Teaching Critical Reflection Through Narrative Storytelling

Nancy P. Chin
University of Rochester Medical Center

Anthropological concepts and methods provide an important framework for organizing community service learning. Critical reflection is central to both anthropology and community service learning. However, an anthropological approach to reflection stimulates the learner to consider their own cultural background. Little is understood about how to teach critical reflection. This article explores narrative storytelling among medical students, as a pedagogical process for reflection on cultural assumptions and to spur subsequent action toward social change in the practice of medicine among the poor. Students generated stories based on their own experiences to illuminate how unconscious cultural assumptions can create medical care that is harmful or useless to patients on the margins and stimulate a re-thinking of how unexamined assumptions may render care not in the patients' best interests. The article concludes with 'best practice' recommendations for teachers in community service learning programs.

> Action without reflection is wrongheaded; reflection without action is self-indulgent.
> —Anthropologist Nancy Scheper-Hughes

The concepts and methods of anthropology provide an ideal framework for community service learning. Consider the central elements of an anthropological approach: 1) emphasizing community engagement through participant-observation; 2) understanding social justice issues through an analysis of class structures; 3) promoting social change by understanding power distribution; and 4) using critical reflection to stimulate researchers to consider their own cultural background, and at the same time raise consciousness about how social organizations can advantage certain groups while disadvantaging others. So why is anthropology so marginal to the field of community service learning? How can practicing anthropologists make the concepts and tools of our discipline more widely available? This special issue, in which we tell *how* we do *what* we do, is an important step in disseminating anthropology as a core element of service-learning. In this article I report on the development of pedagogical tools to promote critical reflection among health professional students in a community service learning (CSL) program. I used narrative storytelling to provide students with triggers to critically reflect on the practice of medicine as community service to the urban poor, and on their own cultural biases in working with these marginalized populations.

Critical Reflection in Community Service Learning and in Anthropology

A reflective practice is central to CSL and intended to foster students' understandings of connections between their community service experiences and classroom learning (Seifer, 1998). What anthropology adds to the existing literature on reflection is the element of culture. At its most fundamental level, CSL is a cross-cultural experience. Anthropology presumes that for students to work across cultural boundaries of class, ethnicity, race, gender, disability, and/or sexual orientation, students need to be aware of their own cultural values and traditions. Understanding one's own culture is not easy to do because most cultural processes occur on an unconscious level and are considered a natural, even necessary, way of thinking about and acting in the world. This is especially true for the subcultures surrounding medicine and health. There is an illusion of scientific objectivity, an assumption that medical knowledge is unrelated to cultural ideas. The presumption that doctors practice altruistically—acting for the patient's good—itself can further obscure instances where stereotypes or assumptions produce medical care not in a patient's best interest.

In addition to the culture of medicine posing obstacles to understanding community needs, the United States' cultural focus on individuality and independence makes it especially hard for students to understand health as anything other than the result of individual behaviors. In a previous work, I have described the dominant model medical students use to make sense of their encounters with marginalized communities: that poverty (or marginality) is the result of, at worst, individual pathology, or at least, bad choices on the part of individ-

uals (Chin, 2002). It is difficult for students to see the social contexts that shape and inform individual decision-making; it is even harder for them to see instances of oppression and disenfranchisement. Students are often genuinely mystified by the relations of power and domination that can produce ill health and restrict access to health care. What often remains unexplained to educators is how to cultivate and teach a reflective practice to students that will illuminate these relationships.

Setting

From 1995-1998, I directed a program placing medical students at community agencies serving the urban poor. Students tutored school children, helped out at soup kitchens, attended support groups for women in transition, and worked at health fairs. Students also had the opportunity to 'shadow' primary care physicians in these urban poor communities. Using an anthropological framework, students were trained in in-depth ethnographic-style interviewing and participant-observation to understand health problems from the point-of-view of the communities in which they served. Discussion groups with other students and community members promoted reflection on how economic and political circumstances shape individual lives. Seminars on culture and bias in health care delivery helped students recognize how unwarranted assumptions about people influenced the delivery of medical care at both an interpersonal and institutional level.

Despite all these pedagogical tools, after four years of running the program I found that students still struggled to see how medical care—supposedly grounded in objective science—could be influenced by wider social structures (such as politics and the economy) and by cultural biases that arise out of assumptions made about patient populations at the margins. For instance, one student who had worked at an inner-city clinic wondered aloud at why low-income people could not adequately manage a chronic condition such as diabetes. After all, he pointed out, they have 'continuity of care.' That is, the patients have the same doctor and same clinic, the supposition being that the doctor will gain familiarity with the patient's concerns and context. This student had made two unsupported and incorrect assumptions: 1) that poor patients at a medical clinic see the same doctor at each visit over the course of their condition; and 2) that poor patients with chronic health problems were irresponsible in managing their own disease. "Don't residents [student doctors] staff that clinic?" I asked, "And don't the residents move on after three years?" He slowly nodded his head in agreement and then recalled that just that morning he witnessed a resident saying good-bye to a diabetic patient, telling the patient that he would have a new doctor the next time he visited the clinic. "But you've been through this before, haven't you?" asked the resident. The patient nodded wearily and shrugged.

This scenario illustrates the impetus for my introducing narrative storytelling into teaching critical reflection in CSL during the fifth year of my tenure as program director. It also illustrates the risk inherent in any service-learning program. For students who have never had contact with impoverished or marginalized communities, interactions without critical reflection might actually reinforce pre-existing biases about people on the margins as being fatalistic, irresponsible, or disinterested in their own welfare, resulting in a tendency to "blame the victim" for their plight. Hence, without structured reflection, teachers risk leaving students in considerable confusion or with myths reinforced. This "blame the victim" stance can preclude the next step in CSL: action to create solutions involving social change.

Layered onto the need for different pedagogy on cultural bias were institutional and community goals: while the medical school wanted students to gain experiences in underserved areas, our partnering community agencies wanted to work with the medical school to create changes in medical education and, subsequently, in patient care. A recurring theme heard from community partners and their clients was that health delivery to the poor and marginalized was informed (or misinformed) by assumptions practitioners' made regarding their patients. The community believed that these often negative assumptions about individuals served to reinforce the existing social order as right and just, while rendering marginal individuals as "not deserving."

I sought to better understand how assumptions (both positive and negative) on the part of practitioners and institutions impacted care by eliciting cases medical students witnessed, of health care interactions in which students thought cultural difference was at play. The social change I sought to make was in the medical practitioners' community. At the community's repeated request, this meant changing clinical encounters so that health providers avoided making assumptions about their patients' moral character, asked non-pejorative, non-judgmental questions about the patients' social circumstances, and showed empathy for families struggling with multiple priorities in which maintaining health competed with finding safe, affordable housing, getting a job, and avoiding the violence of poor neighborhoods. The tool used was

narrative storytelling. The reflection I sought to stimulate was on the culture of medicine.

Method

A narrative approach to critical reflection was inspired in part by Renato Rosaldo's (1986) work among Ilongot hunters. Rosaldo suggested eliciting stories or narratives to more fully understand what is important about a situation from the natives' point of view. First- and second-year medical students are an interesting group of 'natives' to engage in storytelling. They have not been fully socialized into the culture of medicine. In their liminal position, situated between the general public and soon-to-be doctors, they are 'outsiders' to the culture of medicine and hence can see behavior to which they may be blinded in only a few years. They are especially aware of practices that seem to contradict, or work in opposition to, the stated goals of medicine.

What are the stories students tell about cultural bias in medicine? My goal in asking this was to create a pedagogical approach that would stimulate medical students' critical reflection on system-level bias in health care, and create a way for students to consider their own personal biases or cultural assumptions. There are multiple challenges to teaching reflection: students must stay engaged and interested, not frightened away by fears of being labeled as racists or other types of "*-ists*." I asked students to reflect on actual instances of interactions of the health care system with marginalized people in which cultural difference seemed to be at play, create narratives of these instances, and write stories describing how the interactions unfolded.

Narratives were developed during weekly lunch seminars. The first discussion centered on bias. What was bias? Could it be a manifestation of institutional policies rather than the acts of an individual? Do we all have biases? Should we, could we, eliminate them? In subsequent meetings, students took turns telling their stories to the group. Questions about the stories' plots, characters, reactions, and temporal sequences gave the student-authors important direction on how to flesh out the description of each case, for their narratives to be intelligible to an audience. The cases were then written down.

Three students did extra work and turned their stories into scripts for filming; these are the stories presented in this article. These three students asked classmates, medical school staff, and faculty to portray the characters. We worked with a cameraman from the medical center's media office to film the skits, acted out in an empty room fitted with an exam table. The students presented their film clips in seminars and anti-bias training sessions as a "trigger" for discussion of the role bias plays in encounters with others. Seminars were offered to two levels of students: medical students and medical residents (student doctors that had completed the study of medicine). Medical students were recruited for seminars to discuss the stories through postings offering a meal. The residency directors in emergency medicine and internal medicine assembled resident audiences.

Students on the Margin

Interestingly, the three students who scripted their stories were all international students from formerly colonized countries. Aswa was from Somalia, Emanuel from Nigeria, and Niraj from India. Aswa, Niraj, and Emanuel knew from their own experience that misunderstandings and differential treatment can occur based on insufficient or assumed information about the 'other.' They had all negotiated difference when it placed them at a disadvantage; that is, in interactions with others who were biased against them and had power over them. They were especially sensitive to bias in interactions with former colonial powers. Aswa mentioned that social and political hierarchies in her native country demanded that subordinated actors mask their true feelings under a guise of politeness. Emanuel and Niraj concurred. At the beginning of our experiment, however, they were unsure as to what in *health care* would constitute biased treatment of a patient. They were unable to conceive of medical expertise as working in opposition to a patient's best interests. Their understandings would change and develop as we moved through the narrative storytelling process.

Narratives

Here I present three narratives this process produced; readers may judge the effectiveness of the approach.

Story #1:Taking a History

Niraj's story was about a doctor, patient, and himself as a student 'shadowing' the doctor. Niraj submitted a script in which the doctor's bias was so evident that it made both the patient and observing medical student exceedingly uncomfortable. The story involved a routine physical exam by a doctor who was not the patient's usual doctor. The male patient discusses concerns about having diabetes, a condition from which his father died, based on recent symptoms of headache and fatigue. The doctor takes a medical history, during the course of which, the patient self-identifies as gay. The doctor's attitude and manner changes abruptly. She

becomes hostile and judgmental, asking bluntly and aggressively, "Do you know the dangers of anal intercourse?" Both the patient and the medical student are confused and uncomfortable with this change in demeanor, a sudden shift from following the symptoms of concern to the patient, to the physician's concerns about what she imagines to be a homosexual lifestyle. The patient, although discomfited, assures her that he is knowledgeable about HIV transmission, having worked as a counselor for an AIDS advocacy group. He tells her that he is in a committed, monogamous relationship with a man he trusts. The doctor is unsatisfied. She leaves the room, telling the patient the student will finish taking the history and she will return later. The student is left alone with an angry, upset patient. The story ends with the patient and medical student uneasily looking at each other. This was a three-minute film that opened with a cheerful and pleasant physician and ended with the medical student and patient staring at each other in disbelief. The physician's level of hostility and her insistence on pursuing a course of investigation not of immediate concern to the patient made this a combative, unproductive, and upsetting encounter.

In the seminars in which this vignette was shown, audience reactions varied. One group of emergency room residents laughed out loud and refused to believe this had actually occurred. Other audiences of medical students and internal medicine residents found it credible, but could not decide if it was merely the physician's manner that was inappropriate, or the questions themselves. "Was not the category 'homosexual' a scientifically-defined category for the risk of getting HIV," they wondered? Stewart, the gay medical student who had portrayed the patient in that video, reminded the group that there is nothing inherent in the category 'gay male' that predisposes for HIV. It was behavior that defined risk, Stewart noted, not sexual orientation, ethnicity, nor race; and behavior cannot be assumed from social location.

Everyone agreed it was the physician's responsibility to create a comfortable environment for the patient and give primacy to the patient's concerns, which in this case was possible diabetes, not HIV exposure. Some thought the doctor's questioning was not out of line as a medical screening practice, but that her approach and obvious discomfort with homosexuality created conflict with the patient, and that this was irrelevant to the patient's reason for the appointment. Students were very gentle criticizing the physician. Only one medical student defended the doctor as having taken the correct approach.

Story #2: It is Routine Here

Aswa prefaced her story with the disclaimer, "I don't know if this would be considered biased." She described a situation she had encountered in an inner-city clinic for teens, in which the routine clinic practice was to do gynecological exams and screening for sexually transmitted infections on all young Black females at the clinic-irrespective of their presenting complaints. This was not the routine for the White teens. In her story, Aswa depicted a Black teen presenting at the clinic with symptoms consistent with seasonal allergies. After a preliminary history taken by a nurse practitioner with a medical student observing, the patient is asked to undress and put on a gown in preparation for "a routine GYN check and STD screen." The teen protests the need for such an exam, saying that she has not been sexually active in several months. "That is okay," the nurse assures her, "it is a service we provide for all the young women here." Outside the exam room, the medical student also questions the nurse practitioner about the need for such an exam. A physician overhearing the situation corroborates the nurse practitioner's reasoning, saying, "I know the girls from that area and, on top of having all kinds of STDS, they are all having babies." The doctor turns to the nurse practitioner, "You are going to want to do a pregnancy test and tell her that we have Norplant available."

In the next scene, a White teen complains of cold symptoms, which have mostly subsided. She is feeling tired. She mentions that her boyfriend and "kid" had the same cold that has resolved untreated. The nurse practitioner follows-up on the cold symptoms, but fails to engage the teen over any issues concerning her sexual activity.

Aswa, as a student working at the clinic, tried to understand the interactions in terms of good clinical care, but found it hard to believe that it was not racially motivated. The fact that it was clinic policy and not the actions of a single individual confused her. Could institutional policies and routines be constructed based on biased knowledge?

In screening sessions where the story was viewed, medical students commented that neither teen was well served. Students thought the nurse practitioner's inappropriate care of the Black teen was informed by unfounded assumptions regarding her truthfulness, sexual activity, and sense of responsibility. However, medical students also noticed that the nurse practitioner's care of the White teen was inappropriate as well, being based on assumptions that the teen was in control of her fertility. Medical students also discussed practitioner's tendency to "gossip" about the patients outside of the examination room. Students explained that beyond earshot of the patient, derogatory remarks were often made about patients, while inside the room patients were treated in a manner that did not reveal providers'

true feelings. Students say they find this confusing—what prompted their teachers to act one way in front of a patient and a different way outside the examination room?

Aswa and I also showed this film clip to a group of internal medicine residents. A young, Black, female resident commented that she too had similar experiences, explaining that whenever she sought care at her college health clinic, she was given (unwanted) birth control advice. A young White male student angrily refuted her interpretation, banging on the table and saying, "That's not true! You weren't treated that way because you were Black. You were treated that way because you were young." The group sat for a moment in stunned silence. The female resident withdrew from further comment. An older resident suggested that everyone's account of their own experience be respected. After the session, a group of medical students stayed behind to speak with me. Laurie, a Black medical student, noticed my lingering shock at the incident.

"You're surprised, aren't you?" she asked.

"Aren't *you*?" I replied.

"No, of course not. This always happens. They deny what we know to be true," she told me.

Aswa caught up with the female resident who had been silenced by her colleague's anger to ask about her thoughts on what had transpired. That resident, too, was resigned that the structures that oppressed were invisible to, or denied by, many Whites in U.S. society.

Story #3: Demons in the Examination Room

In this scenario, Emanuel locates the source of bias in himself. He prefaced the first reading of this scene with an explanation of the patient's physical condition and his own emotional reactions as what he calls "a naïve and inexperienced student." Emanuel described the patient, Charles, as someone in physical disarray, his clothing is unclean and wrinkled, and his hair is uncombed. He reeks of urine and body odor. Even more disconcerting to the student is the patient's behavior, which is bizarre, showing evidence of active hallucinations. Emanuel arrived late to the exam room and therefore was not briefed by his preceptor about the patient. He squeezed himself into a far corner of the small examination room, looking to the attending physician for clues as to how to respond to Charles.

Charles was a schizophrenic patient whose doctor's appointment was for treatment of high cholesterol. His psychiatric care was given in a different clinic. During the course of the physical exam, Charles asks several provocative questions in a challenging manner, including, "Do you believe in the devil?" and "Do you think that Christ can heal sick people, doc?" He stares around nervously and intently, especially behind the door, as if looking for something. The student is alarmed and feels uncomfortable with this behavior, reacting nervously to the questions, uncertain of how to respond. The doctor shows no evidence of discomfort, nor that anything was particularly amiss. He answers the patient's questions as best as he can without condescension or incredulity. He was friendly and smiling in his interactions with the patient, making eye contact with Charles throughout the exam.

Outside the examination room, the physician immediately prepares for the next patient, examining her file. "Interesting case," remarks the student, trying to gain the physician's attention. There is a short but awkward pause as the doctor appears to be engrossed in the patient's chart. Then for a brief moment the physician looks up and casually mentions, "Poor man. Charles used to be a chemist at Kodak before he was diagnosed with schizophrenia."

Emanuel was surprised that a schizophrenic patient with the poor hygiene and dress formerly was an educated, middle-class chemist. After the narrative storytelling exercise, Emanuel recognized it was his own bias about the stigma of mental illness that would have precluded him from giving dignified patient care. Fortunately, the doctor modeled unbiased medical care for the student.

Seminar reactions to Emanuel's case presentation were especially interesting because it evoked comments and interpretations unrelated to bias toward people with mental illness . A group of residents (the same group in story #2) identified the case as a demonstration of how one should ideally interact with a patient. Emanuel emphasized that the physician's consistent treatment of patients both inside and outside the exam room (no gossiping) made a profound impression. Students concurred that gossip undercuts a preceptor's effectiveness as a teacher by acting duplicitously with patients. Students also pointed out how the social stigma associated with mental illness can affect students and that preceptor guidance and modeling becomes very important.

An unexpected discussion by most audiences, however, was about the racial discordance between the physician and the medical student: Emmanuel is Black; the actor representing the doctor was White. Discussants questioned whether the doctor was being dismissive and inattentive to the student's concerns and discomfort. Emmanuel reassured them that this was not the case.

Discussion

Critical reflection occupies a central place in most models for intercultural understanding

(Pedersen, 1980; Tervalon & Murray-Garcia, 1999), and in consciousness-raising practices intended to demystify political structures that advantage some groups, while disadvantaging others (Freire, 1970). I used narrative storytelling to provide students with triggers to critically reflect on the practice of medicine as community service to the urban poor, and on their own biases in working with these marginalized populations. In discussion students realized that medical care without adequate knowledge of the patients' cultural and social circumstances often resulted in medical care that was not needed, or was delivered in demeaning and offensive ways.

Pedagogically, using the students' own stories exceeded my expectations to initiate discussion and reflection in the groups that viewed the filmed stories. That the stories originated with students rather than faculty ensured that issues would be relevant to students' questions and concerns about medical service. The filmed stories were admittedly amateurish and stilted. The briefest scenarios worked best. The discussion groups were most effective when the medical student authors introduced their own work and led the discussion, with faculty acting in a secondary support role. In the single seminar in which I took the lead, discussion was not as robust. Two other stories not described here were presented orally as paper cases, and storytelling through this medium generated as much discussion as the film clips. Again, the student-authors presented their own works and led discussion. This method worked best within a peer group with the students presenting to their own peers. It worked least well when I presented the film stories to an audience that did not know the authors. Rather than re-use stories from previous years, I now routinely ask students to write stories from their own experiences and discuss them with one another.

It is also significant that the case-writers were all foreign students. This suggests that biased practices might be easier to identify when the students are 'outsiders' to the culture, in this case the culture of American medicine. It may also indicate that prior experiences with former colonizers sensitized them to relationships of power and dominance in a way that is not available to many U.S. students.

Conclusion

We all have biases—introduced through cultural practices, operating beyond our conscious awareness—that become challenged in cross-cultural encounters. The goal is not to rid ourselves of biases. That would be impossible. The goal is to find ways to identify biases, understand their roots in cultural learning, and find ways to prevent biases from interfering with our capacity to understand lives very different from our own. Students in CSL programs can have difficulty understanding this process. In CSL for health professionals, these students also struggle to understand the culture of medicine. It is especially difficult for students to accept that cultural bias exists when opinion leaders in their culture deny that differential treatment on the basis of culture exists. They unconsciously learn not to see it.

This project represents a methods-development phase of investigation designed to test the feasibility and acceptability of narrative storytelling among students as a reflection tool. As such, it would be premature to apply quantitative evaluation tools to determine outcome success. Rather, outcome success at this stage of investigation is determined by student acceptance of this process (both in their roles as authors and discussants at seminars) and in terms of the products of this process. The resulting narratives successfully identified problems of cultural bias; the discussions that ensued generated viable solutions.

Best practices for educators wishing to replicate this process in their own CSL programs include:

- Ask students (not faculty) to identify the problems of cultural bias in community encounters
- Schedule a series of meetings with student-authors to discuss the goals of reflection and produce the stories
- Have student-authors lead discussions of the finished cases
- Set ground rules for discussion before the story is presented—respect the other person's experience and opinions, listen carefully, realize that everyone has biases.
- Generate a new set of stories with each new group of students; do not recycle old stories.

Narrative storytelling, in which the stories are supplied by the students and the discussion is led by the student-author, is an effective way to stimulate critical reflection.

References

Chin, N.P. (2002). Medical student learning in the community: Creation of a compassionate physician, social activist, or biological reductionist? *Anthropology of Work Review, 2*, 122-135.

Freire, P. (1970). *Pedagogy of the oppressed*. Translated by Myra Bergman Ramos. New York: Herder and Herder.

Pedersen, P. (1988). *A handbook for developing multicultural awareness*. Alexandria, Virginia: American Association for Counseling and Development.

Rosaldo, R. (1986). Ilongot hunting as story and experience. In V. W. Turner & E. M. Bruner (Eds.), *The anthropology of experience*. Urbana, IL: University of Illinois Press.

Seifer, S.D. (1998). Service-learning: Community-campus partnerships for health professions education. *Academic Medicine, 73*, 273-277.

Scheper-Hughes, N. (1992). *Death without weeping: The violence of everyday life in Brazil*. Berkeley and Los Angeles: University of California Press.

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in Multicultural education. *Journal of Health Care for the Poor and Underserved*, 9, 117-125.

Author

NANCY CHIN is a medical anthropologist and assistant professor in the Department of Community and Preventive Medicine, Division of Public Health Practice, University of Rochester Medical Center. Although she no longer directs the community service learning program for medical students, she does routinely incorporate medical students into her field research projects in such diverse locations as Himalayan Buddhist villages in Ladakh, urban neighborhoods in La Paz, Bolivia, and inner-city schools in Rochester, New York. Storytelling still plays an important role in their training for these experiences.