Original Research Paper

Transferring a medical curriculum to Malaysia

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Abstract

Objective: To explore the cultural challenges that emerge when delivering part of a Western medical curriculum (communication skills) in Malaysia and to generate possible solutions. The franchise of Western higher education programmes to the East is a growing phenomenon, yet there is a scarcity of discourse around curricular transfer.

Methods: This was a qualitative, explorative, study drawing from the tradition of ethnography. Data collection included: participant observation, semi-structured interviews and focus group discussions. Thematic analysis followed Spradley's ethnographic technique of domain, taxonomic, componential and cultural analysis.

Results: Thirty eight cultural themes emerged relating to three levels of challenge to teaching communication skills in Malaysia: Practical challenges, implementation challenges and deeper concepts. The practical level covered linguistic, translation and teaching material issues. The implementation level related to the challenge of implementing the taught communications skills (CS) into busy Malaysian clinical practice and clear differences in expectations of the doctor-patient consultation. Finally, more complex challenges to CS teaching emerged related to behavioural, emotional and cultural concepts.

Conclusions: A novel conceptual framework classifying the challenges and offering potential solutions to CS teaching at NUMed has emerged based around three levels: Practical challenges including the 'localising' of content and contextual components of the course. Implementation challenges that highlight contextual differences that require further exploration within the Malaysian and other resource-limited contexts. Deeper challenges that require local in-depth discussion and international study. This original conceptual framework addresses the complex issue of transferring curricula to cross-cultural contexts, facilitates further critical research and informs practice.

Key words: Communication skills; curriculum transfer; internationalisation

Background

In response to an invitation from the Malaysian Ministry of Health, Newcastle University (NU) medical school, in the North East of England, opened an international campus in Malaysia in 2011 providing a programme of study identical to Newcastle's UK-based provision (http://www.ncl.ac.uk/numed/).

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This transnational education, in which learners are located in a country different from the awarding institution (Huang, 2007), is a relatively new phenomenon, although not uncommon during the colonial era, and is one component of the globalising agenda of medical education. The trend can also be seen in initiatives such as the 'Global Standards for Quality Improvement' proposed by the World Federation of Medical Education, the internationalisation and migration of medical students and the medical workforce and the rise of international medical education conferences (Harden, 2006; Karle, 2006). However, globalisation of medical education has exposed two opposing views and theoretical perspectives. Neo-institutionalists, who take a sociological view of institutions and would stress their similarities, argue for the

importance of the internationalising and standardising of the quality of medical education quoting academic, humanitarian and economic benefits (Karle, 2006). In contrast, those with a culturalist perspective who would emphasise the cultural differences across societies, have pedagogical, homogenisation and cultural imperialistic concerns (Hodges *et al.,* 2009; Bleakley *et al.,* 2011). This fundamental lack of accord is concerning for medical educators undertaking similar initiatives. Although there is increasing financial pressure and resultant expansion for Western universities to participate in transnational education (Huang, 2007), there is a lack of literature exploring this process and many have suffered due to programme failure and recipient resistance (Kanu, 2005).

Communications Skills teaching

Communications skill (CS) teaching has become a core essential within medical curricula in Western medical education (Silverman, 2005; Brown, 2010). However, the evidence for its effectiveness is based on studies almost exclusively from English-speaking countries in Western contexts. Proponents of the neo-institutionalist view promote global standardisation of the teaching of CS and international consensus statements have been proposed (Makoul & Schofield 1999; Karle, 2006). In contrast, culturists argue that cross-cultural educational research has demonstrated epistemological differences in conceptions of learning between cultures, such as differences in culture-related ways of learning (Stigler & Hiebert, 1998), student preferences (Apfelthaler *et al.,* 2002) and learning styles (Joy & Kolb 2009). Cultural studies demonstrate consistent, empirical differences between cultures, which may influence the teaching of medical education (Hofstede, 2001). A useful framework highlighting the differences that cultural influence has on academic learning between the East and West is the Confucian-Socratic model (Tweed & Lehman 2002). In this model, Eastern Confucian learning values effort, respect, pragmatic learning and behavioural reform. Conversely, Western Socratic learning values questioning of knowledge, evaluation of other's beliefs and the generation of new hypotheses.

Published research into the implementation of CS teaching in non-Western contexts is limited. A key component of CS teaching is the doctor-patient relationship and there are clear cultural factors influencing doctor-patient communication (Schouten & Meeuwesen 2006). Claramita (2011) studied doctor-patient communication in Indonesia suggesting challenges in transferring Western models are due to differences in social hierarchy, limited autonomy of social members and the use of traditional medicine. Evaluation studies of CS teaching in Asia have been reported but culture or cultural difference have been rarely addressed (Chandratilake *et al.,* 2012). The establishment of NU medical school in Malaysia provided a unique opportunity to study the transfer of CS teaching and learning in its earliest phase. An understanding of the cultural issues involved in teaching a Western CS curriculum in a non-Western context will inform CS teaching by NU, other international medical facilities and other health care professions.

Methods

The study was a qualitative, explorative study from a post-positivist epistemological stance. The phenomena under study were the cultural issues that emerged when delivering the CS curricula at NUMed, which were identified from the perspectives of an observer, teachers and students. A critical ethnographic approach was taken, integrating critical theory and a post positivist paradigm into ethnography (O'Brien, 1993; Madison, 2011) fitting with the epistemological perspective of the study.

Data collection

After institutional ethical approval and with funding from ASME (Association for the Study of Medical Education) the lead author travelled to Malaysia performing three sets of data collection: student observation, staff interviews and student focus groups. First, student observations were completed (n=3). A CS lecture (one hour) including the entire year cohort and two small group tutorials were observed (2 hours each). This teaching occurred early in year one and was selected as it is a central component of CS (Silverman *et al.,* 2005) and is an early session so might more clearly highlight cultural factors as students are still very early in their course. Field notes were kept, recording specific and focussed observations and discussions witnessed relevant to the research question (Spradley, 1980). All CS teachers were interviewed, (n=5, averaging 45 minutes) and two focus groups of volunteer students (n=5, n=8) were facilitated by the author. Interviews and focus groups were recorded using digital recording equipment, transcribed by an independent company and scrutinised for accuracy. All

interviewees were staff employed by NU Med; two were Malaysian and three were British and all five were Western trained.

Data Analysis

A cultural domain analysis was undertaken (Spradley, 1979). All three data sets were combined and analysed using a systematic approach meticulously following Spradley's (1979) four steps: Firstly, a systematic search of each data source for cultural domains (domain analysis), defined by Spradley as a "category of cultural meaning" (Spradley, 1979). Secondly, semantic relationships of components of each domain were explored and listed (taxonomic analysis). Thirdly, the data was searched for the attributes of terms in each domain (componential analysis). Finally the theme analysis entailed mapping out the domains and their components to conceptualise the emerging themes, searching across data sources for similar and contradictory findings. Groups of cultural themes were explored together within overarching organising domains.

Rigour

Rigour was sought through a number of standard qualitative techniques (Mays & Pope 2000). Triangulation of data and methods, respondent validation of the teachers interviewed, a clear audit trail, researcher reflexivity throughout data collection and analysis, and deviant case analysis. Reliability and 'accuracy' were addressed as the data analysis was reviewed by a second researcher.

Results

Thirty eight cultural themes emerged from the final analysis and were grouped logically into three levels of challenge to CS teaching: Practical challenges, implementation challenges, and deeper concepts.

Practical challenges

A number of challenges that appeared to be of a practical nature were highlighted: For example, language issues and teaching material:

> "*Obviously language is a barrier for some of the students"* (Interviewee 2)

Language was a widely known and accepted difficulty noted by all participants affecting many aspects of CS learning and it appeared to be a given that language was a significant problem. Participants highlighted the use of expressions, nuances, pronunciation, comprehension, who can speak to who in which language, expressing emotions, difficulty in examinations and the use of translators.

Participants commented upon aspects of the CS teaching content that "*doesn't sort of translate"*, including cultural references in the lecture, video clips and pictures

Implementation challenges

Cultural themes emerged related to the clinical challenges and actual implementation of CS into practice. 'Campus life' was contrasted to 'real life': There were perceived differences between the *"ideal"* world (of teaching CS on the NUMed campus) and the *"real"* world of clinical practice in Malaysia.

> *"some of the stuff that we're teaching is kind of the ideal and we know that, I think we know that it's not going to happen when they enter the real world."* (Interviewee 1)

The reality of Malaysian clinical practice (i.e. busy clinics) was thought to make the implementation of the taught CS difficult. A paradox emerged that the taught CS model was not currently observed yet it was perceived to be needed in Malaysian clinical practice.

Teachers wondered if students realised the relevance of the CS teaching in practice and whether patients would be expecting it. There was concern over the emphasis of asking patients about their concerns and expectation when this may be foreign to clinical practice:

> *"will patients understand them and will they make sense in real life?"*(Focus Group 1)

Teachers state students can and do learn to use these questions but it is the "*most"* difficult thing to put into clinical practice. It feels *"false"* to the students and feels *"ridiculous"* to the patients. Participants perceive that they are not used currently in practice; patients do not discuss their agendas and students do not see it role modelled.

Deeper concepts

Further, more complex challenges to CS teaching emerged related to behavioural, emotional and cultural concepts. Participants suggested that Malaysians were perceived to be less expressive, more reserved and less

open than other nationalities. Malaysian students were thought to be too polite to give constructive feedback (they just say *"its fine"*). The behavioural factor most commonly mentioned was the appropriateness of not touching Muslim Malay women:

> *"the only thing that we do… very differently is about touching. … I have made it a point to make them think about whether it's appropriate to touch or not"* (Interviewee 1)

Participants explicitly stated that they felt that religion did not influence CS teaching. All participants agreed there is a stronger emphasis on 'familial involvement' in decisions and looking after family members in Malaysia than in the West. Observations of the role play highlighted that the role of the family was raised earlier and more commonly than would be expected in the same scenarios in the UK.

Some participants viewed emotions in CS teaching as being an individual, not a cultural factor whereas others felt that Malaysian students find it difficult to display emotions. Other participants questioned whether empathy can be taught, reporting difficulty in trying to do so. An additional concept to the CS teaching that emerged was an expression the Malaysian students articulated commonly, to give "warmth": It was used as positive feedback to students who had shown empathy. Doubts were raised by participants as to whether the CS model being taught was appropriate for the Malaysian cultural context.

> *"let's face it, we are teaching them Western style communication, that we deem to be correct. And whether it is correct here or not… I don't think it would be wrong here. But I think it might just be slightly out of context at certain times or just a bit different"* (Interviewee 5)

> *"because I'm sure the systems are quite different. So to just bring that from Newcastle and just put it here, I thought it wouldn't work so well."* (Focus Group 1)

One Malaysian teacher in particular struggled with the Western method of compartmentalising CS in order to teach it.

> *"It's a different challenge obviously because having to divide further sometimes can take a quite amount of work whereby we know in any communication, most of the time it's not...it's never compartmentalised"* (Interviewee 4)

Possible solutions to the challenges

Most participants offered spontaneous suggestions to the challenges of transferring CS teaching suggesting both an awareness of barriers and a desire to improve. The solutions mirrored the three levels of challenges described above: practical, implementation and deeper or conceptual suggestions. These are presented in Table 1.

Table 1: Levels of challenge and solutions proposed by participants

Level of Challenge	Potential Solutions
Practical	Change the slides, names and video clips; make their own video materials; use Malaysian clinical scenarios; use Malaysian data. To "numedify" the course, i.e. adapt it for Numed.
Implementation	To ask ICE (ideas, concerns and expectations) questions more subtly. Use the expression 'to give warmth'
Deeper concept	Help the students to understand the broader context; make it (the CS model) suitable more 'for us' and for 'the locals here'.

Discussion

Conceptual schema

The emergent cultural themes relating to levels of challenge are conceptualised into the scheme in *figure 1*.The use of a triangle, like an iceberg, demonstrates the most outwardly obvious challenge is at the practical level, working down to the arguably most important and influential level and most difficult to remediate, the deeper concepts. *Figure 1*

Practical challenges

Practical factors were identified as being challenges, such as the video clips and cultural references alluded to in the lecture. The issue of language and its many components were, perhaps unsurprisingly, a central challenge. While NUMed, like most medical schools in the world, use English as the language of instruction, this will influence students' communication skills as will the languages they use with patients. A study of transnational medical students and staff highlighted the impact of language on learning as a problematic multifaceted issue incorporating similar challenges to those that have emerged from this study; issues related to translation, pace of speech, use of colloquialisms and professional medical English (Lindley, McCall *et al.,* 2013). Important questions emerged for educators pertaining to CS teaching. In which language should CS be assessed: the instructional language or the clinical language? Does the use of interpreters hinder students' ability to practice and implement CS? How difficult is it to learn to express emotions in your second (or third) language?

Implementation challenges

Challenges of transferring CS teaching from classroom to clinic, or the "*campus"* to *"real life"* to quote the study participants, have been published (Brown 2010). These findings suggest that there are both common and unique barriers to communications and consultation style when transferring a Western model to the Eastern context: limited time for consultations, high patient demand and patients not prepared for a more shared consultations style (e.g. the use of ideas, concerns, and expectations).

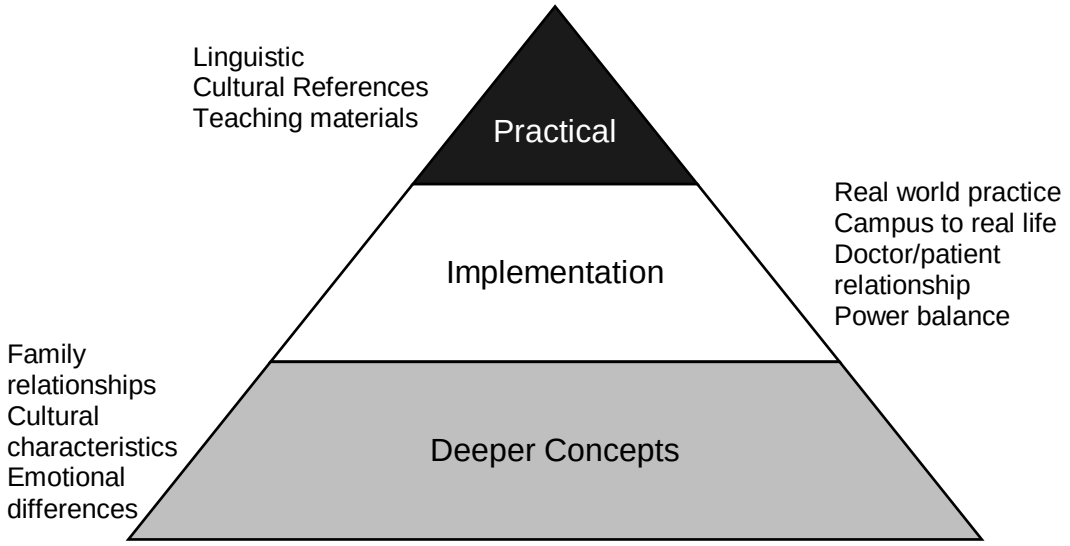

Figure 1: Challenges to CCS teaching

Work within a similar context demonstrated the contrast between the 'ideal' (as defined by Western CS models) communicant style and the reality of busy, clinical practice in a Southeast Asian setting (Claramita, Utarini *et al.,* 2011). Their conclusions correlate with our findings related to expectation of a consultation, as do their barriers to implementation of a more shared communication style. Questions educators must ask are: Can the Western CS model, contextualised for example in UK primary care in a 10-minute consultation, be implemented in a context of 5.4 minute consultation (Claramita, *et al.,* 2011) or less?

Clear hierarchical divisions highlighting doctor and patient inequalities emerged correlating closely with Hofstede's cultural dimension on power distance (Hofstede, 2001): In large power distance countries patients treat doctors as superiors, consultations are shorter and controlled by the doctor and there is an attitude of "*doctor knows best"* (Chandratilake, *et al.,* 2012). The study results correlate with Malaysia being a very high power distance country (Hofstede, 2011). We would encourage educators to be cognizant of Western CS curricula, with its emphasis on patient involvement and choice within the consultation, in this context.

Deeper concepts

Participants identified a number of Malaysian cultural characteristics affecting the consultation and implementation of CS. This correlates with anthropological work of Malays, the predominant ethnic group, suggesting they tend to be reserved and are not expressive of their emotions (Goddard, 1997; Kim, *et al.,* 2001). In addition, participants questioned whether emotions can be taught. Studies from Western contexts have suggested some evidence that empathic skills can be taught, or enhanced, in medical students (Hojat, *et al.,* 2013), but these findings cannot be presumed to be transferrable cross-culturally.

A strong dependence on family members in Malay culture was described, supported by (Eng, *et al.,* 2012), and corresponds to Malaysia being classed as a collectivist society (Hofstede, 2011). The strong emphasis placed on the family context, *"we are closer to our families",* even within the very first stage of the CS framework, suggests that setting the family scene warrants a more central focus in CS teaching in Malaysia.

A struggle emerged with the Western method of compartmentalising CS in order to teach it. This supports the Confucian-Socratic framework contrasting Eastern and Western learning (Tweed & Lehman 2002). The CS curriculum has a classic Western Socratic basis, with its emphasis on a linear approach, independence rather than interdependence and compartmentalisation. This contrasts a cultural psychology approach, which would be to construct an Eastern framework of CS that would be more cyclical, interdependent and holistic. This deviance was noted by participants, suggesting the taught CS framework might not be the *"best model for this setting"* (Interviewee 1). Some Western authors have also questioned the behaviourist deconstruction of CS teaching when in practice CS are applied in an integrated consultation, and have called for more assimilated and authentic CS teaching (Brown, 2010).

Implications Unequivocally, medical curricula do not sit in a vacuum. There are societal, political, economic and regulatory (General Medical Council and the Malaysian Ministry of Health) drivers influencing the delivery of medical education. The aim of this study was to inform this delivery by identifying challenges and potential implications (Table 2). Cultural influences on the teaching and learning process are extremely complex, yet an attempt has been made to simplify and classify the cultural factors that have emerged in order to inform both local and wider practice (Table 2).

Table 2: Levels of challenge and potential implication

Level of Challenge	Implications
Practical	Review the content of curricula prior to any cross-cultural transfer to assess any obvious culturally sensitive content, such as video clips, references and pictures.
	Consider the linguistic challenge of different instructional and clinical languages, and the use of professional rather than 'ad hoc' interpreters.
Implementation	Explore culturally appropriate means of assessing the patients' agenda.
	Monitor and evaluate the transfer of CS teaching into Malaysian clinical practice among the current NUMed students when they become junior doctors.
Deeper	Acknowledge, teach and promote the central importance of the family within the consultation from the initial 'information gathering' stage onwards.
	Consider incorporating the concept of 'warmth' within the consultation roleplays and in the CS teaching model.
	Review the appropriateness of the CS model to be taught in relation to any contextual clinical setting.

Conclusions

A conceptual framework classifying the challenges and offering potential solutions to CS teaching at NUMed has emerged based around three levels: Practical, implementation and deeper concepts. This model provides a transferable and functional classification as the transfer of Western medial curricula continues. The practical challenges may be remediable at an institutional level through the process of 'localising' content and contextual components. The implementation level relates to the challenge of transferring CS teaching from the classroom to a busy clinical Southeast Asian setting including the differences in expectations of the doctor-patient consultation. The deeper concepts identified, such as differences in family and cultural characteristics, highlight Western constructs and are worthy of more in-depth discussion and study within the international arena. This original conceptual framework enables a deeper understanding of the complex issue of transferring CS curricula to cross-cultural contexts and may facilitate much needed critical reflection of this practice (Kanu, 2005). As we head towards 'global citizenship', internationalisation of HE has faced developmental limits (Van Damme, 2001) and cultural considerations have not been part of the educational goals to date (Svensson & Wihlborg 2010). This research addresses these needs and fulfils the international call to address the lopsided academic relationship between the West and the East by a reconceptualization of curriculum transfer (Kanu, 2005).

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