tutor

Vol. 15, N. 2, 2015: 13-20
DOI: 10.14601/Tutor-16459

Cultural competent care: educational needs of junior doctors in palliative care for ethnic groups

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ABSTRACT

In this article, the results of a qualitative study on the educational needs of junior doctors working in a university hospital in Rome, with regard to providing palliative care (PC) to ethnic groups, are presented. Focus groups were held to identify the educational needs on cultural competence applied to PC during medical training. The expressed needs were clustered in three main themes: language as a barrier, empathy and management of emotions, knowledge (pain management, culture). A set of recommendations were issued towards the medical board to redesign the medical curriculum.

Key words: Graduate education, palliative care, cultural competence

RIASSUNTO

Premessa. In Italia sta aumentando il numero di pazienti di origine non italiana e – parimenti – le cure palliative stanno ricevendo attenzione sempre maggiore. Questa ricerca qualitativa si propone di esplorare i bisogni di formazione percepiti da un gruppo di specializzandi, relativamente alla pratica di cure palliative a pazienti non italiani.

Materiali e metodi. Sono stati condotti quattro focus group con specializzandi in formazione presso il Policlinico Umberto I di Roma. Le domande di conduzione dei focus group sono state derivate dai costrutti previsti dal modello di competenza culturale proposto da Camphina-Bacote. Le trascrizioni sono state sottoposte ad analisi tematica.

Risultati. Sono emersi tre temi principali relativi ai bisogni di formazione: la conoscenza di una lingua straniera e la capacità di dialogare comunque con un paziente che non parla italiano, lo sviluppo dell'empatia e della capacità di gestire le emozioni, le conoscenze specifiche di competenza culturale e relative alle cure palliative.

Conclusioni. I risultati ottenuti indicano che i bisogni di formazione espressi sono ritenuti utili ma secondari rispetto al nucleo fondamentale delle competenze mediche. Vengono proposte alcune raccomandazioni per lo sviluppo della progettazione formativa per il corso di laurea in medicina.

Parole chiave: Formazione post-laurea, cure palliative, competenza culturale

http://www.fupress.com/tutor
ISSN (print) 1971-7296
ISSN (online) 1971-8551

INTRODUCTION

Culture, which, "to some extent can be seen as the 'lens through which the individual perceives and understands the world that he inhabits and learns how to live within it'" [1] is, together with individual factors, education, socio-economic status and environmental factors, one of the determinants of health [1, 2]. Cultural background might influence the way health, disease and death are perceived by a patient. Due to cultural and linguistic differences, ambiguities can arise between patient and healthcare provider [3]. Poor knowledge of healthcare providers about the influence of cultural and linguistic differences may result in low quality of care, low compliance in treatment and medication use by patients [4]. In the field of PC, differences in culture and language might be even more influential because beliefs about death and pain relief, as well as the provision of PC differ strongly among cultures [5].

To improve healthcare for ethnic groups, healthcare workers can be educated in cultural competence. Cultural competence is a concept which is used in healthcare to increase the quality of care and to prevent health disparities among patients with a different cultural and linguistic background. It aims to develop a healthcare environment, which is suitable to respond to the needs of patients with a different background and language [6].

In Italy, at University La Sapienza in Rome, researchers have developed an educational framework for the development of professionalism including socio-cultural competence of medical students [7]. Because of increasing cultural diversity in the population of Italy [8] the social cultural competence should be given according to Consorti et al. [7] a high priority in this framework. However, when this study was designed, medical students did not receive much education on the influence of culture on healthcare or specifically PC. Furthermore, little insight exists on the gap between the medical curriculum on cultural competence and the educational needs of undergraduate and graduate medical students. Therefore, this study focussed on the educational needs of junior doctors in providing PC to ethnic groups in Policlinico Umberto I, related to the University La Sapienza. By increasing the attention for education on cultural and linguistic differences in medical school, the knowledge and awareness on cultural and linguistic differences of future doctors can be expected to improve, which will contribute to the improvement of the quality of PC for ethnic groups. Based upon the results of this study, we also aimed to provide recommendations towards the medical board for redesigning the medical curriculum.

METHODS

Focus groups (FGs) were used in this study as a tool to find an answer to the main research question: *What are the perceived educational needs of junior doctors in providing PC for ethic groups?* Five sub questions have been formulated based upon the model of the process of cultural competence in the delivery of healthcare by Camphina-Bacote (2002) [9]. This model was chosen because it focuses specifically on the healthcare provider while others, such as the sunrise model of Leiniger and the model of Purnell, focus more on the patient, as well as learning and understanding culture [10, 11].

In the Camphina-Bacote model [9] five constructs are used, namely: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. Cultural awareness (CA) is defined as the reflection on the healthcare provider's own cultural and professional background. In other words, a healthcare provider should be able to recognize his prejudices and assumptions about people with a different background. Cultural knowledge (CK) is seen as a combination of having knowledge about health-beliefs and cultural values, occurrence of diseases in a specific culture and knowledge about the interaction of medicine in groups. Cultural skill (CS) is regarded as the use of cultural knowledge in the physical assessment of patients. When assessing the patient, the healthcare provider should have knowledge about the physical, biological, and physiological differences between patients. Cultural encounter (CE) is defined as healthcare professionals being encouraged to interact with patients with a different cultural background. Cultural encounter also includes the assessment of the patient's linguistic skills. Cultural desire (CD), finally, comprises and refers to the provider's motivation to give cul-

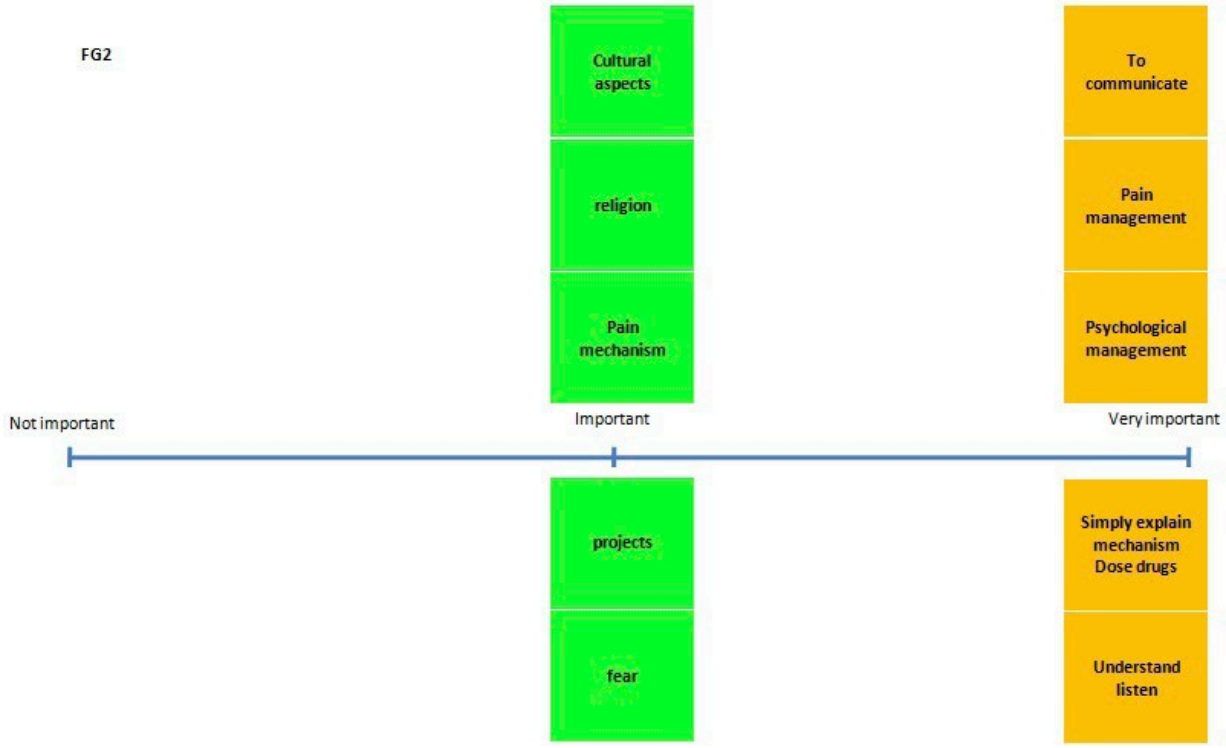

Figure 1. Example of scale used in FG's

turally competent care; cultural competence is not only having the skill and knowledge to be culturally responsive, but also includes the willingness to provide cultural competent care.

The following questions were derived from the model, related to one or more of these concepts: How do junior doctors take into account culture in providing PC to ethnic groups (CA)? Which is the needed knowledge to provide culturally competent PC according to the junior doctors (CK)? Which are the needed skills to provide culturally competent PC according to the junior doctors (CS)? What role does language play in PC for ethnic groups according to junior doctors (CE)? Which training would have been necessary during medical curriculum to provide appropriate and effective PC to ethnic groups (all constructs)?

Because of the exploratory nature of this study, FGs were chosen as methodology because they are very effective to this aim [12, 13]. An additional property is that they can produce more information than other qualitative methods such as interviews, beacause of the interactions between participants [12]. Finally, opinions of several participants can be discussed and differences between opinions can be explored, allowing for a better understanding of the topics than a survey or an interview [14].

The FGs were held with residents working in Policlinico Umberto I, Rome, Italy. The choice for junior doctors was motivated by the expectation that they have more experience with PC for ethnic groups compared to medical students. Approximately 4 to 8 FGs were planned with 4 to 8 participants. Participants were recruited by email invitation and by phone call.

A script was developed for the FGs, to maintain consistency in their execution over a period of several weeks. The five sub questions were used in several exercises to collect opinions. The exercises consisted of different kind of first-thought associations, followed by an explanation phase. During the latter the participants were able to explain their association

	Total participants	Gender	Mean age	Medical Specialty (amount)
FG1	3	1 male	33	• General surgery (2) • Internal medicine (1)
FG2	4	1 male	32	• Oncology (1) • Internal medicine (3)
FG3	3	2 male	30	• Gastrointestinal surgery (3)
FG4	8	2 male	30	• Gastroenterology (8)

Table 1. Participant characteristics

and discuss them with other participants. The final stage consisted of a ranking phase, in which the concepts were ordered by the participants by priority in PC for ethnic groups (see Figure 1).

The FGs were recorded, transcribed, coded and labelled using the concepts named by the participants. All data were summarized in a matrix to get a clear overview of the answers in the different FGs. Finally, the results were compared with the model of the process of cultural competence in the delivery of healthcare by Camphina-Bacote [9].

RESULTS

The response rate for the FGs was low with respect to the delivered invitations. Initially, a total of four FGs were conducted, with junior doctors of the residency in general surgery, oncology and internal medicine (Table 1).

The results show that experience with PC for ethnic groups was scarce. However, experience with PC in general or with ethnic groups in general was present. Two main, contrasting opinions came forward. For one group, the needs were seen as the same for all patients, regardless of their background.

Pain, if you're sick, you're sick, it may be a Roman, an Italian, Frenchman or Englishman

On the other hand, ethnic groups were perceived to have different needs because they thought differently about PC. Nevertheless, all agreed that cultural, religious and linguistic differences can be obstacles in providing care to ethnic groups.

Furthermore, the participants observed problems in the access to healthcare and non-compliance in treatments due to lower socioeconomic status and language barriers.

Only one participant mentioned the difference between cultures in the attitude towards certain medications:

I'm thinking about morphine […] in some cultural groups it could be a negative thing to use morphine […] for Italian patients for example the use of this kind of drug is like a death sentence.

NEEDS IN KNOWLEDGE AND SKILLS

When asked which is the needed knowledge to provide PC to ethnic groups, knowledge about religion was regularly mentioned, because differences were often associated with differences in religion. The main reason to consider this knowledge as essential was to empathize with the patients or to know how to treat a patient. With cultural and religious knowledge the physician is better able to understand the worldview of the patient. This can help in establishing a good patient-physician relationship. Besides, the participants said that patients with a diverse background have diverging views on life, illness and death. One participant stated:

We are facing the patient at the end of his life. So we must approach him with empathy, which is hearing and understanding how he manages his problem. Including his cultural background; maybe a patient who has a faith stands differently in relation to his disease than one who hasn't.

Beside the need for knowledge about culture, the participants prioritized the knowledge about physiological, pharmaceuticals, pain management and PC which are already part of their education.

	Priority 1	Marked*	Priority 2	Marked*
FG1	• Language	3	• Culture	3
FG2	• Communication	4	• Psychological management • Pain management	2 1
FG3	• Language • Relationship with patient • Palliative care	1 1 1	• Different culture and traditions • Palliative care	2 1
FG4	• Language • Medical knowledge & side Effects • Drugs, structure, support, nutrition • Spiritual problems	1 3 3 1	• Language • Medical knowledge & side effects	6 4

* Amount of participants that chose a certain concept.

Table 2. Priorities in education of knowledge and skills

When the participants were asked which skills are needed, all groups mentioned being able of speaking another language. Language barrier was mentioned as the most frequent occurring problem with ethnic groups.
Furthermore, empathy and the ability to build the relationship with the patient were seen as an important skill.

NEEDS IN EDUCATION

Participants were asked about the knowledge and skill domain where education was mainly needed. Education to improve language skills was regarded in all FGs as the basis of the relationship with the patient and thus very important. Education on culture and religion was seen in some FGs as essential, where in other FGs it was deemed unimportant since knowledge on cultures and religion is, or should be, part of your general development. Knowledge about physiological and pharmaceutical factors and about pain mechanism was seen as general requirements and therefore needed. When participants were asked to prioritize their educational needs, language or communications were the most important. However, in one FG more participants chose medical knowledge and knowledge about side effects and drugs, structure, support and nutrition above language (Table 2)

In one FG a discussion ensued about the need of education on empathy. Empathy, the understanding of and listening to the patients, was often seen as an educational need. On the degree to which empathy can be acquired through education opinions differed: some stated empathy is a part of you and you do generally not become a doctor when you are not empathic, and therefore education on empathy is not essential.

METHODS OF EDUCATION

In the last exercise participants were asked how they would like to receive education on the considered subjects. Most skills and knowledge should be taught during the last years of medical school. However, language should be taught starting from elementary school. Nonetheless, some participants thought a course during medical school was necessary, as well as joining students' exchange programmes or going abroad, together with interactive lessons, such as discussion groups or simulations. Such education should be provided during the medical study but also during the medical career.

DISCUSSION

The results suggest that junior doctors are aware of the influence of culture on care. Most of them

believed that knowledge on cultural and religious background is needed to establish a good physician-patient relationship. Knowledge about the patients' view on illness and death is needed to adapt physicians' approach towards the patient. However, though cultural knowledge and skills were seen as important, they were not ranked as essential for their work as physician.
In synthesis, discussion in the FGs revolved among three recurring themes:

LANGUAGE

The junior doctors themselves saw language as the most important skill. Several participants thought that not speaking other languages was an obstacle in the interaction with the patients. The language barrier is not only caused by patients not speaking Italian but also by the physicians not speaking other languages but Italian.
An often recurring topic related to the language barrier was the establishment of the patient-physician relationship. Participants thought that establishing a good patient-physician relationship is important. However, the participants noted that it is hard to establish a relationship with a patient in the case of cultural or linguistic differences. Linguistic problems make these relationships almost impossible. To be emphatic may contribute to the establishment of the relationship, but this was seen by the participants as difficult when there is a language barrier. When the participants were asked how they were empathic some answered that they could smile or try to use a holistic approach.

EMPATHY

In addition, it's a worth noting that when talking about empathy, the recognition of emotions (e.g. pain, frustration, anxiety…) was barely mentioned, which might suggest a lack of empathy in the junior doctors themselves. Participants seemed to give mainly answers from their own perspective without reflecting on the situation of patients. They associated empathy with the fact of the absence of patients' family but not with their acknowledged emotions. Another example to underpin this observation is the comment of one of the participants noting that it is difficult to explain to patients that things work differently in Italy but the participant did not express any empathic reaction with the patients difficult situation. Those examples might suggest that the participants are aware of the influences of the patient's background, but they do not empathize with them.
This might be described as a lack of ethnocultural empathy, described by Rasoal at al. as "feeling, understanding and caring about what someone from another culture feels, understands and cares about" [15].
Rasoal et al. suggest that ethnocultural obstacles are the result of a lack of: knowledge about cultures, practical experience of being in other cultures other than their own, knowledge specific to the other's culture, experience specific to the other's culture and the ability to see similarities and differences between the culture of yourself and that of others [15].
At least two of the five obstacles for ethnocultural empathy might be recognized in, at least in some of the FG participants.
First of all the obstacle of lack of knowledge about cultures seems to be present, since the results of the FGs indicate a low level of cultural knowledge. The second possible obstacle is the lack of practical experience with other cultures. Some participants did not have any experience with patients from ethnic groups and this might prevent them from understanding and empathizing with patients with a different background. This was partly recognized by the FG participants themselves, who mentioned that they should go more often abroad to come in contact with other cultures and languages.

EDUCATION

The participants themselves had the opportunity to prioritize their educational needs (Table 2). Notably, together with PC, pain management and management of psychological aspects of the patients were specifically regarded as necessary. This may reflect that scarce attention is paid to PC in current education. In contrast to the WHO definition, pain management and care for psychological and spiritu-

It is recommended to

include in the medical curriculum, education on cultural competence to the following:
- Awareness of the influence of culture; on health outcomes, patient-physician relation and patient's satisfaction.
- Awareness in future physicians that they might project their own culture on their patients, which may contribute to ambiguities in the delivery of care.
- Knowledge about physiological and physical differences in patients with different ethnic backgrounds to prevent under- or overuse of medication.
- To stimulate and encourage foreign exchanges to improve language skills and intercultural experience

to improve or include education on palliative care (with taking into account the cultural background of the patient) with a focus on:
- Awareness that PC is also part of the work in hospitals and not only of hospices and homecare.
- Awareness that PC starts early in the stage of a life threatening disease and not only in the terminal phase.
- PC as not only pain and symptom management but also includes psychological and spiritual support for patients and their families.
- Communication skills, especially in breaking bad news.
- To create awareness that patients with different cultural backgrounds have different needs in the end of life.

in education on PC and ethnic groups to:
Provide education in form of discussion groups and /or working groups
Provide education in form of simulations
To provide education on PC and ethnic groups in both undergraduates and graduated physicians

Table 3. Recommendations toward medical board

al aspects were not mentioned as a specific part of PC [16]. Furthermore, PC was often seen as care in the end of life (terminal care), and associated with cancer and not with other life threatening diseases. In addition many participants stated that PC is not practiced in primary care, but is practiced only in hospices and homecare.

The comment that PC is practiced mainly in hospices and primary care is in contrast with the WHO definition, which states that PC should be started in an early stage of a life threatening disease [16]. This definition implies that also in secondary healthcare settings such as hospitals, PC should be provided. Therefore it is necessary to raise awareness among physicians about the definition of PC to start such care in an early phase of a disease, and clarify why PC is not only something for hospices and homecare.

Besides PC and communication also the development of empathy was considered an educational requirement. This is in line with a questionnaire held on the University of Padua, Italy, among first, fifth and sixth year's medical students. In this study students declared that medical professionalism values and skills (e.g. empathy, communication etc.) were poorly taught [17]. However, competence, in form of medical knowledge and practical skills, was prioritized over medical professionalism values and skills. This is in line with this study wherein technical medical competence was rated more important compared to communication skills and empathy.

CONCLUSIONS

We can conclude that the perceived main educational needs of the junior doctors can be identified in cultural knowledge and language skills. Language was prioritized because language barriers are an obstacle in communication with the patient. Beside these two needs, the junior doctors also expressed the need to have more education on PC, as well as on pain management, psychological support of the patients and communication skills.

Despite the fact that the junior doctors regard knowledge about different cultures as useful but not fundamental, education on this subject might be needed. Little awareness of the influence of different cultural backgrounds and/or differences in physics and physiology might explain why the junior doctors describe this subject as needed but not fundamental. Cultural and religious knowledge was

seen as 'good to have' but not fundamental in order to be able to perform your job.

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