# Viewpoint: **Physician, Know Thyself: The Professional Culture of Medicine as a Framework for Teaching Cultural Competence**

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## Abstract

The need for physicians who are well equipped to treat patients of diverse social and cultural backgrounds is evident. To this end, cultural competence education programs in medical schools have proliferated. Although these programs differ in duration, setting, and content, their intentions are the same: to bolster knowledge, promote positive attitudes, and teach appropriate skills in cultural competence. However, to advance the current state of cultural competence curricula, a number of challenges have to be addressed. One challenge is overcoming learner resistance, a problem that is encountered when attempting to convey the importance of cultural competence to students who view it as a "soft science." There is also the challenge of avoiding the perpetuation of stereotypes and labeling groups as "others" in the process of teaching cultural competence. An additional challenge is that few cultural competence curricula are specifically designed to foster an awareness of the student's own cultural background. The authors propose the professional culture of medicine as a framework to cultural competence education that may help mitigate these challenges. Rather than focusing on patients as the "other" group, this framework explores the customs, languages, and beliefs systems that are shared by physicians, thus defining medicine as a culture. Focusing on the physician's culture may help to broaden students' concept of culture and may sensitize them to the importance of cultural competence. The authors conclude with suggestions on how students can explore the professional culture of medicine through the exploration of films, role-playing, and the use of written narratives.

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*As I walk into the classroom all eyes are on me, the new teacher in this first session on cultural competence. More than half the year has gone by for these first-year medical students, and I notice that already they look older. Many are tired. Most appear distracted by the volume of information and exams from all of their other courses. A few even look a bit annoyed at being here. As I enter, they look up and wait. Where does one begin?*

There has been a tremendous movement to incorporate cultural competence programs into the medical school curriculum. As a result, more than 90% of medical schools in the United States have incorporated cultural competence training into their curriculum. This movement has been fueled by both the Liaison Committee on Medical Education[1] and the Association of American Medical Colleges (AAMC),[2] who have individually developed standards and guidelines to facilitate this process. The AAMC's Tool for Assessing Cultural Competence Training[3] provides a broad array of learning objectives with which to shape cultural competence curricula. In an effort to achieve some of the objectives and standards that have been set, different modalities, such as didactic lectures on the key concepts of cultural competence, exercises to teach verbal as well as nonverbal communication skills, and self-reflection techniques that help students to explore their personal biases, have been developed.[4–8]

The benefits of cultural competence education have been clearly delineated. Studies have demonstrated that cultural competence education can improve knowledge, attitudes, and skills of health professionals and can affect patient satisfaction.[9] However, to effectively achieve these benefits, several challenges must be addressed: overcoming learner resistance, choosing an appropriate conceptual framework that does not promote cultural stereotypes, and developing a curriculum that fosters students' awareness of their own culture. Failure to address these barriers makes it difficult to engage students and perhaps may make it difficult to motivate them to change their attitudes and subsequent behaviors as practicing physicians.

The purpose of this article is threefold: (1) to describe challenges that are encountered in the process of teaching cultural competence, (2) to introduce the professional culture of medicine as a conceptual framework for addressing some of these challenges, and (3) to provide examples of strategies of how discussions on the professional culture of medicine can be incorporated when teaching cultural competence.

## Challenges Encountered When Teaching Cultural Competence

### Overcoming learner resistance

Teaching cultural competence may be a "hard sell" influenced by the learners' preexisting attitudes and the context, timing, and content of the cultural competence curriculum. Medical students may be of the opinion that "*we didn't come to medical school to learn*

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*about soft social science type things,"* as Kai et al[10] found in a study on medical students' perceptions of cultural competence curricula. A similar view is that *"physicians have more important things to worry about than cross-cultural issues,"* which was reported in a study by Shapiro et al.[11] If not obviously shrouded in an evidence-based medicine framework, some students may feel that this is "soft medicine."[12]

Some students may be in the ethnocentrism stage in which they deny, minimize, or are defensive about the influence of culture on medicine.[13,14] Raising awareness and changing attitudes may be more difficult if some students are resistant to the discussion of diversity, bias, social inequities, and health disparities or feel that they are being blamed for social problems that exist.[15] Learner resistance may also be influenced by the timing and the context in which students are taught cross-cultural communication skills. These skills are usually presented in the first- or second-year doctoring courses at a time when students may not have had sufficient patient contact, may not recognize the value of these skills in optimizing health care for all patients, or may have had little opportunity to practice these skills. Therefore, in order for students to value the role of cultural competence in medical education and patient care, efforts must be targeted at reducing learner resistance.

**Broadening the concept of culture**

Another challenge that is encountered in cultural competence education is broadening the way in which the term *culture* is conceptualized and how images of cultural groups are portrayed in the educational setting. Although it is important to be curious about the attributes of a particular cultural group, there is an inherent risk of generalizing these attributes to everyone who shares aspects of that culture.[6] The approach of focusing on distinct groups works well with discrete populations that are isolated by geographic or political boundaries. However, increased globalization has made it less likely that any one group will remain completely isolated or that all of the individuals within that group would share the same beliefs and attitudes. Furthermore, culture is not a static trait that can be committed to memory and applied categorically. Rather, it is constantly in flux and influenced by various social and environmental factors. Cultures may change according to political climate, restructuring of neighborhoods, and patterns of immigration.[16] Cultures do not exist in a vacuum; therefore, cultural competence cannot be taught as a set of immutable concrete facts. Thus, when teaching about cultures, the concept of *culture* must be broadened, and students must also be taught the importance of individual preferences and the individual socioeconomic factors that are at play.[17–19]

**Minimizing the process of "othering"**

Another challenge encountered when teaching cultural competence is minimizing stereotypes and the process of *othering*.[5,20] Othering is a process whereby a group is defined as different from another group that is considered the norm. The othered group may be subject to being labeled, marginalized, and excluded. In the clinical setting, making presumptions about the values, morals, and beliefs of specific groups may have implications on clinical decisions that are made.[21] In the context of teaching cultural competence, students' learned othering may make it more difficult to teach them the importance of negotiation and mutual understanding in the doctor–patient interaction. One way that cultural competence programs can minimize the process of othering is by broadening the context in which cross-cultural skills are applicable. Steps must be taken to avoid limiting cross-cultural communication skills to only interactions where the patient and physician belong to discordant racial or ethnic groups. This practice may effectively create a greater chasm and further promote the idea of *them* and *us*.[22]

**Focusing on the learner**

Another challenge to teaching cultural competence is developing curricula that are learner centered and that can motivate students to embrace their own culture while embracing that of their patients. During the past three decades, the profile of U.S. medical students has changed; currently, more than 45% of students in the 126 allopathic medical schools are women. The number of students belonging to underrepresented racial or ethnic minority groups is approximately 12%.[23] Many more belong to other minority groups or are immigrants or first-generation Americans. As a result of these changes, the face of the medical profession is no longer predominantly male and Caucasian. However, the fact that more physicians will resemble their patients in terms of race, gender, country of origin, or ethnicity does not obviate the need for cultural competence education. Rather, the changing profile of the physician workforce necessitates a change in the approach to teaching cultural competence. It calls for a learner-centered approach that recognizes this increasing diversity and incorporates the student's own background into the curriculum. Students should be challenged to examine their own beliefs and the factors that have shaped them so that they can be conscious of what they bring to the encounter. Finally, given that physicians also have their own professional culture, the term *cross-cultural interaction* may be applicable to most if not all, provider–patient interactions.

**Addressing the challenges**

Several educators have suggested alternative strategies to teaching cultural competence. For example, Tervalon and Murray-Garcia[24] suggest that when discussing cultural competence, students must also be taught the notion of *cultural humility*. Cultural humility refers to a process of ongoing self-reflection and critique of one's pattern of behaviors.[24] Carrillo and colleagues[6] stress the need for understanding the potential biases of the "biomedical culture" and state that this realization is critical to negotiations in the cross-cultural interaction. Similarly, Betancourt[17] states that discussions about the student's own cultural values are important aspects of cultural competence education. The role of self-reflection is also espoused by Epstein,[25] who describes self-knowledge as being essential to the expression of core values in medicine, such as empathy, compassion, and altruism. One recurring theme that is common to all of these approaches is the focus on introspection and self-reflection, which Mezirow[26] describes as components of transformative learning.

According to the transformation theory of adult learning, transformative learning is the process by which one's frame of reference is altered.[26] Frames of references are influenced by cultural

assimilations and can serve to establish one's view of the world. For medical students, understanding the culture of medicine is important in developing their view of the profession of medicine. This understanding can begin with the processes of self-reflection and critical reflection. Self-reflection is a process by which students begin to reframe prior assumptions, take alternative perspectives, and recognize their induced roles. Critical reflection is another approach that can help to foster self-awareness.[25] Through critical reflection, learners may come to question some of their prior assumptions about culture and come to understand how their perceptions of health and professionalism were formed. In the context of cultural competence education, in order for students to develop a new perspective on the importance of culture, they must first appreciate the processes that frame their own attitudes about health and illness and then question their prior assumptions. The professional culture of medicine is a framework that can be applied in teaching medical students about the importance of culture while emphasizing those factors that shape their values, attitudes, and belief systems.

## The Culture of Medicine as a Theoretical Framework

*Culture* refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.[27] Building on this definition, the professional culture of medicine can be viewed as the language, thought processes, styles of communication, customs, and beliefs that often characterize the profession of medicine. This may be a difficult concept for students to grasp initially because they may not view medicine as a culture or may view it as described by Taylor[28] as the "culture of no culture." Students may find difficulty in viewing medicine as a culture because the culture of medicine is not a topic that is formally discussed in medical school education. The culture of medicine is most often learned through the hidden curriculum and through role-modeling. Although it is not a part of the formal curriculum, the hidden curriculum often dictates certain customs, rituals, and rules of conduct thereby, defining the cultural milieu of medicine.[29–31] Incorporating topics that are usually part of a hidden curriculum into a more formal discussion on cultural competence may help to overcome some of the challenges we identified above and may also provide a framework for a formal discussion of the culture of the medical profession.

Traditionally, when discussing medicine as a culture, the focus tends to be on reinforcing the virtues of medicine, such as honesty, empathy, altruism, honor, and respect. Although these attributes are the core of lectures on professionalism in doctoring classes, they may be difficult for students who are just embarking on medical training to grasp. Applying the professional culture of medicine as a framework for teaching about culture can highlight elements within the culture of medicine that are more obvious and tangible to medical students who are in the early stages of their education. Examples of these elements include the white coat, a shared stylized dress code among physicians; *doctor talk*, a shared language or unique pattern of communication among physicians; and the physician explanatory model, a shared system of beliefs regarding health.

### The white coat

The white coat is a symbol of the medical profession and other health professions that can be used as a tool in teaching about culture. Traditionally, it symbolized sterility, science, and healing, and it has now become a time-honored tradition among physicians. In fact, many medical schools begin the first year with the White Coat Ceremony, a ritual which reinforces the virtues of medicine as a profession.[32] The doctor's donning of the white coat may confer a sense of authority in the doctor–patient relationship. Studies have shown that wearing a white coat is associated with patients' trust and confidence in their physician as well as their willingness to disclose personal matters to their physicians.[33] One study found that doctors who wore white coats were described by their patients as being more hygienic, professional, authoritative, and scientific.[34] The white coat may also elicit certain physiological responses, as evidenced by the well-documented white coat phenomena in hypertension.[35–37] Students should be encouraged to discuss the meaning of the white coat and to consider what it symbolizes to them and their patients and the influence it may have on the doctor–patient interaction. This discussion provides an excellent segue to a discussion of stereotypes and biases in the doctor–patient interaction, topics that may be difficult to discuss. Just as it is important to encourage students to consider the meaning of the white coat to them and to their patients, students should also be encouraged to consider the possible meanings of their patients' garb or outward presentation and any preconceived notions they may have based on their patients' appearances or customs.

### Doctor talk

The way in which physicians express themselves verbally, *doctor talk*, is another element of the culture of medicine that is rarely taught explicitly. The lexicon of physicians is characterized by statistical facts, presented in terms of probability, gradations of severity, and the use of acronyms and medical terminology that is often unfamiliar to the patient. Just as cultural anthropologists have analyzed the patterns of speech of different cultural groups, students may be interested in learning that similar analyses have been done on the way that physicians express themselves. In an analysis of case reports and presentations, Anspach[38] described key elements of medical discourse. One element is depersonalization of the patient or the separation of biological processes from the person. An example of this type of depersonalization is the use of impersonal terms in describing the patient and referring to the patient as simply *baby boy* or *female*. Another element particular to medical discourse is the omission of mention of the provider of care, such as the physician. Anspach noted that while physicians often omitted mention of the provider during case presentations, technology was often described as the agent (e.g., "the CT scan revealed these findings"). A third element described by Anspach is the use of account markers, such as patient "denies," "states," or "reports," which may suggest that physicians often view patients' accounts as more subjective than factual. This type of discourse is often not evident to the first-year medical student and is important to address so that it does not become an unconscious habit.

The use of doctor talk can also impact the provider–patient interaction. A number of studies have shown that medical

terminologies that are used by health care providers are often misunderstood by patients.[39,40] Pointing out the sometimes indiscriminate use of medical terminology may help to reinforce the importance of linguistic competence and communication skills to students. Linguistic competency ensures that health information is communicated either verbally or in writing in a way that is understood by the patient.[41] In cultural competency curricula, this concept is often applied when discussing discordant language between the physician and the patient. However, it can be broadened to encompass situations when medical terminology is used with patients. Medical students should appreciate that this pattern of speech is a part of the medical culture that may impede effective doctor–patient communication.

**The physician's explanatory model**

In addition to a shared custom of dress and pattern of speech, the way in which physicians conceptualize health is another example of the physician's culture. This is referred to as the *explanatory model*, a term that is most often used when referring to patients. When used in reference to patients, explanatory models describe how patients interpret the meaning of an illness and the impact that it has on their ability to function.[42–45]

Physicians' explanatory models reflect their perception of the etiology, onset, pathophysiology, course, and treatment of a disease process. Whereas patients' explanatory models may be derived from social network experiences, the physician's explanatory model may be derived from the content of the medical school curriculum, the medical school environment itself, and the interactions with peers and mentors. Just as the patient's explanatory model may determine his or her clinical presentation or decision to seek treatment, the physician's explanatory model is an important determinant of clinical behavior and the physician's medical decisions.[44,46] As a teaching point, students should be reminded that physicians' explanatory models are often incongruous with that of their patients.[47] It should be stressed that the patient's explanatory model is no less important than that of the physician in negotiating a therapeutic plan. Comparison of the physician's model with that of the patient can enable physicians to identify major discrepancies that can affect clinical management. In applying this framework, it is also important for students to recognize the influence that their individual cultures have on their attitudes toward health.[43] It is equally important to emphasize the cross-cultural differences that exist within the profession of medicine and that their view of medicine is seen through the lens of the American and Western culture.[48]

## Strategies for Applying the Framework of the Professional Culture of Medicine

There are several strategies that can be used to engage students in discussions about the professional culture of medicine as it relates to cultural competence. Film and literature are approaches that have been used in teaching about medical professionalism and can be used to engage students in discussions about culture.[49–51] The analysis of short films that feature physicians can engage students in a discussion on the topic of the medical culture. This strategy has appeal because it is familiar to students, because the culture of medicine has become somewhat of a popular culture itself and has been featured on several popular television programs. Educators can use this to their advantage by exploring the culture of medicine through the analysis of films or short stories.[51–53] An example of this approach is used by Winter and Birnberg,[49] who use video clips of popular movies to teach medical residents about professionalism.

Students' written narratives describing their clinical experiences and their personal view of the medical profession can be used to facilitate discussions of the professional culture of medicine.[50] This approach has been used by Brady and colleagues[50] to help residents in training reflect on how their experiences influence their learning and professional life. Another strategy is the use of narratives in medicine as a model for students to examine the healing process through exploration of patients' stories. This can also help students to better understand their own thoughts and responses to patients. Students can begin to cultivate a greater sense of what it means to be a physician through narratives.[51] Role-playing is yet another way of helping students to examine themselves in the role of the physician.[54] In small group settings, students have the opportunity to place themselves in the role of physicians at an early stage and begin to reflect on this new role.[55] This type of reflective exercise may encourage the habit of *reflective practice* as practicing physicians.[56]

## Teaching the Professional Culture of Medicine

Using the professional culture of medicine as a framework for cultural competence education has several potential benefits. First, engaging students in a reflective discourse on the culture of the medical profession may help to reframe their perceptions on what constitutes culture and perhaps make them more receptive to learning about cultural competence. Second, discussion of the culture of medicine shifts the focus of the cross-cultural encounter from the patient as the "deviant other" to examination of perspectives of both patient and physician which may help to minimize the tendency for othering. Finally, the focus on the culture of the medical profession encourages students to gain self-awareness by exploring their shared customs, their methods of communication, and their explanatory models regarding disease and illness.

In this article, we have discussed the challenges that are often encountered at the level of the target audience (learner resistance) and the curriculum itself (narrow conceptualization of culture and lack of learner-centeredness) when teaching cultural competence to medical students. These challenges were selected because they have received considerable attention in the literature on cultural competence, yet still remain as problem areas. We propose using the professional culture of medicine as a framework that can complement traditional cultural competence programs. We provided strategies that could be used to engage students in discourse on the professional culture of medicine. These strategies are based on tools that others have used to foster self-reflection and critical reflection. However, these are our recommendations and future studies will need to adapt or tailor these strategies to meet the needs of the particular target audience.

*So, where does one begin? As the class quiets down, all eyes are on me. I know where to begin. Begin with, "Physician, know thyself."*

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