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Cultural Competence? Objectives

Underlying question: " Is there such a thing as cultural competence?"

Explore four layers of culture - 'cultures within culture':

- Ethnicity – individual culture as the point of reference
- Education – the climate of educational culture and the expectations that follow
- Organisational culture - the climate of the workplace and differing expectations
- Professional culture – expectations of the NHS

Before we start…..!

- Cultural issues NEVER justify poor performance
- The responsibility of learning and improving performance lies soley with those who have joined the profession – whether international or national medical graduates
- Occasional political incorrectness
- Occasional polarisation and generalisation – for building baseline understanding in a short space of time

Culture

"Collective programming of mind, which distinguishes the members of one group of people from another and leads them to live their lives in way that are shaped by unwritten social codes…..

Social codes are revealed in patterns of thinking, feeling and acting - a sort of collective software of the mind.

(Hofstede, 1991)

Core of Culture - Values

* Broad tendencies to prefer certain states of affairs over others
* Implicitly learned
* Are not always conscious
* Can be inferred by the way people react to different circumstances

Dimensions of Culture

'an aspect of culture which can be measured relative to other cultures'

(Hofstede G Cultures and Organisations 1991,p14)

Six dimensions:

Authority –v- Submission (power distance)
Individualism -v- Collectivism
Certainty –v- Uncertainty Accepting
Short term –v- Long term vision
Masculinity –v- Femininity
Goals –v- Process

Dominant Cultural Themes

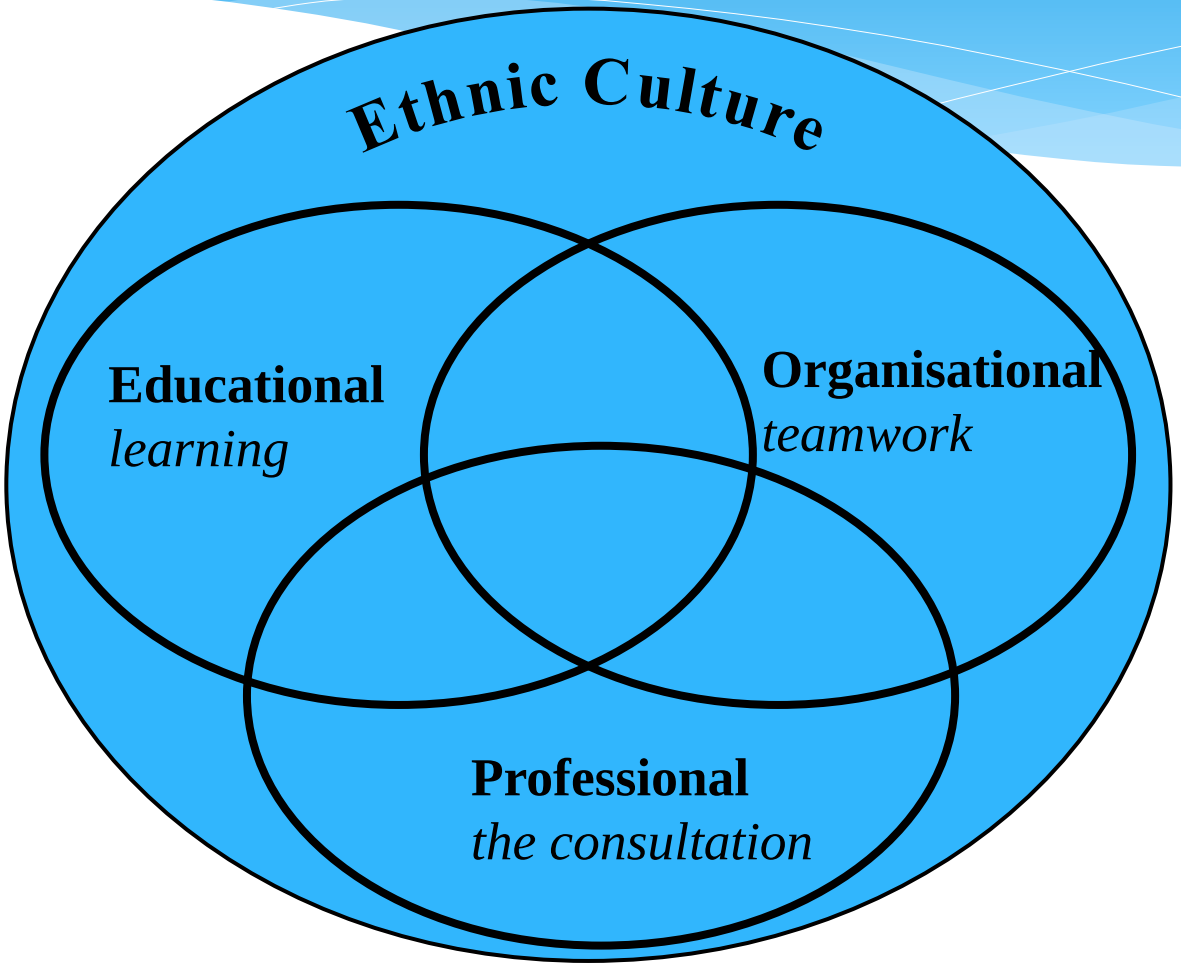
East

* Large power distance
* Collectivist
* Masculine
* Uncertainty avoiding
* Short term orientation to future
* Goal orientation – just do the task

West

* Small power distance -
* Individualist
* Feminine
* Uncertainty accepting
* Long term orientation to future
* Process orientation – learning through doing

Cultural Influences on Medical Profession



THE CULTURE OF EDUCATION AND TRAINING

THE EXPERIENCE OF LEARNING

Professor R Freeman and Dr M Jalil January 2014

Medical Educational - Traditional Model

Traditional Teacher

* expert depositor
* expert withholder
* depowering authority
* member of elite
* distant

Traditional Learner

* repository - banked recipient of knowledge
* cashes in the ‘right’ answers
* passive - teacher led
* lacks ownership
* not exposed

Medical Educational – Contemporary Model

Contemporary Teacher

* expert resource
* recipient and purveyor of knowledge
* manages uncertainty
* is empowering
* is in partnership
* is exposed

Contemporary Learner

* purveyor and recipient of knowledge
* manages uncertainty
* active - self-directed learner
* has ownership
* is exposed

Assessment Models

Traditional Models

•Examinations for assessment

•Emphasis on knows and knows how – no contribution from workplace performance

•Assessment standard depends on experts conducting the examination – independent of criteria

•Competence assumed for life

Contemporary Models

•Workplace based assessment

•Emphasis on does and shows how - evidence to demonstrate competence

•Assessment standard dependent on the criteria set by *panels* of experts

•Competence required to be continually demonstrated – cpd

Educational Dimensions in Culture
The Educational Experience of IMG's

* Teachers (like parents) receive formal respect, are not challenged or criticised
* Learning process is teacher-centred, achievements stem from the personal wisdom of the teacher – universal truths
* Debate and critical analysis are not encouraged
* Learning dependent on quality of teaching – fewer external resources
* Competitive – 'standing first'

Cultural Outcomes of Educational Model IMG's common expectations when training

* Look for directed learning, controlled teaching and being told rather than asked
* Find self-directed learning difficult and without value
* 'winning' above co-operative group work and sharing
* Perceive educational supervisors as wise parents who will 'fix it'
* Tend towards subservience rather than active debate – passive learning
* 'Loss of face' can incur an unrealistic view of achievements and progress and blaming others for failures

Educational Supervisors and Trainers in the NHS Preferences for educational relationships

- Manage boundaries between organisational environment, professional authority and keep appropriate social dimension (PD)
- Trainees who balance respect with challenge, questioning, debate – asking 'why'
- Participation and responsibility – shared learning, the curious learner, active learning
- Learners who can manage uncertainty, recognise limits of competence, learn from negative experiences
- Display appropriate attitudes towards peers, can work in a team, show collegiality

ORGANISATIONAL CULTURE

The experience of working in the team

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Organisational Culture
What IMG's are likely to bring with them

* Clear hierarchy, enforced, inequalities between subordinate and superior accepted
* Ideal boss is the 'good parent', relationships are emotionally laden
* Follow instructions, wait to be directed, no reward for 'thinking outside the box'
* Doing favours to extended family is a duty and expected (finding jobs etc)
* Leaders are expected to be decisive, assertive, loud
* Revenge culture – negative reporting incurs risk to career progression

Organisational Culture – what they are likely to find in the NHS

- Flat pyramids, hierarchies are veiled, leaders can change according to task, co-operative team membership, overt collegiality is valued
- Subordinates have a voice in decision making, encouraged to contribute ideas to the task, are expected to actively engage in the development of the organisation
- "no blame culture' - quality improvement and risk management strategies rely on raising concerns openly, without prejudice
- Nepotism, overt inequality and privileges are actively discouraged
- Responsive to social, political and financial changes
- Cultures within culture –nurses, managers, specialities

◆*Scott T, et al Implementing Culture Change in Health Care: Theory and Practice International Journal for Quality in Health Care, 2003*

Professional Culture

The experience of clinical roles and consultations

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Professional Medical Culture - What IMG's are likely to bring with them

* Doctors are gurus, experts, unquestionable authority
* Doctors are expected to lead the team, provide identity to their institution
* Effectiveness is measured in numbers and fast results rather than processes and quality
* Nurses, managers, administrators never lead but are told what to do
* Patients have no direct influence over service provision – no need to act on feedback
* Gender can influence perceptions of authority

Meeting the needs of Patients in Consultations – What IMG's are likely to bring with them

- The doctor should take control, show authority, 'tell' not ask
- Accept patients' perception of him/her as unquestionable authority – the healer as an instrument of divine mercy
- Frequently-interrupted consultations are evidence of importance and high status
- Unnecessary physical examination is evidence of thoroughness; over-investigation/referrals avoids risks
- Confidentiality interpreted differently – family consultations
- Patient's should be seen and not heard – no requirement for patient education or information

Meeting the Needs of Patients in Consultations – what they are likely to find in the NHS

- Maintain power distance, balanced with equality but accepting professional authority
- Uninterrupted consultations demonstrate undivided attention and obvious listening
- Opportunity for information sharing and partnership in the treatment process
- Revalidation and on going accountability reassure patients and politicians of safe services
- Watchful waiting is an acceptable management model – uncertainty can be managed

Summary

* Culture influences learning and subsequent professional practice – internal models
* Behaviours are influenced by culture and relate to differing ways of perceiving situations
* Professional cultures are systems of beliefs, expectations and practices about how to perform professionally – but are rarely made explicit
* Burden of transitions - host culture, educational, professional and organisational cultures

Some Conclusions

The Culturally Challenged Learner and the Culturally Competent Teacher?

Taking on the NHS – Tasks for the Culturally Challenged Learner

* aware of transitional state across layers of culture
* clarify differences in educational model – know what is expected and find ways of responding, **unlearn** in order to embed new knowledge
* recognise cultural differences in practice, making objective observations and seeking discussion and feedback in the workplace
* review perceptions of the doctor/patient relationship and the meaning of team membership

Qualities that aid transition

* Emotional Intelligence – awareness of others alongside a ‘sense of self’
* Critical thinking and reflection that aids learning from experience and develops insight
* Recognise cultural influence – the problems are the same, solutions are different
* Resilience – avoiding victimisation and instead rising to the challenge of failure
* Using learning from experience to develop robust energies to move forward

Managing the Educational Transition
Tasks for the Culturally competent teacher

* Recognise that overseas doctors are continually having to manage ethnic culture on top of educational, organisational, and professional cultural practices – constantly working across cultures
* Make clear and overt the differing expectations between educational models and the requirements of contemporary medical education
* Clarify the relationship between assessment methods and the NHS educational model – applied and demonstrated knowledge rather than regurgitated abstract knowledge
* Make early observations and assessments
* Recognise that education is not the answer to all problems

Qualities that Support the Transitional Process

* Awareness of one's own cultural worldview
* Sensitive attitude towards cultural difference without losing sight of required standard to be met
* Courage to address perceived cultural differences overtly to aid understanding and progression
* Making 'institutional discourse' clear – the hidden language of medical subculture
* Open to learning
* Prejudice is "not making it overt for those who are struggling"

Final thoughts ….. to be or not to be!

* Instability – can educators develop cultural competence when the organisational, educational and professional culture is in constant change and pulls the rug from under their feet?

* Stability - it is more certain that trainees are consistently culturally challenged and will benefit from support through this maze of transition