# Cross-Cultural Training in Pediatric Residency: Every Encounter Is a Cross-Cultural Encounter

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TRAINING IN CROSS-CULTURAL COMMUNICATION is essential to preparing physicians to care for an increasingly diverse patient population.[1,2] Physicians must be skilled not only in working across language and socioeconomic barriers, but also in navigating patients' belief systems and their understanding of health and disease. Patient satisfaction and compliance with medical recommendations are closely linked to the effectiveness of communication and the doctor-patient relationship.[3,4]

In recognition of its importance, the Accreditation Council for Graduate Medical Education (ACGME) Outcomes Project includes cross-cultural communication as required elements of competency in both professionalism and interpersonal communication. In the Pediatric Milestones,[5] early learners see the world through the eyes of their own backgrounds and have trouble understanding or accepting the cultures of others. As learners' skills grow, they develop "cultural humility," coming to understand the cultures and worldviews of others and eventually to celebrate cultural differences and actively use this awareness to provide more effective patient care.[5] According to Tervalon, the concept of cultural humility includes: " a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations."[6]

Effectively teaching cross-cultural communication in a way that assists residents in achieving relevant milestones presents a significant challenge for program directors. To address this challenge, in this article we review briefly what is known about best practices in cross-cultural communication training (CCT), describe what we have done to build on best practices, and provide a set of recommendations for program directors.

## MODELS OF CROSS-CULTURAL EDUCATION TRAINING

Previous educational approaches to cultural competency have focused primarily on two methods: anthropologic and patient-centered templates.[7] Anthropologic approaches involve learning about specific characteristics, norms, and values of various cultural groups and then placing patients into one of those groups, which then provides a guide to how to approach caring for them.[8] Although this approach may offer some benefit, many leaders in the field argue that the group approach to cultural competency education is potentially counterproductive because it risks promoting stereotypes, which in turn can promote "othering."[9,10] Othering occurs when one group is defined as different from the "normal" group, which can lead to labeling, marginalization, and exclusion.[10] In addition, othering may make it more difficult to teach learners the importance of negotiation and mutual understanding.

An alternative strategy is to use a patient-centered template approach that provides physicians with broadly applicable skills, knowledge, and attitudes so they can approach all individual patients without stereotyping by trying to understand the environmental or social contexts in which they exist. This approach promotes cultural humility, which frames medicine as its own culture—and physicians as a part of a unique cultural group. The core principle is that trainees are taught to treat *all* patient encounters as cross-cultural and to consider all patients' unique cultural beliefs and practices on an individual basis.[10] This method has been widely adopted, and there is evidence that participants in the trainings were highly satisfied and found them useful and effective.[11,12] The two most common patient-centered template tools are the LEARN (ie, Listen, Explain, Acknowledge, Recommend, and Negotiate) model[13] and Kleinman's cultural assessment questions (Table).[14] Both of these models use interview techniques that focus on communication and


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**Table.** The LEARN Model and Kleinman's Cultural Assessment Questions

| LEARN Model[13] | Kleinman's Cultural Assessment Questions[14] |
|---|---|
| • **L**isten to the patient's perception of the problem<br>• **E**xplain the biomedical perspective<br>• **A**cknowledge and discuss differences and similarities<br>• **R**ecommend treatment<br>• **N**egotiate treatment | • What do you call the problem?<br>• What do you think has caused the problem?<br>• Why do you think it started when it did?<br>• What do you think your sickness does?<br>• How does it work?<br>• How severe is the sickness? Will it have a short or long course?<br>• What are the chief problems the sickness has caused?<br>• What do you fear most about the sickness?<br>• What kind of treatment do you think you should receive?<br>• What are the most important results you hope to receive from this treatment? |

encourage physicians to set their expert knowledge alongside, not over and above, the patients' own explanations and viewpoints.[15]

## Impact of Cross-Cultural Training Interventions

Both quantitative and qualitative approaches have been used to assess the impact of CCT interventions on learners. Published quantitative tools, which focus primarily on self-assessment, show limited evidence of validity and reliability.[16] Qualitative tools, such as reflective writing or journaling, encourage learners to internalize and make meaning out of real cases and patient experiences.[11,17,18] One investigator has suggested that the best practice is to use a combination of qualitative and quantitative methods to assess knowledge, skills, attitudes, and the impact of curricular interventions on health outcomes.[19] This approach is obviously time intensive and requires significant faculty expertise.

There is strong evidence that CCT improves the cross-cultural knowledge of health professionals and good evidence, although less strong, that CCT improves the attitudes and skills of health professionals and patient satisfaction.[20] However, there is only limited evidence that CCT improves patient adherence and no clear evidence that it improves patient health status outcomes.[20] In regard to patient outcomes, very few high-quality studies that address this critical issue.

## Barriers to Implementation of CCT Curricula

Numerous barriers to the implementation of CCT have been reported.[21–23] Examples include learner resistance (eg, residents feeling they either had or did not need these skills); time constraints; lack of faculty training or expertise; and institutional or system barriers to cross-cultural care and key leadership buy-in. One critical challenge is the lack of a broadly accepted definition of culture and what cultural competency training should be. Even the use of the term *cultural competency* has been criticized because it can imply the need to learn and become proficient in the understanding of all cultures, which is, of course, an impossible task. This problem can lead to a misunderstanding by trainees that communication difficulties could be resolved solely by the attainment of culture-specific knowledge.

## Our Experience Implementing Cross-Cultural Training

Based on the principles discussed above and the previous work of one of the authors,[24] we implemented a pilot CCT curriculum. The overall goal of the curriculum was to encourage residents to move along the continuum from lack of cultural awareness to cultural curiosity by deliberate application, practice, and integration in the clinic setting.[24] We elected to use the patient-centered template model, which emphasizes the core principle that every patient encounter is a cross-cultural encounter.

The curricular objectives were to (1) increase residents' awareness of the gaps between their perspectives and those of their patients; and (2) teach residents to use patient-centered template tools to bridge cultural gaps in the clinical setting. The patient-centered template tools were adapted from materials provided in a Pediatric Academic Societies Meeting workshop presented by DeLago and colleagues.[25] We addressed time constraints by adding a minicurriculum in cross-cultural communication to the required community pediatrics rotation for first-year residents. The curriculum centered on application of the LEARN and Kleinman frameworks in the context of clinical care and on reflective writing as a tool for teaching and evaluation. Teaching strategies included (1) discussion of a broadened definition of culture that includes factors such as socioeconomic status, sexual orientation, religion, and immigration status; (2) a video-triggered discussion of the LEARN model and Kleinman framework (ie, a short film that featured a physician's interaction with a patient); and (3) a role-play of a clinical scenario focused on the application of the framework during a clinical encounter. All residents were required to complete a reflective-writing exercise responding to the prompt: "Describe a patient encounter where you used or wish you had used the LEARN model and Kleinman framework."

To assess the impact of the curriculum on residents, we performed a content analysis of the answers to the reflective-writing essays of all residents (20 total) who participated in the first year (2005–2006) of the curriculum. In the analysis we identified common themes, including perceived benefits and lessons learned from using the LEARN/Kleinman model. Three core themes

emerged: first, the vast majority of residents reported that using the tools allowed them better understanding of patients' perspectives; second, a great majority of residents found that using the tools enhanced the residents' perceived patient satisfaction; and finally, it was very common for the residents to explore the patients' perspectives only after attempts to explain the medical/providers' perspective had failed. The following two quotations illustrate these themes:

> I spent the first part of the visit explaining, as I thought my job was to convince…but that wasn't effective.… Only after listening did I understand that the medicine I recommended seemed "bad" to the family.

> Even though these parents came from a similar ethnic background as me, they still had widely different views about medical interventions.

Similar to previous studies using the LEARN and Kleinman frameworks,[9,26] we found high satisfaction among learners and successful learning of cross-cultural concepts and skills. From the content analysis, we also confirmed that residents were able to integrate the patient-centered interview tools into routine clinical care with real patients. Although most residents did not use the tools at every clinical encounter, they did use them frequently. We concluded that the curriculum provided residents with a concrete set of tools they could apply to the clinical setting when they encountered problems in communicating with patients and families. It is important to note that our approach was cost- and time- efficient because it was integrated into an existing rotation and required very limited faculty preparation or other resources. We believe this curriculum would be easy to adopt in a broad range of other training programs (curriculum details are available on request).

## RECOMMENDATIONS

Based on our experience and evidence from the work of others, we have the following recommendations. First and foremost, educators should emphasize that every patient encounter is a cross-cultural encounter. To do this efficiently, we need to integrate cross-cultural curricula into existing training and provide opportunities for deliberate practice, application, and self-reflection in the clinical setting. Also, in order for CCT to be effective and overcome learner resistance, it should provide residents with a set of practical tools that they find useful when taking care of patients. Finally, educators must address the paucity of high-quality research demonstrating the impact of cross-cultural training on patient health outcomes and health disparities.

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