

POSITION PAPER

Strengthening PBL Through a Discursive Practices Approach to Case-Writing

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ABSTRACT **Context:** *In many ways the task of physicians is to listen to stories and place them within larger social contexts. Problem-based learning (PBL) can potentially reinforce such a view of the physician's work. The conventional PBL case, however, largely replicates the medical record, which in turn, is restricted in its purview to biomedical concerns. The conventional case thus encourages an approach to clinical reasoning that insufficiently recognizes (1) the cross-cultural nature of all clinical encounters, (2) the central role of narrative, and (3) the political economic influences that contribute to disease and suffering in our world.*

Methods: *We suggest ways to modify the traditional medical curriculum to include the learning of cross-cultural health through appropriately written problem-based learning (PBL) cases. We discuss two cases to illustrate how PBL cases can incorporate dialogue between patients and physicians, demonstrate the narrative character of the medical encounter and examine the political economic contributors to disease production.*

Conclusion: *Fluency in language games other than that of biomedicine is required if students are to become more aware of the wider factors that contribute to suffering, and to be able to respond with compassion and understanding to that suffering. Our approach is a discursive practices approach to culture that emphasizes the emergent, participant-constructed qualities of social phenomena while also acknowledging large-scale social forces.*

KEYWORDS *Problem-based learning, narrative, cross-cultural education, political economy, discursive practices.*

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Context

Problem-based learning (PBL) is an educational philosophy that has achieved widespread use in recent years. Some of the central aspects of PBL in medical education include the use of cases and fostering clinical reasoning. Conventional PBL cases follow a sequential disclosure format (Barrows, 1986; Lloyd-Jones *et al.*, 1998). A typical case has a chief complaint on the first page, and subsequent pages reveal the history of present illness, physical examination and so on. The conventional PBL case can be easily abstracted from a medical record. This, we suggest, reflects an approach to the clinical reasoning that insufficiently recognizes (1) the cross-cultural nature of all clinical encounters, (2) the central role of narrative, and (3) the political economic influences that contribute to suffering in our world.

From a *discursive practices* perspective, “*culture*” is regarded as systems of resources used by participants in the negotiation and discovery of every day interactions. Culture is the overarching context that shapes meaningful action in any given situation. Drawing upon linguistic anthropology, we suggest that physicians look at culture as a locally produced phenomenon that is discovered through ongoing interactions with patients, not as transcendental norms somehow internalized by all members of some particular group, ethnic or otherwise. A discursive practices approach produces more competent physicians by demanding that physicians examine the ways in which individual patients participate in constructing meaning, not just within the clinical encounter but throughout their lives.

All illness episodes are initially communicated as *narrative* (Kleinman, 1988; Cassell, 1994; Greenhalgh & Hurwitz, 1999; Yamada *et al.*, 2003), as patients must tell their stories to their practitioners. Hunter asserts, “Medicine is not a science. Instead, it is a rational, science-using, inter-level, interpretive activity undertaken for the care of a sick person.” (Hunter, 1991) In order for medical students to understand their patients and their concerns, they must learn to negotiate the narrative nature of illness.

As physicians listen to their patients’ stories, they must learn to place them within larger social contexts. Historically *political economy* preceded the disciplines of sociology, anthropology, and economics—and concerned itself with “the wealth of nations, the production and distribution of wealth within and between political entities and the classes composing them” (Wolf, 1982; 8). Political economy emphasizes the “structural relationship among economic systems, political power, and ideologies” (Morsey, 1990: 27). While political economic influences on the production of disease and suffering are generally considered to be outside the purview of medicine (Yamada & Palafox, 2001), the appropriately written PBL case can demonstrate their relevance.

Methods

A Discursive Practices Approach: Incorporating Narrative and Dialogue into PBL Cases

To meet these instructional needs, we began to write new PBL cases in which patients present narrative accounts of their illness experience. These cases incorporate dialogue between patients and physicians, and they acknowledge large-scale social forces. We utilize a discursive practice approach, emphasizing the emergent, participant-constructed qualities of social phenomena.

Researchers have noted that cases used in medical education can reflect racial and gender stereotypes (Philips, 1997; Turbes *et al.*, 2002). Cognizant of the pitfalls, we hope that the formal involvement of participants will allow for accurate and respectful representation.

Two Cases

Our first example is that of George “Tiny” Napu’uwai, a 56-year-old native Hawaiian man with diabetes. Students learn about type 2 diabetes from this case. This case was written by a native Hawaiian family physician, Peter Donnelly, who based the case on a composite of patients and acquaintances, and by the first author. Dialogue in the case, with the patient speaking in Hawaiian Pidgin, illustrates the relevance of the patient’s family, cultural and occupational background on how he experiences diabetes and the therapy for it.

The second case is that of Gloria Alvarez, based upon a real patient, a 40-year-old Filipina immigrant to Hawaii with chronic myelogenous leukaemia. This case was written by the authors, a family physician and a cultural anthropologist respectively. We interviewed the patient in her home to elicit her explanatory model of illness. With approval from the University of Hawaii Committee on Human Studies and with the patient’s written informed consent, the interview was audiotaped to provide quotes that preserve her idioms and which illustrate the effect the illness has on her emotional state, her family and her work.

Cross-Cultural Health: A Discursive Practices Approach

The physician in the “Tiny” Napu’uwai case attempts to implement the best practices that she has gleaned from the biomedical literature. Tiny, meanwhile, is overwhelmed by the restrictions on his daily life.

You know what, Doc? One month ago I came in for one physical for my job. Now you guys poke my finga every time I come. You tell me take medicine dat going to make me sick. . . . You tell me I going blind. You going cut off my leg. I going end up on dialysis. . . . Das why I no like coming to da doctah. . . If I going die from diabetes, I may as well do what I like.

We suggest that medical students learn to view the medical encounter as a negotiation among at least three “cultures” in the examination room: the patient’s, the physician’s, and the overarching “culture of medicine”, which has values distinct from the physicians who practice within it. Likewise, the culture of specialties, such as family medicine, may differ significantly from the wider “culture of medicine” (Rogers, 2002). In this example, the culture of medicine (which defines the best practices for diabetes) clashes with the culture of the patient (the practices that he uses to negotiate his lifeworld). Consequently, all medical encounters may best be seen as “cross-cultural”, even when both physician and patient identify themselves as members of the same ethnicity.

An example of the culture of medicine in the Gloria Alvarez case occurs on day 3 of her hospitalization when bone marrow biopsy results become available in the evening. The patient and her family are informed of the diagnosis by an international medical graduate intern doing inpatient service in an American hospital for the first time. The patient recalls receiving the news from the perspective of her family:

They said, “My mommy no more around”, “Leukaemia”. Everybody was crying, because they couldn’t accept. Especially me... we really couldn’t accept that sickness. It’s so hard, it’s so hard.

In other quotes, Gloria Alvarez tells us some of what is at the core of her being, including her economic responsibilities to her extended family.

My emotional problem was so bothering me a lot, you know, because I thinking I get too much responsibility in my life. I got my nice husband, my two kids. I got mortgage to pay, you know, and then I got my family in the Philippines and over here. It is sad for me. I couldn’t accept the very first time. I cried every day and asking the Lord to help me out with this problem.

So I go work while waiting for the transplant, the blood match. I went work because I couldn’t accept stay home, and I not used to stay home.

The Narrative Nature of Medicine

The PBL case can be utilized to emphasize the narrative nature of the task of the physician. In dealing with Tiny’s poor adherence to his treatment regimen, the physician decides that “talk story” is a necessary part of the medical encounter with her patient. She asks how his job playing music is going.

Aah, at least I get some extra money. Da tourists, dey no really appreciate Hawaiian music. Dey like hear Pearly Shells, Tiny Bubbles, Blue Hawaii – das not Hawaiian music. Back in da ‘70s, plenty local people used to come out for listen to music at da bars. But now, too

expensive. Gotta pay for parking, cover charge. Den da beer and *pupus* (snacks)! *Auwe* (an emotive expression)! No moa enough money!

Within the conventional history and physical format, such an utterance might be reduced, through selective listening and editing to “Occupation: musician.” It is only by selective non-listening and a severe editorial function that narratives become transformed into conventional histories, physicals, and progress notes (Donnelly, 1996). Our case contains patient utterances of this nature in order to emphasize the importance of careful listening, since the patient’s central values are revealed. In this way, students can recognize that, to learn more about a particular case, the patient is their primary resource.

The following from the Gloria Alvarez case highlights the contrast between what is relevant for a discharge summary, which fails to convey the patient’s suffering (Cassell, 1994), vs. what is relevant for the patient herself.

She was admitted for busulfan and Cytosan conditioning chemotherapy. She underwent allogeneic bone marrow infusion from her HLA match sister. A total of 4.46×10^6 CD34 cells per kg were infused without complications.

The patient had neutropenic fever, for which she received antibiotics. The patient had an early engraftment on day 12.

The patient’s graft vs. host regimen included cyclosporine, prednisone, and CellCept. No methotrexate was given. The patient had graft vs. host disease of the liver with elevated bilirubin of 3.0. Steroids reduced the bilirubin to normal levels.

“I am so weak at the time because of the chemo. So all my hair was fall down, and all my fingernails was come out. And my skin, too, it’s like I come dark and then it peel. And my throat was really sore, and I always vomit and diarrhoea, like that. I cannot eat for the whole month I stay in the hospital. So I only eat the TPN.”

Political Economy

Tiny was born and raised in Kalama Valley, where his parents were pig farmers. In a note to the tutor, we learn more about the recent history of Kalama valley.

Kalama Valley (near Sandy Beach) is owned by Bishop Estate. This area was previously leased for a nominal fee to Hawaiians, most of whom were pig farmers. In the late ‘60s, Bishop Estate was nearly bankrupt. In order to put the Estate on a firm financial footing, the Estate sought to renegotiate the expiring land leases. Leaseholders with the means, such as those in the Kahala area, took Bishop Estate to court. The land

reform act that mandated lease-to-fee conversion resulted from this legal struggle. Those who could not afford legal representation, such as the pig farmers in Kalama Valley, were forcibly evicted. The eviction of the inhabitants of Kalama Valley was a rallying point for the modern Hawaiian renaissance of the late '60s and early '70s.

As a native Hawaiian, Tiny's ties to the land is at the core of his being. But as this excerpt gives the sort of information about Tiny that one is unlikely to discover in a clinical encounter, it does not appear as part of the dialogue between patient and physician. Thus, this information is placed in the tutor notes. For it to become a focus of the student's learning experience, the tutor has to be willing to introduce the topic, and the students have to be willing to acknowledge it.

Gloria is an immigrant from a former US colony. Speaking English as a second language, Gloria is a worker in the service industry. In order to meet her economic responsibilities, Gloria works two jobs while her husband works three. Yet she does not see her work as a burden. She expresses the loyalty that she feels to her employer as follows:

My manager at work was helping me out. They call everybody from the hotel to get tests to see who can match with me, because they wouldn't give up, and they no like me go, because I am helping them. And I work for them 14 years at the hotel, and they said they have to look the way to help me out.

The case closes with Gloria's wish to return to work soon. A suggested learning issue for the case is the conditions of the working class in Hawaii.

Conclusion

Medical educators have begun to recognize the extent to which the conventional language of medicine restricts its purview to biomedical concerns (Engel, 1977). Throughout their education, physicians-in-training are socialized into adopting this conventional gaze (Foucault, 1973) which grants primacy to the biomedical model. Foucault identifies the "gaze" [*régard*] in medical practice as a nonverbal structure from which all medical language and behaviour proceeds. Entering medical students are already fluent in the biological "language game" (Wittgenstein, 1958; Rorty, 1989), skills that are reinforced during medical education (Konner, 1988; Good, 1994). Conversely, cultural and social language games are foreign languages for them. By its very structure, the traditional medical curriculum does not facilitate the learning of knowledge, attitudes, and skills needed by the 21st century physician,

specifically in cross-cultural health, the narrative nature of medicine and political economic aspects of health and disease.

We have used two cases, one largely fictional, another drawn from life, to illustrate the manner in which PBL cases can better represent the patient's experience and perspective. For students to become adept at caring for patients, they must learn to focus on more than gathering the relevant biomedical information. They must also listen to patients' stories and place them within larger social contexts. To accomplish this successfully requires fluency in language games other than that of biomedicine, and we assert that PBL is a medium with potential to accommodate a wider view of medicine that includes "existential concerns and humane values, as well as... social commitments" (Good, 1994: 181). Students who learn the language games of narrative, culture, and political economy can gain a better understanding of health and illness from the patients' perspectives as well as from a broad social perspective. They can become more effective at helping others to reshape their experiences into more meaningful stories (Brody, 1994), while they become more aware of the wider factors that contribute to suffering in our world. They may become physicians who heal their patients as well as cure disease.

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