

Primary care resident, faculty, and patient views of barriers to cultural competence, and the skills needed to overcome them

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Introduction Primary care residencies are expected to provide training in cultural competence. However, we have insufficient information about the perceptions of stakeholders actually involved in healthcare (i.e. residents, faculty and patients) regarding commonly encountered cross-cultural barriers and the skills required to overcome them.

Method This study used a total of 10 focus groups to explore resident, faculty and patient attitudes and beliefs about what culturally competent doctor-patient communication means, what obstacles impede or prevent culturally competent communication, and what kinds of skills are helpful in achieving cultural competence. A content analysis was performed to identify major themes.

Results Residents and faculty defined culturally competent communication in terms of both generic and culture-specific elements, however, patients tended to emphasize only generic attitudes and skills. Residents

and patients were liable to blame each other in explaining barriers; faculty were more likely to consider systemic influences contributing to resident-patient difficulties. All groups emphasized appropriate skill and attitude development in learners as the key to successful communication. However, residents were sceptical of sensitivity and communication skills training, and worried that didactic presentations would result in cultural stereotyping.

Discussion All stakeholders recognized the importance of effective doctor-patient communication. Of concern was the tendency of various stakeholders to engage in person-blame models.

Keywords *Communication; *culture; delivery of health care/*standards; focus groups/methods; *physician-patient methods.

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Introduction

Achieving cultural competence in learners is an important goal for all primary care residency programmes. Promoting this end, cross-cultural training guidelines have been formulated for family medicine,¹ internal medicine² and paediatrics.³

Cultural competence in physicians has been defined as 'the ability to understand and work with patients whose beliefs, values, and histories are significantly different from one's own',⁴ and includes elements of awareness, knowledge and skill.⁵ Failure to pay attention to cultural differences can lead to misdiagnosis,

lack of cooperation, poor use of health services, and patient alienation and mistrust.⁶

Developing effective cross-cultural training curricula must take into consideration the needs of those most directly affected by such training, i.e. residents, faculty and patients. Yet we have little information about the perception of these 3 groups regarding the barriers they typically encounter when trying to achieve culturally competent communication, or the attitudes and skills that they believe can successfully surmount these difficulties. This study is aimed at addressing these issues.

Little information currently exists on this topic. The investigators therefore chose a qualitative methodology, the use of focus groups, to explore their research concerns. Focus groups use discussion among a small group of people, selected according to a predetermined set of criteria, to express their viewpoints or opinions on a topic about which they have special expertise or life experience.^{7,8} By definition both subjective and interpretive, focus group data cannot provide generalizable

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Key learning points

In defining cultural competence, primary care residents tended to emphasize language skills and specific knowledge; faculty placed more attention on culturally sensitive attitudes; patients thought about cultural competence in generic rather than culture-specific terms.

Residents, patients and to some extent faculty were likely to use person-blame models in identifying barriers to culturally competent communication.

Residents, faculty and patients all focused on changing resident behaviour as a way of improving cross-cultural communication.

Residents expressed considerable scepticism about the value of cross-cultural curricula, and instead stressed experiential learning.

conclusions.⁹ However, they are considered an effective way to learn about people's attitudes, beliefs, and behaviours regarding sensitive subjects.^{10,11} Relevant to the interests of this study, focus groups have been used to learn more about teaching sensitive aspects of residency curricula such as communication skills,¹² palliative care,¹³ psychological counselling,¹⁴ delivering bad news¹⁵ and women's health.¹⁶

Method

Design

This study employed a prospective series of focus groups with 3 sets of participants. Five focus groups were conducted with faculty, 3 with residents, and 2 with patients.

Participants

Residents and faculty from family medicine, internal medicine, and paediatrics primary care training programmes (University of California Irvine College of Medicine) took part in the focus groups, along with patients from a low-income primary care community clinic where many of the residents and faculty practised. Faculty were recruited from 4 practice sites, each with a different ethnic mix. Residents were recruited from the institution's residency programmes. Interns were excluded because resident focus groups were conducted during the first half of the academic year,

when first year residents still had only a limited clinical familiarity with the multiethnic patient population. Residents and faculty came from socioeconomically and culturally diverse backgrounds. All clinic patients came from a socioeconomic background falling below the federal poverty line. Residents and faculty were not compensated for their participation, however patients received \$10.00 for their time. Focus groups took place between September 2000 and April 2001.

A total of 11 internal medicine faculty, 6 paediatric faculty, and 7 family medicine faculty participated, representing respectively 85%, 86% and 70% of faculty in each of these specialties at the study sites. Ten general internal medicine residents, 6 paediatric residents, and 11 family medicine residents participated, representing respectively 56%, 44% and 48% of the second and third year family medicine, paediatric and general internal medicine residents at these sites. Nineteen male and 9 female second and third year residents, 8 male and 17 female faculty, and 6 male and 8 female patients participated in the study. Approximately 40% of residents and faculty were Asian, 34% were non-Hispanic white, and the remainder came from various ethnic backgrounds. Fifty percent of patients were native American Indian, 21% low-income non-Hispanic white, 14% Latino, and 7% each African and African-American. Because we were unable to hire a bilingual transcriber, all sessions were conducted in English and patients who did not speak English were excluded from participation.

Procedures

Residents and faculty were initially emailed by the authors of this study, then approached in person by chief residents or a study investigator and asked to participate in a focus group (to be held at a convenient time and location). Special effort was made to recruit residents and faculty who were known to have an interest in cross-cultural issues as well as residents and faculty who had little background in this area. Our goals were to include at least 75% of the faculty and 50% of the residents at each site, a goal that we achieved or came close to achieving. It was felt that these goals were reasonable since, on any given day, the entire complement of faculty and residents was not present at a given site, so the total actual pool from which to draw potential participants was less than the theoretical pool. Patients were recruited through fliers and with the support of their personal physicians. Attempts were made to recruit patients not only on the basis of ethnicity, but also to include persons with disabilities and different sexual orientations. We could

not, however, predict which patients would actually turn up for the sessions. It proved to be particularly difficult to recruit patients, although both day-time and evening sessions were offered in addition to financial compensation. Thus, while the recruitment procedure was purposive, the focus groups themselves contained elements of convenience sampling. Resident groups included 7–11 participants each ($x = 9.3$). Faculty groups included 4–8 participants each ($x = 5.6$). Patient groups consisted of 6 and 8 participants, respectively, and were held in the familiar setting of the patients' primary care clinic. Although the number of focus groups was relatively small, content analysis revealed a theoretical saturation of the data in that categories and themes identified in the first groups were replicated in subsequent groups, with no significant additional topics or insights introduced.

All 10 groups were facilitated by a team of one clinical psychologist and a nurse with a PhD in health psychology. The psychologist was trained both in general group facilitation techniques and in running focus groups, and had previous experience conducting multiethnic focus groups. The psychologist provided focus group training to the health psychologist-nurse. Facilitators explained the purpose of the study and presented guidelines for the discussion,¹⁷ including the importance of participation by all group members, and the honest expression of differences of opinion. Groups were conducted in a conversational, informal atmosphere, and food was provided. Participant/facilitator introductions included reference to their own cultural backgrounds. Facilitators used a question route that helped organise participant thoughts, set priorities, and incorporated a logical flow to the discussion¹⁸ (see Table 1). Resident/faculty groups lasted approximately one hour, while patient groups lasted approximately 2 hours. All sessions were audiotaped with permission of participants, and the secondary facilitator also took comprehensive notes.

Data analysis¹⁹

As with other types of qualitative research, data collection and data analysis proceeded simultaneously. Each focus group was followed by a debriefing session for facilitators, in which they suggested initial categories and themes emerging from the data, checked for consensus, explored disagreements, and discussed modifications or additions to the question route. We also monitored theoretical saturation of the data, i.e. attempted to determine when group content became redundant with previous groups. Verbatim transcripts were made of all focus groups. As a single rater may not

extract all the important information from a given session,²⁰ transcripts were reviewed by all investigators. This approach was also intended to reduce investigator bias. Extensive transcript notations were also made by the first two authors and exchanged for comment and revision. The third investigator reviewed all conclusions.

Data were approached through a content analysis that was initially descriptive, then interpretive.²¹ The primary unit of analysis was each focus group, and not individual comments,²² although data were compared both within group and across groups. Data analysis paid attention to invalidating evidence and outliers. Analysis also took into account elements of frequency, extensiveness, and intensity.¹⁹ Ideas or phenomena were first identified and flagged (open coding), then fractured and reassembled (axial coding) by making connections between categories and subcategories. Finally, categories were integrated to form a grounded theory (selective coding). The analysis was aimed at finding patterns, making comparisons, and contrasting one set of data with another.

Results

The meaning of culturally competent doctor–patient communication

Residents

Culturally competent communication was defined by residents primarily as language competence. Many residents expressed the conviction that if they could simply speak to their patients in a common language, everything else would fall into place. Others, however, asserted that communication competence was more than just a shared language. These residents talked about cultural sensitivity (understanding cultural 'do's and don'ts') and specific cultural knowledge, such as understanding patient health beliefs. They also used phrases such as 'being on the same page with the patient' and 'sharing common ground', and stressed the importance of establishing a trusting relationship in describing cultural competence. Several residents expressed the belief that their own culturally different backgrounds made them more sensitive to other cultures. A minority of residents voiced the opinion that 'physicians have more important things to worry about than crosscultural issues'.

Faculty

Faculty recognized language as a key component of culturally competent communication, but viewed it as secondary to knowledge and attitudes. Faculty all agreed that it was important to know something about

Table 1 Question route used to explore cross-cultural doctor–patient communication

1	Opening/introductory Faculty/resident version Please tell us your name, your department, and the cultural/ethnic/socioeconomic background of your family or origin	Patient version Please tell us your name, how long you've been a patient at this clinic, and something about your background. <i>Prompt:</i> Just tell us something about yourself you'd like us to know
2	Transition Faculty/resident version What does the phrase 'culturally competent communication' mean to you as physicians?	Patient version What does good communication with your doctor mean to you as a patient? <i>Prompt:</i> Think of a particularly good experience you've had with a physician, then think about what he/she said to you or how he/she handled the interview that impressed you
3	Key Faculty/resident version What are some of the obstacles that you run into in trying to communicate effectively with patients of different cultural and/or socioeconomic backgrounds? <i>Prompts:</i> language barriers, differing expectations for patient and physician, differing health beliefs	Patient version What are some of the most common problems you run into when talking to a doctor in the clinic? <i>Prompt:</i> Think of a particularly bad experience you've had with a physician, then think about what in particular made it so bad. <i>Additional prompts:</i> language problems, insensitivity to health beliefs, culture, differing expectations
4	Key Faculty/resident version What would help you fix these problems?	Patient version What would help fix these kinds of problems in your opinion?
5	Key Faculty/resident version What are some of the things you do in your interactions with patients of different cultural and/or socioeconomic backgrounds that improve the quality of the communication?	Patient version What are some of the things you've noticed good doctors do that improve the quality of their communication with you?
6	Key Faculty/resident version What kind of training do you think would actually improve the way you interact with culturally and socioeconomically diverse patients?	Patient version Do you have any thoughts about what doctors need to learn to help them communicate better with patients, especially patients who come from different backgrounds? <i>Prompts:</i> Information about other cultures, better cross-cultural communication skills.
7	Key Faculty/resident version What would you say is the proper balance between teaching about specific cultures vs. emphasising patient-centred teaching?	
8	Ending Faculty/resident version What would you say is the most important factor in successful cross-cultural communication and how can it be achieved?	Patient version What would you say is the single most important thing in successful cross-cultural communication between doctors and patients?

the health beliefs, expectations, folk treatments, and alternative medical practices within the population in order to deliver good care. Some faculty participants added that the physician must also tease out the patient's individual relationship to his or her ethnicity and culture. Many felt that knowledge of culture was in itself insufficient. As one physician expressed it, 'you must know what is inside the patient'. Another stated, 'You must have an awareness, an understanding, an intuitive feel for others'. A paediatrician introduced the concept of having '*educacion*', which she defined as extending courtesy, respect, warmth, and a personal

relationship to patients across socioeconomic lines. Many faculty agreed with residents that 'if a doctor is bicultural, cultural competence is already innate and internalized'. Similar to residents' opinions was the minority view that health care could be delivered without cultural sensitivity as both patient and doctor had shared concerns about the patient's symptoms.

Patients

Patients appeared to interpret culturally competent communication between doctors and patients generically, without much specific cultural reference. They

mentioned physician behaviours such as taking time, writing things down, being thorough and doing all necessary tests, calling with results, apologising for being busy, answering questions and providing complete explanations. They thought a doctor who communicated well would be caring and interested in the patient and his or her problems. They also felt that good communication included involving the patient in the decision-making process, taking into account the patient's particular situation, and using a collaborative rather than an authoritative model of care. Two non-Hispanic white patients said of good communication that 'it's an ethnic thing', and thought it was preferable if doctors and patients shared the same ethnicity. However, patients of other ethnicities disagreed with this contention. As one African-American woman said, 'Ethnicity is not important. If there is good-will, we can work out our differences'. A native American man put it this way: 'What is most important is not an Indian doctor, but a doctor who cares'.

Barriers to culturally competent communication

Residents

Residents identified 3 major obstacles to culturally competent communication:

1. Time constraints: all residents complained about having insufficient time to spend with patients, and seemed to feel that if they had more time, they could resolve many of their communication problems.

2. Language and interpreter limitations: many residents expressed concern about the effects of language barriers on the doctor-patient relationship. These residents stated that language limitations made it impossible to use their other communication skills. In the words of one resident, 'Without language, nothing else can happen.' Residents who could not communicate directly with their patients felt constrained to regularly omit 'the touchy-feely, more complex aspects of the interview'. One resident said hopelessly, 'Even if you know something's wrong, you can't do anything about it because there's no language'. Residents generally disliked interpreted interviews, complaining that they were less personal, less natural, and too time-consuming. They also believed interpreters were poorly trained, and didn't translate accurately. A minority of residents defended interpreters, identifying them as cultural brokers and important resources.

3. Patient shortcomings (See Table 2): many residents criticised patients as being passive and demanding. 'They expect everything to be done for them.' They also berated patients for failing to use the health care

system properly, and for not having any understanding of their medical problems. One exasperated resident exclaimed, 'You have to repeat everything 10 times to these people!' Some residents criticized patients for not learning English. A few residents defended patients as simply holding different, but not necessarily worse, expectations and beliefs.

Faculty

Faculty recognized similar barriers to those mentioned by residents, but also noted some additional ones. For example, many faculty acknowledged the difficulty of achieving effective cross-cultural communication within significant time constraints, however unlike residents they appeared to regard the time pressures of residency as a given.

Also similarly to residents, faculty expressed the sentiment that there is a sense of 'disconnection' without a shared language. Faculty observed a pervasive sense of helplessness among residents about communicating effectively with language-discordant patients. Furthermore, they expressed concern that residents who thought they understood enough Spanish to get by frequently missed or misinterpreted important information. Like residents, faculty agreed that interpreters lacked skill; using an interpreter inhibited a personal connection with the patient and could potentially damage the doctor-patient relationship.

Patient shortcomings. Faculty sometimes complained about patients, but put less emphasis on this dimension than did residents. They were bothered by patients who 'expect that the doctor knows all and will do all.' They similarly expressed frustration with patients who didn't understand their medical conditions and voiced disappointment at frequent non-compliance. Some condemned patients 'who have an attitude problem', specifically, expecting all doctors to speak Spanish. However, they were more likely as a group to talk about patient-resident differences than about patient deficiencies.

Socioeconomic factors

Faculty. commented much more frequently than residents that socioeconomic factors were often responsible for patient difficulties in effectively accessing and utilizing health care. In their view, socioeconomic differences complicated language and cultural differences. 'As the differences between patient and resident mount, it becomes harder to communicate'. In the opinion of faculty, residents often held unrealistic expectations towards patients in terms of compliance, follow-up, and understanding of disease based on the influence of socioeconomic factors.

Table 2 What residents and patients dislike about each other

Residents' dislike of patients

-
- Acting demanding, entitled
Acting passive
Lack of understanding of their medical condition
- failing to take responsibility for their own health
 - ignoring preventive issues
 - failing to understand that chronic illnesses could not be cured
 - unable to comprehend the need for daily, permanent medication
 - inability to read medication labels
 - not filling prescriptions
 - non-compliance with medical regimens and treatment plans
 - suspicious of Western medicine; preferring Eastern, folk or homeopathic remedies, yet not telling their doctor they used these
 - inability to comprehend efforts at patient education
 - indicating apparent agreement and comprehension with physician, but in reality neither agreeing nor understanding
 - presenting too many complaints for the allotted time
- Failing to use the health care appropriately
- inability or unwillingness to make appointments
 - failure to cancel appointments
 - being late for appointments
 - coming on the wrong day
 - not making or keeping follow-up appointments
 - not following through with referrals
- Inability to speak English – expecting the doctor to speak Spanish
-

Patients' dislike of physicians

-
- Acting like they know it all
Intimidating patients
Being excessively controlling
Treating patients as stupid or ignorant; treating patients 'like dirt'
Giving patients the 'runaround'; trying to placate rather than addressing the problem
Not following-up
Telling patients nothing is wrong
Telling patients the problems are 'all in their head'
Minimizing patients' complaints or not taking them seriously
Using technical language
Receiving unnecessary or inappropriate treatment
Focusing on the insurance rather than the patient
Being dismissive of patients' efforts to research their own medical conditions
Telling patients not to use folk or homeopathic remedies
Taking out their problems on their patients
-

Resident shortcomings. Faculty were likely to point out lapses in resident knowledge and attitudes that complicated cross-cultural communication. They noted

that sometimes the resident 'thinks the communication was good, but it really wasn't'. Faculty talked about residents who 'just want to get out on time, tune out, move on', 'who are just trying to get through, as opposed to trying to figure out problems', or who have a judgmental attitude toward patients of different cultural backgrounds.

Patients. Patients discussed barriers that appeared to be more generic than culture-specific. They all complained about excessive waiting time. Almost every patient agreed with the statement that the biggest problem to good communication was that 'doctors don't really listen' to the patient. Other complaints against physicians are listed in Table 2. Several patients agreed that doctors often made erroneous assumptions based on skin colour or surname.

Approaches for overcoming communication barriers (Table 3)

Residents. Residents made several suggestions to improve communication with culturally different patients.

Language and interpreters. Residents advocated using limited language skills to establish a personal connection with patients, and believed patients generally appreciated and responded favourably to such efforts. In terms of working with interpreters, they recommended techniques for maintaining the connection with the patient, such as direct eye contact. Some reported trying to 'force' the interpreter to translate everything they said. Others suggested a more sophisticated model in which they identified the interpreter as a cultural expert, important ally, and resource. One resident suggested making sure the interpreter 'is conveying the doctor's empathy, as well as the facts'.

Experience. Most residents felt strongly that the best way to develop culturally competent communication was to spend time with patients.

Cultural knowledge. Residents noted the importance of becoming familiar with specific cultural health beliefs, and incorporating them into treatment recommendations.

Communication skills. Residents often mentioned basic communication skills as useful in improving cross-cultural communication. They resisted the idea that there should be one set of skills for culturally similar and another for culturally different patients. Residents also stressed the importance of using communication skills to probe 'the underlying reasons why patients do certain things, and to assume that all patient behaviour had an inherent logic.

Table 3 Suggestions for improving doctor-patient cross-cultural communication

Culture specific		
<i>Residents</i>	<i>Faculty</i>	<i>Patients</i>
Develop language skills	Language skills	
Use interpreters properly	Use interpreters as cultural resources	
Develop knowledge about different cultures	Have cultural knowledge. Develop sensitivity towards other cultures	Don't make assumptions about patients based on skin colour, surname
Have desire to connect with patients from other cultures	Show interest, enthusiasm in patients' culture	
Generic		
Introduce self	Be on time	
Maintain eye contact		
Sit down		
Make sure patient doesn't feel rushed	Don't rush patient	
Acknowledge the patient as a person before moving on to a differential diagnosis	Listen to patient's story. Develop personal knowledge of patient	
Reflective listening (paraphrasing, clarifying, summarising)	Pay attention to patient non-verbal cues and body language	Listen carefully to patient
Elicit the patient's agenda	Patient-centred approach Patient self-diagnosis	Take patients seriously Acknowledge patient has expertise about own body
Clarification of patient reluctance or disagreement	Confirm patient understanding, agreement before proceeding Use problematic patient behaviour as a cue for further investigation Provide clear explanations	Give clear, complete, step-by-step explanations
	Use ordinary language Provide adequate information	
Ask important questions more than once, and in different ways	Leave time for the patient to ask real questions	Question patients thoroughly/probe symptoms
Set priorities	Prioritise problems in a gentle, persuasive manner	
Negotiate treatment plan	Negotiate problems/solutions	Incorporate folk/homeopathic remedies
Show warmth	Be empathic, caring	Have empathy
	Adopt patient's perspective	Be caring, concerned
Show respect	Be respectful of patients	Treat patient with dignity, respect
Be patient	Be patient, non-threatening	
Encourage trust	Establish continuity of relationship to develop trust	Apologise after making a mistake

Patient as person. Residents were insistent about treating patients as individuals, incorporating personal knowledge of patients into the doctor-patient interaction, and not making assumptions about patients based on ethnicity, race, or socioeconomic status.

Global attitudes. Residents spoke of the importance of having the desire to connect with culturally different patients. Other 'virtuous' characteristics they espoused included showing respect, expressing warmth, demonstrating a professional attitude, encouraging trust,

making the patient feel comfortable, not appearing rushed, having patience, and giving the patient a sense of control.

Faculty. Faculty focused on similar areas to residents in their suggestions for ways of overcoming cross-cultural communication barriers. They also underlined the importance of continuity of care.

Language and interpreters. Faculty felt residents should make a sincere effort to acquire non-English language skills, especially Spanish, and 'should not be

let off the hook' in this regard. Faculty wanted residents to learn the proper use of interpreters by making the interpreter part of the team, orienting the interpreter to the patient's diagnosis and background, explaining the physician's agenda, and defining specific tasks to accomplish during the interview.

Cultural knowledge. Faculty believed that residents should have some specific cultural knowledge. Faculty appeared less concerned than residents about the cultural stereotyping that might result from imperfect acquisition of this knowledge. However, several faculty members did acknowledge that lectures and other academic presentations had the potential to create inaccurate cultural assumptions. One faculty cautioned that learners should 'focus on process [between doctor and patient] and avoid cultural databases'.

Communication skills. In common with residents, faculty held the view that basic communication skills were very useful in overcoming cross-cultural barriers, but tended to mention more complex skills than residents.

Patient as person. Even more strongly than residents, faculty emphasized acquiring personal knowledge of patients by understanding both their daily experience and their general life context. One faculty member suggested that residents should 'treat patients like you would treat your mother'. Another recommended that the resident should become 'a compassionate advocate for the patient'. They stressed the value of learning to empathise with the patient, particularly when the patient was upset, angry, or noncompliant.

Resident global attitudes. Faculty expected residents to develop 'an interest, an enthusiasm' for their patients, as well as a receptivity to learning about their cultures and beliefs in a sensitive and non-judgmental way. They wanted residents to be open to the idea that 'people think differently about things'. One faculty suggested that residents should 'view every patient as a cross-cultural encounter'. Faculty encouraged residents to be 'patient, non-threatening, non-judgmental, respectful and courteous; to convey concern and caring, and to exhibit understanding rather than anger about problems of compliance and follow-through'. Similarly, another faculty urged that 'residents should view patients as good, as resources, not as the enemy'.

Continuity care. Many faculty stressed that continuity of care was key to developing personal knowledge of particular patients as well as trust and understanding. They also noted that continuity was important so that cultural issues could emerge over time.

Patients. Patients emphasized the importance of careful listening, as well as trust, respect and empathy.

As one patient said, 'The doctor should try to experience the patient's feelings and concerns'. Another said, 'Doctors must care about patients, take an interest in them, and want to help'. Patients wanted to be taken seriously, and hoped doctors would be thorough, and really probe symptoms, because 'a good doctor will try to get to the bottom of the problem'.

Teaching techniques

Residents. Residents expressed considerable scepticism about the value of cross-cultural curricula. Many held views that such training was a waste of time. They were particularly dubious as to the value of communication skills training and self-awareness exercises, stating that residents already had these skills, didn't need them, or were set in their ways. The teaching techniques they were willing to recommend were extremely specific, such as Spanish language classes, or lectures about specific cross-cultural health beliefs pertinent to their particular patient population. They felt that the best individuals to provide such content knowledge were experienced physicians who were familiar with the patient population. However, they also worried that such content knowledge would lead to cultural stereotyping. Residents also mentioned faculty as good role models to promote culturally competent communication. A few residents identified the importance of learning from the patient as an ideal 'cultural educator'. Most stated that simply learning by doing was probably the best way to develop cultural competence. They also thought videotaping their interactions and providing feedback would be useful.

Faculty. All faculty groups mentioned role-modelling as the best way to convey skills of cultural competence. Bicultural faculty in particular felt they made excellent role models, and could act as mediators between the patient and resident. They also agreed with residents that exposure to patients promoted cultural competence, and one faculty advocated seeing patients as ideal resources for learning about culture. They appeared somewhat more enthusiastic than residents about lectures and formal coursework as a method of conveying fundamental cross-cultural knowledge, although they too were worried that lecture-format teaching could lead to stereotyped views. They also endorsed role-playing, the use of video clips, and direct observation. They were aware that residents often regarded cross-cultural sensitivity training as 'a turn-off'.

Discussion. The most important conclusions to be reached from this study may be summarized as follows: In terms of understanding cultural competence, although both residents and faculty emphasized language

skills, cultural knowledge, and general attitude, differences in emphasis did emerge. Residents were somewhat more language-focused than faculty, who tended to give greater importance to cultural understanding and culturally sensitive attitudes. Despite encouragement from focus group facilitators to address cultural issues explicitly, patients seemed to think about competence in generic rather than culture-specific terms.

Regarding barriers to culturally competent communication, residents and patients were most likely to use person-blame models. Faculty also endorsed these models, but were the group most likely to see the larger picture and comment on systemic difficulties such as socioeconomic factors, access problems, or lack of continuity. Perhaps not surprisingly, all three groups tended to place blame on other stakeholders rather than take responsibility for failures in cross-cultural communication. Residents were inclined to criticize interpreters and especially patients for creating obstacles to successful communication. Patients blamed doctors. Faculty held both patients and residents accountable. Interestingly, despite repeated facilitator prompting, focus group participants appeared reluctant to talk about cultural differences *per se*, other than language, as barriers to good communication. Instead, their frustration tended to focus on behaviours (i.e. patient lack of understanding of their medical condition or their failure to use the health care system properly; physician tendency to treat patients as ignorant, or to focus on insurance issues rather than the patient) that are probably strongly mediated by cultural differences, but that might occur between any doctor and patient.

In contemplating solutions to cross-cultural communication problems, all three groups focused on provider behaviour. A couple of patients and one or two faculty mentioned the importance of patients learning to be their own 'advocates' in the health care system, but generally most suggestions were resident-focused. Residents and faculty shared similar views that included developing language skills, working with interpreters, acquiring personal knowledge of patients, and maintaining an attitude of interest and respect. They also strongly endorsed improved generic communication skills. Patients were less concerned with cultural issues than residents and faculty; like these groups, they also emphasised the importance of good communication and evidence of being taken seriously and treated with respect. Faculty, and especially residents, expressed only limited endorsement of didactic cross-cultural education. Residents tended to feel that the best way to develop cross-cultural competence was through experience with patients.

Faculty placed greater importance on their own role-modelling to provide bridges between residents and patients.

Limitations. The conclusions of this study are restricted by several factors. First, we were limited in soliciting groups from a single academic university setting. Although we are confident that the conclusions we reached accurately reflect this population of primary care stakeholders, they cannot be simplistically extended to other populations of stakeholders. Secondly, although we found that the 'mini' focus groups (i.e. 4–6 participants) conducted with faculty and patients yielded a somewhat richer, more detailed quality of information, for practical reasons some of our groups exceeded these parameters. Nevertheless, our data analysis suggested that this variation did not substantially affect our overall conclusions.

Third, while we were quite confident in the theoretical saturation of our data for faculty, and reasonably so for residents, our patient focus groups were restricted in both number and language. Due to Institution Review Board and concerns about the possibility of inadvertent coercion contaminating the recruitment process, patients were required to initiate interest in the project before we could contact them directly. This constraint may have hampered our ability to attract patients to the study. Further, we were able to solicit views only from a bilingual, and therefore more acculturated, segment of the patient population. Nevertheless, it is possible to argue that the segment of the patient population to which we did have access was uniquely situated – i.e. with a foot in the worlds of both their culture of origin and in mainstream American culture, so to speak – to articulate insights and share perceptions that less acculturated patients might not have been able to provide. Finally, although patients participated eagerly, more of the time in the patient groups as compared to the resident/faculty groups was taken up in lengthy anecdotes about their own, family members' or even friends' encounters with the health care system. The result was a more limited quantity of pertinent information from patients.

Implications for training. Most cross-cultural training includes components of self-awareness and sensitivity.^{23,2} Faculty on the whole appeared to be sympathetic to this broader perspective. Residents, on the other hand, expressed considerable scepticism about the value of such exercises.²⁴ Since residents were so focused on obtaining practical tools, they may have little patience for examining larger contextual cross-cultural issues. Anyone designing such curricula

will have to take this discrepancy into consideration. Further, residents were not especially receptive to didactic lectures, worrying that they could end up transmitting cultural stereotypes rather than useful knowledge. If such a teaching model is adopted, it should be taught by experienced clinicians whom residents trust, and should emphasize clinical problem-solving rather than global cultural generalizations. Finally, although experts in cross-cultural competence argue against substituting generic patient-centred communication skills for detecting, eliciting, and addressing cultural issues,²⁵ these generic skills were precisely what residents relied on to get them through cross-cultural patient exchanges, and what patients seemed to value.

Perhaps most disturbing was an implied adversarial undercurrent to many of these focus group discussions. By turns, each group of stakeholders was likely to see at least one of the others as the problem, at least to the extent of being critical and judgmental of the attitudes and behaviours of its members. The prevalence of such attitudes suggests the importance of developing training programmes that incorporate qualities of compassion and humility, as well as content knowledge, among both teachers and learners.^{23,26}

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Contributors

JS was responsible for the overall design and implementation of this project. She had lead responsibility for developing the question route and conducting all focus groups. She developed and coordinated the data analysis plan. She was responsible for initial manuscript drafts and for the final manuscript preparation.

JH was responsible for all subject recruitment. She participated in all focus groups as a facilitator, and took part in all post-group debriefings. She also transcribed the interviews and participated in their content analysis. She participated in the writing of the final manuscript.

EHM is Principal Investigator on the grant that provided funding for this research. She played a key role in the initial conceptualisation of the project and in the development of the focus group question route. She participated in the content analysis process and contributed important theoretical ideas to the final manuscript.

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