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The Value of Qualitative Methods in Cross Cultural Education: A Case Study from a First Person Perspective

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ABSTRACT

This paper presents a first-person account of using qualitative research methods to address medical residency education. The results of this project have been published. However, the study's process and its educational impact on the participants have not been well-described. The purpose of this article is to describe the background and conduct of the study itself. A family medicine residency program, the setting for this project, had recently begun accepting international medical graduates (IMGs) who had lived and received medical school education outside of the United States. The author, a faculty member in the residency and a clinical psychologist, and the physician faculty observed residents as they saw patients in the family medicine residency clinic. Concern was expressed about some of the IMG resident physicians' knowledge base and their ability to develop rapport with patients. In providing instruction in behavioral science, the author and a psychologist colleague noted that some of the IMG residents were confused by aspects of U.S. family life and the educational system. The relationship with clinical instructors and expectations of faculty also differed from the pedagogical norms in U.S. medical education. As a result, a qualitative interview project was undertaken to understand better how these IMG residents were experiencing and interpreting faculty-learner and resident physician-patient interactions. The results were beneficial in multiple ways. First, recognizing that faculty members were interested in their experiences helped develop rapport and trust between the faculty and residents. Providing the project results to the residents helped open discussion about cultural differences in medical education and patient care. For educators who may have difficulty understanding the perspective that learners bring to their education, the process described could be of potential benefit.

Keywords: Qualitative Research; Research in Medical Education; Applied Qualitative Research

1 Background and Context

While there are multiple sets of published guidelines for systematically formulating and testing hypotheses (Morling, 2020), choosing a statistical technique for quantitative studies (Watt & Collins, 2022), conducting interviews (Creswell & Baez, 2021) and determining validity in qualitative research (Hayashi et al., 2021), there are few recent first-person accounts of condcuting research (Streiner & Sidani Souraya, 2010).The purpose of this paper is to describe the process of conducting an applied qualitative research study in a medical education setting. The focus in terms of methodology is not on the specific qualitative interview questions that guided the data gathering but, instead, is on the rationale (Mulisa, 2022) for the qualitative approach used in this particular project, how it was carried out, ethical issues, and the presentation of the findings to the participants. This latter technique, member checking, is considered a qualitative validity assessment (Motulsky, 2021). The study's results are available (Searight et al., 2014, 2020; Searight & Gafford, 2006). It is hoped that this account will be of value to faculty and researchers who may find themselves in a situation in which a study of this type would be useful for enhancing the quality of education (Thompson Burdine et al., 2021). In keeping with the goals and theme of the article, the narrative will often be presented in the first person.

This qualitative study was conducted at a community-based university-affiliated family medicine residency program. The author is a clinical psychologist who also received an additional master's degree in

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public health. I was the Director of Behavioral Science in the residency and a Clinical Associate Professor of Community and Family Medicine at the time of this project. The residency program with which I was affiliated had recently undergone changes that added a distinct international dimension to medical education. As a result, the recent classes of incoming residents for the three-year family medicine program included many physicians who received their education and medical school training outside the United States.

2 International Medical Graduates and Residency Education

From a clinical perspective, my psychologist colleague and I taught behavioral science in two venues. First, we both saw patients regularly that primary care physicians referred for diagnostic evaluation or brief psychotherapy. Residents typically joined us for these encounters. In addition, we were responsible for clinical instruction in physician-patient interaction and effective patient interviewing.

As a result of these experiences, I, along with other faculty members, noted several issues among our international medical graduates that we had not typically seen among graduates of U.S. medical and osteopathic schools. For example, while a core component of family medicine and a basic competency in the specialty is mental health, many of our international graduates appeared uneasy. They were unclear about how to proceed when patients presented with depression or anxiety disorders symptoms. Additionally, many patients with mental health issues that a family physician could effectively manage were being referred to me or outside psychiatrists. As we got to know these residents better, they indicated that they had had little formal instruction in psychiatry during medical school. Often, their sole exposure to mental health was following an attending physician on ward rounds in large long-term psychiatric facilities.

As part of my role as a faculty member, I also participated in monthly reviews of resident progress in the program. In these discussions, resident evaluations from recent rotations were reviewed, and observations by physician preceptors about the resident's performance in the family practice clinic were described. During these meetings, concern was expressed about some international medical graduates' perceived knowledge and skill level (IMGs). For example, one repeated situation was that when IMG physicians verbally presented a patient to a supervising physician that the IMG resident would describe the presenting problem, describe the relevant aspects of the history, and any physical examination findings but then not go on to the expected differential diagnosis and recommendations for treatment. As a result, supervising faculty often concluded that these physicians had an inadequate knowledge base. We later learned that this style was an expression of humility and respect for the faculty physicians and not indicative of a knowledge deficit (Searight & Gafford, 2006). There were also observations that the IMG residents did not seem to appreciate some of the psychosocial aspects of patient care. For example, in an encounter with a pregnant adolescent female, the resident physician focused solely on the technical aspects of the pregnancy, such as assessing fetal heart rate and fundal height and asking about diet and smoking. However, issues surrounding the psychosocial development of the 15-year-old who was pregnant were not addressed (Searight et al., 2014).

3 Choice of Research Method

While I had some tentative hypotheses about the possible cultural dynamics underlying the behavioral patterns described, I was also aware that my piecemeal understanding was uncertain at best. I also thought that any observations and recommendations regarding the training of IMG residents would have a more significant impact if they were based on systematic inquiry. Since this was a topic area in which there was little in the medical education literature for guidance, a qualitative project appeared appropriate (Ng et al., 2018).

Several recent qualitative health studies that I had conducted yielded both surprising findings and led to a much deeper understanding of the topic under study than corresponding quantitative findings. I had previously collaborated with clinical pharmacists overseeing drug trial studies in the family medicine clinic. We were initially interested in participants' recall and understanding of the study information presented

during the informed consent process. We developed a scale, The Deaconess Informed Consent Comprehension Test (Miller et al., 1994), which provided a summary score of the participants' recall and understanding of the study information. Participants recalled approximately 70% of the information over which they were tested. It was helpful to have a psychometrically sound measure of the elements of informed consent (there were few such instruments at the time). However, one of my pharmacy colleagues and I became interested in how drug trial participants viewed their role, their perceptions of the consent process, and the corresponding explanation of the study they received. We developed a series of open-ended questions and interviewed 14 participants from recent clinical studies. After coding the interview narratives for common themes, we generated a description of the participants' views of informed consent ("It prevents lawsuits") and random assignment ("I imagine they rolled dice for it.") (Russell Searight & Miller, 1996).

Given my previous successful experience with ethnographic methods, such as the long interview (McCracken, 1988) and thematic coding of the resulting narrative transcripts (Strauss et al., 1998), this approach appeared to be a good fit for this study. Another reason for selecting a qualitative interview approach was that this research topic had received relatively little attention. Qualitative studies are often recommended for the initial exploration of a domain of interest (Pokhrel et al., 2021).

The number of participants required for valid qualitative research is typically significantly less than for a quantitative study. Data saturation is used to determine adequate sampling (Hennink & Kaiser, 2022). At saturation, adding further interview narratives does not add additional information to the study's findings. Another standard suggested for data saturation is the number of interviews necessary for another investigator to replicate the results with a similar sample (Hennink & Kaiser, 2022). For extended, in-depth interviews of the type used in this study, saturation may occur with as few as six protocols. Ten IMGs participated in the study.

Member checking involves presenting the study's results to the participants who were the source of the data (Thomas, 2016). The process of presenting and the feedback generated may also help further refine the descriptions of the themes generated through the coding process. Member checking is also a validity check (Harper & Cole, 2012; Motulsky, 2021) that can ensure that the inductively generated themes are accurately described.

4 Research Design

Before the IMG study, I had used qualitative interview methods in several previous studies in the family medicine setting. Qualitative interviews are particularly useful in understanding health-related issues that have not been well studied. In particular, an open-ended inductive approach is most beneficial when the goal is to understand the subjective perspective of a specific culture or subgroup. Additionally, in-depth interviews provide flexibility in that an unanticipated category of meaning may spontaneously arise. For example, medical education includes the official curriculum of courses, clinical clerkships, and residencies but also has a hidden curriculum of norms, values, and expected behavior (Mahood, 2011). This hidden curriculum was something IMGS were found to be struggling to understand, as this excerpt illustrates: "I don't know how to interact with other staff in the office, like the nursing staff. In India, they would never question a doctor. Also, it is hard to figure out who does what here. For example, at home, the doctor would draw the patient's blood (Searight & Gafford, 2006).

In conducting the interviews, I followed (Spradley, 2016) general guidelines by opening the interview with "grand tour" questions ("What has your experience been as a resident in the U.S.?"). These were often followed by "mini tour" questions focusing on a particular area ("How are you finding the patients that you are encountering in the residency clinic and hospital?"). Compare and contrast questions help clarify key differences and the boundaries of the interviewees' meaning categories ("We have been talking about how mental health problems are common in American primary care patients. Are these the same types of problems that would be placed in the category of 'mental health problems in your home country?"). Primarily because of the IMG residents' interest, the findings were presented at a conference attended by

all family medicine residents and faculty. As noted earlier, this presentation was an unplanned forum for member checking (Thomas, 2016).

5 Research Practicalities

In this study, there were a few obstacles. However, being in the role of a faculty member conducting the research interview could be perceived as a conflict of interest. On the other hand, the topic area and the methodology were not areas in which other faculty had much experience. While I did not provide ongoing counseling or psychotherapy for residents, it was not uncommon for residents to occasionally share personal information with me. Although I had also discussed some of the interview topics informally with residents during clinical instruction, I did promise our informants confidentiality. I indicated that we wanted their input to help us improve behavioral science education within the program. At the outset of the interviews, I had no clear intention of doing anything formal with the findings, such as publishing or presenting them at a conference.

6 Methods in Action

As noted above, in conducting qualitative interview studies, I typically begin with a "grand tour" question—a broad, open-ended query about the topic area. Then, based on participants' responses to this question, I will follow up with a more specific question or follow the respondent's lead if they take me in an unanticipated direction. I have found these surprises often lead to issues I had not considered.

While I usually have a formal list of questions (often necessary for Institutional Review Boards Proposals), I may depart from these prepared queries when a potentially meaningful, yet unexpected issue arises. For example, in the informed consent study, participants were aware they were in a double-blind, placebo-controlled pharmaceutical trial. However, when I questioned them about their understanding of these conditions, nearly all participants indicated that they were sure they had been given the active drug and not the placebo (Russell Searight & Miller, 1996). Given the number of interviewees and the process of assignment to experimental or control conditions, it was highly unlikely that all of these interviewees had indeed been prescribed the active drug. This issue, called the "therapeutic misconception," had not been widely recognized in biomedical research (Russell Searight & Miller, 1996).

In the current study, I was surprised by the degree of engagement that the IMG residents demonstrated during the interviews. While several interviewees were initially a bit guarded, my expressions of support and interest seemed to increase their comfort rapidly. It often seemed as if they were eager to discuss their experience and were pleased, and even flattered, that a faculty member was interested. One issue in the interviews was that many of the IMGs lived with an ongoing fear that they would be "found out" their visa canceled, resulting in being sent back to their home countries. This "imposter" experience seemed to contribute to keeping a low profile and a highly deferential style when engaging with faculty. As a faculty member, I was surprised by hearing this theme and responded empathically, albeit with some sadness on my part, that this fear was so prominent and pervasive.

7 Practical Lessons Learned

The history of this study illustrates how a research project can have unintended consequences. To some extent, the focus on IMGs was an "elephant in the room" issue. IMGs have often been viewed as medical second-class citizens (Chen et al., 2011). A high level of sensitivity was necessary to carry out and present the research findings without conveying discriminatory overtones. Unfortunately, these overtones are familiar in discussions of IMGs. For example, the primary governing and oversight bodies for medical education often made a clear distinction between U.S citizens educated in U.S. medical schools, U.S. citizens receiving their medical education abroad. and non-citizen IMGs. There has often been an unspoken prejudice against these physicians, of which IMGs are very aware (Moore & Rhodenbaugh, 2002; Searight et al., 2014).

While I have published multiple qualitative studies, this project did not originate as a formal study per se. Instead, the focus was to understand better some of the educational issues that arose when U.S.-trained faculty were teaching and supervising the clinical work of IMGs. While IMGs comprise about 25% of the U.S physician workforce, at the time of this study, there was little information for medical educators aside from demographics. In particular, little literature was available about how these physicians experienced and managed the abrupt transition from countries where outpatient medical care was less developed. Many new researchers often become discouraged when considering a topic with little associated research literature. However, the absence of literature on a topic is often a cue that a qualitative study would be of benefit.

When the initial manuscript based on this project was submitted for publication to a specialty medical education journal, it was promptly rejected and not sent out for review. The editor indicated that the paper would be considered only if we presented quantitative findings consistent with our qualitative results. This editorial response illustrates a common issue with qualitative research in the scholarly community. We submitted the manuscript to another journal (*Academic Medicine*) which enthusiastically accepted the paper with minor revisions and used the paper as the center of several articles on international medical graduate education. With 86 citations to date, it is hoped that the paper has positively influenced medical education.

8 Conclusion

Educators at all levels encounter situations in which learners are not demonstrating progress in meeting educational goals. Rather than assuming deficiencies in the learners, educators may wish to consider how the learners are interpreting the educational setting and the instructors' expectations. Qualitative methods are particularly useful in investigations in which the goal is to understand how a minority culture interprets situations created by the dominant culture. Notably, the dominant culture rarely reflects upon habitual behavior's inherent values, assumptions, and meaning. Qualitative interviewing often brings additional dimensions to awareness that would not be captured by a Likert scale quantitative survey.

9 Declarations

9.1 Competing Interests

The author has no competing or potentially competing interests with respect to this article.

9.2 Publisher's Note

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