Losing Culture on the Way to Competence: The Use and Misuse of Culture in Medical Education

Jessica Gregg, MD, PhD, and Somnath Saha, MD, MPH

Abstract

Most cultural competence programs are based on traditional models of cross-cultural education that were motivated primarily by the desire to alleviate barriers to effective health care for immigrants, refugees, and others on the sociocultural margin. The main driver of renewed interest in cultural competence in the health professions has been the call to eliminate racial and ethnic disparities in the quality of health care. This mismatch between the motivation behind the design of cross-cultural education programs and the motivation behind their current application creates significant problems. First, in trying to define cultural boundaries or norms, programs may inadvertently reinforce racial and ethnic biases and stereotypes while doing little to clarify the actual complex sociocultural contexts in which patients live. Second, in attempting to address racial and ethnic disparities through cultural competence training, educators too often conflate these distinct concepts. To make this argument, the authors first discuss the relevance of culture to health and health care generally, and to disparities in particular. They then examine the concept of culture, paying particular attention to how it has been used (and misused) in cultural competence training. Finally, they discuss the implications of these ideas for health professions education.

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> I have come to believe that her life was ruined not by septic shock or noncompliant parents but by cross-cultural misunderstanding.[1]
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> Too often, poverty and violence against the poor become collapsed into an all-accommodating concept of culture. . . . "Culturally sensitive" explorations have served to undermine explorations of other forces that shape the lives of our subjects.[2]

In her 1997 book *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures,* Anne Fadiman eloquently makes the case for incorporating cross-cultural education in medical schools and training programs. She recounts the compelling and tragic story of a Hmong family's experiences with the Western medical system when the family's youngest child, Lia, develops a seizure disorder. Ultimately, and partly due to cross-cultural misunderstanding, the little girl suffers a massive seizure complicated by septic shock and lapses into a coma from which she has not recovered. Fadiman concludes her book by expressing the hope that medical schools and training programs will recognize the need to address cross-cultural issues in health care in order to avoid repeating tragedies like Lia's. Five years later, after reviewing the evidence for disparities in health care among racial and ethnic minorities, the Institute of Medicine (IOM) echoed Fadiman's sentiment with their recommendation that medical training programs "integrate cross-cultural education into the training of all current and future health professionals."[3 p.20]

Medical education is heeding that call. Since the early 1990s, efforts to implement cross-cultural education, more commonly termed "cultural competence" training, have burgeoned across the country, and significant time, training, and resources have been poured into attempts to make that education optimally effective. Most of these programs are based on traditional models of cross-cultural education that were motivated primarily by the desire to alleviate barriers to effective health care for immigrants, refugees, and others on the sociocultural margin. The idea was that immigrants' unfamiliarity and potential discomfort with mainstream American practices and institutions, and physicians' unfamiliarity and discomfort with immigrant beliefs and behaviors, led to a "cultural distance" between immigrants and the Western health care providers from whom they sought care. That distance led to significant cross-cultural misunderstandings and occasionally disastrous health care consequences. The cultural competence movement appropriately recognized this problem and began to address it, primarily by educating physicians and policymakers about culture, culture-specific beliefs, and their potential impact on health and health care.

The motivation behind the more recent resurgence of interest in cross-cultural education, however, is substantively different. As reflected by the IOM's recommendation, the main driver of renewed interest in cultural competence in the health professions has been the call to eliminate racial and ethnic disparities in the quality of health care. In this article, we argue that the mismatch between the motivation behind the *design* of cross-cultural education programs and the motivation behind their current *application* creates significant problems. First, in trying to define cultural boundaries or norms, programs may

Dr. Gregg is assistant professor of medicine, Division of General Internal Medicine, Oregon Health and Science University, Portland, Oregon.

Dr. Saha is staff physician, Portland VA Medical Center, and associate professor of medicine, Oregon Health and Science University, Portland, Oregon.

Correspondence should be addressed to Dr. Gregg, Oregon Health and Science University, Division of General Internal Medicine, 3181 SW Sam Jackson Park Rd., L-475, Portland, OR 97201; telephone: (503) 494-3317; fax: (503) 494-0979; e-mail: (greggj@ohsu.edu).

inadvertently reinforce racial and ethnic biases and stereotypes while doing little to clarify for physicians in training the actual complex sociocultural contexts in which patients live. Second, in attempting to address *racial and ethnic* disparities in care through *cultural* competence training, educators too often conflate these distinct concepts. This leads to an inappropriate collapsing of many of the forces affecting racial and ethnic minority populations—such as poverty, violence, and racism—into the less threatening concept of culture. It also leads to the misdirected application of cultural competence education as a solution to health care disparities for minority populations who are as familiar with mainstream American health care practices and institutions as the majority population, but who lack the resources and political clout to improve their health and health care.

To support these arguments, we first discuss the relevance of culture to health and health care generally, and to disparities in particular. We then examine the culture concept, paying particular attention to how it has been used (and misused) in cultural competence training. Finally, we discuss the implications of our examination for health professions education.

Culture and Health: The Case for Cross-Cultural Education

A large body of research confirms that physicians' and patients' models of disease and health care often vastly different. This makes sense. While definitions of culture vary, most agree that, at minimum, culture constitutes a set of behaviors and guidelines that individuals use to understand the world and how to live in it. If individuals interpret the world through different guidelines (i.e., if they come from different cultural backgrounds), they will likely interpret the "same" disease in different ways. This can become a problem if a clinician and a patient have different cultural backgrounds. Each operates under a different set of assumptions, and the potential for miscommunication and frustration is great. In fact, research has demonstrated that patient and physician interpretations of disease are often quite dissimilar, and may affect the quality of care a patient receives.[4–7]

To give just one example, now classic research among low-income African American women in New Orleans, Louisiana, disclosed two different interpretations of the medical synonyms high blood pressure and hypertension, a condition that disproportionately affects African Americans. Study participants explained that "high blood" was the result of too much or too-thick blood. The condition was thought to be exacerbated by rich diets and red meat, and best treated with medication. "High-pertension," on the other hand, was perceived as a more acute condition in which blood rose rapidly to the head. It was described as being caused by anxiety or nervousness, and as being unaffected by medication. Women subscribing to either of these two illness interpretations had poor adherence to prescribed antihypertensive regimens. Women who believed they had "high blood" as opposed to "high-pertension" were the least likely to adhere to their medical regimen. The authors suggested that adherence to medical regimens might improve if physicians were aware of, and able to work with, their patients' illness conceptions.[8]

Of course, it is not only patients whose beliefs may adversely affect health care. Western health professionals also have distinct belief systems, arising largely from their biomedical cultural orientation. Biomedical culture, born of the post-World War II explosion in science and technology, is characterized by a strong belief in the value of newer, Western, and more technically sophisticated treatments.[9] These beliefs may have led physicians to embrace therapies for arthritis, for instance, including arthroscopic knee surgery and COX-2 inhibitors (e.g., Vioxx), that proved to be ineffective or even harmful,[10,11] while snubbing "complementary and alternative" therapies such as acupuncture, long valued by patients,[12,13] that have proved to be effective.[14] Furthermore, physicians are not immune to the larger cultural context in which they live and practice. Thus, physicians from different cultural backgrounds differ markedly in the medical therapies they offer and in how they understand health and disease.[15]

Clearly, then, different cultural beliefs and illness interpretations between patients and physicians may contribute to disparities in health and health care, and, implicitly, cross-cultural education should help reduce these disparities. To the extent that cross-cultural education equips health professionals to elicit from patients their differing health beliefs and to effectively negotiate potential conflicts between the patient and provider belief systems, it has a well-justified role as a component of efforts to reduce racial and ethnic disparities in health and health care.

Misusing Culture: Stereotyping and Simplification

Acknowledging that it is important for clinicians to understand that both they and their patients have cultural filters that color their interpretations of both health and disease, it is equally important to appreciate the complex ways in which these filters operate. Otherwise, cultural competence programs run the risk of reinforcing cultural stereotypes and biases, and of seeing stable cultural norms or predictable culturally based behaviors where none exist.[16–18] Yet within the cultural competence movement, culture *is* frequently defined in a rather uncomplicated fashion—as a fixed, knowable entity that guides individuals' behavior in linear ways. For example, Leininger, in work on the importance of cultural sensitivity in nursing care, defines culture as "learned, shared and transmitted values, beliefs, norms, and lifeways of a particular group that guides their thinking, decisions, and actions in patterned ways."[19, p. 47] Similarly, on a Web page devoted to promoting cultural competence, the Bureau of Primary Health Care defines culture as "the shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people."[20] At first pass, these definitions seem reasonable, and, in fact, they correspond to classic anthropological definitions of culture as reflecting "a complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society."[21, p. 1] On closer examination, however, it becomes clear that those definitions may obscure more about people, their lives, and their motivations than they clarify. Culture is not that simple. Rather, it is complex, problematic, and frequently contested.[22–24]

For example, cultures cannot be considered discrete bounded wholes. Particularly now, at a time in which people are increasingly technologically connected, and ideas travel rapidly across continents, it is hard to imagine discrete, stable cultural "wholes" that can be readily learned.[25] Most anthropologists now agree that it is not legitimate to assume that any distinct ethnic, linguistic, or other group in the United States can ever be said to be unaffected by contact with the multiple other groups—ethnic, religious, socioeconomic, sexual, and so forth—with whom they must invariably rub shoulders.[25,26] As a result, the idea of culture considered as a neatly packaged and separable whole that can be summed up simply enough for "competence" is antiquated.

Furthermore, individuals invariably belong to multiple cultures, and those cultures are not necessarily coherent nor will they always join together seamlessly.[22,27] A second-generation Salvadoran woman with cervical cancer who works as a nurse may belong, simultaneously, to cultures unique to El Salvador, to women, to the ill, and to the medical profession. These cultures may hold mutually contradictory or mutually reinforcing values that the individual somehow must negotiate. And the value that the individual privileges at any one point in time may not be the same value or belief that she privileges at another.

Anthropologist Janelle Taylor makes this point in a critique of *The Spirit Catches You and You Fall Down*. She notes that while Fadiman's account of a Hmong family's attempts to negotiate the American medical system is compelling, it presents a static notion of Hmong culture that does not allow for the possibility of dissent or individual variation within that population, and that therefore moves perilously close to stereotyping an entire community. Thus, when Hmong individuals in the book act in ways that do not accord with "Hmong culture" they are considered Americanized or simply "American," and no longer fully Hmong. As Taylor notes, a more appropriate interpretation of individual variation might be "that people in the community do not simply act out shared understandings and values, but instead argue and struggle over what is the right way to live, what shall count as 'Hmong culture,' and who gets to decide this question."[28, p.166] That is, what is Hmong may not be the same for all individuals of Hmong background, and what it means for an individual to "be Hmong" may change for that person, and for others, over time.

In addition, even if one does have some knowledge of another person's cultural beliefs, this does not mean that it is possible to predict that person's behavior or preferences at any given time. Cultural beliefs do not simply "cause" us to behave in a certain way. Anthropologist John Larsen, studying patients with schizophrenia, found that patients' explanations and understandings of their first psychotic break continually changed depending on those individuals' involvement in different medical, social, and institutional contexts.[29] Thus, knowing what an individual believed about his or her disease at one point in time did not predict her or his belief or understanding at other points in time. Rather, as Ann Swidler has explained, individuals may use culture as a "'tool kit' [or a repertoire] of symbols, stories, rituals, and world-views, which people may use in varying configurations to solve different kinds of problems."[30, p. 273]

Thus, the danger of overly narrow and simplistic conceptualizations of culture is that they may reinforce stereotypes and contribute to, rather than reduce, cross-cultural misunderstanding. They may also then prevent in-depth exploration of the multiple, complex, and interrelated social, cultural, political, and economic factors that combine to influence patients' behavior.

Misusing Culture: Conflating Concepts

An overly broad understanding of culture is equally dangerous. As mentioned above, the cultural competence movement has been largely "adopted" from efforts to care for unacculturated immigrant populations and applied to the newer goal of addressing racial and ethnic disparities in health and health care. Racial and ethnic disparities are in most cases complex and undoubtedly multifactorial. The cultural competence moniker, however, has been used to describe nearly all efforts to reduce disparities, including those related and unrelated to the concept of culture, presumably for the sake of simplicity. For example, the National Center for Cultural Competence, a federally funded center at Georgetown University, suggests that cultural competence education should include a commitment to addressing racism and decreasing problems with access for the poor and minorities.[31] Yet, while cultural differences may exacerbate the problem of differential access and discrimination, "culture" is ultimately not the central problem for the large segments of our population who live in unhealthy conditions, have limited health care access, and have little power to change the circumstances of their lives. Suggesting that addressing these issues is part of culturally competent care implicitly sends the message that poverty and discrimination produce adverse health effects through their impact on cultural beliefs, a notion that unjustly trivializes the larger problems of social disadvantage and deprivation.

Indeed, the cultural distance between health care providers and immigrant patients that has driven the evolution of cross-cultural education may not apply to the populations for whom research has most convincingly demonstrated disparities in health and health care in the U.S. These groups—principally African Americans and, to a lesser extent, Latinos and Native Americans—certainly have unique cultural identities and traditions, but many if not most individuals from these groups were born and raised in the United States[32] and are as familiar with mainstream American health care practices and institutions as the majority population. In other words, the cultural distance that cultural competence is intended to bridge may not be so great for many of the groups most affected by racial and ethnic disparities in health and health care.

In fact, a focus on culture may dangerously distract us from disturbing issues of racial discrimination in health and health care. Individuals often conflate the terms "ethnicity" and "culture," suggesting that each is equivalent to the other. They are not. Persons who share an ethnic background *may* hold particular cultural beliefs and behaviors in common, yet a shared ethnic background does not necessarily or invariably mean that they share those cultural traits. For all the reasons outlined above, including that cultures

are nondistinct and, perhaps most important, that individual behavior is not determined by any set of definable cultural norms, an individual's race or ethnicity cannot serve as a guide for how a physician should interact with a patient in a clinical encounter. It is equally important to note that while multiple studies have shown that a patient's perceived race does in fact affect the quality and type of care he or she receives,[3,33,34] racism is not solved by teaching about culture. Once again, simplistic notions of culture may actually reinforce stereotypes by introducing reified ideas of racial culture and beliefs. By subsuming race under the rubric of culture, racism and discrimination become part of "cultural differences" and are thereby more palatable and easier to ignore.

Additional examples of the mismatch between traditional cross-cultural education and the goal of reducing racial and ethnic disparities in health care come directly from lectures and curricula on cross-cultural health care. As researchers and educators interested in the intersection between culture and health, we have attended numerous conferences and lectures focusing on cultural competence as a mechanism to reduce disparities in health care. We have been struck during these sessions by the recurrent use of slides displaying a single image: the pockmarked back of an Asian woman who has recently undergone "cupping" or "coining," healing practices involving the application of heated cups or coins to the skin, leaving multiple circular marks. Cupping may be used by healers to address a variety of somatic complaints. In showing this image, lecturers typically point out the potential for a "culturally incompetent" health care provider to misinterpret this finding as evidence of physical abuse. The image provides a simple yet striking illustration of the potential adverse consequences of cross-cultural misunderstanding. But it has little if any relevance for the majority of Americans, both Asian and non-Asian, affected by disparities in health care and therefore ironically distracts from the purported motivation behind their use.

Making a related point, based on her work with migrant farm workers, anthropologist Jennifer Hirsch has argued that efforts aimed at improving the cultural appropriateness of health care for some immigrant groups unfortunately promote a "consumer choice approach" to public health. This may make services more attractive to those who have access to those services, but does nothing to address the even more pressing needs of those who, by virtue of their social and economic status, are unable to access any kind of health care, culturally appropriate or not. Further, she suggests that by targeting health care resources to discrete ethnic and cultural groups, "the interweaving of health services and identity politics works against the recognition of the shared inequalities faced by all the poor, native and immigrant alike."[35] Thus, in the process of recognizing cultural differences and culture-specific health risks, systemic inequalities that affect all the poor or underprivileged, regardless of their ethnic or cultural background, are not addressed.

Implications for Health Care Education

Given these critiques, is there still a role for cross-cultural education in the campaign to eliminate racial and ethnic disparities in health and health care? We believe that there is. The problems with the current application of cross-cultural education arise not from a lack of relevance of culture to racial and ethnic disparities, but from simplistic treatment of the inherently complex concept of culture; careless use of the term "culture" to describe *social* and *psychological* phenomena; inappropriate extrapolation of phenomena arising in situations where cultural distance is great to those where cultural distance is small; and inadequate attention to the existing knowledge base, derived mainly from the field of medical anthropology, describing the myriad and often complex ways in which culture affects health and health care.

We suggest, therefore, that cross-cultural curricula in medical settings need to stress five central concepts. First, culture matters in health and health care. It affects every aspect of our lives—what we eat, how we work, how we play, and how we think about disease, health, and healing. Therefore, understanding the role of culture, and learning the skills to elicit patients' individual beliefs and interpretations and to negotiate conflicting beliefs is important to good patient care, regardless of the social, ethnic, or racial backgrounds of the patient. At the same time, it is critical to understand the limitations of a cultural analysis and to be exposed to the critiques and contradictions that such analyses engender. While this approach may make teaching about culture more complicated, it also makes it more compelling, honest, and ultimately more relevant to the care of patients whose lives will not fit in a predetermined cultural box.

Second, learning about culture and becoming "culturally competent" is not a panacea for health disparities. Individuals who, by virtue of race or language or dress, seem most culturally distant from health care providers also often have the poorest health outcomes. But, as long as the poor and the socially disenfranchised do not have access to affordable, quality, health care, attempting to bridge cultural distance is not the only, and probably not the most important, step clinicians and policymakers can take to alleviate health disparities.

Third, culture, race, and ethnicity are distinct concepts. Just as learning about culture will not eliminate disparities, neither will it eliminate racism. This is complicated because culture *is* clearly tied up with race and ethnicity. Individuals self-identify and they are identified by others on the basis of how they look and what language they speak, and communities organize around these obvious markers. But, as we hope we have shown, members of a particular racial and ethnic group do not necessarily share the same cultural background or beliefs.

Fourth, culture is mutable and multiple. Therefore, any understanding of a particular cultural context is always incompletely true, always somewhat out of date and partial. That said, the logical conclusion is not to throw up one's hands and walk away from the whole endeavor. Rather, educators need instead to recognize the limitations of cultural analysis and know that while it is not possible (or even desirable) to codify abstract realities, it is possible to recognize and attend to those realities, and in the process to learn something, if not everything, about particular cultures and their impact on health.

Finally, context is critical. Because culture is so complex, so shape-shifting, and so

ultimately inseparable from its social and economic context, it is impossible to consider it as an isolated or static phenomenon. Thus, attempts to "learn" or "teach" about culture outside of the context of lived reality will inevitably fail. Curricula that attempt to teach about culture must be able to show students culture in its historical, socioeconomic, and geographic contexts, and must be able to show students how those contexts both maintain and alter culture and health on an ongoing basis. Some cultural competence curricula have already begun to provide this more holistic and complex view of culture and health disparities, by interactively exposing learners to the communities and environments in which their patients live their daily lives.[36–42]

As Delese Wear has argued, this type of robust curriculum not only will clarify the contextual nature of others' cultures, but will allow students to "see themselves as 'situated' individuals who have a very specific social and economic location that influences each and every interaction they have with patients."[43, p. 553] In becoming familiar with the families, communities, and economic circumstances of members of their patient population, physicians-in-training are allowed the opportunity to challenge their own stereotypes and to examine their own biases. They may learn not only to attend to differences in beliefs or attitudes, but also to understand the role that individual, social, and economic factors have in shaping those beliefs and attitudes. With this more nuanced understanding of culture, and with a greater appreciation of the fundamental role of social and structural factors in determining health, future clinicians will be much better prepared to understand and address health disparities.

Conclusion

Culture matters, and it cannot and should not be ignored by clinicians or the health care systems within which they work. It affects every aspect of our lives, including how we think about disease, health, and healing. It is part of the puzzle of human meaning-making and behavior that makes clinical encounters and the practice of medicine itself so rich, interesting, and alternately frustrating and rewarding. But culture, in all its richness, does not simply explain health behaviors, nor does sensitivity to culture solve health disparities. Rather, culture works dynamically, in conjunction with economic and social factors, to affect health behaviors and to alleviate or exacerbate health disparities. Thus the difficult but important task of cross-cultural education in medical settings must now be not only to effectively communicate the ways that culture affects health and health care, but also to make clear the limits of cultural analysis and the unfortunate contributions of social and structural factors in maintaining health disparities by race, ethnicity, and social class.

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Teaching and Learning Moments

Chief of Service

Facing the attending physician was more difficult than usual. Although stunning, the light reflecting off Lake Michigan caused all members of the medical team to squint while on chief of service rounds. It was an unusually warm Thursday in April 1983 at Chicago's Michael Reese Hospital, at the time a nationally renowned teaching institution and major affiliate of The University of Chicago.

The student subintern presented the story of a man who came to the emergency room 72 hours earlier with frothy urine, an impaired sense of taste, and shortness of breath. After reciting the differential diagnosis, the student awaited the drill of questions and the inevitable moment when, without an answer, the focus would turn to others on the team. This afternoon, however, the chief of service engaged the student and the patient in a conversation not about the differential diagnosis of amyloidosis but of the patient's life—his family, occupation, interests, and hobbies—and how this diagnosis would impact the patient and his wife, his work, and his prognosis.

I was the fourth-year-student presenting at the bedside on that April day and Dr. Jordan Cohen, then chairman of the Department of Medicine, was conducting chief of service rounds. I learned a foundational lesson for my career in medicine that day on 6 Main Reese. Beyond cutting-edge technology and scientific advances, there is a patient with a story whose life in context means far more than diagnosis and prognosis in isolation. In this bedside teaching session, Dr. Cohen communicated the values of humanism and professionalism, which lie at the core of the doctor–patient relationship and of medicine itself. Most of all, our conversation regarding this patient left an indelible mark that is still with me more than 20 years later.

Little did I know then, that this was the first of many lessons I would learn from Dr. Cohen. Over the years, he became a role model, a mentor, the wise one—whose advice I would later seek for my own career path. The compelling themes about science and values and the profession that he professed at the bedside in 1983, I would later hear him espouse from the podium at national meetings, in written papers and transcripts, and in personal conversations. His voice united us when government and insurers sought to pull us apart. His voice called for collaboration, compassion, and professionalism at a time when others were unwilling and always less articulate in laying out the challenge and calling us to action. His is a courageous kind of leadership offering a refreshing sense of hope and optimism when the profession has needed it most. Most of all, his voice is unwavering and steady in these turbulent times.

The same compassionate and steady voice that I heard at the bedside more than two decades ago is the voice that has led academic medicine faithfully and boldly into the 21st century. Boldness without a moral framework will not stand the test of time; and so his commitment to the higher purpose found in becoming a physician has kept the dream alive for all of us. Today, I squint not because of the sunlight, but in restraining the emotions of deep gratitude for the multiple moments in my own career when academic medicine's chief of service touched my life.

> By strengthening our explicit commitment to the ethical underpinnings and moral imperatives of the doctor–patient relationship, and by making that commitment unmistakably visible to applicants, to our students, to the public at large, and to ourselves, we can ensure that the best and brightest continue to clamor for entry into medicine, the most appealing of all possible human endeavors.
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> —Jordan J. Cohen, MD, from the President Address presented at the plenary session of the 112th annual meeting of the Association of American Medical Colleges. This address was published in *Academic Medicine* (2002; 77:475–80).

Holly J. Humphrey, MD

Dr. Humphrey is professor of medicine and dean for medical education, The University of Chicago Pritzker School of Medicine and The University of Chicago Hospitals, Chicago, Illinois.