Perspective changes through transcultural mediation training

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Title:

Perspective changes through transcultural mediation training: a qualitative study of trainees, instructors and experts

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Contributors' Statement Page

Doctors Ogrizek and Lachal conceptualized and designed the study, designed the data collection instruments, collected the data, carried out the initial analyses, drafted the initial manuscript, and reviewed and revised the manuscript.

Dr Bouznah conceptualized and designed the study and critically reviewed the manuscript for important intellectual content.

Prof Moro conceptualized and designed the study, coordinated and supervised data collection, and critically reviewed the manuscript for important intellectual content.

All authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

Abstract

Background:

To deal with cultural misunderstandings in health care due to increased migration, the Babel Centre – a training and mediation centre – developed "*transcultural mediation"*: a service meant to help health-care professionals encountering difficulties with migrant patients and their families. One of the centre's health-care professionals, trained as a mediator, and a cultural broker jointly conduct the mediation session. In 2017, the centre initiated a specialised training programme to teach health-care professionals the skills needed to serve as transcultural mediators. We conducted a study to evaluate, through the trainees' and instructors' subjective experiences, the quality of this innovative training.

Method:

We used semi-structured interviews and focus groups to question seven trainees, three instructors, and three experts in transcultural psychology at different stages of the 10-month programme (before, at midpoint, and afterwards). we used Interpretative Phenomenological Analysis to explore the data.

Results:

The themes are organised around the central concept of the transmission of knowledge from instructors to trainees and vice versa. Trainees were globally satisfied with this programme by its end but did not feel able to lead a mediation by then, due to insufficient anthropology knowledge and practical training.

Conclusion:

Training in transcultural mediation resembles that for resolving situational problems. It cannot be taught by an approach based on reasoning by the inverse problem method, used for teaching medical sciences. Paedagogical tools more suited to problem solving, such as role-playing or use of senior-assisted mediations, should be used to improve the quality of this training.

Key words:

Patient – Health-care professionals' communication issues, Health-care professionals, Instruction, Qualitative research, Transcultural mediation,

Introduction

In this period of globalisation, more and more people move from one country to another, where they inevitably encounter ethnic cultural differences (Larchanché, 2012). Recent public health studies examining migrants' medical status report a higher than anticipated rate of chronic diseases (de Waure et al., 2015; Giannoni et al., 2016). These migrants often experience delays in diagnosis, treatment or care, together with discrimination and substantial communication difficulties related to differences in language and cultural elements (Mirza et al., 2014). Health-care institutions have developed various initiatives to help with these issues, including hiring cultural brokers. But while cultural brokers share substantial knowledge of the patient's cultural background, they are most often unfamiliar with medical clinical language and the world of health-care professionals (Bouznah & Larchanché, 2015).

To deal with this, in the 1990s, the Babel Centre – a European training and mediation resource centre for transcultural issues — developed a new service called *transcultural mediation* (Baubet T, Moro MR, 2009; Bhui et al., 2015; Kirmayer et al., 2003).

T*ranscultural mediation* is a service offered by the Babel Centre to Paris hospitals that have contracted with the centre for situations when their health-care professionals encounter difficulties in providing care for migrant patients. It can be useful in all medical fields but is most often needed in medical specialties when families must be fully involved in the patient's care, such as paediatrics, psychiatry, palliative care or obstetrics.

Transcultural mediation is a unique and innovative service, which differs from other cultural consultations in its purpose, its organization, and in the role of the health-care professional leading the sessions; this medical professional trained in cultural mediation is called a "transcultural mediator".

At the request of one of the health professionals involved in the patient's care, a transcultural mediator, teamed with a cultural broker from the same ethnocultural background as the patient, sees the patient, his or her family and the medical team for a single two-hour consultation aimed at improving the team's interactions with the patient and family. The objective of the transcultural mediation consultation is to modify the conditions of the interaction between the medical teams, on the one hand, and patients and their families on the other (Bouznah, 2020; Lachal et al., 2019a). The shared narrative of cultural and medical representations may allow each to find meaning in what goes on in treatment and to understand that the different concepts and discourses about the disease can coexist that is, that one does not necessarily exclude the other. The transcultural mediator helps in building a bridge between

families and professionals by clarifying the medical culture and its perspectives whereas the cultural broker helps in building that bridge by illuminating the patient's ethnocultural background and its perspective.

The transcultural mediation consultation is organized in three parts. In part 1, the hospital physician — care coordinator — is asked to describe the patient's medical condition, the proposed treatment, and the problems or concerns that led the health care team to request the mediation. The transcultural mediator, from the Babel Centre, reformulates some of the doctor's statements, making them more accessible to the cultural broker, who translates it, if necessary, and uses his/her knowledge of the patient's ethnocultural background to make the medical statements accessible to the patient and family. In part 2, the patient and family are invited to express, with the help of the cultural broker, their own understanding of the origin of the disease and the treatments or protection possibilities available in the cultural area they come from. The transcultural mediator reformulates pieces of information, making them understandable by the western medical doctor in charge. Finally, in part 3, with the help of the transcultural mediation team, the family and the hospital medical staff are invited to build a story together, in which the disease finds a meaning in the patient's life history and which integrates simultaneously the resources of Western medicine and those of the family's cultural background.

A 2016 evaluation of this service in a children's hospital found that it: i) cut health care costs, by reducing emergency department visits, ii) improved the patient-physician relationship and helped them to understand one another, and iii) significantly enhanced trust between doctors and patients. The doctors reported, in particular, that

this trust was owed in part to their increased confidence in the families' ability to manage the disease by better adherence to the treatment. (Lachal et al., 2019b).

In 2017, the Babel Centre created a specialised programme to train hospital-based health-care professionals as transcultural mediators to extend transcultural mediation to other French health-care establishments. The Centre asked us to study the trainees' and instructors' subjective experience to evaluate the quality of this innovative training.

Method

We used interpretative phenomenological analysis (IPA) to conduct a qualitative observational study of the caregiver trainees and instructors, as we consider phenomenology to be the most appropriate theoretical framework for exploring complex, ambiguous and emotionally laden experiences of a small group of participants. It is a method that aims to bring general sense out of detailed accounts of the lived experience of individuals in their own words, by examining each case in turn (Smith, J. A., 1996). The Ethics Review Committee (CEERB) of Paris Nord University (AP-HP) approved this study (IRB N° IRB 00006477).

Programme organisation

The mediator training programme took place two to four days monthly from September 2017 to June 2018. Theoretical lectures were selected from already existing courses available at the Centre (covering transcultural psychiatry, the work of cultural brokers, and issues in transcultural mediation), based on their relevance to the practice of this

mediation in health-care facilities. All lectures were given in the lecture halls of the Maison de Solenn, Cochin Hospital, APHP, Paris.

Each month, the programme included:

- One to two days of theoretical training (classroom work), totalling 83 hours for the year;
- Half a day of supervision by a psychiatrist;
- Half a day of role-playing sessions in a smaller "practical mediation" group with students from other courses at the Centre;
- Attendance one to three times monthly at transcultural medical mediations at a French paediatric hospital, with a trained transcultural mediator.

The lectures were presented mainly by anthropologists, doctors, and psychologists dealing with transcultural issues in their day-to-day professional practice.

Participants and Sampling

We chose to examine the subjective experiences of both the instructors, who were more likely to be able to analyse the theoretical quality of this training, and the trainees, that is, the learners, who were in the best position to provide data on the experience of the training and on their perception of its effectiveness.

All participants and the major instructors (i.e., those most involved in this programme) were asked to participate in this study; no financial compensation was offered.

We also selected three French medical "experts", considered by the French scientific community to be knowledgeable professionals in this field, and asked them for interviews before the course began, to help us develop the guides for semi-structured

interviews of trainees and instructors and to determine the essential theoretical skills to be acquired and clinically experienced.

Before the study began, neither the trainees nor the instructors had met the focus group facilitator.

Data collection

The research group worked collectively to construct the interview guides (**Table 1**), based on open-ended questions that are likely to induce to a dialogue around the research themes (Smith, J.A., 2008). **Table 2** summarises the different times and types of data collection. The interviews took place at the participants' workplace.

One researcher (AO) conducted all the interviews between June 2017 and June 2018. All individual interviews were audio-recorded, and the focus groups were filmed to avoid accidental misattribution of statements from one participant to another during transcription. All recordings were used only for the purposes of this research, with participants' authorisation. Interviews and focus groups took place in French, were transcribed verbatim by the interviewer from the recordings, and subsequently anonymised. The extracts used were translated into English for the purposes of this paper.

Data Analysis

The interviews, conducted before the programme, around its midpoint and at its end, were analysed separately, according to IPA guidelines (Smith, J.A., 2008). This method makes it possible to analyse the subjects' feelings and experiences (Chapman & Smith, 2002; Macleod et al., 2002; Smith et al., 2002). The three transcripts for each participant

were then examined together to analyse the changes over time and finally assembled into a single thematic framework.

Analysis involved repeated readings of the transcripts for new insights, followed by manual coding of the text and recurrent themes (Morse, J. M., & Field, P.-A., 1995) to identify the perspectives that instructors and trainees shared. Themes were gathered into superordinate themes to depict the participants' experience throughout the programme. The interviewer (AO) performed the main analysis, which was then reviewed by two other authors (JL & MRM) to improve its validity, provide multiple perspectives to prevent any individual interpretation analysis bias, and thereby ensure the scientific validity of the themes (Smith, J.A., 2008).

The results include quotations from transcripts to illustrate each theme. Each participant's role in relation to the programme and the timing of the interview are specified for each excerpt.

Results

This study includes the seven trainees in the 2017-2018 training programme, as well as three instructors and three experts. Two trainees dropped out prematurely due to professional constraints and had only pre-training interviews. **Table 2** briefly describes all participants and their role in the research and training programme.

The results are organised around four superordinate themes: *knowledge transmission from instructors to trainees, knowledge transmission from trainees to instructors, implicit transmission between instructors and trainees,* and *the weaknesses of the training programme*.

Knowledge transmitted by instructors to trainees

Improving the encounters between health professionals and patients

The trainees moved from an asymmetric and hierarchical perception of the professional-patient relationship – frequently the norm in the organisation of French health-care services – to a more symmetric, egalitarian perspective, transmitted directly by the trainers to the trainees, as the experts expected.

Pre-training **–** *expert 1 "We come with a cultural broker who knows the patient's language and world perfectly, and we consider the patient and the doctor on the same level."*

Pre-training **-** *Instructor1 "… between the medical institution and the user there's asymmetry that we can reduce using mediation to help these two worlds meet."*

Midpoint *- Trainee5: "There's symmetry in the relationships where there used to be asymmetry because of the health-care providers' [higher] status."*

Trainees seem to progressively reach the same conclusion as the experts in transcultural issues, who consider the practice of mediation in the health-care system as a way to improve the mutual understanding between the patient and the health-care staff and thereby facilitate a better relationship.

Pre-training *– expert 3: "The purpose of mediation is to improve meeting conditions between a particular health worker, part of a particular world, and a particular patient, also part of a particular family from a particular world."*

Midpoint*- Trainee1: "I can already see… some small differences in… the way that I'll be able, actually want to encounter the other."*

Prioritising the preferences of patients over those of health-care institutions

Instructors were able to transmit to their trainees the importance of pushing their institution to take patients' desires and preferences about medical care into account and bend institutional constraints to the patient's needs.

Pre-training *- Instructor1: "The contribution of the mediation program will be precisely to give patients their [appropriate] place in the institution."*

Midpoint *- Trainee3: "What patients say is never taken into account… and… this programme makes us reconsider that."*

End *- Trainee5: "[This programme] made us think about how to take what patients say into account and make it determinant in medical decisions."*

Considering health care as a culture in itself, as different and peculiar as the patient's culture

Medical care is a culture of its own with its own language and codes, which can be difficult for patients to understand. Advancing through the programme trainees began to understand this, gaining more empathy for migrants as patients confronting medical institutions.

Pre-training *- Instructor1: "I don't exclusively mean 'culture' in the ethnic or national sense of the word, but it can be [thought of as] … a professional world."*

Midpoint *- Trainee3: "The patient is not necessarily the foreigner in this relationship; as health professionals, we are more likely to be the foreigner."*

End *- Trainee1: "Transcultural mediation should be implemented at the very beginning, at the admission of any new patient to the hospital, because the hospital is a cultural world of its own."*

Learning to use the acquired knowledge to deal with transcultural issues

One of the major aims that instructors had for this programme was to give trainees knowledge that could be used as tools to deal with transcultural issues. This goal was achieved for all trainees:

Pre-training *- Instructor1: "There are people who have a real inclination to those questions, and we are going to give them tools, to…make it work, so that after … All that they have understood or learned… They can transmit it to their colleagues, … to the health care community… They can experience it directly."*

End *- Trainee3: "We will now be able to use what we have learned of transcultural mediation with others."*

Knowledge transmitted by trainees to instructors

Trainees were not the only ones to learn from this programme. Analysis of the interviews revealed changes in the instructors' perspectives on mediation, probably due to the trainees' calling their attention to many previously unconsidered aspects relevant to leading cultural mediations.

Switching from one type of professional practice to another

Very early, trainees underlined the difficulties of switching from their usual professional practices in providing health care to those required in this completely different field – transcultural care. Instructors reached that conclusion much later.

Midpoint*- Trainee3: "We know our job very well, in an environment that we know, and we are being forced to practice our job differently."*

End *- Instructor3: "They drew our attention to the fact that mediation is different from care giving during which you have to provide empathetic support… In mediation you have to take a strong stand, which isn't always easy to hold."*

Importance of remaining external to the mediation's clinical situation

Knowing either the other professionals or the patients too closely before the mediation can make impartiality difficult for the mediator. The trainees underlined the importance of leading a mediation only for patients in whose medical-care decisions they had not previously participated. This important finding in the first set of trainee interviews was only mentioned later by the instructors, prompted perhaps by the trainees' comments in class.

Pre-training *- Trainee7: "People … must be detached from the subject at hand …someone who is a third party, unconnected to the patient's issue, unconnected to the doctors' or other professionals' decisions."*

Midpoint *- Instructor1: "They must remain a third party in the medical care process."*

The importance of personal reading during the training programme

The instructors appear to have overlooked the importance of personal research and reading during the programme. Trainees, however, were aware they could benefit from it.

Midpoint *- Trainee2: "There is the programme on the one hand and my reading on the other."*

End *– Instructor2: "There is undeniably extra work that takes place outside study time that is really interesting. They make the effort to be prepared for classes in advance, which is very good."*

Difficulties in finding their place in the programme

One of the main challenges encountered by the trainees during this year was finding their rightful place as trainees in the programme. Mediation is based on triangulation: a health-care professional asking for help, a patient, and the mediation team composed of a health-care professional trained as a transcultural mediator and a cultural broker. The position held in this programme by the trainee, who is also a health care professional, was difficult to define, and the margin between staying passive and active as a trainee in the mediation seemed unclear. This issue was something the instructors had not anticipated.

Pre-training*- Trainee3: "Considering how this programme is set up…The question is how we will be involved in the programme, in front of the patients and in front of… the patients and their families."*

End *- Instructor2: "They succeeded in… placing themselves not only as observers, but also as participants during the mediations… And they succeeded in having a role either as a facilitator or … as a mediator."*

Implicit transmission between instructors and trainees

Among the trainees' interviews, some themes appeared to develop over the course of the training, going from a simple statement in the early interviews to a more profound

or detailed assertion in the final ones. Since the source of these changes were not clearly identified in the instructor's discourse, our hypothesis is that they might be due to implicit transmission between the two groups — the trainees and their instructors – as opposed to previous explicit transmission of knowledge for which stages and sources of transmission could be identified in both groups. Implicit transmission seems to have yielded more fundamental insights into the transcultural mediation process than explicit transmission did.

Changes in daily professional practices due to transcultural mediation training

The trainees realised that the skills they acquired in the programme had changed their daily professional practices and their representations of providing care.

Pre-training *- Trainee3: "Since we are part of an in-hospital mobile care unit, I realise that in a way we are always in the position of mediator."*

End *- Trainee1: "It really led me to rethink the way I conduct my usual medical consultation, not only regarding cultural issues, but more generally."*

Finding the appropriate distance in the relationship with the patient

Switching from the position of a health-care professional to that of a mediator disrupted the trainee's traditional medical perception of the right distance to keep from their patient.

Pre-training *- Trainee7: "That's maybe …where the mediation ends, it's when you don't know how far you can go when you open the door to … the patients."*

Midpoint *- Trainee3: "Our professional culture is…very intrusive…we do a job that violates privacy…we know everything [about them]…"*

End *- Trainee3: "I am the care provider, but also a person and I provide care as the person I am."*

Difficulties of the dual role: a health-care professional in a specific unit and a professional mediator in the rest of the institution

Transcultural mediation implies transdisciplinary practice. Professional mediators must move from one medical unit to another, as needed. Trainees called attention to the difficulty of handling both the mediator role and their original positions as health-care professionals in a specific unit of the institution.

Pre-training *- Trainee1: "What is going to be tricky …is to be considered in the institution as a doctor in my care unit but to be requested as a mediator in another unit of the institution."*

End *– Trainee 4 "I think the most difficult aim was to train us to be able to operate everywhere in the institution, regardless of our other role."*

Moving towards share-decision making and collaborative care

The mediation training programme helped trainees to change their mental model of the relations between doctors and patients. The medical hegemony model, clearly held by Trainee4 in the first excerpt below, before the training began, is one in which patients do not need to understand their medical condition but simply fully agree to the doctor's suggestion. The trainees moved from this model to a share-decision making and collaborative care model in which patients, by gaining an understanding their medical condition, do not oppose the proposed management but instead actively build a shared plan and a shared decision with the doctor.

Pre-training *- Trainee4: We give patients the information that will help them agree with the medical plan."*

Midpoint *- Trainee2: "Actually, we are gradually realising that our role is not to protect the patient."*

End - *Trainee5: "It brought me to the conclusion that providing health care is actually about telling the patients directly what is going to happen to them."*

End *- Trainee1: "Providing health care is building a medical plan together with the patient, which will include what I want to put, and which he will accept or not … but there will also be a part of what he wants to put in it … and we are going to mix them and agree to make something where we will each have things to do."*

Training programme weaknesses

Although trainees were generally satisfied with this training, they clearly identified its limitations. Most had one or more goals that they had wanted but failed to achieve.

Full autonomy in transcultural mediation practice

Consistent with the aim of the training program, trainees had expected to become totally independent in leading mediations at the end of the programme, but did not think that they were.

Pre-training *- Trainee6: "[I want] to gain total autonomy in leading transcultural mediations."*

End *- Trainee1: "I think we are still discovering things … more than skills."*

Their lack of experience was the main barrier in achieving this full autonomy. The relatively low number of transcultural mediations currently completed per year in Paris led to insufficient practical training.

Midpoint *- Instructor3: "The main problem is that we don't have enough situations that we can share with the trainees."*

End *- Trainee4: "I cannot begin to imagine being able to handle a transcultural mediation on my own, with my lack of practical experience."*

Mixing trainees from different professional backgrounds

Trainees participated in lectures with groups of diverse professional backgrounds (e.g., psychologists, psychiatrists, and interpreters). They experienced individual distress and feelings that ranged from deprivation to self-depreciation as well as culture shock when their colleagues talked in a professional language they did not understand.

Midpoint *- Trainee4: "What really confused me was that everyone else reacted [to the speaker] as if he was presenting basic knowledge."*

End *- Trainee3: "I definitely didn't have the background to understand what they were saying."*

To cope with this missing prerequisite background, trainees suggested that special classes be organised for them, to give them a basic foundation in anthropology and other must-have concepts needed to follow these lectures.

End *- Trainee1: "Maybe what was lacking was a class dedicated to basics in anthropology maybe."*

Obtaining the theoretical and practical knowledge in one year

Trainees considered that one year of theoretical coursework was adequate, but not optimally divided, with too much psychology and not enough anthropology. Moreover, the practical training needed to be much longer. The prospect of being considered by their institutions as fully trained transcultural mediators at the end of the year, as expected, was somewhat frightening, and they asked for extended coaching to be able to gain confidence in their skills gradually.

End *- Trainee6 "One year of theoretical classes is enough, I think."*

End *- Trainee1 "I think we have to continue some kind of supervision… or at least do some transcultural mediation alongside a professional who can advise us."*

The instructors agreed that coaching beyond this first year was required.

End - *Instructor3: "I wasn't convinced myself that this organisation in just one year would be enough … [for them] to be able to handle a mediation."*

Imperfect conditions for lessons based on human communication

The trainees were not completely satisfied with the organisation of the theoretical lectures. They pointed out that the size of the groups (sometimes more than 60 individuals) and the large auditoriums in which the lessons took place were inappropriate for the aim of the course, to optimise human communication.

Midpoint *- Trainee3: "We're working on the relationship, on the importance of special moments between two people (…), and these conditions do not facilitate that."*

Midpoint *- Trainee5 "I think that the location has a big role to play [in learning]), that, I'm sure…"*

End *– Trainee3 "About the premises, there were no seats left. It might sound stupid, but actually it influences our capacity to concentrate properly on the lecture…"*

End *- Trainee4 "How can you teach students something about human relationships, when there are more than 60 of them in the room?"*

Discussion

This study was based on 16 individual interviews — two interviews of each of the three instructors (at different points during the training period), one interview of each of the three experts in transcultural care and each of the seven trainees (all before the training started, together with two focus groups, each including the five trainees who completed the programme, at midpoint and at the end of training. It explores the experience of a new training programme in transcultural mediation. Trainees were globally satisfied with this programme in which they reported learning a substantial amount about the professional and personal aspects of transcultural issues. They nevertheless criticised the programme as too short; they felt unable to lead a mediation on their own at the end of the year; they felt that they had failed to reach the initial goal — to become self-sufficient transcultural mediators, independent and able to work unsupervised with a cultural broker. They also criticised what they considered the excessive time devoted to theoretical training in transcultural psychology, and insufficient time devoted to the fundamentals of anthropology. They wanted to spend more time learning how to deal with the patients' ethnocultural background related to health-care issues. They had not

been prepared to need to change how they think about patients: moving from their habitual medical perspective to analysing the patient's cultural representations and processes for coping with pain and distress. But while they focused on their lack of cultural knowledge as the potential cause of their difficulties in acquiring the ability to lead transcultural mediations, we suggest that the main difficulty is at a more basic educational level: the trainees are imbued with medical education techniques; all of them have spent years in the medical education system. Medical and health-care problem-solving and thinking has been theorized by some authors as relying on the educational method of the *inverse problem,* that is, going from a set of given clinical data (symptoms) to find an acceptable original cause (diagnosis). This *inverse problem* solving requires synthesis, or regressive reasoning, from conclusions to premises, that is, from effects to causes (Peña, 2010).

The second step in medical reasoning is to develop and deliver a treatment, which implies *direct or forward reasoning*. That is, when the cause (the diagnosis) of the medical symptoms is known, a treatment is chosen to cure the cause or counteract its consequences (the symptoms). Diagnosis and treatment thus have a causal relation (Peña, 2010). Medical reasoning calls for analysis, or progressive reasoning, either from premises to conclusions or from causes to effects.

Mediation, however, relies on a totally different paradigm. Leading a mediation session requires training in *solving a situational problem*. The mediators must adapt constantly to their environment by applying both their acquired theoretical knowledge and their experience (Kirmayer et al., 2003).

The trainees pointed out that mediation relies on this particular type of thinking because it is about building something new and unique, based on the particularities of the given environment. Moreover it mobilises not only procedural capacities, but also emotional ones (Dewey, 1910). In day-to-day medical practice, on the other hand, emotions are often put aside to preserve impartiality in medical decisions.

A situational problem implies going from an unsatisfactory to a satisfactory situation. Determining whether the solution is satisfactory is very subjective and varies from one problem solver to another, depending on their lifetime personal and professional emotional experiences (Kamasheva et al., 2015).

Implications

The training of medical professionals rarely, if ever, include situational problem solving. Therefore, training good *transcultural mediators* necessitates teaching them a completely different way of reasoning and how to switch between them. These findings suggest that this training programme could improve by integrating educational techniques based on learning *"what"* (insightfully)*, "how to",* and *"who with"* (Kamasheva et al., 2015; Peña, 2010).

In the professional mediation programme, learning *what* constitutes the theoretical part of the course. Trainees are learning *who with* by participating in diverse working, role-playing, or supervision groups with people from different backgrounds – health care, anthropology, sociology, cultural brokerage. What this training programme neglects, however, is learning *how to*.

Practical education is a major aspect of situational problem solving. It is all about putting trainees into action, so that they can experiment with trying and even experience failing, improving their knowledge along the way. The major barrier to this process in this training programme is that leading a mediation is about dealing with patients and dramatically influencing their lives: failure can have important consequences.

The first step in overcoming this problem is the development of simulation methods. The time dedicated to *role playing* should be increased (Nestel & Tierney, 2007), which has proved successful in other transcultural training programs (Kirmayer et al., 2008). In particular, it is effective in improving trainees' cultural decentering capacities (Carballeira Carrera et al., 2020), which still seem to be poor among our trainees, in view of their rare references to cultural issues in their interviews. We might also think about computer-assisted simulation sessions, which have shown good results (Sinclair et al., 2015), as well as Objective Structured Clinical Examinations (Khan et al., 2013). Another interesting direction might be developing senior-assisted mediation: having trainees at a given stage lead a mediation but accompanied by a mediator specialist able to correct failings immediately if needed. This practical education should include scheduled debriefing sessions with the experienced mediator for feedback. This also has proven to be a successful teaching method in cultural consultations. (Kirmayer et al., 2008)

Limitations

Our study showed some limitations in our exploration of this training program.

It took place in French health-care institutions that all share the same paternalistic approach to health care, which is not necessarily as widespread in other countries. Moreover, our trainees' participants represented a very homogenous population: 4 of

the 5 trainees who completed the full program came from the same health-care institution, and 3 of them from the same unit. This might have limited their abilities in decentering. The short duration of the training program made it difficult for us to analyse the more profound changes induced by this training on the trainees' perception and abilities in transcultural mediation.

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Tables & Figures

<table>
<tr><th colspan="3">TRAINEES</th></tr>
<tr><th>BEFORE</th><th>MIDPOINT</th><th>AFTER</th></tr>
<tr><td>• Please describe what transcultural mediation means to you
• What do you think would be the perfect profile for a good transcultural mediator?
• What do you think would be the most appropriate kind of training?
• How do you plan to evaluate what you've learned?</td><td>• What is your experience of the program so far? What worked well for you? What didn’t work?
• What kind of knowledge have you acquired so far? What do you still have to learn?
• How would you define transcultural mediation? Has this definition changed since you started this programme?</td><td>• What is your global experience of the training? What worked well for you? What didn’t work?
• What kind of knowledge have you acquired? What do you still have to learn?
• What changes would you suggest to improve the program?</td></tr>
<tr><th colspan="3">INSTRUCTORS</th></tr>
<tr><td>• Please describe what transcultural mediation means to you
• What do you think would be the perfect profile for a good transcultural mediator?
• What are the most important concepts that you would like to transmit to the participants?
• How do you plan to evaluate your teaching?
• How do you plan to evaluate what the participants have learned?</td><td>• Please describe your teaching experience so far. What worked out and what did not?
• How well have you succeeded in transmitting the knowledge that you wanted to the participants to acquire?
• How would you evaluate your teaching skills so far?
• What do you think the participants have learned so far? What do they still have to learn?
• How could the program be improved?</td><td>• Please describe your teaching experience. What worked out and what did not?
• How well did you succeed in transmitting the knowledge that you wanted the participants to acquire?
• How would you evaluate your teaching skills?
• What do you think the participants have learned? What do they still have to learn?
• How could the program be improved?</td></tr>
<tr><th colspan="3">EXPERTS</th></tr>
<tr><td colspan="3">1) What do you think are the differences between ethnopsychiatry, transcultural care and intercultural care?
2) How would you define transcultural mediation?
3) What are according to you the differences between transcultural psychotherapy and transcultural mediation?
4) How do you think this training programme should be constructed?</td></tr>
</table>

Table 1 – Guides for semi-structured interviews

TRAINEES							
Id	Sex	Occupation	Hospital	Department	Pre-training	Midpoint	End
T1	F	Physician	Hospital 1	Palliative Care	SSI	FG	FG
T2	F	Physician		Palliative Care	SSI	FG	FG
T3	M	Nurse		Palliative Care	SSI	FG	FG
T4	M	Physician		Maternity	SSI	FG	FG
T5	F	Nurse	Hospital 2	Palliative Care	SSI	FG	FG
T6	F	Psychiatrist	Hospital 3	Child and Adolescent Psychiatry	SSI	-	-
T7	F	Psychologist	Hospital 4	Child and Adolescent Psychiatry	SSI	-	-
INSTRUCTORS							
				Training programme role			
I1	F	Anthropologist	Company providing cultural broker services	Theoretical training (lecturer)	SSI	SSI	-
I2	M	Child Psychiatrist	Hospital 4	External supervision	-	SSI	SSI
I3	M	Physician		Leader of the training program Expert in transcultural mediation Lecturer	-	SSI	SSI
EXPERTS							
E1	F	Child Psychiatrist	Hospital 4		SSI	-	-
E2	M	Child Psychiatrist	Hospital 5		SSI	-	-
E3	M	Public Health Physician	Hospital 4		SSI	-	-

Table 2 – Participants' characteristics. *Legend: M: male, F: Female, SSI: semi structured interview, FG: focus group*