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## Gallup, New Mexico

As I get off of the airplane in Albuquerque, N.M., the first thing I notice is the sky—a deep-blue dome that cuts into the desert at a right angle all the way around the horizon. On the drive west to Gallup, the shimmering highway never wavers from its straight path through waterless scrub, flanked on both sides by low, red cliff faces.

Gallup is close to the Arizona border, its billboards rising up suddenly out of the sparse growth. The town—a cluster of muted brown buildings—squats to the south of the highway and stretches its arc of neon lights north into the Navajo reservation. This is high desert—its elevation more than

perches on the highest point of Gallup and leans its crumbling stone façade into the persistent wind. A dusty smudge follows each car or pickup truck that drives in on the dirt reservation roads leading to this largest of Indian Health Service hospitals. Patients wait to be seen in cracked red fiberglass chairs. Long, parallel, colored lines of tape bunch and diverge on the hallway floors, directing patients to the various clinics. The hospital fans out in all directions over four floors of skinny hallways and 1960s décor. Faded blue doors open into rooms with thin orange curtains that try, in vain, to keep out the harsh glare of the desert.

The hospital is dated, and the town of Gallup is financially undernourished, but both are thriving

By Timothy Rooney

# Cross Purposes

a mile—and the rays of the sun, having less atmosphere to penetrate, are brilliant and unwavering on this warm spring afternoon.

I step out of the car and into an arid westerly wind (which never stopped blowing the entire time I was there). The wind blurs the sharp boundary between desert and sky, scraping meager, dusty soil from the red earth and forming a roiling, ocean-like wave that moves ever-eastward. This wave breaks in dusty grit against the west-facing walls at the high points of the town. The town of Gallup is where I will spend the next month, caring for pediatric hospital inpatients as a third-year medical student.

Navajo children come to the hospital with a parent or relative after having traveled most of a morning to this, the largest and nearest town. Both the town and the hospital look tired and dusty. Even the ubiquitous, familiar fast-food signs seem somehow to have been muted over time by the scratchy desert wind and unrelenting sun. The predominant noise in this town is the hum and vibration of truck tires on Interstate 40—bearing loads headed westward to Arizona and beyond. For the few trucks that pause here, historic Route 666 curves through the north end of town, connecting a row of pawnshops and truck-stop motels.

The Gallup Indian Health Service Hospital

compared to the reservation that lies to their north. The Indian Health Service cares for a Navajo population that is, by some estimates, almost 75 percent unemployed. Most homes on the reservation have dirt floors, and only rarely is there a phone, electricity, or running water. And, yet, when I interact with these people—some of whom have ridden for hours with a neighbor to bring in a screaming child—I am always left with a deep sense of their quiet dignity.

In Gallup, I am able to witness in actual patients what I have previously only read about in medical textbooks. I see gall bladder disease in young teenagers, and signs of insulin resistance in a slim and active 13-year-old. In non-Native American populations, these are both largely adult diseases. Behind the health problems in this town of pawn-

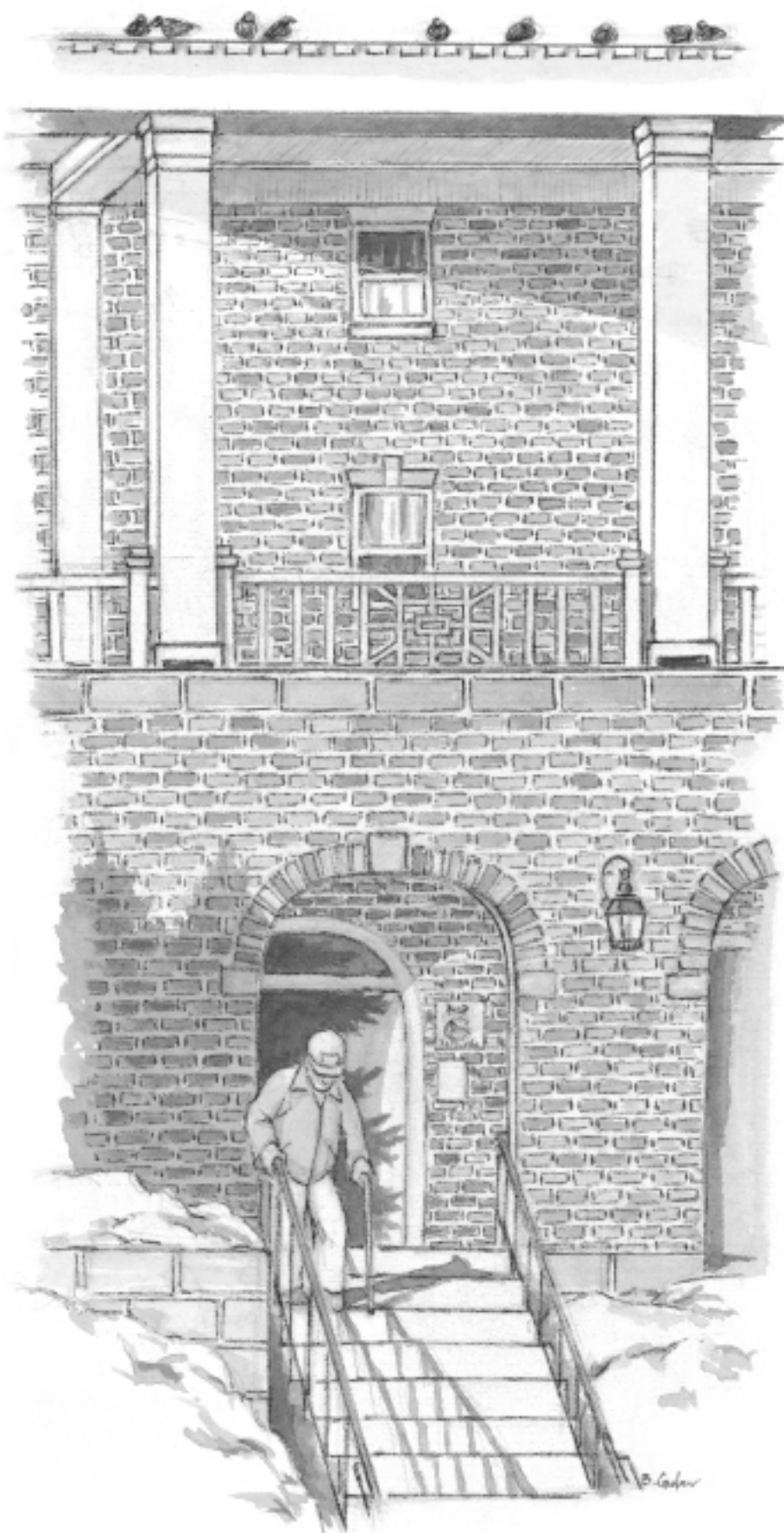
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*The author is currently a fourth-year student at Dartmouth Medical School. After earning his undergraduate degree, in earth sciences, from Dartmouth College in 1987, he entered the Navy and spent the next 10 years as a pilot. He flew F-14s as a fleet naval aviator from an aircraft carrier in the Mediterranean and Red Seas, enforcing the no-fly zones over Bosnia and Iraq, and F-18As as a fleet adversary pilot in Key West, Fla. He has also taught in the Naval ROTC unit at Texas A&M University. After his graduation from DMS in June, he plans to do a transitional internship at the Naval Hospital in San Diego, Calif.*

There is growing recognition today of the importance of cross-cultural issues in medicine. No matter how well-intentioned a caregiver is, it's not possible to truly serve the needs of patients without understanding *their* cultural assumptions and tenets.

This point is illustrated by a medical student's perspective on two clinical rotations in very different settings.



## White River Junction, Vermont

He comes in on one of two intersecting highways, driving in the far right-hand lane, his vintage windowless van tracing a thin line of gray smoke around one of the many interstate cloverleaves encircling this hillside setting. He has traveled from a small town in northern Vermont, leaving behind the quiet safety of his trailer in the woods to make the hours-long drive to the VA.

The "VA" is the Veterans Affairs Medical Center in White River Junction, Vt. It looks like a small, disorganized city from its front entrance at the bottom of the hill. The hospital rises up in a jumble of red-brick additions, between a row of gas stations and truck stops on the road down below and the Vermont woods that stretch northward behind the water tower out back.

I follow the green and gray van up the curved driveway. Now, I turn into the main parking area, while the van continues slowly into the crowded handicapped lot right in front of the main building, with its heavy white columns and too-small windows. Glittering red, white, and blue Disabled American Veterans' vans shuttle infirm patients to the different entrances. As I walk in from the parking lot, it is immediately apparent that this is a culture of bumper stickers. One bears a small, black profile and the words "You are not forgotten," while another shows only the green, gold, and red of the Vietnam Service Medal. Many of the rusting vans or pickups have spraycan-mottled amateur paint jobs and license plates emblazoned with a Purple Heart. I also pass a group of symmetrical, polished gray granite blocks that stand at attention and list the names of local veterans who served in Vietnam. As I near the building, I see a group of stooped and watchful fair-weather smokers chatting just outside an entrance.

The doors to the emergency department open automatically, noisily. Inside, the clinics are clustered, seemingly randomly, by numbered desks. The place is a labyrinth. There are outpatient adult clinics, a drop-in clinic (where some patients wait all day), specialized referral clinics, and inpatient wards; there's radiology, pharmacy, and the financially-threatened surgical service. In fact, this VA hospital has been at a fiscal crossroads for the past few years, expanding and shrinking, wondering if its hallways will get a new coat of paint to cover the lime-green of the 1970s, or if the veneer of dust over closed clinics will ever be lifted.

White men in their forties, fifties, sixties, and seventies—the majority of the VA's patient population—  
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## Learning to celebrate differences

By Joseph O'Donnell, M.D., and Lori Arviso Alvord, M.D.

In the accompanying two stories, fourth-year DMS student Tim Rooney has illustrated a couple of the cultural experiences that our students have the opportunity to explore. One is set far away in New Mexico, where our students get a chance to immerse themselves in a very different culture from the one they experience in New Hampshire and Vermont. And in the other, Rooney writes about a place that is nearby geographically, as a reminder that we can learn a lot about culture even from those who superficially seem just like us. All of us bring our own “culture” to the table, and we must learn how to be open to different ways of viewing the world and to celebrating these differences.

Cross-cultural training, an appreciation of cultural diversity, and experience in different cultural settings have become important topics in medical training these days, as medical educators are coming increasingly to appreciate the fact that we don't live in a one-size-fits-all world. The U.S. population will become much more diverse over the next few decades, and we need to prepare our students to thrive in this environment.

In our “New Directions” curriculum at DMS, our medical education committee has commissioned what we call Vertical Integration Groups (VIGs), to look at how we teach certain topics over the four years of medical school. Many of the topics are ones you might expect—like cardiovascular diseases, cancer, or immunology—but some of the most interesting reports have been about topics like ethics, death and dying, and geriatrics. These subjects cross many disciplines, and we often fail to appreciate the opportunities for integrating them into existing curricular structures. Last year, a group led by Dr. Alvord reported on how we should approach the teaching of diversity and how we should prepare our students to practice in an ever more diverse society. The group reviewed what we were doing already and especially what we could do better. It surveyed alumni/ae who were practicing in places very different from the Upper Valley, identified what other schools were doing, and made suggestions for new offerings.

We quickly realized that our most precious resource was our students themselves, who come to New Hampshire from all over the country

and, indeed, the world, bringing to DMS all sorts of different “cultural” experiences. Our Office of Minority Affairs has now developed a diversity-training workshop that is offered during orientation and also sponsors both formal and informal activities throughout the year that allow students to teach each other from their own experiences. We have also added formal training in cross-cultural patient interviewing to our “On Doctoring” course, and all cases used in problem-based learning sessions or in courses are being reviewed to see where we can insert appropriate materials that elucidate cultural issues.

In addition, starting with the class that matriculates this fall, all students will be expected to do one clinical experience at a site that exposes them to cultural issues. Currently, besides Gallup, N.M., which Tim Rooney has written about, we offer experiences in primary-care in Miami, Fla., with a predominantly Hispanic community and in Bethel, Alaska, with the indigenous population there; in pediatrics in Tuba City, Ariz.; and in ob-gyn and surgery in an inner-city setting in Hartford, Conn. A new site at another Indian Health Service hospital, in Zuni, N.M., just hosted its first DMS student [see the story on page 11 for details of this program]. And we are developing other opportunities—such as an experience with Boston Healthcare for the Homeless and partnerships with predominantly minority medical schools.

Finally, the diversity VIG suggested that there be a culminating cross-cultural experience just before students graduate, as part of our required fourth-year “Health, Society, and the Physician” course. The group also suggested increased efforts to recruit minority role models to Dartmouth, especially to the faculty.

We invite readers of Dartmouth Medicine to share their thoughts on this topic; they can be sent to us in care of the magazine [see page 1 for the address]. This is an exciting time for DMS, as we expand the opportunities we offer for learning about this important topic, in the hope of sending our students out well-prepared for the diverse world in which they'll be practicing.

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He has traveled from a small town in northern Vermont, leaving behind the quiet safety of his trailer in the woods to make the hours-long drive to the VA. The hospital rises up before him in a jumble of red-brick additions.