

Chapter two: Developing skills for the supervision of clinicians from diverse cultural and linguistic backgrounds

Time: half-day minimum

Session aim:

- to enable supervisors to offer more effective support to learners from diverse cultural and linguistic backgrounds through the development of cultural and language awareness

Objectives:

- to review participants' awareness of DA and the role of supervisory relationships as a protective factor
- to provide opportunities to share experiences, good practice, and challenges of supporting clinicians who are internationally trained or who have a minority ethnic or language heritage
- to introduce specific educational knowledge and facilitation skills for supervision of trainees from these demographic groups
- to explore common educational and linguistic challenges for clinicians trained overseas and/ or practising in English as a second language, and sources of specialist support

Intended learning outcomes:

By the end of the session participants should:

- have increased their understanding of the influence of first language and culture on educational and professional relationships and how this may impact on attainment
- be better able to recognise when language and cultural 'transfer' may cause behaviour or messages to be misunderstood
- be able to adapt their own language and supervision style according to the individual learner
- be confident in using a range of basic linguistic terms to describe learners' communication challenges more precisely and be able to signpost them to specialist support

Session outline:

The session will include group discussions, interactive tasks and presentations.

Supervising clinicians from diverse language and cultural backgrounds:

Session plan

Time: 2 hours 30 mins

Resources: Slide presentation (sound needed for podcast); flipchart and pens; handouts for discussion activity

Time	Activity	Procedure	Resources
10m	Welcome and introductions; housekeeping	Facilitator and participants introduce self and role	
5m	Session Outline: <ul style="list-style-type: none"> • Orientation: identifying challenges • Developing cultural awareness • Building the toolkit 	Review aims and objectives; present session outline	Slide 2
5m	Orientation	Brief introduction to topic	Slide 3
10m	Sharing experiences of supporting IMGs – what challenges are there for doctors new to the UK? For their educators?	Groups of 3/4. One person to scribe/feedback	Notepaper/flipchart
10m	Feedback (whole group)	Capture key points	Flip chart
10m	Summary, additional input and discussion	Presentation	Podcast slide 4 and Slide 5
5m	Developing cultural awareness in the training relationship	Brief introduction to topic	Slides 6-11
5m	What is culture? Small groups to write/discuss definitions and feed back	Groups of 3/4	Note paper
15m	The cultural iceberg; intent v effect; culture and concepts of professionalism	Interactive presentation	Slides 12-16
15m	Theory into practice: reflecting on our own and others' cultural assumptions	(new?) Groups of 3/4 discuss vignettes	Handouts and slides 17-19
10m	Break		
5m	Building a toolkit of skills, activities and sources of further support	Brief introduction to topic	Slides 20-21
10	Developing flexibility in approach and content; negotiating the learning contract	Small groups and interactive presentation	Slides 22 - 23
25	Linguistic challenges: analysing talk; facilitating clearer conversations	Presentation/Groups of 3/4 review communication examples (see slides)	Slides 24-26 (examples on slides or could print as handouts)
5	Feedback on tasks and further discussion	Groups then plenary	Slides 27 -28
5	Signposting to specialist support	presentation	Slide 29
	Summary and close		

Cultural and Concepts of Professionalism

Small group activity (slides 17-19)

Read the following vignettes and discuss the questions 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.
 2. A group of qualified GPs newly recruited from Spain 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.
 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.
 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.

Cultural and Concepts of Professionalism

Supplementary 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 and especially face to face communication with trusted colleagues over written, and may gain richer contextual understanding through indirect statements, non-verbal cues, pauses and silences, and what is not said. This may cause their written communication to appear vague or incomplete to those from a relatively 'low context' culture such as the UK, that relies on detailed, evidenced documentation, with associated professional, contractual or legal implications.

English spelling is notoriously difficult because of its irregularity and lack of direct correspondence between sounds and letters (e.g. consider the different pronunciations of the letter 'a' in 'hat', 'parent', 'quality', 'blockage').

Although technology offers easy ways to check this, interestingly the implicit link we make in the UK between correct spelling/presentation and professional credibility does not always apply in other cultures, where checking for these kinds of mistakes may not be seen as 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, that may be more energetically delivered. (Consider: 'That's an interesting idea', 'I'm afraid that might not be possible' etc)

2. A group of qualified GPs newly recruited from Spain 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.

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

Different assumptions around timekeeping 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. The fact that not arriving at the stated time might be viewed as unprofessional in the UK did not occur to them.

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 risky 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 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'!