KSS Differential Attainment Project

Supervising clinicians from diverse language and cultural backgrounds

Vignettes for discussion - with notes

Read the following vignettes and discuss in small groups:

- What immediate assumptions might be made about the behaviours described?
- What other interpretations might there be?
- How would you approach giving feedback to the parties involved?

1. An internationally trained doctor, whose spoken English is highly proficient, has poor record-keeping skills. There are significant omissions and spelling mistakes in his notes, despite him having been given feedback on this several times. His performance is otherwise excellent.

No specific cultural background is given here so there are several possible interpretations.

*'High context' cultures tend to prioritise oral, especially face to face communication with trusted colleagues, over written, and may gain richer contextual understanding through non-verbal cues, pauses and silences, as well as what is **not** said. This may cause their written communication to appear vague or incomplete in a relatively 'low context' culture such as the UK, that relies on detailed, evidenced documentation, with associated professional or legal implications.*

English spelling is notoriously difficult because of its irregularity and lack of direct correspondence between sounds and letters. Although technology offers easy ways to check this, interestingly the implicit link we make in the UK between correct spelling/presentation and professional credibility may not necessarily apply in other cultures, so checking for these kinds of mistakes may be seen as less important.

Another aspect to consider could be that in the UK we normally express feedback in cautious, understated terms, with very limited emotional display, so the relative seriousness may not always be conveyed to someone who is used to direct, unambiguous expression of opinion. (Consider: 'That's an interesting idea', 'I'm afraid that might not be possible' and many other e.g.s online under 'What the British really mean' etc)

2. A monocultural group of IMGs are unhappy after an induction session with an educator. They describe being told to speak one at a time and felt they had been 'treated like children'. The educator later asked to swop sessions with a colleague, as she had found the group unruly and disrespectful. The session had been difficult for her to manage with late-comers, mobile calls being taken and constant interruptions to her presentation.

This example illustrates some of the misunderstandings that can occur when 'synchronic'/ 'multi-active' and 'sequential'/'linear-active' cultures work together.

In the UK (and US, Northern Europe) we expect to approach tasks one at a time, in order, especially in professional situations. Other cultures (Southern European, S America, Asia) are at ease dealing with different issues/tasks/individuals simultaneously and may find it restrictive or patronising to have to follow a strict agenda.

There might be some apparently inappropriate multi-tasking (phone calls etc) and lots of 'overlapping' talk, which is considered a sign of engagement in multi-active societies but may be viewed as interruption by those used to a linear-active approach.

Different assumptions around time-keeping may also cause friction. Members of this group were regularly very 'late' for the start of 9.30 sessions, and were surprised when this was noted, but quite open that they had been to the gym on the way in or had to wait for a delivery before they were able to leave home. They were unaware that not arriving at the stated time for an educational event might be viewed as unprofessional in the UK.

3. In response to a reflective writing task on learning needs, an IMG writes long descriptions of events where they have received positive feedback on their performance.

This example illustrates differences in the cultures of learning and teaching.

In some academic cultures the teacher is responsible for identifying any 'deficits' in the learner. Concepts such as 'reflection' and 'insight' are not universal and may be misinterpreted as activities that expose an individual's professional weaknesses, resulting in loss of 'face'.

Some non-western approaches to learning value mastery over discovery – a good learner listens closely to the teacher and reproduces what he or she is told, without challenge. Where originality is not expected or sought, the concept of plagiarism may be difficult to grasp.

4. Patients have made informal complaints that an international doctor talks non-stop, constantly interrupts, and uses complex medical language in explanations that are impossible to understand.

What constitutes professional presentation in patient encounters is influenced by deeply held cultural values around:

- *Turn-taking patterns in conversation: overlapping speech as a sign of involvement and interest, rather than impatience; tolerance of silence, which varies across cultures (minimal in this case)*
- *Demonstrating knowledge/competence through use of academic/medical language; degree of formality expected in the relationship, also linked to -*
- *Relative status/power of doctor and patient*
- *Understanding UK patient expectations of involvement*

- *Awareness of professional models of consultation in the UK*

This doctor's initial impression was that 'in the UK, patients tell you nothing'!