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# Anthropological immersion: a new concept of Continuing Professional Development to improve attitudes in general practice


**GGRAM – SFTG: General Practitioner's Medical Anthropology Research Group. Workshop at the Wonca meeting, Basel, 2009**

### Presentation of the SFTG

The SFTG (Société de Formation Thérapeutique du Généraliste) is one of the most important French CME/CPD organisations for GPs. This National Level Scientific Society was created in 1977. It is composed of 30 local groups of GPs and more than 2500 members. Values and aims of SFTG are defined in a charter: independence, humanism, scientific rigour. The society works in four main areas: Continuing Medical Education, Continuing Professional Development, Social and Human Sciences, Research.

### Presentation of the work of GGRAM (General Practitioners' Medical Anthropology Research Group)

A group of about 20 doctors played the role of an anthropologist to learn about health practices in various countries (Senegal, Benin, Southern India [Tamil-Nadu and Karnataka] and the Himalayas [Sikkim, Nepal and Tibet]). They regularly shared, within pairs, their experiences from during their voyages. They then evaluated the changes brought about in their GP practices under the supervision of a professional anthropologist.

### Aim of GGRAM

During a consultation, we most often believe that our speech is understood and that we speak the same language as our partner. According to individuals, culture, experiences and history and the words used, concepts of diseases and treatments have different meanings. We must make the effort to access the representations of each other by trying to use a comprehensible language. If the individuals facing us are similar to us, we believe this special effort is spontaneous and we think that we unconsciously speak the same language. Meeting people with obvious social and cultural difference is the aim of "SFTG anthropological voyages", to develop awareness of the need to seek the meaning of the words and the representations of every patient.

### Voyages and themes

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| 1999 | **Senegal:** Bases of Medical Anthropology (an introduction) |
| 2001 | **Benin:** Influence of Vodu in Health and diseases resolution ( divine influence, trance) |
| 2003 | **Tamil Nadu** (India): Ayurvedic and Tibetan Medecine (Holistic thinking versus Hermeneutic thinking) |
| 2005 | **West Bengal and Sikkim** (India): Public Health – mass education, Buddhist – Tibetan Medicine). |
| 2007 | **Karnataka** (India): Place of Woman in society and role in child education |
| 2009 | **Nepal and Tibet:** Care of elderly people in Himalayan area (Health Care and social work) |

### Review of literature

The basic idea is as follows: the situation of a doctor in front of his patient is analogous to that of the anthropologist who immerses himself in a new world before having identified his theories. The latter will come to him whilst listening to the accounts of his interlocutors. This conception of the practice can have consequences on the doctor's attitude.

It follows that if we are immersed in a different culture, we could draw lessons for our own practices, creating a new vision.

This idea is not only ours since it is found in the work of *Arthur Kleinman*, in the following statement: "anthropologists and clinicians share a common belief – the primacy of experience. The clinician, as an anthropologist of sorts, can empathise with the lived experience of the patient's illness, and try to understand the illness as the patient understands, feels, perceives, and responds to it".

We must define what anthropologists call immersion. *Immersion* is participatory or participant observation. Participant observation is a concept that corresponds to a paradoxical situation. In fact, if you observe you don't participate and if you participate, you do not observe. Immersion is active fieldwork, opposed to the work of the anthropologist in armchairs. According to Levy-Strauss, immersion involves a psychological revolution: to leave his home, his habits, to learn, to contemplate and wonder. This implies a change of the self. Along with the observation of the object, self-observation is important; the observation of his own reactions in another environment. This leads us, in the words of G. Devereaux, to be aware of our own subjectivity. Finally, the immersion experience leads to a narrative; an ethnographic description.

We said that immersion could change some of our attitudes, but what are those attitudes? *"Attitude"* is a word of Latin origin used in Italian and then for the first time by the French painter Poussin to describe the posture of a figure. A little later the word had the same meaning in English and it was not until the early 18th century that the word also implied a mental state. In the 19th century, it was the behaviour reflecting feeling or opinion.

Gartoulla, an anthropologist with whom we worked with in Nepal, defines, in his book "Medical Anthropology", the KAB system; *knowledge, attitude and behaviour*. "It has generally been described that behaviour is the consequence of a decision and the decision is preceded by knowledge and attitude. In other words, it has been commonly understood or accepted that the individual first knows or gathers information about something and then by a process of further thinking and feeling develops an attitude which may be translated into action or behaviour of doing something which has been understood and liked." The doctor must have an up to date knowledge, an action based on good skills, and adequate attitudes.

*Why change or improve the attitudes* of a doctor in CME-CPD? To develop culturally competent communication with migrant patients, to develop patient centred communication, to be interested to investigate the medical history of patients, and to develop more self-reflectivity (to prevent burn-out). If we return to the literature on attitudes in medicine, there are also the following: curiosity, empathy, courage, determination, prudence for example. We meet with the so called virtues in classical philosophy.
What attitudes should we develop in cross-cultural care? Betancourt says: "certain attitudes are particularly important if one is to effectively engage in cross-cultural care: humility, empathy, curiosity, respect, sensitivity, awareness. Moreover, the assessment of students in cross cultural education should focus on attitudes".
*What is a culturally competent physician?* This is the definition of Teal. "A culturally competent physician has the capacity to recognise and reconcile socio-cultural differences between the physician and the patient in order to have a more patient-centred approach".
In the experience of GGRAM, the observed changes after the voyages are: a modified method of questioning the patient during consultation, greater attention to oneself and finally an increased writing ability. The ability to write, the construction of a narrative, is certainly something very special in our group because some of us who had never written have begun this new activity. We will also publish some of these texts later in the journal of the SFTG which will be available on the website.
The increased self-awareness is reflected in a change of attitude. We also reflected on communication skills. What change in the medical examination is provided by anthropological immersion, not only with migrant patients but also with our usual patients. Again we have the literature to construct an evaluation table. The culturally

**You can do many things with salt**

A man and a woman entered the doctor's office. They were 50 years old with foreign accents. They take their place in front of the doctor without hesitation: they clearly know the scene.

– Doctor M: You're both well today?
– He: She is wrong since Friday ...
– M: What's happening?
– She: It is the stomach, it swells and I am always hungry when I eat too much. I cry all the time at work ... I think of something else ...
– M: What is the problem?
– She: I don't know. I cry and I cannot stop ...
– M: Is it like your husband last month when his stomach burned and he was stressed at work?
– She: I don't know what happens …
– He: It's too much ...
– M: What do you mean?
– She: I don't know ...
– M: You told me the last time, that you worry about your son Giuseppe ...
– She: It is true, I became upset because he returned home late, at 9 pm. This is not normal at 12 years. I told him to talk to him (she refers to her husband, who smiles without reacting). But I don't think that's what makes me cry, because it was before ... (decrease tone) I have too much concern with the family …
– He: She thinks too much ...
– M: What happens with your family?
– She: When my grandfather died ten years ago, I received a small legacy from him ... fields, vineyards ... I did not have this legacy nowadays, because we are on trial for eight years with my uncle. He asked me by phone to sign a proxy for it to finish and I refused.
– He: They could talk to me when I went down to the village at Christmas. They said nothing and now they call.
– M: And what have you told your uncle?
– She: I said that I don't sign now, perhaps when I will go to the village this summer. They were not happy with my answer.
– M: Are you speaking about your uncle only?
– She: Yes, the brother of my mother, his wife, but also my mother.
– M: And what happened?
– He (embarrassed): They put salt on my car ...
– M: Salt?
– He: To worry us ...
– M: Please wait, I don't understand. Is it a tradition in your village?
– He: No, fortunately this is not a tradition but it's witchcraft. But I don't believe in that ...
– M: But who has such bad intentions against you?
– He (referring to his wife): Her uncle. But I think that it's not him but his wife who is evil.
– M: But from Italy, how have they been able to put salt on your car here in Switzerland?
– He: No, it's not here. My car is still at our house in the village.
– M: But who informed you of this story about salt?
– She: It's my brother who saw it and called me.
– M: And what do you think about it?
– She: It was bad ... I was very angry.
– He: If we go down, it will be the fight. I shall buy five pounds of salt to them.
– She: You must not say that ...
– M: You think it can play a role in your state?
– He: I saw at the supermarket a book where they explained all we can do with salt. But I don't believe it ...
– M (turns to her): And you?
– He: She is afraid anyway ...
– M: It does not matter. Whether we believe it or not, it is a strange fact that somebody can be so bad. It can be a cause of stomach ulcer. But what do they do in your village when something like this happens?
– She: They meet a woman who looks at the cards ...
– M: And from here in Switzerland?
– She: You can't do anything ...
– M: And, what about all of this?
– She: I think all the time ...
– M: But your husband said you are afraid?
– She: It is for my mother who is sick and alone: she does all they want.

competent CC movement, tables of the Association of American Medical Colleges, the questionnaire of Kleinman, the work of anthropologists, and the narrative based primary care of Launer. Based on this literature, our group has worked to retain some useful communication skills.

Kleinman for the interview technique focuses on *the patient's explanatory model*. For Gartoulla, there are two types of explanatory models.

- *A personalistic system* "is one in which illness is believed to be caused by the active, purposeful intervention of a sensate agent who may be a supernatural being (a deity or god), a non-human being (such as a ghost, ancestor, or evil spirit), or a human being (a witch or sorcerer). The sick person literally is a victim, the object of aggression or punishment directed specifically against him, for reasons that concern him alone".
- *A naturalistic system* "is one in which illness is explained in impersonal, systemic terms. Naturalistic systems conform above all to an equilibrium model; health prevails when the insensate elements in the body, the heat, the cold, the humors or dosha, the yin and yang, are in balance appropriate to the age and condition of the individual in his natural and societal environment. When this equilibrium is disturbed, illness results". As an example, western medicine and Indian systems of traditional medicine are naturalistic systems.

Its design has at least the merit of being simple and can help us in medicine.

How can the explanatory system in which the patient lies be highlighted? There were first the 8 questions of Kleinman:

– What do you call this problem?
– What do you believe is the cause of this problem?
– What course do you expect it to take?
– How serious is it?
– What do you think this problem does inside your body?
– How does it affect your body and your mind?
– What do you most fear about this condition?
– What do you most fear about the treatment?

We can also mention the techniques of narrative based medicine of J. Launer:

– *Exploring differences and correlations*: it is quite unusual for you to have this pain …
– *Hypothesising*: is there any other reason you might worry about that?
– *Circular questioning*: What effect does it have on you if it is in your family …
– *Strategising*: are there things we can do to help you …
– *Sharing power*: if you were in my shoes, would you try …
– *Reflection*: making space for reflection.
– *Finding a good new story*: coherent, aesthetically appealing, useful.

Our participants responded to a questionnaire asking what about their attitude had changed the most after immersion travel. At the top they mentioned awareness, humility, caution and curiosity. Other attitudes proposed were cited by only a few people: empathy, respect, sensitivity, courage and determination.

From the Kleinman's questionnaire, the two questions considered the most useful by our group were:

– What do you believe is the cause of this problem?
– What do you most fear about this condition?

From the Launer's method, it was the technique of hypothesising to find a good new story. The workshop in the Wonca-Congress in Basel discussed about *the scenario of a consultation.*

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