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Teaching Cultural Sensitivity to Pediatric Residents

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Introduction

Teaching cultural sensitivity to healthcare professionals is critical in providing appropriate care to diverse patient populations. Constantly increasing U.S. immigrant population and growing numbers of international medical graduates practicing in the U.S. bring the issue of appropriate cross-cultural training to the forefront of addressing health disparities.

Cultural competence training of healthcare professionals and provision of culturally sensitive patient care is the responsibility of healthcare leadership.¹ Acquiring awareness and knowledge about cultural differences requires focused development of skills to communicate with patients from diverse cultures; this is a process developed through professional training and experience.² Few professional continuous education programs have been offered to prepare mentors and role models in the field of healthcare to ensure culturally sensitive approach in patient service.^{3,4,5}

Background

According to the U.S. Census Bureau, the numbers of foreign-born individuals in the U.S. will double by the year 2050, expected to increase from 26.0 million to 53.8 million.⁶ The state of California will have a minority group as its majority population as soon as year 2025, and states such as Florida and Texas grow rapidly due to immigration.⁷ Therefore, physicians practicing in the U.S. must be culturally competent in serving diverse patient populations.

While the need for education in multiculturalism is recognized in many higher education institutions, few professional medical colleges offer such programs. In general, informal curricula have been considered superior to formalized classroom teaching in developing knowledge and skills in cultural competency.⁸ Cultural competency curricula in medical schools have used case discussions in small group environment, role play scenarios in simulated encounters with standardized patients, panel discussions and cultural immersion programs; however, the measurement of the outcomes of such programs has been controversial and inconsistent.⁹⁻¹³

A majority of cultural competency curricula in medical schools remain limited to the pre-clinical years of medical education (usually the first and second year), which disconnects the cultural learning from students' clinical encounters with patients.^{9, 14} Studies have reported the failure of such programs to elicit long-term effectiveness.¹⁵ If few U.S. medical schools offer cultural sensitivity programs, even fewer residency physician programs have developed inter-cultural curricula. While the need for cross-cultural residency training has been well recognized, the residency programs send mixed messages, failing to institute required formal training in this area.¹⁶

A study by Weissman and colleagues (2005) determined that less than half of the graduating residents entering independent clinical practice felt prepared to serve diverse or minority patient populations in cross-cultural settings.¹⁷ Lack of time during the busy residency training schedule, lack of faculty role models, and lack of formal cultural competency evaluation were identified as barriers to implementing cross-cultural curricula and patient care approaches.^{13, 17}

Healthcare providers' lack of cultural diversity awareness and skills might be an important contributing factor to the healthcare disparities existing in the U.S.² Few studies have demonstrated successful results of teaching culturally effective patient care through specially-tailored curricula^{18- 20} or using

standardized patients.²¹ The challenge is to develop training curricula in cultural sensitivity for students, residents and attending physicians while providing appropriate culturally sensitive care at each patient encounter.^{8, 9}

Cultural education for healthcare professionals should be geared towards the specific population served and must bridge the gap in health and illness paradigms between professionals and patients.^{18, 22} It has been suggested that residency programs need to integrate cross-cultural training and evaluation, and support faculty development as mentors and role models in cultural awareness and competency.²³

Context

We share our experience in implementing a cultural sensitivity training in a residency program in the city of El Paso, Texas, and a quality improvement initiative to improve residents' curriculum and the environment of patient care. The city of El Paso is located on the border with Mexico, and together with its sister-city Ciudad Juarez in the state of Chihuahua, Mexico, forms the largest border metroplex in the world. The population of El Paso is rapidly growing, and approximately 80% of it is Hispanic.⁶ Many of the El Paso residents are bi-lingual (English-Spanish), and some speak only Spanish. The Department of Pediatrics at the Texas Tech University Health Sciences Center in El Paso routinely provides care to about 30,000 pediatric patients per year, more than 25,000 of which are Hispanic. Our pediatric residency program accommodates 45 physician trainees from the U.S. as well as international medical graduates. The makeup of the residency program has remained consistently culturally diverse throughout its 30 years of existence. For example, currently the program consists of physicians from 4 U.S. states and 16 foreign countries.

Cultural Sensitivity Curriculum

In such a multicultural environment, it is important to teach the residents how to care for pediatric patients and their families in the context of a multi-national residency program serving predominantly Hispanic local communities. In 2006, we developed and implemented a series of cultural sensitivity workshops, as a longitudinal cultural competency curriculum, delivered continuously throughout the three years of residency training. An introductory workshop on cultural sensitivity is given to each group of new residents at the time they join the program, and two workshops are presented every academic year to all residents. Topics include cultural and healthcare practices among different ethnic groups, effects of ethnocentrism, stereotyping, generalization, bias and discrimination, cultural sensitivity approaches, cultural competency and its components, variables affecting cultural sensitivity, acculturation process, and culturally-sensitive communication techniques. Case scenario discussions and role-plays are part of every workshop. The workshops aim to provoke in a small-group setting active self-reflection on cultural sensitivity awareness, knowledge and practices, and teach the participants communication techniques to promote culturally sensitive patient care.

In addition to the workshop series, the residents take part in an annual celebration of multiculturalism. An entire afternoon is devoted to this event, where each resident prepares a presentation about his or her place of origin and discusses the various cultural, healthcare and educational practices in that country/U.S. state. Thus, through a peer-teaching approach the residents learn about others' cultural heritage and are able to compare diverse healthcare systems. Residents are welcome to wear traditional attire and bring food customary for their home countries/states.

Methods

To assess the educational gain and effectiveness from the longitudinal curriculum in cultural sensitivity

we conducted a resident patient care quality improvement project, involving six focus groups, discussing the value and effects of our longitudinal cultural sensitivity curriculum as related to personal professional behaviors. Focus group analysis interprets findings by discussion themes. Participants' involvement was voluntary and no discussion contributors are identified by name.

Participants

Focus group participants were pediatric residents across a three-year training program at the Texas Tech University Health Sciences Center in El Paso. Sixty (60) residents participated in 6 focus groups conducted within two academic years. Fifteen (15) residents participated in two focus groups.

Focus Groups

The practice of pediatrics in the complex environment of a residency program could greatly benefit from a deeper understanding of individual cultures, improved awareness of systems of healthcare in different countries, better knowledge of the demographic and socio-economic determinants of health, national and international public health issues, and their comparisons to the healthcare system in the U.S. In order to understand the effect of cultural sensitivity training on resident attitudes and beliefs, it was essential to explore the cultural dynamic of being in a multinational program within in a bi-national community; these experiences were obtained through a series of focus group discussions.

Group interviews are useful in a multitude of ways. Focus group interviews can generate a large amount of data in a relatively short amount of time from a greater number of people than would be possible from one-on-one interviews. They are helpful in investigating complex, rich and diverse personal perspectives on a topic of interest. Group interviews also allow recording and analyzing participant reactions to ideas and elicit conversation in their "natural language" that enables common communication patterns and expressions about a certain topic.²⁴

As a part of quality improvement project aiming to improve the environment of patient care, between February and August 2008, six focus groups were conducted with pediatric residents in an informal setting. The size of the focus groups was decided by a normative approach; each group consisted of ten participants and a group moderator. The moderator actively encouraged the discussion, asked the pre-determined open-ended questions with attention to the group interactions, and took notes to supplement the recorded transcripts. Two chief residents, two residency program directors, and a research staff served as group moderators. Each moderator followed a semi-structured questionnaire to guide the discussion (Table 1).

Table 1: Semi-structured Questionnaire for Focus Group Discussions

1. Do you believe that there are benefits from learning in a formal curriculum about other people's cultures and what are those benefits?
2. Do you believe that there are barriers to being sensitive to the cultural beliefs of other people?
3. How do you feel about learning cultural sensitivity as it relates to your professional relationships?
4. Do you think other health providers on the healthcare team are culturally sensitive?
5. Have you witnessed your peers in a situation of cultural miscommunication? Give specific examples. How do you think it could have been handled better?

6. How do you feel about learning and applying cultural sensitivity as related to your own practice in the clinical setting? Could you please recount any experience that other residents could learn from?
7. Do you think you are culturally sensitive to your patients? How do you think you can improve?
8. What, if any, have been your issues or struggles with cultural diversity in the delivery of patient care? What did you learn from this experience?

Questions were developed based on review of literature related to cultural competence training in the medical profession. Before beginning each focus group session, participants were briefed on the focus group protocol and advised that their participation is strictly voluntary. Each focus group discussion lasted about forty-five minutes and was tape-recorded. At the end of each focus group session, the moderators probed the groups about the discussion themes to ensure understanding of the group thoughts and that no details were missed.

The focus group discussions were transcribed verbatim and coded into qualitative research software, The Ethnograph version 5.08. Two of the authors (R.B.A and K.A.C.) independently coded each focus group transcription using the same codebook definitions. Findings for each focus group transcription were based on the principles of naturalistic inquiry²⁵ identifying similar and agreed-upon themes and overlapping codes between the two coders. Recurring themes that emerged from all focus group discussions were grouped into a single category or “parent” code. “Child” codes were topics that were related to the more general “parent” codes.

Lessons Learned

There are a number of lessons we learned through the conducted focus groups. Most of the residents felt that the biggest change that the longitudinal curriculum on cultural sensitivity introduced was in “learning not to assume.” As one resident elaborated, “I learned to open my mind to different points of view, reinforced in my mind the necessity of treating with respect all people, learned not to assume that my ways of thinking or interacting are necessarily correct or acceptable.” Another resident described her personal journey in cultural diversity:

“I tend to be shy, conservative and quiet, which is a sign of weakness in the U.S. society, but in my country it is a sign of humility. I was able to express what is important to me in practicing medicine that sometimes may be incongruent with the norms here in the U.S. The fact that my peers were interested in what I had to say strengthened the bond between us.”

The residents, through their continued cross-cultural experiences, discovered that “there are more similarities than differences” between and among them, and learned to approach their patients with an open mind, without pre-assumptions and with ultimate respect to different cultures as the essence of providing culture-sensitive patient care. The themes that emerged included the role of the formal curriculum in teaching cultural sensitivity, the impact of individual beliefs, and the benefits from and barriers to exercising cultural sensitivity in healthcare.

Formal Training in Cultural Sensitivity

A major theme that emerged was the need for appropriate formal cultural sensitivity training. Formal curricula in cultural competence vary among medical schools, and many residents who came from other countries expressed a need for sensitivity training in order to practice in the culturally diverse patient environment in the U.S. Participants verbalized their willingness and interest to learn how to be culturally sensitive in providing patient care. Residents considered targeted training in physician-patient

communication skills as a useful way to teach culturally effective care. A need was identified for learning culturally-sensitive interviewing skills involving patients' social and medical histories, patient use of complementary medicine, dealing with special topics such as sexuality, and use of non-verbal communications in patient-focused care. For example, questions about truth-telling practices and family decision-making preferences should be asked early in the patient interaction, especially when involving terminal illness.

The majority of residents felt that experiential learning by the day-to-day patient encounters and working alongside ethnically diverse peers have helped them become more culturally sensitive. They showed strong preference for interactive learning involving small-group discussions and role-playing over lecture-based learning. The residents expressed that the culturally diverse peer and clinical encounters, coupled with the longitudinal curriculum on cultural sensitivity have heightened their cultural awareness.

Role of Individual Beliefs

Acknowledging traditions and religion constitutes a huge part of cultural sensitivity. Many residents shared stories about communication misunderstandings due to religious practices of peers, mainly the use of the call room as a place for private worship. Several

participants relayed examples of truth-telling as a major ethical conflict during their care of patients.

Expectations for privacy and autonomy in patient care were considered strongly dependent on individual's culture. Misunderstanding the family dynamics about priorities in decision-making and limitations in delivering bad news might pose strain on physician-patient communications and trust.

Therefore, a conflict may arise if the physician's culture is vastly different from the patient's:

"For example, in the US, you have differences from the Chinese culture, when you talk about privacy, autonomy and drug abuse. These questions are inappropriate in China. They are American concepts. In China, the parents, relatives, everyone knows about your condition. You can make decisions for others and others can make decisions about your health."

Each culture has different beliefs about health and healing, about family hierarchy in decision-making and perceptions about the importance of health. One important skill to learn is appropriately incorporating patient's use of complementary medicine into modern-day treatment:

"You can bring alternative medicine into your own medical care as long as it is not harmful to the child. Like putting cotton balls in the ear...there's no harm in having the patients feel like they can participate in their care. And as a matter of fact, you're more likely to have the patients listen to you. They'll listen to you if you listen to them."

A tradition-based alternative medicine approach from one culture could be mistaken for child abuse in another, as is with the practice of "cupping." The practice of "cupping" is widely used in Asian countries; the child is subjected to treatments with heated cup, applied to the skin of the back, which is believed to purify the body, and at the same time leaves red marks from the hot cup. A child treated at home with "cupping" could easily be suspected for child abuse when seen at the ER. Physicians' reactions to different cultural beliefs and practices could sometimes be overshadowed by the stress of the environment:

"Sometimes I forget, I guess. Really, because you are in a place with high stress and sometimes you get overloaded with work, and then at some point you get into a 'flight or fight' mode, and sometimes you forget about other cultures and you just react. But that doesn't mean you are not culturally sensitive; it's just your defense mechanism. I think you can forget sometimes."

Barriers to Cultural Sensitivity

The focus group discussions identified several barriers to physician's ability to understand diverse

cultures. Language could be a significant barrier, especially if the patient does not speak English and the physician is not fluent in patient's native language. The time and expenses involved in providing translation services may augment this barrier. Physicians are also limited in the time spent with each patient and the family, due to the necessity for time management in a reality of low cost reimbursement and especially in communities with high numbers of underinsured population or patients on Medicaid. Thus, the patients and families that need physician time and cultural sensitivity approach the most may experience the most significant barriers in obtaining culturally sensitive services.

The ability to express facts and feelings in a language understandable to the patient is extremely important. As one resident shared, there could be awkward moments even when physician and patient speak the same language if they use different lingo or jargon:

"I am Hispanic. When I came to this town on my first few days as a resident, I was asking a Spanish-speaking mother how she fed her child. So, she said, 'I do breast and sometimes bottle.' But the way she said 'bottle' here was *tetera* and where I come from, it is a similar word for breast. So, I was wondering, so you give breast, and you give... breast? And I was from the same culture, but there was a sub-culture."

Ignorance about different cultures was identified as an important barrier; if there is a lack of knowledge on physician's part about the pillars of patient's culture, there will be, undoubtedly, misunderstanding and insensitivity. In such cases, the role of stereotyping becomes very powerful. As a female Muslim described it:

"I feel that doctors come into patient's room with stereotypes in their mind. When they see my head covered, they start talking to my husband. I want them to know that if my head is covered, my mind is not covered."

In such cases, the unawareness about cultural differences becomes a barrier to providing culturally sensitive patient care. A formally taught cultural sensitivity curriculum is critical in making resident physicians aware of cultural differences and their importance in delivering culturally appropriate patient care.

Benefits from Practicing Cultural Sensitivity

Practicing medicine with cultural sensitivity presents many benefits for both physicians and patients. Having knowledge about patient's cultural background brings more comfort in taking care of the patient and helps establish a better doctor-patient relationship, based on understanding, confidence and trust. Improving peer relationships and the environment of patient care, better understanding of the local community culture, providing better patient care, camaraderie, sharing knowledge about diverse cultures, desire for learning a new language and improved culturally-sensitive communications were reported as positive experiences directly related to the formal longitudinal curriculum in cultural sensitivity.

One participant noted her attempts to speak Spanish with her patients to build rapport and trust has maintained patient continuity throughout residency in result of being willing to learn and adapt to her environment:

"My patients know that I am not a native Spanish speaker. But because I've been trying to learn it for the past three years...they come to me. I have a lot of patients who stay with me because they see my effort to learn about their culture."

In medicine, there is an expectation to learn about different cultures. A physician can become more sensitive to cultural differences if taught about them, and if working with diverse patient populations. Medicine is being referred to as an art; and this art is to be practiced not only with a certain group of people, but with all people, professionals and patients. As a resident put it, "If you truly, truly want to

become proficient in this art, you have to understand all expressions of humanity.”

Discussion

Residency programs should encourage curricular activities in a social context that creates a culturally competent learning environment.²⁶ An environment supportive of cultural sensitivity learning includes a combination of clinical training, appropriate orientation, language training, and faculty mentorship.²⁷ In addition, each institution has its own multicultural education curriculum that may be unknowingly taught in the informal setting.²⁸

In our focus groups, participants cited language as a major barrier in providing better patient care, confirming the findings of Abbe et al²⁹ in which pediatric specialists experienced problems with interpreter and parent understanding of medical information. Even though a physician may speak the same language as the patient, communication skills remain essential for providing culturally effective care. These skills include teaching how to listen to needs of the patients³⁰ as well as flawless communications within the healthcare team.

Sidelinger et al.³¹ showed that improving cultural sensitivity can be achieved by open discussions about culture’s effects on the healthcare system and providers’ understanding of socially acceptable approaches to patient care. Prior studies^{32, 33} support the finding that cultural competency training increases knowledge, attitudes, and skills, and overall patient satisfaction, which were similarly found in our focus group discussions and cultural sensitivity training survey. We found that the cultural diversity among peers in the residency program provides informal cultural experiences that augment the formal curriculum, which has been previously noted to be beneficial.^{34, 35} Betancourt found that residents may feel unprepared to deliver care to patients who are immigrants, use complementary medicine, or have different health beliefs³⁶; however, in our focus group discussions, these issues were not major.

Sensitivity to people of other cultures is of paramount importance to the profession of medicine, especially for those physician residents who have chosen the U.S. as their new home country. Residents’ awareness of the local culture could be additionally enhanced through community experiences focusing on the ethical and psychosocial implications of the provision of care. Residents’ readiness to deliver cross-cultural patient care is related to the availability of faculty and peer role models, and experiences with culturally diverse patient populations.³⁷

Conclusion

Our cultural sensitivity training includes interactive didactics for pediatric residents across the three residency years. The longitudinal training in cultural sensitivity has helped our residents to better understand each other and relate to peers, other health professionals and patients. Our findings suggest that the formal curriculum in cultural sensitivity including interactive didactic sessions throughout the residency training has positively impacted residents’ understanding of the role of cultural diversity in healthcare and has supported an improved healthcare delivery. Residency programs should be encouraged to include formal curricula on cultural sensitivity to create culturally competent learning and practice environments.

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