Joining Ethnography and History in Cultural Competence Training

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Introduction

It is a particular pleasure for me to add some observations and ideas to this impressive collection of papers on four training programmes on cultural competence in the United States and Canada. Because of my engagement with similar matters in Germany and Latin America (cf. Knipper et al. [2010a, b](#); Knipper [2010](#)), I was kindly asked by the editors of this special issue to collaborate with a view from abroad. I feel especially privileged by the possibility of adding some thoughts on the importance of the often neglected historical dimensions of cultural diversity and the benefits of combining the anthropological with an adequately defined historical perspective.

Instead of commenting on all pairs of papers individually, I decided to structure my comment according to the two main issues—history and ethnography—with references to the particular articles in this volume interspersed. I will start, however, with a brief and admittedly personal look at the situation of cultural competence training in Germany, because I very much support the assumption expressed by Willen and Carpenter-Song in the introduction, that an international perspective is crucial for the improvement of cultural competence training in medical education (Willen and Carpenter-Song [2013](#)).

Cultural Competence Training in Germany

For several years now, awareness has been growing in Germany and in Europe at large regarding the need to include cultural competence issues in medical education (cf. Dogra et al. [2005](#); Seelman et al. [2009](#); Dogra et al. [2009](#); Knipper et al. [2010b](#); Grützmann et al. [2012](#)). In Germany, the first regular teaching programme in

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undergraduate medical education, which, in contrast e.g. to the United States comprises 6 years of general training (2 years of basic science, 3 years of clinical science and 1 final year of clinical teaching, followed by postgraduate specialisation), was launched as a clinical elective on “migrants’ health” at Giessen University in 2004 (Knipper and Akinçi 2005). My personal engagement in teaching cultural competence issues started with this course. Right from the beginning, ethnography was a constitutive element of the didactic philosophy, in combination with clinical issues and a modest component of “community immersion” to raise awareness of the real living conditions of migrants in the immediate surroundings of the medical school (ibid.; Knipper et al. 2010a).

Several local initiatives evolved in the years to follow, and a working group on “cultural competence in medical education” initiated by colleagues from Hamburg University recently identified ten (out of 36) medical schools in Germany offering activities in this field.¹ In 2012, this group was engaged to incorporate cultural competence issues into a new competency framework for undergraduate medical education that is currently being developed in Germany.

Both on the European level and in Germany, however, medical education on matters of cultural competence is still far from being sufficiently developed. According to Willen’s clarifying differentiation of two types of pedagogical interventions (Willen 2013), several courses would probably fit the first, “knowledge based” type, which corresponds with the demand of many students for learnable “facts” about, for example, particular “migrant groups”. “*What do I have to know to offer better care to Turkish patients?*” This paraphrase of a typical expression amongst students exemplifies the expectation to acquire practically useful skills and knowledge for better attending “migrants”. Other courses, however, take a more “reflective” direction, and I agree with Willen that the best option would be to combine both perspectives, on condition of an extremely critical examination of the issues to be taught as “knowledge”.

At least for undergraduate education, recent efforts to create networks, guidelines and defining learning outcomes will probably improve the situation in Germany within the coming years. At the postgraduate level, in contrast, the situation is even more difficult. Training in “cultural competence” or similar domains, for example in Psychiatry or Psychosomatic Medicine, still relies on individual initiatives, which certainly have been increasing a lot during the last years.² The key question is whether the current “boom” is only a flash in the pan or the starting point of a sustainable development at all levels of medical education.

Diversity, Migration and Medicine in Germany

Issues of culture, identity and ethnicity are essential parts of the social dimension of medical practice and healthcare. The crucial question is whether this common place

¹ http://www.uke.de/institute/medizin-soziologie/index_76728.php.

² One important initiative is the Federation of Transcultural Psychiatry, Psychotherapy and Psychosomatic in German speaking countries, DTPPP e.V [<http://www.transkulturellepsychiatrie.de/>].

tenet is actually taken seriously, or if the commitment to these allegedly “soft” aspects still remains a matter of political or individual convenience. Despite the growing quantity of initiatives, the general perception of cultural competence issues in Germany still tends towards marginalisation. Issues of culture and diversity are still relegated to a rather inferior—or probably more accurately: “exoticist”—position within the field of medicine and health.

The most obvious point is perhaps the observation that in the German context, “cultural diversity” is usually identified as a rather exclusive issue of “migrants”, very similar to Llerena-Quinn’s (2013) observation that “culture” is still perceived as “something ‘others’ have” and Bullon’s (2013) report on finding himself considered “expert” on cultural diversity only because of his minority background. In Germany, almost any statement, conference, article or book on cultural diversity in medicine and health currently starts with the magic numbers “16 million” and “nearly 20 %”, which indicate the total number and the percentage of “migrants”, respectively. One can receive the impression that “cultural diversity” itself would have “immigrated” into the realm of medicine and healthcare in the baggage of migrants and that it is relevant only because of the growing number of foreigners or foreign born individuals and their families in Germany and Europe. The hidden and probably unacknowledged assumption is that without migrants, cultural diversity would not be an issue in German medicine (and in German society) at all.

To understand current debates on “migration” and diversity in Germany, one must consider an important change in the statistical classification used to assess diversity in 2005, comparable in social and political significance to the historical shift in the U.S. Census from one-dimensional categories of “race” to the possibility of multiple “racial” responses in 2000. However, in contrast to the U.S. Census, the new statistical approach in Germany did not prepare the ground for better reflecting the dynamic and multidimensional character of “identity” between self-assignment and ascription, but rather the opposite.

Before 2005, “migrants” were commonly identified with “foreigners”, based on the German conception of citizenship. Up to today, double (or even multiple) nationality is largely excluded and in the eyes of important parts of society still incommensurate with German identity. Since 2005, the new classification draws, instead of nationality, on the axiomatic distinction between people with and without “migration background”. The supporting rationale is that a huge number of German nationals are also supposedly not fully “integrated” due to issues of migration. As a result, more than 50 % of people officially termed “migrants” are German nationals today; e.g. by naturalisation or because at least one of their parents is of foreign origin or bears a foreign passport. Many “migrants” were actually born in Germany (some even in the second generation) and never moved in or out. One of the largest groups of migrants by definition only comprises German nationals, albeit with complex migration histories and problems of identity, belonging and social exclusion: emigrants from countries of the former Soviet Union, who are descendents of German emigrants to Tsarist Russia in the eighteenth and nineteenth centuries and came “back” to Germany in large numbers after the fall of the Iron Curtain in the 1990s. Psychiatrists consider some “Germans from Russia”

(*Russlanddeutsche*) to be particularly at risk for psychosocial problems and mental disorder (Kornischka et al. 2008).

Due to German history and the complex criteria for classification, “migrants” in Germany are a large and heterogeneous group. The boundary between “migrants” and “non-migrants” is anything but self-evident (cf. Wimmer 2009). Notwithstanding, the 2005 classification is widely used, even in medicine (cf. Castañeda 2011). Statistics are published with epidemiological data that contrast migrants and non-migrants, often without considering underlying assumptions, for example regarding the possible meaning of “migration background” or a supposed “national origin” for particular health conditions or issues of access and quality of care. “Migration” has become a popular topic, providing access to project funding in terms of charity and “helping migrants help themselves”. It largely frames all considerations regarding cultural diversity even in medicine, with a robust neglect of sociological, anthropological or historical evidence. It is a homogenising, morally charged category which fosters the false impression of a clear cut boundary between “non-migrants” and “migrants” and obfuscates not only the huge heterogeneity of immigrants, but also the afflictions and desperate needs of some particular groups like undocumented migrants and refugees.

Up to now, the bloom of the politically framed discourse on migrants’ health in Germany has tended to support the already widespread perception that cultural diversity is external to medicine. Cultural competence thus still remains an issue of voluntary commitment and charity.

By Tomorrow, Today will Already be History

Similar to the descriptions of the United States and Canada in this special issue, this short outline of recent developments in Germany illustrates a central dimension of a historically based approach to cultural diversity in medicine: the increasing diversity not only in North American societies and the growing numbers and changing patterns of global migration are nothing but ongoing historical processes that shape and re-shape the societies in which medical practice and healthcare are embedded. Several papers of this special issue refer, for example, to the notion of “hyperdiversity” (Good et al. 2011) that implies ongoing dynamics of social and cultural change. Kirmayer (2013) draws attention to the changing public discourse on immigration and cultural identity in Quebec. In Europe, in contrast, we are observing changes following the financial crisis: migratory movements, for example, between Spain and Latin America inverted in 2010.³

Push- and pull-factors that make people leave their countries and define the destinations change over time, as do migration laws and other international regulations that determine the ways and physical means of migration, costs (in money, time but also social status, health and dignity), legal status and the way migrants are received or not in the host countries. All these factors are—directly or

³ The Economist, Oct. 6th, 2012: “¡Ya me voy! Latinos and locals alike are leaving for the new continent.”

indirectly—of crucial importance both for the health of immigrants (especially but not exclusively psychosocial conditions and mental health) and access to care. History, in this context, is a perspective that not only looks at the past, but which also helps to understand ongoing historical processes and how they are framed politically, and by politically informed science and scientists (cf. Roelcke 2010a). By tomorrow, today will already be history, and one must be aware of these dynamics and include this historical perspective whenever issues of cultural diversity are at stake.

The Second Historical Lens: Medical History

Key features of cultural competence training are transmitting awareness for the social, cultural and biographical dimensions of health, disease and suffering of the individual patient. A particular aim is to overcome what often is termed the “reductionist” and “fragmented” view of physicians prompted by a largely biologically defined understanding of disease and disciplinary boundaries, and to re-insert individual physicians and patients into a social relationship. Within this special issue, these points are especially present in the contributions of the three clinical educators, Bullon (2013), Malik (2013) and Llerena-Quinn (2013). From a historical perspective, this sort of critique and demands are anything but new. Even ethnographical approaches in medicine are not as rare and exotic as they may appear today (cf. Comelles 2000). Medical history shows, instead, that these have been central questions of medical epistemology and practice, as well as physicians’ professional identity, ever since natural science based approaches fostered the “disappearance of the sick man from medical cosmology” (Jewson 1976) in the nineteenth century.

In the first decades of the twentieth century, for example, a large and heterogeneous debate evolved among leading German physicians on the failures of emerging “modern” medicine to address the individual—including social and psychological—dimensions of disease. The fragmentation of medicine in a growing number of disciplines was perceived as compromising the physicians’ attention to the “whole man” (cf. Timmermann 2001). In the United States, similar ideas led, for example, to the creation of the “Yale Institute of Human Relations” by Milton C. Winternitz in 1931, with the participation of notable individuals like James R. Angell, Harvey Cushing and Franz Boas (and the opposition of Abraham Flexner) (cf. Viseltear 1984; Roelcke 2010b). However, for several reasons, Winternitz’ plan to build a centre where biological, psychological and sociological aspects of life were considered equally important, finally failed. The gap between the ambitious goals and implementation was impossible to overcome. Another example of similar though not identical dynamics is the rise and fall of “Primary Health Care” in the 1970s and 1980s (cf. Cueto 2004). Will current initiatives for “cultural competence” or “intercultural health”, which is the usual term in Latin America (cf. Fernández Juárez 2006; Salaverry 2010), suffer the same fate?

History makes evident that both the need and the struggle for a broad and serious recognition of social dimensions and relations in medical science and practice, as

well as the tendency to ignore or at least marginalise them, are part of modern medicine. The tendency to drift towards reductionism (even when claiming “holism”, see: Lawrence and Weisz 1998) is probably part of biomedicine like gravity in our physical environment, though with a decisive difference: gravity is a natural force and thus beyond our scope of influence. Medical science and practice, in contrast, are man-made and can therefore be not only understood (by historical, anthropological and sociological analysis) but also modified. However, just as climbing up the slope of a mountain or flying do not work without power and continuous efforts to overcome gravity, the realisation of a comprehensive and sustainable acknowledgment of social and cultural dimensions in medicine does not work by itself either.

Ethnography

In their introduction, Willen and Carpenter-Song (2013) draw attention to the important fact that the “sophisticated understandings of culture”, that informed the educational endeavours presented in this volume, did not automatically make the courses a success. In part, this was due to harsh resistance among students and some medical staff towards perspectives and methods that from a strictly biomedical point of view may appear “unscientific” or even provocative to physicians’ identity as representatives of “real” scientific medicine (most strikingly in Carpenter-Song and Whitley 2013). On the one hand, these are drastic but not so much surprising examples of present days’ representations of the historical struggles about the position of social and cultural sciences (and scientists) in medical institutions. On the other hand, such reactions always have a very “local” background, shaped by the local context that includes the history and identity of academic institutions (ibid.). This dimension can only be grasped by ethnographical research.

The research articles in this collection (Willen 2013; Carpenter-Song and Whitley 2013; Hannah and Carpenter-Song 2013) vividly show that ethnography is indispensable for understanding the social and cultural dynamics that—largely independent of good intentions and theoretical suppositions—are decisive for the success and acceptance of cultural competence training programmes in the medical field. Ethnography is a privileged approach for assessing the particular social and cultural dynamics which make up the “gravitational force” towards the marginalisation, omission and/or reification of “culture” in any specific medical setting. For clinicians, in contrast, it represents a fruitful perspective that helps to better understand and collaborate with patients across cultural and social barriers, and to assess the individual scope of action.

Applying Ethnography in Cultural Competence Training: Three Approaches

For the purpose of clarifying the various benefits of ethnographical approaches in cultural competence training raised by the present collection, I would like to distinguish three different ways of applying ethnography in this context:

The *first* would be the “classical one”, that according to my experience, proved to be useful in everyday teaching (cf. Knipper et al. 2010a): ethnography as a perspective students can learn to understand and to apply in clinical practice, as suggested by Kleinman and Benson (2006). Key elements include the shift in perspective to ask for “what is at stake for the patient” and to consider the meaning of ethnic identity for the individual “other”. Moreover, such an approach encourages students and physicians to look for particular features of the “culture of biomedicine” at the local level (see also: Hannah and Carpenter-Song 2013), and to assess the individual scope of action in a given situation. Key issues include communication, social and professional hierarchies, as well as real or alleged economical and time pressures that constrain a satisfying physician–patient-relation.

The issue of counter-transference, introduced to this collection by Willen (2013), is essential in this context, and I was delighted to meet with this strong reference to Devereux here. The highly emotional reactions documented by several papers in this special issue give a vivid account of the importance of taking counter-transfer into account (especially: Willen 2013; Bullon 2013; Carpenter-Song and Whitley 2013). However, it is important to note that counter-transference is not always that explosive and not specific to situations in which ethnic minority patients, migrants or indigenous people are involved, but relevant in any physician–patient-interaction. It is a general and often very subtle issue, yet the effect is likely to increase in case of perceived cultural—or other form of social—“distance” between health professionals and patients and/or relatives from social groups “at the margin” of society (cf. Mohr et al. 2012 on homeless people).

The *second* application of ethnography is the approach presented by the research papers of this collection: the use of ethnography for investigating “cultural competence in action”, and, as I would like to add: “in situ”. These articles actually comply with the announcement in the introduction by Willen and Carpenter-Song (2013), to provide detailed and meaningful insights into “real-world efforts to teach clinicians and health researchers (...) issues of culture, difference, and inequality”. These papers brilliantly display the strengths of ethnography in the field of medical education, where this approach is still uncommon (Leung 2002; Atkinson and Pugsley 2005).

Also in this application, the “counter-transference” concept provides an extraordinarily useful theoretical framework that adds meaning to the empirical data. In addition, it exemplifies a very important, but for outsiders probably challenging epistemological principle of the ethnographic endeavour: ethnography is both a very open, inductive approach *and* guided by theory, like “counter transference” or Kleinman’s “explanatory model” (Kleinman 1980; Kleinman and Benson 2006). The art of ethnography is to bring empirical openness, adaptability *and* theory into productive dynamics. Furthermore, the different study designs of the three research articles demonstrate the adaptability of this approach. I will only draw attention to Carpenter-Song and Whitley’s “auto-ethnographic” approach (2013), which elucidates the possibility of doing ethnographical research parallel to and in correspondence with other activities, like—in this case—engagement in an inter-institutional collaboration in research and training. Taken together, the three research articles give a very good idea of what ethnography means and what it is

able to accomplish in medical education, and that it is much more than only applying “qualitative methods” or conducting focus-group-discussions and surveys.

The *third* application, finally, was inspired by writing about the German situation with the research articles and companion essays of this special issue in mind: By applying ethnography to study “cultural competence *in action*”, the course itself becomes the anthropological field, in which crucial matters of the “cultural competence” teaching curriculum are constantly played out and thus can be observed and mirrored to the participants. The negotiation of cultural and professional identities, including, for example, the dynamics of cultural attributions, the often subliminal power of stereotypical thinking, and the implicit but persistent demand for “do’s and don’ts” about “cultures”, are typical ingredients of any programme of cultural competence. It might be useful to adopt (as a teacher) and impart (to the students) a constant “auto-ethnographic” perspective on these issues, theoretically based primarily on migration and ethnic studies (e.g. Wimmer 2009). The goal is to make clinical teachers, students and clinicians understand that whenever “culture” is addressed as a relevant matter, they are directly involved in social processes around identity and the constant negotiation of ethnic, professional and social boundaries of any kind. The rich ethnographical accounts and the frankness in the clinical instructors’ accompanying essays show this quite plainly. This correlates with my own experience in Germany, where the migrants’ health course is often said to be the first and only opportunity to deal with issues of diversity among students and physicians: for the first time after years of sharing the same classrooms, students without a “migration background” get insight into the “different lives” (Hannah and Carpenter-Song 2013) of their peers and the more or less subtle experiences of racism they face both outside and inside medical school. Sometimes, these moments are emotionally disturbing and tense. Such strong reactions as those reported for example in Willen’s, Bullon’s and Carpenter-Song and Whitley’s papers (Willen 2013; Bullon 2013; Carpenter-Song and Whitley 2013), however, I have never experienced as yet.

Finally, Carpenter-Song’s and Whitley’s paper (2013) draws attention to a further aspect: Their account of the academical cooperation between a historically Black university and the Ivy League research centre shows the different layers of identity that are at stake. The ethnic dimension is often entangled with questions of professional identity: the “disciplinary divide” between medicine and anthropology. The particular challenge for cultural competence training is to make the multilayered dynamics of identity visible and tangible for the students.

Safe Space and Knowledge

How can these rather theoretical issues be operationalised in teaching? The articles in this collection draw attention to especially two issues of cross-cutting relevance: Creating “safe space” and the question of “knowledge”.

Nearly all authors highlight the importance of creating “safe space” for reflective processes, most explicitly Hannah and Carpenter-Song (2013), Llerena-Quinn (2013), Guzder and Rousseau (2013), and Kirmayer (2013). I very much agree with this point

and will highlight only a few additional thoughts: To my eyes, the most significant evidence of the need for “safe space” and reflective processes can be found in the research paper on the rather knowledge-based course for psychiatric residents by Willen (2013): Willen’s article shows that the ethnographical interviews turned out to be used for reflection by the course participants. To a certain extent, talking with the anthropologist converted into the “safe space” they needed to express themselves and to reflect on their impressions and feeling regarding the course topics.

A further valuable tool to stimulate reflective processes, which has not been mentioned yet, is reflective writing (cf. Lie et al. 2009). In my experience, reflective writing proved very useful e.g. for seeing “the ‘different other’ beyond stereotypes” and improving “cultural awareness”, as Llerena-Quinn (2013) pointed out. Not only the authors but also other students benefit from such creative exercises, as they get inspired and encouraged by the narratives of their fellows and by the discussions that follow.

This brings me to the second point: the question of suitable knowledge. Since “facts” on “cultures” or cultural “traits” are completely inappropriate, the first step in teaching must always be to defy such expectations and to discuss the underlying assumptions. Useful issues to learn, in contrast, are “facts” about the historical background of our societies (e.g. history and legacy of the U.S. Census categories) and present day social and cultural dynamics including migration and demographic trends at local, national and global levels. The evolving history of medical approaches to diversity is a further topic, as well as “social determinants of health” in general and combined with ethnographical insights into the real lives and living conditions of minority groups at home and abroad.

The Canadian seminar, for its international participants, broad thematic spectrum, interactive approach and especially for explicit endorsement of “recurring tensions” between, inter alia, “holding and discomfort” or “expert position and multiplicity of voices”, looks like a very well-developed model (Guzder and Rousseau 2013; Kirmayer 2013). However, it is still—as the authors admit—an isolated activity, surely very interesting and intellectually nourishing, but probably with little long lasting relation to participants’ everyday clinical life. However, only a constant engagement with these topics will finally make the difference. The gravitation pull towards marginalisation of the social and cultural dimensions of medicine needs continuous attention. I am thus particularly grateful for Guzder and Rousseau’s final remark that one intensive seminar “cannot replace continuous supervision and team reflection” (ibid). The best option would probably be to combine this sort of intensive courses with continuous reflective practices, like Balint reflective groups, with diversity as one topic among others (cf. Leggett 2012).

Conclusion

The inclusion of “cultural competence” in medical education is actually a matter of increasing relevance “around the globe” (Willen and Carpenter-Song 2013) just as “hyperdiversity” and migration are essentially global issues, yet with always particular “local” shape. The challenges for research and training are to keep pace with these accelerated historical and social developments, and to overcome the

prejudicial disciplinary divides not only between clinical medicine and social sciences. The disjunction within the latter, e.g. between anthropology, history and the various sub-disciplines in these fields, also needs to be bridged.

The anthropological approach presented in this highly recommended special issue is essential for improving cultural competence. Yet especially in connection with history, it may actually become a means for providing “quality care to patients everywhere, from anywhere, with whatever differences in background that may exist” (Betancourt 2006, p. 501).

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