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- 'docendo ac discendo' - 'by teaching and learning'

In this issue:

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International Journal Of Clinical Skills
P O Box 56395
London
SE1 2UZ
United Kingdom

E-mail: info@ijocs.org
Web: www.ijocs.org
Tel: +44 (0) 845 0920 114
Fax: +44 (0) 845 0920 115

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The International Journal of Clinical Skills looks forward to contributing positively towards the training of all members of the healthcare profession.

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Foreword

Clinical skills change lives…

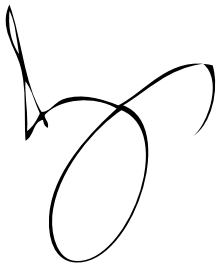
Dr. Abigail Boys & Regina (October 2010)

Amidst the fast paced achievements in international healthcare and education, it is important not to forget what clinical skills mean in reality for our patients – clinical skills change lives.

After having initiated the charitable society Willing and Abel in 2008, many health care professionals have had the pleasure of using their specialised and expert clinical skills to help children of developing nations requiring specialist surgery. An example is 13 year old Regina who was born with a tumour fatally spreading across her face (congenital lymphangioma) – she successfully underwent major surgery at The Royal London Hospital (United Kingdom) in December 2010 and now continues to lead a normal life in Ghana, West Africa (www.bbctelevision.co.uk).

Such success exemplifies a fundamental strength of the clinical skills community in its ability to evolve and adapt to meet the challenges and expectations of a modern healthcare arena. Healthcare professionals need to have clinical skills training which will allow them to meet present and future challenges, which include an ageing population, multiple morbidities and increasing patient expectations.

There is no doubt that the International Journal of Clinical Skills provides an excellent forum for the global healthcare community to further clinical skills research, as well as advancing the training of students, academics and health professionals. I wish the International Journal of Clinical Skills continued success for its admirable work in this important field.



Dr. Abigail Boys MBBS MRCS (Eng)
Founder of Willing and Abel
www.willingandabel.org.uk

Adapting clinical skills training to an Arabian Gulf setting

Dr Deen Mohammad Mirza MBBS MRCGP *
Academic Director, Better Doctor Ltd

* GP Appraiser, NHS Sutton and Merton, United Kingdom

Correspondence:
Dr Deen Mohammad Mirza
Better Doctor.org
P. O. Box 60046
London
SW16 9FJ
UK

E-mail: info@betterdoctor.org
Tel: +44 (0) 8450920114
Fax: +44 (0) 8450920115

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Abstract

Background: The approach of teaching clinical skills to pre-clinical students within a skills facility is increasingly used in different international contexts. However, some modifications are necessary to clinical skills curricula in order for such models to be locally effective. This paper will analyse such a concept within a Gulf Arab setting.

Description: In the United Arab Emirates (UAE), students come from a conservative Muslim Arab background. Their clinical skills training is affected by a number of issues. They have English as a second language and will eventually need to interact with patients in Arabic. There is also a large migrant labour workforce with whom students will have to interact.

Recommendations: Non-native English speaking medical students need specific training in interprofessional medical communication in English. Local patient languages and the use of interpreters should be included within communication skills training. Facilitators must be aware of social class issues on communication skills. Cultural and religious feelings towards physical touch between genders must be dealt with sensitively. Simulation equipment must be functional rather than aesthetic.

Introduction

Medical school curricula developed in Western, English speaking countries, are increasingly being exported to varied international settings [1]. Often neither those who give nor those who receive such pedagogy fully appreciate which aspects need adjusting for the local cultural context. This culture clash can affect almost any component of the curriculum, including the seemingly neutral clinical skills curriculum. This article describes what considerations may be necessary when implementing an undergraduate clinical skills programme to an Arabian Gulf setting. This is based on the author's four years of experience across two different medical schools within the United Arab Emirates (UAE).

Integrating the local patient language into communication skills training

In the UAE, native Arab medical students will go on to see Arab patients within the governmental health system. However, the medium of instruction for teaching communication skills is English. Students attend lectures, watch videos and perform role plays with simulated patients, all such activities being conducted in English. Sometimes this is due to the fact that those teaching the students are non-Arabs and therefore unable to facilitate communication in Arabic. Despite this, even those teachers who can speak Arabic often continue to teach in English. This is partly due to the limited teaching materials available on communication skills in Arabic. However, some feel that Arab students will be able to automatically translate what they learn in English, into their mother tongue when seeing patients [2].

The theory underpinning communication skills models is predominantly based on research into Western English speaking populations [3, 4]. The language component of a consultation in English does not translate easily into Arabic, even if the target language is the mother tongue of the student attempting translation [5, 6]. Furthermore, there are many cultural aspects of a conservative Arab setting that affect the communication style of the consultation. This includes communicating with female patients wearing the face veil, using religious reference in everyday dialogue, Arab styles of emotional expression, and the role of the family in an individual patient's decisions [7, 8, 9]. Such differences in language and culture have a profound impact on the nature of the doctor-patient interaction [10, 11, 12].

Arab students need to practice finding the right questions to ask in Arabic, with feedback from their tutors. They also require guidance on the particular communication issues that emanate from the local culture. This can be done within the safe environment of the skills laboratory, where trial, error and open discussion is acceptable.

Using English as a language of medical communication

English is a second language for the majority of medical students in the UAE. However, the hospital culture is such that formal communication between Arab doctors usually takes place in English, as in many other parts of the world [13]. Western medical students may not need specific training in interprofessional communication due to their native proficiency in English. However, for non-native English speakers, a greater emphasis on articulating patient information in English is needed [14, 15]. There is a particular terminology and style required to summarise a patient's history succinctly, or to describe a patient's clinical signs. Such a style is required when referring a patient to another doctor on the telephone or presenting on a post take ward round. This is distinct to general presentation skills which students will practice at other times in their undergraduate training.

Clinical skills sessions must therefore include opportunities for students to practice verbalizing adjectives and phrases relevant to the appearance of lesions and deformities. Additionally, whenever students take a history from a simulated patient, they should be asked to present the history to the facilitator, at the end of the consultation. Feedback should be given on the student's case presentation skills as well as their history taking and communication skills. These skills of articulation need to be a specified aim for undergraduates in this setting [3].

Social class and the doctor-patient divide

The Gulf region has a broadly similar social structure, with the native citizens of each country being at the higher end of the social hierarchy, with the labour force from the Indian subcontinent being at the bottom [16]. Medical students generally come from the higher echelons of society, and have interacted with the labour class according to their social norms since childhood. Students sometimes cannot perceive how working class South Asian patients may be intimidated by them, or how such patients may not trust them. The social history taken from such patients is usually very brief; often focussing only on how many years they have been in that particular country and what type of accommodation they have. Details that humanise the patient and describe their complete psychosocial context are often neglected. And in a small minority of cases, students express views about the rights, treatment and autonomy of such socially disadvantaged patients that are inappropriate.

This issue is sensitive and should be approached carefully [17]. Facilitators of simulated communication skills interviews can encourage students to reflect upon some of these issues within feedback sessions when appropriate. Linked to this topic is training in the use of interpreters, as those patients who need interpreters (i.e. they speak neither English nor Arabic) will tend to be from this socioeconomically disadvantaged population. The role of the interpreter for such patients is usually fulfilled informally by a worker at the clinic or hospital. Such casual use of untrained interpreters presents ethical issues and needs to be addressed through formal training [18, 19]. Such training is not currently carried out in any undergraduate medical setting within the UAE.

Cultural issues about gender and touch

For logistical reasons, many medical schools across the world employ peer physical examination for students to learn how to examine [20, 21]. In a conservative Muslim society, students may not accept to be examined by other students of the opposite sex [22]. However, some female students are even reluctant to examine male simulated patients in the skills lab setting. This can be due to a cultural shyness which is overcome with time. Other students hold a religious position that females should not touch males, to whom they are not related [23].

Confronting this dilemma head on at an early stage in the students' career may produce negative consequences, such as some students leaving medical school. Students in the pre-clinical phase are still developing their attitudes, and their approach will undoubtedly be more mature by the time they graduate.

These students will not be the first healthcare professionals to experience a clash between cultural values and hospital practice [24]. The clinical skills lab setting is supposed to be a safe environment for students, free from the stress associated with learning in the hospital setting [25]. The medical school can explore finding solutions for the students in a supportive way, as the students get accustomed to the professional expectations of medicine.

Display versus functionality

A characteristic of the newly industrialised countries in the Arabian Gulf is an emphasis placed on superficial image and glamour. This culture filters down to the medical school. There is consequently some indirect pressure on the skills facility to 'look good' for visitors. For example, such pressure can result in the purchase of several expensive, high specification simulation mannequins that are on permanent display, but which no-one knows how to use properly.

In reality, there is a need to showcase a skills lab in order to secure higher funding and promote the status of the institution. However, items bought must be linked to what needs to be taught. It is better to have 20 basic life support mannequins than one advanced cardiac life support mannequin when one is teaching 100 undergraduates. If more complicated simulation

is needed, e.g. for postgraduate training, then money must be invested in employing appropriate (human) technical support to maintain and use such items.

Author Information

Dr Deen Mohammad Mirza was formerly Assistant Professor of Family Medicine at the Faculty of Medicine and Health Sciences, UAE University, United Arab Emirates. He is currently a GP Appraiser working for the National Health Service (NHS) Sutton and Merton. He is also the Academic Director of the Better Doctor Medical Education Company.

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