Cultural Literacy

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In 2007, the Liaison Committee on Medical Education (LCME) published a revised set of standards for the accreditation of medical education programs in the USA and Canada. The LCME now mandates that medical schools in the USA and Canada include "cultural competency" as one of their central educational goals [1]. Over the course of the last decade, medical schools have responded to this mandate by implementing a wide variety of programs. The American Psychiatric Association has also begun recognizing the need to address social diversity, cultural heterogeneity, and associated disparities in healthcare delivery and, as part of their efforts, included the Cultural Formulation Interview (CFI) in DSM-V, along with definitions of several so-called culture-bound syndromes.

It is tempting to describe these programs as having varying levels of success, but because the measures of what constitutes success are as varied as the programs themselves, such a declaration would be inaccurate. A recent (2014) Cochrane review of cultural competence education programs in health professions training essentially concluded as much, stating that "The quality of evidence is insufficient to draw generalisable conclusions, largely due to heterogeneity of the interventions in content, scope, design, duration, implementation and outcomes selected." Notably, in order to perform the review at all, the Cochrane reviewers had to develop their own "four-dimensional conceptual framework" of what constituted a cultural competence education program in the first place [2].

This last point is the one I find most interesting. The 2014 Cochrane review could not come to a generalizable conclusion, because while everyone involved seemed to agree that "cultural competence education" is a necessary thing, it does not seem there was any consensus about how such a thing ought to be taught, or, by extension, what the meaning of that phrase, "cultural competence education," might be.

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H. S. Moffic et al. (eds.), *Islamophobia and Psychiatry*,
https://doi.org/10.1007/978-3-030-00512-2_9

How can we move forward without defining our terms? That is, without knowing what constitutes movement, or which direction is forward?

Before we can begin to contemplate cultural competence education, we must define the term. What do we mean by "cultural competence?" When I was presented with the opportunity to redesign the cultural competence curriculum for the psychiatry residency program at the University of Wisconsin-Madison, I contemplated that very question. As I strove to define my terms, I came to the conclusion that "competence" is the wrong word to describe the real educational goal. It remains my belief that until we are using the right words, we will be dismal failures at changing both our own thinking and the thinking of the new generation of psychiatrists.

The AMA code of medical ethics states: "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights." This is a laudable principle. My critique of the use of the word "competence" in this context is not intended to diminish this ethical principle. Of course physicians should provide competent care and do so with compassion and respect. My contention is that in the particular case of cross-cultural understanding, a goal of competence falls short of what is needed to provide care with compassion and respect. It falls short because such a competence is not possible, and it is not possible because competence is simply the wrong standard by which to measure the skill in question. Competence, in the realm of cross-cultural understanding, is not an appropriate goal, because if one examines the meaning of the word, the idea that one could ever be "competent" in understanding culture does not make sense.

What is competence? Merriam-Webster defines it as "the quality or state of being competent," which is then defined as "having requisite or adequate ability or qualities; legally qualified or adequate." Competence is a finite state, an endpoint. It is reached, and then one stops moving. One can, by definition, be finished becoming competent.

How does one attain "requisite or adequate ability" in culture? What is requisite? What is adequate? What would constitute a culture "ability"? What would we actually want mental health clinicians to do in order to adequately understand "culture," whatever we may take that to mean? This is not merely a semantic point. We cannot teach something properly until we define what it is that we are teaching. If culture, like language itself, is always in flux, it would be disingenuous of us as clinicians to pretend it can be taught as a competency, as something that one can finish. As Drs. Kumagai and Lypson state in their excellent 2009 article for the *Journal of Academic Medicine*: "Cultural competency is not an abdominal exam. It is not a static requirement to be checked off some list but is something beyond the somewhat rigid categories of knowledge, skills, and attitudes: the continuous critical refinement and fostering of a type of thinking and knowing—a critical consciousness—of self, others, and the world" [3]. For these reasons, I prefer the term cultural literacy—literacy, because with books as with human beings, one is never really finished learning to read. Psychiatrists know this better than most. Or we ought to, anyway.

I am hardly the first person to suggest using the term "cultural literacy." The idea of characterizing the development of a cultural consciousness as an act of reading is

rooted in the work of Paolo Freire, who described the act of "reading the world" [4]. In Freire's work, learning to read the world involves becoming aware of the inequities that are built into the social relationships and environment all around us, and learning to both reflect and think critically about these relationships and inequities—a process similar to literary criticism and analysis. This ability to read the world is the first step in developing an orientation toward social justice.

Again, what I am saying has been said before. To those with a background in social justice, social science, or the humanities, it probably sounds old hat. But for too long, medical education in this country has not viewed the creation of a cultural consciousness as part of its mission. It has tended to align itself with the "hard sciences," relegating the idea of social justice to the realm of public health. Counterexamples are, of course, to be found in various individual programs, but there is very little consistency.

The push for "cultural competency" in medical education should not be viewed as one more arbitrary measure to meet, one more correct-sounding thing to which we should pay lip service. Rather, it should be viewed as a call for a shift in our mission as clinical educators, to move into a space where the humanities, in particular the social sciences, have already outdistanced us: the space of creating a broader social consciousness in our new young doctors, to help them view themselves as part of a larger mission not just to care for the physical health of other humans, but to view that care as one part of the uplifting of humanity as a whole. The practice may need to be tailored to the needs of individual programs, but the principles, at least, should be generalizable.

When I began planning my redesign of the cultural literacy curriculum at UW-Madison, I sought some guidance from the medical literature. Like the Cochrane reviewers, what I found was occasionally helpful, but not terribly consistent. In Hawaii, for example, an entire team had been assembled to investigate the task I was doing on my own [5]. Other institutions had attempted to address the problem of cultural bias in faculty educators themselves [6–8]. Still others enacted practical, but limited interventions, such as seminars on working with interpreters [2, 3]. I had been given a limited number of hour-long seminars, to be geared toward second-year psychiatry residents. In this particular program, the second year involves the heaviest burden of emergency and inpatient call, making it the year of most sleep deprivation and burnout and simultaneously the year of most exposure to the most in need. How does one ignite the spark of a change in mindset, in minds whose resources are already being pushed to the limit?

There is often a temptation in designing cultural competency curricula to treat it as a sort of introduction to mental health in various categories of people: in women, in the LGBTQ community, in Muslims, in African Americans, and so forth. This type of curriculum design has the advantage of being well-suited to limited episodic contacts and fits well with the pattern of providing easily categorized bits of information to which residents are likely accustomed by the system-focused or disease-focused lessons of medical school. However, I would argue that this type of curriculum design is dangerous, and likely to undermine the aim of cultural literacy itself, because it encourages not only stereotyping, but reductive thinking in general.

The message of this type of curriculum is that there is a finite amount of information a medical student or resident could acquire about any particular religion, ethnic group, or culture, and once that information is satisfactorily acquired, the trainee will be adequately prepared for any encounter with any individual from one of these populations.

Such an approach is easy to implement, and therefore seductive in an environment like medical school or residency, where teaching time may be limited, and any substantial change in the core academic structure is likely to be slow and face many institutional hurdles. However, because it does not explicitly involve self-reflection, it is unlikely to effectively target implicit bias. Further, the choice of faculty to teach this type of curriculum can be problematic in at least two different ways: firstly, if a faculty member who may have a great deal of experience with one ethnic group, but is not a member of that group, teaches a seminar (e.g., a white male psychiatrist leads a seminar about delivering mental health care to a marginalized ethnic group), then no matter the level of experience or sensitivity of the lecturer, the content of the presentation will be filtered through his perspective and experience only, and the voice of the marginalized group itself will not be heard. However, the alternative places an undue burden on faculty members or community leaders who happen to be members of marginalized groups, to continually speak on behalf of their group, regardless of what their own experiences have been.

There are those individuals from marginalized groups who enjoy educating others and take both pride and pleasure in that position. These individuals should be allowed the space and agency to speak, and be heard, as much as they wish. But placing the burden of cultural ambassadorship on marginalized people should not be a default position. It is not the job of any group to explain itself to outsiders in order to "earn" or "deserve" respectful treatment. Rather, it is the duty of the outsider to seek education, to listen openly, and to give respect without demanding to be made comfortable first.

This kind of open, curious attitude is (rather ironically) not usually encouraged in higher education, particularly not in the sciences. Instead, medical students are often encouraged to cope with the overload of information being firehosed at them by learning to break it apart and rapidly categorize it into small, easily digestible component parts. Because the information in question is about human beings, medical students are often, therefore, inadvertently encouraged to stereotype. For those medical students with undergraduate science majors, the encouragement to compartmentalize, sort, and stereotype begins even before medical school, due not only to the challenges of the curriculum but to the traditional, top-down, memorization-focused ways in which the material is taught. Stereotyping is, after all, highly efficient. It is, by definition, a mental shortcut. In any educational or organizational culture where efficiency is highly valued, stereotyping is bound to thrive, and if we do not believe medical education and medicine are cultures of this sort, we are fooling ourselves.

In addition, the competitive admissions process for medical school encourages students to fear failure, tacitly if not directly discouraging them from taking courses that might in any way detract from a "perfect" application. The fear of failure and

the avoidance of risk are further strengthened in medical school, where the first 2 years are still often graded in a ranked system that keeps these already competitive students in competition with one another, always seeking the "correct" answer, the end and not the means, the top mark that guarantees survival with the least possible risk. Later, in their clinical years, students learn that failure to provide a correct answer on rounds results in shame, and possibly the loss of opportunity. The fear of failure and the avoidance of risk are further cemented as performance pressures on students mount.

Thus a group of intelligent people are molded by their very education into black and white thinkers, stereotypers, and seekers of ends rather than means. To cultivate an attitude of open curiosity in medical students and residents, an attitude that embraces mistakes as inevitable rather than fearing them, is to seek to undo many years, in some cases half a lifetime, of rigorous training. And, I would argue, this cultivation cannot be done effectively by an outsider, who is not familiar with the effect of medical education on the mind. Just as a man is more apt to listen to feminist ideas when a man speaks them, just as white people are less threatened by discussions of institutional racism when they come from other white people, we are the ones who did this to our residents and students. We must be the ones to undo it. To teach cultural literacy effectively, we must both model and instill new habits of mind. To model cultural literacy effectively, we must be always teaching ourselves to undo our own habits of mind, instead of perpetuating them.

To begin cultivating an open and curious habit of mind, we must first help the group of residents that we are teaching to see each other as trusted allies, not competitors, in a classroom environment. This last clause is important. Residents will naturally learn to rely on each other in a work or on-call environment, because doing so is essential to survival. But in a classroom environment, or in rounds, in the presence of an authority figure such as an attending, the old closed, stereotyping, risk averse, and competitive habits of mind will be apt to emerge again. Attendings can choose to perpetuate these habits, teaching in the way that they were taught, or they can choose to disrupt them. How do we disrupt competition in a classroom environment? How do we encourage openness, and willingness to admit limitations, to make mistakes?

One way is to model such traits in ourselves, as attendings, as authority figures, and as teachers. The first session of our cultural literacy seminar functions as a modified version of a traditional T-group. (Notably it became more effective when our residency programs implemented T-groups as part of training from year 1, so less time had to be spent acclimating residents to the framework.) In this session, the attending models vulnerability by being the first to offer his or her own cultural history. It is important that the attending not take any aspect of their own background for granted as "normal," from skin color to religion, to gender, names, and pronouns. In this way, residents who may be used to viewing themselves as "default" or "without culture" will see an alternate perspective modeled [9]. The facilitator works to encourage awareness of one's own background and experience, taking nothing for granted, and to encourage self-reflection. Doing this as a group encourages trust that will be useful when more contentious subjects, such as bias and

institutional racism, are explored. Clinical cases are then brought forward and explored from this base.

During clinical case discussions, the attending, as an authority figure, must be particularly careful not to fall into the trap of encouraging judgments. It is important to model a mindset in which there are no right or wrong answers, so that students do not feel afraid to express their viewpoints or to have their viewpoints interrogated—an experience that can feel incredibly threatening, particularly for those students from backgrounds of multiple privileges, who are used to academic success and social rewards. The point is not to judge who among us is the least Islamophobic, the least racist, the most right-thinking—the most culturally competent, if you will. The point is to disrupt the idea that learning is, in any way, a contest. The point is to begin to create a new mindset, a consciousness of injustice, and one's own role both in perpetuating it, and in fighting it, that can be carried into every social interaction, clinical and otherwise, with the ultimate goal of improving both healthcare delivery and the culture of medicine itself.

The most difficult sessions of our framework involve exploring how to implement these concepts in practice, as this is where students and residents are most vulnerable, most eager to prove themselves, and, often, most defensive regarding the skills they've already acquired. (The same is often true of experienced clinicians, who can in fact be even more defensive of their skills, experience and methods.) It is often helpful to begin by using an example from the news, if possible from a different state or facility, to help it feel more neutral, and then gradually shift to more personal examples. Again, it also helps tremendously when the instructor is willing to model vulnerability for the students and share an encounter that could have gone better.

One story I often tell is from my family medicine rotation as a fourth-year medical student. I was working with a family medicine doctor at a clinic in Minneapolis that served a large Somali population. He asked me to start seeing a young woman who had come in for her annual exam, as she preferred to be examined by a female clinician. I had done a lot of reading about the Somali immigrant population and was eager to demonstrate my competence and sensitivity in working with them. For instance, I had read that modesty, propriety, and traditional gender roles were important to this population due to their strict observance of Islamic law, and I assumed this was why the young woman preferred a female clinician. I assumed she was a strict observer of the tenets of a culture I thought of as repressive, and I assumed she had probably undergone a female circumcision ritual. I was prepared to speak to her in hushed, sympathetic tones and find subtle ways to inquire about abuse. My intentions were entirely compassionate, and none of the assumptions I made were necessarily unreasonable. But the fact remains that I had made them all before even speaking a single word to the patient herself. In fact, I'd made some of them before I'd even entered the room.

When I walked in, I met a young woman in her 20s, with a hijab and scarf wrapped carefully to create an artful two-tone effect that perfectly matched her lipstick and eyeshadow. She was very chatty, with a loud laugh and several different decorations hanging from her phone. She reminded me forcibly of myself. When I

asked apologetically if I could examine her underneath her headscarf, she asked me if I could just push it aside for the exam, because it had taken her a good half hour to get it wrapped perfectly, and she would rather not redo it. When I started to ask my hushed, carefully sympathetic questions regarding her sexual history, she rolled her eyes and looked embarrassed for me.

"You want to ask me if I've been cut, right?" she said. "I was. My husband and I are dealing with it. You don't have to talk to me like I'm some little oppressed person. We're not all the same."

It transpired that she had wanted to talk to a woman that day not only because she preferred it but also because she had been hoping to get some straightforward answers on the subject of lubricant, and she thought her questions might embarrass her regular doctor. She was disappointed in how little I knew on that subject and impatient with a sympathetic concern that I now realized had actually been condescending. My intentions were good, but my sympathy had come from a place of paternalism in myself that I had not even been aware of before that day.

What I did in that visit might not have been in line with the more obvious examples of racism and Islamophobia, the dramatic examples that are easy for most people to spot, satisfying to decry. But it was much more in line with the kinds of well-intentioned but ultimately frustrating and silencing assumptions that minority groups deal with every day—the sort of thing even the best clinicians have been guilty of at some point, every single one of us. Here I was, complacent in the conviction of my own cultural superiority when it came to feminism and women's rights, thinking that I knew that I was competent and that I could understand. But in practice I had made assumptions based only on reading, not on data from the patient, and in the end did not have enough knowledge to even address the question the patient was there to ask me. I had been condescending without ever intending to be. I had stereotyped her. In the end, she was remarkably patient with me, and I learned a lot from her about the sexual experiences of women following FGM—more, I should note, than she was obliged to teach anyone, and I remain grateful to her. But if this patient had not been such an open sort of person, or if she'd had a long day of explaining, and assumptions, and was too tired to do anything but play along with the role into which I had chosen to put her (as often happens), think of the opportunity for true learning, connection, and communication that I would have missed.

This story may seem like a small, relatively harmless example of stereotyping, but its smallness is part of the point. The Islamophobia and racism typically encountered in a clinical setting, particularly in clinicians ourselves, are not usually about open, obviously violent, hate. The key often lies in the small things, the little shortcuts, the assumptions and stereotypes masquerading as facts, and the little bits of condescension hiding behind good intentions. It is in these small things that we find the seed that grows the bigger fears, the bigger silencing walls, and the barriers to real, meaningful understanding, across cultures and between human beings.

The goal of this book as a whole is to explore Islamophobia in psychiatry, how to recognize it, how to prevent it, and how to treat it. I would argue that the project of a well-designed cultural literacy curriculum is foundational to all aspects of that goal. Islam may be one of the world's major religions, but it is not a cultural

monolith, and viewing it as such has the same dangers as any bias. Ireland and Mexico are both largely Catholic nations, with a long history of colonial involvement, but would we ascribe the same needs and cultural values to an Irish Catholic as we would to one from Mexico? Can the Westboro Baptist Church be reasonably compared to any other Southern US Baptist community? And even within larger groups, there are divisions based on sect, location, family heritage, family culture, etcetera. If we can acknowledge these distinctions, why would we think for a moment that we could lump Rohingya Muslims in with those from Pakistan or Somalia? Education is a wonderful cure for ignorance. But to provide it in broad strokes, inside an educational mindset that is already primed for reductive thinking, will not prevent bias and is less likely to disrupt it than we may want to believe.

If we want to build a better future clinician, if we want to become better clinicians ourselves, we must begin within. We must begin by cultivating a mindset that is open and curious, unafraid to admit our own failings, and able to at least begin interrogating what aspects of our worldview we are taking for granted. In the moment, in the room with a client, what aspects of our experience are we assuming they share? What attitudes are we ascribing to them? And what is our evidence? Where did we get that evidence? How high is its quality? Can we slow down? Can we ask a question without fear of mistakes or embarrassment? Can we show humility when we are caught in a bias, as we inevitably will be, and when we make the errors we will inevitably make?

Bias is pernicious, but it is also efficient. To be truly flexible and open in our thinking, we need to be able to slow down. In many ways, our healthcare system pushes us away from flexibility, from taking our time. Building a better healthcare system, one that is more apt to reward time spent with patients than quantity seen, is an important part of reducing biased thinking and perpetuating the changes in mindset I have discussed. But as we practice self-reflection and humility, and as we teach it, we can find ways inside ourselves to resist.

To combat the evils of Islamophobia, racism, and prejudice, we must begin, or remember, to acknowledge as a profession that there is no such thing as perfect knowledge. There is only perfect learning. And perfect learning is a lifetime of humility, error, correction, processes and tweaks, perspective shifts, and revelations. Only through cultivating a socially conscious, open mindset, one that strives toward both justice and learning, as processes, not as ends, and that resists the efficient rigidity of bias, can we hope to create a generation of clinicians equipped to practice truly good medicine.

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