Article

Cross-cultural medical education: Using narratives to reflect on experience

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Introduction. Educating students in a multi-cultural society is a challenge as teachers, students and the community they serve all tend to represent various social groups. Skills alone are not adequate for competency in understanding cultural aspects of consultations. A combination of knowledge, skills and attitude is the most widely accepted current approach to teaching culturally competent communication to medical students. Collaborative reflection on narratives of experienced clinicians' cultural encounters served to construct an understanding of how to develop these attributes.
Process. An interest group of medical teachers met to address the specific needs of teaching a relevant cross-cultural curriculum. Participants offered narratives from their professional life and reflected on these encounters to understand how to improve the current curriculum to better address the needs of the students and patients they serve.
Results. Through narratives, participants were able to reflect on how their experience had allowed them to develop cultural awareness. All stories represented how attitudes of respect, curiosity and unconditional positive regard were held above all else. The process of collaborative reflection with peers unpacked the complexity and potential in the stories and different learning opportunities were discovered. Learning was personalised because the stories were based on real experiences.
Conclusion. The use of collaborative reflection on narratives of clinical encounters could facilitate insights about cultural aspects of medical practice. Elements such as curiosity, respect and unconditional positive regard are illustrated in a unique way that allows students to appreciate the real-life aspects of cross-cultural clinical encounters.

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The modern world has become a global village with a multi-cultural society. Institutions have a mandate to educate students, as well as a social responsibility to provide a service to the community. Educating students for this environment has become a challenge, as traditional methods of communicating and relating have changed. Balancing the demands of efficient and effective healthcare delivery, while serving the needs of a multi-cultural society, has become a formidable undertaking.

The University of KwaZulu-Natal (UKZN) is part of the global, multi-cultural village and the multi-cultural issues encountered in this context are in many ways similar to those encountered by international institutions. The students and staff at the Nelson R Mandela (NRM) School of Medicine encompass a wide range of ethnic, language, social, cultural and class backgrounds. Patients accessing state healthcare represent a considerable diversity in ethnicity, class, language, social life and culture. Predictably, challenges arise when health practitioners, with varied socio-cultural backgrounds, are tasked with teaching students with such diverse backgrounds – often different to their own – how to interact with patients, who may represent a further range of socio-cultural groups. It is not uncommon to find practitioners, students and patients who concurrently represent more than one social grouping. Therefore, innovative approaches to teaching about culture in the clinical context are required.[1]

Healthcare provider-patient relationships have become an important aspect of medical curricula. As healthcare moves from a patriarchal to a patient-centred approach, healthcare providers find it necessary to improve their relationships with patients, beyond clinical practice alone.[2] Improved healthcare provider-patient relationships, addressing the patient's agenda and involving the patient as part of the team, have become vital components to healthcare delivery. Achieving these objectives can be learned by improving communication skills.[3,4]

As part of Curriculum 2010, communication skills at UKZN's NRM School of Medicine were included early in the curriculum and integrated throughout the pre-clinical and clinical years. However, it is acknowledged that skills alone are not adequate for competency in communication, especially where there is disparity between healthcare providers' and patients' cultural frameworks.[4] A combination of knowledge, skills and attitude supported by reflective practice appears to be the most widely accepted current approach to teaching culturally competent communication to medical students.[3,4] Knowledge alone is insufficient to promote cultural competence. Attitude, skills and reflective practice are essential.[4] Curiosity and genuineness are important tools to level power disparities between clinicians and patients, creating contexts that are conducive for patients to develop a relationship of trust and share information.

Reflective practice is widely regarded as a method to improve professional practice in a range of professions.[5] It is encouraged in medical education where programmes attend to developing medical students' communication and reflective skill.[6-10] Collaborative reflection is a practice in which ideas

and experiences are exchanged with others to enhance professional practice.[11-13] It is considered essential for enhancing the quality of reflection.[9,14] Building on basic reflection in teaching, which is generally restricted to the 'how to' of teaching, collaborative reflection involves broadening the range of reflection to consider the moral, political, and emotional aspects of the education-related issues under discussion.[11]

In this paper we track the process of how we used collaborative reflection to arrive at an understanding of applying medical educators' practical experiences to their teaching of cultural competency to medical students. Tigelaar *et al.* note that little is known about how peer meetings stimulate educators to reflect and it seems useful to examine educators' communication processes during such meetings.[11] We elucidate a process in which medical educators realised, through collaborative reflection, how they used narratives of their experiences of cultural disparity in clinical encounters to develop their own cultural competency skills. This process led to the understanding that collaborative reflection of shared narratives in clinical encounters could be used in teaching about culture in clinical encounters.

It has been noted that culture and the 'situatedness' of physician and patient influence telling and listening in important ways.[15] These experiences are difficult to replicate or recreate outside of sharing narratives of such experiences. In the process of deconstructing elements of these types of encounters for teaching purposes or providing generic vignettes of 'typical' cross-cultural clinical encounters, certain important elements are lost. Primary among these is the human element of the clinician's personal experience and reflection. In addition, the richness and complexity of real stories are difficult to replicate in vignettes and case studies structured for teaching purposes. The latter tend to be 'cleaned up' and purged of conflicting ideas, themes and content to facilitate teaching and avoid confusing students. We would argue that it is uncertainty, conflicting ideas, messiness and real-world feel present in authentic clinical encounters that contain the material to advance students' understanding of the cultural implications in clinical encounters.

Process/methodology

An interest group of medical educators/health practitioners was formed at UKZN to discuss how the curriculum could best be adapted to address the specific needs for a relevant culturally competent curriculum. Participants in the group represented a wealth of knowledge and experience in cross-cultural communication, came from various disciplines (Family Medicine, Behavioural Medicine, Medical Education, and Public Health) and had a keen interest in enhancing teaching practice.

During the meeting, the group of six participants discussed various methods to incorporate cultural aspects into medical education. It emerged that the members of the group consistently used the method of recounting narratives of personal or colleagues' experiences to illustrate a cultural aspect relevant to medicine. The stories which were spontaneously narrated illustrate the complexity of the dynamics between participants and patients in a cross-cultural milieu.

Group participants reflected with each other on their past experiences in similar or related clinical encounters to understand the meaning of their own and patients' behaviour in these encounters. Through this process narratives were recognised as a valuable tool that could be used in curriculum development, illustrating to the group as a whole how to improve the current curriculum to better address the needs of the students and patients. Participants then used a process of collaborative reflection to develop a perspective on how narratives could be used in teaching to facilitate an in-depth and reflective understanding of culture in the clinical context.

In the process of collaborative reflection the group participants listened to each other tell and re-tell narratives that illustrated positive examples of clinical cultural encounters. Group participants collectively identified and agreed on themes or key elements that the narratives had in common, i.e. curiosity, respect and unconditional positive regard for patients. The participants held the view that these attitudes enhanced personal reflection, encouraging them to learn from mistakes and improve their consultations over the course of their careers.

Beyond the elements of curiosity, respect and unconditional positive regard narratives used by the clinicians shared the following elements, which contributed to their effectiveness in conveying the nuances of clinical encounters in which cultural issues were relevant.

- The narratives were **complex** as they incorporated various elements, including unconventional clinical settings, multiple cultural dimensions, and multiple socio-cultural contexts.
- They were **real** accounts of the personal perspective and credibility of the clinician narrating the story. The element of 'reality' of the narratives enhanced credibility. This could be explored from different angles by questioning the narrator. Therefore, perspectives that the narrator had not previously explored could be uncovered.
- The narratives were **rich** as they included great detail in terms of ethical and clinical content and emotional aspects.
- The stories were **dynamic** as they were presented with the potential to be used and understood in different ways. Different plot elements, characters and potential plot directions meant the audience had the choice of inhabiting different roles within the story. Questions could be posed to facilitate deeper understanding and re-create real-life experiences, e.g. 'What would you feel if you were me in this situation? How would you have reacted in this situation?'.
- Stories incorporated professional and **personal** reflections by the clinician/narrator.

This paper utilises, as illustration, two of the many narratives related during the meetings.

Narrative 1 (Dr J)

'On a busy day in the outpatients' department a young woman came for a consult. She was dressed in a pinafore and had a colourful handkerchief tied around her neck. She was reserved and answered quietly when I greeted her in isiZulu and asked how I could assist her. She avoided eye contact and indicated that her problem was the isinye (bladder/lower abdomen). I nodded and stated that perhaps we should perform a pregnancy test, to which she agreed. Without any other enquiries or exploration, I gave her instructions to go to the nurses' station to have a urinary pregnancy test done. She seemed to expect this, and left the consultation room.

'When she returned she placed the open envelope with the result on the table, and I asked her what the result was. She looked down, but started smiling slightly. I started laughing, and she started laughing, relieved and very happy – she was pregnant. I continued the consultation, including arranging antenatal clinic, HIV testing for her and her partner and prescribing iron and folate supplements. At the end she gave me a hug and left.'

'A local custom for when a young woman is betrothed (*ganile*), is that she indicates this by wearing a handkerchief or cloth tied around her neck. In the lengthy process of formalisation of the marriage this is an important step, where the woman now starts living with her husband, and there is an expectation that she will become pregnant and demonstrate that she is able to bear a child. The knowledge of this custom and how it is signified, together with understanding the cultural limits of a young woman discussing reproductive health issues with an older man, was important to allow a focused and patient-centred consultation to take place. Having worked in this community for some time, the event also indicated to me how the knowledge and respect of isiZulu culture had become part of my consultations and facilitated the mutual demonstration of care.'

Narrative 2 (Ms S)

'The military is known for a strict code that permeates all aspects of life and members are expected to conform to the military culture regardless of their culture of origin. One day I was referred a patient, Sergeant SB, who presented with a pronounced tic. His head jerked involuntarily to over his right shoulder constantly. A neurologist who had examined the patient concluded that the condition was "functional". The patient was visibly distressed and expressed his concern that the condition was preventing him from working. A note from his commanding officer confirmed that his sick leave was exhausted and leave for treatment for the condition would have to be specifically motivated for by the relevant health practitioner. Sergeant SB consented to a session of hypnosis during which the tic disappeared. In the discussion following the hypnosis session Sergeant SB confided that his presentation had been identified by his family and an *iSangoma* (traditional healer/diviner) that had been consulted as the call to enter into a spiritual life and train to become an *iSangoma*. He also revealed that he had been having dreams that were usually associated with the call to spiritual life.'

'Sergeant SB was not keen to take up this call and was then required to participate in a series of rituals under the direction of an *iSangoma* that would release him of this obligation.'

'As a clinical psychologist I occupied a role in which I could translate health issues yet also consider emotional and spiritual aspects of health. As a military psychologist, I held the legitimacy to sanction Sergeant SB's desired consultation with the *iSangoma*. This encounter occurred fairly early on in my career but I find myself returning to it often in teaching both to clinical psychologists and medical students, as it seems to illustrate for me some important aspects of cultural interaction in the clinical encounters. Firstly my relative inexperience with both military and Zulu culture at the time compelled me to take a humble position in both arenas and adopt a curious, non-judgemental and respectful attitude. As different as they were, one thing that these two cultures held paramount was respect, seen as discipline in the military and *hlonipha* (respect) in Zulu culture. In their extreme diversity these two cultures were joined in the common human understanding of respect for others. When I ascribed to this position as clinician I was able to effect a satisfactory agreement for all concerned. I had told this story to different audiences for different purposes but all with the underlying theme that this particular narrative represented a step in my ever-developing cross-cultural competence.'

Reflections and discussion

Both narrators acknowledged that they had used the stories on various occasions and in various ways. The practice of repeated reflections in different contexts and to different audiences enhanced learning. Each telling of the story was influenced by the varying purposes of the telling, i.e. whether it was at a job interview, peer consultation or teaching. The different audiences also influenced the telling. For example, BG would sometimes tell his story to illustrate how making assumptions, as he had in his narrative, could have negative consequences if one was not familiar with the cultural context or there were subtle factors which were not immediately evident. Each re-telling had some impact on the narrator/participant whose own in-depth understanding of the narrative was enriched by the telling and seeing the familiar narrative from the audiences' new perspective.

Participants noted that the stories illustrated important aspects of their practice, such as cultural sensitivity and recognition of culture-specific signifiers, respect, unconditional positive regard and curiosity. Narratives had specific reference to how meaning was being given for the individual participant arising out of a process of reflective practice, reflecting on a clinical situation and wanting to make sense of what happened. The particular narratives had struck a personal and an emotional chord with the narrator and had acquired some significance as being illustrative of a moment of developing cultural competence in some way. The process of collaborative reflection with colleagues who were health professionals and medical educators offered the opportunity to examine the political, moral, cultural and social aspects of the narratives and discover how they could be used in teaching about culture in clinical practice.

Collaborative reflection led to understanding the significance of the narrator's personal and emotional reflections on the stories in the teaching representing cultural sensitivity. Unconditional positive regard, mutual respect, curiosity and willingness to share and learn created the context for learning. During collaborative reflection other group participants reflected on the narratives offered, exploring further possible dimensions of the interactions and additional interpretations. Lessons from one narrative were reflected on with reference to other narratives. Collaborative reflection facilitated the realisation among group participants that they had told specific stories about the development of their cultural competence in different ways and in different contexts before.

It had offered yet another perspective for the narrators and for group participants. This process developed the narrative into a dynamic tool that could be used to illustrate what the clinician felt s/he had learned and what they could teach their students. Each re-telling conveyed that the

narrative could be used for different purposes, depending which elements of the narrative were highlighted. Collaborative reflection constructed the understanding that narratives of personal encounters by practising clinicians were a valuable resource.

The medical consultation cannot be regarded as a culturally neutral context. Curiosity, genuineness, respect and unconditional positive regard were seen as imperative preconditions to culturally competent practice.[16] The process of collaborative reflection about the narratives revealed that it was candid reflection and discussion with an attitude of genuineness, curiosity and unconditional positive regard in a respectful non-judgemental environment that could facilitate successful cultural interaction in clinical settings.

Conclusions

In this paper we describe the process of using collaborative reflection on the narratives of clinical encounters to facilitate insights about cultural aspects of medical practice. We pose that these types of narratives offer the opportunity to clinicians, to colleagues and potentially to students to share in the clinicians' insights with a depth, richness, complexity and real-life feel. Furthermore, collaborative reflection allows for a deeper understanding and complexity of the encounter to be explored, pointing to important aspects to be included in the teaching. Elements such as the clinicians' attitude, curiosity, respect and unconditional positive regard are readily conveyed and illustrated when using a narrative first-person account of real clinical-cultural encounters.

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References

1. Sears KP. Improving cultural competence education: The utility of an intersectional framework. Medical Education 2012;46:545-551. [http://dx.doi.org/10.1111/j.1365-2923.2011.04199.x]
2. McWhinney IR. Textbook of Family Medicine. 2nd ed. New York: Oxford University Press, 1997.
3. Seeleman C, Selleger V, Essink-Bot ML, Bonke B. Teaching communication with ethnic minority patients: Ten recommendations. Medical Teacher 2011;33(10):814-819. [http:dx.doi.org/10.3109/0142159X.2011.600646]
4. Betancourt JR. Cross-cultural medical education: Conceptual approaches and frameworks for evaluation. Academic Medicine 2003;78:560-569. [http://dx.doi.org/10.1016/S1607-551X(09)70553-4]
5. Mann K, Gordon J, MacLeod A. Reflection and reflective practice in health professions education: A systematic review. Advances in Health Sciences Education : Theory and Practice 2009;14(4):595-621.
6. Aronson L. Twelve tips for teaching reflection at all levels of medical education. Medical Teacher 2011;33(3):200-205. [http://dx.doi.org/10.3109/0142159X.2010.507714]
7. Boutin-Foster C, Foster JC, Konopasek L. Viewpoint: Physician, know thyself: The professional culture of medicine as a framework for teaching cultural competence. Academic Medicine 2008;83(1):106-111.
8. Clandinin J, Cave MT, Cave A. Narrative reflective practice in medical education for residents: Composing shifting identities. Advances in Medical Education and Practice 2010;2:1-7. [http://dx.doi.org/10.2147/AMEP.S13241]-
9. Muir F. The understanding and experience of students, tutors and educators regarding reflection in medical education: A qualitative study. International Journal of Medical Education 2010;1:61-67. [http://dx.doi.org/10.5116/ijme.4c65.0a0a]
10. Teal CR, Street RL. Critical elements of culturally competent communication in the medical encounter: A review and model. Soc Sci Med 2009;68(3):533-543. [http://dx.doi.org/ 10.1016/j.socscimed.2008.10.015]
11. Tigelaar DE, Dolmans DH, Meijer PC, de Grave WS, van der Vleuten CP. Teachers' interactions and their collaborative reflection processes during peer meetings. Adv Health Sci Educ Theory Pract 2008;13(3):289-308. [http://dx.doi.org/10.1007/s10459-006-9040-4]
12. Nicholson SA, Bond N. Collaborative reflection and professional community building: An analysis of pre-service teachers' use of an electrnic discussion board. Journal of Technology and Teacher Education 2003;11(2):259-279.
13. Martin JA, Double JM. Developing higher education teaching skills through peer observation and collaborative reflection. Innovations in Education and Training International 1988;35(2):161-170.
14. Breiter C. Education and Mind in the Knowledge Society. Mahwah, NJ: Lawrence Erlbaum Associates, 2002.
15. Aull F. Telling and listening. Constraints and opportunities. Narrative 2005;13(3):281-293. [http://dx.doi.org/10.1353/nar.2005.0015]
16. Rogers CR. Client-centered Therapy. Boston: Houghton Mifflin, 1951.