Internal Medicine Residents' Perceptions of Cross-Cultural Training

Barriers, Needs, and Educational Recommendations

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BACKGROUND: Physicians increasingly face the challenge of managing clinical encounters with patients from a range of cultural backgrounds. Despite widespread interest in cross-cultural care, little is known about resident physicians' perceptions of what will best enable them to provide quality care to diverse patient populations.

OBJECTIVES: To assess medicine residents' (1) perceptions of cross-cultural care, (2) barriers to care, and (3) training experiences and recommendations.

DESIGN, SETTING, AND PATIENTS: Qualitative individual interviews were conducted with 26 third-year medicine residents at Massachusetts General Hospital in Boston (response rate =87%). Interviews were recorded, transcribed, and analyzed.

RESULTS: Despite significant interest in cross-cultural care, almost all of the residents reported very little training during residency. Most had gained cross-cultural skills through informal learning. A few were skeptical about formal training, and some expressed concern that it is impossible to understand every culture. Challenges to the delivery of cross-cultural care included managing patients with limited English proficiency, who involve family in critical decision making, and who have beliefs about disease that vary from the biomedical model. Residents cited many implications to these barriers, ranging from negatively impacting the patient-physician relationship to compromised care. Training recommendations included making changes to the educational climate and informal and formal training mechanisms.

CONCLUSIONS: If cross-cultural education is to be successful, it must take into account residents' perspectives and be focused on overcoming residents' cited barriers. It is important to convey that cross-cultural education is a set of skills that can be taught and applied, in a time-efficient manner, rather than requiring an insurmountable knowledge base.

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As the U.S. population becomes more diverse, the importance of assuring quality communication between physicians and their patients is greater than ever. "Talk is the main ingredient in medical care and it is the fundamental instrument by which the doctor-patient relationship is crafted and by which therapeutic goals are achieved."[1] Evidence suggests that physician-patient communication can affect patient satisfaction, adherence, and subsequently, health outcomes.[2,3] Components of effective communication identified by a systematic review of randomized clinical trials of patient-physician communication confirmed a positive influence of quality communication on health outcomes.[3] Furthermore, improvements in patient-physician communication can have beneficial effects on health outcomes,[4] and findings from patient-physician research can be used to inform curriculum development in medical education.[3]

Sociocultural differences between patients and providers have been found to influence communication and clinical decision making.[5,6] Patients present distinct perspectives, values, and beliefs regarding health and illness based on their sociocultural background. These include variations in patient presentation of symptoms, thresholds for seeking care, ability to understand prescribed management strategies, expectations of care, and adherence to preventive measures and medications. Patient-centered approaches to care are increasingly being incorporated into communication training for physicians. Patient-centered care is included as key component of health care quality,[7] and the Institute of Medicine Report "Unequal Treatment" included a recommendation linked to patient-centered care—cross-cultural education—as a proposed as a mechanism for addressing racial/ethnic health disparities.[8]

Given the importance of patient-physician communication and understanding and addressing sociocultural factors in the medical encounter, it was decided that a cross-cultural curriculum would be integrated into the internal medicine residency program at Massachusetts General Hospital. The goal of this curriculum would be to teach residents to communicate effectively with socioculturally diverse patient populations. In this study we conducted in-depth interviews with third-year internal medicine residents shortly before they completed their training. The purpose of this study was to assess medicine residents' (1) perceptions of cross-cultural care, (2) barriers to delivering quality cross-cultural care, and (3) training experiences and recommendations in cross-cultural care. Study results were to be used to shape the new residency curriculum in cross-cultural care and communication.

METHODS

Participants and Recruitment

We conducted 26 interviews from January 2002 to June 2002 with third-year internal medicine residents at Massachusetts General Hospital. Fifty-eight percent of the participants were

Data contained in this manuscript have been presented at the Society of General Internal Medicine and at the Society of Behavioral Medicine annual meetings.

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female. Nineteen residents self-identified as white, 4 as Asian, 2 Hispanic, and 1 African American. We recruited residents through letters from the program director and emails from the project staff (response rate=87% of the 30 senior internal medicine residents). Interviews were approximately 20 to 30 minutes in length and conducted at the hospital at a time convenient for the residents.

Data Collection

Each resident completed a brief demographic survey prior to the beginning of the interview and was given modest remuneration for their time and participation. As this was an institutional medical education study, this project was deemed exempt from Institutional Review Board review. Nevertheless, the students were given an orientation about the study and its potential for external publication.

A semi-structured interview guide was developed based on information from a review of the literature[9–12] and a previously developed cross-cultural curriculum (see interview guide in Appendix at www.jgim.org).[13] This guide was pilot tested and revised. Cross-cultural care was operationalized as "treating patients who differ from us in cultural background, race, ethnicity, socioeconomic status, gender, sexual orientation and religion, regardless of whether they are born in the U.S. or not." The interview guide consisted of questions about training, differences between needs and experiences in care settings, challenges and rewards of cross-cultural care. The guide was piloted with 2 third-year residents to assess its content, length, and understandability. Individual interviews were administered by 2 experienced qualitative interviewers; training for the interview guide was conducted by a qualitative researcher (E.R.P.). Residents were asked to be frank and were assured that the purpose of the study was to gather information about all opinions, rather than to reach a consensus. Interviewers used probes to assure comprehensive collection and to clarify responses. All interviews were audiotaped.

Data Analysis

All session tapes were transcribed. Thematic content analysis was conducted by 3 research assistants. The 3 coders separately reviewed transcripts and entered data into a Microsoft Access© database. Thematic analysis was done until saturation was reached, and categories within each theme were identified.[14] The reviewers developed a list of codes and refined the content and parameters of the codes. Reviewers coded for frequency, intensity, and extensiveness.[15] At each analysis phase, the 3 coders compared their results and resolved discrepancies. Statements characteristic of the sentiment of the group were highlighted by the coders and selected by facilitators. An expert review of the data was conducted (J.R.B. and V.E.S.).

Careful attention was paid to assuring reliability and validity. Data analyses were overseen by a qualitative researcher (E.R.P.). The interviewers reviewed the transcripts to assure that the interview content was complete and accurate. The 3 coders carefully reviewed, separately and then together, all of the transcribed data. The 3 coders and supervising psychologist compared their results. If results were discrepant or unclear, the group explored these differences by comparing the themes, categories, and codes to the actual transcript text and then reached a resolution. The process of comparing the coded data to the transcript text was also done for results that were unexpected or needed clarification.

RESULTS

Perceptions of Cross-Cultural Care

Most residents expressed a genuine interest in learning skills to identify and address cross-cultural factors in the medical encounter and acknowledged the salience of cultural factors on medical care. One resident responded regarding receiving training:

> Not very much . . . I think for the most part most of the training that I had was back when I was in medical school.

Some residents did not endorse the usefulness of cross-cultural training. Reasons for this skepticism were concerns that they would be expected to know every detail about every culture, as well as beliefs that only information specific to the cultures that they were treating would be helpful. In addition some felt that time, not lack of skills, was their biggest barrier, and that there was not enough time to assess a patient's belief system and incorporate that information into the clinical encounter. A few residents held the belief that cultural awareness is not a trait that can be taught; rather they believed it is inherent or only experientially gained.

> . . . I also think that it's an unrealistic expectation for all of us to understand everybody's background. I don't think that that's a realistic goal.

> Whatever training would have to be completely relevant to what really comes up in clinic.

Benefits of Delivering Cross-Cultural Care

Most residents believed in the importance of delivering high-quality cross-cultural care and expressed a genuine interest in learning skills to identify cross-cultural factors and improve communication in the clinical encounter. Many residents felt that the spirit of cross-cultural care was what made medicine interesting. A benefit to a successful cross-cultural encounter was earning a patient's trust, and thus being privy to underlying social and cultural issues that affect his or her health care.

> . . . It's one of the joys of being a physician because everyone has a unique background . . .

> I learn a lot from people and their different backgrounds, their perspectives on life, their perspectives on things that are important, the way they construct their families . . .

Reported Barriers to Cross-Cultural Care

Barriers to cross-cultural care fell into 3 areas: patient based, resident based, and systems based.

Barriers Related to Patient's Backgrounds and Beliefs. Patient demographics that were associated with cross-cultural communication difficulties included gender, age, sexual orientation, limited English proficiency, and low socioeconomic status.

> . . . I have a lot of young patients . . . when you start talking about safe sex and things, it sounds like you're putting a value judgment on them . . .

> . . . doctors assuming that patients have—you know—the finances to do X, Y, and Z . . . and it takes 'em five visits before they can

actually tell you that the problem is that they can't afford whatever it is ...

Language was the most common barrier cited.

I guess the most difficult one would just be different languages. Just on a nuts and bolts level, sometimes to be able to communicate with . . . (patients) in different languages . . .

Residents expressed having difficulties communicating with patients who had different belief systems than their own or had different perspectives about the importance of following a medical regimen. Often residents struggled to understand the cultural and religious beliefs that influenced patients' interpretations of their illness and symptoms. Thus, when patients seek care through alternative medicine, or involve numerous family members in decision making, the treatment picture is further complicated.

Sometimes there will be belief systems which are sort of hard to deal with. I have one or two clinic patients who certainly see their illnesses very differently from the way I would see them.

. . . I think sometimes barriers to care are just understanding the importance of taking care of themselves or the ability to kind of rally and get to their appointments on time and follow through.

. . . a lot of my patients see other non-traditional practitioners . . . and will say, "I have this problem and you gave me this medicine that didn't help, but I went to the witch doctor and he did this and that helped." And it's very hard to take care of that patient when I don't know what else they're taking and I don't even really know what those other practices are.

Barriers Related to Resident Characteristics. Residents also recognized that their own background and appearance could be a barrier to communication. Patients might have different expectations of what a doctor will be or do.

The problem is probably more with them relating to me, because I'm a minority, and I might be different from the people they would normally see . . .

This is embarrassing because I was raised an atheist, so I don't know anything about religion ... I'll walk out of a room thinking they want a priest, but literally I have no religious education and I don't know if there are Catholic priests . . .

Barriers Related to Health Care Systems Issues. Residents cited that lack of time and availability of interpreters were the 2 most significant systems barriers. Often interpreters are not readily available and residents resort to working with non-professional interpreters.

. . . that's probably the biggest challenge, finding interpreters, you know, at the appropriate time of day to take care of patients. Getting a translator takes far longer than the 20 to 30 minutes that you have for a visit.

Implications of Barriers

Residents cited many implications to these barriers, ranging from negatively impacting the patient-physician relationship to compromised care. They reported that an unfortunate outcome for the patient-physician relationship that they had observed is loss of trust between the patient and provider, which can lead to noncompliance. Within a medical encounter, there can be a loss time or of any type of preventive focus or, worse, overuse of diagnostic testing.

Training Experiences

Most residents had very little cross-cultural training during residency. Limited formal training had occurred at grand rounds, retreats, and resident reports. Residents learned, informally, through interactions with interpreters, preceptors, other house staff, and patients.

Most of the residents reported that the opportunities to practice cross-cultural care differed in the inpatient and outpatient settings. Because of time constraints and the crisis milieu of the inpatient setting, cross-cultural issues were not often addressed unless they related directly to the patient's chief complaint; rather, culturally relevant issues often only arise at the time of discharge. In the outpatient setting, however, residents were able to take a comprehensive social history and discuss cross-cultural issues as they built a relationship, over time, with patients.

Cross-Cultural Training Needs and Recommendations

Residents emphasized that training should occur throughout residency. Residents were interested in learning how to elicit patients' health beliefs and in gaining a greater awareness of how their own cultural context influenced the care they provided. They wanted more practice in general interviewing, with feedback, as well as opportunities to observe interviews with patients from diverse backgrounds. Residents also requested skills training for working with interpreters, and having increased access to interpreters and social workers.

. . . probably the most useful . . . would be a witnessed interview with . . . a patient from a different ethnicity . . .

What I would love is for you to bring in a patient who has limited knowledge of English . . . . Have (somebody) interview them.

Some expressed an ongoing need for teaching in this area, and to facilitate this they suggested that attendings receive cross-cultural training as well.

(I want) strong mentors in that area who could come in and say, "You know, this is how I deal with this."

Residents came up with many recommendations for training improvements, which included both formal and informal mechanisms, patient involvement, and changes in the educational climate. Formal training suggestions included: discussion of cross-cultural research in journal clubs, basic language training and language cards, and fact sheets and lectures that are culturally specific for patients frequently treated. Residents noted that some of this learning could be conducted informally, by including culturally related issues into case presentations and providing residents with opportunities to discuss challenging cases. Residents also felt that patients should be involved in the teaching process (e.g., patient panel presentations, teaching interviews). Lastly, residents suggested making changes to the educational environment, such as increasing the ethnic diversity of staff and providing training to auxiliary and senior staff. They also requested increased opportunities for community training experiences to take care of patients from cultures rarely seen at the hospital.

DISCUSSION

This study suggests that although residents did not receive much training in cross-cultural care, there was a genuine interest in obtaining skills in this area; these findings are similar to a recent national resident study.[16,17] Most residents endorsed its importance and genuinely enjoyed working with a diverse group of patients. Furthermore, residents acknowledged that the physician-patient relationship could be negatively impacted and less than optimal care could result from difficulties with cross-cultural care.

It is encouraging that since 2002 curricular changes have been made to promote cultural competence in medical education[18] and, similarly, that residency programs now have cultural competence guidelines, put forth by the Accreditation Council on Graduate Medical Education,[19] to follow. Although it is promising that the number of residency programs providing cultural competence training has increased[20] and is anticipated to continue to do so, there is a need for development and assessment of quality, effective curricula.

Several cross-cultural training guidelines have been recommended,[21–23] but there is great variability in the quality of training programs as well as a need for a unified conceptual teaching framework.[24] The Cultural Competence Research Agenda project, sponsored by U.S. Department of Health and Human Services and the Agency for Healthcare Research and Quality, identified unanswered questions that need to be examined in the realm of cross-cultural teaching including the *content* of training (e.g., what competencies and basic skills produce behavioral changes by trainees and improvement in health and health care delivery outcomes) and the *form* of training (e.g., which educational delivery techniques are most effective at conveying key knowledge and skills and changing trainee behavior).[25]

Residents in our study recommended increasing community-based opportunities, involving patients in the teaching process, training staff and attendings, and integrating cross-cultural care into their existing training (e.g., journal clubs, case presentations). Key academic informants who were interviewed about their impressions on cultural competence[24] also noted that education of faculty was crucial given their impact as clinical role models. Thus, both residents and field experts emphasize that faculty need to be trained as well. This is likely out of concern that a system be created in which expectations about the residents' cultural competencies are higher than that of their supervisors.

This study also highlighted residents' perceived barriers in delivering cross-cultural care. Residents in this study expressed some similar barriers that have emerged from previous research. Shapiro et al.[26] reported that residents perceived 3 major barriers to cultural competence: time constraints, language and interpreter limitations, and patient shortcomings. Therefore, skill-based training must include ways to problem-solve communication difficulties when confronting language barriers and diverse health beliefs; hospitals must strive to address issues regarding lack of interpreters and time.

When developing cross-cultural curricula, the challenges of conducting this training, at the residency level, must also be acknowledged. This study revealed how, at the residency level compared with the medical school curriculum, one faces the reality of time limitations and fixed ideas about what cross-cultural skills mean. Of concern was that some residents felt that cultural competence was something inherent that could not be taught, which was similar to Shapiro's findings about residents' skepticism about the value of cross-cultural curricula. Another concern raised in our study was that some residents were overwhelmed by their own expectations that they would need to know about every patient culture. Similar to a study conducted by Lingard et al.,[27] some residents believed that communication difficulties could be resolved by attainment of cultural-specific knowledge. Therefore, cross-cultural training must emphasize the time efficiency of this practice and teach the difference between cultural-specific and cross-cultural approaches. Bearing this in mind, in implementing a cross-cultural curriculum, we need to clarify that cross-cultural education is a set of skills that can be broadly applied rather than a required insurmountable knowledge-base.

There are several limitations to this study. First, although our response rate was quite high and we interviewed almost all of the graduating medical residents at Massachusetts General Hospital, this was a small 1-hospital sample. Therefore, these results are reflective of residents' impressions within an academic medical center setting, which may not be generalizable to all internal medicine residency programs or to trainees in other specialties. As this is a qualitative study, which by definition is exploratory in nature, our findings do not provide data on causation, but instead provide direction and insights about themes, which should be assessed in future research. Finally, we acknowledge that although we focused on the perceptions of preparedness of individual practitioners, the cultural practices of institutions and the health system may also be quite important in reducing disparities in health care.

This study greatly informed our cross-cultural curriculum development. Applying what we learned from this research endeavor through the lens of a residency program director, we felt that learning about residents' needs, what they valued about their training, and specific challenges they were confronting at our institution, helped us to create a cross-cultural curriculum that was appealing and relevant. We incorporated their concerns (e.g., fear of stereotyping) and addressed skepticisms (this is something that cannot be taught) and erroneous beliefs (that they would be expected to know a lot about many cultures) upfront. Furthermore, we learned about the importance of making the curriculum relevant to the patient population that they were treating.

In conclusion, we found that, despite limited formal training, residents seemed to genuinely value and have an interest in cross-cultural care. In developing quality cross-cultural curricula, we must build on residents' training recommendations such as making changes to the educational climate, involving patients in the teaching process, and providing a format for residents to discuss challenging cases. Furthermore, if this training is to be successful, it must be focused on overcoming barriers that the residents illustrated: at the patient, physician, and systems levels.

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Supplementary Material

The following supplementary material is available for this article online at www.blackwell-synergy.com

Appendix A.