Teaching Cultural Competency Through Narrative Medicine: Intersections of Classroom and Community

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Background: *Cultural competency and narrative medicine are perspectives that assist medical educators in teaching effective, empathetic communication and service delivery to a variety of patients.*
Purpose/Methods: *In this article, we describe a unique educational activity at the crossroads of these perspectives in which pediatric residents participated in a monthly reading and discussion group with staff members of an inner-city Dominican American community organization.*
Results: *By discussing a literary text rather than cases and facilitating discussions with particular attention to power, not only were historic conflicts between the groups circumvented, but an environment was created in which discussants drew heavily from personal and professional experiences. Qualitative evaluation of both groups revealed improved self-reported understanding of (a) issues of cultural diversity, (b) issues of medical culture, and (c) physicians' attitudes and behaviors in practice.*
Conclusion: *Methodologies drawing from cultural competency and narrative medicine can be used to help physicians work in multidisciplinary, multicultural teams in and out of the medical institution.*

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Community-Based Cultural Competency and Narrative Medicine

Cultural competency and narrative medicine are perspectives that assist medical educators in teaching effective, empathetic communication and service delivery to a variety of patients. Unfortunately, educational endeavors in both arenas are often classroom based and at the level of the individual student. Few exercises in either cultural competency or narrative medicine place students directly in contact with the community outside of the medical institution. By describing a unique educational activity, in this article, we explore the intersections of cultural competency and narrative medicine as well as the potential of such exercises to increase residents' connections to the local communities in which they serve.

At the Columbia University Community Pediatrics Program, which is located within the University's Division of General Pediatrics in New York City, the cultural competency training program reaches beyond traditional teaching methodologies including didactic lectures, small-group sessions, or problem-based learning sessions. The residents participate in educational endeavors with a Northern Manhattan (Washington Heights) Dominican American community organi-

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zation, Alianza Dominicana—in particular, a program within the organization called Best Beginnings, which is targeted to families of infants at risk of abuse and neglect. This sort of community-based training falls under the rubric of service learning, which integrates community service with explicit learning objectives. Service learning challenges artificial distances between the medical center and community by locating the educational classroom in the community and placing community partners at the level of teacher.[1]

Unfortunately, such nontraditional educational endeavors are not without their challenges. Particular issues the cultural competency training program has faced emerge from the role reversal of teacher and learner, the cultural disconnect between medical center and community-based organizations, and the mistrust and misunderstanding that may unfortunately exist between residents and community partners. Needs that have emerged for our program include a need to familiarize community partners with medical culture, a need to familiarize residents with culture of the community and community-based organizations, and a need to familiarize residents with the role of cultural differences in practice.

A New Training Module: Narrative Methods

With these issues in mind, a new teaching module was developed as part of a 2nd-year resident block in community medicine. A monthly reading group was formed between pediatric residents and Best Beginning staff members utilizing a literary-based case study, with one chapter of the text being read and discussed each session. Best Beginnings staff members were all provided individual copies of the text from the community pediatrics program, and lunch was provided by the program as well. The module ultimately became known to both residents and staff as the "narrative lunch."

The text used was *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* by Fadiman,[2] which is an account of a Hmong girl's epilepsy and her community's interactions with their local medical facility. Fadiman's[2] narrative illustrates many culturally relevant issues including language barriers, "noncompliance" with medical regimen, and discontinuation of parental rights. In our particular context, the text represented a "neutral" culture to the extent that no one felt a sense of personal or professional ownership over the Hmong experience; rather, both community workers and pediatric residents were placed in the position of learner in regard to this predominantly unfamiliar culture. This avoided to a great extent the territoriality and historical conflicts that emerge when utilizing real-life case examples or examples located within more familiar cultures such as African American or Latino communities.

Facilitation of these hour to hour-and-a-half discussions were conducted by both pediatrics faculty and the Best Beginnings Director, with particular attention to including the voices of all participants. Ground rules regarding confidentiality, respect for differing opinions, and the importance of each participants' experience were reiterated at each session. All participants were asked to introduce themselves, and the role of the facilitator as a group member but not authoritative leader was emphasized. Physician facilitators introduced themselves by first name and discouraged the use of the title "Doctor." Facilitators usually began the discussion with questions from the text and subsequently allowed the conversation to flow organically, occasionally intervening when more than one person spoke at a time or to encourage a reticent participant. Physician facilitators often critiqued medical culture, whereas the Best Beginnings Director often suggested explanations for physician behavior and supported the statements of the residents. Facilitators also encouraged participants to draw from personal and professional experiences that illustrated the topics discussed including birthing practices, cultural miscommunication, use of complementary therapies, and experiences with chronically ill or dying patients. Physician behavior, medical culture, and issues relevant to the health care team were often the foci of discussion.

Of the 13 narrative lunch sessions held between January 2002 and April 2003, attendance per meeting averaged 15 community workers, two to three residents, and one to two community pediatrics faculty members. Although the Best Beginnings community workers were fairly consistent in their attendance, pediatric residents rotated each month. The majority of pediatric residents attending the sessions were from New York Presbyterian Hospital; there were occasionally residents in attendance from Columbia's affiliated city hospital, Harlem Hospital, as well as occasional medical students from Columbia College of Physicians and Surgeons. The majority of participants had read the assigned chapters and actively participated in the discussion.

Evaluation

The evaluation of this project was two-tiered. Evaluation of the community workers was conducted through a focus group held with 16 Best Beginnings staff, not including the director, and conducted in Spanish and English by a member of the community pediatrics evaluation team (A. Calero-Breckheimer). During the focus group, the facilitator welcomed the audience, gave an overview of the purpose of the group, explained the ground rules, and asked ques-

tions, giving opportunity to all participants to contribute. Topics of discussion included questions regarding logistics and discussion points, the book, cultural diversity, physicians' points of view, communication skills, and general evaluation issues (See Table 1). At the end of the session, the facilitator summarized all main points. Participants agreed with the summary and provided missing details. A week later, the information was summarized and analyzed by the facilitator using a note-based approach in which she studied the field notes, looked for emerging themes, created coding categories, and coded the information. She then sorted the information by category, drafted answers to each of the questions, and created an evaluation report.

Resident evaluations were based on self-reported evaluation cards filled out after each community pediatrics month that asked two questions about each of their educational activities including the narrative lunch: (a) Describe one thing that you learned, and (b) describe one way that you can apply the knowledge/skills learned into patient care. A total of 24 residents rotated through the community pediatrics month over the specified time period, but 6 residents were unable to attend the narrative lunch activity because of illness, commitments to other meetings, or because they were postcall. Of these 18 residents, 13 filled out the evaluation cards (72%). Content and thematic analysis of the evaluation cards was conducted by two readers (S. DasGupta and A. Costley) using an iterative process, and consensus was arrived at regarding major thematic issues.

Table 1. *Narrative Lunch Focus Group Questions*

Questions Regarding Logistics and Discussion Points
1. What do the narrative lunches mean to you? Why do you attend the lunches?
2. Did you feel free to speak your mind during the lunches?
3. Do you feel this sort of experience is important for a community-based worker? For a physician?
Questions Regarding the Book
4. Have you enjoyed reading this book? Why?
5. What are the different skills/lessons/ideas that emerge from reading this sort of book?
6. Are these issues discussed in the book applicable to your life/work?
7. Do you think the discussion would be different if the book were different?
Questions Regarding Cultural Diversity
8. What are the benefits of reading a text about an unfamiliar culture? Is such an experience valuable for a community-based worker/physician in Harlem or Washington Heights?
9. Has reading the text helped you understand different perspectives?
10. Before coming to the lunches, what was your understanding of cultural diversity?
Questions About Physicians' Points of View
11. Do the discussions during lunches help you to better understand the physicians' points of view?
12. Do you believe these lunches have helped the physicians to understand your points of view?
13. Did the discussions help you learn more about the medical system?
14. After attending the lunches, do you perceive the residents differently?
15. Do you think the residents perceive you differently?
16. Do you think you could work better with the physicians after sharing the lunch experience with them?
Communication Skills and Other Strategies
17. Have the lunches aided your communication skills?
18. Have you learned new strategies since attending the lunches? Which strategies?
19. Have the lunches helped you prepare clients to better meet with clinicians?
Evaluation Issues
20. What worked best?
21. What could be improved?
22. If you want anything to change, what would that be?

The larger thematic areas that emerged from both qualitative data sets are as follows: issues of cultural diversity, issues of medical culture, and physicians' attitudes and behaviors in practice.

Issues of Cultural Diversity

Both Best Beginnings staff members and residents reported that the narrative lunch made them recognize the importance of acknowledging and learning about cultural differences. Residents' awareness of potential miscommunication between doctor and patient due to language and culture was heightened by this module, and participants of the focus group were made aware of intercultural variation and the inability to consider Dominican American experiences as normative for other groups. In addition, both residents and staff reported being enabled to examine their own prejudices. Regarding the care of patients, one resident commented, "We are constantly making assumptions based on limited experience/background." The focus group specifically mentioned that these issues were not previously evident to them. Said a staff member, "The book made me more culturally sensitive."

Issues of Medical Culture

Focus-group participants stated that the activity was a good opportunity to understand the medical point of view while discussing more "objective material." The activity helped participants to better understand the existence of a medical culture and the day to day realities of physicians including long hours and limited amount of time to work with individual patients. Similarly, the narrative lunch exercise introduced residents to the different perspectives of patients and ancillary staff regarding the role of the physician. The activity enabled them to better understand the community's expectations, their perspectives on hospitals, the practice of medicine, and physicians' day to day activities. In the words of a resident, "People outside medicine don't understand that we have a culture of our own—[here] we are able to discuss this culture."

Physicians' Attitudes and Behavior in Practice

Staff believed that the lunches helped residents understand the community's point of view and that residents would change their attitudes and behaviors in practice after the lunches. Said one staff member, "We hope that now residents would keep the families in their minds, try to see their point of view and their needs. Remember them, perhaps sometimes even call to check on them." Said another, "I truly believe that the residents would work better with families now." Consistent with this perception, residents reported a variety of intentions to change their attitudes and behaviors. These included an intention to be more sensitive to cultural difference, be more patient, and recognize their biases and their effect on caregiving. Residents also reported the intention to more effectively elicit information from patients such as encouraging open dialogue and asking patients about cultural beliefs and practices. They also reported that they intended to better explain their own reasoning and treatment choices to patients, "treat(ing) parents as equals in making care plans."

Lessons Learned

Very few narrative endeavors address the interprofessional/cultural interactions between various members of the health care team. At Columbia University, there exists a program in which physicians, nurses, and social workers write and share their experiences taking care of a common set of patients.[3] Another institution reports interdisciplinary reading collectives of professionals including doctors, nurses, and administrators.[4] Such exercises have been described by participants as "community building," allowing members to "overcome traditional hierarchical stereotypes and appreciate the important contribution that each member brings to the work of medicine"[4] (p. 966). The narrative lunch took this sort of exercise one step further—beyond the walls of the medical institution. As service learning brings the classroom to the community, this narrative medicine exercise created a community from the classroom of literary discussants.

The creation of community within the classroom may not, however, be automatic. This activity was conducted with particular attention to the power discrepancy between physicians and community workers. Facilitation of discussions was conducted with the goal of creating a safe space in which the voices of all participants were honored equally. The theoretical foundation of this sort of facilitation draws from Brazilian educator Freire[5] whose writing is particularly concerned with decentering the power of the classroom from the teacher to the students. It is also consistent with what activist and educator bell hooks[6] called, in the context of multicultural education, "transformative pedagogy." In bell hooks's[6] words, "I enter the classroom with the assumption that we must build 'community' in order to create a climate of openness and intellectual rigor. … [O]ne way to build community in the classroom is to recognize the value of each individual voice" (p. 93). In addition, community is created from the diverse interpretations that emerge when discussing a story with others. The very nature of such interpretive ambiguity may challenge the "single, authoritative view" (p. 966) of physicians in medicine.[4] In other words, the power imbalance between physician and other health care staff, or community members, is not only addressed through careful facilitation with an eye to inclusion but the very act of encouraging multiple narrative interpretations of texts.

Future applications of this project should include comparable evaluation methodologies between groups. In addition, the role of the facilitator should be examined closely, and ideally, facilitation should rotate between all participants. It is critical that facilitation is conducted with careful attention to issues of power and hierarchy. Ensuring that representatives of the medical center are able to consistently attend is also an important direction to explore, although it will undoubtedly be challenging secondary to the demands of patient care and other scheduling difficulties.

Cultural competency and narrative medicine are perspectives that greatly enrich medical educators' abilities to teach effective, empathetic, and appropriate communication and care. The intersection of these methodologies will only further empower medical education toward these ends. By bringing the classroom to the local community and recognizing the potential of creating community within the diverse classroom, we can help train new doctors to think beyond traditional teaching methodologies and reach beyond the walls of the medical institution.

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