

The Case of the Returning Traveller

Case Written by Dr. Amy Walsh

Case

Dr. Amy Walsh

Objectives:

Dr. Teresa Chan

Expert Responses

Ashley Lucas, RN

Dr. Jennifer Thompson

Curated Community

Commentary

Dr. Sarah Lockett-Gatopoulos

MEdIC Project Lead

Dr. Teresa Chan

ALiEM Editor-in-Chief

Dr. Michelle Lin

Olivia hadn't seen her friend Miguel in a few weeks as he had been away on an international elective. He was really interested in global health and this was his second trip to Africa in the last year. She saw him leaving the locker room and hoped to catch him before they started their shift. She quickly walked down the hall of the emergency department and called out, "Hey Miguel, welcome back!"

He turned around with a big smile. Olivia was excited to hear about his trip and asked, "Do you have time to grab a beer after work and tell me about Ghana?"

"Sure, I'd love to! It was such a great experience. The people are incredible and I felt like we really made a difference. I'll even bring my computer so I can show you some photos!"

They made plans to meet up after their shift at a local pub. As they walked into the department, Miguel noticed that the waiting room was unusually empty. It was typically quite busy on a Friday evening. He figured that although it was slow and he may not get to see much, this would actually be a great shift to transition back to western emergency medicine.

Olivia was in the staff lounge getting ready to leave for the evening. As she packed her bag Miguel quietly walked into the lounge and sat down, looking quite upset, almost angry. This was odd, she thought. He seemed so happy earlier.

"What's wrong? What happened?" she asked, genuinely concerned.

"It's just so hard to come back and see how wasteful we can be with our resources. And how incredibly entitled some of our patients are.

There just seems to be a general lack of respect towards the system and towards physicians. You wouldn't believe what just happened, Olivia! The father of my last patient got incredibly upset with me because he had to wait 20 minutes to be seen by a doctor. His daughter had a very minor bump on the head with one episode of vomiting. Perfectly fine now with a normal neuro exam and negative CT head criteria. Yet he is demanding we obtain imaging and get some bloodwork done... and my attending just signed off for all that unnecessary testing! It makes me so angry!"

"It's just wild how quickly I forgot how different things are back home. People in Ghana wait for hours in the heat to see a physician and when they do, they're incredibly grateful that you took the time to see them. And at the end of the day there were usually still lines of people waiting to be seen that we simply didn't have the time or resources to evaluate. No one argued with our treatment plan. It's just so hard to gain perspective again. How do we not realize how lucky we are to be living in a country where we have clean water to drink and 24/7 access to world-class healthcare? It's sobering really."

Olivia was overwhelmed by how upset Miguel was. She had never had the experience of working abroad and didn't have much knowledge of other healthcare systems or cultural practices. She didn't know how she could help Miguel get through this.

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Questions for Discussion

1. How do you cope with culture shock after your international experiences?
2. What advice would you give Miguel as he transitions back to his normal residency work
3. What strategies do you use in working with demanding and entitled patients?

Competencies

ACGME	CanMEDS
Professional Values (PROF1)	Professional Communicator Collaborator

Intended Objectives of Case

1. Identify cultures shock in colleagues returning from overseas experiences.
2. Describe an approach for preventing culture shock.
3. List specific strategies for dealing with demanding (or 'difficult') patients.

The Return for a Medical Practitioner

by Ashley Lucas RN, MSc (Candidate)

Being exposed to different cultures elicits a highly individual response that encompasses psychological, physiological and emotional adaptation, the phenomenon commonly known as “culture shock”(1,3,5,6). Taft (1977) described the term culture shock as having the following elements(1):

- Tension due to the ongoing necessary psychological adjustment.
- A sense of loss of friends, status, occupation and property.
- Being not accepted by and/or accepting members of the new culture.
- Confusion in role, role expectations, values, feelings and self-identity.
- Surprise, anxiety, even disgust and anger after perceiving cultural differences.
- Feeling of helplessness due to not being able to deal with the new circumstance.

Returning home to an industrialized country, after being overseas in a severely resource-restricted setting, elicits many feelings that might be viewed as “reverse culture shock” or “re-entry shock”(5). Similar to Taft’s concept, return travellers can have strong feelings of anger, sadness, disbelief, depression, anxiety and guilt(5). These feelings can literally hit you like a ton of bricks. Returning home, your professional identity - and even your sense of personal identity - has been altered and shaken by the daily struggles of the people you have served; people who may suffer from devastating diseases you had only ever read about in textbooks. This well-documented ‘reverse culture shock’ is a common phenomenon among expatriates, soldiers, and aid workers returning home after spending time overseas; many have even described this adjustment as worse than the initial culture shock itself (2,7)

In Miguel’s case, talking to other healthcare workers that have been overseas, and practiced in resource poor settings, is a great way to sort through and attempt to understand the feelings he might be struggling with. Chances are these individuals also went through significant re-entry adjustment. Having supportive friends, with whom Miguel can share pictures and stories, will also help ease the transition. There

appears to be some consensus that post-mission interventions by aid organizations can be beneficial for re-entry adjustment, but no clear guidelines exist. (2,4,8).

Personally, I found self-reflection and expression through writing (keeping a journal of my experience before, during and after) to be incredibly helpful. This allowed me to reflect on my adventures and better understand the strong feelings and reactions I experienced upon returning home. In other overseas assignments, I have made the effort to do extensive pre-departure research about the language, religious practices, cultural norms and expectations, in order to be better prepared for what I might encounter. Finally, upon returning home, I often find it helpful to seek out a group or individual in Canada from the country/region in which I worked. Even a short discussion about the challenges they have faced adjusting to life in Canada is incredibly therapeutic. These are all strategies I believe would help ease Miguel’s transition back from Ghana.

Dealing with ‘Difficult’ patients

Miguel’s case also brings up an interesting point about dealing with “difficult” or “entitled” patients.

As healthcare professionals we often unconsciously attach positive or negative labels to patients based on our expectations and plans of care. These labels are based on many factors: the structure and flow of the department/ institution, our own personal experiences, our previous experiences with patients having similar symptoms and diagnosis, and cultural stereotypes(10,14). It can be difficult for practitioners to understand a situation with a patient and/or family when the other party acts vastly different from our expectations. At times it can even be our mood or particular life circumstances that make an encounter difficult or challenging, and not the patient or family member at all. Practitioners must understand that many factors, including personal ones (e.g. institutional constraints, differential knowledge, our own attitudes and experiences) can all play a substantial role in a negative interaction (10,14).

About the Expert

Ashley Lucas (@AshleyFayeLucas) was formerly a Registered Nurse in the Emergency Department at Hamilton Health Sciences, and a critical care flight nurse with Latitude Aeromedical Works Inc. She has worked overseas in the Middle East, and on health projects in Indonesia and Africa. She has a huge passion for global health issues and providing care and access to essential services in developing countries. I am currently in the process of completing my masters of science in global health at the University of California, San Francisco

Expert Response

More specifically, we can see that healthcare practice, research and expertise has changed dramatically over the last 25 years. Nursing and Physician roles continue to expand, change and evolve (9). It is this very changing landscape that can result in confusion and discrepancies' between patient/family expectations and reality. With such dynamic changes in healthcare practices, and varied practitioner roles, misunderstandings and conflict can result, and provider-patient interactions and relationships can be adversely affected.

When a challenging situation arises with a patient, we should all take a step-back and analyze the big picture. Ask questions and listen to the patient and their family. Let patients explain their concerns and find ways to empower them where possible, but set firm limits when they are behaving in a confrontational manner.

Communication is key among the entire healthcare team, which includes patients and their families. Remembering and practicing this collaborative approach can help us to begin understanding the complexity of patient needs, and in that way, develop safe and appropriate interdisciplinary patient-care solutions (10, 11, 12, 13, 14).

Conclusions

The global healthcare landscape is dynamic, constantly changing and evolving. Cultural re-entry for healthcare practitioners can be challenging, but manageable with some pre-departure preparation, and strong support upon returning home. Similarly, dealing with difficult patient situations with an open-minded, collaborative team approach ensures the best possible outcome for all involved parties.

References

1. Taft, R. (1977): Coping with Unfamiliar Cultures. In Warren, N. (Ed.). *Studies in Cross-Cultural Psychology*, 1. New York: Random. pp. 125-153.
2. Townsend CJ1, Loughlin JM (1998): Critical incident stress debriefing in international aid workers. *J Travel Med.* Dec;5(4):226-7.
3. Alena Řiháková, Pavel filo. (2010). Culture Shock: The Organization of Civil Societas Meaningful Actor. *Anthropologia Integra*: vol. 1 no. 1, 201
4. McCormack, L., Joseph, S., & Haggar, M. (2009): Sustaining a Positive Altruistic Identity in Humanitarian Aid Work: A Qualitative Case Study. *Traumatology*, 109-118.
5. Gwen Vogel, PhD, Justin Stiebel, JD, Rachele Vogel, MA. Reentry Trauma: the shock of returning home. American Psychological Association: *Psychology International*. December 2011 | Vol. 22, No. 4. Online. <http://www.apa.org/international/pi/2011/12/index.aspx>
6. Winkelman, M. (1994): Cultural Shock and Adaptation. *Journal of Counseling and Development*, 73 (2), 121-126.
7. Culture Matters. The Peace Corps Cross-Cultural Workbook. Online. http://files.peacecorps.gov/multimedia/pdf/library/T0087_culturematters.pdf
8. S. Wessely, M. Deahl.(2003) Psychological debriefing is a waste of time. *The British Journal of Psychiatry*. 183: 12-14. July 2003
9. Barbara Sheer, Frances Kam Yuet Wong. (2008) The Development of Advanced Nursing Practice Globally. *Journal of Nursing Scholarship*. 40 (3), 204-211, 2008
10. Shattell, Mona PhD, RN (2004). Nurse-patient interaction: a review of the literature *Journal of Clinical Nursing*. 13(6) 714-722, 2004.
11. Michael P. Kelly BA MPhil and David May BA Dip Crim PhD. (1982). Good and bad patients: a review of the literature and a theoretical critique. *Journal of Advanced Nursing* . 7(2) 147-156, 1982
12. Russell S1, Daly J, Hughes E, Hoog Co Co. Nurses and 'difficult' patients: negotiating non-compliance. (2003) *J Adv Nurs*. 43(3):281-7, Aug 2003.
13. Juliana, Carol A; Orehowsky, Susan; et al (1997). Interventions Used by Staff Nurses To Manage "Difficult" Patients. *Holistic Nursing Practice*. 11 (4); July 1997
14. MacDonald, Marilyn. (2003). Seeing the Cage: Stigma and Its Potential to Inform the Concept of the Difficult Patient. *Clinical Nurse Specialist*. 17(6); 305-310, July 2003.

Expert Response

The Transition Back

by Jennifer Thompson RN MD

“There is nothing like returning to a place that remains unchanged to find the ways in which you yourself have altered.” - Nelson Mandela

Culture Shock is described as the disorientation, stress or anxiety an individual feels in a new cultural environment.¹ Reverse or re-entry shock is the experience of an individual as they try to re-adjust to life and work at home after working or living in a culture that is vastly different than their own.

On returning to work in the Emergency Department Miguel is frustrated and irritable after an encounter with a patient he perceives as entitled and unreasonable. He becomes overwhelmed with the significant disparity in health care as he compares the expectations and health of his patient to those he treated during his elective in Ghana. Prichard (2012) describes similar struggles with culture shock as she returns from working in Pakistan:

“The first patient I saw once back at work in Canada was an older gentleman, a poorly controlled diabetic who seemed to be vying for the world record in the number of jelly beans consumed by one patient during a hospital stay. Predictably, he was in hospital for diabetes-related complications and spent his days lying in bed, complaining about the “system” and the “care” he was receiving, pausing only to reach for another jelly bean. His sense of entitlement and lack of personal accountability were overbearing.”²

Likewise, when I returned to work in Canada after an international elective in rural Tanzania, I found the transition difficult as I was still struggling with my experiences. I witnessed considerable suffering from preventable or treatable illnesses and a severe lack of access to basic health care. While working in a local clinic, I saw countless numbers of patients with chronic wounds and advanced infections without access to antibiotics or surgical procedures, untreated fractures and dislocations resulting in permanent deformities, and undiagnosed cancers that had progressed

beyond repair. I treated patients with seemingly uncomplicated illnesses who were suffering needlessly due to the lack of clean water, antipyretics and other supportive treatments. Hospitalization in Tanzania was also very different from the concept of hospitalization in the western world. Admission required patients bring their own food, family members had to provide much of the bedside care and the blood bank operated on a take one give one basis. Similar to Miguel’s experience, when I returned to Canada I found myself becoming frustrated with patient and family expectations and criticisms of our health care system as well as the general lack of regard for healthcare resources.

Transitioning Back to Western Medicine

Reverse Culture shock is typically described in four stages (1) disengagement from the host country as you prepare to return home (2) initial euphoria and excitement to go home (3) irritability and hostility with your home country, longing to go back and finally (4) Adaption and gradual readjustment.

In order to help Miguel readjust and adapt to life back home I would first validate and acknowledge his frustrations and reassure him that his response is a normal part of cultural re-entry after his experiences in Ghana. I would suggest he keep in touch with the people he has travelled with and/or seek support networks of like-minded people. Most universities have global health interest groups and journal clubs; perhaps he can start one if none exist locally. In addition, sharing his experiences in the form of a presentation for colleagues, an article or blog can help educate and inspire others who are thinking about international work. Working with an advocacy group, non-governmental organization or exploring further opportunities for global health education can help keep him inspired and continue to build on his international experience. I would also encourage him to try and incorporate what he has learned as well as the positive aspects of his international experience into his personal life and work.

About the Expert

Jennifer Thompson is a senior resident at McMaster University. She is also a former nurse, and is an experienced international health practitioner. Beyond international medicine, she also is currently developing an area of academic and clinical experience in Sports Medicine.

Dealing with Difficult Patients

Difficult patients are defined in the literature as “those who raise negative feelings within the clinician.”³ For the purposes of this discussion I’m not referring to the patient who is dangerous, a risk to themselves or others, psychotic or intoxicated, but rather the difficult patient or family member that presents a challenge because of their hostility, anger, anxiety or seemingly unreasonable behavior.

It is important to remember that by seeking help in the Emergency Department our patients and or their families are experiencing an emergency, and whether real or perceived, they are in crisis. When faced with an emergency even rational well-adjusted people can demonstrate extremes of behavior.³ Fiester et al. (2012) suggests reframing the concept of the “difficult patient” instead to someone who is reacting to the perception of ill treatment, suggesting this creates an ethical duty to “address, validate, repair, or assist in making amends”. This concept is summarized in Wasan’s Five A’s for dealing with hostile patients.

Five A’s for dealing with hostile patients⁴

- Acknowledge the problem.
- Allow the patient to vent uninterrupted in a private place.
- Agree on what the problem is.
- Affirm what can be done.
- Assure follow-through

This case highlights the influence of the physician’s personal, social, and professional expectations on the interaction. As physicians, we often respond to patient anger and dissatisfaction in a calm and non-defensive manner, thus avoiding confrontation.³ When dealing with difficult patients we must remember to take a moment and become self aware. For example, reminding ourselves, “slow down your breathing, speak slowly and quietly, lower your tone, and think about your body language”.⁵ It’s also important to recognize that we’re all human and we will certainly encounter situations where we maybe unable to suppress our negative feelings or interact with

our patient in a neutral or productive way and may have to leave the interaction. Consider enlisting a nurse, social worker or in the case of a resident or medical student, a supervising staff physician to provide mediation or take over where you leave off.

After returning from Tanzania my heightened frustrations with patient expectations and entitlements eventually faded as I readjusted to work and life back in Canada. By reflecting on my experiences in a resource-poor health care setting I was able to appreciate what I had previously taken for granted - how lucky I am to work in a system that, although not perfect, allows us to provide health care 24 hours per day, 7 days per week to every person that requires our services regardless of their socioeconomic background. Despite the initial shock and seemingly rocky transition back to life and work in Canada, my international elective introduced me to another culture and sparked my interest in tropical medicine and global health. If trainees have the opportunity to pursue similar electives abroad, I highly recommend that they do. It will undoubtedly change their perspective on health care, life and medicine.

References

1. Christofi, V., & Thompson, C. L. (2007). You cannot go home again: A phenomenological investigation of returning to the sojourn country after studying abroad. *Journal of Counseling & Development*, 85(1), 53-63.
2. Pritchard, J (2012) A Change in Perspective. *Canadian Journal of Emergency Medicine* 14(3):198-199.
3. Fiester, A. (2012). The “difficult” patient reconceived: An expanded moral mandate for clinical ethics. *The American Journal of Bioethics*, 12(5), 2-7.
4. Wasan, A. D., Wootton, J., & Jamison, R. N. (2005). Dealing with difficult patients in your pain practice. *Regional anesthesia and pain medicine*, 30(2), 184-192.
5. Grewal and Helman (2014) Effective Patient Communication: Managing difficult patients. *Emergency Medicine Cases* Episode 51 available at: <http://emergencymedicinescases.com/episode-51-effective-patient-communication-managing-difficult-patients/> *Emergency Medicine Cases*

Curated Community Commentary

By Sarah Lockett-Gatopoulos MSc, MD, FRCPC (candidate)

This case generated thoughtful commentary on both culture shock and “reverse culture shock” in international medical electives. Practitioners from a variety of backgrounds and levels of experience commented, and the following themes arose:

Culture shock and “reverse culture shock” are real and happen during international electives and in our emergency departments.

Resident Shawn Mondoux points out that ‘culture shock (or reverse) occurs when transitioning from one system to another, whether it is a low resource setting or simply similarly resourced and differently managed’. His personal experience with the frustrations that occur were part of transitioning between France and Canada, but he believes that ‘more disparate environments must contribute to greater emotional reactions’. Chris Fabian, who has participated in international electives in Peru, Thailand/Burma, South Africa, and Nepal, believes that culture shock is inherent in these experiences. He asserts that ‘nothing will really prepare you for this’ because each experience is unique. He believes that ‘investigating what the health care system is that you’ll be working in, and what it is not’, is an essential part of minimising the shock that accompanies these experiences.

Staff physician Stella Yiu extends the idea of culture shock to interactions within a single shift in a single emergency department. She likens the experience of ‘getting out of the room after a particular[ly] challenging and emotionally difficult code, only to be greeted by the next patient with (comparatively) ‘lesser’ complaints’ to the shock of moving between medical systems.

Preparation and debriefing are key.

In addition to understanding the goals of an international elective and the relevant healthcare system, commenters pointed to the importance of appropriate cultural preparation and debriefing. Melody Ong reports that she underwent mandatory pre-departure training prior to international electives, which included a discussion of roles and expectations, cultural sensitivity, safety, and boundaries. Following the elective, she was required to write a reflection and attend debriefing. She felt fortunate to undertake her elective with friends, with whom she could ‘share [her] experiences and emotions’. Amanda Collier agrees, stating that ‘it’s important to debrief, just as we would with difficult cases, when culture shock happens’.

Contributors

Thanks to the participants (in alphabetical order) for all of their input:

Blog

Michael Chaikof,
Amanda Collier,
Chris Fabian,
Tamara McColl,
Shawn Mondoux,
Melody Ong,
Loice Swisher,
Amy Walsh,
Stella Yiu

Twitter

Lawrence Loh
Amy Walsh

It is important to understand the context of emergency department complaints.

Several commenters made note of the special significance of context in emergency department complaints. While patients in low resource settings expect to wait and may be grateful to receive even limited care, those in higher resource settings are not necessarily motivated by ‘entitlement’. Medical student Michael Chaikof points out that the father demanding care for his daughter in the vignette is not just an ‘ignorant and ungrateful jerk’; rather, ‘he is a scared father who is trying to do everything he can [to] protect his daughter, but is misguided’. Staff physician Loice Swisher ‘start[s] with the premise that almost all patients are coming to the ED because of someone’s pain or anxiety’. Asking them about this anxiety may facilitate a respectful interaction free of preconceived notions about entitlement. Stella Yiu agrees, stating that ‘it is tempting to weigh the ‘appropriateness’ of why [the patients] are there, but it is not useful for the encounter’. She believes that ‘the patients clearly are worried’ and it is our job to ‘comfort and reassure always’.

Shawn Mondoux took a slightly different perspective in suggesting that ‘we must see the reactions of our patients as those generated by the system in which they live and we practice’. He acknowledges that the respect and reverse for physicians in low-resource settings are the product of ‘a profound lack of medical resources’ and that patients in higher resource settings ‘expect more because they can have more’. He believes that this signifies that we are doing a good job and that ‘managing the increased resources is as much a part of being a good physician as is good clinical practice’.

Curated Community Commentary (continued)

Resident Melody Ong helps to manage resources by 'set[ting] expectations with regard to investigations and management early on in the patient encounter'.

Understanding the context of presenting complaints in both resource-poor and resource-rich settings can help ameliorate the sense of reverse culture shock on return from medical electives.

Channelling anger into positive change in our communities and emergency departments can help in transitioning from a low resource setting to a higher resource setting.

Medical student Michael Chaikof believes that learners undertaking international electives should 'come up with a concrete way in which their training abroad enhances their learning and skill set' back home. He points out that Miguel, the resident in our case, 'is a Canadian resident, and therefore the central focus of his elective abroad is to supplement his training' in Canada. He suggests that Miguel might be 'gently encouraged to refocus his anger and frustration to generate positive change in his home department'. Chris Fabian agrees that most short-term projects contribute much more to the education of the learner than they do to the international community. Leaving 'changed' and with a 'greater appreciate for your life and health here in North America' are the true outcomes of most electives, though longer-term projects may provide stronger contributions to the community in which they are undertaken. Michael suggests that learners experiencing the reverse culture shock of returning to a well-resourced environment after visiting one that is resource-poor might use the lessons learned on elective to

'teach his co-residents and faculty about conservation of resources and effective triage'.

Staff physician Amy Walsh 'like[s] to look at the attributes of [her] host culture that [she] really admired and trie[s] to incorporate them into [her] life as much as possible' on returning home. She finds herself more mindful about the distribution of resources and unnecessary investigations when applying this principle. Amanda Collier agrees that her experiences abroad have made her a better physician, and believes that 'you can take what you learned to teach your department' and learners.

About

The Medical Education In Cases (MEdIC) series puts difficult medical education cases under a microscope. We pose a challenging hypothetical dilemma, moderate a discussion on potential approaches, and recruit medical education experts to provide their insights. The community comments are also similarly curated into a document for reference.

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