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Tight and loose culture in medical education

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Intercultural competence is the ability to function effectively across cultures, to act appropriately and to communicate and work with people from different cultural backgrounds [1], a prerequisite for effective international collaboration. A deeper understanding of the motivations behind observed behavior fosters the ability to address differences in communication more sensitively. As medical students from Germany undertaking clinical rotations in South Korea, we initially struggled to adapt to the new learning environment. We found that our behaviors and norms learned in Germany were at odds with the apparent expectations of students in Korea.

> Why were we the only students asking questions un-prompted?
> Why were students not being instructed to scrub into cases in the operating room?
> What were the expectations of students, if not those that we had learned at home?

No aspect of our formal education prepared us to easily integrate into our role as junior trainees in the hierarchy of Korean medical education, beyond just the obvious language barrier.

There is growing emphasis placed on intercultural competence in healthcare practice [2], particularly on training students in cultural sensitivity and awareness early in their careers. Yet, intercultural competency in the professional learning environment, with trainees and their mentors from varying cultures, remains under-addressed. "Culture" in the context of medicine is variably defined. We borrow our definition of culture from Bearman et al. [3]: "behaviors, values, norms, beliefs, assumptions and attitudes that are found within a particular organization or context." In the medical education context, individual cultures lead to differences in students' experience not only between international rotations, but also between different medical specialties. We were interested in better understanding what underlies the intercultural differences we observed during our experiences abroad.

One theoretical framework explaining these discrepancies discusses cultural "tightness" and "looseness," the overall strength of social norms and tolerance of deviance away from those norms. First described in 1968 by Pelto

Received: June 9, 2022 • Revised: July 25, 2022 • Accepted: July 27, 2022
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Korean J Med Educ 2022 Sep; 34(3): 239-241
https://doi.org/10.3946/kjme.2022.234
eISSN: 2005-7288
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[4] to compare variations across nations' cultures and expanded upon by Gelfand et al. [5] in 2011, the framework asserts that tight cultures have "strong social norms and low tolerance of deviant behavior," while loose cultures exhibit "weak social norms and high tolerance of deviant behavior," where "strong" and "weak" refer to how likely people are to adhere to social norms. South Korea ranks as one of the tightest cultures, while Germany falls in the middle [5]. Gelfand et al. [5] postulates the tight/loose dichotomy as a method of increasing cross-cultural understanding. We argue this method can be utilized to understand the tight, hierarchical culture of medical education as well as the differences in approaches to medical education in Germany and Korea.

It is not possible to fully understand the nuances between the two medical systems after only a 4-month rotation at one institution in South Korea, and Korea's unique insurance system and medical delivery system need to be taken into account when discussing the differences we observed. However, we can extrapolate from our experiences and identify areas where the tight/loose framework could be used to provide a deeper understanding of differences in approaches to the students' educational experience and their roles or expectations between the Korean and German systems.

During an observership at an outpatient clinic, we found that efficiency in serving patients was the primary object, with little time allotted for teaching or involving medical students. In Germany, we are accustomed to directly interviewing patients and practicing physical examinations. While it would be more efficient for the attending to conduct these tasks, we find the hands-on learning experience valuable. In the operating room in Korea, we observed how the only interaction between the professor and the medical students was a 2-minute overview of the pathological specimen at the end, with no guidance throughout the 2-hour long laparoscopic procedure nor questioning by students, again prioritizing efficiency. When interested, students in Germany are permitted to scrub in and surgeons explain the steps of the procedures, allowing questions to be asked unprompted. While these are only two individual comparable experiences, we noticed patterns in trainer-trainee interactions as well as students' behavior that can be interpreted through the tight/loose framework.

Across nations, the culture of medical education generally shows stricter hierarchies and likely would independently rank as a tighter culture. We observed that the features of a tight culture like in Korea, exemplified by the even stronger social norms in medical education, placed professors in charge of trainee knowledge acquisition, with little room to explore the gaps in students' knowledge. Heightened situational constraints limited trainees' opportunities for individualized educational experiences, meaning students did not feel they could ask questions and had little freedom in what was considered appropriate behavior. There was also a more delineated delegation of tasks and expected knowledge base at each level of training, when compared with Germany. The hierarchy of medical education, which is in place to increase the safety and efficiency of the system, places young trainees in a position where their presence on the wards may initially divert focus from efficiency in patient care, and the exact roles and afforded behavior that students of the same level of training take on or are permitted to exhibit depends on the culture of the department, institution, or country of training. While medical education may not be the highest priority in patient care, Korea's health care system is unique in that it incentivizes low cost, extremely high productivity, and research, values that are important for young trainees to learn early on in their education.

Awareness of the concept of cultural tightness/looseness gave us a framework through which to view our

experiences on the wards, allowing us to better predict appropriate behavior and to adapt preconceived expectations to the reality of the new situation. We believe this framework improved our understanding of the differences in approaches to medical education in a culturally sensitive manner, which in turn maximized our clinical clerkship experience. We hope this can provide a similar benefit for other students facing a new cultural learning experience, whether it be rotations abroad or the first days on a new ward at their home institution. Heightened intercultural competency can foster productive professional international collaborations in a world increasingly reliant on effective communication with people from different cultural backgrounds, and this work must begin promptly, as students develop professional networks early in their medical education.

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Acknowledgements: We are grateful to the Department of Surgery at Anam Hospital, Korea University, Seoul, for sharing their surgical knowledge and mentorship. We would like to thank Guglielmo Niccolò Piozzi for sharing his insights about cultural differences between different countries and healthcare systems with us. We also want to thank Naejeong Kong from the International Faculty Affairs at Korea University Anam Hospital and Sunhee Park from Korea University for helping us navigate our clerkship experiences and life in Korea. Lastly, we would like to express our gratitude to Karin Heisen and Kyle Proctor for their critical review of the manuscript.

Funding: No funding was obtained for this study.

Conflicts of interest: No potential conflict of interest relevant to this article was reported.

Author contributions: Conception of the work: CH, CW, YML; literature review and interpretation: CH, CW, HP, YML; drafting the article: CH, CW, HP, YML; critical revision of the article: CH, CW, HP, YML; and final approval of the version to be published: all authors.

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