

Insurgent Multiculturalism: Rethinking How and Why We Teach Culture in Medical Education

Delese Wear, PhD

ABSTRACT

The author proposes a theoretical orientation for cultural competency that reorganizes common curricular responses to the study of culture in medical education. What has come to be known in medical education as cultural competency is theoretically truncated and may actually work against what educators hope to achieve. Using Giroux's concept of *insurgent multiculturalism*, she suggests that the critical study of culture might be a bridge to certain aspects of professional development. Insurgent multiculturalism moves inquiry away from a focus on nondominant groups to a study of how unequal distributions of power allow some groups but not

others to acquire and keep resources, including the rituals, policies, attitudes, and protocols of medical institutions. This approach includes not only the doctor-patient relationship but also the social causes of inequalities and dominance. Linked to professional development efforts, insurgent multiculturalism can provide students with more opportunities to look at their biases, challenge their assumptions, know people beyond labels, confront the effects of power and privilege, and develop a far greater capacity for compassion and respect.

Acad. Med. 2003;78:549-554.

Humility, and not so much the discrete mastery traditionally implied by the static notion of competence, captures most accurately what researchers need to model and hold programs accountable for evaluating in trainees under the broad scope of multicultural training in medical education.¹

Cultural competency, frequently addressed in many academic medicine publications and conference papers during the past decade, is perceived by medical educators and accrediting bodies as deficient in the curriculum, and by extension, in medical students. In this article, I develop a theoretical orientation for cultural competency that reorganizes common curricular responses to the study of culture in medical education. In fact, I contend that what has come to be known in medical education as cultural competency is

theoretically truncated and may actually work against what educators hope to achieve. I explicate Henry Giroux's idea of *insurgent multiculturalism* as a more useful orientation to cultural competency in medical education and then propose it as a bridge to critical aspects of professional development.² But first, I offer a critique of prevailing concepts of cultural competency in medical education.

TEACHING CULTURE IN MEDICAL EDUCATION: WHAT'S MISSING

Cultural competency, agreed upon as a core value and ostensibly modeled in clinical settings, has taken hold in curriculum decision making in medicine at all levels, from medical school to residency to continuing medical education (CME). Cultural competency (sometimes known as cultural awareness, cultural sensitivity, or simply multiculturalism) usually has a definite curriculum component that is knowledge- or skill-based. It would probably surprise the "laity" to learn that this is a relatively new curricular project because it seems commonsensical that the study of patients in all their varieties would be found throughout the medical curriculum: How does one take care of patients without

Dr. Wear is professor, Department of Behavioral Science, and associate director, Human Values in Medicine program, Northeastern Ohio Universities College of Medicine, Rootstown.

Correspondence should be addressed to Dr. Wear, Department of Behavioral Sciences, Northeastern Ohio Universities College of Medicine, 4209 State Route 44, P.O. Box 95, Rootstown, OH 44272; telephone: (330) 325-6125; e-mail: {dw@neucom.edu}. Reprints are not available.

knowing the social and cultural contexts from which they come or without knowing the complex interplay of patients' values and beliefs with their conceptions of health and illness?

Unfortunately, such patient-focused inquiry has not always been present in the medical curriculum. George Engel's now classic article in *Science* charged medicine with reducing humans to their smallest biological parts and provided a biopsychosocial model of medicine, a heuristic based on complex interaction among the organizational levels (i.e., the biological, social, and cultural dimensions) of human beings.³ Medical education rose to this challenge and responded in several ways, devising new programs that brought students to patients in more natural settings outside hospitals and urging more collaborative relationships with other health care providers such as nurses and social workers. People have social dimensions, young doctors-in-training were told, and attention should be paid to these areas as significant determinants of health and illness. Now such pronouncements sound oddly dated, self-evident, like old wine in new bottles. But they have appeared again in the medical education literature under the guise of cultural competency, as though diversity in race, ethnicity, cultural identity, religious belief, and sexual identity suddenly appeared in medical settings!

Very few academic medical educators would deny the need for students to understand and respect differences among people based on gender, race, ethnicity, social class, physical or intellectual abilities, sexual identity, or religious beliefs. Yet, racial disparities in health have been documented throughout history, and socioeconomic status remains a "persistent and pervasive predictor of variations in health outcomes."⁴ The recent Institute of Medicine's (IOM) study, "Understanding and Eliminating Racial and Ethnic Disparities in Health Care,"⁵ is a direct confrontation of injustices in medical care in the United States based on providers' attitudes, lack of knowledge, and lack of skills. Thomas Inui, one of the committee members, reported that committee members were "stunned" by the evidence of the roles that "bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers play in perpetuating health care disparities."⁶ In fact, the committee found that "when sociocultural differences between patient and provider aren't appreciated, explored, understood, or communicated in the medical encounter, the result is patient dissatisfaction, poor adherence, poorer health outcomes, and racial/ethnic disparities in care."⁵

The IOM's report is one of the most direct and searing looks at the damage brought to patients because of providers' cultural biases and ignorance. Identifying current efforts in teaching cultural issues to medical students, one chapter, "Cross-cultural Education in Health Professions,"

is a short overview of curricular strategies most commonly used in health care curricula, such as cultural sensitivity/awareness approaches (focusing on attitudes), multicultural approaches (focusing on knowledge), and cross-cultural approaches (focusing on skills). These approaches revolve around the development of respectful attitudes, accurate knowledge, and appropriate behaviors in care givers toward diverse groups and cultures. However, these approaches often lapse into the familiar, reductionistic, add-a-lecture-test-for-knowledge curricular response, what Fox calls "biologizing" the cultural aspects of health, illness, and medicine.⁷

Unfortunately, medical education rarely looks outside its own literature to examine how culture is conceived and taught in other domains. The discourses conceived in cultural, curriculum, feminist, and postcolonial studies are critical and complex and provide alternative ways of thinking about teaching culture relevant to medical education. The *cultural sensitivity/awareness approach*, for example, has been criticized for over a decade for its naive emphasis on the role of individual attitudes in the formation of and transformation of racism (i.e., if educators just talk about it and "expose" students to different cultures, they will become more sensitive, understanding, and respectful). Of course, this approach (like many others) assumes that the locus of normalcy is white, Western culture—that "difference" means nonwhite, non-Western, non-heterosexual, non-English-speaking, and most recently, non-Christian—how *they* are different from *us*. But this difference can not be too great; the proponents of cultural awareness/sensitivity also hope to convince students that we're all part of the human family and that our differences make our own democratic culture rich—leading to what Cameron McCarthy calls a "Disneyfied" culture with harmony among all groups.⁸

The *cultural competency approach* (which includes the IOM's multicultural and cross-cultural approaches) has its own set of problems in addition to the ones cited above. The approach looks more directly at the language and customs of particular nondominant groups, especially their beliefs and behaviors surrounding health, illness, and health care providers and institutions. The thinking here is that doctors—mostly white, well educated, and middle-class or higher—don't know enough about the range of people they will be caring for (be they people of color; people from nondominant racial, ethnic, or religious groups; people who are economically disadvantaged; people who are disabled; people who do not speak English; or people who are not heterosexual). When medical students learn *characteristics* of these groups, they can provide better health care because they will no longer hold ignorant or biased beliefs about those groups. The problem with this approach is that groups of people are often essentialized, lumped together, all of

their members possessing traits unilaterally. Within this orientation people are rarely viewed as complex interplays of identities (e.g., female, first-generation Korean, professional-class lesbian), but rather are viewed as one overarching identity (Korean), so that care givers' attitudes toward such patients can sometimes remain simplistic. As Hunt reminds us,

culture is neither a blueprint nor an identity; individuals choose between various cultural options It is not possible to predict the beliefs and behaviors of individuals based on their race, ethnicity, or national origins. Individuals' group membership cannot be assumed to indicate their culture because those who share a group label may variously enact culture.⁹

Moreover, both the cultural sensitivity/awareness and the cultural competency approaches leave out one critical factor in the study of cultural differences and inequities. Because they are based on individual attitudes, they totally ignore the *sources* of inequality. When cultural inquiry moves into this domain, which is what Giroux calls insurgent multiculturalism,² students may begin to gain a more significant understanding.

INSURGENT MULTICULTURALISM

Giroux² argues that most multicultural studies have kept the focus off structures, institutions, and governmental policies by limiting discussion to individual attitudes. A more insurgent multiculturalism—sometimes called anti-racist pedagogy¹⁰—does not limit itself to “communicative competence” or the “celebration of tolerance”² but shifts the discussion to power and the *foundations* of inequalities.

In a medical curriculum that ascribes to this approach, students would not just spend time memorizing a potpourri of racial, ethnic, and religious differences and then be evaluated for “cultural competence” by matching traits to groups. In fact, according to Giroux, attention must be shifted “away from an exclusive focus on subordinate groups, especially since such an approach tends to highlight their deficits, to one that examines how racism [and other forms of dominance and neglect] in its various forms is produced historically, semiotically, and institutionally at various levels of society.”² That is, students would also learn to identify and analyze unequal distributions of power that allow some groups, but not others, to acquire and keep resources, which would also include the rituals, policies, attitudes, and protocols of the very institution educating them. Such a curriculum incorporates a fuller range of factors that contribute to inequities by looking not only on the doctor–patient relationship but also on the *social* causes of suffering.¹¹ Ayers argues that teaching for social justice—a

foundation of cultural competency efforts—demands a dialectical stance, “one eye firmly fixed on the students. . . and the other eye looking unblinkingly at the concentric circles of context—historical flow, cultural surround, economic reality.”¹² In medical education, then, we would expect that students learn to fix one eye on their patients, the other eye on the concentric circles of their patients' social contexts.

According to Giroux, students often experience the curriculum as “a form of learning that prescribes, dictates, but never really critically engages them to ask tough questions, take risks, and commit themselves as public intellectuals.”¹³ Similarly, Waitzkin believes that most doctors want to help patients but believe they cannot do anything to change the social structures at the source of their patients' problems. He writes,

When a professional encourages mechanisms of coping and adjustment, this communication conveys a subtle political content. By seeking limited modifications. . . which preserve a particular institution's overall stability, the practitioner exerts a conservative political impact. Despite the best conscious intents the practitioner thus helps reproduce the same institutional structures that form the roots of personal anguish.¹¹

Often these social issues are found literally in the backyards of medical training. Many teaching hospitals serve poor and minority populations in their immediate surroundings, and according to Inui, “often the only aspects that students see of [these] communities . . . are what produces the circumstances that bring individuals to the hospital: violence and drugs.”⁶ How does students' education prepare them to care for patients from these circumstances? Inui fears that educative efforts are often marked by “simple-minded stereotypes and a formulaic approach, such as ‘If this patient is Hispanic, I must be careful about overestimating the amount of pain he is in because they are demonstrative about pain’.”⁶ McCarthy summarizes this critique well:

We must go further than the compensatory strategy of simply adding diverse cultural knowledges to the dominant curriculum. . . . The ultimate objective . . . is to seek the generalized diffusion throughout the whole system of [medical education] of counter-hegemonic knowledge based on the experiences of the disadvantaged. . . . A political and ethical principle of social justice should inform the selection of knowledge in the [medical] curriculum . . . [and] should privilege the human interests of the least advantaged.¹⁴

The perspectives of the least advantaged are rarely considered because they have never been a part of curriculum decision making in medical education. Or, if members of various minority groups are consulted, they are often viewed as speaking *for* the entire group membership.

Most decisions about culture and how it is approached are made by insiders—medical educators, clinicians, and other academics who have read the multicultural and cultural-competency literature written by their peers inside academic medicine. Medical education, like most other professional schools, gives rise to “semi-official narratives that authorize and provoke certain sequences of cause and effect, while at the same time preventing counter-narratives from emerging.”¹⁵ And as Susan Sherwin reminds us, “With its authority to define what is normal and what is pathological . . . medicine tends to strengthen patterns of stereotyping and reinforce existing power inequalities.”¹⁶

What might the least-advantaged groups in North America say about cultural competency efforts in medical education? Risking what I condemn—speaking for others without consulting them—my hunch is that nondominant groups would find such efforts a bit off the mark in terms their own health needs and access to care, discrimination in all its forms, unemployment, safe housing, inferior or nonexistent child care, violence, and depression, all of which contribute directly to health and illness. For example, when considering the poor in the United States, David Hilfiker believes that “medical students (and most physicians) don’t know about [their] desperation . . . because myths keep affluent people from knowing the burdens under which the poor labor.”¹⁷ And as Jeanette South-Paul notes, “The bulk of patients cared for by our medical students are suffering from poor lifestyle choices, a lack of insurance and therefore a lack of access, and conditions that patients allow to get worse before they seek treatment.”¹⁸ By focusing too narrowly on the doctor-patient relationship without critically examining context, most cultural competency efforts miss the mark.

As an unrealized curriculum project, then, this most recent call for cultural competency is an opportunity for medical educators to address culture more critically through insurgent multiculturalism than it has been possible to do in past and current efforts. Plus, another opportunity looms here to link insurgent multiculturalism directly to professional development, itself another significant current in academic medicine.

INSURGENT MULTICULTURALISM AND PROFESSIONAL DEVELOPMENT

The vocabulary of professional development currently includes, among others, such attributes as sensitivity, empathy, caring, compassion, dedication to patients, serving the greater society, equanimity, and self-knowledge, along with goals such as health promotion and disease prevention based on knowledge of the social, environmental, and emotional factors bearing on health. The overlap between

these attributes and cultural competency is obviously extensive, but professional development and cultural competency are often treated as discrete entities.

Take, for example, what the American Board of Internal Medicine’s *Project Professionalism* has to say about duty, altruism, and respect, arguably essential components of any approach to cultural competency:

Duty is the free acceptance of a commitment to service. This commitment entails being available and responsive when “on call,” accepting inconvenience to meet the needs of one’s patients, enduring unavoidable risks to oneself when a patient’s welfare is at stake, advocating the best possible care regardless of ability to pay, seeking active roles in professional organizations, and volunteering one’s skills and expertise for the welfare of the community.

Altruism is the essence of professionalism. The best interest of patients, not self-interest, is the rule.

Respect for others (patients and their families, other physicians and professional colleagues such as nurses) is the essence of humanism, and humanism is both central to professionalism, and fundamental to enhancing collegiality among physicians.¹⁸

These abstractions beg for context: What are the varied meanings of being available and responsive? To whom? How much volunteering is enough? What is meant by the “free commitment to service”? What is meant by “the best interests of patients”? What is humanism? Flesh and blood are missing here, and with no context there can be little or no meaning in the glib recitation of such abstract qualities.

If insurgent multiculturalism were to form the basis of curriculum decision making and were linked to cultural elements of professional development, students would have opportunities to learn and practice the skills of critical analyses to identify the inequities and injustices within the doctor-patient relationship, medical education and teaching hospitals, and health care access and delivery in the United States. Such skills involve scrutinizing oneself, knowing and respecting human variations, and critically focusing on and working against policies, structures, institutions, and governmental protocols that contribute to inequalities in health. Such skills focus on parts and wholes: not only oneself and one’s patients, but also patients’ illnesses and the historical, cultural, and economic conditions that contribute to them.

Moreover, unless students attempt to get honest with their “personal attitudes, biases, fears, emotional reflexes, [and] psychological defenses,” they are less likely to “arrive at an accurate diagnosis, prescribe appropriate treatment, and promote healing.”¹⁹ This kind of self scrutiny often flies in the face of the medical mantra of “objectivity” that students come to believe they possess when working with

patients, no matter what patients look like, how they act, what they believe, what they want, or what they will or will not do regarding their health. Curriculum experiences could be designed to help students see themselves as “situated” individuals who have a very specific social and economic location that influences each and every interaction they have with patients.²⁰

Such experiences are difficult for many students, given the skewed, class-based consciousness of most North American medical students. According to Waitzkin,¹¹ only 12% of North American physicians come from the working class, a figure that did not change throughout the 20th century. In fact, the socioeconomic origins of medical students may become even less representative of the larger culture as medical schools downplay social class in admission decisions.²¹ Recent data from the Association of American Medical Colleges (AAMC) confirm this. The mean parental income for all AAMC-affiliated medical school matriculates in 2000 was \$101,319, and the mean educational level for all fathers was some graduate or professional schools, and for mothers it was a college degree.²² Developing curriculum experiences that encourage cultural sensitivity and awareness in students from this kind of privilege is particularly challenging.

In addition, what is known as cultural competency would be accompanied by a mindfulness that learning about groups in terms of “their” characteristics, beliefs, or behaviors has tendencies toward “othering” such nondominant groups as inferior, exotic, or deviant, as I discussed earlier. In such a model, all “others” possess the “culture” in which the dominant “we” must become competent; “they” are the “multi” of multiculturalism. As Maxine Greene puts it, “It seems clear that the more continuous and authentic personal encounters can be, the less likely will it be that categorizing and distancing take place. People are less likely to be treated instrumentally, to be made ‘other’ by those around.”²³ This is what Cornel West²⁴ means when he talks about how important it is for people to recognize the “distinctive cultural and political practices of oppressed people,” and *not* to focus on their “different” traits in ways that may marginalize them further.

Insurgent multiculturalism, particularly when it is tied to professional development focusing on altruism, duty, and respect, must take into account personal attitudes in the patient–doctor relationship and then move on into the community where patients live, patients whose health is often impeded by policies, structures, institutions, and governmental protocols. This cannot be achieved by a community experience that correlates with the pop-up lecture—one-time visits to free clinics, social service agencies, or neighborhood initiatives. Although they provide students with important resources, one-time visits

provide them with little understanding about the lived experiences of those who use such services and sometimes lapse into a kind of “safari” experience where “tourists” view the unfortunate inhabitants who need these services. A few hours at a homeless shelter does not address the issue of affordable housing any more than a few hours at hot meal program addresses how some people find themselves in circumstances without enough money to buy food.

Longitudinal curricular experiences must be developed that allow students to develop relationships with individuals and families whose “differences”—nondominant ethnic identities, poverty, disability, language difficulties—put them at disadvantage for health-related services and at risk for illness. Edward Eckenfels has written extensively about voluntary, student-generated community service that he believes provides “the real conditions for altruism, duty, and authentic development.”²⁵ Miller, Mellon, and Waitzkin argue that a broader definition of health, such as the World Health Organization’s that includes “social, physical, economic, emotional, and spiritual well-being, in addition to the absence of disease,” belongs in the medical curriculum.²⁶ When this guides curriculum decision making, they continue, there is an increased recognition “that the major causes of morbidity and mortality cannot be addressed simply in individual practitioners’ offices” and that correlates of health must be addressed, such as socioeconomic status, education, social support and networks, self-efficacy and empowerment, community development and increased community capacity.²⁶

As young doctors, Miller and Mellon became involved with a housecleaning cooperative formed by low-income, Spanish-speaking, immigrant women, some of them undocumented. They had to “unlearn” many orientations they had been taught as physicians. But perhaps the greatest insight they gained “concerned the insulation from disorder and misfortune that wealth and privilege provide”:

The women’s ability to arrive [at meetings] depended on a host of factors beyond their control. Most of them came from households with many people and one car, and the women usually were not the drivers. Being able to arrive at a meeting meant that no child got sick, no one was late coming home from work, no one else needed to be picked up, and the car, usually secondhand and well used, did not break down Several times women could not attend meetings because they urgently needed to do a job to get enough money to pay that month’s rent. One woman’s son was deported. The children of several other women were involved in violent incidents. One woman and her entire family were evicted We learned that the people of this community lived far more on a day-to-day basis than we had ever imagined was possible. Investing gradually for the future, we learned, becomes very difficult when one is trying to survive until next week.²⁶

These are insurgent multicultural experiences that have everything to do with professionalism: They provide students with opportunities to look at their biases, to challenge their assumptions, to know people beyond labels, to confront the effects of power and privilege (and how life is lived without them), and as Eckenfels argues, to develop a far greater capacity for compassion and respect.²⁵

In the already overstuffed curriculum, where, one might ask, might spaces be found for such experiences? **Spaces already exist if one keeps in mind that insurgent multiculturalism is not content but is, rather, a critical approach, a system of beliefs and values that can influence how and by whom curriculum decisions are made.** Spaces can be found in existing courses on patient–doctor relationships and medical interviewing, in existing courses or modules on cultural competency, and in existing courses that examine sociocultural issues in medicine. Insurgent multiculturalism involves “thinking about our thinking . . . [and] seeking a community of concern.”²⁷ Finally, insurgent multiculturalism, rather than providing precut, premade, pretested curricula with an eye toward the United States Medical Licensing Exam, “tells us there are no answers; or rather, it tells us that answers are easier to come by, and less reliable, than questions”²⁸ Insurgent multiculturalism asks questions that no profession can avoid, particularly those devoted to health care, and in asking such questions it goes to the heart of professional development.

When medical education is ready to get serious about cultural competency and multiculturalism—serious enough to give them more time than a few pop-up lectures or afternoons at free clinics—and to deepen and enlarge the abstractions of professional development, insurgent multiculturalism is one place to start.

The author thanks two colleagues, Dr. James R. Boex and Dr. Denise Gibson, for their careful readings and valuable suggestions for this paper.

REFERENCES

1. Tervalon M, Murray-García J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor Underserved*. 1998;9:117–25.
2. Giroux H. Insurgent multiculturalism and the promise of pedagogy. In: Duarte EM, Smith S (eds). *Foundational Perspectives in Multicultural Education*. New York: Longman, 2000:195–212.
3. Engel GL. The need for a new medical model: a challenge for science. *Science*. 1977;196:129–36.
4. Williams D, Collins C. U.S. socioeconomic and racial differences in health: patterns explanations. In: Charmaz K, Paterniti DA (eds). *Health, Illness, and Healing*. Los Angeles, CA: Roxbury, 1999:349–76.
5. Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. (<http://www.nap.edu/books/030908265X/html/biomedicine>). Accessed January 14, 2003; Bethesda, MD: Institute of Medicine, 2002.
6. Gabriel BA. Confronting “unequal treatment”: the Institute of Medicine weighs in on health care disparities. *AAMC Reporter*. 2002;11(9):6–7.
7. Fox RC. Training in caring competence: the perennial problem in North American medical education. In: Hendrie HC, Lloyd C (eds). *Educating Competent and Humane Physicians*. Bloomington, IN: Indiana University Press, 1990:199–217.
8. McCarthy C. *Race and Curriculum*. Philadelphia, PA: Falmer, 1990.
9. Hunt LM. Beyond Cultural Competency. *Park Ridge Center Bulletin*. 2001;Nov/Dec:3–4.
10. Grinter R. Multicultural or antiracist education: the need to choose. In: Duarte EM, Smith S (eds). *Foundational Perspectives in Multicultural Education*. New York: Longman, 2000:135–54.
11. Waitzkin H. *The Politics of Medical Encounters*. New Haven, CT: Yale University Press, 1991.
12. Ayers W. Popular education—teaching for social justice. In: Ayers W, Hunt JA, Quinn T (eds). *Teaching for Social Justice*. New York: The New Press and Teachers College Press, 1998, xvii–xxvi.
13. Macedo D, Bartolome LI. *Dancing with Bigotry: Beyond the Politics of Tolerance*. New York: St. Martin's Press, 1999.
14. McCarthy C. After the canon: knowledge and ideological representation in the multicultural discourse on curriculum reform. In: McCarthy C, Crichlow W (eds). *Race, Identity and Representation in Education*. New York: Routledge, 1994:289–305.
15. Said E. *Culture and Imperialism*. New York: Knopf, 1993.
16. Sherwin S. Feminist and medical ethics. In: Holmes HB, Purdy L (eds). *Feminist Perspectives in Medical Ethics*. Bloomington, IN: Indiana University Press, 1992:17–31.
17. Hilfiker D. From the victim's point of view. *J Med Humanities*. 2001;22:255–63.
18. American Board of Internal Medicine. Project Professionalism. (<http://www.abim.org/pubs/profess.pdf>). Accessed January 14, 2003. Philadelphia, PA: ABIM, 2001.
19. Novack DH, Epstein RM, Paulson RH. Toward creating physician–healers: fostering medical students' self-awareness, personal growth, and well-being. *Acad Med*. 1999;74:516–20.
20. McGibbon E. The situated knowledge of helpers. In: James C (ed). *Experiencing Difference*. Halifax, N.S.: Fernwood, 2000.
21. Mangus SA, Mick SS. Medical schools, affirmative action, and the neglected role of social class. *Am J Public Health*. 2000;90:1197–201.
22. Association of American Medical Colleges. *Parent's Education and Income Level of All Medical Matriculates: 2000*. Washington, DC: Association of American Medical Colleges, 2001.
23. Greene M. *Releasing the Imagination: Essays on Education, the Arts, and Social Change*. San Francisco, CA: Jossey–Bass, 1995.
24. West C. Black culture and postmodernism. In: Kruger B, Mariani P (eds). *Remaking History*. Port Townsend, WA: Bay Press, 1989.
25. Eckenfels EJ. The case for keeping community service voluntary. In: Wear D, Bickel J (eds). *Educating for Professionalism: Creating a Climate of Humanism in Medical Education*. Iowa City, IA: University of Iowa Press, 2000:165–73.
26. Miller FA, Mellon WD, Waitzkin H. Experiencing community medicine during residency: the La Mesa housecleaning cooperative. In: Wear D, Bickel J (eds). *Educating for Professionalism: Creating a Climate of Humanism in Medical Education*. Iowa City, IA: University of Iowa Press, 2000:134–49.
27. Greene M. Lived spaces, shared spaces, public spaces. In: Weis L Fine M (eds). *Construction Sites: Excavating Race, Class and Gender among Urban Youth*. New York: Teachers College Press, 2000. 293–303.
28. Rushdie S. *Is Nothing Sacred? The Herbert Read Memorial Lecture*. London, U.K.: Granta, 1990.