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Taiwanese medical students' narratives of intercultural professionalism dilemmas: exploring tensions between Western medicine and Taiwanese culture

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Abstract In an era of globalization, cultural competence is necessary for the provision of quality healthcare. Although this topic has been well explored in non-Western cultures within Western contexts, the authors explore how Taiwanese medical students trained in Western medicine address intercultural professionalism dilemmas related to tensions between Western medicine and Taiwanese culture. A narrative interview method was employed with 64 Taiwanese medical students to collect narratives of professionalism dilemmas. Noting the prominence of culture in students' narratives, we explored this theme further using secondary analysis, identifying tensions between Western medicine and Taiwanese culture and categorizing students' intercultural professionalism dilemmas according to Friedman and Berthoin Antal's 'intercultural competence' framework: involving combinations of advocacy (i.e., championing one's own culture) and inquiry (i.e., exploring one's own and others' cultures). One or more intercultural dilemmas were identified in nearly half of students' professionalism dilemma narratives. Qualitative themes included: family relations, local policy, end-of-life care, traditional medicine, gender relations and Taiwanese language. Of the 62 narratives with sufficient detail for further analysis, the majority demonstrated the 'suboptimal' low advocacy/low inquiry approach (i.e., withdrawal or inaction), while very few demonstrated the 'ideal' high advocacy/high inquiry approach (i.e., generating mutual understanding, so 'intercultural

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competence'). Though nearly half of students' professionalism narratives concerned intercultural dilemmas, most narratives represented disengagement from intercultural dilemmas, highlighting a possible need for more attention on intercultural competence training in Taiwan. The advocacy/inquiry framework may help educators to address similar disconnects between Western medicine and non-Western cultures in other contexts.

Keywords Culture · Cultural competence · Intercultural competence · Professionalism · Intercultural professionalism dilemmas

Introduction

In an era of globalization, healthcare practitioners must treat, work and communicate with people from diverse cultural backgrounds. Cultural competence has been widely acknowledged as essential to the provision of quality healthcare (Anderson et al. 2003; Betancourt 2006). However, while cultural competence training has been incorporated in Western medical curricula (Betancourt 2003; Brach and Fraser 2000), similar training has yet to gain traction in non-Western medical education contexts. At the same time, enamored with global migration and its attendant flows of culture, existing medical education literature has tended to focus on 'other' or minority cultures within Western contexts. Current literature largely ignores the challenges experienced by non-Western students learning Western medicine in non-Western countries, such as Taiwan.

Intercultural professionalism dilemmas in Taiwan

In Taiwan, research suggests that medical students are not well prepared to deal with cultural issues encountered in patient care (Lu et al. 2014). Although brief educational interventions have improved students' cross-cultural communications skills, long-term retention is of concern (Ho et al. 2008, 2010). Moreover, some quantitative assessments of cultural competence based on Western frameworks have been found invalid or unreliable in the Taiwanese context, which has raised the question of their applicability (Ho and Lee 2007). Still, existing notions of cultural competence in Taiwan tend to focus on encounters with minority or 'foreign' cultures (Kleinman and Benson 2006), overlooking the challenges of Western medicine in Taiwanese culture. For medical students trained in Western medicine in non-Western contexts, as in Taiwan, intercultural dilemmas may be more pronounced.

Culture and cultural competence

Culture is a broad term used to signify patterns of belief and behavior, as manifest in values, norms, practices, roles and relationships (Anderson et al. 2003; Betancourt 2003). Far from denoting a singular group identity, each individual is a unique chimera of cultural influences beyond simply race, ethnicity or religion (Betancourt 2003). By extension, *cultural competence* implies the ability to operate effectively in interpersonal interactions and contexts characterized by diverse cultural practices and beliefs (Betancourt 2006). This ability has also been referred to as 'cultural relativism' (Sobo and Loustaunau 2010), 'cross-cultural efficacy' (Núñez 2000), 'cultural humility' (Tervalon and Murray-García

1998) and 'transnational competence' (Koehn and Swick 2006). Earlier movements towards cultural competence sought to impart students with cross-cultural knowledge and skills (Kripalani et al. 2006; Altshuler et al. 2003) relying on cultural stereotypes and oversimplifying inter- and intra-cultural heterogeneity (Koehn and Swick 2006; Dreher and Macnaughton 2002). Recent approaches to cultural competence, however, have shifted towards the integration of cultural background in the provision of empathic, individualized care for patients (Tervalon and Murray-García 1998; Koehn and Swick 2006; Dreher and Macnaughton 2002).

Theoretical perspectives on intercultural competence

While many scholars have explored intercultural competence in teaching and learning and healthcare contexts (Byram 1997; Leininger 1996; Srivastava 2007), we draw specifically on Friedman and Berthoin Antal's contributions from management studies to cross-cultural communication (Berthoin Antal and Friedman 2008; Friedman and Berthoin Antal 2005, 2006). We chose this theory because of its action-orientated approach to intercultural competence, drawing on concepts of action science and identity-based conflict (Friedman and Berthoin Antal 2005). These authors define *cultural competence* as differing from *intercultural competence* (Berthoin Antal and Friedman 2008; Friedman and Berthoin Antal 2005, 2006). In their view, cultural competence denotes non-reflective action in cross-cultural interactions; reliance on a set of learned skills, knowledge or assumptions about 'other' cultures. *Intercultural competence*, on the other hand, involves 'negotiating reality': a process of generating mutual cultural awareness and reflection through a careful combination of high advocacy and high inquiry (Berthoin Antal and Friedman 2008), where *advocacy* involves expressing and championing one's own culture and *inquiry* means exploring and reflecting upon one's own and others' cultures (Friedman and Berthoin Antal 2005).

A *high advocacy/low inquiry* approach involves exhorting one's own values without considering those of others—not uncommon in healthcare settings, where one might encounter 'medicocentric' practitioners (Campinha-Bacota and Munoz 2001; Pfifferling 1981) and hierarchical provider-patient relationships (Chandratilake et al. 2012). On the other hand, a *low advocacy/high inquiry* approach involves exploring the views and values of others without sharing one's own views, with potential detriment to patient care. A *low advocacy/low inquiry* approach can be interpreted as withdrawal or disengagement from a cross-cultural encounter. The most desirable approach, according to Friedman and Berthoin Antal, is *high advocacy/high inquiry*: an open exchange of views in the spirit of exploration, discussion and mutual understanding (Berthoin Antal and Friedman 2008; Friedman and Berthoin Antal 2005). Although the applicability of Western cross-cultural frameworks is questionable in the context of Taiwan, due to a lack of existing indigenous theoretical frameworks, we adopt Friedman and Berthoin Antal's model as a heuristic device to analyze our data without commiting to their conclusion that high advocacy/high inquiry is ncessarily the best. The alternative to not using a Western theoretical framework was to not use a theoretical framework at all. However, we decided against this theory-free approach as we felt that theory would bring rigour to the qualitative analytic process (Rees and Monrouxe 2010).

Rationale and research questions

As medical education in non-Western contexts becomes increasingly Westernised, there is a need to address any disconnects between Western medicine and non-Western cultures. In Taiwan, while the formal curriculum in medical schools follows Western standards, including formal teaching and assessment of Western professional codes and communication models articulating patient autonomy, confidentiality and informed consent, the informal and hidden curriculum in clinical practice is affected by local culture. For example, families play important roles in medical decision-making, to the degree of compromising patient autonomy (Ho et al. 2012).

In line with existing models of cultural competence that encourage patient-centered care, mutual understanding and joint decision-making (Betancourt 2006), we employed the concept of 'intercultural competence' (Friedman and Berthoin Antal 2005) in our analysis of Taiwanese students' intercultural dilemma narratives. These narratives were elicited through an exploration of students' professionalism dilemmas: situations that they witnessed or participated in, which they believe to be immoral, improper or unprofessional from their own cultural perspective (Christakis and Feudtner 1993). Since medical students frequently encounter professionalism dilemmas involving cultural differences, developing cultural competence is key to students' learning and practice of professionalism (Ho et al. 2008; Monrouxe and Rees 2012). This paper, therefore, addresses two research questions: (1) Which aspects of Taiwanese culture are highlighted in students' intercultural professionalism dilemma narratives? (2) Which combinations of advocacy and inquiry do Taiwanese medical students narrate in response to these dilemmas?

Methods

Study design

This study is part of a larger research project investigating Taiwanese medical students' narratives of professionalism dilemmas. It employs qualitative narrative interviewing (Monrouxe and Rees 2012; Monrouxe et al. 2014) and is underpinned by social constructionism, which conceptualizes knowledge as negotiated through social interaction and acknowledges the existence of multiple realities (Crotty 2003). We therefore take a qualitative interpretive approach in this study, despite identifying some basic quantitative patterns in our data (Maxwell 2010).

Context

Taiwanese medical education is based on Western medical education (Ho et al. in press), despite the cultural backdrop embracing both Western and traditional medicine to varying degrees (Huang et al. 2014). Taiwanese medical degrees are typically seven years, and in the participating school, year 4 students spend one afternoon per week learning to do physical examinations and take patient histories. Year 5 and 6 students undertake clerkships in different clinical departments, observing and taking on limited responsibilities in patient care. Finally, year 7 students act as interns with direct but supervised responsibilities in patient care.

Participant recruitment

Following ethical approval, we used electronic bulletin boards and assistance from student association representatives to recruit participants. In total, 14 focus groups at one Taiwanese medical school were conducted with 64 students in 2013–2014 (15 females and 49 males, reflective of the school's gender ratio) in Years 4–7 (age ranged from 20 to 33, mean age = 24.5). The focus groups included 10 students from Year 4 (4 females, 6 males), 15 students from Year 5 (3 females, 12 males), 16 students from Year 6 (3 females, 13 males), and 23 students from Year 7 (4 females, 19 males).

Data collection

We employed a discussion guide based on previous studies conducted by two of the authors (Monrouxe and Rees 2012; Monrouxe et al. 2014) in order to ensure consistency in interviewing across the groups. After a general welcome to focus group participants, introductions and a discussion of ground rules, we started each group discussion with an orienting question: "what is your understanding of professionalism as a [*state year*] medical student?". Then, participants were asked to share their professionalism dilemmas based on their discussion of their definitions of professionalism. In the literature, professionalism dilemmas are defined as day-to-day experiences of students in which they witness or participate in an event that they find unethical, unprofessional, immoral or wrong (Christakis and Feudtner 1993). Professionalism dilemmas include, but are not limited to, ethical dilemmas. Once students' professionalism dilemmas were exhausted, we closed the interviews, thanking participants for their important contributions to the discussions and asking them to complete a questionnaire before they left. This included basic demographic (e.g. age, gender) and education-related details (e.g. year of study) so that we could define the characteristics of our sample and each sub-group.

Data analysis

Group discussions were audio-recorded, transcribed, anonymized and entered into ATLAS.ti Version 7.5.2 (Scientific Software Development GmbH, Berlin, Germany). First, we identified personal incident narratives (i.e. stories of specific events) as the primary unit for coding, rather than generalized talk (e.g. "it happens all the time…"). In total, 233 personal incident narratives were identified. A primary thematic analysis of this data was undertaken using the five stages of framework analysis (Ritchie and Spencer 1994):

1. All authors familiarised themselves with the data independently (at least 6 transcripts each) in order to identify themes and sub-themes. Note that two of five authors did this in a deductive manner based on their knowledge of a previously developed coding framework for professionalism from the UK and Australia (Monrouxe and Rees 2012; Monrouxe et al. 2014). The other three authors engaged in this process in an inductive fashion.
2. We came together to share our insights and to develop a mutually-agreed coding framework. As intercultural dilemmas were among the most common themes identified in students' narratives, we decided at this point to undertake a secondary analysis of intercultural professionalism dilemma narratives, which became the focus of this paper. We then developed an additional coding framework for intercultural

professionalism dilemmas (for example, what types of intercultural dilemmas did students experience?) and employed Friedman and Berthoin Antal's (2005) combinations of advocacy and inquiry, to code the data.
3. The second author coded all intercultural professionalism dilemma narratives and a research assistant double-checked the coding (see acknowledgements). Disagreements were resolved through discussion with the first author.
4. The data were charted (i.e., patterns were explored within the themes).
5. These themes were interpreted in light of Friedman and Berthoin Antal's (2005) theoretical framework and existing literature.

Results

We identified 109 intercultural dilemmas, 98 (90%) of which referred to one or more Taiwanese cultural issues and 10 (9%) to international cultural issues, as well as one narrative (1%) referring to both (Monrouxe and Rees 2017).

Which aspects of Taiwanese culture are cited in students' intercultural dilemmas?

The following Taiwanese cultural themes were identified, with some narratives involving multiple themes: (1) Family relations and role (n = 37); (2) Local policy (n = 33); (3) End-of-life care (n = 15); (4) Chinese medicine (n = 15); (5) Gender relations (n = 11); (6) Taiwanese language (n = 7); and (7) Other cultural issues (n = 8). See Table 1 for a description of each theme and illustrative narratives.

Which combinations of advocacy and inquiry do Taiwanese students narrate?

Of the 109 intercultural dilemma narratives, 62 provided sufficient detail about interpersonal interactions to apply the advocacy/inquiry framework (see Table 2 for definitions and examples). Below, we provide examples of the combinations of advocacy and inquiry identified.

Low advocacy/low inquiry

Most of the students' narratives reflected their reluctance to engage with Taiwanese cultural dilemmas, though a few observed superiors taking the same approach. Interestingly, students often expressed uncertainty or disappointment in such cases. In a narrative combining end-of-life care, the role of the family and Chinese medicine, a Year 7 student shared that her own relative, while taking blood thinner for a pulmonary embolism, began to use Chinese medicine. The student suspected that the combination of Western and Chinese medicines led to her relative's death:

> I participated in a traditional medicine club in the university… So I learned… that there… [is] some research about… ginseng and… dong-quai hav[ing an] anticoagulation effect. (Y7F2)

Yet, upon hearing of her relative's death, she chose not to get involved:

Table 1 Descriptions of intercultural dilemmas in Taiwan with illustrative narratives

Cultural issue	Description	Illustrative intercultural dilemma narrative
Family relations and role	In Taiwan, families play an important role in patient care and decision-making. Without the patient's knowledge, families may make life-saving or life-ending decisions. They may also choose not to inform the patient of fatal diagnoses (Hu et al. 2002; Tang et al. 2006)	"The patient's family did not want her to know the condition because they think that the poor old lady would collapse when she knew that she had terminal cancer… there was [a][a] visiting staff who was treating the lady with me, but he decided not to tell the patient about her condition… because I think he… didn't want to mess up the relationship with the family and he wanted to respect the opinion of the family, but… I'm not sure… because I… [could] not ask the patient if she wanted to know the truth because her son or her grandson was always there with her." (Y7M2)[b]
Local policy and legislation	Constraints on human and financial resources imposed by the National Health Insurance system place significant pressures on Taiwanese healthcare providers (Chi and Huang 2006; Chien et al. 2012). Insurance policies can create dilemmas for practitioners as they consider the best course of treatment, which may not always be covered by insurance. Local laws can also cause dilemmas in relation to reporting patients' illicit drug use or women's abortion requests	"I [wasn't]… in the clinic with my dad [a doctor], but […] later [he told me that]… he saw the patient [who wanted to have an]… abortion… She [found]… my dad to [give her the] abortion, [but]… my dad [couldn't]… find [out who was] the real dad… [which is needed to get permission for an abortion in Taiwan]. So, the patient shouldn't have the abortion, but because of the patient's economic status, [she] cannot afford that child, so it's a very difficult dilemma for my dad [whether to give] her [an] abortion… or not. He just g[a]ve the… girl [an] abortion because it [was] a very difficult things for him to figure it out." (Y4M4)
End-of-life care and death	For many Taiwanese, discussions of death are taboo (Wen et al. 2013). Families may refuse to discuss death and opt to withhold information about fatal diagnoses from patients (Hu et al. 2002)	"It's very common in the palliative ward in our hospital… most, like, for the elderly people. They have very protective children… [who] feel… if they know they have cancer they cannot accept that… it's a cultural norm in our society… our society is really afraid of talking about death, especially for the older generation." (Y5F2)
Traditional medicine	Traditional Chinese medicine is widely used in Taiwan and covered by Taiwan's National Health Insurance (Chen and Chang 2003; Chi 1994). Healthcare professionals trained in Western biomedicine have little knowledge of traditional medicine	"When you ask them [i.e., patients], they always say 'no… I don't take Chinese medicine'… but they just don't tell you, and even [if] they say 'yes', they don't know what kind of medicine that is… They might tell you some very weird name that you have never heard before and even [if] you go online and check it… it's hard to get any information." (Y7F1)

Table 1 continued

Cultural issue	Description	Illustrative intercultural dilemma narrative
Gender relations and norms	Many Taiwanese are conservative when it comes to allowing someone of the opposite sex to view intimate body parts, potentially causing discomfort for both patients and students	"One time I [went] to the bedside. We were going to perform [a] physical examination, but the patient was female and she refused to [allow] that male medical doctor to practice on her, especially [since] we need[ed] to do the heart and the chest part… Taiwan people, especially female patients, feel very uncomfortable for [a] male to do a physical examination on those kind of body part. So it's really hard to, for male medical students to get a real first-hand experience of how to do physical examination on the female patients." (Y4M6)
Taiwanese language	Though Taiwanese language is widely spoken, the younger generation is less proficient due to the prioritization of Mandarin in the public sphere and as the language of instruction in schools. Furthermore, English and Mandarin are the languages of instruction in Taiwanese medical schools. Communication with Taiwanese-speaking patients about medical conditions can therefore pose serious challenges (Beaser 2006)	"Our Taiwanese [is]… usually not that good… so, especially when we [are talking about]… diseases or… nouns [related to our profession],… it is difficult to explain to them [i.e., the patients]." (Y5F3)
Other cultural beliefs and practices	Other cultural beliefs and practices range from discomfort in examining patients' intimate body regions (regardless of gender) to dealing with hierarchy in the Taiwanese healthcare setting, where senior healthcare professionals may be dismissive of their subordinates' opinions and ideas	"I challenged my professor once just one month after I came back from [*names overseas school*]… My professor said that to take a history you need to be straightforward, and you need to be short, like 2 min[s] to 3 min[s]. But I like to sit on the bedside and then talk to the patient and also the family. So when I start[ed] a conversation I would just say 'oh, how is everything going?' And the professor behind me just said, 'Why are you saying that? That is not useful'… so they blamed me in front of the patient, so after… [being blamed a lot], I just sort of cr[ied]. Yeah, that was a terrible situation." (Y5M3)

[a] Square brackets indicate words inserted to clarify meaning or to correct mistakes in students' spoken English. Ellipses (…) indicate words omitted for clarity or brevity, or in cases of repetition or English errors

[b] Y7M2 refers to Year 7, male medical student, number 2

> I didn't explain that to the family… because I think it's the patient's daughter that suggest[ed] that… [her] father should seek… traditional medicine… They… don't know that traditional medicine also include[s] some anticoagulation effect. (Y7F2)

This student's familiarity with Chinese medicine was, however, uncommon. Most students, having been trained in Western biomedicine, expressed little interest in learning

Table 2 Advocacy/inquiry framework—Definitions and sample quotations

High advocacy/low inquiry (n = 11; 18%)	*Low advocacy/high inquiry (n = 7; 11%)*
Definition: Exhorting one's own views and values while ignoring others' perspectives (Friedman and Berthoin Antal 2005). *Example*: "I know one professor… he really… [doesn't] like Chinese herbs, and he has told us that Chinese herbs… [are] nothing. It is truly nothing in his mind… He… [doesn't] want to hear the patient if he or she… is taking… Chinese medicine." (Y6M14)	*Definition*: Respectfully exploring the views and values of others while concealing or suppressing one's own perspectives (Friedman and Berthoin Antal 2005). *Example*: "As his physician, we can just support his choices [to use Chinese medicine]… if that's the thing he want[s] to do before he die[s], then we will respect it… so we just [said] 'okay, if that's your choice, we will respect that'… it's something about the autonomy of the patient." (Y6F3)
Low advocacy/low inquiry (n = 35; 56%)	*High advocacy/high inquiry (n = 9; 15%)*
Definition: Hiding one's own views and values while failing to engage with others' perspectives; also, observing or withdrawing from a cross-cultural encounter (Berthoin Antal and Friedman 2008) *Example*: A student does not engage with patients about their use of Chinese medicine "because maybe I just think it's not really my business." (Y4M1)	*Definition*: Mutually and openly stating one's views and reasoning; inviting inquiry and discussion in order to better understand one another's perspectives and to jointly devise a way forward (Friedman and Berthoin Antal 2005) *Example*: Regarding Chinese medicine, a student says, "we cannot really deny those therapies, because maybe they really [are] helpful, but… they might have some interaction and cause some bad outcome. And sometimes it is hard to change… [the patient's] mind… They will ask you, '…[Is that] right?' and you cannot tell them, 'it's wrong', but… the most I can… say is that 'I don't know, but I strongly [do] not recommend those kind[s] of therapies because we have no proof'." (Y4M6)

about traditional medicine. One student shared that, instead of inquiring further when a patient mentioned Chinese medicine:

> I just write [it down], but I think nobody cares about that as long as it is not some kind of toxin. (Y5M4)

Due to cultural taboos surrounding death in Taiwan, the families of critically ill and elderly patients often make important end-of-life decisions without consulting patients. A Year 7 student shared the story of a patient with cancer whose family, rather than telling the patient about his condition, waited until he was in a coma to sign a 'do not resuscitate' order. The student expressed discomfort with this practice, saying:

> but that doesn't make sense, because we should let the patient know that he will [not be resuscitated]… but I think in… Taiwanese culture, this situation is really common. (Y7M5)

The student observed that a low advocacy/low inquiry response is common among medical students faced with this type of dilemma:

> some of the medical students will just withdraw… because they d[o]n't want to face that strange situation. (Y7M5)

High advocacy/low inquiry

While some students shared their own experiences using a high advocacy/low inquiry approach, most were critical of their superiors who used this approach. For example, a Year 5 student noted the ineffectiveness of a chief resident's high advocacy/low inquiry approach in an incident concerning family involvement in patient care. When a patient's daughter-in-law expressed frustration with the medical students visiting her mother-in-law:

> the chief resident was also a little bit angry and [told] her, 'this is the teaching hospital, so you should not decline the students'. (Y5F3)

The student recognized, however, that the chief resident made no effort to inquire about family pressures on the daughter-in-law, who often bears the brunt of a Taiwanese family's blame:

> We've heard from other residents and [another] chief resident that she's the only caregiver of the patient, but the other [family members] may… question her, 'Did you take good care of my mother? Did you take good care of my grandmother?' So maybe she's under great pressure [from] the family, and there's only one of her. (Y5F3)

A Year 6 student observed a professor whose 'medicocentrism' was evident in interactions with patients who used Chinese medicine, as indicated in Table 2. A Year 5 student echoed this observation, describing a doctor who:

> doesn't want to bother himself [with]… Chinese medicine, so he just say[s], 'oh come on… please just take this drug, don't take Chinese medicine'. (Y5M3)

This approach, the student recognized, may harm the patient, as it:

> results in… bad compliance… because the doctor just simply doesn't explain what kind[s] of characteristics the drug that he prescribe[s has]. (Y5M3)

High advocacy/high inquiry

Students often admired the high advocacy/high inquiry approaches taken by their superiors, with others being proud to share their own successful use of this approach. For example, as explained in Table 1, many Taiwanese people speak Mandarin and are no longer able to communicate in Taiwanese. Although language skills cannot typically be learned during brief patient encounters, a Year 5 student related how she was better able to communicate with and learn from Taiwanese-speaking patients:

> I try to use the limited words I can speak in Taiwanese and when they tell us what they understand in their own way, I can learn more Taiwanese word[s]… so I can use the words [t]o explain better to them so… I'm improving. (Y5F3)

By further inquiring of the patient, she could:

> make sure [of] what they understand… and make [a] better understanding. (Y5F3)

As highlighted in Table 2, a Year 4 student exercised high advocacy/high inquiry when talking about Chinese medicine with family and friends, responding with empathy and honesty.

Low advocacy/high inquiry

A few students shared experiences and observations of low advocacy/high inquiry approaches, many of which concerned families' refusals to inform patients about fatal diagnoses. A Year 6 student shared how he respected a family's point of view while suppressing his belief in patient autonomy and concerns about legality:

> the family sort of lie[d], persuade[d] the doctors… not [to] tell… their father about… his health. They wanted [him] to live happily and… refuse[d] any medical treatment. But actually, in order to respect the patient's autonomy, we're supposed to tell the patient about what's going on in his body. But in Taiwan… perhaps due to… social or traditional value[s] or norms… we tend to… respect what [the] family decide[s]. But it's… in the law. It sa[ys] even the terminal[ly] ill patient, you have to tell him about the treatment plan or his options… but in practice… [it's] usually not easy to. (Y6M8)

On the other hand, as highlighted in Table 2, a Year 6 student cited patient autonomy as a reason to respect the use of Chinese medicine during end-of-life care, regardless of her own beliefs. In a similar situation, a Year 7 student observed how a visiting staff did not oppose a visit from a Chinese medicine doctor to administer acupuncture and blood-letting.

Discussion

In this study we observed that, nearly half of the professionalism dilemmas shared by Taiwanese medical students related to culture and nearly all were intercultural dilemmas, in that they concerned tensions between Western medicine and Taiwanese culture. In terms of our first research question, we identified seven themes for Taiwanese intercultural professionalism dilemmas: family relations and role, local policy and legislation, end-of-life care and death, traditional medicine, gender relations and norms, Taiwanese language and other cultural beliefs and practices. With respect to our second research question, we found that a low advocacy/low inquiry approach was narrated the majority of the time, suggesting that students typically opted out of engagement with intercultural dilemmas. Interestingly, students frequently spoke positively about experiences classified as high inquiry/high advocacy, while they often criticized superiors in narratives categorized as high advocacy/low inquiry. In cases of low advocacy/low inquiry, they often expressed uncertainty or disappointment.

Comparison of findings with existing literature

We employed the same focus group methodology with narrative interviewing as was used to collect student narratives in the UK and Australia (Monrouxe and Rees 2012). However, the previous study did not find intercultural dilemmas, probably because it involved students in a Western context learning Western medicine, which meant fewer opportunities for students to experience such intercultural tensions. The intercultural dilemmas expressed by our Taiwanese medical students may, in part, be explained by the Western style of medicine and medical training in Taiwan. Such Westernised medical culture can set Taiwanese students at odds with certain Taiwanese values, practices and beliefs (Dreher and Macnaughton 2002). Although the conflict between Western medicine and non-

Western cultures may be more pronounced in non-Western settings, similar challenges have been found to exist in Western contexts (Westerhaus et al. 2015).

That most students opted out of engagement with Taiwanese intercultural dilemmas through low advocacy/low inquiry approaches highlights that cultural knowledge alone is insufficient. Students' reliance on a low advocacy/low inquiry approach might be explained by their lack of authority and experience, which precluded them from taking decisions in sensitive situations. Indeed, students in a moderately hierarchical society like Taiwan (Hofstede n. d.) may leave their superordinates to deal with complex issues like cultural conflicts, as their voices might not be heard (Sidanius and Pratto 1999). As intercultural competence is related to empathy and individualised patient care, the low empathy levels previously reported among Asian students may have contributed to disengagement (Berg et al. 2015). Also, in emotionally charged scenarios (e.g., end-of-life care), students might withdraw in an effort to regulate their own emotions (Gross 1998; Gross and Thompson 2007). Previous research in Taiwan indicates that palliative care workers recognize that they should not proselytize, but educate, support and openly communicate with patients' families (Hu et al. 2002). In Taiwan, where 'face' is important, a low advocacy/low inquiry approach might be preferred, permitting students to maintain their own and the patients' *positive face* (i.e., self image) while allowing patients to maintain their *negative face* (i.e., freedom to act as they wish: Goffman 1967; Johnson et al. 2004).

Although a high advocacy/high inquiry approach might seem best-suited to *low context* communication styles (typically found in Western contexts), where meanings are expressed explicitly and directly, our findings (that students spoke about high inquiry/high advocacy narratives positively) suggest that intercultural competence might also work in *high context* communication settings (typically in Asian contexts). Physicians and patients may communicate less explicitly in *high context* communications settings, but could still find culturally appropriate ways to express differing perspectives and work towards mutual understanding (Gudykunst et al. 1996; Nishimura et al. 2008).

Methodological challenges and strengths

There are a number of methodological challenges concerning our study. First, focus groups were conducted at a single Taiwanese medical school and may not reflect the experiences and observations of students at other institutions. For example, students at some medical schools in Taiwan study both Chinese and Western medicine. Students who opt for programs including Western and Chinese medicine might conceptualize intercultural professionalism dilemmas differently. Second, this study did not set out to examine Taiwanese intercultural dilemmas, but instead identified local culture as a theme for secondary analysis, meaning that we did not ask students for their reasoning of and reactions towards the cultural aspects of their narratives. Finally, although Friedman and Berthoin Antal's Western-developed framework advocates for a high advocacy/high inquiry approach, the assumptions underpinning this framework might not be wholly applicable in non-Western cultural settings. For example, Friedman and Berthoin Antal developed their framework in the context of international business, in which the power relationships among members of multinational corporations differ from the doctor-patient and teacher-student interactions outlined in our study. In the context of our study, there are circumstances in which advocacy might be interpreted as disrespectful, and inquiry as rude. Thus, high advocacy/high inquiry approaches may need to be applied thoughtfully in different cultural contexts and scenarios.

Despite these challenges, our paper has a number of methodological strengths. First, to our knowledge, our study is the first to consider Taiwanese students' intercultural dilemmas and the combinations of advocacy and inquiry employed in the face of these dilemmas. Though Taiwanese culture ostensibly encompasses patients, students and healthcare professionals, we highlight how 'home' cultures—not just 'foreign' or minority cultures—can pose challenges to student learning and patient care in any context. Second, our study introduces a useful framework—intercultural competence—from the management literature to the field of medical education. Despite the caveats mentioned above, we believe the intercultural competence framework can serve as a useful basis from which to approach intercultural professionalism dilemmas. Finally, we add to the limited body of existing research on cultural competence in non-Western medical education contexts (Ho et al. 2008; Lu et al. 2014), though aspects of the Taiwanese experience may resonate with medical educators across cultural settings.

Implications for education practice

Taiwanese students' frequent adoption of a low advocacy/low inquiry approach highlights the challenges faced in engaging with intercultural dilemmas and suggests that attention needs to be paid to developing students' practices of intercultural competence. This is crucial given that previous research suggests, on the one hand, that failure to address cultural differences can result in dissatisfied patients, misdiagnoses and less optimal health outcomes (Barker 1992; Lavizzo-Mourey and Mackenzie 1996); and, on the other hand, that strong physician-patient communication improves patient satisfaction and compliance (Beckman and Frankel 1984; Betancourt et al. 1999) and patient-centered models of communication can improve patient health (Epstein and Street 2007; Mead and Bower 2002). Our study suggests the potential need for a shift in understanding, teaching and practice towards intercultural competence, so that healthcare practitioners can effectively bridge cultural gaps in any context.

We believe, therefore, that educators could adapt their teaching of intercultural competence to suit local communication styles and foster understanding of *when* to use intercultural competence. Indeed, in considering how we might educate students for intercultural competence, our findings indicate the importance of medical culture and role modeling to students' learning and practice. Some students recognized the negative implications of high advocacy/low inquiry approaches role modeled by their superiors, while others expressed admiration for superiors' adeptness in 'negotiating reality'. The finding that medical educators were recognized by some students as negative role models warrants further faculty development. Formal curricula could also be refocused to reflect local needs. In the Taiwanese case, certain knowledge and skills related to commonly encountered intercultural dilemmas (e.g., Taiwanese language, Chinese medicine) could be incorporated into the curriculum.

Fostering intercultural competence will be a complex endeavor, requiring long-term and integrated teaching in formal and hidden curricula (Berthoin Antal and Friedman 2008). As students gain experience, they may practice *phronesis* (i.e. practical wisdom) and find that different combinations of advocacy and inquiry are better suited to particular circumstances (Dowie 2000; Hofmann 2002).

Implications for further research

While our study only scratches the surface of intercultural dilemmas for Taiwanese students, further research is now needed to investigate cultural and intercultural competence initiatives at other non-Western medical schools and elicit views from those learning both Western and traditional medicine. Additional longitudinal research should explore whether students employ different combinations of advocacy and inquiry as they gain clinical experience. Further research could also explore students' reasoning of and reactions towards the cultural aspects of professionalism narratives. It could employ narrative inquiry, drawing on intersectionality theory (Tsouroufli et al. 2011; Monrouxe 2015), to explore how students construct their intersecting personal and professional identities while narrating these cultural dilemmas. Finally, additional research could focus explicitly on the culture-related experiences and observations of students, teachers and healthcare professionals, with the aim of understanding why and how they adopt certain advocacy/inquiry approaches.

Conclusions

Our findings highlight the potential need for improved intercultural competence among Taiwanese medical students and offer insights for medical educators seeking to foster intercultural competence in their own educational contexts. Not only should healthcare practitioners be equipped with the skills and tools to negotiate everyday encounters with majority cultural issues, but they must be prepared to provide high quality, individualized care to any patient, regardless of cultural background. Global medical educators witnessing a similar disconnect between Western medicine and non-Western cultures may use this study as a basis from which to reconsider the teaching and practice of cultural and intercultural competence in their own healthcare settings.

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Authors' contribution MJH, CER, MC, and LVM developed the study and contributed to data collection. All authors participated in the analysis and interpretation of data. KG wrote the first draft of this article, while CER revised the article significantly after thorough peer-review feedback. The final version was edited and approved for publication by all authors and agree to be accountable for all aspects of the work.

Compliance with ethical standards

Ethical approval This study was approved by the institutional review board of the hospital affiliated with the Taiwanese university where the study was conducted.

References

Altshuler, L., Sussman, N. M., & Kachur, E. (2003). Assessing changes in intercultural sensitivity among physician trainees using the intercultural development inventory. *International Journal of Intercultural Relations, 27*, 387–401.

Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E., Normand, J., & Task Force on Community Preventive Services. (2003). Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine, 24*(3 suppl), 68–79.

Barker, J. C. (1992). Cultural diversity-Changing the context of medical practice. *The Western Journal of Medicine, 157*(3), 248–254.

Beaser, D. (2006). The outlook for Taiwanese language preservation. *Sino-Platonic Papers, 172*, 1–18.

Beckman, H. B., & Frankel, R. M. (1984). The effect of physician behavior on the collection of data. *Annals of Internal Medicine, 101*(5), 692–696.

Berg, K., Blatt, B., Lopreiato, J., Jung, J., Schaeffer, A., Heil, D., et al. (2015). Standardized patient assessment of medical student empathy: Ethnicity and gender effects in a multi-institutional study. *Academic Medicine, 90*(1), 105–111.

Berthoin Antal, A., & Friedman, V. (2008). Learning to negotiate reality: A strategy for teaching intercultural competencies. *Journal of Management Education, 32*(3), 363–386.

Betancourt, J. R. (2003). Cross-cultural medical education: Conceptual approaches and frameworks for evaluation. *Academic Medicine, 78*(6), 560–569.

Betancourt, J. R. (2006). Cultural competence and medical education: Many names, many perspectives, one goal. *Academic Medicine, 81*(6), 499–501.

Betancourt, J., Carrillo, J. E., & Green, A. (1999). Hypertension in multicultural and minority populations: Linkin [sic] communication to compliance. *Current Hypertension Reports, 1*(6), 482–488.

Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review, 57*(1 suppl), 181–217.

Byram, M. (1997). *Teaching and assessing intercultural communicative competence*. Bristol, PA: Multilingual Matters.

Campinha-Bacota, J., & Munoz, C. (2001). A guiding framework for delivering culturally competent services in case management. *The Case Manager, 12*(2), 48–52.

Chandratilake, M., McAleer, S., & Gibson, J. (2012). Cultural similarities and differences in medical professionalism: A multi-region study. *Medical Education, 46*(3), 257–266.

Chen, Y. F., & Chang, J. S. (2003). Complementary and alternative medicine use among patients attending a hospital dermatology clinic in Taiwan. *International Journal of Dermatology, 42*, 616–621.

Chi, C. (1994). Integrating traditional medicine into modern health care systems: Examining the role of Chinese medicine in Taiwan. *Social Science and Medicine, 39*, 307–321.

Chi, C. H., & Huang, C. M. (2006). Comparison of the Emergency Severity Index (ESI) and the Taiwan triage system in predicting resource utilization. *Journal of the Formosan Medical Association, 105*, 617–625.

Chien, T. W., Chou, M. T., Wang, W. C., Tsai, L. S., & Lin, W. S. (2012). Intraclass reliability for assessing how well Taiwan constrained hospital-provided medical services using statistical process control chart techniques. *BMC Medical Research Methodology, 12*, 67.

Christakis, D. A., & Feudtner, C. (1993). Ethics in a short white coat: The ethical dilemmas that medical students confront. *Academic Medicine, 68*, 249–254.

Crotty, M. (2003). *The foundations of social research: Meaning and perspective in the research process*. London: Sage Publications Ltd.

Dowie, A. (2000). Phronesis or "practical wisdom" in medical education. *Medical Teacher, 22*(3), 240–241.

Dreher, M., & Macnaughton, N. (2002). Cultural competence in nursing: Foundation or fallacy? *Nursing Outlook, 50*(5), 181–186.

Epstein, R. M., & Street, R. L. (2007). *Patient-centered communication in cancer care: Promoting healing and reducing suffering*. Bethesda, MD: National Cancer Institute.

Friedman, V., & Berthoin Antal, A. (2005). Negotiating reality: A theory of action approach to intercultural competence. *Management Learning, 36*(1), 69–86.

Friedman, V., & Berthoin Antal, A. (2006). Interactive critical reflection as intercultural competence. In D. Boud, P. Cressey, & P. Docherty (Eds.), *Productive reflection at work: Learning for changing organizations*. Abingdon: Routledge.

Goffman, E. (1967). *Interaction ritual: Essays on face-to-face behaviour*. New York: Doubleday.

Gross, J. J. (1998). The emerging field of emotion regulation: An integrative review. *Review of General Psychology, 2*(3), 271–299.

Gross, J. J., & Thompson, R. A. (2007). Emotion regulation: Conceptual foundations. In J. J. Gross (Ed.), *Handbook of emotion regulation*. New York: Guilford Press.

Gudykunst, W. B., Matsumoto, Y., Ting-Toomey, S., Nishida, T., Kim, K., & Heyman, S. A. M. (1996). The influence of cultural individualism-collectivism, self construals, and individual values on communication styles across cultures. *Human Communication Research, 22*(4), 510–543.

Ho, M. J., & Lee, K. L. (2007). Reliability and validity of three cultural competency measures. *Medical Education, 41*(5), 519.
Ho, M. J., Lin, C. W., Chiu, Y. T., Lingard, L., & Ginsburg, S. (2012). A cross-cultural study of students' approaches to professional dilemmas: Sticks or ripples. *Medical Education, 46*, 245–256.
Ho, M. J., Shaw, K., Shih, J., & Chiu, Y. T. (2017). Mission and modernity: The history and development of medical education in Taiwan. In Chen L, Reich M, Ryan J. (Eds.). *Medical education in East Asia: Past and Future*. Bloomington, IN: Indiana University Press (in press).
Ho, M. J., Yao, G., Lee, K. L., Beach, M. C., & Green, A. R. (2008). Cross-cultural medical education: Can patient-centered cultural competency training be effective in non-Western countries? *Medical Teacher, 30*(7), 719–721.
Ho, M. J., Yao, G., Lee, K. L., Hwang, T. J., & Beach, M. C. (2010). Long-term effectiveness of patient-centered training in cultural competence: What is retained? What is lost? *Academic Medicine, 85*(4), 660–664.
Hofmann, B. (2002). Medicine as practical wisdom (phronesis). *Poiesis & Praxis, 1*, 135–149.
Hofstede, G. (n. d.) *Cultural dimensions*. Stockholm: Itim International. Retrieved May 26, 2016 from http://www.geert-hofstede.com/index.shtml.
Hu, W. Y., Chiu, T. Y., Chuang, R. B., & Chen, C. Y. (2002). Solving family-related barriers to truthfulness in cases of terminal cancer in Taiwan: A professional perspective. *Cancer Nursing, 25*(6), 486–492.
Huang, T. P., Liu, P. H., Lien, A. S., Yang, S. L., Chang, H. H., & Yen, H. R. (2014). A nationwide population-based study of traditional Chinese medicine usage in children in Taiwan. *Complementary Therapies in Medicine, 22*(3), 500–510.
Johnson, D. I., Roloff, M. E., & Riffee, M. A. (2004). Politeness theory and refusals of requests: Face threat as a function of expressed obstacles. *Communication Studies, 55*, 227–238.
Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. *PLOS Med, 3*(10), e294.
Koehn, P. H., & Swick, H. M. (2006). Medical education for a changing world: Moving beyond cultural competence into transnational competence. *Academic Medicine, 81*(6), 548–556.
Kripalani, S., Bussey-Jones, J., Katz, M. G., & Genao, I. (2006). A prescription for cultural competence in medical education. *Journal of General Internal Medicine, 21*(1), 1116–1120.
Lavizzo-Mourey, R., & Mackenzie, E. R. (1996). Cultural competence: Essential measurements of quality for managed care organizations. *Annals of Internal Medicine, 124*(10), 919–921.
Leininger, M. (1996). Culture care theory, research, and practice. *Nursing Science Quarterly, 9*(2), 71–78.
Lu, P. Y., Tsai, J. C., & Tseng, S. Y. H. (2014). Clinical teachers' perspectives on cultural competence in medical education. *Medical Education, 48*(2), 204–214.
Maxwell, J. A. (2010). Using numbers in qualitative research. *Qualitative Inquiry, 16*, 475–482.
Mead, N., & Bower, P. (2002). Patient-centred consultations and outcomes in primary care: A review of the literature. *Patient Education and Counseling, 48*, 51–61.
Monrouxe, L. V. (2015). When I say… intersectionality in medical education research. *Medical Education, 49*, 21–22.
Monrouxe, L. V., & Rees, C. E. (2012). "It's just a clash of cultures": Emotional talk within medical students' narratives of professionalism dilemmas. *Advances in Health Sciences Education, 17*(5), 671–701.
Monrouxe, L. V., & Rees, C. E. (2017). *Healthcare professionalism. Improving practice through reflections on workplace dilemmas*. Oxford: Wiley-Blackwell.
Monrouxe, L. V., Rees, C. E., Endacott, R., & Ternan, E. (2014). 'Even now it makes me angry': Healthcare students' professionalism dilemma narratives. *Medical Education, 48*, 502–517.
Nishimura, S., Nevgi, A., & Tella, S. (2008). *Communication style and cultural features in high/low context communication cultures: A case study of Finland, Japan and India*. Retrieved Feb, 2015, from www.helsinki.fi/~tella/nishimuranevgitella299.pdf.
Núñez, A. E. (2000). Transforming cultural competence into cross-cultural efficacy in women's health education. *Academic Medicine, 75*(11), 1071–1080.
Pfifferling, J.-H. (1981). A cultural prescription for medicocentrism. In L. Eisenberg & A. Kleinman (Eds.), *The relevance of social science for medicine*. Dordrecht: D. Reidel Publishing Company.
Rees, C. E., & Monrouxe, L. V. (2010). Theory in medical education research: How do we get there? *Medical Education, 44*(4), 334–339.
Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R. Burgess (Eds.), *Analyzing qualitative data*. London: Sage.
Sidanius, J., & Pratto, F. (1999). *Social dominance: An intergroup theory of social hierarchy and oppression*. Cambridge: Cambridge University Press.

Sobo, E. J., & Loustaunau, M. O. (2010). *The cultural context of health, illness, and medicine*. Santa Barbara, CA: Praeger.

Srivastava, R. H. (2007). Understanding cultural competence in health care. In R. H. Srivastava (Ed.), *The healthcare professional's guide to clinical cultural competence* (pp. 3–27). Toronto: Mosby Elsevier.

Tang, S. T., Liu, T. W., Lai, M. S., Liu, L. N., Chen, C. H., & Koong, S. L. (2006). Congruence of knowledge, experiences, and preferences for disclosure of diagnosis and prognosis between terminally-ill cancer patients and their family caregivers in Taiwan. *Cancer Investigation, 24*, 360–366.

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117–125.

Tsouroufli, M., Rees, C. E., Monrouxe, L. V., & Sundaram, V. (2011). Gender, identities and intersectionality in medical education research. *Medical Education, 45*(3), 213–216.

Wen, K. Y., Lin, Y. C., Cheng, J. F., Chou, P. C., Wei, C. H., Chen, Y. F., et al. (2013). Insights into Chinese perspectives on do-not-resuscitate (DNR) orders from an examination of DNR order form completeness for cancer patients. *Supportive Care in Cancer, 21*, 2593–2598.

Westerhaus, M., Finnegan, A., Haidar, M., Kleinman, A., Mukherjee, J., & Farmer, P. (2015). The necessity of social medicine in medical education. *Academic Medicine, 90*, 565–568.