Cultural Competency 2.0: Exploring the Concept of "Difference" in Engagement With the Other

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Abstract

Cultural competency efforts have received much attention in medical education. Most efforts focus on the acquisition of knowledge and skills about various groups based on race and ethnic identity, national origins, religion, and the like. The authors propose an approach, "Cultural Competency 2.0," that does not reject such efforts but, rather, adds a more critical and expanded focus on learners' attitudes and beliefs toward people unlike themselves. Cultural Competency 2.0 includes learners' examination of the social position of most U.S. medical students,

Bourdieu's concept of habitus, and the phenomenon of countertransference to come to new critical insights on learners' attitudes, beliefs, and, ultimately, interactions with all patients. Suggestions are offered for how and where Cultural Competency 2.0 can be used in the curriculum through narrative medicine, particularly through the development of reading practices that unmask illusions of "pure" objectivity often assumed in clinical settings, and that make visible how words and images constrain, manipulate, or empower individuals, groups, ideas, or practices.

The authors argue that these educational approaches should be sustained throughout the students' clinical experiences, where they encounter patients of many kinds and see clinicians' varied approaches to these patients. Further, these educational approaches should include assisting students in developing strategies to exercise moral courage within the limitations of their hierarchical learning environments, to strengthen their voices, and, when possible, to develop a sense of *fearlessness*: to always be advocates for their patients and to do what is right, fair, and good in their care.

> There is no way to speak of a patient's culture from a culture-free point of view.
>
> —N. Aultman, 1995[1]

It has been over six years since three of us (D.W., J.Z., J.V.) began our inquiry into medical students' use of cynical and derogatory humor directed at patients that resulted in an article published in this journal.[2] Our work built on the earlier critical work of such scholars as Becker et al,[3] Mizrahi,[4] Christakis and Feudtner,[5,6] and Parsons et al,[7] who explored how and why cynicism and "moral erosion" occur during medical education. The underlying assumption we presented in the earlier article was that students arrive at medical school full of idealism, often to have their beliefs and values challenged in the clinical environment, leading to what Newton and colleagues[8] refer to as a "hardening of

the heart" during medical school. Thus, the development of cynicism and the use of derogatory humor arise *during* and *as a result of* medical education.

Over the past several decades medical educators have similarly focused on students' knowledge, skills, and attitudes toward patients from cultures different from their own, resulting in curriculum efforts labeled "multiculturalism" or "cultural competency."[9] Unlike efforts to reverse or quell the rise in cynicism and derogatory humor leveled at patients, cultural competency efforts came into being because of perceived knowledge and skill deficits in students, deficits they arrived with rather than developed over the course of their medical education. The thinking is that students, because of their general demographic profile as a group, do not have the requisite understanding of the cultural beliefs, patterns of health-related behaviors, and values of patients whose backgrounds are different from the students' largely white, Western, Judeo-Christian, middle class, heterosexual, English-as-first-language backgrounds. These are persons known as the Other, a term used here (and throughout much of the social sciences

and humanities literature) as a rhetorical device to denote how one group is "us" and all others are "them." That is, because of a lack of both life and curriculum experiences that might open such worlds to them, students do not know enough about people unlike themselves. The thinking was (and remains) that if only learners would acquire more knowledge and better skills related to patients from other countries, cultures, or religions, those acquisitions would enhance the care they give to such patients. However, in the context of considering the negative influences of the hidden curriculum on medical students' attitudes toward patients, we should ask whether efforts in cultural competency might backfire and result in a similar "hardening" of the perspectives of doctors-in-training such that reductionist generalizations and dehumanizing stereotyping are actually reinforced and further internalized.

James Banks,[10] arguably one of the most respected educational theorists of multicultural education in the United States, describes various approaches to multicultural education that have been adopted in varying degrees from elementary through professional schools.

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Two approaches are relevant to this discussion. The first is the *contributions* approach, which focuses on the dress, food, heroes, and other characteristics of cultures outside that of "mainstream," non-ethnic-identified Americans. In professional schools, such approaches are found outside the regular curriculum, but the messages are unmistakable, whereby most

> deal wholly with the cultural distinctiveness of various groups and little more. Almost never is there any sustained attention to the ugly realities of systematic discrimination against the same group that also happens to utilize quaint clothing, fascinating toys, delightful fairy tales, and delicious food.[11]

Although these programs may honor the various traditions in multiple cultures, they have the potential to represent an overly simplistic accounting of cultural differences, rarely add to any significant understanding of the cultures under display, and often just provide a "side-show" for people to "look on with delight at all the differences that surround them."[12]

The second is the *additive* approach, which merely adds various content, perspectives, and skills to existing curricula without changing their structures. Although it may be critical to know particular genetic determinants of diseases or how religion may influence end-of-life care, this approach may lead learners to sort and categorize groups of people on the basis of just one dimension of their identity such as race, country of origin, or sexual orientation. Yet Banks[10] reminds us that

> cultures are dynamic, complex, and changing…. Such factors as time of immigration, social class, region, religion, gender, exceptionality, and education influence the behaviors and values of both individuals and subgroups within an ethnic group.

Cohen[13] offers a compelling example, arguing that countries are not the same as cultures:

> A southern Baptist male from Sacramento, a Sephardic Jewish grandmother from San Francisco, and an agnostic Japanese American student at the University of California, Berkeley share a language, a historic time period, and a geographic region yet might not share

their most important attitudes, beliefs, norms, or values.

In addition to these theoretical and practical concerns, what we begin to explore below is that most cultural competency efforts may offer a too-narrow approach to a larger phenomenon involving learners' understandings and attitudes regarding the full spectrum of human differences. Yet even using the word "differences" casts the phenomenon in the same problematic language of existing efforts. "Differences" or "different" assumes a *location* from which one is looking at the Other; it also assumes that *something* or *someone* is normative, usually the one doing the observing. Understanding that the perspective that defines "normal" is often localized to a position of privilege or power reveals how efforts in cultural competency may actually reinforce the "Otherness" and marginalization of disenfranchised groups and individuals. This phenomenon exists when learners are faced not only with patients whose differences (from learners) arise from national origins, race, or religion but also with patients whose differences arise from socioeconomic class, sexual identity, occupation, disability, or specific health-related physical attributes or behaviors. What string of associations and responses in a student's mind—most of them unconscious—arise when he or she walks into two separate exam rooms and meets in one a Latino man who does not speak English and, in the other, a morbidly obese or alcoholic/drug-addicted woman? Are such responses related in any way? The former patient with his assumed cultural "characteristics" is emblematic of cultural competency curriculum efforts; the latter is not. Yet the educational potential of these two scenarios may have much more in common than what our traditional curricular efforts have attempted to address.

In fact, one may argue that the intellectual and epistemological processes that are honed as part of medical training, when applied to diversity, may actually reinforce psychological processes that foster the development of prejudice. In diagnostic reasoning, we use inductive, heuristic ways of thinking to piece together a variety of symptoms, physical signs, and laboratory data into a probable diagnosis. As a corollary, when a disease is known, deductive reasoning may lead to the attribution of common

characteristics to a specific disease process (e.g., "She has Graves disease, so we should ask her about nervousness and anxiety, heat intolerance, and weight loss and look for eye changes and a goiter"). In clinical care, we are also trained to think instrumentally—to analytically approach situations in order to understand and intervene in the course of abnormal physiologic states. The diagnostic approach involves making assumptions about a diagnosis based on experience and knowledge of common characteristics, whereas the instrumental approach involves *acting on something*—a disease process, a medical condition or emergency, a patient. Although these types of reasoning are critical when applied to disease, their application becomes problematic when applied to human beings—especially those individuals who represent "an unfamiliar Other" to the clinician. Inductive, heuristic reasoning may lead to unconscious assumptions and biases regarding intelligence, abilities, educational background, honesty, and morality, depending, for instance, on the racial identity, religion, social class, or national origin of a given individual. Likewise, instrumental reasoning, when applied without reflection and humanistic intent, may lead to viewing the patient as a collection of abnormal processes rather than as a human being. Both cognitive processes have the potential, when applied to individuals, of *treating people as things*.

The document "Tool for Assessing Cultural Competence Training,"[14] published by the Association of American Medical Colleges (AAMC), defines *culture* as "integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups." The primary focus of cultural competency efforts in the medical curriculum, then, is to help students work effectively with patients from those stated groups. Yet the "thoughts, actions, customs, and beliefs" of patients that result in obesity, addictions, or health-related practices stemming from poverty that place them in stark contrast to the physical, social, and cultural backgrounds of the vast majority of medical students are generally not found under the umbrella of cultural competency efforts. How

is the potential stereotyping and bias toward racial, ethnic, or religious groups different from the stereotyping and bias toward the morbidly obese patient, the addicted patient, or the chronically unemployed, second-generation welfare recipient patient? While recognizing that addressing health care disparities in historically discriminated groups should be a major priority in medicine, are we unwittingly developing a "hierarchy of prejudice" in which bias against certain groups is named and addressed while bias against other identities remains unacknowledged and, thus, unaddressed?

In exploring these questions below, we draw on diverse studies. We theorize cultural competency from several vantage points, "walking around" it and viewing it from several lenses that may raise new questions about current efforts in cultural competency education. We offer curriculum implications for what we call Cultural Competency 2.0, which we hope will result in a more vital awareness of educators' and caregivers' thinking and values related to those unlike themselves, and a deeper understanding of human diversity *in all its forms.* This, we believe, may lead to improved, more authentic relationships between doctors and patients, beginning with and never leaving critical consciousness of one's own values, beliefs, privileges, biases, and always-incomplete knowledge.

Retheorizing Cultural Competency: Three Perspectives

Social location

Although there is a widescale belief that including students from diverse socioeconomic backgrounds (parental income, education, and occupation) is an important goal for medical education, there has not been much movement in this direction. In terms of their families of origin, medical students are far more likely to have parents who have graduate degrees and are less likely to have parents with no college education.[15] In addition, AAMC data[16] indicate a noticeable *increase* of medical students "from families with higher socioeconomic backgrounds between 1992 and 2008," particularly among white students. In terms of parental income, figures across the past 25 years are quite consistent:

> The percentage of medical students from the highest quintile has never been less

than 48.1 percent…. More than three-quarters of medical students came from families in the top two quintiles of family income…. A continued increase in the fifth [i.e., highest] quintile percentage would be a warning that medical education is becoming out of reach for applicants of modest means.[16]

What do these medical student demographics mean to cultural competency efforts? What if the concept of "culture," while keeping a critical eye on race, religion, class, or national identity, also includes other forms of bias and stereotyping, how we are all cued by our socialization to view and value people in certain ways: how one speaks or dresses, how one cares for one's body, how and where one works, and other cues? Aultman points out that

> one's class membership becomes a part of one's relatively stable sense of identity, of one's sense of the type of person one is. The class status of one's parents is hard to outgrow, even for the upwardly mobile…. One's preconceptions and stereotypes about social classes thus become important factors determining one's self-image and the images one has of other people. We do tend to assume that there are defined "types" of people, and class status is an important marker for the distinctions that we make.[1]

To look at this issue from yet another angle, we need to consider the role of white privilege in shaping encounters with the Other. Murray-García and colleagues[17] continue to provide some of the most important theorizing on this issue in medical education, particularly as it relates to *whiteness* as a social concept as it has been developed in many disciplines outside of medicine, including sociology, psychology, history, education, and cultural studies. They describe the "ubiquitous nature of a 'white' U.S. identity" and its "profound health status, institutional, and relational implications for us in medicine"—in spite of the fact that one's whiteness is generally perceived about the same way as one thinks about the air one breathes. Most often, U.S. whites fail to see themselves as "racial beings," a tag that usually refers to *nonwhite* people who are thus always the ones under study and who become the "objects" of cultural competency. When this occurs, the social, cultural, and economic experiences of whites are the unspoken norm, and discussions focus on the difficulties (if not failures)

of nonwhite groups to achieve such a norm. Thus, the whole idea of the unearned, unacknowledged privileges of whites ignores the historical structures of inequality still at play in the United States.

Habitus

Little attention is paid to the issues that may influence *physicians'* understandings of cultural phenomena; most attention focuses on the values, perspectives, beliefs, and health behaviors of patients. However, given that the doctor–patient relationship is an interaction between *two* individuals, it is relevant to ask, "What does the clinician bring into the interaction with his or her patients?" To that end, Bourdieu's[18] concept of *habitus* offers another way to think about "location" as described above. In contradistinction to the very physical concept of habitus taught to medical students that relates to the external body and its "build" or overall shape, Bourdieu's concept of habitus describes the largely unconscious, internalized social structures, perspectives, and dispositions that one acquires through past experiences and that determine behavior. Habitus in this construction internalizes *objective* differences in social location, such as social class, privilege, and power, into *subjective* values and worldviews, and these views in turn serve to guide individual action. That is, Bourdieu describes habitus generally along class lines, arguing that judgments of taste are tied to one's social position; however, it can easily be (and has been) applied to the complexities of race/ethnicity, gender, sexual identity, and national origin. On the basis of multiple factors but particularly related to high levels of social and spatial segregation, each person develops a particular habitus that reflects his or her position in the social world and his or her ways of seeing the Other. One classifies the world in terms of one's own habitus: the way one dresses and moves; one's tastes, opinions, and mannerisms; one's speech, accent, and grammar. It is clear that habitus manifests in every clinical encounter as roles are played befitting the social status of each individual. Further, it could be argued that habitus is actually taught or inculcated in the so-called hidden curriculum of medical education. That is, students' own habitus continues to take shape as they "learn" how to *be* through

modeling or aspiring toward the habitus of those who mentor them in the clinical educational arena.

Countertransference

We now look at diversity and cultural competency from yet another related perspective, by considering *countertransference* in this context. *Mosby's Medical Dictionary*[19] defines it as "the conscious or unconscious emotional response of a psychotherapist or psychoanalyst to a patient. The response may be positive or negative." In more general terms, it involves the complex feelings of a psychotherapist toward a patient. Curiously, the term is generally not used outside of psychiatry or psychology, even though each clinical encounter involves a physician's response to a patient, mostly unacknowledged and mostly unconscious. Although never using the term *countertransference* explicitly, the cultural competency literature in medical education does acknowledge that physician bias is a barrier to its achievement, even as such literature stops short of a robust theoretical discussion of bias and its continued presence in medical encounters.

Yet we posit that acquiring knowledge and skills related to cultural competency pales in comparison to the difficult, complicated, never-ending process each of us faces in identifying, confronting, *and* attempting to unlearn such biases and stereotypes. When we stop at merely identifying our biases, most of the work still lies ahead of us. Recognizing that one has a bias is not an end point but the beginning of a larger process of awareness—there must be a willingness to go somewhere else, to look at humans in a different way, to make new sense of ideas and beliefs that were previously rigid and categorical. Simply knowing that one has a bias does little to change the relationship the biased person has with the person who is the object of that bias; the relationship is plagued by what Gustafson[20] calls a "mismatch" between physician and patient. The bias—the mismatch—must be reconciled before there is a "match," and, if not, a significant barrier remains. If a student has certain beliefs about but no understanding of why someone would become, say, an addict to alcohol, drugs, or food, that student will not be very helpful in

crafting a relationship that offers hope to the patient. The patient remains a category or type, and the student assumes he or she fully understands people of that category or type. Rather than ask what would turn a person down this path, the student may view that individual as lazy, weak, annoying, hopeless. Rather than wade through the emotions that have been stirred up by an encounter with this patient, the student may pretend that the bias does not matter—that, after all, doctors are "objective" and treat all patients fairly regardless of their feelings toward them. Yet the existence of such bias matters, and patients sense the resultant mismatch as well.

Psychiatrist and writer Irvin Yalom[21] describes the countertransference phenomenon in painfully frank language relevant to this discussion. He expresses his unedited, internal response to Betty, a 5-foot-2-inch, 250-pound woman as she enters his office:

> I have always been repelled by fat women. I find them disgusting: their absurd sidewise waddle, their absence of body contour—breasts, laps, buttocks, shoulders, jawlines, cheekbones, *everything*, everything I like to see in a woman, obscured in an avalanche of flesh. And I hate their clothes—the shapeless, baggy dresses or, worse, the stiff elephantine blue jeans with the barrel thighs…. The origins of these sorry feelings? I had never thought to inquire. So deep do they run that I never considered them prejudice. But were an explanation demanded of me, I suppose I could point to the family of fat, controlling women, including—featuring—my mother, who peopled my early life.

Is Yalom's bias against obese women in the same family of bias that exists among medical students, residents, and attending physicians toward people that is based on race, ethnic identity, national origins, religion, sexual identity, and so on? We suggest that they are related and that they should be offered the same curriculum attention that is given to the more traditional targets of cultural competency efforts. This is an extraordinary challenge to teachers: to give attention to the traditional categories of cultural competency (when they make sense) and then move beyond—beyond those categories, beyond "mere" identification of one's biases, beyond even the evidence that biases are

harmful to patient care—to classrooms where students can come to more fully understand what got this *particular* patient—the one sitting before them, to where he or she is right now, and what got them (students) to where *they* are in their attitudes and beliefs regarding the patient sitting before them—and then be moved to action.

Implications and Applications

How do the perspectives offered above shift cultural competency efforts in the medical curriculum toward a more multilayered, complex project, a Cultural Competency 2.0? Here we are clear: The curricular implications arising from these perspectives add to the traditional focus on cultural issues in health care as something to be "learned" and "practiced" to include a vital focus on learners' attitudes, values, and beliefs regarding human differences *in all their various forms.* There are no comfort zones in such a curriculum for students *or* faculty, who must be full participants in such inquiry; this is no place for faculty to position themselves as above such considerations in themselves. Rather, these are experiences that require us to ask tough questions, take risks, interrogate our privilege, and commit ourselves to social justice.[22] These are learning moments that are marked by a more robust, complicated, and demanding examination of ourselves and of medical education, medical practices, and medical institutions. These moments also make explicit the "conventional wisdom" circulating in clinical settings surrounding patients' race, ethnic identities, national origins, linguistic abilities, class status, and religion, *along with* their bodies, their lifestyles, their choices, and their specific health-related behaviors and beliefs. In this regard, faculty development is essential to assist instructors in modeling the type of critical consciousness and reflection that we require in our students.[9,23,24]

As it now stands, cultural competency efforts are found in multiple locations throughout the medical curriculum and are so designated in a variety of ways. There may be conditions or diseases found in particular racial groups, as noted in a "Principles of Medicine" course (e.g., sickle cell disease or

Tay-Sachs); there may be aspects in a patient-interviewing lecture that identify individuals from particular countries or cultures that are more collectivist than individualist; there may be "how-to" sessions in clinical settings regarding patients whose religious beliefs require additional knowledge and skills regarding exams or procedures. Cultural competency may also be addressed in small-group sessions like the ones described by the Society of General Internal Medicine's Health Disparities Task Force, where

> learners can examine their personal beliefs and practices and compare them with beliefs and practices of other cultures … reflect on their reactions to discordant cultural practices and beliefs between caregivers and patients, self-examine for conscious and unconscious personal biases, and contemplate the interplay between these attitudes and health disparities.[25]

Still, we press for the meanings of the verbs "examine," "compare," "reflect," "self-examine," and "contemplate." Do they suggest that learners are aware that their biases can or should be eliminated? How, and on what grounds? That they are simply untrue? Harmful? That they are sometimes useful, sometimes not? That they may be a source of mismatch between themselves and their patients?

In the remainder of this article, we offer suggestions on how to proceed with educational efforts in diversity and cultural competency with the perspectives described above anchoring such efforts. The first has to do with *reading practices*, which can be used in existing course work at both the preclinical and clinical levels where such cultural issues are explored, or in any curriculum experience having to do with ethics, humanities, and professionalism. The second suggests that students read not as "spectators" but, rather, engage with the texts in "testimonial" reading.

Reading practices

The argument that reading practices can lead to greater openness to and understanding of patients in all their varieties strengthens the case for exposing medical students to the field of narrative medicine and engaging them in experiences aimed at developing their narrative skills. In fact, a narrative approach to understanding the Other is a form of *competence* that transcends the more narrow terminology of culture. This framework for competency teaches students how to explore particularities rather than generalities; it engages students in an ever-changing and dynamic process and is not "checklist-able." This framework for competency is focused on what one can *imagine* about the Other rather than on what one can *know* about the Other.[26] In the teaching of these capabilities, students must always be reminded that it is never possible to fully know the lived experience of the Other and that maintaining a sense of humility about such limitations remains critically important. DasGupta[27] describes this stance as *narrative humility*, which

> acknowledges that … patients' stories are not objects that we can comprehend or master, but rather dynamic entities that we can approach or engage with, while simultaneously remaining open to their ambiguity and contradiction, and engaging in constant self-evaluation and self-critique about issues such as our own role in the story, our expectations of the story, our responsibilities to the story, and our identifications with the story—how the story attracts or repels us because it reminds us of any number of personal stories.

Because medical students have had, at least by virtue of their youth, relatively limited life experiences, exposing them to stories of the Other can be a powerful technique in expanding these forms of competency. Narratives have appeared throughout the curriculum in many medical schools, sometimes in the form of a short story or essay inserted in a course merely to illuminate a clinical encounter or the experience of illness; sometimes in an elective more focused on the relationship between literary methods and clinical practices; sometimes in the reading of texts as culturally constructed entities. Regardless of curriculum placement, here we suggest that this strategy of exposing students to the stories of the Other could be tailored specifically to focus on biases and injustices based on race, class, gender, ethnic or sexual identities, addictions, and disabilities, among others. Such readings could include literary, visual, historical, media, and social texts along with other arts-based and cultural artifacts that focus on issues related to power, authority, and justice in medicine and in the larger culture. These activities would provide opportunities to learn and practice reading habits that unmask illusions of "pure" objectivity often assumed in medical settings and that make visible how words and images constrain, manipulate, or empower individuals, groups, ideas, and practices. Such practices, we believe, are useful ways of making sense throughout medical environments.

Moreover, such reading practices may also bring to light the mechanisms by which we, as health care providers, dehumanize those whom we care for. Possibilities abound, including William Carlos Williams' "A Face of Stone,"[28] Richard Selzer's "Brute,"[29] or Rafael Campo's "Like a Prayer,"[30] all containing interior monologues that allow readers access to the physician–narrators' countertransference when faced with particular "types" of patients. Indeed, the opening sentence of the Williams story is a powerful case in point when the narrator thinks to himself on meeting the baby's father in the exam room that he was "one of these fresh Jewish types" and that the mother "looked Italian, a goaty slant to her eyes, a face often seen among Italian immigrants…. A face of stone."[28] Selzer's widely anthologized story in the form of a letter to a young doctor is similarly blunt. When a drunken, unruly patient is brought into the emergency department in the middle of the night, the fatigued doctor describes the "toxic, fuming, murderous" black man as a "great mythic beast broken loose in the city … less a human than a great and beautiful beast."[29] Campo's nonfiction essay, even more remarkable for its candidness, relates the burned-out young trainee's level of disheartenment with his disclosure of happiness seeing a "despicable AIDS patient" finally die: "I was glad, and relished his death over an unappetizing late-night meal with a few of my colleagues in the nearly deserted cafeteria. Still I knew he would only be succeeded by others."[30]

Tools such as these offer extraordinary opportunities for learners to reflect on the nature of their biases and stereotypes, to critically examine cultural representations of the Other, and to consider how all of this leaks into the quantity and quality of care they give to patients. They may provide educational experiences that may, if crafted in safe environments where learners can talk

to one another, mitigate their fear of appearing naïve or using the incorrect language and enable them to retrieve parts of themselves that get buried or hidden out of fear for being labeled "unprofessional" or unworthy of being doctors. Still, we offer a cautionary note that must inform all such classroom discussions. In spite of their remarkable similarities on many indicators, some medical students are also members of these scorned groups—students who are obese, who are in recovery, who come from economically disadvantaged families, or whose racial or sexual identities are under scrutiny in a story or poem under discussion. Faculty must know their students well and must be attuned to discussion nuances and expect the same of students, lest classrooms become toxic, hurtful locations for such students whose classmates are "working out" their biases and stereotypes.

Whether the texts under scrutiny are novels, films, poems, essays, or pharmaceutical ads in the popular press, their use in classrooms must be informed by critical reading practices, not merely as encounters with interesting, provocative, or entertaining content. Their use may urge learners to "make the invisible visible," to critically peel back the facade of objectivity and scrutinize their personal biases more earnestly; to rethink the legitimacy of their biases as templates for all members of such groups; and to engage in an ongoing examination of how their biases may, even in the most nuanced ways, obstruct the care they give to patients when they are otherwise at their best.

Spectating versus testimonial reading

This "peeling back," however, is not a given, for the ways in which stories are taught are as critically important as the stories themselves. In discussing "the risks of empathy," Megan Boler[31] differentiates "spectating" from "testimonial reading." In the former, reading evokes what Boler refers to as "passive empathy"—that is, an identification with the sufferings of an absent Other in which the readers are not pushed to take responsibility and examine themselves and their own values. In spectating, reading does not effectively challenge the readers' worldviews nor make them aware of issues of power relationships; although

it may emotionally move the readers, it leaves them *unchanged*. By contrast, in testimonial reading, the reader is called on to bear witness to suffering or injustice and, in doing so, must acknowledge and struggle with a critical examination of his or her own assumptions, biases, privileges, and perspectives, as well as a sense of responsibility to find solutions. Just as important, testimonial reading never presumes a full understanding and ownership of the sufferings of the Other. Both historical context—be it that of Jews during the Holocaust or African Americans during the Watts riots in the 1960s—and also the *uniqueness* of the individual whose story is being told, are acknowledged and respected. *Difference* itself is preserved while, at the same time, one acquires a sense of identity with the Other as another human being who struggles and suffers, and a sense of responsibility for that individual's—and society's—fate. Bearing witness is not to passively receive stories; it is a prompt toward socially relevant *action*.

One may ask about the educational setting in which these investigations of difference, Otherness, bias, privilege, and habitus take place. We suggest that these types of explorations cannot productively occur within the solitude of an individual's thoughts; rather, they are best carried out through interactive exchanges and discussions. One approach is to create longitudinal discussions and learning activities held over months and years. The membership and faculty facilitators in the small groups in which these activities occur should be changed as little as possible in order to allow rapport, trust, and safety to develop and grow. In these groups, students may explore differences in perspectives, beliefs, values, and life experiences—habitus— and begin to tackle the really difficult issues of privilege, justice, witnessing, and responsibility. An ideal vision of such a group would include a small number of individuals of diverse backgrounds, identities, and experiences who, through committed, honest, interactive discourse, examine and challenge their own and each other's perspectives and beliefs in an environment free of coercion—what Habermas[32] refers to as communicative action. In this setting, achieving consensus would not be required (and may not be possible); instead, a critical understanding of one's own

ethical worldview, as well as a shared understanding of common concerns, meanings, and motives, may be used as the foundation for future moral action in clinical practice.

We also argue that these educational approaches should be sustained throughout the clinical experiences of our students, positioned in the treacherous clinical educational landscapes where they encounter patients of many cultures, socioeconomic backgrounds, and races— patients with many narratives—and where they see many clinicians' varied approaches to these patients. Further, these educational approaches should include assisting students in developing strategies to exercise moral courage within the limitations of their hierarchical learning environments, to strengthen their voices, and, when possible, to develop a sense of *fearlessness*[33]: to always be advocates for their patients and to do what is right, fair, and good in their care.

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References

1 Aultman N. The Analyst in the Inner City: Race, Class and Culture Through a Psychoanalytic Lens. Hillsdale, NJ: Analytic Press; 1995.

2 Wear D, Aultman JM, Varley JD, Zarconi J. Making fun of patients: Medical students' perceptions and use of derogatory and cynical humor in clinical settings. Acad Med. 2006;81:454–462.

3 Becker H, Geer B, Hughes E, Strauss A. Boys in White. Chicago, Ill: University of Chicago Press; 1961.

4 Mizrahi T. Getting Rid of Patients: Contradictions in the Socialization of Physicians. New Brunswick, NJ: Rutgers University Press; 1986.

5 Christakis DA, Feudtner C. Ethics in a short white coat: The ethical dilemmas that medical students confront. Acad Med. 1993;68:249–253.

6 Feudtner D, Christakis DA, Christakis NA. Do clinical clerks suffer ethical erosion? Students' perceptions of their ethical environment and personal development. Acad Med. 1994;69:670–679.

7 Parsons GN, Kinsman SF, Bosk CL, Sankar P, Ubel PA. Between two worlds: Medical student perceptions of humor and slang in the hospital setting. J Gen Intern Med. 2001;16:544–549.

8 Newton BW, Barber L, Clardy J, Cleveland E, O'Sullivan P. Is there hardening of the heart during medical school? Acad Med. 2008;83:244–249.

9 Kumagai AK, Lypson ML. Beyond cultural competence: Critical consciousness, social justice, and multicultural education. Acad Med. 2009;84:82–87.

10 Banks JA. An Introduction to Multicultural Education. 3rd ed. Boston, Mass: Allyn and Bacon; 2002.

11 Weinberg M. Notes from the editor. Chron Equal Educ. November 1982;4:7.

12 Dyer R. The matter of whiteness. In: Rothenberg PS, ed. White Privilege: Essential Readings on the Other Side of Racism. New York, NY: Worth Publishers; 2008:9–14.

13 Cohen AB. Many forms of culture. Am Psychol. 2009;64:194–204.

14 Association of American Medical Colleges. Tool for Assessing Cultural Competence Training. https://www.aamc.org/download/54344/data/tacct_pdf.pdf/. Accessed February 16, 2012.

15 Grbic D, Garrison G, Jolly P. Diversity of U.S. medical school students by parental education. AAMC Analysis in Brief. August 2010;9. https://www.aamc.org/download/142770/data/aibvol9_no10.pdf. Accessed February 6, 2012.

16 Jolly P. Diversity of U.S. medical students by parental income. AAMC Analysis in Brief. January 2008;8. https://www.aamc.org/download/102338/data/aibvol8no1.pdf. Accessed February 6, 2012.

17 Murray-García JL, Harrel S, García JA, Gizzi E, Simms-Mackey P. Self-reflection in multicultural training: Be careful what you ask for. Acad Med. 2005;80:694–701.

18 Bourdieu P. Outline of a Theory of Practice. New York, NY: Cambridge University Press; 1977.

19 Mosby's Medical Dictionary. 8th ed. Philadelphia, Pa: Elsevier; 2009.

20 Gustafson JP. The Great Instrument of Orientation. http://webspace.psychiatry.wisc.edu/gustafson/docs/The_Great_Instrument_of_Orientation_omi.pdf. Accessed February 6, 2012.

21 Yalom I. Fat lady. In: Love's Executioner. New York, NY: Basic Books; 1989:87–117.

22 Giroux H. Insurgent multiculturalism: A dialogue with Henry Giroux. In: Macedo D, Bartolomé LI, eds. Dancing With Bigotry: Beyond the Politics of Tolerance. New York, NY: Worth Publishers; 2008:93–117.

23 Lypson M, Ross P, Joiner T, Kumagai A. Using multimedia in faculty development on multicultural education: Scenes from the movie "Crash." MedEdPORTAL. April 27, 2010. http://services.aamc.org/30/mededportal/servlet/s/segment/mededportal/?subid=8008. Accessed February 6, 2012.

24 Kumagai AK, White CB, Ross PT, Purkiss JA, O'Neal CM, Steiger JA. Use of interactive theater for faculty development in multicultural education. Med Teach. 2007;29:335–340.

25 Smith WR, Betancourt JR, Wynia MK, et al. Recommendations for teaching about racial and ethnic disparities in health and health care. Ann Intern Med. 2007;147:654–665.

26 Engel JD, Zarconi J, Pethtel LL, Missimi SA. Narrative in Health Care: Healing Patients, Practitioners, Profession, and Community. Oxford, UK: Radcliffe Publishing; 2008.

27 DasGupta S. The art of medicine: Narrative humility. Lancet. 2008;371:980–981.

28 Williams WC. A face of stone. In: Coles R, ed. The Doctor Stories. New York, NY: New Directions; 1984:78–87.

29 Selzer R. Brute. In: Letters to a Young Doctor. New York, NY: Simon & Schuster; 1982:59–63.

30 Campo R. Like a prayer. In: The Desire to Heal. New York, NY: W.W. Norton; 1997:34–63.

31 Boler M. Feeling Power: Emotions and Education. New York, NY: Routledge; 1999.

32 Habermas J. Moral Consciousness and Communicative Action. Cambridge, Mass: MIT Press; 1990.

33 Wear D, Zarconi J. Challenging the profession: Mentoring for fearlessness. In: Humphries HR, ed. Mentoring in Academic Medicine. Philadelphia, Pa: American College of Physicians; 2010:51–66.