CROSS-CULTURAL INTERVIEWING

A Guide for Teaching and Evaluation

University of Toronto
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TABLE OF CONTENTS

Introduction 1
Background Material for a Cross-Cultural Curriculum 3
Curriculum Design Model 9
A Guide for Writing a Cross-Cultural OSCE Case 13
Case 1: Mrs. Chan – Cross-Cultural Interviewing 35
Case 2: Mrs. Chan – Triadic Interviewing 39
Bibliography 43
Appendices 45

VIDEO INDEX

PART 1: CROSS-CULTURAL COMMUNICATIONS

Expectations 00:01:36
Subtleties and Nuances 00:08:41
Frustrations 00:14:52
Health Beliefs and Practices 00:18:18
Language 00:21:24
Communication Techniques 00:22:18

PART 2: TEACHING THE TRIADIC INTERVIEW

Section 1 – Working with a Professional Interpreter 00:26:43
Section 2 – Working with a Non-Professional Interpreter 00:36:35

PART 3: OSCE STATIONS

1) 'Mrs. Chan' 00:48:13
2) 'Mrs. Chan' with Interpreter 00:58:27

INTRODUCTION

This manual is intended to provide background material, which may be useful to those who contemplate including cross-cultural communication training in their curriculum.

The material is designed primarily for use in faculty development, to aid those teachers unfamiliar with the field of cross-cultural communication in planning and implementing a skills training module for their students. However, parts of the manual are also suitable as background reading for students as well as faculty. The material concerning standardized patients can be used to train SPs in cross-cultural roles for either teaching or evaluation. The scenarios can also be adapted for role-play if standardized patients are not available.

The authors approach this task not as experts in cultural issues, but as educators who plan and implement clinical skills curricula for medical students. This module has been used in the second year curriculum at The University of Toronto for the past 3 years, in the clinical skills course called "The Art and Science of Clinical Medicine" (ASCM). What we have learned from this experience is incorporated into this manual. We continue to modify and try to improve the module, to make it more relevant to students and accessible and efficient for faculty. We would be pleased to hear of the experience of others who may use or adapt the material to their own contexts.

The authors wish to thank the following people for their contributions:

♦ Ms. Ruth Lee. The organization of the background material is based on a lecture given by her to University of Toronto medical students.

♦ Ms. Jane Leung and Mr. Kerry Bowman, experts in the field of cross-cultural issues, who gave freely of their time and expertise.

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BACKGROUND MATERIAL FOR A CROSS-CULTURAL CURRICULUM

The following material is intended to provide a brief theoretical foundation to faculty inexperienced with the field of cross-cultural medicine. Some of the issues raised are also suitable as discussion points for students. A bibliography is included for those who wish to explore the field in greater depth.

IMPORTANCE OF CROSS-CULTURAL TRAINING IN MEDICINE

1. Continued immigration of people to Canada, especially from Asia and Africa.
2. Toronto is one of the most culturally diverse cities in the world.
3. There are over 100 different cultural groups in Ontario.
4. 55% of Canadian immigration is to Ontario.
5. Immigrants comprise 38% of the population of Toronto
6. By the year 2000, 50% of all Canadians will have a mother tongue other than English or French.

BARRIERS TO THE IMPLEMENTATION OF A CURRICULUM IN CROSS-CULTURAL COMMUNICATION

1. Belief that such a program would entail learning the details of every cultural belief system.
2. Belief that such skills are impractical in that it is too time-consuming to obtain the services of interpreters.
3. Belief that the Western biomedical model is the only valid model of health care.
4. Physician/faculty inexperience.

These perceptions, and the inexperience of most physicians, have made the cross-cultural doctor-patient encounter a frustrating and unsatisfactory experience for both parties. The position taken here is that with a basic knowledge of the technique of patient-centered interviewing, relatively little additional knowledge and skills are required to perform a cross-cultural interview. This is

because of the considerable overlap of the two models: in both, physician self-awareness, willingness to relinquish power and find common ground with the patient, and appreciation of the distinction between disease and illness are central to the doctor-patient interaction.[1]

ISSUES TO CONSIDER WHEN INTERVIEWING TRANSCULTURAL PATIENTS

Health Beliefs and Practices of Physician and Patient

The doctor-patient encounter is an interaction between two explanatory models of illness (see box below). This is true even when both are from the same "culture", in that intra-cultural differences in how sickness and health care systems are viewed can be as great as inter-cultural differences. To avoid any misunderstanding, the physician must be aware of his/her own belief system, and take care not to stereotype or make assumptions about the patient's system (see Appendix 1).

The physician's model is usually disease-oriented, with the goal of determining the biologic or pathologic cause, and executing a cure of that disease process. However, while it is commonly assumed that biomedicine, as a reductionist science, is objective and neutral, dealing only with "truth" or facts, it is in fact grounded in social and cultural behaviours as are all human activities. Therefore, the physician, to be culturally sensitive, must be aware of his own assumptions about medical systems, and recognize that other systems may be equally valid for others.

The patient's explanatory model will be illness-oriented. This model is culturally determined, and provides the meaning of the sickness for the individual: how we decide that we are ill, what the reason for it at this time may be, how we cope, and when we decide we are no longer ill. While explanatory models are culturally determined, they may differ in the same individual with different illnesses, or different stages of illness. Therefore, the physician must determine the model for each illness episode for each patient. For instance, a patient may have a relatively biomedical approach to a sickness episode until the stress of end of life issues results in a reversion to original values and traditions.

The physician can determine the patient's explanatory model, at least in broad terms, by asking a few additional questions during the interview:

Determining a Patient's Explanatory Model of Illness

1. What do you call this illness? What do you think caused it?
2. Why did it happen at this time?
3. How does the illness work in you? What does it do to you?
4. How bad is it? How long do you think it will last?
5. Do you think treatment will work for it?
6. What kind of treatment do you think you should have?
7. Have you tried any other treatments already?

These questions cover the major issues of concern to the physician: etiology, pathophysiology, course, and treatment. Neither the physician's nor the patient's model is sufficient by itself. Both are needed for culturally sensitive, patient-centred care. Having ascertained some knowledge of the patient's model, the physician can determine if treatments previously or concurrently used by the patient are beneficial, harmful, or neutral. The physician's model can be explained to the patient, and negotiation of a shared understanding of the illness and treatment plan is begun.

Socio-Economic Status and Support Systems

Many patients come from "high-context" cultures, in which the family and community are much more involved in the individual's illness episode than occurs in the more "low-context" societies of Europe and North America (see Appendix 2). This has implications for how the physician deals with issues such as consent, confidentiality, and where treatment should be given. The following information should be obtained:

1. Family structure.
2. Decision-making process (patient may not make them).
3. Size of community/resources (confidentiality may be an issues in small groups).
4. Educational background and current status.

Language

The physician needs to assess the patient's fluency in English, if the patient is communicating without an interpreter. Fluency can be quite adequate in individuals with strong and difficult

accents. Conversely, patients may seem fluent, but understanding is found lacking when they are asked to repeat back an explanation or instruction. Many patients will nod or indicate agreement out of respect or embarrassment, even when they don't understand. Use of language, even in fluent individuals, may cause misunderstanding. Rules of grammar from the traditional culture may make a person seem vague and indecisive. The physician's use of idiomatic expressions may baffle a person not well grounded in English (e.g. the use of "cold turkey" in discussing smoking cessation).

Physiologic Variation

Patients of certain genetic backgrounds may be peculiarly susceptible to certain illnesses, some of which may be precipitated by the unwary physician. Culturally determined dietary practices are among the most common features of patients' explanatory models, but many of these practices are well founded, and should be respected. For instance, lactose intolerance is common among many Asian and African people, and therefore their avoidance of the ubiquitous milk on the hospital tray is understandable. Even body size should be remembered in prescribing. Many Asian adults are small and tolerate usual drug doses poorly.

Acculturation

Canada has made an explicit effort to encourage acculturation, not assimilation, as in the United States. Therefore, as people integrate new cultural norms, they will retain their traditional values and beliefs in varying degrees. This is one reason why each illness episode has to be explored for different explanatory models. The degree of acculturation can be assessed by obtaining the following information:

1. Similarity of primary culture (not necessarily country of origin).
2. Age at immigration and length of time in Canada.
3. Degree of interaction with the new, or other cultures.
4. Experience of and understanding of the Canadian health system.
5. Level of education; rural or urban background.
6. Language fluency.

WORKING WITH INTERPRETERS

It is essential that the doctor-patient encounter fully explore all of the medically and culturally important issues as described above. Therefore, interpreters are often critical participants in the interview. If the problem is not urgent, it is preferable to postpone the interview until the services of a cultural or professional interpreter can be obtained. This is time-consuming, often frustrating, but well worth the effort in the quality of information that is obtained. Family members should be avoided unless absolutely necessary, since they, or the patient, may editorialize extensively, thus greatly reducing the amount and accuracy of the information transmitted both from and to the patient. Probably one of the major reasons for substandard immigrant health care is the failure of physicians to take the time to work with interpreters to make sure that adequate communication is taking place.

Teaching students the technique of working with an interpreter in a triadic interview is simple, and requires only a little practice. The major points are:

1. Ascertain the interpreter's qualifications. If a trained professional is available, they probably need no instructions or reminders about confidentiality or the process of triadic interviewing. They will also be capable of culturally interpreting the patient's meaning, which saves time. If it is a non-professional, such as a hospital employee who speaks the same language, you will need to explain the process more thoroughly.

2. Brief the interpreter with what information you have about the situation, and how you wish to proceed. Remember that not all medical employees are familiar or comfortable with the medical encounter, particularly in acute situations.

3. In the interview, speak to the patient, with the interpreter translating exactly what is said by both parties. Brief sentences will allow the interview to proceed more quickly than if complex ones are used.

4. If it is necessary to deal with a family member, ask them not to edit, but be alert for signs that information is not being translated accurately (e.g. a long conversation in their language, followed by a short answer to you).

CURRICULUM DESIGN MODEL

Skills in cross-cultural interviewing are best taught and evaluated as a required component of medical school clinical methods courses. In this manner, such skills are considered on par with more traditional skills in clinical interviewing and physical examination. The challenge for curriculum planners is translating these new skills objectives into the traditional and time tested design of clinical methods courses - the small group, clinical bedside teaching model.

THE ASCM MODEL

The Art and Science of Clinical Medicine course (ASCM) emphasizes skills in patient-centred interviewing. In the course's second year, advanced skills in patient-centred interviewing are taught. Cross-cultural interviewing skills are considered one component of these advanced skills. One four-hour clinic is devoted to skills in cross-cultural medicine. Three skills objectives have been selected: 1) culturally sensitive interviewing, 2) triadic interviewing, and 3) the "anthropological research" method (Mull 1993). The ASCM Cross-Cultural Committee adopted these objectives subsequent to extensive consultation with local experts in cross-cultural medicine. The first two objectives are skills generic to all cross-cultural clinical encounters. These objectives are taught at the bedside. The third objective introduces students to a method of inquiry for obtaining the cultural health beliefs, practices, etc. of patients. This objective is taught by means of a small group seminar.

ASCM employs generic clinical teachers for the majority of clinical skills teaching. This provides for consistency in the teacher/student relationship throughout the academic year. For clinical skills not routinely practiced and/or taught by these teachers, specialists (either medical or non-medical) facilitate a lecture before the clinical bedside teaching component. This lecture provides a forum for the specialist to review the background material necessary for students and clinical teachers to proceed with the bedside teaching to follow. In the ASCM cross-cultural medicine clinic, non-medical hospital staff and university faculty (nurses, social workers, and

psychologists) primarily fulfill this specialist role. Topics covered in this lecture are listed in the box below.

Cross-Cultural Medicine

Suggested Topics:

1) Cross-Cultural Medicine
   - Case vignettes demonstrating various cultural health beliefs, practices, etc.
2) Culturally Sensitive Interviewing
   - Questions for patient
   - Questions for oneself
   - Questioning techniques
3) Cultural Interpreters
   - Interpreter availability
   - Confidentiality issues
   - Working with interpreters
4) Triadic Interviewing
5) Anthropological Research

The bedside teaching component which follows requires planning by each generic clinical teacher. Prior to the clinic, a patient in which cultural factors are pertinent to the illness presentation and, where appropriate, a cultural interpreter are invited to participate. Optimally the patient selected should require a cultural interpreter. In this manner, both skills in cross-cultural interviewing and triadic interviewing can be practiced with teacher supervision, and students can receive feedback regarding their performance. ASCM requires one appropriate patient and cultural interpreter per clinic group of six students. For clinic groups using a cultural interpreter, time must be devoted to briefing/debriefing with the cultural interpreter. The bedside teaching component and briefing sessions are estimated to require 1¾ hours.

A "selected readings" seminar is the final component of this clinic. These readings outline clinical case examples of cross-cultural medicine for discussion. In addition, faculty and students themselves represent a vast array of cultural groups. Each clinic group is to undertake some "anthropological research"; teachers are to discuss relevant clinical experience and both teachers and students are to discuss health beliefs, practices, etc. they believe unique to their own culture.

This task may demonstrate to students their own contribution to the cross-cultural medical encounter.

The ASCM cross-cultural medicine clinic schedule is as follows:

Lecture: Cross-Cultural Medicine (Facilitated by cross-cultural medicine specialist.) (all clinic groups together) 1 hour	Brief the interpreter (individual clinic groups) 15 minutes	Interview patient with interpreter. Clinical teacher observed interview (individual clinical groups) 45 minutes	Review of patient's condition and interview process with clinical teacher and interpreter (individual clinic groups) 45 minutes	Break 15 minutes	"Selected Readings" Seminar with clinical teacher (individual clinic groups) 1 hour

TEACHING MATERIALS AND RESOURCES

Coordinating a clinical bedside teaching experience in cross-cultural interviewing is a significant undertaking. This clinic does not lend itself to last minute preparation on the part of clinical teachers. Specific teaching materials and resources can contribute to the success of this endeavour.

The majority of medical teaching faculty have had limited experience in the bedside teaching of these skills to junior medical students. The task is made simpler by providing detailed teaching materials outlining educational objectives, pertinent background material and selected readings. These materials should be provided not only to faculty but to students well in advance of the clinic day. In this manner, all students and faculty are cognizant of educational objectives and teaching methodology. Non-medical teachers (interpreters and lecturers) require not only these materials but "information" meetings describing 1) the place of this clinic within the medical course, 2) the nature of clinical bedside teaching, and 3) their teaching role.

A faculty development video has been developed by the ASCM Cross-Cultural Committee. This video demonstrates a mock bedside teaching session in both cross-cultural interviewing skills

and triadic interviewing skills. To demonstrate the value of this educational initiative for junior medical students, testimonials from senior medical students attesting to its need are included.

This clinic puts a significant demand upon clinical teachers regarding patient recruitment. To alleviate this demand somewhat, the ASCM Cross-Cultural Committee is coordinating development of a pool of multicultural standardized patients (SPs). This SP pool possesses great teaching potential. SPs can substitute for real patients if real patient availability or teaching appropriateness is uncertain. SPs have proven to be a valuable tool for introducing clinical skills to junior medical students and we assume this educational value extends to the teaching of cross-cultural clinical skills. Our assumption, however, awaits more specific investigation. This SP pool will be available to all courses at the University of Toronto, Faculty of Medicine (see Appendix 3).

STUDENT EVALUATION

Student evaluation is important to the success of any educational endeavour. The OSCE format is employed to evaluate student skills in cross-cultural interviewing and triadic interviewing. (For more specific details see OSCE section of this manual.) The enlarged pool of multicultural SPs is available for all OSCE stations, not only those testing cross-cultural skills. In this manner, the SP population available for clinical examinations in ASCM and other medical courses will more realistically portray real patient populations.

IN SUMMARY

CURRICULUM DESIGN CHECKLIST	
1.	Secure course time commitment.
2.	Consult with local specialists in cross-cultural medicine. Identify skills objectives for course.
3.	Review course teaching methodology: • bedside teaching • seminars • lectures
4.	Match skills objectives with appropriate teaching methodology.
5.	Identify curriculum components requiring participation of non-medical teachers.
6.	Develop and select teaching materials/resources to support both clinical and non-medical teachers.
7.	Recruit non-medical teachers and orient them to their role.
8.	Develop and implement student evaluation methods: OSCE format preferred.

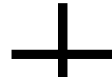
9.	Course evaluation: • by students • by faculty

A GUIDE FOR WRITING A CROSS-CULTURAL OSCE CASE

AUTHOR (S):
____

This guide was originally prepared for the Undergraduate Education Committee, Department of Family and Community Medicine, University of Toronto. It has been modified to include cross-cultural considerations for case writing.

You may want to consult the opposite page before you begin to create your scenario. This matrix is not exhaustive but it will help you choose various aspects of cross-cultural interviewing to include in your scenario. You will probably choose only 1 point from each category.



Whenever possible, develop your station from a real patient problem that has occurred in the ambulatory, emergency room word, or any other appropriate setting.

λ STATION NAME: ____

λ CORE CLINICAL FUNCTION:
- o explanatory model of illness
- o strategies used to access health care system
- o the healing encounter
- o dealing with outcomes
- o other ___________________________________

λ TYPE OF INTERVIEW:
- o diadic
- o triadic

λ CHOICE OF INTERPRETER:
- o professional
- o non-professional
- o family member
- o non-family member
- o no interpreter (same language)
- o no interpreter (different language)
- o other ___________________________________

λ SAMPLE TOPICS FOR SCENARIOS:
- o intergenerational tension
- o diet
- o religion
- o stereotyping
- o compliance
- o MD culture (e.g. patient only wants to see staff doctor)
- o end of life issues
- o autonomy
- o other ___________________________________

λ TECHNIQUES REQUIRED:
- o working with an interpreter
- o cross-cultural interviewing
- o triadic interviewing
- o awareness of cultural context of both MD and patient
- o negotiation
- o physical examination
- o other ___________________________________

λ TYPE OF PATIENT ENCOUNTER: (e.g. follow-up, new patient, emergency, etc.)

____

λ TYPE OF ENCOUNTER: (e.g. office, out-patient clinic, etc.)

____

λ PATIENT DEMOGRAPHICS:

- age range (please provide as broad a range as possible) ______________________
- sex (if this is not critical please circle 'either') M F either
- socioeconomic level (to be simulated) ______________________
- educational background (to be simulated) ______________________

λ DESCRIPTION OF PATIENT: (e.g. body build, weight)

____

λ CULTURAL INFORMATION:

- Country of origin ______________________
- Reason for emigration (choice vs refugee) ______________________
- Experience with Canadian health care system______________________
- Interaction with major culture ______________________
- Concept of time and space (will they show up on time) ______________________
- Length of time in Canada______________________
- Age when arrived in Canada ______________________

λ PATIENT’S SUPPORT SYSTEMS:

- Family structure and availability of care at home.

____

- View of authority

____

- Decision making process (autonomy vs family)

____

- Community resources (appropriate culturally and linguistically)

____

λ THE PATIENT’S EXPLANATORY MODEL OF ILLNESS:

- What name does the patient have for their problem?

____

- What does the name mean? What does the illness mean?

____

- What is the patient’s cultural explanation of the medical problem?

____

- What cultural remedies exist for the patient’s problem?

____

- What are the patient’s perceptions of Western medicine?

____

- What is the patient doing in terms of treatment?

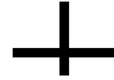
____

- What are the patient’s expectations?

____

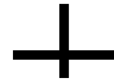
PATIENT'S AGENDA

Why has the patient come to see the doctor now? What does the patient (really) want? The patient's agenda might never be verbalized to the candidate but provides a critical framework to guide SP responses, e.g. patient is fed up with pain and wants relief; patient fears surgery and hopes that pills will suffice; patient believes problem must be cancer; patient believes problem is minor, etc.



PATIENT BEHAVIOUR

Indicate how the patient feels about his/her illness and how that is manifested in the encounter. What is the general emotional "tone" the patient should display? Provide us with information about the patient's attitude toward the medical interview (he/she is actively seeking help, is reluctant, or is hostile to encounter) and what questions or behaviour on the part of the candidate will trigger a change in behaviour of the patient.



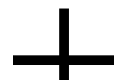
QUESTIONS / CHALLENGES

This will allow us to standardize the patient presentation. Some examples of these are:

"Why do I have to take the pills?"
"Am I going to die?"
"Will I be able to keep on working with this?"
"I need something for pain right now."

or

"I don't want to be in the hospital. I want to go home."



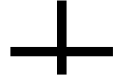
λ **PATIENT'S AGENDA**

λ **PATIENT BEHAVIOUR**

λ **ANY QUESTIONS PATIENT WILL CONSISTENTLY ASK, OR CHALLENGES THAT PATIENT WILL PRESENT TO CANDIDATE**

DESCRIPTION OF THE CASE

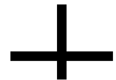
CHIEF COMPLAINT



This should be very brief and described in the patient's own words.

HISTORY OF THE PRESENT ILLNESS

Please include answers to all applicable items.



Please provide enough detailed information …

1. Terms such as "occasionally," "frequently," or "a few days" need to be defined. Patients need responses, which specify dosages, duration of symptoms and similar information.

2. Descriptions of pain should include a rating on a 1 to 10 scale. "Right upper quadrant pain" is not clear enough. The nature of the pain should be provided (e.g. sharp/dull, intermittent, lasts for only 3-5 minutes at a time, etc.).

Please use terms or phrases used by real patients you have seen.

PATIENT HISTORY

CHIEF COMPLAINT

HISTORY OF THE PRESENT ILLNESS
Onset
Duration
Progression
Frequency
Location
Radiation
Quality
Intensity
Alleviating factors

HISTORY OF THE PRESENT ILLNESS (continued)
Aggravating factors
Precipitating event(s)
Temporal/environmental/physical considerations
Prior episodes
Associated symptoms
Current medications

RELEVANT PAST MEDICAL HISTORY
Past illness(es)
Past medications
Hospitalizations
Allergies
Accidents/injuries

RELEVANT SOCIAL HISTORY and RELEVANT FAMILY HISTORY

Please provide enough detailed information …

1. Specify the nature of occupation, parents' health, and lifestyle information that is relevant to the problem. The information given to SPs must go beyond what is given on the examiner's checklist.

2. Provide information about family members. Describing the patient's brother as hypertensive should be expanded to include details of how long, how managed (e.g. pills). Whatever the patient would reasonably know about her brother's health should be provided.

… but not too much!

3. Too many details in the peripheral elements of the case create needless memory work for SPs. Names of siblings, birth dates, or employment details are usually left for trainers and SPs to work out. Two good descriptions of employment are "a high pressured office position" or "involves lifting and carrying."

4. If the patient's past medical history and family history are not relevant to the problem, state this. Do not make up an interesting background for the SP.

RELEVANT SOCIAL HISTORY
Marital status
Living environment (where & with whom)
Habits (drugs, alcohol, tobacco, etc.)
Work (type, environment, exposures)
Sexual history
RELEVANT FAMILY HISTORY
Parents
Siblings
Other relevant family members

CRITICAL REVIEW OF SYSTEMS		
	PERTINENT POSITIVES	PERTINENT NEGATIVES
HEENT		
Skin		
Hematopoietic/lymph		
Respiratory		
Cardiovascular		
GI		
Genito-urinary		
Menstrual/reproductive		
Endocrine		
Musculoskeletal		
neurological		

CRITICAL REVIEW OF SYSTEMS		
	PERTINENT POSITIVES	PERTINENT NEGATIVES
Psychiatric		
Other (sleep, energy, sense of well-being, etc.)		

HISTORY CHECKLIST

1. The checklist must be coordinated with the SP script.

2. Each assessable/observable item should be a separate item on the checklist.

3. Checklist items need to be clearly written. Sometimes guidelines for scoring need to be incorporated (see examples below).

THE STUDENT:	DONE CORRECTLY	NOT DONE CORRECTLY
1. asks about associated symptoms of chest pain (e.g. sweating, dizziness, nausea, vomiting, SOB, etc.) … asking about any 3 symptoms gets full marks …	2	0

THE STUDENT:	DONE CORRECTLY	NOT DONE CORRECTLY
1. elicits information as to cultural remedies for diabetes.	1	0

4. It is possible to assign a relative weight to each item by specifying how many marks it is worth.

HISTORY CHECKLIST

THE STUDENT:	DONE CORRECTLY	NOT DONE CORRECTLY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		

PHYSICAL EXAM CHECKLIST

It is important to inquire into any cultural considerations such as gender issues or religion that may create a barrier or sensitivity to physical examination.

Items you may want to consider for physical exam checklist:

- appropriate exposure and draping
- inspection
- palpation
- percussion
- auscultation
- ROM
- reflexes
- specific manoeuvres

The patient's responses to various manoeuvres or tests, even if they are not on the checklist, need to be included. Specify how a symptom affects the patient's movement when not being examined (such as how back pain might affect patient's ability to get out of a chair).

Include detailed descriptions of physical findings to be simulated. A diagram can be very helpful. For instance, saying the patient limped is not enough, as there are many ways to limp. Describe the mechanics of the limp or provide graphic description such as "patient walks as if there is a stone in the heel of his shoe."

PHYSICAL EXAM CHECKLIST

THE STUDENT:	DONE CORRECTLY	NOT DONE CORRECTLY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		

INSTRUCTIONS TO STUDENT:
RELATIONSHIP TO PATIENT

The relationship of the student to the patient must be clearly stated. For example:

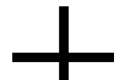
> *"You are a clerk in the Family Practice Clinic. You are about to see a new patient to the clinic. She is a newcomer to Canada and speaks little English."*

INSTRUCTIONS TO STUDENT:
OPENING SCENARIO

The problem that the candidate is required to deal with must be stated in a clear and concise way. For example:

> *"This woman has come to your office complaining of shortness of breath."*

or *"This patient was brought to the ER by ambulance after falling from a scaffold. He is conscious and complains of severe back pain."*



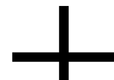
INSTRUCTIONS TO STUDENT:
STUDENT'S TASK

The task that the candidate is required to perform must be stated in a clear and concise way. A time limit must also be given. This time limit is 10 minutes for a history station, and 5 + 5 minutes for a combined history/physical station. For example:

> *"Obtain a focused and relevant history. You have 10 minutes to complete this task."*

or *"Explore this patient's explanatory model of illness. You have 10 minutes to complete this task."*

or *"Take a relevant history of this man's complaint. You have 5 minutes to complete this task. Then, do a focused physical examination relevant to this patient's history. <u>Describe to the examiner what you are doing and your findings.</u> You have 5 minutes to complete this task."*



λ INSTRUCTIONS TO STUDENT: OPENING SCENARIO

λ INSTRUCTIONS TO STUDENT: STUDENT'S TASK

EQUIPMENT REQUIREMENTS

e.g. cervical collar
IV set up
NG tube
simulation makeup
reflex hammer
BP cuff
X-ray view box
etc.

POST ENCOUNTER PROBE (PEP)

1. The PEP should be linked to the specific patient problem the candidate has just seen.

2. The length of the PEP must be appropriate for the time allotted (5 minutes).

3. If questions rely on a prop (e.g. an X-ray), these should be supplied by the author.

4. Be aware of a PEP's structure. Does an X-ray inadvertently provide the answer to more than one question?

5. Does the answer key supply all the likely answers, including those which are only worth a zero (e.g. must the answer be "colon cancer" or will "cancer" suffice?).

CROSS-CULTURAL OSCE STATION BLUEPRINT

STATION NAME:	**Mrs. Chan Isn't Taking Her Medication**
ISSUE:	Cross-Cultural Interviewing
PRESENTING SITUATION:	Mrs. Ruth Lee has come to discuss concerns about her mother Mrs. Chan. Mrs. Chan is not taking the medication prescribed for her diabetes.
ACTIVITIES:	Patient encounter
TIME REQUIRED:	10 minutes

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Dr. M.L. Russell (416) 340-4832

For additional SP training information please contact: Anja Robb (416) 978-3465

INSTRUCTIONS TO CANDIDATE

You are doing a locum for a family physician who is away on maternity leave. You are about to see **Mrs. Ruth Lee** who has come to discuss concerns about her mother Mrs. Chan. Mrs. Chan is not taking the medication prescribed for her diabetes. As Mrs. Chan does not speak English she has given her daughter permission to act as her advocate in health matters and to consult with you today.

CHECKLIST ITEMS

The Candidate:		YES	NO
1.	elicits information concerning Mrs. Chan's present medical status		
2.	elicits information as to Mrs. Chan's diet.		
3.	elicits cultural explanations of diabetes.		
4.	elicits information as to specific cultural remedies for diabetes.		
5.	asks if Mrs. Chan is using any of these specific cultural remedies.		
6.	elicits Mrs. Chan's perception(s) of Western medicine.		
7.	elicits information as to why Mrs. Chan does not take her medication for diabetes.		
8.	elicits Mrs. Lee's concerns about her mother's compliance with treatment for diabetes.		
9.	elicits information as to the nature of family conflict between Mrs. Lee and her mother Mrs. Chan.		
10.	elicits information as to other family, friends or community support(s) that Mrs. Chan could consult concerning her diabetes.		
11.	elicits information as to the differing opinions that Mrs. Lee and Mrs. Chan have in regard to Western medicine and traditional medicine.		
12.	suggests a subsequent family meeting with a medical interpreter.		

GLOBAL RATING SCALES Circle the rating which best corresponds to your judgment of the student's performance in the following 5 categories:				
1) Student's response to patient's feelings and needs (empathy).				
1 Does not respond to obvious patient cues	2	3 Responds to patient's cues, but not always effectively	4	5 Responds perceptively, genuinely, and appropriately
2) Degree of focus, logic and coherence in the interaction.				
1 Exhibits no recognition of the problem and no plan or approach	2	3 Exhibits appropriate response to the medical context, but organizational approach is formulaic and minimally flexible.	4	5 Exhibits superior judgment and organization, demonstrating both focus and flexibility with respect to the medical context
3) Non-verbal expression.				
1 Fails to engage, or frustrates and antagonizes the patient	2	3 Exhibits enough control of non-verbal expression to engage a patient willing to overlook deficiencies such as inappropriate persistence passivity or self-consciousness	4	5 Exhibits finesse and command of non-verbal expression (eye contact, gesture, posture, use of silence).
4) Overall approach to the problem.				
1 Responds inappropriately and ineffectively to the task	2	3 Responds with some logic and comprehension, but not applied consistently to the task	4	5 Responds precisely, logically and perceptively to the task, integrating all components
5) Give an overall rating of the student's performance on the station.				
☐ Unsatisfactory		☐ Satisfactory		

INSTRUCTIONS TO STANDARDIZED PATIENT

Your name is Ruth Lee. You are a middle aged married woman who came to Canada with your husband and two children seven years ago from Hong Kong. Three years ago you were able to bring your mother, Mrs. Chan, from Mainland China (Canton) to join you here. Your mother (Mrs. Chan) looks after the home and the children (who are now teenaged) while you and your husband are at work. Except for shopping in China Town and Tai Chi with a group at the community center your mother has little to do with the outside world. Your mother, who has a strong personality, is considered the matriarch of the family. There are many tensions with three generations under one roof in a new country.

Your mother was diagnosed two years ago with late-onset diabetes and was prescribed Diabeta (oral medication). You have come to the doctor to discuss your mother's reluctance to take her Diabeta medication. She does not trust the medication prescribed to her and you claim that your mother is conveniently forgetting to take it. You are well aware of the danger your mother could face in not taking the medication. You have warned your mother that injected insulin will be the next step if she does not do what she has been told. This has resulted in your mother becoming even more unwilling to trust Western medicine and is indeed reluctant to return to the family doctor. There are ongoing arguments between you and your mother because of this medical issue. Your mother is not presently sick but you are concerned that since she is not taking her medication that she might become sick. This is the reason you have come to see the family doctor today.

Your mother was sent to a dietician but the advice meant nothing to her. The dietician recommended that she cut back on rice, eat whole grain breads, increase dairy products and drink milk. Your mother just tuned out the dietician and planned to eat a traditional diet.

Your mother has her own thoughts about her medical problem (diabetes). In her culture, having diabetes means having too much sugar in the urine. She is accepting it as a rather common problem of aging - with no real stigma attached to it. Your mother does not believe in "Western" medicine. She sees it as more of a "bandaid" approach – i.e. meant more to control than to cure. With doctors she is "pseudo" compliant but really she would rather look to traditional remedies which she believes are more beneficial. Those remedies rely heavily on eating a proper diet which includes special tea, (fresh killed) chicken with lime soup that is cooked for a very long time, and mushrooms (which look small and roasted). She also does specific exercises involving circling the arms in reverse, as well as Tai Chi to enhance the flow of "chi" (life energy). She is very inconsistent about checking her urine for sugar (with chem-strips).

Prompts are used to standardize the scenario and give all candidates an opportunity to address relevant issues.

PROMPT I: Early in the scenario, the standardized patient (Mrs. Lee) should bring out the fact that Diabeta is an oral medication and insulin is an injectable medication so that medical students do not become worried about specific medication issues of which they are unfamiliar.

PROMPT 2: The standardized patient (Mrs. Lee) should present her mother's medical condition as presently stable but that she is worried that it will become unstable since her mother is not taking her medication (i.e. her mother is not presently sick but she is worried that she could become sick).

PROMPT 3: The standardized patient should emphasize the conflict that has arisen between herself and her mother because of differing cultural expectations regarding the medical treatment for diabetes.

CROSS-CULTURAL OSCE STATION BLUEPRINT

STATION NAME:	**Mrs. Chan Isn't Taking Her Medication**
ISSUE:	Cross-Cultural Interviewing / Triadic Interviewing
PRESENTING SITUATION:	Mrs. Chan is not compliant with her medication for diabetes. Her daughter is concerned and forced her to come to the doctor today. Mrs. Chan does not speak English so there is an interpreter in the room with her.
ACTIVITIES:	Triadic Interview
TIME REQUIRED:	10 minutes

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Dr. M.L. Russell (416) 340-4832

For additional SP training information please contact: Anja Robb (416) 978-3465

INSTRUCTIONS TO CANDIDATE

You are doing a locum for a family physician who is away on maternity leave. You are about to see **Mrs. Chan.** Mrs. Chan's daughter called the office to say that her mother is not taking the medication prescribed for her diabetes. The daughter made this appointment but could not accompany her mother today. Mrs. Chan does not speak English so an interpreter is present in the examination room. Explore Mrs. Chan's cultural beliefs about her illness and treatment.

CHECKLIST ITEMS

The Candidate:		YES	NO
1.	CROSS-CULTURAL CHECKLIST elicits cultural explanation for causation of diabetes		
2.	elicits any special name diabetes has in patient's culture		
3.	elicits information as to cultural remedies for diabetes		
4.	clarifies if patient is using any of these cultural remedies		
5.	elicits any patient concerns regarding Western medical care of diabetes		
6.	clarifies if patient's family should participate in treatment planning for her		
7.	TRIADIC INTERVIEW CHECKLIST introduces self to interpreter		
8.	introduces interpreter to patient		
9.	clarifies interpreter status (i.e. family member, professional or non-professional interpreter)		
10.	explains to interpreter his/her approach to an interview using an interpreter		
11.	clarifies interpreter's knowledge of patient's condition		
12.	sits or stands face to face with patient and beside the interpreter		
13.	addresses patient (not the interpreter) when asking questions		
14.	asks interpreter about patient's emotional state		

GLOBAL RATING SCALES
Circle the rating which best corresponds to your judgment of the student's performance in the following 5 categories:

1) Student's response to patient's feelings and needs (empathy).

1	2	3	4	5
Does not respond to obvious patient cues		Responds to patient's cues, but not always effectively		Responds perceptively, genuinely, and appropriately

2) Degree of focus, logic and coherence in the interaction.

1	2	3	4	5
Exhibits no recognition of the problem and no plan or approach		Exhibits appropriate response to the medical context, but organizational approach is formulaic and minimally flexible.		Exhibits superior judgment and organization, demonstrating both focus and flexibility with respect to the medical context

3) Non-verbal expression.

1	2	3	4	5
Fails to engage, or frustrates and antagonizes the patient		Exhibits enough control of non-verbal expression to engage a patient willing to overlook deficiencies such as inappropriate persistence passivity or self-consciousness		Exhibits finesse and command of non-verbal expression (eye contact, gesture, posture, use of silence).

4) Overall approach to the problem.

1	2	3	4	5
Responds inappropriately and ineffectively to the task		Responds with some logic and comprehension, but not applied consistently to the task		Responds precisely, logically and perceptively to the task, integrating all components

5) Give an overall rating of the student's performance on the station.

☐ Unsatisfactory ☐ Satisfactory

INSTRUCTIONS TO STANDARDIZED PATIENT

Mrs. Chan emigrated from Mainland China (Canton) to join her daughter's family 3 years ago. Mrs. Chan looks after the home and the children (who are now teenaged) while her daughter and son-in-law are at work. Except for shopping in China Town and Tai Chi with a group at the community center Mrs. Chan has little to do with the outside world. Mrs. Chan has a strong personality and is considered the matriarch of the family. There are many tensions with three generations under one roof in a new country. Her daughter and son-in-law are assimilating to "Western" culture and the teenaged children are even more reluctant to follow traditional Chinese ways.

Mrs. Chan was diagnosed two years ago with late-onset diabetes and was prescribed Diabeta (oral medication). Mrs. Chan is reluctant to take her Diabeta medication. She does not trust the medication prescribed to her and is conveniently forgetting to take it. Mrs. Chan's daughter is well aware of the danger Mrs. Chan could face in not taking the medication. Mrs. Chan has been warned that injected insulin will be the next step if she does not do what she has been told. This has resulted in Mrs. Chan becoming unwilling to trust Western medicine - and is indeed reluctant to return to the family doctor. There are ongoing arguments between Mrs. Chan and her daughter because of this medical issue. Mrs. Chan is not presently sick but her daughter practically forced her to see the doctor today.

Mrs. Chan was sent to a dietician but the advice meant nothing to her. The dietician recommended that she cut back on rice, eat whole grain breads, increase dairy products and drink milk. She just tuned out the dietician and planned to eat a traditional diet.

Mrs. Chan has her own thoughts about her medical problem (diabetes). In her culture, diabetes means "sugar in the urine". Having diabetes means having too much sugar in the urine. She is accepting it as a rather common problem of aging - with no real stigma attached to it. She does not believe in "Western" medicine. She sees it as more of a "bandaid" approach – i.e. meant more to control than to cure. With doctors she is "pseudo" compliant but really she would rather look to traditional remedies which she believes are more beneficial. Those remedies rely heavily on eating a proper diet which includes special tea, (fresh killed) chicken with lime soup that is cooked for a very long time, and mushrooms (which look small and roasted). She also does specific exercises involving circling the arms in reverse, as well as Tai Chi to enhance the flow of "chi" (life energy). She is extremely inconsistent about checking her urine for sugar (with chem-strips).

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APPENDICES

APPENDIX 1

CULTURAL CONSIDERATIONS

- No one has more culture or less culture than anyone else.
- The way we view the world and our understanding of "what makes sense" is based on culture.
- Culture is not fully on the conscious mind, therefore it cannot always be verbalized.
- Culture is passed from generation to generation often without being articulated.
- There is an inaccurate belief that if people do not participate directly in their cultural beliefs and traditions they are not affected by them.
- The first step with cross-cultural awareness is to understand how one's own culture works.

CULTURAL PATTERNS

LOW CONTEXT	HIGH CONTEXT
Emphasis is on the worth and fulfillment of the individual	Emphasis is on the group; individuals fill roles in the group – sometimes resistance to outsiders
Independence (highly valued)	Interdependence (valued); everyone has clearly defined functions and expectations of others
Separateness (example of separation of physical and emotional health)	Relatedness – people see themselves as related to everything else
Equality (by belief but often a myth)	Hierarchy (often male-dominated)
Gender integrated – fewer norms about sex roles	Gender separated – strong norms about male and female roles
Questions beliefs (most values are open to question)	Unquestioning belief (in traditional ways)
Secular – religion is compartmentalized	Religious – everything has a spiritual dimension or component
Time – clock-time (one hour is the same as the next and usually is assigned material value	Natural Rhythms – (do many things at once when it feels right, not when the clock says to)
Need for great deal of Space (physically and psychologically)	Little need for space

Adapted from Edward Hall, Beyond Culture, Anchora Press, Doubleday, 1977.

APPENDIX 3

STANDARDIZED PATIENTS

Being a standardized patient is hard. To be effective you must be realistic and to be realistic you must explore some pretty difficult emotions and situations on cue. The work is occasional and the hours limited to two or three for teaching, longer for exams. The pay is somewhere around $12 to $15 for simulations and $8 to train. Do the math - often it's cheaper to stay home. But people are really intrigued by the work. The real challenge is to find people who have flexible enough schedules. Generally speaking, new immigrants do not often have small blocks of time available during working hours. All that said, people who do come on board just love the work for a variety of reasons - they are making a contribution, they are actively involved in medical training, they will learn communication skills useful in everyday life, and they will meet other extraordinary, dedicated people, to name a few.

There are many possible sources for recruiting people for cross-cultural scenarios. Community organizations, professional and amateur acting associations, and E.S.L. classes are just some of the possibilities. Referral to a programme by word of mouth is probably best. That usually means someone has described what standardized patient work is all about and there is less likelihood of misconception. Physicians who work with standardized patients can also be contacted and asked to refer anyone they think would be suitable. We recently recruited a group through a high school with a large population of people from many varied cultural backgrounds. We formed a kind of partnership in education with the physical education department so that the young people who participated were introduced to our programme with a talk about protocol and professionalism using a workshop format with role playing, videos and exercises. They visited the Department of Family and Community Medicine boardroom for a lecture on working with a medical interpreter. Everyone found it to be a very enriching experience. The students not only earned a credit in physical education but were also well prepared for standardized patient work.

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APPENDIX 4

NOTES ON THE SCENARIOS DEPICTED IN THE MANUAL AND SHOWN ON THE VIDEO

We used the same basic scenario about a Cantonese woman with diabetes to develop the two OSCE cases depicted in the manual and shown on the video ("Mrs. Chan isn't taking her medication"). In the first scenario, the task was to explore Mrs. Chan's cultural beliefs about her illness by interviewing Mrs. Chan's daughter who speaks English. In the second scenario, the focus shifts from a diadic cross-cultural interview to a triadic interview including an interpreter. Using the same basic information about the patient and her illness we created two cases with very different evaluation criteria. By utilizing other options on the matrix (shown on page 15 of this manual), even more scenarios may be possible.

The two interviews were not meant to be perfect but more to illustrate an interaction and to stimulate discussion. Interestingly, 45% of the medical students at the University of Toronto are from non-Canadian backgrounds making it very likely that doctor and patient will come from different cultures. For example, the scenarios on the video show a Lithuanian doctor caring for a Cantonese patient.

We are in the process of producing a compilation of cross-cultural vignettes on video, with an accompanying manual, which can be used for teaching and evaluation. We would greatly appreciate hearing from anyone with a cross-cultural scenario they think would be useful for this purpose.

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