

Culture and Healthcare in Medical Education: Migrants' Health and Beyond

Medizin und ethnisch-kulturelle Vielfalt in der medizinischen Ausbildung: "Migrantenmedizin" und mehr

Abstract

One of the main challenges for teaching programs on immigration, ethnic diversity and health is to transform the commonplace notion of "culture" into a helpful tool for medical training and practice. This paper presents the teaching approach of an interdisciplinary course on "migrants' health" established at the University of Giessen since 2004, which has recently been complemented by a thematically related collaboration with two universities in Latin America (Ecuador, Peru). The overall goal is to translate the abstract philosophy of "*think global and teach local*" into medical practice, and to provide students with the insights, attitudes and skills needed for a fruitful use of concepts like "culture", "ethnicity" and "migration background". A key feature of the course is the strong commitment to ethnography as an important means for looking under the surface of superficial attributions to culture, and for grasping the interplay of medicine and health with cultural, social, religious, economic and legal aspects in its particular local and/or individual shape. Three elements of the course are presented to illustrate this approach: First, a unit on Islam and Medicine, as important parts of the local immigrant community are Muslims. The second one deals with psychosomatic aspects, because in case of immigrants, complex symptoms and disease representations like somatisation are easily misinterpreted as "cultural". The third element consists of a unit with specialized social workers from outside the university, who provide direct insights into the living conditions and health problems of local immigrant communities.

Keywords: cultural competency, migration, ethnic diversity, ethnography, Islam, psychosomatic medicine, medical anthropology

Zusammenfassung

Eine der zentralen Herausforderungen für Lehrprojekte zum Thema Medizin und ethnisch-kulturelle Vielfalt besteht in der Vermittlung eines angemessenen Konzepts von „Kultur“. Vor allem gilt es, den exklusiven Fokus auf als „fremd“ wahrgenommene Bevölkerungsgruppen und die Gefahr oberflächlicher kulturelle Zuschreibungen zu überwinden. Der vorliegende Beitrag stellt den Ansatz eines interdisziplinären Kurses zur „Migrantenmedizin“ an der Justus-Liebig-Universität Gießen vor, der jüngst durch ein Kooperationsprojekt zur Stärkung interkultureller Aspekte in der medizinischen Ausbildung mit zwei lateinamerikanischen Universitäten ergänzt wurde (in Ecuador und Peru). Durch den internationalen Vergleich soll das abstrakte Prinzip „think global and teach local“ für den medizinischen Bereich nutzbar gemacht werden. Gleichzeitig wird die Bedeutung der Ethnographie für eine sinnvolle Verwendung von Begriffen wie „Kultur“, „Ethnizität“ oder „Migrationshintergrund“ auch in der Medizin betont. Als wichtigste Forschungsmethode der Kultur- und Sozialanthropologie vermittelt die Ethnographie differenzierte Einblicke in die jeweils konkrete Ausprägung der komplexen Zusammen-

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hänge zwischen Krankheit, Medizin und „Kultur“ – jenseits von Stereotypen und unter explizitem Einschluss der im Einzelfall relevanten sozialen, religiösen, ökonomischen und rechtlichen, aber auch medizinischen Aspekte. Der Artikel verdeutlicht die Umsetzung dieser Perspektive in der medizinischen Ausbildung exemplarisch anhand von drei Lehreinheiten des Kurses an der JLU Gießen: Ein Modul zum Thema „Islam und Medizin“, eines zu psychosomatischen Aspekten und eine dritte Einheit, in der Sozialarbeiterinnen eines lokalen Migrationsdienstes unmittelbare Einblicke in die reale Lebenswirklichkeit von Migrant/innen vermitteln.

Schlüsselwörter: kulturelle Kompetenz, Migration, ethnisch-kulturelle Vielfalt, Ethnographie, Islam, Psychosomatische Medizin, Medizinethnologie

Introduction

Immigration and ethnic diversity have become central characteristics of German society today. Current data of the Federal Statistic Office (*Statistisches Bundesamt*) indicate that 19 percent of the German population are considered having a “migration background” (approx. 15.3 million people), including both Germans and foreign nationals [1]. In some cities, like Berlin, Hamburg or Frankfurt (Main), migrants constitute up to 40% or more of the local population, especially among young people. But also in rural areas, ethnic diversity is a social reality that can no longer be ignored. Immigration and the political goal of “integration” have thus become priority issues of the federal government’s policy.

In the medical field, awareness for the particular needs and problems of, for example, foreign labour workers and refugees is not a novelty. Already in the 1970s, physicians were concerned about the medical consequences of especially hard labour conditions, social exclusion, cultural isolation and the difficulties of physician-patient-communication across barriers of culture and language [2], [3], [4]. However, systematic attention for ethnic diversity and health at large is a rather recent phenomenon in Germany. Only since the beginning of the broad public debates on immigration and the integration of migrants in the first years of the new millennium, these issues gained momentum also in the medical field. Significant efforts were made, for example, in epidemiology, health monitoring and regarding problems of access to and quality of care [5], [6], [7], [8], [9], [10], [11]. Observations in this field are frequently framed by notions like culture, ethnicity or migration background, though without adequate consideration of the complex theoretical questions behind and of the pitfalls of an unreflecting use of these categories in the field of medicine and health. Serious cooperation with social and cultural anthropology is scarce [12], [13].

In medical education, issues of culture and ethnic diversity are almost absent until today. Only two medical schools in Germany are currently offering courses dedicated to ethnic diversity: The first was established at Giessen University Medical School in 2004 [14], and the initial focus on migrants’ health in Germany has been

expanded recently towards a global perspective, by starting a subject related partnership for teaching “inter-cultural cooperation in health” with two universities in Ecuador and Peru.¹ A second initiative was launched at Hamburg University Medical School during the summer term 2009.² The present article is based on the Giessen experience and gives special emphasis on the question of how to fix the ambiguous issue of “culture” appropriately in medical education.

Culture, Healthcare and Ethnography

It is widely admitted that one of the main challenges for educational programs dedicated to ethnic diversity and healthcare is to translate the commonplace understanding of “culture” into a helpful tool for medical training and practice [15], [16], [17], [18], [19]. One of the main problems is that a careless use of this notion yields stereotype images of, for instance, traditionally minded “Turks”, who in contrast to the supposedly rational “Germans” adhere to magical ideas of disease [20]. From a theoretical perspective, the shortcomings of such a fairly simplistic concept of culture are obvious: the wide spread equation of culture and ethnicity is one of the popular fallacies disproved by anthropologists because the social and cultural reality especially of immigrants proved to be far more complex and dynamic [12], [15], [21]. Moreover, empirical evidence shows that despite common assumptions, the actual way migrants conduct their lives in Germany – including cultural values, religious orientation and identity – is rather independent of ethnic categories and ancestry. More important are social and economic conditions as well as education, biographic factors (including the individual migration history) and social support [22]. In times of hybrid identities and transnational social worlds becoming part of social normality, the assumption of “ethnic groups” as culturally static and homogeneous communities bound by a common ancestry, identity and language, is challenged heavily [21], [23], [24]. Medical studies and statements that are based on improperly defined ethnic or cultural categories, and fail to address social, economic, medical and other relevant aspects

adequately, even contribute to the reification of false ethnic boundaries and the stereotype thinking in medicine and beyond [25].

The complex dynamics between culture, ethnicity and healthcare have to be addressed in a far more differentiated way. Yet what can this way be? How can theoretical critique be translated into positive action and especially into teaching modalities for future physicians? A first step is to reflect seriously on the meaning of culture and the "hidden assumptions" [18] behind:

A core aspect of anthropological understandings of culture is that it is not a single factor but a multilayered set of potential modes to perceive, to understand and to evaluate all issues of everyday life including pain, disease, healing and medical devices [11], [12], [26]. Culture is acquired throughout lifetime and is constantly developing based on personal as well as collective experiences in the course of all perpetual social interactions. Even ethnic identity is shaped only in the context of social relations, namely in the dynamics of belonging and differentiation, and can thus change depending on time, place and social context [21]. Young second generation migrants in Germany, for example, are considered strangers ("Russian", "Turks", etc.) in their country of birth and "Germans" when they visit the home of their parents and grandparents. The meaning of "traditional" orientations (e.g. values, language, religion, etc. of the parent generation), finally, depends on the particular situation of the individual. Not only in case of severe disease or near death, many people, independent of ethnicity, develop a renewed interest in religious and spiritual issues even after decades of a rather secular lifestyle.

Against this background, a second aspect of the anthropological understanding of culture, that outside of professional anthropology is often neglected, gains in importance: ethnography [15]. Ethnography is the key methodology of cultural and social anthropology and features huge potential for improving in-depth-understanding in health service research at large [27]. Characteristic is the combination of a holistic approach of observation and analysis with a critical attitude towards generalizing statements about ethnic groups or cultural traits. Social situations are examined explicitly *within* a particular "local" context. It includes a reflexive mindset regarding one's own perspective, priorities and possible prejudice in a given situation.

Since generalized statements about the culture of individuals or ethnic groups are impossible, the ethnographic approach is indispensable. It provides empirical insights into the social reality of patients and relatives beyond stereotypes and preconceived images of "migrants" and the members of particular "ethnic groups". Ethnography permits a closer look on the multilayered social reality and to understand the patient's perspective on health, disease and medical care. Instead of reducing the situation of a sick person to an abstract disease category, it tries for a comprehensive view and for identifying – as precisely as needed – the different aspects involved (social, economic, bureaucratic, etc.). Moreover, ethnography

includes a critical attitude towards all kind of supposedly natural and self-evident categories within and without biomedicine (like disease classifications, concepts of body and illness, or ethnic boundaries) and subjects them to analysis both historically and cross-culturally [28], [29], [30].

There is no need for physicians and other health care providers to become anthropologists, yet the adoption of an ethnographic perspective is necessary for at least getting closer to the real needs and living conditions of the people concerned. And despite the huge gap that apparently separates medicine from anthropology and qualitative research methods, this kind of a clinically adapted ethnographic approach is not strange to medicine at all. Instead, it is very similar to what is usually meant to be the most fundamental means of any physician's daily work: taking the individual patients' medical history. In essence, ethnography applied within healthcare means communicating appropriately to understand the patient's problem and trying to grasp his or her personal situation comprehensively. In addition to conventional anamnesis, it includes explicit attention to the broader social and cultural context, in the case of migrants with issues like legal status, language skills, identity, and probably "unconventional" resources of social support like mosques or transnational family networks. However, the line between both is blurred and it depends on the disposition and abilities of the individual physician to advance in ethnography as far as the individual case demands.

Think global, teach local

To support future physicians in the development of an ethnographic perspective in health care is the primary goal of the educational program in culture and healthcare at Giessen Medical School. In various ways, students are encouraged to have a closer look at different issues that are discussed in regard to ethnic diversity, migration and health today. The particular topics range from epidemiology and health service provision to legal regulations (immigration laws) and intercultural cooperation in healthcare. Background information is given about the history of migration and immigration policy in Germany, and on anthropological theory (definitions of "culture") and method. Already when discussing epidemiological findings, the anthropological perspective is exemplified by a careful examination of the criteria used in a study to distinguish the different groups and the underlying assumptions. What does it mean, for example, to apply criteria like ethnicity or nationality in epidemiological research, when growing parts of the target group have hybrid identities or have acquired German citizenship more or less recently?

The main strategy for applying the ethnographic approach in this program can best be characterized under the label "*think global and teach local*". Ethnic diversity and migration are global phenomena, but they materialize locally in very different ways. In Hamburg the situation is different

from that in Giessen or from that in rural areas near the Dutch border and in Saxony. Content and teaching activities are thus explicitly oriented towards the local situation, because demographic aspects (e.g. unequal numbers and origin of the migrant population in Germany) as well as the particular social, economic and political conditions define the situation a physician is confronted with. Moreover, for widening the personal scope of action it is necessary to know in detail helpful resources available locally, like NGO's or religious communities. In addition, the cooperation with Ecuador and Peru opens a true global dimension through the comparison of multiple local sites internationally.

One of the teaching modules most appreciated by our students is, for example, a visit to social workers of the local Caritas service for the support of immigrants.³ The act of leaving the university building and translating the lesson into the office of the social workers symbolizes the idea of "going local". The teaching purpose of providing a *closer* look on the living conditions of migrants at the very same place of the student's daily life becomes tangible. In the final evaluations sheet of the course, students almost unanimously highlight the great value of this meeting. The stories of real patients told by the social workers and the high capacity they display to solve problems that in first instance appear to be insuperable, provide vivid insights both into the normally hidden social reality of these people and the wide scope of helpful resources available.

Under the surface of culture

Legal status and complex social as well as economic aspects have a huge influence on an individual's way to display pain and other symptoms, on compliance and communication style. In case of patients of seemingly foreign ethnicity, however, this kind of variations and problems are often wrongly attributed to cultural factors or ancestry. Assumptions about patient's culture can actually impede better understanding [15], [31]. It's a widespread cliché, for instance, that people from Islamic countries are "different" with regards to the perception and expression of pain: they are supposed to be unable to provide medically exact information and to use rather metaphorical and socially distorted ways to display pain [20], [32]. Apart from the complete neglect of the complex interplay between physiological, psychological, social and cultural dimensions of pain [33], [34], statements of this kind mistake culture, religion and origin as synonyms and consider an idealised "Western" standard universal. Yet physicians have to be able to look under the surface of what at first glance appears to be cultural. In the Giessen course, this is exemplified with two important modules that have not been mentioned so far: One provides basic knowledge about *Islam in relation to medicine*; the second is on the *psychosomatic dimension of diseases* among patients with migration background.

Regarding Islam, students get to know basic principles of faith relevant to medical practice, and learn about the main sources of religious knowledge and guidance: the Qur'an and the collection of the Prophet Muhammad's traditions and actions, Sunnah. Priority is given, however, to link religious principles with real situations from daily medical life. Students are encouraged to bring in personal experiences and questions that evolved during practical trainings in the hospital. What can be done, for example, if a patient with diabetes insists to fast during Ramadan though this would be inconsistent with his treatment? After learning that religious rules (like to fast in Ramadan) are not obligatory, and that any Muslim is free to decide and at the same time responsible to God for maintaining his body healthy [35], new possibilities for solving what at first glance appears to be a conflict between faith and medicine evolve. Students' feedback in course-evaluation show that this kind of basic knowledge about Islam is highly appreciated and considered helpful for daily practice.

Psychosomatic medicine is emphasized because the migration background of a patient implies multiple risks for important medical factors being overlooked or misinterpreted as "cultural". Yet migration in itself is not "pathological", ambivalent social relations and feelings both towards home and receiving country can become a strain. For various reasons, migrants are known to be a vulnerable group for affective disorder and somatization [36], [37], [38], [39]. Moreover, the dynamics of difficult verbal communication and cultural assumptions about foreign patients may foster both equivocal interpretations of allegedly "bizarre" presentations of symptoms as "cultural" as well as the accentuation of pain symptoms (and thus further somatisation) by the patient. To improve the quality of care and prevent inappropriate prescription of analgesics and antidepressant drugs, awareness for these dynamics and for adequate communication is necessary, also beyond specialized services of psychosomatic medicine.

Conclusion

Making culture and ethnicity useful categories for medical practice is not an easy task. A strong commitment to anthropological theory and methods is needed, just as an adequate adaptation of these to the particular context of healthcare. For teaching purposes, the ethnographic approach proved useful, just as the inclusion of attending physicians and social workers who in addition to formal lectures strengthen the didactically important "informal curriculum" [16]. The best way, finally, to deepen the impact of the course as well as to assess the achievement of the teaching objectives turned out to be the compulsory elaboration of a term paper in the form of "mini-ethnography" [15] based on personal observation by the student. They are encouraged to write about experiences during medical clerkship and to provide a differentiated analysis of concrete situations or case histories from the

perspective of an actively engaged, participant observer. The results usually echo what other studies have shown repeatedly: thoughtful attention to culture is a way to recover awareness for the individual in the healthcare system in general [16], [17], [40]. Since the importance of culture is not bound to a particular ethnicity or profession, both patients and health care providers benefit from this rehumanising effect.

Notes

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Erratum

Title: "byond" corrected to "beyond". Subheadline "Culture, Healthcare and Ethnography" corrected to "Culture, Healthcare and Ethnography". Notes 3: "Fatma Kaya" corrected to "Fatma Kisa".

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