Literature and the Arts in Medical Education

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Editor's Note: In this column, teachers who are currently using literary and artistic materials as part of their curricula will briefly summarize specific works, delineate their purposes and goals in using these media, describe their audience and teaching strategies, discuss their methods of evaluation, and speculate about the impact of these teaching tools on learners (and teachers).

Submissions should be three to five double-spaced pages with a minimum of references. Send your submissions to me at University of California, Irvine, Department of Family Medicine, 101 City Drive South, Building 200, Room 512, Route 81, Orange, CA 92868-3298. 949-824-3748. Fax: 714-456-7984. jfshapir@uci.edu.

Teaching Cross Cultural Competence Through Narrative

Stephen Murphy-Shigematsu, EdD

The importance of developing cultural competence in health professionals is increasingly being recognized.[1] Practitioners seek knowledge to help them cope with the growing diversity of their patients and colleagues. However, even though requirements designed to address cultural competence are incorporated into medical school curricula,[2] the institutional culture of medical education systematically tends to foster static and essentialist conceptions of "culture" as applied to patients.

So how can we give medical students a more flexible and useful knowledge of culture to work effectively with patients from diverse backgrounds? In a short amount of time it may seem that the best we can do is to explain some basic cultural characteristics to look for and use in clinical encounters with patients from different groups. However, while helpful in providing some guidelines to work with, this approach stereotypes and objectifies patients by ignoring individual variation and the fluidity of cultural change.[3] It creates resistance in students who feel they are not part of the discussion. This method of teaching is distancing by its very nature, as it describes a constructed group rather than individual patients, which is what we actually encounter in practice.

Many questions emerge when we try to teach in a way that brings alive the humanity of patients. How can students hold general knowledge without it overwhelming their perceptions? How can they remain open to learning from the patient before them? How can they maintain awareness that any patient is like all other humans in some ways, like some other humans in certain ways, and also has a particular life story?

One approach is to use narrative, by emphasizing how telling, receiving, and creating stories are integral features of clinical practice, teaching, and research. The goal is to provide health care professionals with practical wisdom in comprehending what patients endure in illness and what they themselves undergo in care of the sick. Narrative humanizes by putting the patient first and the cultural group second. A narrative approach helps students make connections, see similarities as well as differences, and deal with complexity rather than reduce to simplicity. Although the class includes didactic readings, these are not its main focus. Rather than talk about narrative, I tell stories, and encourage students to tell theirs. Here is an abbreviated example of a narrative I share in a class on Asian immigrants:

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From the Center for Comparative Studies in Race and Ethnicity, Stanford University.

When my grandmother came home from her appointment with Dr Tanaka, an internist at a large hospital, I noticed her go into the closet, take something out of her purse, and then close the door. After she left, I looked and found a large shopping bag full of medicine. I approached her in the other room and asked:

"Grandma, what is that bag of medicine in the closet?"

"Oh, that's the medicine I get from Dr Tanaka."

"But why is it in the bag?"

"Well, you don't think I'm going to take all the medicine do you?"

"Then why do you receive it from the doctor?"

"Oh, just to make him feel like he's doing his job."

"Why don't you tell him you're not taking it?"

"Oh, I can't, Dr Tanaka is very proud and famous."

In the afternoon I accompanied Grandma to a small clinic where she received acupuncture and shiatsu from Dr Tokuda, a licensed practitioner. She received a diagnosis and advice about lifestyle, diet, rest, and avoiding stressful thoughts and situations. This doctor taught me how to deliver a treatment at home of burning a small piece of an herb called moxa on certain points on her back.

A discussion follows the telling of this narrative. One common theme that emerges is the use of dual medical systems—Grandma is using a Western system in the morning and a traditional East Asian system in the afternoon. We acknowledge the benefits Grandma gets, her doubts, and her beliefs in the strengths and weaknesses of each system. Students are asked about the problems the physician faces in working with a patient who is simultaneously being treated by another doctor and what can be done in this situation to ensure the best treatment for the patient.

We reflect on the particular cultural elements of the situation, including the way that Grandma integrates seemingly incongruent belief systems of two forms of medicine. She does so by suspending assumptions that one view must be right and one wrong, and allowing each to make valuable contributions to her understanding of health. The discussion broadens to topics such as complications in assessment of Asian patients, including age, generation in the United States, and ethnicity. We discuss demographics, such as the dramatic increase in Asian immigrants who are more likely than those born in the United States to use alternative systems. Students are alerted to the reality that cultural differences are often inequalities that need to be addressed as health disparities in certain populations.

When I ask my students if they know someone who uses dual medical systems, the answers are surprising in the sense that many acknowledge family and friends who participate in both Western medical treatment and other systems based in alternative or complementary medicine. We then do an exercise in which students are asked to reflect on a personal illness experience and reflect on what their experiences show them about their worldviews of illness and healing and how these worldviews could affect their clinical encounters as a doctor. They pair with a partner and share stories.[4] Then we return to the whole group and reflect on these exchanges.

What emerges is fascinating. Like Grandma, students have experiences of illness in which their beliefs about why they were sick were at odds with the doctor's explanation. Their beliefs about how they would get better too were often different. They utilized alternative medicine. In a recent class, a student shared his experience of being examined for digestive problems and being told by his physician that he should take Prozac. He was referred to a psychologist for depression, but his father could not accept the diagnosis and refused the treatment, leaving the student to cope with his illness through martial arts and meditation. Another student shared the dramatic story of her childhood cancer and how family members argued about the cause of the leukemia. When she went into remission, her mother endorsed the doctor's claim that it was due to the chemotherapy, but her grandmother told her she had been healed from the power of her prayers to Saint Peregrine.

I stress that we all have culture, some more mainstream American than others and some less so, but for each of us culture plays an important role in terms of how we interpret and respond to illness. I encourage students to reflect on their own and their families' illness experiences as a resource in understanding the illness experiences of their patients. We talk about illness as a more complex concept than disease that includes how the sick person and others in the environment live with and respond to their symptoms and disability.

My intention in using narratives of self and others to teach is to humanize the patient and to reduce what the practitioner sees as alien or exotic to the ordinary and understandable. I want students to regard all clinical encounters as cross-cultural and see culture as not only ethnic or racial but including many other aspects of the individual such as religion, sexual orientation, and class. Examining situations of obvious cultural differences can heighten sensitivity to basic clinical issues in the general populations of clients to which we may have become desensitized. Recognizing the need to see each patient clearly and listen completely are clinical skills needed to treat all patients.

Students' written evaluations of the class show appreciation for the

narrative approach. In particular, comments suggest that narrative leads to different understandings and apprehensions than a textbook clinical presentation. Students are delighted to have a topic introduced to them in a way that brings it to life by discussing real people. They are excited that the narrative method of teaching values a different kind of knowledge. Students find self-reflection on their own illness narratives insightful and express respect for a stance of "not knowing" and desire to know more.

Asking people to deal with complexity when they want simplicity is a struggle. It challenges medical students to deal with vulnerability when they seek certainty and to be humble when they want to feel competent. My experience shows that many students are up to the challenge and that what we discuss through narrative may actually prove to be more useful and more immediately practical in terms of everyday clinical experience than a detailed list of general cultural characteristics. It is the reason I continue to develop this method of teaching and tell Grandma's story.

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