# Chapter 15
# Cross-Cultural Academic Experience in Medical Education: Enrichment of Teaching Through Confucian, French and American Influences

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**Abstract** I was born in Vietnam, a country that had a strong Chinese cultural influence, and grew up at the transition between the French and American influence. I began teaching medical students in Vietnam when anatomy teaching was still influenced by the French philosophy and methods. I came to Australia as a refugee and returned to medical practice and resumed lecturing anatomy at the University of New South Wales where I have seen the changes from the traditional British-influenced programme to the new Problem-based method. I had previously completed my surgical training in the American system and recently had some teaching experience in North America as a visiting professor of anatomy. Thus I have been a student and lecturer in three different social and cultural environments (Confucian, French and American) prior to my current work as an academic in Australia. This chapter is an account of my observations and personal experience of the influence of cultural background on student-lecturer interactions.

## 15.1 Introduction

Born in Vietnam in 1947 at the end of French domination, I was raised in three mainstream philosophical traditions (Confucianism, Buddhism, Taoism), in a family that was amongst the earliest to convert to Christianity. At that time, French influence remained strong in universities, especially in medical schools until my early undergraduate years; it was later supplanted by the American influence as the war escalated when I finished my undergraduate and postgraduate training in 1973 and started teaching anatomy to medical students. I came to Australia in 1979 as a refugee, repeated my medical training and returned to academic work in Sydney,

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teaching anatomy in a medical education system that is modelled on the British system. This is a reflective account of my personal experience as an academic in three cultural environments. This review of cultural background is more about my personal observation and interpretation than a scholarly in-depth study of oriental and western cultures.

## 15.2 Brief Background of Vietnamese History and Culture Up to 1975

Vietnam had been under Chinese rule for a thousand years until the X century. Although we gained our independence, Vietnamese administration, social organisation and culture was adapted from the Chinese. The official written language for learning and administrative records was in Chinese characters. Christianity was introduced to Vietnam in the XVII century by the missionaries, mostly from Portugal and France. This new religion was seen as a threat to the king's authority and social order, so the missionaries and new converts were persecuted. This gave the French colonialists a primary pretext to bring the troops to Vietnam and colonise the country in 1888. Under French domination, the traditional education system and selection of government officials was replaced by the French education system from primary to secondary school. French was introduced as a compulsory second language in primary school. Secondary schools were opened in only a few major cities for a small number of privileged or brilliant students where French was the main language of instruction. In addition, there were a few French Lycées reserved for French children and children from families of high social ranking (e.g. doctors, lawyers, high-level government officials).

The long struggle for independence provided fertile ground for the growth of the communist party led by Ho Chi Minh. In July 1954, the French colonisation ended with their defeat at Dien-Bien-Phu. According to the Geneva Peace Accords in 1954, Vietnam was divided temporarily into communist North Vietnam and democratic South Vietnam. The general election scheduled for 1956 to unify the country never took place. The communist led insurgence in South Vietnam under the banner of the National Liberation Front (NLF) had the command from North Vietnam and logistic support from Russia and China and spread throughout the South. The American support to South Vietnam was correspondingly stepped up to control the insurgence.

A coup d'état in November 1963 replaced the elected president of South Vietnam with a series of short-lived American-backed governments. American troops were sent in large number to Vietnam to deal with increased activity of the communist insurgence. While the war was escalating, the US government began negotiating with North Vietnam in 1968. The result was the signing of the Paris Peace Accords in 1973 that marked the beginning of the end of the Vietnam war. In April 1975, the entire country was unified under the control of the Hanoi communist government.

## 15.3 My Education and Academic Work in the Timeline of Vietnamese History

I moved to the South in 1954 after the Geneva Accords. The Medical School of Indochina had been established in Hanoi in1902 by the French government as an annex of the University of Paris. It became the Faculty of Medicine in 1936. All faculty members were French professors. Medical students counted only about a dozen, and all had to go to Paris to take their final exams. Many of them continued their postgraduate training in France to become professors, and some of them returned to teach in Hanoi. The number of medical students grew slowly to about 60 students a year, with the development of the Faculty. After the Geneva Convention, the original faculty of the Medical School of Indochina divided, those members who remained in Hanoi formed the Hanoi Medical School, the remainder moved to form a Saigon Medical School.

When I completed my Baccalauréat II (equivalent to High School Certificate in Australia) in 1965, the selection of 120 medical students each year was extremely competitive, based on an entrance exam which included three papers based on the principle Baccalauréat subjects (philosophy, physics, biology), a short-answer paper on general knowledge that included history, geography questions, and two essays in French and English. Although teaching was still in French, the American influence began with the appointment of some American-trained professors, and most importantly, the establishment of a small group of selected students, of which I was a member, to be taught in English by professors sent from the USA.

Gradually, French was no longer the exclusive language of instruction. More and more lectures were given by American and American-trained professors, textbooks in English filling up more shelves in our medical library, and British and American journals crowded out the French ones. Some lectures were even given in Vietnamese interspersed with either French or English medical terms, a practice that many professors and students found unsatisfactory. Exam questions could be answered in any of the three languages. However, it was more common for graduates to further their study in America, and some postgraduate specialist training courses (orthopaedic surgery, obstetrics and gynaecology) were conducted in Saigon by specialists coming from America.

I finished my orthopaedic training and completed my MD thesis in 1973. Thus my medical training began under the French system, but gradually became American-influenced in my later undergraduate and postgraduate years. I started teaching anatomy at Saigon University in 1972 during my surgical training.

Under the law of general mobilisation, I was drafted into the army after my graduation but I was allowed to stay at university to finish my specialist training. I then served in the Qui-Nhon General Army hospital as an orthopaedic surgeon from 1973. After the fall of Saigon in 1975, and because I had served in the South Vietnamese Army, I was sent to a series of “Re-education camps”, a euphemism for labour camps. The idea of labour camp is to keep the inmates exhausted and

half-starved, to the point that their existence is reduced to basic survival instinct. I saw myself and other inmates going through all the stages (including suicide) described by Viktor Frankl (1959), a psychiatrist who survived the Auschwitz camp, so I tried desperately to maintain my spirits, my faith and my sanity. I resisted the process of brainwashing by speaking to myself each night in French and English to keep my brain active. An ex-navy officer taught me how to identify constellations and how to learn basic navigation. I was released late in 1977, but was for practical purposes under house arrest and worked in a District Hospital. Following a friend's advice, I bought the book *The Bowditch's American Practical Navigator* (Bowditch 2002) in the black market, tore it apart and hid each chapter in a different place in my house. I learned the chapter on latitude navigation, and climbed on the roof every night I was on call at the hospital to have a glimpse of the stars over the southern hemisphere. After one failed attempt, I managed to escape on a small trawler with my wife, my 3-year old daughter, my brother, his wife, his sister-in-law and 33 other people. With a school protractor, a small plumb-bob and an army compass as instruments, an Almanac page torn from *Dutton's Nautical Navigation* (Cutler 2004) to track declination of the stars, and the coordinates of potential landing places in Malaysia scribbled on a piece of paper, I navigated my boat successfully to Kuala Terengganu. We were sent to the worst refugee camp on the island Pulau Bidong on the east coast of Malaysia, where 40,000 refugees lived in an area of sand the size of a football field with no sanitation and one single well for washing water. The waiting time before re-settlement was many months on average, so I made myself useful by serving as an interpreter for the High Commissioner for Refugees and the Australian delegation, and as a volunteer doctor in the Dispensary. I resurrected the School of Languages not only to teach English, French and German to the refugees but also to keep young people busy and out of mischief. I was selected by the Australian Delegation to resettle in Australia and arrived in Perth in July 1979. As a foreign medical graduate, I could take the AMEC exam as the first step to get into medical practice, but I elected to retrain at the University of New South Wales (UNSW) because I believed that to practise medicine and to work as an academic, I needed more time to learn about the health care system, and to be familiar with the Australian culture and historical background. As soon as I finished my internship, I joined the School of Anatomy at my second *alma mater* to teach anatomy, a task that I had been doing part-time for many years since my surgical training in Vietnam. Currently, I practise part-time as a general practitioner but my full-time work is teaching anatomy to medical students and to trainees and practitioners in radiology, ophthalmology and different branches of surgery.

Accordingly, since 1986, I have been a practitioner and academic in the Australian system, which is based on the British system. I have recently served as visiting professor at McMaster University in Hamilton, Canada and at Henry Ford Hospital, Detroit, USA, and had the experience of teaching in the American medical education system.

## 15.4 Effect of Vietnamese Culture and French Influence on Teaching and Learning

### *15.4.1 Cultural Background: From Confucianism to the French Influence*

In this chapter, the word 'culture' is used in the sense of a set of beliefs, morals and social values and practices that are integrated in all members of a society.

Traditional Vietnamese culture has been under Chinese influence since the beginning of our written history. The most popular religion was the Mahayana branch of Buddhism, but the prevailing belief affecting every aspect of daily life in Vietnam has been a combination of Buddhist philosophy, Confucianism and Taoism. Children were taught self-cultivation (xiu-shen) from childhood and had to strive to become a jun-zi (a morally *superior person*) by learning and following maxims distilled from all three philosophies. In broad terms, Buddhist philosophy influenced people's concept of life and afterlife much like Christian belief in Western society, and Confucianism regulated social and political hierarchy and organisation. Taoism dictated some social and religious rituals, and misinterpretation of Lao Tsu teachings resulted in some common superstitions that persist until the present day.

In the traditional patriarchal society, the King or Emperor commanded the supreme respect, then the Teachers and lastly the Fathers. The role of Mothers was to raise the family, to support the Husbands and Sons so they could devote all their time and effort to study the classical canons and bring honour to the family.

Although mathematical knowledge was advanced in ancient China, mathematics, science and technology were not emphasised in schools in ancient Vietnam. Students learned philosophy and wrote essays about self-cultivation, filial duties, social hierarchy… The aim was to excel in civil service examinations organised by the King to select local and imperial officials which were based on exegesis of Confucian classics. The ultimate dream of any scholar was to become a mandarin in the King's court. Some scholars chose to learn traditional medicine and became traditional physicians who enjoyed the respect of the general public and was second only to the respect of mandarins. A good physician restoring his patient's health and welfare was considered as respectable as a good mandarin ruling the state bringing peace and prosperity to his people (Tsai 1999).

A Human was considered as a microcosmos, an integral part in harmony with the greater cosmos. This integration of *Heaven* with *Man* meant that Man must constantly improve himself morally to align the *Way of Man* with the *Way of Heaven* (Tang 1991). Self-cultivation was at the centre of social order because Confucius stated in *The Great Learning* that scholars must cultivate their own moral character first, then bring order to their houses, then order to their kingdom, and the whole world will be at peace (Tsai 1999). The key to maintaining successful intergenerational and interpersonal relationships is to observe custom, tradition, manners and rituals. Good rulers rule by observing ritual propriety and deferring to others

(Rosemont 2006). Confucius emphasised the importance of proper title or proper name, “let the ruler be a ruler, (…) the father a father, the son a son”. One should live up to the expectations of one’s title because “if names do not match reality, then nothing can be done successfully” (Rainey 2010). Adaptation of Buddhist belief in re-incarnation expanded Confucian “humaneness” to respect of all life forms. This tradition lives on even today, judging from the higher proportion of applications for admission into the medical course from high school graduates whose background can be traced back to countries with Chinese influence in South East Asia. When I finished my study and started teaching in medical school, the traditional belief was still strong, and academics in medical schools occupied a very high position in the socioeconomic scale because they were not only physicians but also teachers. Anatomy in particular was considered one of the most important preclinical subjects.

When Christianity was introduced into Vietnam, the new converts, like my own forefathers and myself, had no difficulty integrating the new religion with traditional beliefs, just like Confucian China embraced the importation of Buddhism during the Han dynasty (I century). They practised the Christian “religion” while living by the traditional beliefs as a “philosophy”. Christians do not have an ancestral altar and do not burn incense or offer fruits or sacrifice at the altar, but they pray for their ancestors on the anniversary of their passing. The French invasion wiped out the power of the old monarchy but not the traditional culture and beliefs.

However, the French colonialisation introduced a new social class with more privileged, those who worked for the French government. Their children went to French schools and Lycées, and had a clear advantage in entering and graduating from the most coveted university programmes like law or medicine over the rest of the “indigenous” who were not fluent in French.

### *15.4.2 Effects on Teaching and Learning Anatomy in Medical School*

When I entered medical school, although the traditional value system had been eroded by 60 years of French influence, the university remained an ideal learning environment because education and academic achievement were still highly valued.

Students were enthusiastic for many reasons. As there was only one medical school in the country accepting 120 students, medical students had a sense of pride and privilege to belong to the selected few. Medicine had been regarded as a respectable career from the time of Confucius. This belief is still seen today in Chinese-influenced countries in South East Asia and evidenced by the proportion of medical students of Asian background in our university. In my time, the medical course was even more desirable and students more motivated because it was the longest university course, and students were exempted from army duty until they finished their

first university course or failed a second time during the course. The majority of students came from more well-to-do families and were provided for by their parents. They were usually conscientious in their study at least in gratitude to their parents, and they could devote all their time to study because most did not have to work for a living. Unfortunately, the difficult entrance exam and the relatively high failure rate tended to select highly competitive and driven individuals who were often not ready for team work or group learning.

The teachers' task was made easier by the sense of respect of elders and authority inculcated into students by their previous schooling and their family. It was easy to teach students professionalism or ethics because many of them had learnt the Confucian idea of rituals and behaved according to their title, from dress code and mannerism to respect of patients' well-being.

The same applied to academics because most also endeavoured to live up to what was expected of them. The selection process for specialist training and pathways for progression in the academic hierarchy was also modelled from the French system and was therefore based on opinions of individual professors rather than selection committees. When one was chosen by a famous professor of surgery, one belonged to his "school" not unlike Plato had been to Socrates. While it promoted a sense of pride and almost a paternal relationship in training, it at times led to favouritism.

In my field of anatomy, the French influence was obvious in the way the course was designed and delivered. Anatomy was the most respected and dreaded course in the first two medical years. Respected because of our traditional respect of the human body especially after death, and because of its importance as a foundation of medical study. Dreaded because it was the most difficult of the basic sciences and the most common cause of drop-outs in the first 2 years of the medical programme.

At that time, the French way of teaching anatomy put much emphasis on fine details, minutiae and eponyms. The French standard textbook of anatomy in four tomes, L. Testut's *Traite d'Anatomie Humaine* (Testut 1905), the equivalent of *Gray's Anatomy* (Standring 2008) of the Anglophone world, was three times thicker than the latter.

But in addition to such encyclopaedic tomes, there were also short teaching textbooks and atlases with creative drawings to illustrate three-dimensional conceptualisation of difficult areas of anatomy. The same principle of simplification and systematization was applied in teaching anatomy as well as other clinical subjects. The main branches of the carotid artery for example were presented to beginners almost dogmatically, leaving all variants for a later stage such as surgical training in senior years. The "gray areas" such as anatomical variations, unusual presentation of diseases… were only included in encyclopaedic comprehensive books such as Testut's textbook. This approach, which was very helpful for junior students, was only obvious to me when I compared French to American books which tend to include the common variants even in a basic textbook such as *Grant's Atlas of Anatomy* (Grant 1972).

Written assessments were composed of essay questions, not multiple-choice questions. I still remember an open-ended essay question in my end-of-year exam:

"compare and contrast the upper limb and lower limb basing on your knowledge of anatomy, histology and embryology". Answers to that type of question can range from a page to a book chapter. There was always viva voce in front of an anatomical specimen or a cross-section of a specimen such as an arm or a chest. That is another example of the philosophy of teaching anatomy that was focused on the understanding of spatial anatomy. Sectional anatomy was then purely an intellectual exercise, as its real-life application only came with the first CT scanner installed in 1974.

Verbal communication was a component in exams at all levels, and students learned from the way professors delivered their lectures. All lectures or presentations ideally had to end at the time given, and follow proper structure: introduction, transition between sections, and conclusion. My favourite professor of anatomy was a vascular surgeon. He talked and drew diagrams on the blackboard at the same time, and his blackboard diagrams were worth putting in a printed atlas.

## 15.5 Effect of American Influence on Teaching and Learning

From the early 1960s, the American influence in Saigon medical school grew in strength and supplanted the French influence. This was achieved by the building of a new state-of-the-art medical school and special care units such as a Burn Unit in a major teaching hospital, the formation of an English-speaking group of students, sending American professors on teaching tours in Saigon, appointing American-trained professors, and selling American medical books to students at a cheap price.

At this time, escalation of the war required general mobilization. Young men not doing a university course were all drafted into the Army. Although this motivated university students, it demoralized the majority of youth, some of them turning to drugs out of desperation. The political unrest after the 1963 coup d'état was the result of a weakening government which had lost the people's trust, and an increase in activities of communist infiltrators in South Vietnam who instigated protests and riots in major cities. All this social turmoil together with the spread of the Hippie movement brought about a disintegration of the traditional value systems in our society. General distrust of the government and its authority figures eroded the traditional respect for elders and teachers.

The medical school was not immune to social turbulence; the friction between the French and American trained academic became a battle for power. Our Dean was replaced by a committee with a majority of American-trained professors. There was some disruption caused by student political protests within the medical school and the respect our professors had enjoyed previously was no longer absolute.

Fortunately, the attitude to learning of most students went unchanged not only because the ingrained cultural influence was still strong amongst the highly selected medical students cohort, but also because failing one yearly exam meant army duty.

With the introduction of English textbooks and lectures in English, the first difficulty for our students was to master a new language in addition to French as the traditional language of instruction. The adaptation process had to go deeper than the

language level as the medical curriculum was gradually changed to adopt the American model. Anatomy teaching was no longer systematic and comprehensive. The American approach to anatomy was the regional approach, lighter on details but heavier on clinical application. In other fields such as medicine and surgery, the teaching was less dogmatic with less clear-cut systems of signs and symptoms. Variations and contradictory or controversial findings of recent research were introduced. Contrary to French textbooks of medicine which were dogmatic, American textbooks included latest research papers in their text and their bibliography. Students were encouraged to read journals, and received tutorials on how to use *Index Medicus* (a monthly comprehensive index of medical scientific journals) to look up the latest research publications. This new research-oriented approach made the textbooks and lectures more confusing to weak students, but instilled a new way of learning and fired up interest in research.

While American professors were more accessible to students for consultation and made use of more modern audiovisual technology, fewer could talk and draw perfect diagrams on the blackboard like my favourite French professors; most projected in their lectures colour slides taken from established atlases. As a student, I found those slides less effective in explaining complex structures in anatomy than building up layer by layer with hand drawn diagrams as the lecture was delivered. Assessment in anatomy now included multiple-choice questions scoffed at by the old school professors, and there were fewer and shorter essay questions. As verbal communication skill was less emphasized, viva voce lost its importance in preclinical subjects like anatomy.

At postgraduate level, the selection of candidates for specialist training was still based on the old French system with individual professors "hand picking" residents to be trained by themselves in their department. There were no selection committees or Colleges as in America.

My experience with the American influence in Vietnam was mostly on the receiving end because I only taught anatomy for a short time during my orthopaedic training. In recent years, while teaching clinical and radiological anatomy in America and Canada, I had the experience of being an academic in a different culture. By then, I had experienced the American way of teaching and learning as a student in Vietnam and I also had gained much experience as an academic in Australia.

In 2002, I went to teach anatomy at McMaster University, Ontario in order to gain real experience of teaching in the Problem-based Learning (PBL) system before my university switched to a PBL approach. At McMaster, students did not have formal lectures or schedule practical classes in anatomy. They taught themselves by visiting the stations in the anatomy museum where specimens were set out on the table with accompanying guides and reading materials. Students negotiated their own classes with professors. The academics had no sense of obligation or any authority on students' learning, only a short-term learning contract for one particular topic. When I agreed to guide a group of students through "anatomy of hernia", my task was only to help them understand the anatomical basis of groin hernia, I had no responsibility for their learning of the rest of the abdominal anatomy and did

not even have to set an exam. Only when I took students on a three-week Independent Learning Project on a topic of their choice did I have responsibility to guide them, teach them and complete an assessment form on their attitude and aptitude during the project. Thus academics saw themselves as providers of information on demand, and had neither ownership of nor responsibility to plan or organise any course. Some students even treated professors like their equals.

The radiology residents were selected by the national resident matching system, not by an individual professor at an accredited hospital, and exited the training programme by taking exams set and run by the College of Radiologists, a national accreditation body. The professors in the hospital department were teachers and mentors; they could facilitate residents' learning and could recommend residents for or discourage them from taking the College exam, but could not directly pass or fail them. I found that in this system a professor's respect depended on his/her expertise and capability rather than on the fear of absolute power as in the old French system. I was a visiting professor with absolutely no influence on their career, but I could still command enough respect from them to positively affect their learning. This was achieved firstly by adapting the Confucian principles as I have done in my teaching in Australia (vide infra), and secondly by using the teaching methods from the French school of anatomy systematization and spatial conceptualization.

From my experience, even for a short-term request such as "anatomy of hernia", I imposed my authority on their learning by establishing ground rules and a learning contract: "I only teach you if you learn and read the pre-tutorial readings I give you". They always turned up on time because I was punctual. The first time they didn't read the chapters, I cancelled the tutorial. The interesting observation is that as I made them address me by my title, Dr Vu, our interaction in the lab assumed a teacher-student pattern, not a first-name interaction. As they found that my tutorials were useful to them, they were happy to abide by my rules.

## 15.6 My Experience of Learning at the University of New South Wales (UNSW)

When I came to Australia, my MD degree was considered equivalent to the Australian MBBS. I could lecture but could not practice medicine. I elected to go back to study at the University of New South Wales to graduate a second time with an MBBS, then resumed teaching anatomy at the University.

The Australian healthcare and medical education systems are based on the British system. Unlike my first adaptation from the French to the American system, there are no such striking differences between the Australian and American system in which I had been trained. The organization and funding of state universities in Australia are slightly different from the American state universities. The hierarchy is very similar except for some terminology. For example, in North America, a lecturer is only a tutor, not considered as an academic. Academic titles begin with

assistant or associate professor and progress to full professor. Conversely, the Australian academic hierarchy begins with the title of lecturer, and progresses through senior lecturer to associate and full professor.

I found that compared to American anatomy textbooks, the classical British textbooks are in general more succinct and read less like a journal review. However the difference is now increasingly blurred. British and American textbooks in all fields of medicine have been used interchangeably in both systems. There are more and more similarities and fewer differences due to the instantaneous exchange of ideas and experience amongst academics and students on the internet, through exchange students and academics on fellowship or sabbatical leave. Many scientific societies such as The American and the British Associations of Clinical Anatomists even hold joint meetings regularly.

The important difference now is the almost universal adoption of the new problem-based learning (PBL) system in Australian medical schools. Most medical programmes in North America still follow the model recommended by Abraham Flexner for the medical education reform in America in1910 and include in addition to 2 years of college or university study of science, two *pre-clinical* years for basic sciences such as anatomy, physiology, biochemistry… and two *clinical* years for medicine, surgery and specialties. Incidentally, French universities today still use this traditional model with their first and second “cycles of medical studies”. In our PBL system, students do not learn each subject systematically, but learn small parts of all subjects relevant to the problems that serve as triggers for their learning. The extreme example is the McMaster model where PBL was born, there are no scheduled lectures or tutorials at all, learning is entirely student-driven and by peer-teaching with group meetings in the presence of a facilitator who can be an academic from any field in the faculty of medicine.

## 15.7 My Current Teaching at UNSW and How It Has Been Influenced by My Previous Cultural Experience

My teaching is shaped by my own beliefs on many aspects of teaching and learning, from the lecturer-students interaction to the practical aspect of planning and delivering lectures, beliefs that have been influenced by my cultural background and previous experience.

### *15.7.1 Students’ Attitude to Teachers*

The students’ attitude to learning and authority is different to that in my student days. In the Confucian influenced society of Vietnam, and almost similarly in the French system, professors and lecturers were more *authoritarian* while in Australia they are more *authoritative*. I often see examples of the respect of teachers from

these overseas students, such as in an anatomy workshop that I ran 5 years ago for a group of surgeons from Taiwan. The deferential treatment they gave me even extended beyond the laboratory. A surgeon of my age sitting next to me at the dinner table after the workshop treated me with much respect and explained "because you are our teacher today". In my student days, professors had almost absolute power over their students, from teaching to assessment, and were not easily accessible. At UNSW, it is easier for a student to consult a professor for clarification or even to discuss the marks of an exam paper.

Unlike in Vietnam or other "old countries" in Asia or Europe, many professors or lecturers here prefer to be addressed by their first name. The Confucian idea of social rituals and behaving according to the name/title is often not strictly followed. When not seeing patients in the hospitals, medical students can even wear shorts to lectures or practical classes. One can argue that this environment allows for more individuality and personal development without the stifling inflexibility of dress code or authoritarian professor-student interaction. However, according to Confucian thought, teachers are more likely to behave like teachers when they are addressed and treated respectfully as teachers. Confucius also clarified that although teachers, even emperors, were respected, they would lose that respect if they did not fulfill the responsibility expected of their title. The best way to lead is not by authority but by example.

For the last 25 years lecturing at UNSW, I have asked my students to address me by my title, not because I want to feel a sense of status or power, but because my role is Dr Vu, a teacher who can offer them some expertise in anatomy. As I have behaved like a teacher, trying my best to teach and help my students even outside of working hours, no student has ever had issue with calling me by title. As an anatomy examiner for the Royal Australian and New Zealand College of Ophthalmologists, I have seen candidates presenting in suit and tie for the viva voce and written exams in the early 1990s, and in shorts and T-shirt in recent years when there has been no more viva voce. Although I have noticed that the candidates' behaviour was more serious and professional when they wore suit and tie, I see no disadvantage with the relaxed dress codes so long as it does not interfere with their performance in the exam. More importantly, I interpret the students or candidates attire, mannerism or attitude according to the current university culture, not by the Confucian rules of my cultural background.

### *15.7.2 Students' Attitude to Learning*

Another cultural difference is the students' attitude and approach to learning. UNSW enrolls many overseas students from Asia who remind me of my own background. In general, due to the Confucian upbringing, many of them trust and accept their lecturers' instructions more readily than local students who tend to be more inquisitive and critical of what they are told to learn, and want to know why they have to learn certain topics. The change from the relatively more passive and

"obedient" attitude of my own cultural background is in fact a change for the better and has been behind the current concept of andragogy and the change of our medical programme to a PBL approach. In my student days, medical education was very much subject-centred, Anatomy was taught and learned with an aim for clinical application, but the emphasis was on learning anatomy systematically, the applied aspect was only implicit and not spelled out in lectures or course books. Since I started lecturing in Australia, I have been observing and analysing my students' attitude in order to continually refine the effectiveness of my teaching. Even before the implementation of the PBL system, my lectures usually began with a clinical problem that could only be solved with some anatomical knowledge, even a few X-rays or CT scans could give my students more interest and motivation to learn the lecture contents.

### *15.7.3 Social Interaction and Culture*

During my psychiatry term of my re-training in Australia, I have learned one of the most significant lessons about communication and social interaction: the influence of cultural background is at least as important as language and verbal communication. By then, I had gone through previous training in English and had worked in a high school and a university in Australia for almost 2 years, yet I was still sometimes misunderstood. I was also often the slowest student in my clinical tutorial group to catch the humorous side of a situation or a remark from a colleague or patient, and the last student to identify as "abnormal" a response or behaviour of a psychiatric patient. I realized that verbal communication involves decoding the words the speaker has used to encode their thoughts. The process of encoding and decoding thoughts is coloured by the cultural background and past experience of the interlocutors, and is supported by non-verbal signs such as facial expression, body language… which are also shaped by their cultural background and past experience. At that time, I had not had enough living experience in Australia to align perfectly my encoding-decoding system with those of my colleagues and patients. Consequently I made an effort to talk to people more, listen to talkback radio and even watch Australian and British sitcoms on TV to gain more exposure to Australian culture. I even took a General Education course (which was and still is compulsory for any degree at UNSW) on Australian political history.

I later noticed that in general, Australian students tend to be more expressive and outgoing while my overseas students with an Asian background like mine tend to be more reserved to the point of being shy because we had been taught from an early age to control our gesticulation and expression of emotion. An interesting phenomenon is over-correction in some overseas students when they attempt to assimilate. I feel that in order to teach efficiently, I must be able to effortlessly get my message across to my students and correctly assess their responses and reactions. This can only be achieved by a conscious and constant effort to observe and analyse the influence of cultural and social background on everyday social

interactions, in and outside the lecture theatres or laboratories. I am still honing my communication skills, and learning even more every time I am misunderstood or commit a social gaucherie.

### *15.7.4 Teaching in the Field of Medicine and Anatomy*

I started my medical training, especially in anatomy, with the French and French-educated professors. Since I started teaching in Australia, I have been sifting through the virtues and shortcomings of the French philosophy and practice of teaching medicine and anatomy, while identifying its strengths to apply to my anatomy teaching at UNSW.

Two general features of the French education system in my student days have now become its weaknesses: the heavy factual content, and the encyclopaedic approach to learning.

As mentioned earlier, in the 1960s anatomy was taught with all the minutiae with almost no explicit mention of applied anatomy. As an example, as a first year medical student in 1966, I had an hour-long lecture followed by a practical class on a single bone of the skull, the *sphenoid*, with all the details that are now only expected in a primary fellowship exam in some specialties that have any contact with the sphenoid, such as ophthalmology or neurosurgery. At that time, only comprehensive reference books in English such as *Frazer's Anatomy of the Human Skeleton* (Breathnach 1965) covered the bone to the same depth.

Education at that time, was encyclopaedic, covering a broad range of subjects. Although students taking a Baccalauréat (high school certificate) exam were streamlined into three streams: humanities, mathematics and experimental sciences, they had to take exactly the same subjects, albeit with slightly different depth and weighting. In my medical course, first and second year students had to take more than a dozen end-of-year exams covering subjects from anatomy to history of medicine, medical ethics and legal medicine, all with the same weighting.

The medical curriculum was subject-centred, anatomy was taught as a discipline of knowledge. Students learned about the human body, system by system, and in progressive steps, from the bony framework, through muscles, then nerves and blood vessels. In the late 1960s, the establishment of "*centres hospitalo-universitaires*" (Hospital-university centres) in France was seen as a revolutionary development and brought in some degree of curricular integration because teaching was carried out in both the hospital and university, but teaching was still subject-centred.

In the current application of the principles of andragogy, especially with the PBL curriculum, the above traits of the French system are no longer desirable. Students do not learn anatomy as a discipline, but they learn only the particular areas of anatomy required to solve a specific clinical problem. However, I personally believe that the French system did have a positive effect on the attitude to learning and on the student-teacher interaction. The systematic approach to teaching anatomy gave the students an opportunity to learn to think like an expert in the field of anatomy; that

gave them a preparation for future research in the field and an appreciation of the importance of the subject. Weekly contact throughout the academic year with an expert in a subject-centred syllabus gave students a role model to follow. As the syllabus was heavy on encyclopaedic knowledge of the subject, good professors had to possess, not only an expertise in small areas of anatomy required by the finite number of PBL projects of the course, but a broad and deep knowledge of the entire subject and were deservedly respected by their students as absolute authorities. This expectation motivated students and professors to try their best to pass their exam and to maintain the respect which drove their students to study.

For teaching purposes, my experience of learning anatomy in the traditional French method can be put into good use. The minutiae and methodology of anatomy as a discipline are no longer taught in the undergraduate course, but are essential for anatomy courses for specialists in areas such as radiology and all branches of surgery and for training research students of all levels, from Honours to PhD. In the first stage of their study, my post-graduate students are required to review relevant anatomy in a systematic way and to the depth of the current state of knowledge.

The strength of the French way of teaching anatomy is the creative way of simplification and systematization to help students learn the organization of human anatomy in three dimensions (vide supra). The technique is widely used throughout many French teaching books, but only used sporadically in anatomy textbooks written in English.

Learning from my past experience, I have developed a reconstructive method of presenting anatomy based on layering and three-dimensional conceptualisation which has proved to be useful for the training of radiology and surgical registrars.

### *15.7.5 Delivery of Lectures*

Similar to the American system, the delivery of anatomy lectures in Australia is focused on content more than presentation. I adopted the French way of giving a lecture with accurate timing, drawing diagrams on the blackboard illustrating the points as I talk, using creative diagrams to illustrate three-dimensional conceptualisation instead of relying entirely on ready-made colour slides or photographs of specimens. This approach presents some novelty and maintains my students' interest and attention.

## 15.8 Discussion and Reflection

The challenge of discussing cross-cultural academic life lies in the title itself, in the fluidity of the definition of "culture". Even by adopting my limited working definition of culture, there is always some degree of stereotyping and bias in the observation of

cultural influence on an individual's reaction and interaction in any given situation. My description of the traditional Vietnamese culture is a stereotype and obviously does not apply to all Vietnamese students. Moreover, I believe that description of cultures is always biased. Firstly, one's observation is always limited to the group that one is in contact with, which is not a random sample of the population. Secondly, as a Vietnamese immersed in my early years in my own culture that is familiar and dear to me, my observations are biased towards the traits that I may have considered as desirable, a case of selective sampling. As an observer of a different society and culture such as the time when I first came to Australia, my observation may be biased because of my incomplete understanding of the history, verbal and body language. Even my account of Vietnamese history may be biased because I was in Vietnam at the time and served on one side of the war, even though I have read books written by authors who were on the other side of the war. However, despite these limitations, it is still important to learn from our observations of various cultures.

My account of my personal experience has limited value in the analysis of the cultural influence on teaching and learning. We cannot have the rigorous scientific control set-up to compare the experience in two cultures because I experienced them sequentially at different times, more than two decades apart. Culture changes with time and is deeply influenced by socio-economic factors and by the means of communication and information technology. This was obvious to me when I was incarcerated in the "re-education camp" and in close contact with my captors. They also came from North Vietnam, where I was born and had lived there until 22 years before that time, and yet they seemed to be of a different culture to me, with peculiarities in their language and their different mannerism and beliefs. The Vietnamese culture that I observed in the 1960s therefore must be dramatically different from the Vietnamese culture today when Vietnam is not at war, under a different political regime and in an instantaneous two-way communication with the world through the ubiquitous internet. However, it is still a valuable exercise to reflect on my personal experience because I have lived through the changes in the Vietnamese culture and by analyzing the factors affecting the changes, I can acquire a deeper insight into the nature of these influences and the dynamic of those cultural changes. For example, my observation of the political and military events after the coup d'état in 1963 helped me understand how they influenced the change in the value system and the attitude of Vietnamese youth in Saigon.

Cultural differences are now much less dramatic than in the past because of the easy and immediate exchange of ideas and experiences through travel and the "information superhighway" in today's "global village". However, the situation is different when we compare cultures that have been so different such as those of the Far East and of the Western world. They were isolated from each other at the beginning of written history. Although differences are being diluted now, their contrasts are still easily noticeable. I think that there are many reasons for this fact. Language and script are the first barrier. For example, only a few languages in Asia have romanised scripts, the remaining languages like Chinese, Cambodian are absolute mysteries to the rest of the world. Without some understanding of the language, one cannot have even a glimpse of the culture. Secondly, the cultural heritage ingrained

in the collective memory of a people only changes slowly if they are prepared to adapt to the global trends. When some countries of the West went out to look for colonies, most countries in South East Asia, such as Vietnam, closed the door and allowed very little exchange with the Western world. They remained a mystery to the world until they were conquered, when the colonised people resisted any changes in order to maintain their identity.

From my personal experience as an academic working in a cultural environment different from my own, the first difficulty to overcome is communication. It is easy to learn the basics of a language, but an academic must master the subtlety of the language. As any student of translation understands, language carries with it the entire cultural make up of its society. When I first came to Australia, I already had a reasonable command of American English from my surgical training, but I was unsure about the true meaning of some Australianisms. For example, the expression "not bad" is not a negative comment in Australia as it is in Vietnam. Correct interpretation of reactions, and verbal and non-verbal communication signs when dealing with students and colleagues of a different culture requires a good understanding of the history and social structure of that society. This understanding only comes from observing reactions of real life situations or from cues which reflect reality, such as books or television. Comedy can be helpful because they often exploit or exaggerate social gaucherie or faux-pas. My simple rule is that I can only teach efficiently when the interaction with students or colleagues in a "foreign" culture has become second nature to me, just like I cannot speak a language effectively if I still have to consciously think about vocabulary or grammatical rules.

This cultural adaptation is easier than one may think. I hold the idea that cultural differences are often only minor and superficial, because deep down, we humans as a species have the same pattern of reaction and interaction towards each other and we have developed similar pathways to maintain harmony. I can easily demonstrate many similarities in the teachings of Socrates and Confucius. Facing the same unpleasant situation, two people of different cultures perhaps express anger in words and body language that may look different but actually have many common traits on close observation. Lullabies in many languages share the same characteristics because the same pattern of sound and melody is soothing to babies of any culture.

On the other hand, academics coming from a different culture can enrich their teaching by taking advantage of their different background, by incorporating new ways or new approaches of teaching into the system. Once they have demonstrated the richness of their knowledge or technical experience and their enthusiasm to share it, as long as they are aware of and respect the cultural differences, their students and colleagues will readily accept the difference. Even some quirky use of language can be accepted if it does not lead to ambiguity or confusion. I personally maintain some attitudes from my own Confucian background, such as respect of authority if they facilitate better communication and learning. While trying to learn more about Australian culture that is becoming my own because this is now my adopted country, I also seize upon the best parts of my cultural heritage and my life experience and use them to improve my communication and teaching.

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