The Case of the Culture Clash

Case Written by Dr. Anne Smith

Case
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It was a typical post intake ward round in the emergency department in Townsville, England. The Irish registrar, Mary, was starting her usual series of questions. 'What is the pathophysiology of acute cardiac failure in this patient?'

Jane glanced at her colleagues – Irina and Shamila – after seeing the same thing for three months she knew how this was going to go. But she was hoping that, somehow, today would be different.

Irina, the intern started.... 'I think it's.....' and she trailed off into nothing. What the others could not tell was that she knew the pathophysiology concepts, but could not command her mouth to use English words to describe them clearly enough. She had studied basic science in her home language, Swedish, and often got confused with medical terminology. She opted, instead then, just to keep quiet.

Shamila, a recent addition to the team, stood quietly at the back and stared intently at her feet. Coming to England had been a huge change for her – in her home country she was never expected to question and argue in public and it was considered rude for her to speak back so directly, especially to a senior in a position of authority.

Mary, an avid teacher, surveyed her erstwhile band of trainees and sighed. For three months, this group of interns had frequently shuffled around answers, avoiding her gaze. All except for her go-to-girl Jane. She wished she could engage the others, but in the end, she just had to keep things moving along. Almost reluctantly, she glanced towards Jane.

"Jane, could you tell us?"

Jane was well accustomed to talking through things on ward rounds as similar teaching methods were used in her home country. She did her best and Mary went on to give her a great tutorial on managing acute heart failure, and complimented her on her knowledge and treatment of the patient. The other two doctors stood quietly at the back and seethed quietly.
'If only I could you tell what I know- this was an easy question and anyway Jane didn't get it all right!' thought Irina.

Meanwhile, Shamila reflected: 'I don't know why Mary seems so frustrated at me – I am doing my best and trying to be respectful, and yet somehow that doesn't seem to matter. She likes Jane, and doesn't' seem to mind her flagrant boastfulness'

As they moved onto the next patient, Mary wondered to herself: 'Was this method of teaching truly effective?' From what she could gather, she seemed to only be reaching one third of her team. They all got along well in social settings, and in their off time, she quite liked Shamila's stories and Irina's reflections. The professional interactions, however, were constantly strained.

Questions for Discussion

1. As a teacher, how do you ensure that you are an effective teacher to people of different ethnic and cultural backgrounds? What other methods of teaching could Mary have tried with Irina and Shamila?
2. As a learner, how do you ensure that your teacher understands what you are comfortable with and how you have been previously taught?
3. In your hospital, residency program, or medical school have you experienced difficulties dealing with diverse groups and how did you overcome them? How have communication difficulties impacted on patient handovers and patients care?

Competencies

ACGME	CanMEDS
Team Management Professional Values	Communicator Professional Collaborator

Intended Objectives of Case

1. Describe the factors impacting communication in a multi-cultural team.

2. Explain the importance of addressing communication challenges within a clinical team.

3. Outline a professionally appropriate strategy to address problems that arise secondary to cultural differences.

Expert Response

Dealing with Culture

by A.H. Oosthuizen MBChB DipPEC Mmed FCEM(SA)

Whenever I meet new people, I find I get along with them faster and easier when we have at something in common. This effect is obvious for some fundamental traits, like language, but if often true for shared interests like sports or art as well. The more we share on a fundamental level (language, world view, social practices, values) the easier it becomes to understand and interpret each other when we interact – it can be tough to have a conversation with someone if I am not sure whether it is OK for me to make eye contact, or even be in the same room. Our beliefs and traits make up our personalities as individuals. When groups of people share such commonalities, it is called their culture [1, 2].

When all the members of a group share the same culture, they share a common set of fundamental beliefs and practices. This facilitates (but does not guarantee) easy communication and interaction in the group.
In diverse groups where the members do not know and understand each other's cultures, communication and interaction can be more challenging [3, 4]. Problems range from the seemingly trivial (in many African cultures, formal greetings and salutation is very important. and neglecting them can result in unexpected tension) to the serious (in some North African and Middle Eastern cultures, any physical contact, and sometimes even eye contact, with an unmarried person of the opposite sex may give great offense).

However, culturally diverse groups have the potential to add value to both the group and its members [5, 6]. These benefits include: reduced uncertainty, increased adaptability, access to a wider perspective, increased active participation and ownership and many more.(reference? Or is this 5,6?) This requires cultural awareness that can be developed by learning about each other's cultures (cultural awareness) and the personal understanding that occurs when we learn about each other as individuals [ref]. A strong knowledge of a friend/colleague's culture can be the entry fee to the main event: getting to know him/her as a person. Neither cultural awareness nor effective personal communication happens automatically: we have to make a conscious choice to do make them happen.

In the case Mary is in a position to be a teacher and mentor to Jane, Irina and Shamila. She is clearly aware that there is a problem and she should take the lead by learning about Irina and Shamila's cultures (anyone with internet access can do this!). Once she has done so, she can have an honest conversation with each of them as individuals. This conversation would hopefully both identify issues and be the first step to a better relationship.

The responsibility can't be Mary's alone, though. Irina and Shamila both find themselves in a situation where, on the surface, they don't have a lot in common with the culture that they are immersed in. They should also learn about their host culture and to talk to Mary (or someone else) about their concerns.

Functional culturally diverse groups are some of the most stimulating environments to work and learn in, but there are no shortcuts to success: we have to actively learn about the cultures of those we interact with, and then get to know them as people.

References

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5. Whitla et al. Educational benefits of diversity in medical school: a survey of students. Acad Med. 2003 May;78(5): 460-6
6. Josh Greenberg. Diversity in the workplace: Benefits, challenges and solutions. http://www.multiculturaladvantage.com/recruit/diversity/Diversity-in-the-Workplace-Benefits-Challenges-Solutions.asp

About the Expert

Dr. Oosthuizen an emergency physician and educator in Cape Town, South Africa. He is particularly interested in the use of collaboration and innovation to increase both our education and service delivery footprints in resource limited settings. I believe education should be designed to improve patient outcomes, not student metrics. Our involvement includes programs in South Africa, Tanzania, Zambia, Ethiopia and more, where cultural diversity is the norm. He is the man behind the EMCapeTown YouTube channel.

Expert Response

One of these is not like the other

by Heike Geduld MBChB, DipPEC, Mmed, FCEM(SA)

There is an increased awareness of diversity in clinical practice. However, it is not just our patients who are different, it is also our colleagues. Increasing numbers of international medical graduates are moving to new health systems for opportunity, lifestyle or even just a change of scenery. (1)

We are constantly reminded to be understanding and empathetic to patients and their families with languages, cultures and belief systems different than our own, it is harder to remember that these cultural differences may apply to our colleagues as well. This may be due to our reliance on the idea that medical culture supersedes all - that no matter where you trained, once you are a doctor you share the common professional beliefs and attitudes of the medical professional. While this may be true to a degree, it does not smooth over all of the differences.

Unfortunately, developing cultural competence is not easy. None of us come from a neutral base - we all have cultural attitudes and biases that shade our interactions.(2) Mary admits that she finds it easier to ask Jane the questions because the response she receives is predictable and familiar. As humans we subconsciously respond to and seek out individuals who are similar to us because we understand the nuances of communication that make it easier to engage.

Communicating in a pressured environment is often difficult for speakers in their second language, and the colloquial terms and abbreviations of medicalese make it worse. In this case, Irina's difficulty with communicating may be interpreted as a refusal to communicate and creates tension. In the same way, the perception that Jane is dominating the group creates distance between her and her colleagues. It is safer and easier for Irina and Shamila to simply stay quiet. This tendency may result in failure to ask for clarification or speak up to disagree with another clinician. (1)

Many of us have an unspoken belief that those moving to our country should try to be more like us and interact in the way we do, and that a failure to do so is their fault, not ours. However, as humane, empathetic clinicians and educators it is our responsibility to make sure that all members of our team are valued and included.

So what can we do? For faculties and hospitals, faculty development interventions and mentorship programs can help.

In day to day interaction:

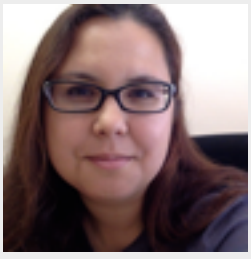
- Create clear expectations about knowledge, behaviours, attitudes and skills.
- Allow learners time to integration comments and circle back to questions later
- Create structure to interactions by allowing preparation time or standard opportunities to demonstrate knowledge
- Debrief teaching sessions to encourage reflection on interactions
- Remember that humor can often be culturally specific and can be confusing for non-native speakers

Diversity in the medical profession is well worth the effort that it takes to achieve harmonious relations with our colleagues from various cultures.

References:

1. Walsh A. International Medical Graduates-Current Issues. The Future of Medical Education in Canada. 2011. Retrieved from www.afmc.ca/pdf/fmec/05_Walsh_IMG%20Current%20Issues.pdf.

2. Fox R. Cultural Competence and the Culture of Medicine. NEJM 2005:353;1315-1319



About the Expert

Heike is the Clinical Head of Education and Training for Emergency Medicine in Cape Town. She directs the Emergency Medicine training at the University of Cape Town and Stellenbosch University. She is secretary of the South African College of Emergency Medicine and a Senator of the Colleges of Medicine of South Africa. She was a SAFRI (Sub Saharan Africa FAIMER Regional Institute) Fellow in 2011. She is secretary of the AFEM (African Federation for Emergency Medicine) where her particular interests are in curriculum development and EM training across Africa.

Curated Community Commentary

By Anne Smith MBChB; FCEM(SA); Mmed Emergency Medicine

A qualitative methodology was used to curate the community discussion. Tweets and blog comments were analyzed, and six overarching themes were extracted from the online discussions. Prior to publication, we sent this analysis to one of our community members to perform a "member check" to ensure credibility (TC, BT).

Most participants agreed that effective cross cultural communication was important, but several commented that it was not something that they had thought about often. Many who commented mentioned that they worked in units where there was diversity in both cultural and language backgrounds, highlighting the importance of this discussion.

Some pointers from the community on improving multi cultural communications and handovers:

1. People have different cultural backgrounds.
Do not make assumptions about people based on the way they look or the language they speak – this is a recipe for misunderstanding and miscommunications. Looks can be very misleading in multicultural societies! A better strategy is to invest some time and energy in getting to know team mates a bit better by in a more informal setting, or simply during day to day 'small talk'. Taking an interest in where people come from personally and professionally goes a long way to improve the way you can work with and teach them. This can lead to an unseen benefit of closer team relationships in the working environment.

2. Comparisons between medicine and other industries.
There are obvious parallels between the 'business' of medicine and other industries- e.g. aviation. These industries learned long ago that outcomes and safety can be improved by using the power of culturally diverse teams and making cross cultural communication a priority. Medicine has a lot to learn from the way big business approaches international relations.

3. Individualizing Education goes beyond Culture.
Educators need to listen and to respond to each learner.. Learners may have specific needs that are unrelated to their cultural background and educators should try and work out the most effective methods to reach the individual. Some specific tactics an educator could try with reticent or shy learners are:

a) one-on-one sessions;

b) giving advance notice about a specific topic of discussion to enable those who are learning in second or third language time to prepare adequately.

Contributors

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

Teresa Chan,
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Lucy Hindle,
Louis Jenkins,
Sa'ad Lahri,
Shannan McNamara,
Anne Smith,
Brent Thoma
Kamil Vallabh

Curated Community Commentary (continued)

4. Educators should use self-reflection and feedback to improve their teaching style.
Frequent reflection on recent teaching sessions and requesting honest and constructive feedback from learners is so important to ensure that you are being effective as an educator. Asking students or peers how they perceived your teaching style will give you tips on where you can improve things.

5. Do not let language get in the way.
Most hospitals now are a melting pot of many different languages – with one or two most likely being the dominant medical language. As an educator and team leader you need to ensure that language does not become a barrier to communication. Avoid this by using clear instructions and getting to know what languages your learners are comfortable with.

6. Set the example.
As educators in Emergency Medicine we need to set a good example to junior staff about the right way to approach a multi cultural team. Being aware of our own prejudices and biases is an essential step in overcoming cross cultural miscommunication. The idea of of 'cultural code switching' was mentioned – as a good educator you should be able to modify your behaviour in specific situations to accommodate various cultural norms.

Other suggested papers or links

1. Yoyo Suhoyo, Elisabeth A. van Hell, Titi S. Prihatiningsih, Jan B.M. Kuks & Janke Cohen-Schotanus Exploring cultural differences in feedback processes and perceived instructiveness during clerkships: Replicating a Dutch study in Indonesia March 2014, Vol. 36, No. 3 , Pages 223-229 (doi:10.3109/0142159X.2013.853117)

2. A 12-year comparison of students' perspectives on diversity at a Jesuit Medical School http://www.med-ed-online.net/index.php/meo/article/view/23401

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.

Did you use this MEdIC resource?

We would love to hear how you did. Please email teresamchan@gmail.com or tweet us @Brent_Thoma and @TChanMD to let us know.

Purpose

The purpose of the MEdIC series is to create resources that allow you to engage in "guerrilla" faculty development – enticing and engaging individuals who might not have time to attend faculty development workshops to think about challenging cases in medical education.

Usage