



Turning cross-cultural medical education on its head: Learning about ourselves and developing respectful curiosity

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Abstract

Cross-cultural education is often understood to mean acquiring cultural knowledge about different cultural groups in order to serve people from diverse groups equitably. However, this article argues that to work effectively in cross-cultural situations, we need to learn about our own culture and develop an approach of respectful curiosity. The first goal of cross-cultural education is to understand how culture influences our thoughts, perceptions, biases, and values at an unconscious level. The second goal is to understand the nature of individual cultural identity as a multidimensional and dynamic construct through exploration of our own cultural identity. This exploration helps us understand the limitations of learning about ‘others’ through learning categorical information and helps us limit the effect of our implicit biases on our interactions. The approach of respectful curiosity is recommended to question our assumptions, understand each unique individual patient, connect with each patient, and build the therapeutic relationship.

Keywords: Cultural competency; diversity; patient-centred care; cross-cultural; self-awareness; respect; curiosity; reflection; medical education; undergraduate

Cross-cultural education is often understood to mean acquiring cultural knowledge about different cultural groups in order to serve people from diverse groups equitably. This categorical approach to gaining knowledge about ‘other’ cultures, which has been referred to as the ‘cultural expertise model,’ assumes that people who belong to a particular group will behave in a common way [1]. Around the world the call for providers to be ‘culturally competent’ has been driven by health care services acknowledging that health inequalities exist for minority populations. In North America ‘cultural competency’ has been incorporated into medical school curricula “to equip healthcare providers with the knowledge, skills and tools to better

understand and manage socio-cultural issues in the clinical encounter” [2]. This model tends to start from the need of a dominant majority to understand the minority perspective. The need to reflect on the diversity within the majority population or individual diversity is not emphasized. However, to work effectively in cross-cultural situations, clinician self-knowledge and self-awareness need to be the starting point [3].

The foundation to working effectively cross-culturally is to learn about our own culture rather than that of others. The first goal of cross-cultural education is to understand how culture influences our thoughts, perceptions, biases, and values. Culture functions at

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a fundamental level in our thinking. Cultural norms provide the framework for how we conduct human relations and make us functional in a society. Be it the culture of the schoolyard, workplace, or nation, cultural norms inform our understanding of what is acceptable, respectable, valuable, and normal. Culture influences our thinking at the unconscious reflexive level. Research indicates that unconscious implicit biases can affect physician behavior [4].

Dual-process theory proposes that humans perceive the world through two different systems [5]. System 1 is the fast automatic and unconscious system which implicitly processes information on the basis of stored knowledge, beliefs, and attitudes. System 2 is slow, deliberate, rational, and conscious, evaluating information explicitly. Cultural norms, values, and biases inform system 1. So when we are confronted with another set of cultural norms which violate our own, we may react with strong value judgments, such as feeling that something is unacceptable, disrespectful, abnormal, or wrong.

Understanding how culture influences our implicit thinking allows us to place our unconscious automatic responses to diversity into the conscious field, where we can understand our reactions. It allows us to look at ourselves and step back so that we can minimize the effect of our biases. This self-awareness can guide our reflection both during and after an event [6]: reflection in action (I am reacting negatively and need to take a step back) and reflection on action (Why did I react like that? What does it tell me about myself?). This is the key to lifelong professional development of what has been variably termed ‘cultural sensibility’ or ‘cultural competence’ [7].

The second goal of cross-cultural education is to understand the nature of individual cultural identity as a multidimensional and dynamic construct. Culture has been defined as a “socially transmitted pattern of shared meanings by which people communicate, perpetuate and develop their knowledge and attitudes about life” [8]. The shared meanings relate to groupings. Each person belongs to several of these groups, which are referred to in the literature as ‘social locations.’ Some groupings are visible, such as sex, age, and ethnicity, but the vast majority are invisible, such as education, religion, profession, family culture, and parental status.

Consider a Malaysian national of Chinese ethnicity, living in Australia, who played hockey to a professional level in his

youth and now works as a financial advisor while campaigning for Greenpeace in his spare time. These are only six facets of this person’s cultural identity but in reality there are far more. Each facet has a stereotype associated with it but the individual is not defined by any one of these facets.

The various cultural facets or ‘social locations’ within each of us interact and intersect depending on the context and change with time. Individual culture is a dynamic construct. Socioeconomic status may be more relevant than ethnicity in one context, and parental status may be more relevant than professional status in another context. Additionally, there is heterogeneity within each cultural group. Sears [9] talks of the utility of an intersectional framework in cross-cultural medical education, where it is understood that people hold multiple social locations “which interact with one another to uniquely shape the health views, needs and experiences of the individuals within the groups.” The complexity of the nature of individual culture is best understood when it is reflected on ourselves. Exercises such as ‘Circles of My Multicultural Self’ help students reflect on the various dimensions of their individual cultural identity as well as the stereotypes associated with each dimension [10]. To consider the heterogeneity of any cultural group, I ask my students, for example, what British people’s attitude is to the elderly. It quickly becomes evident that although most of them would identify as British, they cannot agree on a unified view. This analysis of our own culture helps us understand the limitations of learning about ‘others.’ By learning categorical information about others on the basis of groupings such as religion, ethnicity, social class, disability, or sexual orientation, we may learn something about only one facet of the individual we interact with. Part of this effort is laudable if our meeting people who belong to these groups helps to break the stereotypes linked with these labels. Indeed this has been the thinking behind the cultural immersion programs [11]. However, we also risk generalizing the experience of the person we have met as the experience of the group we associate that person with and creating a new stereotype.

So should we teach specific cultural knowledge about groups based on religion, ethnicity, social class, disability, sexual orientation, and so on? Knowing that each cultural group will represent only one possible facet of an individual’s cultural identity, is there any benefit? Gaining cultural knowledge may



help us to consciously consider our implicit and perhaps unconscious reactions to different cultural norms in advance of clinical consultations. Attending a cultural awareness induction workshop when working at an aboriginal health centre in Alice Springs, Australia, taught me that for some aboriginal people not making eye contact when listening was a mark of respect. This knowledge did indeed go some way toward preventing me from reacting with anger toward what I would normally consider a mark of disrespect. The other benefit of cultural knowledge is in raising one's awareness of what questions to ask. By knowing that some Muslims fast at Ramadan, you may think to ask about this when speaking to a Muslim patient whose diabetes control has worsened over the fasting period. However, it would be important not to make assumptions about your individual patient on the basis of cultural knowledge, such as assuming that the patient was indeed fasting, or that the patient would continue to fast if you advised against it. Teaching cultural knowledge risks oversimplification and stereotyping, and may be more detrimental than helpful [12].

In very diverse cultural settings, with multiple heterogeneous cultural groups, developing cultural competence through knowledge becomes even more precarious and limited. So how then do we connect with patients whose cultural values we know very little about? People whose experience, values, decisions, and choices we cannot fathom or imagine? Research has indicated that physicians are likelier to employ a patient-centered approach to patients from a background similar to their own, compared with patients whose background differs from their own [13]. When we meet someone whom we code as similar to us, we can use the simulation of how we would feel or what we would do to try to connect and empathize with them. Empathy requires us to imagine what it might be like if we were in another person's position. However, constrained as we may be by the cultural norms of our thinking, we may simply not be able to imagine why someone whose cultural norms are very distant from our own would live in a certain way or make certain choices. Instead of grappling with trying to empathize and being frustrated at having to try, we can focus instead on being *respectfully curious*.

For example, in a consultation with a patient, the clinician may ask: "I am wondering why you made the choice to.... I am interested to learn about how you view your condition/future...."

By first becoming conscious of our biases and assumptions, respectful curiosity helps us to challenge our assumptions. For example, when seeing a female patient who may need an intimate examination, we may ask "Do you have a preference for a male or a female doctor?" instead of "I expect you'll want to see a female doctor."

Saha et al. [14] describe the overlap between the principles of cultural competence and patient-centered care. Both have at their core the ability for the health care provider to relate to the patient as a unique person, understand the patient's perspective, approach the patient's health holistically, and develop shared management goals. An approach of respectful curiosity can help us manage the cultural diversity of our patient encounters [15]. We approach with an open mind and a true willingness to understand the individual needs and goals of our patients. What are their concerns? How do they see my role and theirs? What are their health goals? The folk model of Helman [16] allows us to consider the questions patients may wish to have answered regardless of culture, and the explanatory model of Kleinman et al. [17] gives us useful questions to help uncover culturally distant health beliefs. The greater the cultural distance between ourselves and our patient, the greater the need to ask more questions as our assumptions are less likely to be correct.

Attitudes of curiosity, empathy, and respect are central to patient-centered care. Respectful curiosity not only helps us to understand each unique individual patient, it also helps us to connect with them and build the therapeutic relationship, thereby facilitating empathy. People receive our empathy and care through the demonstration of our interest in their individual story. And we demonstrate interest by being curious, by listening to them, by asking questions. We show respect for patients by wanting to learn about them, and this is the first step to a true partnership. Respectful curiosity help us to practice patient-centered care for all our patients, whatever the cultural distance.

So let us turn the common perception of cross-cultural medical education on its head. Rather than learning about 'others,' it is through learning about our own culture and by developing an attitude of respectful curiosity toward others that we can truly learn to work effectively in cross-cultural situations.



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