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COMPANION ESSAY

Learning by Teaching an Unsuccessful "Cultural Sensitivity" Course

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Introduction

It has been several years since Sarah Willen conducted an ethnographic study of the cultural sensitivity course that a colleague and I taught to 3rd-year psychiatric residents. Although the results and feedback were not a surprise to me, they provided plenty of material for reflection on the factors that influenced its lack of success. Time has allowed me a more calm analysis and enabled me to consider possibilities that had not crossed my range of thoughts during the course or immediately thereafter.

Creation of the Course

I was very enthusiastic when I was asked to participate in the implementation of this course shortly after finishing my psychiatric training. Two other colleagues, also recent graduates, joined me in this endeavor. They had been involved in advocacy movements for gay rights and human rights in this country and overseas and had either an undergraduate degree in humanities or had absorbed important insights from medical anthropology, sociology, and philosophy early in their training. I was probably the least knowledgeable about these topics, but I had developed a keen interest in the experience of being "the other" by suddenly becoming part of a "designated minority" after immigrating to this country from Peru in order to pursue residency training after graduating from medical school. "Fish do not know they are wet until they are out of the water" was a saying that I had heard before, and my new personal situation made me reflect on being different from my surroundings, my peers, and especially my

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interlocutors. This new personal situation also provided me with new insights about the realities of the "otherness" that patients experience.

As new teachers, we found ourselves involved in an exciting juncture. At the time, the Accreditation Council of Graduate Medical Education (ACGME) had recommended enhancing cultural sensitivity among residency trainees through courses and workshops. Our respective hospitals wanted to enhance the representation of minority staff and increase awareness of the diversity among patients and medical workers. We were asked to implement "culture-specific" clinics for minority patients and help organize "cultural awareness" seminars for health care staff. Because of our personal interests and ethnocultural and linguistic backgrounds, we found ourselves considered by our hospitals and residency program as the "culture diversity experts," and our opinion and consultation were frequently sought after. This status was very satisfying and enhanced our enthusiasm for creating an interesting course.

Struggles in Teaching the Course

We put all our effort into developing the "course of our dreams." We chose to include topics and lectures that we wished we had had as part of our training. We wanted to convey to our younger colleagues that inequalities, social difference, power differentials, invisible privilege, and racism existed in contemporary medicine. We also wanted to help them understand that health care professionals had a particular way of seeing and experiencing the world that was very different from the way our patients did, regardless of cultural background, and that in our efforts to heal, clinicians had great power, yet our actions could also cause harm if we did not reflect upon the implicit and explicit values that influenced our clinical conduct.

So it was with great dismay that we started to receive lukewarm or negative reviews of the course from the residents year after year. Our own harsh criticisms of teachers we judged boring or inconsequential during our residency training were still fresh in our minds, as were the ways in which we idolized the "good ones." It was certainly not very pleasant to be among the teachers who were not considered "essential" or interesting. As a way of adapting to the common extremes present in the residents' range of feedback (for example, "provide more practical tips on how to deal with the most prevalent minorities" versus "present more academic papers on how different people communicate"), we went through a pendular motion involving different emphases that were never fully satisfying.

We blamed the poor reception of the course on the fact that residents were reflecting the predominant tendency of contemporary medicine and psychiatry toward the values of technical rationality, which appreciates certainty and predictability and resists analysis and deconstruction of notions and concepts. Although I still believe that this conclusion was not entirely wrong, I recognize now that it was somewhat simplistic and stemmed greatly from an emotional defensive reaction.

It is my thinking now that many factors were involved in the lack of popularity and ineffectiveness of the course. One area of review is that the discussions did not stem from the needs that arose from the residents' clinical practice or from the

dilemmas and situations that they faced every day, but rather, from our desire to "convert" them to a point of view of social justice, which was an important component of our stance as teachers. We belonged to a generation that came of age in the 1980s, following the civil rights era, with perspectives on the world and justice that were very different from the generation of young physicians that we were teaching. We did not recognize at the moment that many efforts had already led to the creation of abundant "cultural competency" courses and that residents were already very keen on detecting, and in some cases, resisting the political correctness embedded in them. What we were observing, I now think, was resistance to a society that assumed to have solved complex issues with apparently easy interventions. Unwilling to accept the logic of "here you have a course and you are all set, problem solved," residents seem to have been partly protesting against the oversimplification of issues of greater complexity.

Self-Reflection, Knowledge and Experience: "The Reflective Teacher"

I have come to realize in retrospect that a teacher in a course in this area must have a combination of qualities and skills: self-reflection, a sense of social justice, an understanding of the basic concepts and theories in the social sciences, and, more than anything, experience. While teaching this course, we teachers certainly learned more than anybody else. We started to pay more attention to our interactions with patients and their families and became more reflective about our own excitement and frustration when dealing with patients who were "different" and "difficult", who appeared to clash with our preconceived "ideals" of "a good doctor–patient interaction" and the ultimate goal of providing good care and relieving suffering. We also became more aware of the range of our own emotional reactions (from sympathy to irritation) when dealing with patients who had low educational levels or were poor and whose clinical presentations were complicated or unclear, and all of this, in midst of a medical system that demanded greater productivity and efficiency. We started to discover new understandings and different levels of complexity in the concepts on which we were lecturing. Although as young teachers we had excellent intentions and were full of enthusiasm, we were also lacking a necessary amount of "experience of reflection" in our own clinical work, a path that, over time, can help clinicians to become "reflective practitioners" (Schon 1983). Even if we assume that teachers' and residents' different stances toward sociocultural issues stemmed from generational differences, the great deal of anxiety we experienced at the time as young teachers, especially in reaction to certain residents' confrontational style, prevented us from using these differences as teaching tools and material. An experienced "reflective" teacher would recognize that similar clinical dilemmas will arise in different historical contexts, and he/she would encourage trainees to analyze the appropriateness of "old concepts for new circumstances" or alternatively "new concepts for old circumstances."

As directors of the course, we considered ourselves lucky to have been exposed in our training to excellent supervision in psychodynamic theory and practice that acknowledged the importance of exploring hidden agendas in patients' and

clinicians' world. We recognized that certain behaviors and assumptions frequently emerge from deeper realities that are hidden from individuals' and society's awareness. We felt that the models of psychodynamic exploration developed to understand intrapsychic life could also be adapted and prove helpful in identifying unconscious and ingrained behaviors, assumptions, opinions, and prejudices that come from cultural, social, and racial differences and in addressing the resulting conflicts. However, we had not yet been exposed to the tradition of discussing the "social unconscious." We have observed that collaboration between social scientists and clinicians has resulted in a more sophisticated language that has facilitated the inclusion of psychosocial issues in common clinical practice and medical education.

When we taught this course, we observed that the discussions that commonly ensued among the residents about issues of race, social class, and privilege generated intense emotions, and we found ourselves in somewhat uncharted territory. It is true that we had been trained to "deescalate" angry patients and "debrief" after conflictive situations between an inpatient clinical team and a patient, but we had no models of how to defuse tension after a heated discussion about these issues.

While teaching this course, however, we started to collaborate and have productive discussions with medical anthropologists and sociologists, some of whom became our mentors and provided invaluable help in informing our clinical work and thinking process. In fact, it was in the midst of this collaboration that the idea of utilizing ethnographic exploration as a way of understanding our teaching dilemmas was born.

I think that experienced clinicians who have had some years to reflect on their own clinical practice may greatly benefit from collaborative discussions with social scientists about the medical arena in which clinical cases and situations are discussed, social science concepts are clarified or exemplified, pertinent questions are posed, failures and successes in other academic and clinical settings are shared, and ultimately meaningful research is coordinated. Other collaborations, such as the efforts encapsulated in the current issue of this journal, are excellent examples of interdisciplinary and inter-institutional exchange of experiences and insights. These discussions, coupled with greater training in negotiation skills, could result in teachers much better equipped to teach a course like this one. On the other hand, lesser experience in these realms should not dissuade young, smart and enthusiastic clinicians from participating in such important endeavors. In such cases it could prove very helpful, and perhaps even crucial, to first teach the course in collaboration with a more experienced clinician and to have ongoing consultation and supervision with a medical anthropologist or sociologist.

Based on the experience and reflective process outlined above, it seems appropriate to provide some suggestions regarding the content of future courses of this nature. The first component to be considered involves the exposure of residents to practical models of discussion and integration of the social and cultural into actual clinical narrative and practice. The second aspect—and in my perception, by far the most challenging—is an existential/self reflective component in which the residents/students would be able to recognize their own views of the world, perceptions, and biases as members of an ethnocultural group, a particular social

class, and the "medical establishment" and consider how these views affect their interactions with their patients.

Teaching Skills to Integrate Social and Cultural Issues into Clinical Practice

Recognizing Situations that Generate Strong Emotion

It has been my observation that the need to understand cultural issues in patients becomes especially salient when clinicians are faced with situations that trigger strong emotions such as frustration, anger, worry, or distress. Among these situations are those that involve the patient's non-acceptance of diagnosis and non-adherence to treatment, especially when the patients' backgrounds are very different from the clinician's or when the clinical setting is unfamiliar. These situations trigger a moral dilemma in the clinician who struggles to be simultaneously committed to two important values in medicine: respect for the patient's autonomy, and beneficence to the patient. Early in their training, physicians learn that they have been given societal responsibility for being the "gatekeepers of health," and as part of their mission and work they must "educate" and direct patients regarding what is best for them. The perception of failure to meet this task may result in clinicians feeling that "they are not doing their job", which turns into an affective struggle in which they can get extremely frustrated when patients or their families appear to reject a diagnosis or treatment that could help decrease their alienation and suffering. Patients, on the other hand, may not relate very much or at all to what the clinician and the medical setting are advising and, as a result, perceive the clinician's frustration and end up feeling misunderstood or dismissed. Recognizing such clinical situations, which can occur in the emergency department, in the wards, or in the ambulatory setting, is a crucial starting point for teaching. A successful teacher should be able to explore these situations with trainees and, if they cannot recall "real cases", then illustrative case vignettes from real clinical situations collected by the teachers through the years, either from their own or their colleagues' experience, can be presented for discussion.

Integration of Different Dimensions into Clinical Practice

The Role of Narrative Medicine

There are many models that attempt to explain the struggles and problems that bring patients to mental health care (biopsychiatry, cognitive behavioral therapy, psychoanalysis, interpersonal therapy, humanistic therapy, family therapy, systems theory, existential psychotherapy, cultural therapy, feminist therapies, among others (Lewis 2011). Although the biopsychiatric model by large predominates in contemporary American mental health care, it does not even come close to encompassing the complex experience of the patient.

The problem is not that these different models exist, but that they may develop in isolation from each other with the end result of a fragmented understanding of the

patient. It is not uncommon that in order to prevent this disintegration these disciplines may practically ignore each other or consider the others "irrelevant" or "reductionistic". On the other hand, the tradition of "narrative medicine" allows for practical ways of integrating these views by creating a narrative in which different dimensions interact and flow in ways that are not contradictory, but in fact enhance the understanding and expand the view of the clinician (Charon 2001, 2006; Lewis 2011). The cultural and social contexts in which disease and illness occur should not be discussed in isolation but always in connection with all other dimensions (biological, psychological, spiritual) of the clinical situation. In his book, *Narrative Psychiatry*, Lewis (2011) gives practical examples of how this integration can occur. Clinical narrative workshops, in which residents are exposed to this methodology, may prove very helpful in the development of a practice of integration of these different dimensions.

Experiential Component

As explained in Willen's article, the discussion of race produced some confrontation between residents. It is my conviction that the exploration of this and other difficult issues (for example, social class, invisible privilege in certain social groups, the primacy of medical knowledge as "truth" in comparison with "other beliefs") can stimulate residents to better understand the extent of their impact on their patients' lives. However, as the study shows, without the teachers taking control by providing meaning to the anger, disappointment or frustration in a non-judgmental way, some residents felt quite uneasy in continuing to open up.

Creating a "Holding Environment":

The Ethnographic Method

The concept of a "holding environment" refers to an atmosphere that encourages openness and ease despite difficult topics, and in which contradictions or disagreements are seen as "unavoidable" and "expected," on one hand, and at the same time "non-definitive" and "a process towards" (see also Guzder and Rousseau, this issue).

Witnessing how the ethnographic exploration of this course was conducted, and later becoming aware of its results, helped me to reflect on its practical applications in teaching a course like this. By its non-judgmental way of inquiring and observing a situation, the ethnographic method minimizes the possibility of humiliation of the observed. The differences or disagreements between different groups of people (for example between peers that are of a different race and background, or between patients and their doctors) are not considered "barriers" or "problematic," but "situations that need to be understood better." Because of this attitude, during the research the residents (and the teachers too) felt at ease to reflect openly on the issues and complexities that occur when talking about cultural and societal issues in medicine, thus creating a "holding environment." I must admit that my positive

impression of the ethnographic exploration as minimizer of humiliation may be biased because of my observation of the respectful way it was performed by the researcher, and by my familiarity—based in extensive past collaborative discussions—with her views and respect for the subjects and themes of her research. However, I still think that the ethnographic method in itself has as its main goal understanding a situation in its context and, as much as possible, without preconceived ideas. As teachers we had initially hoped that this course would help the residents to discover their attitudes and biases as members of a particular group. Paradoxically, this objective was achieved to some extent through ethnographic inquiry into their views and perceptions (instead of through the course itself).

An ethnographic stance not only accepts that differences between social groups will always occur and may not be fully breached, but also considers them unique opportunities for mutual respect and growth. Ultimately, any effort to understand the perspective of "the other" is not only essential to the creation of a nurturing teaching environment and a comprehensive and fair clinical assessment, but it is probably the most powerful healing action of the whole clinical endeavor.

In my view, some degree of skill in performing ethnographic inquiry must be acquired by both teachers and residents. As Kleinman (1988); Kleinman and Benson 2006) among others has argued, teaching residents some practical elements of ethnographic exploration can assist them in exploring the social and cultural dimensions of their patients' lives during clinical evaluations. In addition, these skills can also help teachers facilitate discussion of difficult topics such as race and social privilege by helping them create a "holding environment" in which difficult conversations feel safe.

I must be frank; I am not sure whether open existential and experiential exploration of sociocultural issues among medical and psychiatric residents can be achieved in a course like this given the current environment of medical education, in which the tangible demonstration of competencies is of utmost importance. This tendency to objectify knowledge and skill does not welcome open discussions of ethical and social issues and may prove inimical to cultivating a holding environment as described above. Trainees may be concerned about their evaluation by the teachers. Another barrier to the development of a holding environment is that fact that residents will have different levels of comfort in opening up to their peers, with whom they may have developed the kind of friendships, rivalries, allegiances, sympathies, and antipathies that form and evolve in residency classes. Still, a level of discussion and exploration of all these issues, which could help residents observe how they observe and act, should be achievable with knowledgeable and experienced teachers, provided these discussions are not graded.

Lastly, I must say that despite the title I have given this essay, I do not really think that this course was a failure. It has allowed personal growth and important reflections that came afterwards. Many residents expressed that the process of exploring the issues in the ethnographic research was a great source of reflection, and one of the residents who was particularly opinionated in his criticism of the course approached me after graduation to ask whether he could join us in teaching the course again. Finally, many people have commented with admiration on my openness to discussing failure, although I think that discussing failure (and

questioning success) should not be considered "unusual qualities" but instead "usual practices." I think that the way we teach and the way we see patients should be constantly questioned because by nature human beings—including clinicians—have the tendency to reify whatever truth we think we have found.

References

Charon, Rita.
2001 Narrative Medicine: a Model for Empathy, Reflection, Profession, and Trust. Journal of the American Medical Association 286: 1897–1902.
2006 Narrative Medicine: Honoring the Stories of Illness. Oxford: Oxford University Press.
Kleinman, Arthur
1988 The Illness Narratives: Suffering, Healing, and the Human Condition. New York: Basic Books.
Kleinman, Arthur, and Peter Benson
2006 Anthropology in the Clinic: the Problem of Cultural Competency and How to Fix It. PLoS Medicine 3(10): e294.
Lewis, Bradley.
2011 Narrative Psychiatry: How Stories can Shape Clinical Practice. Baltimore: Johns Hopkins University Press.
Schon, Donald.
1983 The Reflective Practitioner: How Professionals Think in Action. New York: Basic Books.