Confronting ‘Culture’ in Medicine’s ‘Culture of No Culture’

Janelle S. Taylor PhD

Academic Medicine(2003)78:555-559

Abstract
The author presents reflections from medical anthropology on the institutional culture of medicine and medical education, which sees itself as a ‘culture of no culture’ and which systematically tends to foster static and essentialist conceptions of ‘culture’ as applied to patients. Even though requirements designed to address cultural competence are increasingly incorporated into medical school curricula, medical students as a group may be forgiven for failing to take these very seriously as long as they perceive that they are quite distinct from the real competence that they need to acquire. To change this situation will require challenging the tendency to assume that ‘real’ and ‘cultural’ must be mutually exclusive terms. Physicians’ medical knowledge is no less cultural for being real, just as patients’ lived experiences and perspectives are no less real for being cultural. Whether this lesson can be effectively conveyed within existing curricular frameworks remains an open question. Cultural competence curricula will, perhaps, achieve their greatest success if and when they put themselves out of business – if and when, that is, medical competence itself is transformed to such a degree that it is no longer possible to imagine it as not also being ‘cultural’.

Efforts to promote cultural competence in medical education and practice that have blossomed over the past decade or so have thus far focused primarily on the task of providing cultural information about various specific immigrant communities. This focus has been fruitful, resulting in expanded and improved resources of many kinds – from courses to training seminars, translator services, highly informative websites, and more – to assist practitioners caring for patient populations that have created (especially in those regions where successive waves of immigrants have congregated most densely) an enormously complex tapestry of linguistic, religious, and other kinds of diversity. In the wake of these accomplishments, cultural competence has earned a secure place among the formal educational goals of medical school curricula, and the moment may now be ripe to pause and consider future directions. With that in mind, in this article I present reflections from medical anthropology on the institutional culture of medical education, and suggest some reasons why achieving the broader goals of cultural competence curricula may require broader institutional changes.

As cultural competence programs have matured, a number of parties involved in promoting them have warned against a too-simple understanding of ‘culture’. One obvious concern is that materials intended to help foster awareness of and openness to difference may – depending upon how they are presented and how they are received – have the contrary effect of perpetuating more or less rigid stereotypes about what members of a particular ‘culture’ believe, do, or want, and how they should be dealt with. Some authors stress that a ‘culture’ is not a state and timeless thing but is constantly changing as people make use of their cultural resources in creative and sometimes surprising ways. Others emphasize that ‘culture’ is multifaceted, encompassing linguistic, religious, educational, class, and many other dimensions of difference, which intersect in complex ways in the life experience and identify of any one individual. It has been proposed that the term cultural ‘humility’ ought to replace cultural ‘competence’ as
the goal of multicultural education in medicine. It is also argued that ‘culture’ must be situated in relation to ‘social’ factors such as literacy or socioeconomic class standing. The point has also been made repeatedly that not only patients and other communities have cultures, but that there is also a ‘culture’ of medicine.

It is tempting to remain at the level of theoretical discussions, and to imagine that what is needed are newer and better definitions for ‘culture’. This temptation is perhaps especially strong for those of us who discuss cultural competence from the discipline of sociocultural anthropology, because we use the same key term ‘culture’ differently. Coming from anthropology, where ‘culture is now viewed by many to consist of acts of competing discourses and practices, within situations characterized by the unequal distribution of power’ (and where, it must be added, one enjoys the luxury of reflecting on culture at some distance from the urgencies of clinical care), the literature on cultural competence can give one the slightly spooky sensation of having encountered the Ghost of Anthropology Past. Guarnaccia and Rodriguez note that:

in reviewing recent works on culturally competent health, writers have often turned to earlier writings by anthropologists to present a definition of culture. In general, these definitions have reflected a static view of culture as the distinctive set of beliefs, values, morals, customs and institutions which people inherit ….. [whereas] more recent approaches to culture in anthropology provide a more dynamic perspective ….. viewing culture as a process in which views and practices are dynamically affected by social transformations, social conflicts, power relationships, and migrations.

Merely to argue about how one ought to define ‘culture’, however, is unlikely to be especially persuasive or helpful. The anthropologist, I am well aware, risks sounding a bit like Humpty Dumpty saying to Alice that ‘when I use a word, it means just what I choose it to mean, neither more nor less!’ A more interesting and useful approach is to ask of cultural competent programs the same question that anthropologists ask of any sociocultural phenomenon that they wish to understand: How do systems of thought relate to what anthropologists sometimes call ‘systems of social action’ (ie the observable patterns in the ways that people act and interact in society)? Specifically, in this case, how do particular ways of conceptualizing and talking about ‘culture’ relate to the sociocultural organization of the institutions of medicine and medical education? To put it very bluntly, are there features of the culture of medicine that might tend to lead those who inhabit it to think of ‘culture’ as a static set of ideas and beliefs that only other people possess?