what I discover, I become sensitive.

— Frantz Fanon, *Black Skin*, *White Masks*

The world is not a safe place to live in.

— Gloria Anzaldúa*, Borderlands/La Frontera*

As second-year medical students, our cultural competency curriculum required us to spend a two-hour session reviewing our results on several Implicit Association Tests, examinations that measure implicit bias: "attitudes and beliefs that people may be unwilling or unable to report." The purpose of the tests, and Project Implicit in general, is to reveal personal biases we might hold, unbeknownst to us, by measuring how quickly we associate particular concepts with one another. Tests like the one I took are increasingly popular in health professions schools across the United States. Indeed, a core function of cultural competency training in medical students is – or at least should be – to enable trainees to become aware of our unconscious biases. Through knowing what lies beneath the surface, we may understand our own latent propensity to, for example, prescribe fewer pain meds to racial minorities or women, or to deny life-saving care to genderqueer and trans patients. Training providers in this way, it's suggested, may in turn create more equitable and just healthcare systems.

As someone who has worked intensively to promote social sciences and humanities training in medical school, I am committed to creating a healthcare workforce prepared to care for our increasingly diverse national population. Approaches which center implicit bias have some promise, as they can convince students, particularly those who swear up and down that they have no biases at all, that there may be some personal growth for them in this department. As a medical anthropologist, however, I also know that simple cures are often not so simple after all. For example, cultural competency training has been critiqued for the ways that it applies

a “check box” approach to education. As many scholars of medical education have argued, this kind of training positions the clinician as one who may achieve a competency based mostly in memorizing traits of putatively homogenous groups, rather than situating the clinician and patient in an encounter based on mutual respect, reflexivity, and trust. At its worst, cultural competency training encourages clinicians to think in stereotypes, a practice that often harms more than it helps.

In response to these critiques, contemporary approaches to cultural competency training now include structural competence – which critically understands power – and cultural humility – which emphasizes uncertainty, unknowing, and questioning. We might, in turn, apply this approach to implicit bias testing itself. I suggest that implicit bias testing is one way in which we train medical students and others to take a “paranoid reading” of both the world around them, and themselves: in other words, we teach students to gaze beyond the surface of their own perceptions and see where their distortions may lie. One goal of the courses in which I have participated was to train students to take this approach to understanding the world at large, by encouraging them to see the hidden power structures which overdetermine social life. Implicit bias training, then, has the capacity to fundamentally transform students into investigators of themselves and the world around them, leading to better service provision. However, as I have experienced it, the framework of implicit bias as a transformative educational tool neglects how people occupying different positionality and subjectivities in the world may experience implicit bias training differently, or perhaps may have different needs in the classroom. In particular, implicit bias curricula tend to center dominant positionalities – whether they be white, upper class, cisheteronormative, or abled-bodied, to name just a few. In other words, in presuming that the task of educating the “woke” physician is to make them more paranoid, we may be presuming a particular orientation to the world among our students. We might instead ask: Is it true that we all need to be taught vigilance? For whom is vigilance useful, and in what ways might it need to be taught?

Women of color feminists have described how a tingly, sensitive attunement to the world is part of the burden of marginalization. In *Borderlands/La Frontera,* Gloria Anzaldúa speaks to this way of attuning to the world as *la facultad*, “the capacity to see in surface phenomena the meaning of deeper realities, to see the deep structure below the surface.”[1] Writing about those who live at “the borderlands,” whose identities and attachments to place span multiple temporalities and spaces, Anzaldúa notes that they possess “an acute awareness mediated by the part of the psyche that does not speak, that communicates in images and symbols which are the faces of feelings, that is, behind which feelings reside/hide.”[2] In other words, an attunement to that which goes

unsaid – the implicit. This skill, women of color feminists remind us, is what makes it possible to survive in worlds which are biased against you, or in some cases, actively trying to kill you. Claudia Rankine's *Citizen: An American Lyric*, composed of scenes of racial disorientation and frustration, captures so many of these moments. *Citizen* is a powerful testament to the double-take of encountering pernicious bias: "Hold up, did you just hear, did you just say, did you just see, did you just do that?"[3] Rankine describes a paranoia that contributes not to a greater clarity, ease, or comfort living in the world but just its opposite – a haze in which you start to wonder whether you have a tether to the real. The nameless narrator of the text despairs as much as she pivots in shock, belatedly taking stock of the scene which has just passed.

For many, the capacity to see what lies beyond the surface is a strategy for getting by. And yet, often what helps us survive just as easily impedes our survival. Or at least, it makes it more fraught. Rankine's poetry reminds us that "you have to learn not to absorb the world," because "just getting along shouldn't be an ambition." Anzaldúa notes that *la facultad* makes one "excruciatingly alive to the world." The aliveness to the world that Anzaldúa notes often takes the form of absorption – not only are we experiencing connections between stimuli, but questioning them too. *Did that happen because of who I am, or who they are?* It is hard for that not to make us *absorb* the world. As a woman of color, practicing medicine, teaching, and being in professional settings is a constant test of one's implicit systems: Am I imagining that? Am I interpreting that incorrectly? For many working class, poor, or queer people, folks with disabilities, and others living at the intersections of those experiences, sensing what lies beneath the surface of encounters is a fact of daily life.

The spark for this article came when I stumbled upon a recent article connecting vigilance with adverse health outcomes. I'd been thinking about the role of vigilance in my own life and those of other people I knew; both a gift and a curse, the ability to see and predict often caused us profound suffering. "Some individuals," the article argues, "proactively prepare for the possibility that they will be discriminated against or mistreated because of their race."[4] This response is a "vigilant coping strategy," or simply, "vigilance." The article measured the relationship between vigilance and health outcomes using a survey instrument that asked the following questions: "In your day-to-day life, how often do you experience: 1) thinking in advance about the kinds of problems you experience; 2) trying to prepare for possible insults before leaving home; 3) feeling that you have to be very careful about your appearance to get good service or avoid being harassed; 4) carefully watching what you say and how you say it; or 5) carefully observing what happens around you?"[5] A growing body of literature draws connections between vigilance and adverse cardiovascular health outcomes; vigilance, it suggests, may

be a complex mediator between experiences of discrimination and poor health.

Vigilance, *la facultad*, a proprioceptive attunement to one's place in the world: these are the burdens and gifts of marginalization. And yet, reading these studies surfaced in me a dissatisfaction. For whom is vigilance a helpful trait? In what ways and for whom is implicit bias useful? If, ultimately, vigilance comes to be framed as one of many mediating factors that transform marginalization into ill health — if it is how the world "gets under our skin" — what forms of care does that ask us to perform? Do we imagine that someday, clinics for minority patients will offer counseling to decrease vigilance? If vigilance is a normal reaction to a pathological situation, should the cure not rest outside the bodies of those for whom life necessitates a mode of getting by that wounds them? And, as Aida Alazar has recently argued, if the cause of inequality is as much structural as it is interpersonal – if not more – should we not consider a radical education in history, politics, and economics the most effective intervention? These are questions for which I do not have answers, but they plague me nonetheless.

Notes

[1] Gloria Anzaldúa, *Borderlands/La Frontera*, 38.

[2] Ibid.

[3] Claudia Rankine, *Citizen : An American Lyric*, 55.

[4] Anika L. Hines et al., "Race, Vigilant Coping Strategy, and Hypertension in an Integrated Community," *American Journal of Hypertension* 31, no. 2 (January 12, 2018): 197, https://doi.org/10.1093/ajh/hpx164.

[5] Hines et al., "Race, Vigilant Coping Strategy, and Hypertension in an Integrated Community."

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