Confronting "Culture" in Medicine's "Culture of No Culture"

Janelle S. Taylor, PhD

ABSTRACT

The author presents reflections from medical anthropology on the institutional culture of medicine and medical education, which sees itself as a "culture of no culture" and which systematically tends to foster static and essentialist conceptions of "culture" as applied to patients. Even though requirements designed to address cultural competence are increasingly incorporated into medical school curricula, medical students as a group may be forgiven for failing to take these very seriously as long as they perceive that they are quite distinct from the *real* competence that they need to acquire. To change this situation will require challenging the tendency to assume that "real" and "cultural" must be mutually exclusive terms. Physicians' medical knowledge is no less cultural for being real, just as patients' lived experiences and perspectives are no less real for being cultural. Whether this lesson can be effectively conveyed within existing curricular frameworks remains an open question. Cultural competence curricula will, perhaps, achieve their greatest success if and when they put themselves out of business—if and when, that is, medical competence itself is transformed to such a degree that it is no longer possible to imagine it as *not* also being "cultural."

Acad. Med. 2003;78:555–559.

Efforts to promote cultural competence in medical education and practice that have blossomed over the past decade or so have thus far focused primarily on the task of providing cultural information about various specific immigrant communities. This focus has been fruitful, resulting in expanded and improved resources of many kinds—from courses to training seminars, translator services, highly informative Web sites,[1] and more—to assist practitioners caring for patient populations that have created (especially in those regions where successive waves of immigrants have congregated most densely) an enormously complex tapestry of linguistic,

Dr. Taylor *is assistant professor, Department of Anthropology, University of Washington, Seattle, Washington. She also has adjunct appointments at that school in the Department of Women's Studies and the Institute for Public Health Genetics.*

Part of this article overlaps with material in a longer article published this month in Medical Anthropology Quarterly.

Correspondence should be addressed to Dr. Taylor, Department of Anthropology, University of Washington, Box 353100, Seattle WA 98195-3100; telephone: (206) 543-4793; e-mail: ⟨jstaylor@u.washington.edu⟩. Reprints are not available.

religious, and other kinds of diversity. In the wake of these accomplishments, cultural competence has earned a secure place among the formal educational goals of medical school curricula, and the moment may now be ripe to pause and consider future directions. With that in mind, in this article I present reflections from medical anthropology on the institutional culture of medical education, and suggest some reasons why achieving the broader goals of cultural competence curricula may require broader institutional changes.

As cultural competence programs have matured, a number of parties involved in promoting them have warned against a too-simple understanding of "culture."[2,3] One obvious concern is that materials intended to help foster awareness of and openness to difference may—depending upon how they are presented and how they are received—have the contrary effect of perpetuating more or less rigid stereotypes about what members of a particular "culture" believe, do, or want, and how they should be dealt with.[4–6] Some authors stress that a "culture" is not a static and timeless thing but is constantly changing as people make use of their cultural resources in creative and sometimes surprising ways.[7] Others emphasize that

"culture" is multifaceted, encompassing linguistic, religious, educational, class, and many other dimensions of difference, which intersect in complex ways in the life experience and identity of any one individual.[2] It has been proposed that the term cultural "humility" ought to replace cultural "competence" as the goal of multicultural education in medicine.[4] It is also argued that "culture" must be situated in relation to "social" factors such as literacy or socioeconomic class standing.[8] The point has also been made repeatedly that not only patients and their communities have cultures, but that there is also a "culture" of medicine.[9,10]

It is tempting to remain at the level of theoretical discussions, and to imagine that what is needed are newer and better definitions for "culture." This temptation is perhaps especially strong for those of us who discuss cultural competence from the discipline of sociocultural anthropology, because we use the same key term, "culture," differently. Coming from anthropology, where "culture is now viewed by many to consist of sets of competing discourses and practices, within situations characterized by the unequal distribution of power"[11] (and where, it must be added, one enjoys the luxury of reflecting on culture at some distance from the urgencies of clinical care), the literature on cultural competence can give one the slightly spooky sensation of having encountered the Ghost of Anthropology Past.[12] Guarnaccia and Rodriguez note that

> in reviewing recent works on culturally-competent mental health, writers have often turned to earlier writings by anthropologists to present a definition of culture. In general, these definitions have reflected a static view of culture as the distinctive set of beliefs, values, morals, customs and institutions which people inherit... [whereas] more recent approaches to culture in anthropology provide a more dynamic perspective...viewing culture as a process in which views and practices are dynamically affected by social transformations, social conflicts, power relationships, and migrations.[2]

Merely to argue about how one ought to define "culture," however, is unlikely to be especially persuasive or helpful. The anthropologist, I am well aware, risks sounding a bit like Humpty Dumpty saying to Alice that "when *I* use a word, it means just what I choose it to mean, neither more nor less!" A more interesting and useful approach is to ask of cultural competence programs the same question that anthropologists ask of any sociocultural phenomenon that they wish to understand: How do systems of thought relate to what anthropologists sometimes call "systems of social action" (i.e., the observable patterns in the ways that people act and interact in society)? Specifically, in this case, how do particular ways of conceptualizing and talking about

"culture" relate to the sociocultural organization of the institutions of medicine and medical education? To put it very bluntly, are there features of the culture of medicine that might tend to lead those who inhabit it to think of "culture" as a static set of ideas and beliefs that only other people possess?

MEDICINE AS A "CULTURE OF NO CULTURE"

In 1988 the sociocultural anthropologist Sharon Traweek published an innovative ethnographic study of an unusual type of human community: high-energy physicists working at the Stanford Linear Accelerator.[14] As an ethnographer, Traweek sought to situate this community's systems of thought in relation to their systems of social action, contextualizing the science of high-energy physics in relation to the patterned ways that the community of physicists organized themselves socially. She was particularly interested in how this community reproduced itself—how it produced new generations of physicists who would assume their places in its social and professional hierarchies, while also assuming the community's values, assumptions, and goals as their own. She stated:

> I believe that to understand how scientific and technological knowledge is produced we must understand what is uncontested as well as what is contested, how the ground state is constructed as well as how the signals called data are produced. When I speak of the shared ground I do not mean some a priori norms or values but the daily production and reproduction of what is to be shared... the forces of stability, the varieties of tradition, in a community dedicated to innovation and discovery.[13]

What emerges from Traweek's study is a portrait of high-energy physics as "a culture of no culture"—that is, a community defined by the shared cultural conviction that its shared convictions were *not* in the least cultural, but, rather, timeless truths.

Physicians obviously differ from physicists in many regards, not least in the fact that the central purpose they share with the medical community is not so much the production of new knowledge as it is the alleviation of human suffering caused by illness and injury. "Medical knowledge," furthermore, encompasses both formally codified knowledge and the quite different kinds of knowledge gained through clinical experience. In general terms, however, it is confidence in the *truth* of medical knowledge that underwrites physicians' special power to alleviate suffering. Medical knowledge is understood to be not merely "cultural" knowledge but *real* knowledge. In this perspective, it may be reasonable to describe medicine, no

less than physics, as perceiving itself to be a "culture of no culture."

This presents obvious difficulties for the project of crafting cultural competence curricula that will go beyond focusing on "other" cultural groups, and attend to cultural dimensions of medicine itself. Lorna A. Rhodes notes that

> in both biomedical settings and the study of other kinds of medicine, it is hard to avoid the assumption that what needs to be explained are the "alternatives," the "other" perspectives, the "misunderstandings" or "misuses" of bio-medicine rather than biomedicine itself.[14]

Or as Byron Good puts it, "Our convictions about the truth claims of medical science rest uneasily with. . .our desire to respect competing knowledge claims of members of other societies or status groups."[15]

One sees traces of this uneasiness in, for example, Anne Fadiman's book *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*, widely used as a text for teaching about issues of culture in medicine. Fadiman writes that

> for better or for worse, Western medicine *is* one-sided. Doctors endure medical school and residency in order to acquire knowledge that their patients do not have. Until the culture of medicine changes, it would be asking a lot of them to consider, much less adopt, the notion that. . . "our view of reality is only a view, not reality itself."[16]

Fadiman asserts that "medicine *is* one-sided" and that doctors have "knowledge that their patients do not have." At the same time, however, she leaves open the intriguing possibility that physicians *might* someday place their medical knowledge on an even footing with (culturally different) patients' knowledge, if and when "the culture of medicine changes." What would have to change? What is it about the culture of medicine that makes it appear, to its members, to be so devoid of culture?

To answer this question following Traweek's lead requires documenting the social processes by which "what is uncontested"—in this case, the conviction that medical knowledge is *real*, i.e., not "cultural"—is produced and reproduced, through the training of new generations.

Mary-Jo DelVecchio Good, writing of her ethnographic study of the training of Harvard University medical students, shows us, at least in part, how this takes place. To earn for themselves a place in the medical community, medical students must establish their competence. "Competence," with no modifier, means mastery of medical—i.e., *real*—knowledge. One of the key ways in which medical students establish their competence, according to Good, is by learning how to craft and perform what she calls "clinical narratives"—in other words, learning to transform what patients say into what physicians write on charts and say to each other. As Good's account shows, these narrative practices through which students demonstrate their "competence" leave precious little room for eliciting the kinds of information that might be necessary to establish "*cultural* competence." These narrative practices are, thus, part of what Frederic Hafferty[9] has referred to as medicine's "hidden curriculum":

> Students were encouraged to learn new narrative forms, to create medically meaningful arguments and plots with therapeutic consequences for patients. In this process, they sharpened their biomedical "gaze" and developed their clinical reasoning. Throughout these exercises, the "psychosocial" aspects of most patients' illnesses, their social histories and emotional states, and their lives outside of the hospitals and clinics were largely irrelevant; these data from daily life were regarded as "inadmissible evidence" in the presentations made during everyday work rounds.[17]

In *The Spirit Catches You*, Fadiman quotes the physician Dan Murphy recounting his own experience of treating Lia Lee, the small sick child of Hmong immigrants who was at the center of the book's story, during one of her seizures. Murphy recalls agonizing over his inability to talk to Lia's parents, but at the same time describes precisely this experience of proving his competence by creating, under these circumstances, a "medically meaningful argument" and a "plot with therapeutic consequences":

> I thought it might be meningitis, so Lia had to have a spinal tap, and the parents were real resistant to that. I don't remember how I convinced them. I remember feeling very anxious because they had a real sick kid and I felt a big need to explain to these people, through their relative who was a not-very-good translator, what was going on, but I felt like I had no time, because we had to put an IV in her scalp with Valium to stop the seizures, but then Lia started seizing again and the IV went into the skin instead of the vein, and I had a hard time getting another one started. Later on, when I figured out what had happened, or not happened, on the earlier visits to the ER, I felt good. It's kind of a thrill to find something someone else has missed, especially when you're a resident and you are looking for excuses to make yourself feel smarter than the other physicians.[16]

His description makes all too clear how medical "competence" can be established and demonstrated by creating clinical narratives, even in the face of the bleakest inability to communicate across cultural difference.

Indeed, one might argue that establishing one's "competence" as a physician *requires* bracketing off questions of the patient's life experience. Byron Good, who carried out

research jointly with DelVecchio Good among Harvard University medical students, quotes one student's explanation of what "presenting a case" to an attending physician involves:

> ...basically what you're supposed to do is take a walking, talking, confusing, disorganized (as we all are) human being, with an array of symptoms that are experienced, not diagnosed, and take it all in, put it in the Cuisinart and puree it into this sort of form that everyone can quickly extrapolate from. They don't want to hear the story of the person. They want to hear the edited version... You're not there to just talk with people and learn about their lives and nurture them. You're not there for that. You're a professional and you're trained in interpreting phenomenological descriptions of behavior into physiologic and pathophysiologic processes. So there's the sense of if you try to tell people really the story of someone, they'd be angry; they'd be annoyed at you because you're missing the point. That's indulgence, sort of.[15]

If, as Good and Good suggest, physicians-in-training establish their overall "competence" by learning to craft clinical narratives in a way that "justifies the systematic discounting of the patient's narrative,"[15] then what does "competence" mean when we attach to it the modifier "cultural"? However one defines "culture," does not attention to it demand, at the very least, taking an interest in what people think and say and what they have experienced – in short, "the story of the person"?

As long as these basic features of the "hidden curriculum" and institutional culture of medical education remain in place, no amount of fine-tuning the theoretical definitions that students are assigned to read on "touchy-feely Tuesdays" is likely to unsettle the tendency of medical education to produce and reproduce itself as a "culture of no culture."

RECONSTRUCTING "COMPETENCE": BEYOND "ADD CULTURE AND STIR"

Increased diversity among those who enter medical school, however, might go some distance toward unmasking the "culture" in this "culture of no culture."

Separate and self-contained though medical institutions in some respects are, they are also integrally a part of the broader sociocultural order in which they are embedded, and tend to reflect its patterns of thought and social action. These are less likely to appear necessary and natural, and thus more likely to become visible as "culture," to people who do not themselves emerge from its dominant segments. Guarnaccia and Rodriguez note that

professional cultures are variants of the dominant culture focused on particular sectors of society and social problems. Thus, dominant cultural norms and values are built into the frameworks for the training of professionals, for assessment of clients, and for developing treatment approaches. For someone from a different culture to become a professional involves at least two processes of acculturation—one to the dominant culture and the other to that of the profession.[2]

This acculturation process can be stressful for professionals from minority cultural groups, who "frequently are in a conflicted position with multiple loyalties to clients and institutions."[2] Nor is the situation of such medical professionals, marked out within this "culture of no culture" as being individuals who have "culture," made any simpler when they are enlisted to serve as mediators, translators, or native informants.

The same dissonance that places such strain on medical professionals from minority groups can, however, also yield insights—which, if heeded, might perhaps help open paths toward change. Mary Canales and Barbara Bowers, writing of cultural competence within nursing, note that

> although the theoretical concepts of "cultural diversity" and "culturally competent care" have been supported and promoted by the largest professional nursing organizations, the practical application of these concepts has often created difficulties for nurse researchers, educators and clinicians. Historically, it has been nursing leaders and educators, operating from a predominantly White, dominant culture perspective, who have initiated and promoted the majority of the directives for professional nursing.[18]

The same certainly holds true for medicine as well. Canales and Bowers conducted in-depth interviews with Latina nurse educators as a way of exploring "cultural competence, particularly how to teach it, from the perspectives of nursing faculty who have often found themselves on the cultural margins within schools of nursing and society in general."[18]

What they found was that Latina participants were less concerned to present their students with information about specific cultural groups than to teach broader constructions of the Other and the phenomena of "Othering." Indeed, Canales and Bowers found that

> what was salient for these participants was the perception that competent care includes cultural competence. According to this theory of teaching practice, preparing students to become competent practitioners requires that students learn to care for those perceived as different from self; that they learn to care as connected members of a community and the larger society; and that students learn to care with a commitment towards changing existing social, health, and economic structures that are exclusionary.[18]

SUMMING UP

I have presented here some reflections from medical anthropology on the institutional culture of medicine and medical education. Medicine, I have argued, sees itself as a "culture of no culture," and its practitioners tend systematically to foster static and essentialist understandings of the "cultures" of patients. Even though requirements designed to address cultural competence are increasingly commonly incorporated into medical school curricula, medical students as a group may be forgiven for failing to take these very seriously as long as they perceive that they are quite distinct from the *real* "competence" that they need to acquire. To change this situation will require challenging the tendency to assume that "real" and "cultural" must be mutually exclusive terms. Physicians' medical knowledge is no less cultural for being real, just as patients' lived experiences and perspectives are no less real for being cultural. Whether this is a lesson that can effectively be conveyed within existing curricular frameworks remains an open question. Cultural competence curricula will, perhaps, achieve their greatest success if and when they put themselves out of business—if and when, that is, medical competence itself is transformed to such a degree that it is no longer possible to imagine it as *not* also being "cultural."

REFERENCES

1. Ethnomed: ethnic medicine from Harborview Medical Center. Department of Anthropology, University of Washington. ⟨http://ethnomed.org/⟩. Accessed 3/10/03.
2. Guarnaccia PJ, Rodriguez O. Concepts of culture and their role in the development of culturally-competent mental health services. Hispanic J Behav Sci. 1996;18;419–43.
3. Sobo E, Seid M. Cultural issues in pediatric medicine: what kind of 'competence' is needed? Paper presented at the annual meeting of the American Anthropological Association, New Orleans, LA, November 2002.
4. Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. J Health Car Poor Underserved. 1998;9(2):117–25.
5. Turbes S, Krebs E, Axtell S. The hidden curriculum in multicultural medical education: the role of case examples. Acad Med. 2002;77: 209–16.
6. Nuñez A. Transforming cultural competence into cross-cultural efficacy in women's health education. Acad Med. 2000;75:1071–80.
7. Santiago-Irizarry V. Culture as cure. Cultural Anthropology. 1996; 11:3–24.
8. Green AR, Betancourt JR, Carrillo JE. Integrating social factors into cross-cultural medical education. Acad Med. 2002;77:193–7.
9. Hafferty FW, Franks R. Beyond curriculum reform: confronting medicine's hidden curriculum. Acad Med. 1998;73:403–7.
10. Costley A, Dasgupta S. The anatomy of intake rounds: examining the reproduction of biomedical culture in the training of pediatric residents. Paper presented at the annual meeting of the American Anthropological Association, New Orleans, LA November 2002.
11. Frank G. Venus on Wheels: Two Decades of Dialogue about Disability, Biography, and Being Female in America. Berkeley, CA: University of California Press, 1999.
12. Helmreich S. After culture: reflections on the apparition of anthropology in artificial life, a science of simulation. Cultural Anthropology. 2002;16:612–27.
13. Traweek S. Beamtimes and Lifetimes: The World of High Energy Physicists. Cambridge, MA: Harvard University Press, 1988.
14. Rhodes LA. Studying biomedicine as a cultural system. In: Johnson TM, Sargent CF (eds). Medical Anthropology: A Handbook of Theory and Method. New York: Greenwood Press, 1990.
15. Good B. Medicine, Rationality and Experience: An Anthropological Perspective. Cambridge, U.K.: Cambridge University Press, 1994.
16. Fadiman A. The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures. New York: Noonday, 1997.
17. Good MJD. American Medicine: The Quest for Competence. Berkeley, CA: University of California Press, 1995.
18. Canales MK, Bowers BJ. Expanding conceptualizations of culturally competent care. J Adv Nurs. 2001;36:102–11.
19. Taylor JS. The story catches you and you fall down: tragedy, ethnography, and "cultural competence." Medical Anthropology Quarterly. 2003;17:159–81.