INTRO: I'll be presenting the results of a combined qualitative/quantitative study - Primary Care Resident, Faculty and Patient Perceptions of Culturally Competent Communication - which my co-investigators and I conducted at our home institution as a preparatory step to expanding our own cross-cultural curriculum

I. GOALS OF STUDY

- **To explore perceptions of primary care residents, faculty, and patients regarding**
  - **the meaning of culturally competent communication (CCC)**
  - **what interferes with CCC**
  - **what are the most useful skills to establish CCC**
- **To assess differences among FM, GIM, and PEDS regarding resident attitudes towards and skills of CCC**
- **To solicit recommendations for introduction of CCC curricula at the residency level**

II. METHODS

- **Qualitative**
  - **10 focus groups total * (5 faculty, 3 resident, 2 patient)***
  - **70-86% of site faculty;44%-56% of site residents**
  - **N = 28 residents, 25 faculty, 14 patients**
  - **40% residents/faculty Asian; 34% NHW**
  - **Patients 50% native AI, 21% NHW, 14% Latino, 7% each AA/African**
    - Overrepresentation of American Indians
    - All patients had to be English-speaking, due to language limitations of focus group facilitators
  - **Faculty: 8 male, 17 female**
  - **Residents: 19 male, 9 female**
  - **Patients: 6 male, 8 female**
- **Quantitative**
  - **69-item survey** of FM, IM, & Peds residents
  - **Response rate 30-58.8%**
    - Not stellar response rate
    - On dimensions of gender and ethnicity, responders were similar to total enrollees for all three residency programs, with the exception that Pediatric residents of Asian background were underrepresented among respondents **(Quant. Table 2)**
  - **N = 71 1st, 2nd, 3rd year residents**
  - **35% NHW; 33% Asian**
  - **Mean age 30.0, sd 4.3**
  - **41 males, 28 females**

III. PROCEDURES

- **Qualitative**
  - **Recruitment:**
    - **Residents/faculty: email/in-person**
    - **Patients: fliers/personal physician**
  - **Facilitators:**
    - **clinical psychologist with experience conducting focus groups**
    - **health psychologist/nurse**

- **Standard focus group guidelines: Focus group questions – (Qual Table 1)**
  - 1) What is culturally competent communication?
  - 2) What are obstacles to CCC?
  - 3) What are things you already do that promote CCC?
  - 4) What kind of training could improve CCC?
  - 5) What is the most important factor in CCC?
- **Duration:**
  - **Residents/faculty 1 hr.**
  - **Patients 2 hr.**
- **Sessions taped; field notes**

- **Quantitative**
  - **Surveys distributed**
    - **required noon conferences**
    - **resident mailboxes**
  - **Survey based on existing instruments (Quant. Table1)**
    - **1-5 Likert scale**
    - **1 item Relevance**
    - **4 scales (Quant. Table 3, Table 4)**
      - **Competence**
        - Caring for a patient who insists on using alternative therapies or healers
        - Addressing patients in culturally appropriate ways
      - **Frequency of use**
        - Making patient feel welcome
        - Working closely with interpreter
        - Using patient's primary language whenever possible
        - Knowing something about patient's cultural background
      - **Helpfulness of technique**
      - **Cross-cultural problems**
        - Insufficient time
        - Patient talks too much to interpreter
        - Difficulty reconciling patient's self-diagnosis with physician diagnosis
        - Patient's cultural beliefs about illness interfere with diagnosis and treatment

IV. DATA ANALYSIS

- **Qualitative**
  - **Post-group debriefing**
  - **Tapes transcribed; extensive notation**
  - **Content analysis**
    - **descriptive**
    - **interpretive**
  - **Grounded theory**
    - **open coding**
    - **axial coding**
    - **selective coding**
- **Quantitative**
  - **Internal reliabilities calculated for scales**
  - **Pearson 2-tailed tests used to calculate correlations**

- **One-way ANOVAS used to test for group differences**

V. RESULTS - Qualitative

- **Culturally competent communication-CCC**
  - **Residents: Language, factual knowledge**
  - **Faculty: Cultural understanding and sensitivity**
  - **Patients: Generic rather than culture-specific communication skills**

- **Barriers to CCC**
  - **Residents/patients: Person-blame models**
  - **Faculty: Systemic factors**
    - ~~systems factors~~
    - culture of poverty
    - ~~lack of access~~
    - cultural differences, not difficulties (world views colliding)

*** What Residents Dislike about Patients (Qual. Table 2)**

- **Acting demanding, entitled**
- **Acting passive**
- **Lack of understanding of their medical condition**
- **Failing to use health care system appropriately**
- **Inability to speak English; expecting doctor to speak Spanish**

*** What Patients Dislike about Doctors (Qual. Table 2)**

- **Intimidating patients; being excessively controlling**
- **Treating patients as stupid or ignorant**
- **Giving patients the run-around**
- **Not following-up**
- **Telling patients nothing is wrong**
- **Telling patients the problem is "all in their head"**
- **Not taking seriously or minimizing patient's problems**
- **Using technical language**
- **Focusing on insurance rather than the patient**
- **Telling patients not to use folk or homeopathic remedies**
- **Taking out their problems on the patient**

***Solutions to CCC problems (Qual. Table 3)**

- **Residents/faculty:**
  - **Developing language skills**
  - **Working with interpreters**
  - **Incorporating communication skills**
  - **Acquiring personal knowledge of patients**
  - **Maintaining attitude of interest and respect**
- **Residents: Skeptical of sensitivity/communication training**
- **Faculty: Importance of role-modeling**
- **Patients:**
  - **Good generic communication;**
  - **Evidence of being taken seriously and treated with respect**

more in-depth skills
listening to pt. stuff
eliciting pt. health beliefs & health practices
using interpreter as cultural resource
• Don't make assumptions based on skin color or surname

VI. RESULTS – Quantitative (Quant. Table 3)

- **Overall descriptive findings**
  - **Perceived CCC as relevant to pt. care**
  - **Rated themselves as moderately competent in CCC**
  - **Used a range of CCC techniques frequently**
  - **Tended to find techniques quite helpful**
  - **Rated a range of patient characteristics and situations as "moderate" problems**

- **Specialty differences (Quant. Table 5)**
  - **FM residents rated CCC as more relevant to patient care than did IM or Peds residents**
  - **FM residents rated themselves as more competent in CCC and CCC techniques as more helpful than did IM or Peds residents**

- **Residents from all three residencies showed a trend to endorse patient-blame strategies: greater than 50% endorsed statements such as (Quant. Table 6)**
  - **Patients seem to agree, but don't follow-through**
  - **Patient history rambling and disorganized**
  - **Patient presents too many problems**

- **Curricular recommendations**
  - **Most useful: curriculum about specific patient health beliefs and expectations**
  - **Least useful: curriculum about personal attitudes and communication skills**
  - **Factors impeding introduction of CCC curriculum**
    - **Insufficient curriculum time to focus on CCC 82%**
    - **Lack of relevant material 45%**
    - **Lack of faculty interest 30%**
    - **Lack of resident interest 25%**
    - **CCC cant be taught 17%**

VIII. OVERALL CONCLUSIONS

- **Differences favoring FM compared to GIM and PEDS residents were found on dimensions of:**
  - **Relevance**
  - **Competence**
  - **Usefulness of CCC techniques**
  - **Perhaps attributable to more fully developed training program**
- **Perception of culturally competent communication:**
  - **Residents defined CCC in narrow, language- and knowledge-based terms**
  - **Faculty emphasized more global factors**
  - **Patients stressed generic communication skills**
- **Person-blame models**
  - **Prevalent among residents and patients**

- **Faculty endorsed more systemic influences**

- **Curricular recommendations**
  - **Residents**
    - **favored language and knowledge-based training**
    - **lack of interest**
    - **skeptical of introspective exercises and communication training**
  - **Patients recommended generic communication skills**
  - **Faculty endorsed more in-depth skills and approaches**

knowing pt. as a person / listen to pts' story
eliciting pt. health beliefs & health practices
using interpreter as cultural resource

Table 1 – Qualitative
QUESTION ROUTE USED TO EXPLORE CROSS-CULTURAL DOCTOR-PATIENT COMMUNICATION

1. Opening/Introductory: Please tell us your name, your department, and the cultural/ethnic/socioeconomic background of your family of origin **(faculty/resident version).**

Please tell us your name, how long you've been a patient at this clinic, and something about your background. *Prompt*: Just tell us something about yourself you'd like us to know **(patient version).**

2. **Transition**: What does the phrase "culturally competent communication" mean to you as physicians? **(faculty/resident version)**

What does good communication with your doctor mean to you as a patient? *Prompt:* Think of a particularly good experience you've had with a physician, then think about what he or she said to you or how he or she handled the interview that impressed you. **(patient version)**

3.**Key**: What are some of the obstacles you run into in trying to communicate effectively with patients of different cultural and/or socioeconomic backgrounds? *Prompts*: Language barriers, differing expectations for patient and physician, differing health beliefs **(faculty/resident version)**

What are some of the most common problems you run into when talking to a doctor in the clinic? *Prompt*: Think of a particularly bad experience you've had with a physician, then think about what in particular made it so bad. *Additional prompts*: language problems, insensitivity to health beliefs, culture, differing expectations **(patient version)**

4. Key: What would help you fix these problems? **(faculty/resident version)**

What would help fix these kinds of problems in your opinion? **(patient version)**

5. Key: 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? **(faculty/resident version)**

What are some of the things you've noticed good doctors do that improve the quality of their communication with you? **(patient version)**

6. Key: What kind of training do you think would actually improve the way you interact with culturally and socioeconomically diverse patients? **(faculty/resident version)**

Do you have any thoughts about what doctors need to learn about to help them communicate better with patients, especially patients who come from different backgrounds? *Prompt*: Information about other cultures, better cross-cultural communication skills **(patient version)**

7. Key: What would you say is the proper balance between teaching about specific cultures versus emphasizing patient-centered teaching? **(faculty/resident version)**

8. **Ending**: What would you say is the most important factor in successful cross-cultural communication and how can it be achieved? **(faculty/resident version)**

What would you say is the single most important thing in successful cross-cultural communication between doctors and patients? **(patient version)**

TABLE 2 - Qualitative
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
- noncompliance with medical regimens and treatment plans
- suspicious of Western medicine; preferring Eastern, folk, or homeopathic
- remedies, yet not telling their doctor they used these remedies
- 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 time allotted

Failing to use the health care system 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 think they know it all
Intimidating patients
Being excessively controlling
Treating patients as stupid or ignorant; treating patients "like dirt"
Giving patients the run-around; try to placate you rather than addressing the problem
Not following up
Telling patients nothing is wrong
Telling patients "the problems are all in their head"
Not taking seriously or minimizing patient's complaints
Using technical language
Receiving unnecessary or inappropriate treatment
Focusing on 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

TABLE 3 - Qualitative
SUGGESTIONS FOR IMPROVING DOCTOR-PATIENT CROSS-CULTURAL COMMUNICATION

Culture-Specific

Residents	Faculty	Patients
Develop language skills	Language skills	
Use interpreters properly	Use interpreters as cultural resources	
Develop knowledge about different cultures	Have cultural knowledge Develop sensitivity toward other cultures	Don't make assumptions about patients based on skin color, 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 to differential diagnosis	Listen to patient's story Develop personal knowledge of patient	
Reflective listening (paraphrasing, clarifying, summarizing)	Pay attention to patient nonverbal cues and body language	Listen carefully to patient
Elicit the patient's agenda	Patient-centered 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 behavior 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	Prioritize problems in gentle, persuasive manner	
Negotiate treatment plan	Negotiate problems/solutions	Incorporate folk/ homeopathic remedies
Show warmth	Be empathic, caring Adopt patient's perspective	Have empathy Be caring, concerned
Show respect	Be respectful of patients	Treat patient with dignity, respect
Be patient	Be patient, nonthreatening	
Encourage trust	Establish continuity relationship to develop trust	Apologize when make mistakes

Table 1 – Quantitative
Cross-Cultural Communication Survey Items

Competence Items (1-5 rating)

a. Caring for a patient who insists on using or seeking alternative therapies or healers
b. Identifying beliefs that are not expressed by the patient or caregiver but might interfere

with the treatment regimen

c. Addressing patients in culturally appropriate ways that result in a therapeutic alliance.

d. Being attentive to nonverbal cues or to the use of culturally specific gestures that might have different meanings in different cultures.
e. Interpreting different cultural expressions of pain, distress, and suffering.
f. Discussing sexuality with people in whose culture such issues are highly sensitive
g. Making mental health referrals which in some cultures might be seen as stigmatizing.
h. Advising a patient to change behaviors or practices related to cultural belief s that impair one's health.
i. Working with a colleague who makes derogatory remarks about patients from particular ethnic or socioeconomic groups.

Technique items (1-5 rating on frequency of use and helpfulness)
a. Making the patient feel welcome_____
b. Making a personal connection with the patient_____
c. Listening carefully to the patient_____
d. Working closely with the interpreter_____
e. Using skills of paraphrasing, clarifying, and summarizing_____
f. Acting as the patient's advocate in the health care system_____
g. Expressing concern for the patient_____
h. Eliciting the patient's agenda_____
i. Clarifying patient's expectations for visit_____
j. Summarizing patient's concerns _____
k. Eliciting the patient's self-diagnosis_____
l. Negotiating treatment plan within context of the patient's life_____
m. Providing simple, clear explanations of diagnosis and treatment_____
n. Showing respect for the patient_____
o. Using the patient's primary language whenever possible_____
p. Addressing language difficulties directly_____
q. Maintaining tight control of the interview _____
r. Allowing time for the patient to tell his/her story_____
s. Allowing time for the patient to ask questions_____
t. Having patient repeat back instructions to make sure they were understood_____
u. Knowing something about the patient's cultural background_____

Problem Items (1-5 rating)

a. Insufficient time
b. Interpreter does not appear to adequately translate patient and/or physician statements
c. Patient talks too much to interpreter
d. Interpreter is a child or inappropriate for some reason
e. Difficulty establishing rapport and connection with patient
f. Patient's history is rambling and disorganized
g. Patient provides inconsistent or contradictory information
h. Patient presents too many problems
i. Difficulty getting patient to understand diagnosis
j. Difficulty reconciling patient's self-diagnosis with physician diagnosis
k. Difficulty getting patient to understand implications of diagnosis
l. Patient does not seem to "buy-in" to treatment plan
m. Patient's cultural beliefs about illness interfere with diagnosis and treatment.
n. Patient uses culturally based alternative therapies that the physician is not familiar with or does not agree with
o. Patient does not seem interested in self-care or health maintenance
p. Patient appears to agree with physician, but then does not follow-through with treatment or lifestyle changes
q. Patient does not want to participate in a partnership with physician
r. Patient does not appear to trust the physician

TABLE 2- Quantitative
Comparison of Resident Responders to All Program Enrollees on Gender and Ethnicity

	Internal Medicine		Family Medicine		Pediatrics	
	Responders	Enrollees	Responders	Enrollees	Responders	Enrollees
Male	74.3%	71.4%	50%	44.4%	35.7%	31.9%
Female	25.7%	28.6%	50%	55.6%	64.3%	68.1%
White	26.5%	33.0%	50.0%	47.2%	58.3%	48.9%
Asian	58.8%	58.8%	38.9%	38.9%	16.7%	36.2%
E.Indian	14.7%	5.1%	0%	0%	16.7%	12.8%
Hispanic	0%	3.1%	11.1%	8.3%	8.3%	2.1%
Black	0%	0%	0%	5.6%	0%	0%

TABLE 3 - Quantitative
Summary of Study Dependent Variables

Scale/Item	# of Items	Mean	sd	N	alpha reliability
Relevance	1	3.88	.88	71	NA
Competence	10	2.96	.50	71	.85
Frequency of techniques	21	3.96	.38	71	.83
Helpfulness of techniques	21	4.24	.43	68	.90
Problems	18	2.81	.79	71	.88

TABLE 4 - Quantitative
Correlations among Scales/Items

		Relevance	Competence	Frequency	Helpfulness	Problems
Relevance	Pearson corr	1.00	.110	.049	.353**	.164
Competence	Pearson corr.		1.00	.287*	.164	-.128
Frequency	Pearson corr	.		1.00	.489**	-.279*
Helpfulness	Pearson corr	.			1.00	.141
Problems	Pearson corr	.				1.00

* $p < .05$; ** $p < .01$

TABLE 5 - Quantitative
Cross-Cultural Specialty, Gender, and Ethnicity Differences

ITEM/SCALE	INDEPENDENT VARIABLE	MEANS	F	SIGNIFICANCE (One-way ANOVAS)
Relevance (Specialty)	FM	4.55	10.39	.000
	IM	3.72		
	Peds	3.57		
Competence (Specialty)	FM	3.17	10.24	.000
	IM	2.96		
	Peds	2.56		
Frequency Used (Gender)	Female	4.06	3.66	.06
	Male	3.88		
Helpfulness (Specialty)	FM	4.46	3.62	.033
	IM	4.14		
	Peds	4.25		
(Ethnicity)	White	4.40		.040
	Other	4.16		
Problems	NS			

TABLE 6 - Quantitative
Cross-Cultural Problems that >50% of Residents Rated as Moderate or Severe

PROBLEM	PERCENTAGE
Insufficient time	89.9%
Patient seems to agree with doctor, but no follow-through	81.1%
Patient presents too many problems	73.9%
Patient history rambling and disorganized	69.5%
Patient provides inconsistent, contradictory information	68.1%
Patient doesn't understand implications of diagnosis	62.3%
Poor interpreter translation	56.5%
Difficulty communicating diagnosis to patient	56.4%
Patient not interested in self-care or health maintenance	56.4%
Patient talks too much to interpreter	50.7%

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Please tell us your name, how long you've been a patient at this clinic, and something about your background. *Prompt*: Just tell us something about yourself you'd like us to know **(patient version).**

2. **Transition**: What does the phrase "culturally competent communication" mean to you as physicians? **(faculty/resident version)**

What does good communication with your doctor mean to you as a patient? *Prompt:* Think of a particularly good experience you've had with a physician, then think about what he or she said to you or how he or she handled the interview that impressed you. **(patient version)**

3.**Key**: What are some of the obstacles you run into in trying to communicate effectively with patients of different cultural and/or socioeconomic backgrounds? *Prompts*: Language barriers, differing expectations for patient and physician, differing health beliefs **(faculty/resident version)**

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8. **Ending**: What would you say is the most important factor in successful cross-cultural communication and how can it be achieved? **(faculty/resident version)**

What would you say is the single most important thing in successful cross-cultural communication between doctors and patients? **(patient version)**

CROSS-CULTURAL COMMUNICATION SURVEY ITEMS

Competence Items (1-5 rating)

a. Caring for a patient who insists on using or seeking alternative therapies or healers
b. Identifying beliefs that are not expressed by the patient or caregiver but might interfere with the treatment regimen
c. Addressing patients in culturally appropriate ways that result in a therapeutic alliance.
d. Being attentive to nonverbal cues or to the use of culturally specific gestures that might have different meanings in different cultures.
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i. Working with a colleague who makes derogatory remarks about patients from particular ethnic or socioeconomic groups.

Technique items (1-5 rating on frequency of use and helpfulness)
a. Making the patient feel welcome_____
b. Making a personal connection with the patient_____
c. Listening carefully to the patient_____
d. Working closely with the interpreter_____
e. Using skills of paraphrasing, clarifying, and summarizing_____
f. Acting as the patient's advocate in the health care system_____
g. Expressing concern for the patient_____
h. Eliciting the patient's agenda_____
i. Clarifying patient's expectations for visit_____
j. Summarizing patient's concerns _____
k. Eliciting the patient's self-diagnosis_____
l. Negotiating treatment plan within context of the patient's life_____
m. Providing simple, clear explanations of diagnosis and treatment_____
n. Showing respect for the patient_____
o. Using the patient's primary language whenever possible_____
p. Addressing language difficulties directly_____
q. Maintaining tight control of the interview _____
r. Allowing time for the patient to tell his/her story_____
s. Allowing time for the patient to ask questions_____
t. Having patient repeat back instructions to make sure they were understood_____
u. Knowing something about the patient's cultural background_____

Problem Items (1-5 rating)

a. Insufficient time
b. Interpreter does not appear to adequately translate patient and/or physician statements
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d. Interpreter is a child or inappropriate for some reason
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n. Patient uses culturally based alternative therapies that the physician is not familiar with or does not agree with
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Comparison of Resident Responders to All Program Enrollees on Gender and Ethnicity
(quantitative study)

	Internal Medicine		Family Medicine		Pediatrics	
	Responders	Enrollees	Responders	Enrollees	Responders	Enrollees
Male	74.3%	71.4%	50%	44.4%	35.7%	31.9%
Female	25.7%	28.6%	50%	55.6%	64.3%	68.1%
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Asian	58.8%	58.8%	38.9%	38.9%	16.7%	36.2%
E.Indian	14.7%	5.1%	0%	0%	16.7%	12.8%
Hispanic	0%	3.1%	11.1%	8.3%	8.3%	2.1%
Black	0%	0%	0%	5.6%	0%	0%

Proposal Information

Introduction. Achieving cultural competence in learners is an important goal for all primary care residency programs. To promote this end, cross-cultural training guidelines have been formulated for Family Medicine (1), Internal Medicine (2) and Pediatrics (3) residency training programs. Developing effective cross-cultural training curricula must take into consideration the needs of the persons most directly affected by such training – ie., learners, teachers, and those who are the "recipients" of training efforts. Yet we have little information about the perceptions of residents, faculty, and patients 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. We also have little information about differences in cross-cultural attitudes and skills across the primary care specialties.

Bringing Education & Service Together (BEST) is a federally-funded research initiative studying "service learning" techniques for enhancing generalist residents' skills in cross-cultural communication and clinical teaching. The purposes of the cross-cultural BEST study were as follows: 1) To explore the perceptions of primary care residents, faculty, and patients regarding the meaning of culturally competent communication, what interferes with culturally competent communication, and what are the most useful skills to establish culturally competent communication 2) To assess differences among the three primary care specialties of family medicine, general internal medicine, and pediatrics regarding resident self-perceived attitudes towards and skills of cross-cultural communication competence and 3) To solicit recommendations for the introduction of cross-cultural communication curricula at the residency level.

Methods. Since we wanted to learn more about the views of primary care residents, faculty, and patients regarding cross-cultural competence communication barriers and skills, we invited potential focus group members who met these parameters, and in addition represented a gender and ethnic mix. Focus group participants were 28 residents and 25 faculty from family medicine, internal medicine, and pediatrics at a single public university school of medicine, as well as 14 patients from a low-income primary care community clinic. A total of 10 focus groups (5 faculty, 3 resident, and 2 patient) were held. Thirty-four percent of residents and faculty were non-Hispanic white; 40% were Asian, 9% Middle Eastern, and the remainder came from various ethnic backgrounds. Patients were 50% native American Indian, 21% non-Hispanic white, 14% Latino, and7% African American, and 7% African. All sessions were conducted in English, and patients who did not speak English were excluded from participation.

We also received attitudinal and skill assessment surveys from 20 family medicine residents, 37 general internal medicine residents, and 14 pediatric residents (N= 71), some of whom participated in the focus groups and some of whom did not. Survey response rates were 58.8% for family medicine; 50% for internal medicine; and 30% for pediatrics. Twenty-five respondents listed themselves as non-Hispanic white. There were 24 residents who identified as Asian, with the remainder "other." Mean age of this sample was 30.0 (sd=4.34). Twenty-eight females and 41 males participated in the study, with 2 not indicating gender.

Procedures. ***Qualitative.*** Residents and faculty were approached by email and in person to participate in a focus group held at a convenient time and place. Patients were

recruited by flyers and by their personal physicians and met in the familiar setting of the patients' primary care clinic. A clinical psychologist and a nurse with a Ph.D. in health psychology facilitated all 10 groups. Facilitators welcomed participants, explained the purpose of the study, and presented guidelines for the discussion (4). Groups were conducted in a conversational, informal atmosphere, and food was provided. Participant/facilitator introductions included reference to their own cultural backgrounds. 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.

Facilitators constructed a question route that helped to organize participant thoughts, established priorities, and incorporated a logical flow (5). The question route focused on the following areas: 1) What did culturally competent communication mean to participants? 2) What did participants perceive to be barriers to culturally competent communication? 3) What were techniques physicians could use to overcome communication barriers? 4) (For residents and faculty only) What specific teaching techniques would be most useful in conveying cross-cultural competence to residents?

Quantitative. Residents were surveyed at required residency noon conferences. Surveys were also distributed in resident mailboxes with instructions for completion and a stamped, return envelope to the study coordinator. In addition, researchers worked closely with the chief residents in each department to encourage residents to complete and return surveys. The study used a 69 item survey based on existing instruments in the literature (6,7; R. Like, personal communication, 2000). The survey consisted of a single item to assess perceived relevance of sociocultural factors to clinical practice; and five scales measuring perceived competence in dealing with various sociocultural issues or situations; frequency and utility of specific cross-cultural communication techniques; and the extent to which residents felt certain patient cross-cultural characteristics or situations were problems. Other questions asked about what content areas residents felt would be most useful in learning about cross-cultural communication; obstacles to introducing a cross-cultural communication curriculum; and the preferred format for such a curriculum. All questions used a 1-5 Likert-type scale.

Data analysis. ***Qualitative*** (8). After each focus group, facilitators held a debriefing session, 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. Verbatim transcripts were made of all focus groups and, because a single rater may not extract all important information from a session (9), reviewed by all investigators. This approach was also intended to reduce investigator bias. Extensive transcript notations were also made by the first two presenters and exchanged for comment and revision. Conclusions were reviewed by the third investigator.

Analysis was based on a content analysis approach that was initially descriptive, then interpretive. The unit of analysis was each focus group, not individual comments (10), although data were compared both within group and across groups. Data analysis paid attention to disconfirming evidence and outliers. Analysis took into account elements of frequency, extensiveness, and intensity (11). 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).

Quantitative. Cronbach's alpha was used to determine the internal reliabilities of the 4 scales described above. Pearson 2-tailed tests were used to calculate correlations among the 5 dependent variables. One-way ANOVAS were used to test for group differences between independent and dependent variables.

Results. ***Qualitative.*** The most important findings from this aspect of the study may be summarized as follows: In terms of the meaning of cultural competence, although both residents and faculty emphasized language skills, cultural knowledge, and general attitude, differences in emphasis did emerge. Residents seemed to be more linguistically and factually focused than faculty, who gave greater importance to cultural understanding and culturally sensitive attitudes. 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 endorsed these models as well, but were more 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 acknowledge responsibility for failures in cross-cultural communication. Residents were inclined to criticize interpreters and especially patients for creating obstacles to successful communication (see Table 1). Patients blamed doctors (see Table 2).

In contemplating solutions to cross-cultural communication problems, most suggestions were directed at residents. Residents and faculty shared similar views that included developing language skills, working with interpreters, incorporating communication skills, acquiring personal knowledge of patients, and maintaining an attitude of interest and respect. Patients were less concerned with cultural issues than they were with good generic communication and evidence of being taken seriously and treated with respect. Residents expressed only limited endorsement of didactic cross-cultural didactic education, and tended to feel that the best way to develop cross-cultural competence was through experience with patients. They were especially skeptical of "sensitivity" and communication skills training, which they often regarded as a waste of time. Faculty placed greater importance on their own role-modeling to provide a bridge between residents and patients than did residents themselves.

Quantitative. The survey generated 5 scales, which were constructed post-hoc by assessing internal alpha reliabilities for groups of items that were theoretically related (see Table 3). Generally, respondents perceived sociocultural issues as relevant to clinical practice. They rated themselves as moderately competent in cross-cultural communication skills. They tended to use a range of cross-cultural communication techniques frequently, and tended to find them quite helpful. They rated a range of patient characteristics and situations as more or less "moderate" problems complicating communication in the clinical setting.

Results found specialty, gender, and ethnic differences in the resident population surveyed (see Table 4). Family medicine residents were significantly more likely to rate sociocultural factors as relevant to the practice of medicine than were internal medicine and pediatric residents. They were also significantly more likely to rate themselves as competent in cross-cultural communication than were other primary care residents, and

were more likely to find the techniques they used to be helpful than did other residents. Post-hoc tests indicated no significant differences between internal medicine and pediatric residents. Female residents were slightly more likely than male residents to use specific cross-cultural communication techniques. Non-Hispanic white residents were more likely to find specific communication techniques useful than were residents of other ethnicities.

Discussion. This study examined attitudes and perceptions about culturally competent doctor-patient communication in three groups of primary care stakeholders – residents, faculty, and patients. Qualitative and quantitative findings tended to reinforce and confirm each other. Generally, residents defined culturally competent communication in narrow, language-based terms; patients emphasized generic skills; and faculty took the most comprehensive view. Person-blame models that targeted deficiencies and shortcomings of others were prevalent among residents and patients in explaining barriers to effective cross-cultural communication; faculty tended to endorse more systemic influences. Residents tended to favor generic communication techniques such as careful listening and showing respect, and were less likely to engage in more complex and culture-specific techniques such as eliciting the patient's agenda, or negotiating a treatment plan. Patients also recommended reliance on basic generic skills to promote good communication, while faculty more often endorsed more in-depth approaches. Differences were found between family medicine residents compared to internal medicine and pediatrics residents on dimensions of relevance, competence, and usefulness of communication techniques.

The introduction of curricula promoting culturally competent communication should take into consideration resident preferences for individual and small group learning, as well as their skepticism about introspective exercises and communication skills training (12). However, such curricula should also emphasize the importance of models that interpret cultural differences respectfully and avoid person-blame, that encourage residents to think beyond specific language and content knowledge competence to contextual variables, and that foster attitudes of interest and commitment in interacting with patients of different cultures.

Equipment Needs: LCD projector

TABLE 1
WHAT RESIDENTS DISLIKE ABOUT 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, long medication
- inability to read medication labels
- not filling prescriptions
- noncompliance with medical regimens and treatment plans
- suspicious of Western medicine; preferring Eastern, folk, or homeopathic remedies, but not reporting use of CAM to physicians
- 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 time allotted

Failing to use the health care system 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

TABLE 2
WHAT PATIENTS DISLIKE ABOUT DOCTORS

Acting like they think they know it all
Intimidating patients
Being excessively controlling
Treating patients as stupid or ignorant; treating patients "like dirt"
Giving patients the run-around; try to placate you rather than addressing the problem
Not following up
Telling patients nothing is wrong
Telling patients "the problems are all in their head"
Not taking seriously or minimizing patient's complaints
Using technical language
Receiving unnecessary or inappropriate treatment
Focusing on 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

TABLE 3
Summary of Study Quantitative Dependent Variables

Scale/Item	# of Items	Mean	sd	N	alpha reliability
Relevance	1	3.88	.88	71	NA
Competence	10	2.96	.50	71	.85
Frequency of techniques	21	3.96	.38	71	.83
Helpfulness of techniques	21	4.24	.43	68	.90
Problems	18	2.81	.79	71	.88

TABLE 4
Cross-Cultural Specialty, Gender, and Ethnicity Quantitative Differences

ITEM/SCALE	INDEPENDENT VARIABLE	MEANS	F	SIGNIFICANCE (One-way ANOVAS)
Relevance (Specialty)	FM	4.55	10.39	<.001
	IM	3.72		
	Peds	3.57		
Competence (Specialty)	FM	3.17	10.24	<.001
	IM	2.96		
	Peds	2.56		
Frequency Used (Gender)	Female	4.06	3.66	.060
	Male	3.88		
Helpfulness (Specialty)	FM	4.46	3.62	.033
	IM	4.14		
	Peds	4.25		
(Ethnicity)	White	4.40		.040
	Other	4.16		
Problems	NS			