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The challenges of cross-cultural research and teaching in family medicine: How can professional networks help?

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Abstract

Modern medical training emphasizes the value of understanding the patient's ideas, concerns and expectations, and the use of their personal perspective to assist communication, diagnosis, and uptake of all appropriate health and treatment options. This requires doctors to be 'culturally sensitive', which "… involves an awareness and acceptance of cultural differences, self-awareness, knowledge of a patient's culture, and adaptation of skills". Yet most of us work in one country, and often one community, for much of our professional careers. Those who enter into academic pursuits will similarly be constrained by our own backgrounds and experiences, even though universities and medical schools often attract a multicultural membership. We therefore rely on our professional training and networks to extend our scope and understanding of how cultural issues impact upon our research and its relevance to our discipline and curricula. This article uses a reflexive narrative approach to examine the role and value of international networks through the lens of one individual and one organisation. It explores the extent to which such networks assist cross cultural sensitivity, using examples from its networks, and how these can (and have) impacted on greater cross-culturalism in our teaching and research outputs.

Keywords: Professional networks; professional development; career opportunities; cross-culturalism

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Introduction

All physicians will have made a cultural transition into a professional culture during their acquisition of key expertise [1]: much has been written about the process of indoctrination into medicine, and its dominant ethos [2]. This professional status is affirmed with legal and regulatory conditions for professional practice, and is usually rewarded by a privileged position in society [3]; this also embeds physicians into a particular worldview of what it means to '*be a physician*.' Within this global cultural definition, there is, of course, a huge variation by individual, country, health care system, and medical speciality. Physicians also experience diverse roles in their careers through service development, education, research, and implementation [4]: each creates a set of subcultures which may feel very different.

Managerial, medical, and nursing discourses within workplace cultures also differ, and creating effective teams can be as challenging [5] as making a bond with a patient whose background is very different from that of the treating physician. So each career,

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each team, and each clinical setting will have its own subcultures, and it is part of our lived experience to make effective adaptation.

One of the ways that professions, including medicine, retain their identity and consolidate their own cultures is by the creation of formal professional networks. Examples include the early years of the Royal Colleges of Physicians and Surgeons in Britain, and their increasing control of medical qualifications and grounds for clinical practice [6]. Such professional bodies often expand their membership to a global level, usually with the declared aim of sharing expertise through conferences, study visits, research projects, and exchange of views and ideas. Another means of enlarging professional influence is through informal social networks – it is well recognized in the leadership literature that such networks can open up new career opportunities to those allowed to access and use them [7].

Medical academics inhabit the additional world of higher education, which brings physicians into the work environment of universities. This sector has been increasingly oriented to international and intercultural collaboration – originally scholastic [8], now more commercially driven, but both about the added value of different perspectives and their essential impact on academic creativity [9]. In the age of the World Wide Web, communication of new knowledge and events is easily done through virtual networks [10], which extends opportunities for groups from different communities to interact across geographical and societal boundaries. Finally, physicians in any setting are likely to meet patients from backgrounds very different from their own.

It is part of modern medical training to emphasize the value of understanding the patient's ideas, concerns, and expectations, and to use the patient's personal perspective to assist communication, diagnosis, and acceptance of all appropriate health and treatment options [1]. This requires physicians to be 'culturally sensitive,' which "involves an awareness and acceptance of cultural differences, self awareness, knowledge of a patient's culture, and adaptation of skills" [2]. Yet most of us work in one country, and often one community, for much of our professional career. Those who enter into academic pursuits will similarly be constrained by their own background and experiences, even though universities and medical schools often attract a multicultural membership. We therefore rely on our professional training and networks to extend our scope and understanding of how cultural issues can impact on our research and its relevance to our discipline and curricula.

So, to summarize, all physicians will have their own cross-cultural career journeys, during which they will be part of different professional networks. In academic settings, physicians are particularly likely to need to be aware of cross-cultural issues as part of the modern curriculum, because their patients, students, and colleagues will be from different cultural settings, and because research is increasingly conducted in an international context. It is therefore of some interest to understand how medical academics use their professional networks to explore and address cross-cultural issues in teaching and research, and particularly so for family physicians, who have the most dispersed geographical base for their practice, and are in many countries a 'new' speciality, with fewer networking opportunities locally.

Methods

This is a commentary article, using my own career as a basis for a reflective narrative [11]. Narrative enquiry is a means of gaining understanding through analyzing stories – both for content and for cultural dynamics. It is also a way in which researchers can take their own experience as a source of data and insight – as Trahar [12] says: "Narrative inquirers engage in intense and transparent reflection and questioning of their own position, values, beliefs and cultural background." Use of the subjective voice is unusual in traditional science but has become an accepted method in modern social science approaches [13], and indeed in family medicine research [14, 15]. In the final phase of my career, where I am now a professor in a medical school, was recently an officer for 7 years at the Royal College of General Practitioners, and am President-Elect of the World Organization of Family Doctors (WONCA), an international network of family medicine organizations, I examine the role and value of international networks, exploring the extent to which such networks assist cross-cultural sensitivity. I also use examples from these networks and how these can impact (and have impacted) on greater cross-culturalism in our teaching and research outputs.

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Reflections

As a student, by far the biggest influence on my understanding of my own cultural limits and perspectives was international travel. Vacation jobs in hospitals as a cleaner, backpacking with other medical students to health volunteer summer camps, university contacts, and meeting real patients were linked to my future career. They took me on a journey to different parts of the United Kingdom and the world, and into different social communities, including the poorer end of East London in the 1970s.

I had every intention of working overseas, but elected to live in Sheffield, and ended up as a family physician there for more than 20 years, mostly in my own practice, again with patients whose lives were very different from mine. But every day, with every patient, I entered that wonderful space of the consultation, where the whole endeavor is to meet another person with that person's needs and worries, to do the medical job, but in the process to use the relationship for therapeutic and effective outcomes [17]. And this, as all physicians (especially family physicians) know, is a dance of moral, communicative, and intellectual effort, where every cultural difference needs to be respected but not allowed to be a barrier to a good outcome.

We taught students and residents at the practice, and hosted research, longing to get the students out to meet real people, to see their lives in their communities, and wanting to add to evidence that was useful. We held meetings, collaborated with other practices, experimented with new services, and, as the literature reveals, were constantly developing our own microculture by exchanging knowledge with others [18]. I then, as many family physicians do, began to teach for the local medical school, and found the very different culture of the university added to my professional and personal impact. I enjoyed the broader range of views and ideas (sociologists, health economists, and psychologists all being part of the faculty). The rigor and challenge, plus the opportunity to improve medical education, were cultural challenges which I enjoyed, although bureaucracy, dysfunctional committee structures [19], and collegial competitiveness were cultural challenges of a more irritating sort. The outcome was that my career shifted increasingly toward academic developments, and it was there that I started to engage with national and international work, and meet colleagues from other settings.

I have found that it is an inherent trend of academic medical practice to make regular use of professional networks to identify, debate, and disseminate new ideas and evidence, and these are very helpful at all stages of an academic career, from junior to senior. For me, these were the Royal College of General Practitioners,[1] the Society for Academic Primary Care,[2] and WONCA[3] – two primarily professional networks for general practitioners/family physicians and one for academics in medical schools and primary care departments – and also medical education equivalents such as the Association for Medical Education in Europe.[4] Here I found for the first time the context to bring higher-level thinking to my teaching and learning about cross-cultural issues. So what is the value of professional networking in medical academia, with particular reference to family medicine? Jumping on 20 years and to examples, I see the excitement of our seven regional young physician leads coming together by Skype, beginning to understand all the things I struggled with early in my career, seeing the systems-level factors that help or undermine family medicine worldwide, and understanding that they as young physcians can play a part in the development of the discipline, as well as their own clinics and teams.[5] I see great cross-setting research, which also empowers lower-income countries, and builds their capacity to undertake research while spreading good clinical practice [20]. I become aware of recent articles on interesting cross-cultural parallels which puzzle me in my own country [21], and always, of course, research that informs our own teaching and assessment practice in our increasingly multicultural medical professional training [22].

But much more than that, the opportunities that an international professional network brings to meet colleagues immersed in championing better work at their own location, train others, take on policy debates and advocacy, and be able to help others as they start that journey[6] is a true inspiration and guide to new thinking.

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1 www.rcgp.org.uk/.

2 https://sapc.ac.uk/.

3 www.globalfamilydoctor.com/.

4 www.amee.org/.

5 www.globalfamilydoctor.com/News/YoungDoctorsMovements-news.aspx.

6 See for just one example the work of the WONCA Working Party on Rural Practice on the WONCA website.

Discussion

Any mode of networking can be critiqued, and there have been particular concerns about climate impact from international travel,[7] bias on educational input to medical conferences from substantive sponsorship by commercial partners, and also bias in the research agenda and funding in universities [23], although none of this is specific to family medicine as a speciality. There are limits to my case study – it is only one version of many events in a life, analyzed at one point in time and constructed for a particular audience and context [24]. But, as Rudolf Steiner, the famous Austrian theosopher, is cited as saying[8]: "To truly know the world, look deeply within your own being; to truly know yourself, take real interest in the world." General practitioners know that a journey of great mutual humanity and privilege can start every time a patient and a physician meet. But to analyze, conceptualize, and advocate, we have to go up a few levels – and that level is always informed by a breadth of thinking that one individual in one setting cannot offer alone. So I argue that any discipline will be enriched by effective professional networks. How these work best depends on opportunity, motivation, and appropriate structural choice for what is inevitably a diverse and fluid setting [26]. In WONCA we have supported the growth of working parties and special interest groups which can collaborate across countries and regions, and which lead to academic projects and exchanges. We use our networks to gather intelligence, and use this both nationally and globally, working with the World Health Organization wherever we can. Financial and organizational capacity is small for an organization of around half a million members – we rely on overheads from membership organizations to permit this additional work for their members. But WONCA has thrived from its 13 startup members to become a truly global professional network with members in every region of the world. We believe that it is our network that encourages the growth of family medicine and its input into strengthened primary care. (How else is a new medical school in Kxxxtan going to believe that it must have an academic family physician as a key faculty appointment at its inception?) Professional networks should build what is needed for patients – they help us to meet the daily challenges of teaching and research, in every setting. We must show their value to our early-career colleagues, and ensure they themselves get that perspective of global health early on so they have that outer perspective and have the chance to contribute to the bigger picture.

7 See www.ghgonline.org/flyingaea.pdf, and also Howe A. Hot on the planet? – should WONCA beconsidering sustainable travel policies?" at www.globalfamilydoctor.com/News/PolicyBites.aspx?CollectionRepeater3=3.

8 http://izquotes.com/quote/269369.

Conflict of interest

The author is President-Elect of the World Organization of Family Doctors, from whom she receives reimbursed expenses for relevant activities. She is also a Fellow of the Royal College of General Practitioners in the United Kingdom, for whom she worked as an Officer of Council from 2009 to 2015.

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