



RESIDENT PHYSICIANS' PREPAREDNESS TO PROVIDE CROSS-CULTURAL CARE: IMPLICATIONS FOR CLINICAL CARE AND MEDICAL EDUCATION POLICY

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ABSTRACT: In a national study of resident physicians in their final year of training, few residents reported feeling unprepared in a general sense to care for patients from racial and ethnic minorities and from diverse cultures. Yet far more felt unprepared to care for patients with specific cultural characteristics, including those who mistrust the U.S. health care system or who have health beliefs or practices at odds with western medicine. This gap in perceived levels of preparedness indicates shortcomings in graduate medical education that need to be addressed. Recommended reforms include integration of cross-cultural training into curricula (both during and after medical school) in accordance with standard principles, the appropriate training of faculty (to ensure useful instruction, as well as mentors and role models), and the mandatory and formal evaluation of residents' cross-cultural communication skills.

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EXECUTIVE SUMMARY

As the United States population grows increasingly diverse, the delivery of quality health care to all patients, regardless of race, ethnicity, culture, and language proficiency, is becoming more of a challenge. Two reports from the Institute of Medicine (IOM)—*Crossing the Quality Chasm* and *Unequal Treatment*—cited persistent racial/ethnic disparities in health care, and both reports highlighted the importance of patient-centered care and cross-cultural training as a means of improving quality across the board. These recommendations were based on the premise that health care professionals need to have the knowledge and skills to provide culturally competent care to a variety of populations. In particular, improvement of provider-patient communication is essential to addressing the quality-of-care differences associated with race, ethnicity, or culture.

In 2003, a national survey of resident physicians in their last year of training was conducted to determine whether the nation's future physician workforce felt sufficiently prepared to deliver quality care to diverse populations. The objectives of this survey were to assess the resident physicians' self-perceived levels of preparedness, assess the educational climate for cross-cultural training, and determine whether respondents received formal training and evaluation in cross-cultural care during their residency. Results of this study were published in the *Journal of the American Medical Association* in 2005. The present report reviews the major findings of that work and identifies their implications for clinical care and medical-education policy.

Findings

The national survey had 2,047 respondents, out of 3,435 eligibles, representing internal medicine, surgery, pediatrics, obstetrics/gynecology, emergency medicine, psychiatry, and family medicine. Men and women were almost equal in number, while respondents' racial/ethnic groups were non-Hispanic white (57.1%), Black non-Hispanic (6.2%), Hispanic (5.0%), Asian/Pacific Islander (22.7%), and other (4.2%). Overall, 25.6 percent were international medical graduates.

Attitudes, Preparedness, and Skills

Nearly all residents thought it was important to consider the patient's culture when providing care (26% said "moderately important" and 70% "very important"). Residents in emergency medicine and surgery were significantly less likely to respond "very important" (43% and 47%, respectively) compared with other specialties, among whom 67 percent to 94 percent ($p < .001$) answered "very important." Many residents felt that cross-cultural issues "often" resulted in negative consequences for clinical care, including longer

office visits (43%), patient noncompliance (21%), delays obtaining consent (19%), unnecessary tests (9%), and lower quality of care (7%).

Although less than half of the residents felt “well prepared” or “very well prepared” to treat patients from diverse cultures or racial and ethnic minorities, few thought they were “very unprepared” or “somewhat unprepared” when asked in a general sense. However, many more residents felt unprepared to deliver care to patients with specific characteristics likely to arise in cross-cultural situations. For example, more than one out of five residents felt unprepared to treat patients with mistrust (28%), cultural issues at odds with Western medicine (25%), or religious beliefs that affect care (20 percent). Similarly, some residents felt unprepared to treat users of complementary medicine (26%), new immigrants (25%), or patients with limited English proficiency (22%). By comparison, when it came to managing common clinical problems and delivering services that each resident expected to perform during his or her medical careers, the percentage citing lack of preparedness was quite low.

Training, Evaluation, and Educational Climate

Most resident physicians—particularly those in emergency medicine, general surgery, and ob/gyn—reported receiving little or no instruction in cross-cultural skills beyond what is learned in medical school. Approximately half reported receiving minimal training in understanding how to address patients from different cultures (50%) or in identifying patient mistrust (56%), relevant religious beliefs (50%), relevant cultural customs (48%), and decision-making structure (52%). Whereas family-medicine residents received more instruction than did those in any of the other six specialties, residents in general surgery and emergency medicine reported having very little instruction in cross-cultural skills.

About 10 percent of all residents reported never being formally evaluated on doctor–patient communication, and an additional 21 percent said they were “rarely” evaluated in that area. Adding the responses of those who were never evaluated on doctor–patient communication in general to the responses of all residents who said that very little or no attention was paid to cross-cultural issues (56%) yields a total of 66 percent of residents who received little or no evaluation on cross-cultural aspects of doctor–patient communication.

Over half of respondents (58%) said that lack of time presented a moderate or major problem for them in delivering cross-cultural care. Other frequently mentioned problems included lack of language-appropriate written materials (62%), poor access to interpreters (53%), and lack of experience (22%). Although dismissive attitudes of

attending physicians or of resident colleagues have been suggested in previous focus groups, only 18 percent and 15 percent of respondents, respectively, mentioned such problems in the survey. About 30 percent cited the lack of good role models as a problem, and 31 percent stated (in response to a separate question) that they had no role models or mentors during their residencies who were good at providing cross-cultural care.

Implications for Clinical Care

Residents felt that poor handling of patients' cross-cultural issues often had negative consequences for clinical care, including longer office visits, patient noncompliance, delays obtaining informed consent, ordering of unnecessary tests, and lower overall quality of care. This is especially troubling, given that residents reported they were unprepared to handle several key cross-cultural issues in the clinical encounter, as noted above. And it is important to note that a broad array of patients—not just racial or ethnic minorities, new immigrants, or patients with limited-English proficiency—may share a mistrust of the health system, or hold a health belief or religious value that can affect care. *Crossing the Quality Chasm* argues that the quality of our health care system needs to be improved, especially in making it more patient-centered and equitable; yet, the reported deficiencies in providing care across a diversity of cultures threaten the realization of such improvement.

Implications for Medical Education Policy

Several key findings from the research should influence graduate medical education. In particular, they lead to recommendations for improving the training of resident physicians so that they are prepared to provide quality care to diverse populations.

1. Cross-cultural issues matter in the care of patients and are central to quality, yet fewer than half of the resident physicians surveyed feel well prepared to deal with them.
Recommendation: Cross-cultural curricula should be integrated into all graduate medical education (GME).
 - Our research corroborates the IOM's recommendations in *Unequal Treatment* and *Crossing the Quality Chasm* and its calls for greater patient-centeredness and cross-cultural skills as a means of improving quality of care and eliminating disparities.
2. Fewer than half of the resident physicians surveyed had any cross-cultural training outside of what they received in medical school.
Recommendation: Cross-cultural curricula in GME should build on what is learned in medical school, focus on practical tools and skills, and be based on a set of standard principles that are useful across clinical disciplines.

- Standard principles of cross-cultural education in residency training should be based on those highlighted in *Unequal Treatment*. They include providing physicians with an overview of health care disparities and their root causes; methods for understanding the clinical decision-making process (including strategies to avoid stereotyping); a framework for communicating across cultures (including assessment of core cross-cultural issues, exploration of the meaning of the illness, determination of the social context, and negotiation techniques); instruction on how to use an interpreter; and skills for better understanding the community receiving care.
 - Cross-cultural education should be integrated into mainstream educational activities—including lectures, morning reports, case reviews, and work and grand rounds—both on a formal and informal basis.
 - The cross-cultural communication skills taught to resident physicians should be readily usable in the clinical encounter, especially given the competing responsibilities and time constraints they face.
 - System supports (such as interpreters, the assistance of multidisciplinary teams, and printed educational information in multiple languages and aimed at people with low levels of health literacy) should be developed in tandem with cross-cultural curricular efforts.
 - Cross-cultural education should span all disciplines—and it is especially critical in emergency medicine and surgery, in which diagnostic accuracy and the obtaining of informed consent are paramount. Yet research highlights serious self-reported deficiencies among residents in both disciplines.
3. One-third of the surveyed resident physicians stated they did not have role models or mentors who could demonstrate effective cross-cultural care.

Recommendation: Faculty development (including for attending physicians and fellows) in cross-cultural education is essential to the training and mentoring of residents in cross-cultural care.

- Given the importance of good role models and mentors in medical education, faculty should be trained in the same standard principles of cross-cultural care, and they should be provided with (or develop) discipline-specific clinical cases as a means of providing cross-cultural instruction to resident physicians.

4. Two-thirds of the surveyed resident physicians stated they were not evaluated in cross-cultural aspects of doctor-patient communication.

Recommendation: Evaluation of resident physicians' general and cross-cultural communication skills is essential and should be mandatory and formalized.

- Given the important message that simply evaluating a particular competency has on resident physicians' perceived value of that competency, it is necessary that evaluation in the area of general and cross-cultural communication be mandatory and formalized.

Creating assessment tools is an important step toward developing a standard nomenclature for measuring the success of cross-cultural education curricula. Once these tools have been created, they can be used to compare program components and in turn contribute to the development and implementation of consistent curricula across graduate medical education.

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INTRODUCTION

As the United States population grows increasingly diverse, the delivery of quality health care to all patients, regardless of race, ethnicity, culture, and language proficiency, is becoming more and more of a challenge. Two reports from the Institute of Medicine (IOM)—*Crossing the Quality Chasm*¹ and *Unequal Treatment*²—cited persistent racial/ethnic disparities in health care, and both reports highlighted the importance of patient-centered care and cross-cultural training as a means of improving quality across the board. These recommendations were based on the premise that health care professionals need to have the knowledge and skills to provide culturally competent care to a variety of populations. In particular, improvement of provider–patient communication is essential to addressing the quality-of-care differences associated with race, ethnicity, or culture.³

In 2003, The Commonwealth Fund, in collaboration with the California Endowment, provided grant support to the Massachusetts General Hospital's Institute for Health Policy to determine whether the nation's future physician workforce felt sufficiently prepared to deliver quality care to diverse populations. The objectives of this project were to assess the resident physicians' self-perceived levels of preparedness, assess the educational climate for cross-cultural training, and determine whether residents received formal training and evaluation in cross-cultural care during their residency. A national survey of resident physicians was conducted, and results of this work were published in the *Journal of the American Medical Association* in 2005.⁴ The present report reviews the major findings of that work and identifies their implications for clinical care and medical-education policy.

FINDINGS

The national survey had 2,047 respondents, out of 3,435 eligibles, representing internal medicine (IM), general surgery (GS), pediatrics (PED), obstetrics/gynecology (OB), emergency medicine (EM), psychiatry (PSY), and family medicine (FM). Information on survey development, design, sampling, and analysis is found elsewhere (4). A complete description of the study sample is presented in Table 1. Notably, men and women were almost equal in number, while respondents' racial/ethnic groups were non-Hispanic white (57.1%), black non-Hispanic (6.2%), Hispanic (5.0%), Asian/Pacific islander (22.7%), and other (4.2%). Overall, 25.6 percent were international medical graduates (IMGs). The

distributions of gender and race/ethnicity were nearly identical to those of all U.S. residents, as reported from American Medical Association surveys.^{5,6}

Attitudes, Preparedness, and Skills

Nearly all residents thought it was important to consider the patient's culture when providing care (26% "moderately important", 70% "very important"). Residents in emergency medicine and surgery were significantly less likely to respond "very important" (43% and 47%, respectively) compared with other specialties, among whom 67 percent to 94 percent ($p < .001$) answered "very important." Many residents felt that cross-cultural issues "often" resulted in negative consequences for clinical care, including longer office visits (43%), patient noncompliance (21%), delays obtaining consent (19%), unnecessary tests (9%), and lower quality of care (7%). These results did not vary markedly by specialty, with two exceptions: fewer psychiatry residents reported that these events occurred often ($p < .01$ for each consequence), and more residents from emergency medicine, internal medicine, ob/gyn, and surgery reported problems obtaining consent (25% for these specialties vs. 6%–16% for other specialties).

Although less than half of the residents felt "well prepared" or "very well prepared" to treat patients from diverse cultures or racial and ethnic minorities, few of them (no more than 8%) thought they were "very unprepared" or "somewhat unprepared" when asked in a general sense. However, many more residents felt unprepared to deliver care to patients with specific characteristics likely to arise in cross-cultural situations. For example, more than one out of five residents felt unprepared to treat patients with mistrust (28%), cultural issues at odds with Western medicine (25%), or religious beliefs that affect care (20%). Similarly, residents felt unprepared to treat users of complementary medicine (26%), new immigrants (25%), or patients with limited English proficiency (22%). Most answers varied by specialty, but the differences were not large. An exception was family physicians, who were significantly less likely to feel unprepared than residents in other specialties.

Table 1. Description of Study Sample

	Number of respondents* (unweighted)	Percent distribution (unweighted)	Percent distribution (weighted)
All	2047	100%	100%
Sex			
Male	1004	49.1	50.6
Female	1043	51.0	49.4
Race/Ethnicity			
White, Non-Hispanic	1265	61.8	57.1
Black, Non-Hispanic	119	5.8	6.2
Asian/Pacific Islander	404	19.7	22.7
Hispanic	115	5.6	5.0
NA/AN/Other	65	3.2	4.2
IMG Status			
USMG	1577	77.0	73.7
IMG	453	22.1	25.6
Born in U.S.			
Yes	1443	70.5	65.8
No	596	29.1	33.8
Some Training Outside U.S.			
Yes	748	36.5	39.2
No	1282	62.6	60.0
Speak language other than English			
Yes	1418	69.3	71.0
No	623	30.4	28.7
Specialty			
Emergency Medicine	299	14.2	9.2
Family Medicine	308	15.1	9.1
General Surgery	278	13.6	8.3
Internal Medicine	271	13.2	40.3
Obstetrics/Gynecology	276	13.5	7.9
Pediatrics	291	14.2	15.4
Psychiatry	312	15.2	9.4

Abbreviations: IMG = International Medical Graduate; USMG = U.S. medical graduate.

* Refers to the number of valid responses in each category.

Some numbers do not total 100 percent because of rounding. Missing numbers/responses are not included.

Source: J. S. Weissman, J. R. Betancourt, E. G. Campbell et al., "Resident Physicians' Preparedness to Provide Cross-Cultural Care," *Journal of the American Medical Association*, Sept. 7, 2005 294(9):1058-67.

By comparison, when it came to managing common clinical problems and delivering services that each resident expected to perform during his or her medical careers, the percentage citing lack of preparedness was quite low. For example, 2 percent or fewer among respondents in selected specialties felt unprepared to treat depression (FM, EM, PSY), vaginitis (FM, EM, OB), or heart disease (EM, FM, IM); to perform hysterectomies (OB) or laparoscopies (GS); or to provide counseling for weight loss or smoking (2%–3% for all specialties except surgery). Overall reports of feeling unprepared to counsel patients for psychosocial issues were higher; these issues included substance abuse (8%), domestic violence (19%), eating disorders (17%), and terminal illness (7%).

Table 2. Percent of Residents Who Were Very or Somewhat Unprepared^a (by Self-Assessment) to Treat Types of Patients or Provide Specified Services, by Specialty

	Specialty								p value
	All	EM	FM	IM	GS	OB	PED ^b	PSY	
Care for patients with cross-cultural characteristics									
Culture different from one's own	8.0	10.5	5.2	7.1	10.8	9.9	9.3	6.1	.12
Racial/ethnic minority	4.6	2.7	3.5	5.2	4.0	4.4	5.7	4.2	.80
Health beliefs at odds with Western medicine	25.4	26.9	20.6	24.7	29.0	35.5	29.1	15.4	<.001
Distrust of U.S. health system	27.9	26.6	22.2	30.1	23.7	37.7	30.4	17.7	<.001
Limited English proficiency	21.6	17.1	17.8	24.7	20.5	12.5	18.6	30.3	<.001
New immigrants	25.2	22.9	20.3	27.6	24.8	23.1	23.5	27.4	.55
Religious beliefs affect treatment	19.5	23.9	15.1	18.8	17.7	19.4	25.5	14.2	.005
Use alternative/complementary medicine	25.8	21.2	15.5	27.5	29.2	30.4	30.6	19.6	<.001

Abbreviations: EM = Emergency Medicine; FM = Family Medicine; GS = General Surgery; IM = Internal Medicine; OB = Obstetrics/Gynecology; PED = Pediatrics; PSY = Psychiatry.

^a Answered 1 or 2 on a scale of 1 to 5.

^b Each question allowed respondents to answer for the patient or a pediatric patient's family.

The proportion of residents who rated themselves as having low skill levels for managing various aspects of cross-cultural encounters ranged from about 3% to 29%, depending on the skill area (Table 3). Among all specialties, approximately one of five residents felt they possessed low skills (1 or 2 on a scale of 5) for identifying mistrust (19%), relevant cultural customs (24%), or relevant religious beliefs (25%) that affect care. While fewer psychiatrists reported low skills for some of the components, no particular patterns emerged from among the other specialties.

Source: J. S. Weissman, J. R. Betancourt, E. G. Campbell et al., "Resident Physicians' Preparedness to Provide Cross-Cultural Care," *Journal of the American Medical Association*, Sept. 7, 2005 294(9):1058–67.

Table 3. Percent of Residents Who Self-Assess Low Skill Levels in Delivering Cross-Cultural Care, by Specialty^a

	Specialty								p value
	All	EM	FM	IM	GS	OB	PED ^b	PSY	
How patient wants to be addressed	5.8	8.0	5.5	4.8	5.7	9.1	5.8	6.0	.39
Assess understanding of illness	7.2	5.7	7.0	8.5	5.5	7.3	8.6	2.5	.07
Identify mistrust	18.9	25.9	24.5	17.8	18.1	23.3	18.9	8.3	<.001
Negotiate about treatment plan	4.7	4.7	4.2	3.7	4.0	10.6	5.5	3.5	.003
Identify relevant religious beliefs	24.7	32.6	24.9	24.5	27.2	27.3	27.5	9.4	<.001
Identify relevant cultural customs	24.1	28.1	20.7	25.6	27.6	28.8	23.8	11.9	<.001
Identify decision-making structure	16.1	22.2	13.2	14.8	12.4	20.7	22.0	8.6	<.001
Work with interpreter	8.8	2.7	6.8	10.8	6.9	5.1	5.8	18.2	<.001

Abbreviations: EM = Emergency Medicine; FM = Family Medicine; GS = General Surgery; IM = Internal Medicine; OB = Obstetrics/Gynecology; PED = Pediatrics; PSY = Psychiatry.

^a Answered 1 or 2 on a scale of 1 to 5.

^b Each question allowed respondents to answer for the patient or a pediatric patient's family.

Source: J. S. Weissman, J. R. Betancourt, E. G. Campbell et al., "Resident Physicians' Preparedness to Provide Cross-Cultural Care," *Journal of the American Medical Association*, Sept. 7, 2005 294(9):1058–67.

Training, Evaluation, and Educational Climate

Most resident physicians—particularly those in emergency medicine, general surgery, and ob/gyn—reported receiving little or no instruction in cross-cultural skills in specific areas beyond what is learned in medical school (Table 4). Approximately half reported receiving minimal training in understanding how to address patients from different cultures (50%) or how to identify patient mistrust (56%), relevant religious beliefs (50%), relevant cultural customs (48%), and decision-making structure (52%). Whereas family-medicine residents generally received more instruction than did those in any of the other six specialties, residents in general surgery and emergency medicine reported having very little instruction in cross-cultural skills. Residents from programs that offered opportunities in cultural-competence awareness (70.2 percent of residents in the sample) were significantly less likely to report receiving little or no training in each of these domains except learning how to identify patient mistrust; however, the differences were not large. For example, 45 percent of residents in programs with cultural-competence offerings still reported little or no instruction in how to identify relevant cultural customs, versus 54 percent in other programs ($p < .001$).

About 10 percent of residents reported never being formally evaluated on doctor–patient communication, although residents in family practice and psychiatry programs were far less likely to so report (1 percent each; $p < .001$). An additional 21 percent of all residents said they were “rarely” evaluated in that area. Adding the responses of those who were never evaluated on doctor–patient communication in general to the responses of all residents who were evaluated but said that very little or no attention was paid to cross-cultural issues (56%) comes to 66 percent of residents receiving little or no evaluation on cross-cultural aspects of doctor–patient communication. This total ranged from about 80 percent for residents in surgery, obstetrics/gynecology, and emergency medicine to about 40 percent for family medicine and psychiatry ($p < .001$).

Table 4. Percent of Residents Receiving Little or No Instruction in Cross-Cultural Skills, by Specialty^a

	Specialty							
	ALL	EM	FM	IM	GS	OB	PED ^b	PSY
How patient wants to be addressed	50.4	68.9	28.8	49.9	75.2	62.7	46.8	29.3
Assess understanding of illness	35.6	49.5	16.1	37.3	56.7	42.8	31.0	16.6
Identify mistrust	56.3	73.2	42.6	52.8	78.7	69.9	58.8	32.4
Negotiate about treatment plan	33.0	46.3	17.1	30.3	55.2	43.8	30.8	20.8
Identify relevant religious beliefs	49.7	64.9	37.5	51.8	66.0	47.8	48.5	26.8
Identify relevant cultural customs	47.9	62.5	31.3	54.4	66.6	50.7	35.8	22.6
Identify decision-making structure	52.2	72.9	33.8	48.2	72.2	61.2	54.2	38.2
Work with interpreter	34.7	37.1	23.5	38.2	45.1	31.8	23.6	40.6

Abbreviations: EM = Emergency Medicine; FM = Family Medicine; GS = General Surgery; IM = Internal Medicine; OB = Obstetrics/Gynecology; PED = Pediatrics; PSY = Psychiatry.

^a Answered 1 or 2 on a scale of 1 to 5. $P < .001$ for all comparisons.

^b Each question allowed respondents to answer for the patient or a pediatric patient’s family.

Source: J. S. Weissman, J. R. Betancourt, E. G. Campbell et al., “Resident Physicians’ Preparedness to Provide Cross-Cultural Care,” *Journal of the American Medical Association*, Sept. 7, 2005 294(9):1058–67.

With research consistently showing the impact of culture and patient–doctor miscommunication on health care outcomes (2, 7), identifying barriers residents that face when delivering cross-cultural care is of the utmost importance.^{7,8} Over half of respondents (58%) said that lack of time presented a moderate or major problem for them in delivering cross-cultural care. Other frequently mentioned problems included lack of language-appropriate written materials (62%), poor access to interpreters (53%), and lack of experience (22%). Although dismissive attitudes of attending physicians or of resident

colleagues have been suggested as possible problems from participants in previous focus groups, only 18 percent and 15 percent of residents, respectively, mentioned such problems in the survey.⁹ About 30 percent cited the lack of good role models as a problem, and 31 percent stated (in response to a separate question) that they had no role models or mentors during their residencies who were good at providing cross-cultural care.

Impact of Training and Climate on Skills

Self-assessed skill levels in each substantive area were significantly associated with the amount of training reported during residency and with the presence of good role models. Compared with residents who had reported receiving a lot of instruction in assessing how patients from different cultures want to be addressed, those who reported receiving little or no instruction were eight times more likely to report low skill levels (Table 5). For assessing patients' understanding of their illness, residents with little or no instruction were 10 times more likely to report low skill levels; and the ratio with respect to identifying relevant religious beliefs was nearly 20. The ratios comparing residents with and without good role models and mentors were smaller, but all differences were statistically significant.

Table 5. Percent of Residents Reporting Moderate or Big Problems with Selected Measures When Delivering Cross-Cultural Care, by Specialty^a

	Specialty								p value
	All	EM	FM	IM	GS	OB	PED ^b	PSY	
Lack of experience	21.6	18.0	20.8	22.6	13.7	18.1	22.4	30.0	0.000
Lack of time	57.6	47.6	62.8	60.2	40.7	61.7	61.6	56.4	0.000
Inadequate training	34.2	26.8	21.4	39.3	24.8	35.5	37.9	33.7	0.000
Poor access to interpreters	53.0	53.8	50.1	53.8	50.4	48.1	56.1	53.6	0.000
Poor access to written materials	61.6	58.5	60.8	64.9	55.4	65.9	57.1	61.8	0.000
Absence of good role models	31.3	29.1	25.6	32.7	29.9	36.6	27.5	36.0	0.000
Dismissive attitudes of attending physicians	18.3	18.7	13.5	20.2	20.1	17.7	16.2	16.9	0.057
Dismissive attitudes of fellow residents	15.2	15.4	12.2	15.7	17.7	12.6	15.9	14.6	0.000

Abbreviations: EM = Emergency Medicine; FM = Family Medicine; GS = General Surgery; IM = Internal Medicine; OB = Obstetrics/Gynecology; PED = Pediatrics; PSY = Psychiatry.

^a Answered 3 or 4 on a scale of 1 to 4.

^b Each question allowed respondent to answer for the patient or a pediatric patient's family.

Source: J. S. Weissman, J. R. Betancourt, E. G. Campbell et al., "Resident Physicians' Preparedness to Provide Cross-Cultural Care," *Journal of the American Medical Association*, Sept. 7, 2005 294(9):1058-67.

IMPLICATIONS FOR CLINICAL CARE

Residents felt that when patient's cross-cultural issues were poorly handled, negative consequences for clinical care—including longer office visits, patient noncompliance, delays obtaining informed consent, ordering of unnecessary tests, and lower quality of care overall—often resulted. This finding is especially daunting in that residents reported they were unprepared to handle several key cross-cultural issues in the clinical encounter—fewer than half believed they were well prepared to deal with these issues. For example, more than one out of five residents felt unprepared to treat patients with mistrust of the health care system (28%), cultural issues at odds with Western medicine (25%), or religious beliefs that affect care (20%). Similarly, some residents felt unprepared to treat users of complementary medicine (26%), new immigrants (25%), or patients with limited English proficiency (22%).

It is important to note that a broad array of patients, not just from racial and ethnic minorities, may manifest characteristics such as mistrust or a religious belief that affect care. *Crossing the Quality Chasm* argues that the quality of our health care system needs to be improved—especially in making it more patient-centered and equitable—but the reported deficiencies in providing care across a diversity of cultures threaten the realization of such improvement.

IMPLICATIONS FOR MEDICAL EDUCATION POLICY

Several key findings from the research should influence graduate medical education. In particular, they lead to recommendations for improving the training of resident physicians so that they are prepared to provide quality care to diverse populations.

1. *Cross-cultural issues matter in the care of patients and are central to quality, yet fewer than half of the resident physicians surveyed feel well prepared to deal with them.* The overwhelming majority of resident physicians believe it is important to consider the patient's culture when providing care (70 percent “very important,” 26 percent “moderately important”). Many suggest that poor handling of cross-cultural issues leads to lower quality care, including noncompliance, longer office visits, delays in obtaining consent (and thus longer length of hospital stay), and the ordering of unnecessary tests. Yet fewer than half of the surveyed resident physicians considered themselves “well prepared” or “very well prepared” to treat patients from diverse cultures or racial/ethnic minorities. (Family medicine residents felt more prepared in general, and emergency department and surgery residents felt less prepared in general.)

Recommendation: Cross-cultural curricula should be integrated into all graduate medical education (GME). Our research corroborates the IOM's recommendations in *Unequal Treatment* and *Crossing the Quality Chasm* and its calls for greater patient-centeredness and cross-cultural skills as a means of improving quality of care and eliminating disparities.

2. ***Fewer than half of resident physicians surveyed had any cross-cultural training outside of what they received in medical school.*** Residents reported receiving little or no training in understanding how to address patients from different cultures (50%) or how to identify patient mistrust (56%), relevant religious beliefs (50%), relevant cultural customs (48%), or decision-making structure (52%). Whereas family medicine in general received more instruction in cross-cultural skills than did any of the other six specialties, residents in general surgery and emergency medicine reported had very little.

Recommendation: Cross-cultural curricula in GME should build on what is learned in medical school, focus on practical tools and skills, and be based on a set of standard principles that are useful across clinical disciplines. Whereas medical school provides a foundation of knowledge and an introduction to clinical medicine, there is no doubt that residency training is where physicians truly develop their clinical expertise and practice style. As such, cross-cultural education is a critical and necessary part of residency training. Standard principles of cross-cultural education in residency training, based on those highlighted in *Unequal Treatment*, include providing physicians with:

- An overview of health care disparities and their root causes
- Methods for understanding the clinical decision-making process (including strategies to avoid stereotyping)
- A framework for communicating across cultures (including assessment of core cross-cultural issues, exploration of the meaning of the illness, determination of the social context, and negotiation techniques)
- Instruction on how to use an interpreter
- Skills for better understanding the community receiving care.

Cross-cultural education should be integrated into mainstream educational activities—including lectures, morning reports, case reviews, and work and grand rounds—both on a both formal and informal basis. The cross-cultural communication skills taught to residents should be readily usable in the clinical

encounter, especially given the competing responsibilities and time constraints they face.

In addition, system supports (such as interpreters, the assistance of multidisciplinary teams, and printed educational information in multiple languages and aimed at people with low levels of health literacy) should be developed in tandem with cross-cultural curricular efforts. Cross-cultural education, moreover, should span all disciplines—and it is especially critical in emergency medicine and surgery, in which diagnostic accuracy and the obtaining of informed consent are paramount.

3. ***One-third of the surveyed resident physicians stated they did not have role models or mentors who could demonstrate effective cross-cultural care.*** About 30 percent cited the lack of good role models as a problem, and 31 percent stated (in response to a separate question) that they had no role models or mentors during their residencies who were good at providing cross-cultural care.

Recommendation: Faculty development (including for attending physicians and fellows) in cross-cultural education is essential to the teaching and mentoring of residents in cross-cultural care. Faculty should be trained in the same standard principles that are taught to resident physicians, and clinical cases specific to each discipline should be used.

4. ***Two-thirds of resident physicians surveyed stated they were not evaluated in cross-cultural aspects of doctor–patient communication.*** About 10 percent of residents reported never being formally evaluated on doctor–patient communication (though residents in family practice and psychiatry programs were far less likely to report never being evaluated). An additional 21 percent of all residents reported that they were “rarely” evaluated on doctor–patient communication, and 66 percent of all residents received little or no evaluation on cross-cultural aspects of doctor–patient communication (by specialty, this figure ranged from about 80 percent for residents in surgery, obstetrics/gynecology, and emergency medicine to about 40 percent for family medicine and psychiatry). Research has shown that formal instruction and evaluation on cultural competence not only improves knowledge and attitudes among health care providers, but also improves health outcomes for patients.^{10,11}

Recommendation: Because evaluation of resident physicians’ general and cross-cultural communication skills is essential, it should be mandatory and formalized. Given the important message that simply evaluating for a particular competency has on resident physicians’ perceived value of that competency, it is necessary that evaluation in the area of general and cross-cultural communication be mandatory

and formalized. Creating assessment tools is an important step toward developing a standard nomenclature for measuring the success of cross-cultural education curricula.¹² Once these tools have been created, they can be used to compare program components and in turn contribute to the development and implementation of consistent curricula across graduate medical education.

SUMMARY

In this national study of resident physicians in their final year of training, few residents reported feeling unprepared in a general sense to care for patients from racial and ethnic minorities and from diverse cultures. Yet far more felt unprepared to care for patients with specific cultural characteristics, including those who mistrust the U.S. health care system or who have health beliefs or practices at odds with western medicine. Many residents also considered themselves unskilled in key aspects of effective cross-cultural care, such as the ability to assess patients' understanding of their illness or to identify relevant cultural customs, both of which contribute to patients' subsequent behaviors. The gap between perceptions of preparedness in the general sense and preparedness for specific situations may itself be a marker of shortcomings in graduate medical education. Particular problems include insufficient time for mentors to deliver instruction on effective cross-cultural care or for residents to receive it, residents not being evaluated on their abilities in this area, and not receiving much training in cross-cultural care after leaving medical school. These phenomena were especially prevalent among residents in general surgery, ob/gyn, and emergency medicine.

In a recent report on the future of academic health centers, the Institute of Medicine emphasized the need to reform medical education through the development and integration of new curricula (12).¹³ The report's findings include the need for improvement in cross-cultural education. Innovation in this area would enhance the quality of care provided to patients of diverse backgrounds and be a major step toward eliminating racial and ethnic disparities in health care.

NOTES

¹ Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington D.C.: National Academies Press, 2001).

² Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington D.C.: National Academies Press, 2002).

³ J. R. Betancourt, “Cultural Competence—Marginal or Mainstream Movement?” *New England Journal of Medicine*, Sept. 2, 2004 351(10):953–55.

⁴ J. S. Weissman, J. R. Betancourt, E. G. Campbell et al., “[Resident Physicians’ Preparedness to Provide Cross-Cultural Care](#),” *Journal of the American Medical Association*, Sept. 7, 2005 294(9):1058–67.

⁵ Graduate Medical Education Database (Chicago: American Medical Association, 2002).

⁶ Graduate Medical Education Directory, 2002–2003 (Chicago: American Medical Association, 2002).

⁷ IOM, *Crossing the Quality Chasm*, 2001.

⁸ J. T. Berger, “Culture and Ethnicity in Clinical Care,” *Archives of Internal Medicine*, Oct. 26, 1998 158(19):2085–90.

⁹ E. R. Park, J. R. Betancourt, M. K. Kim et al., “[Mixed Messages: Residents’ Experiences Learning Cross-Cultural Care](#),” *Academic Medicine*, Sept. 2005 80(9):874–80.

¹⁰ J. R. Betancourt, “Cross-Cultural Medical Education: Conceptual Approaches and Frameworks for Evaluation,” *Academic Medicine*, June 2003 78(6):560–69.

¹¹ B. Majumdar, G. Browne, J. Roberts et al., “Effects of Cultural Sensitivity Training on Health Care Provider Attitudes and Patient Outcomes,” *Journal of Nursing Scholarship*, 2004 36(2):161–66.

¹² E. Pena Dolhun, C. Munoz, and K. Grumbach, “Cross-Cultural Education in U.S. Medical Schools: Development of an Assessment Tool,” *Academic Medicine*, June 2003 78(6):615–22.

¹³ Institute of Medicine, *Academic Health Centers: Leading Change in the 21st Century* (Washington, D.C.: National Academies Press, 2003).

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