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Self-perceived attitudes and skills of cultural competence: a comparison of family medicine and internal medicine residents

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SUMMARY *This study surveyed resident perceptions of competent cross-cultural doctor–patient communication as a step toward developing an integrative primary care cross-cultural curriculum. Respondents were 57 first-, second- and third-year residents in family medicine (FM) and internal medicine (IM) who completed a questionnaire assessing cross-cultural attitudes and skills relevant to clinical practice. As a group, residents endorsed the relevance of culturally competent communication to patient care, perceived themselves to be fairly competent in the use of culturally competent communication techniques, used such techniques frequently, and generally found them to be quite helpful. FM residents rated culturally competent communication as significantly more relevant, themselves as more competent, and culturally competent communication techniques as more helpful than did IM residents. Over half the residents in both specialties tended to identify as serious cross-cultural problems those that focused on perceived patient shortcomings.*

Introduction

Cultural competence has been defined as “the ability to understand and work with patients whose beliefs, values, and histories are significantly different from one’s own”

(Rothschild, 1998, pp. 299). Achieving cultural competence in learners is an important goal for all primary care residency programs (Breuschke, 1998). The ACGME Residency Review Committee, which specifies program requirements for US residency education, requires all of its residencies to include curriculum in cultural competence (Residency Review Committee, 1997). Preparatory to the development of an integrated primary care cultural competence curriculum at our home institution, we assessed how residents' self-perceived attitudes and skills regarding cross-cultural doctor–patient communication issues in the specialties of Family Medicine and Internal Medicine related to standard curricular recommendations.

Methods

Subjects were all residents in FM and IM at the University of California Irvine College of Medicine ($n = 107$). Surveys on cross-cultural communication attitudes and practices were

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administered at required residency noon conferences and distributed in resident mailboxes. After reviewing existing instruments, we developed a 69-item survey [1], consisting of a single item assessing perceived *relevance* of sociocultural factors to clinical practice; a 10-item scale of perceived *competence* in dealing with various sociocultural issues; a 21-item scale that rated both *frequency* of usage and *helpfulness* of particular cross-cultural communication techniques; and an 18-item scale measuring the extent to which residents felt certain patient cross-cultural characteristics presented *problems* in effective communication. Other items addressed which curricular content areas residents felt would be most useful and obstacles to introducing a cross-cultural communication curriculum. All questions used a 1–5 Likert-type rating scale.

Specialty, year of training, ethnicity, age and gender were the study's independent variables. Cronbach's alpha was used to determine the internal reliabilities of the four scales described above. Pearson two-tailed tests were used to calculate product-moment correlations among the five dependent variables. *T*-tests were used to test for group differences between independent and dependent variables.

Results

Of the 107 surveys distributed, we received complete responses from 20 FM residents and 37 IM residents for an overall response rate of 52.8%. Eleven respondents were first years, 22 were second years and 23 were third years (for one, year was blank). Nineteen respondents listed themselves as non-Hispanic white. There were 23 residents who self-identified as Asian, five Middle Eastern, three Filipino, one Latino, one 'mixed', and one Persian. Four residents declined to specify ethnicity/race. Mean age of the sample was 30.3 (SD = 4.73). Nineteen females and 36 males participated in the study, with two not indicating gender. When we compared survey respondents with all program enrollees, we found similar percentages of males and females, and of non-Hispanic white and Asian residents.

Alpha reliability for the four scales ranged from 0.79 to 0.94. With the exception of the *frequency of use* and *helpfulness* scales, which were highly intercorrelated ($r = 0.55$; $p < 0.01$), there were only modest correlations among the remaining scales.

Considered as a group, respondents perceived socio-cultural issues as relevant to clinical practice (mean = 4.01, SD = 0.84). They rated themselves as moderately competent in cross-cultural communication skills (mean = 3.45, SD = 0.45). They tended to use a range of cross-cultural communication techniques frequently (mean = 4.01, SD = 0.35), and to find them quite helpful (mean = 4.26, SD = 0.43). They rated a range of patient characteristics and situations as more or less 'moderate' problems (mean = 2.81, SD = 0.74) that contributed to communication difficulties in the clinical setting.

Over 50% of the sample reported that they 'very often' used basic communication techniques such as making patients from different cultural backgrounds feel welcome, listening carefully to them, expressing concern and showing respect, and found these techniques 'very helpful'. However, over 30% of respondents reported that they were only somewhat or not very likely to use more culturally specific

Table 1. Cross-cultural specialty and ethnicity differences.

Item/scale	Independent variable	Mean	SD	<i>t</i>	df	<i>p</i>
Relevance (Specialty)	FM	4.55	0.76	4.03	55	<0.0005
	IM	3.72	0.73			
Competence (Specialty)	FM	3.65	0.43	2.53	55	0.014
	IM	3.35	0.43			
Helpfulness (Specialty)	FM	4.50	0.37	3.38	55	001
	IM	4.13	0.40			
(Ethnicity)	White	4.46	0.36	2.66	49	010
	Other	4.14	0.44			

skills, such as working closely with interpreters, eliciting the patient's self-diagnosis, negotiating a culturally sensitive treatment plan, addressing language difficulties, or knowing something about the patient's cultural background.

Insufficient time was rated by 92% of residents as a moderate or severe barrier to effective cross-cultural communication. Over half of the sample rated patient characteristics as moderate to serious problems interfering with effective culturally competent communication. These included patient seeming to agree with doctor but having no follow-through (80%), patient having too many problems (75%), patient history rambling and disorganized (70%), patient providing inconsistent, contradictory information (70%), patient not understanding the implications of diagnosis (60%), and patient not interested in self-care or health maintenance (58%).

Results also found specialty and ethnic differences in the resident population surveyed (Table 1). FM residents were significantly more likely to rate sociocultural factors as relevant to the practice of medicine than were IM residents. They were also significantly more likely to rate themselves as competent in cross-cultural communication than were IM residents. Further, compared with IM residents, FM residents were more likely to find the cross-cultural communication techniques they used to be helpful. Non-Hispanic white residents were more likely to find general communication techniques helpful than did residents of other ethnic backgrounds. There were no age, gender or year of training differences.

Residents indicated the most useful topics for a cross-cultural communication curriculum to be patient health beliefs ($x = 3.87$; SD = 1.01) and patient expectations regarding physicians ($x = 3.89$; SD = 0.95); while the least useful topics were residents' own attitudes ($x = 3.46$; SD = 1.09); and training in cross-cultural communication skills ($x = 3.46$; SD = 0.91). They listed barriers to the introduction of a cross-cultural curriculum as time constraints (79%); lack of relevant materials (44%); resentment at having this topic take up valuable curricular time (37%); and lack of interest on the part of both faculty (30%) and residents (28%). Some 14% of respondents agreed that cross-cultural competence 'can't be taught'.

Discussion

This study examined resident self-perceived cross-cultural attitudes and skills in two residencies. Differences were found between FM and IM residents on dimensions of relevance,

competence and helpfulness of communication techniques. These might be explained by the fact that the family medicine residency already had a more systematic, comprehensive cross-cultural curriculum in place, reflective of generally stronger psychosocial training in family medicine than in internal medicine (Gaufberg *et al.*, 2001). Although NHW residents found cross-cultural techniques significantly more helpful, the general lack of ethnic differences suggests residents from majority and minority cultural backgrounds regarded cross-cultural issues similarly. Learners who become part of the medical profession tend to assume majority views (Gurung & Mehta, 2001). Since the dominant view of these residents appeared to minimize cultural differences in favor of universal qualities (Shapiro *et al.*, 2002), minority residents may have emphasized their commonalities with patients from different cultures and therefore devalued the need for specific techniques. As a group, residents tended to favor general communication techniques and were less likely to engage in more culture-specific techniques, despite the latter being considered key elements of effective cross-cultural communication (Scott, 1997). This reluctance may also have been rooted in a minimizing of perceived differences between themselves and their patients.

Despite a generally positive perception of the importance of sociocultural issues in patient care, over half of the residents tended to focus on patient deficiencies and shortcomings in explaining cross-cultural communication difficulties. This attitude suggests a lack of true cross-cultural sensitivity and a tendency to hold patients, rather than physicians, responsible for 'crossing cultures' (Clark & Robinson, 1996). Further, although most cross-cultural curricula emphasize the importance of learner self-awareness and communication skills, residents in this study were least interested in programs that incorporated such training. Almost 40% of the sample expressed resentment that cross-cultural training would cut into limited curricular time. These learner reservations are similar to those reported by Culhane-Pera *et al.* (2000) in a study of a multicultural curriculum, and may be explained in part by resistance to learning and fear of openly dealing with discrimination (Nunez, 2000). Future research should examine how best to reconcile residents' minimization of cultural differences, tendency to 'blame' patients, and skepticism about introspective exercises and culturally-specific communication training with prevailing recommendations for developing cross-cultural curricula (Flores *et al.*, 2001).

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Notes on contributors

JOHANNA SHAPIRO, PhD, had primary responsibility for design and implementation of the study; primary responsibility for development and piloting of the survey instrument; directed

and participated in the literature review; participated in subject recruitment, data collection and data analysis; and had primary responsibility for data interpretation and writing of this article.

JUDY HOLLINGSHEAD, PhD RN, participated in development of the survey instrument; had primary responsibility for subject recruitment, data collection and data analysis; and reviewed and provided feedback on previous drafts of manuscripts, with particular emphasis on interpretation of statistical findings.

ELIZABETH M. MORRISON, MD MSED, was principal investigator on a grant that provided funding for the study; contributed to conceptual development of the survey instrument; had secondary responsibility for data interpretation; and provided feedback on previous drafts of manuscript, with particular emphasis on conceptual issues and implications for medical education.

Note

[1] The survey can be found on the *Medical Teacher* website [<http://www.medicalteacher.org>].

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