

Integrating cultural awareness into busy residency training - What could work?

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Abstract

Introduction: Provision of culturally sensitive healthcare improves patient-clinician relationships and health outcomes. However, traditional cultural competence training may inadvertently reinforce racial and ethnic biases and can be challenging to implement into busy residency programs. This study aimed to contribute evidence-based recommendations for cultural awareness training to be integrated into existing residency programs, to promote holistic and longitudinal learning of cultural awareness.

Methodology: This was a qualitative study of healthcare staff and patient experiences within a culturally diverse population and cultural awareness issues that arise in a tertiary academic paediatric hospital. Nineteen participants (six residents, four faculty, four nurses and five caregivers) were purposefully sampled and underwent semi-structured individual interviews. Transcribed interviews were analysed for emerging themes.

Results: From a multi-faceted perspective, cultural awareness issues that emerged included: 1) addressing the tension between residents' instrumental and expressive behaviour in patient care, 2) cultural and ethnic bias of caregivers towards doctors, 3) residents' concerns about difficult patients, 4) understanding patients' perspectives and 5) bias within inter-professional relationships. As expected, residents' learning experiences about cultural awareness occurred through on-the-job learning rather than formal curricula.

Discussion: Resource-intensive cultural competency curricula may not always be feasibly integrated into busy residency programs. However, some practical methods to facilitate longitudinal workplace-based learning of cultural awareness include: 1) firm and transparent hospital policies against discrimination and engaging residents into developing such policies, 2) faculty development and leadership training on cultural sensitivity and supporting victims of discrimination, 3) incorporating cultural sensitive communication into assessment methods, 4) utilising patients as educators and 5) ensuring inter-professional team diversity.

Keywords: *Cultural Awareness, Professionalism, Postgraduate*

Practice Highlights

- Longitudinal incorporation of cultural awareness into residency training is preferred over rigid curricula.
- Hospital policies, faculty development, reorientating training and assessment methods are essential to integrating cultural awareness into residency training.

I. INTRODUCTION

Cultural competence in health care refers to the ability of an organisation to provide care to patients with diverse values, beliefs and behaviours, in order to meet different social, cultural and linguistic needs (Betancourt, Green, & Carrillo, 2002). There is increasing awareness that cultural competence is required to reduce racial and ethnic disparities in health care (Betancourt, Green, Carrillo, & Ananeh-Firempong II, 2003). These disparities commonly result from care expectations, and

the ability to understand the medical condition and its management, which are driven by cultural factors (Gornick, 2000).

In paediatrics, cultural competent health care improves health services satisfaction and treatment compliance (Britton & American Academy of Pediatrics Committee on Pediatric Workforce, 2004). Similarly, failure to consider a patient's language and culture can result in significant health care barriers (Brotanek, Seeley, &

Flores, 2008). Cultural training in paediatrics has been designed to enhance the knowledge base of local cultures, allow the development of negotiation skills during cultural encounters, and to provide patient-centred care while taking into consideration family beliefs and practices (Macdonald, Carnevale, & Razack, 2007).

However, many traditional cultural competence programs have been designed to reduce health care barriers between underserved sociocultural groups and more privileged individuals (Gornick, 2000), which could inadvertently reinforce racial and ethnic biases (Gregg & Saha, 2006). Residents could also make assumptions that culture is dictated by ethnicity, although both are not interchangeable (Kumas-Tan, Beagan, Loppie, MacLeod, & Frank, 2007). Additionally, although cultural competence programs can increase healthcare professionals' knowledge in managing culturally diverse patients, these are often standalone, discrete programs focusing on specific competencies which may have limited long-term impact on patient care (Horvat, Horey, Romios, & Kis-Rigo, 2014; Renzaho, Romios, Crock, & Sønderlund, 2013). Cultural competence programs can also be difficult to implement into already overbooked resident schedules and longitudinal integration into the overall curriculum can be challenging (Seeleman, Suurmond, & Stronks, 2009; Stevens & Goulbourne, 2014). Hence, the importance of this study is to add the direct practical experiences of health professionals and patients, moving beyond course information to actual application of learning.

In today's diverse world, cultural competency training in healthcare cannot merely be focused on superficially understanding minor ethnic groups, but rather, on truly appreciating the patient perspective and how it is impacted by culture. For example, a "culturally competent" resident may be able to describe traditions or practices of an ethnic minority, but be unable to understand why a patient refused a recommended treatment. Additionally, at present, little is known about what programmatic interventions should look like, or should include in the clinical context which could be effectively implemented into existing residency programs to support on-the-job learning of cultural competency. Furthermore, as the majority of published studies involve homogeneous groups of Western-based health professionals interacting with non-Western patients (Horvat et al., 2014; Renzaho et al., 2013), this study's inclusion of heterogeneous non-Western health professionals and patients provides a broader perspective of cultural awareness. A paediatric hospital setting also has the unique caregiver viewpoint which can be more

complete and perceptive compared to an adult's patient viewpoint, as the patient's care is viewed from a well person's perspective, often with limited input from the patient herself.

Seeleman et al. (2009) described a broad conceptual framework for teaching and learning cultural competence. This included knowledge, awareness of how culture and social context shapes individual behaviour, prejudice and thinking, and the ability to provide understandable information to patients in an adaptable and creative way. Hence, building upon this conceptual framework, this study aims to utilise actual on-the-job experiences to formulate practical, evidence-based recommendations for cultural awareness training to be integrated into existing residency programs, with the aim of providing residents with an ability to view culture in healthcare holistically, in the absence of a traditional cultural competency curriculum. Cultural awareness, an appreciation of the dimensions of culture and values, is more applicable in this study instead of cultural competence, which refers to the application of cross-cultural skills through awareness, knowledge and sensitivity, as no actual cultural competency assessments were performed. Cultural competency assessments are also limited in their quantitative nature, and are not sufficiently explorative. Furthermore, cultural awareness is part of the process of an organisation achieving cultural competence and needs to be thoroughly explored prior to discussing cultural competence. As the theme of culture in this study's context has not been adequately studied, this study focuses on exploring cultural awareness to determine the cultural attitudes of healthcare staff and patients, as a primer to future studies on cultural competence.

Culture is understood primarily through interpersonal interactions, and cultural differences drive the premise of cultural competency curricula. In order to create a practical dimension of this study, rather than to blindly adopt Western-style cultural competency curricula, this study also aims to explore interpersonal interactions as well as whether on-the-job experiences provide informal opportunities for learning about culture.

The research questions for this study are:

1. How do residents currently demonstrate their awareness of cultural differences between themselves and their colleagues, patients and caregivers?
2. What is the perceived impact of cultural differences on interpersonal and group interactions among healthcare staff, patients and caregivers?

3. What are the learning experiences of residents through interacting with their culturally different colleagues, patients and caregivers?

A. Conceptual Theoretical Framework

This study focused on learning experiences because medical professionals in-training most likely acquire cultural awareness through the cross-cultural encounters that they personally experience (Javier, Hendriksz, Chamberlain, & Stuart, 2013), which is based on the experiential learning theory (Kolb, Boyatzis, & Mainemelis, 2001). This theory has also formed the basis of early transcultural health professions education (Carpio & Majumdar, 1993; Lockhart & Resick, 1997).

As reducing cultural competency to a set of knowledge, skills and attitudes can result in rigid stereotyping, it is more important for health care professionals to value and work towards culturally competent practices instead. Therefore, it is hoped that through residency training, residents can demonstrate being affectively neutral while being relational and sensitive (Stevens & Goulbourne, 2014). This study focuses on residents' behaviour because demonstration of their cultural awareness illustrates their stage in the conscious and progressive process of cultural competence, that requires a readiness to learn, reassess, adapt, accept and to experience personal acculturation (Kumagai & Lyson, 2009). The residents' demonstration is a reflection of the perceived impact of cultural differences, both in interpersonal and group interactions, which is another focus of this study.

While the health professional is experiencing this process, the patient is also experiencing the cultural encounter: he/she determines whether the physician is culturally sensitive, multidimensional, and acknowledges his or her needs (Conrad & Poole, 2012). Hence, the experiences of patients and caregivers are also an integral part of the research process through their observation of residents' demonstration of cultural awareness and their perceived impact of cultural differences on residents' behaviour. Based on the developmental phases of cultural competency as described by Culhane-Pera, Reif, Egli, Baker and Kassekert (1997), it is desired that patients and caregivers experience the residents' acceptance of different cultural beliefs, values and behaviours on health, disease and treatments (Level 3).

II. METHODS

A. Design

A qualitative phenomenological approach is taken to this study which used in-depth exploration of experiences of a small number of individuals. In this study,

phenomenology focused on the relationships of people, things and places just as they have been experienced and created, to understand how culture is "in use" (Frykman & Gilje, 2003). These relationships and experiences shape how cultural awareness is formed and embedded in the lives of the individuals.

This study was approved by the SingHealth Centralised Institutional Review Board.

B. Setting

The study context was a tertiary paediatric hospital, where patient and staff populations are ethnically and culturally diverse. The ethnic composition of Singapore consists of predominantly Chinese, followed by Malay, Indian and other ethnicities, including Caucasians and mixed-races. Singaporeans are an immigrant population, originating mainly from Asia but also from Western countries as well.

C. Subjects

Paediatric residents, faculty, nurses and caregivers of children who had experienced medical care in the institution were purposefully sampled to ensure diversity in cultural backgrounds. These cultural differences included country of birth, first language, religion, location where undergraduate and/or postgraduate qualification was obtained, age and gender. The staff sample included residents, faculty and nurses with different educational and work experiences. Caregivers of different countries of origin, occupations and socio-economic status were selected. Recruitment was performed by asking specific individuals of specific backgrounds for consent, and conducting the interview, before asking other individuals. Recruitment continued until data saturation was reached and the themes expressed were repetitive. In total, six residents, four faculties, four nurses and five caregivers participated in this study, with a total sample size of 19 individuals. Of the six residents, half were junior and half were senior residents, and half of them had received their education locally. Of the four faculties, two were consultants, one was a senior consultant and an associate consultant. Two faculty members were born overseas and one was educated locally. Of the four nurses, two were nurse managers, one was a senior staff nurse and the other a staff nurse. Two nurses received initial training overseas before starting work in Singapore. The educational level of the caregivers ranged from primary school to Masters' degree and their occupations were in areas of education, administration, finance and customer service. The three main races in Singapore were represented in all participant groups.

D. Instruments

In order to elicit experiential descriptions which may involve personal and potentially sensitive information from participants, in-depth semi-structured individual interviews were utilised. The interviewer was a faculty member involved in residents' and/or nurses' education but not in assessments and was not directly involved in the medical care of the participants and their children.

Information about demographic and cultural background was obtained from all participants. Interview questions were structured to encourage conversational responses and clinical vignettes (Table 1) were used to help participants contextualise their discussions. Clinical

vignettes were derived from various collective experiences of healthcare staff in culturally sensitive situations experienced in the workplace setting. Structured interview questions to staff included questions such as "Sometimes we may connect better with some colleagues or some patients. Do you think so? What do you think makes you feel more comfortable with them?". For caregivers, clinical vignettes were not relevant hence the interview started with asking about a healthcare professional they trusted and why they felt this way. The interview then progressed to asked specifically about their experiences having their child being managed by a paediatric resident, and their cultural preferences in their healthcare team.

Vignette	Residents	Faculty	Nurses
1	You notice in your rounding list that you have a new 3-year-old patient from the United Arab Emirates, a country in the Middle East, admitted overnight for a week of fever. What will you do to prepare yourself to see the case?	You come to the ward to start rounds on a new 3-year-old patient from the United Arab Emirates, a country in the Middle East, who was admitted overnight for a week of fever. What does the resident do prior to entering the room to see the case?	You notice in your rounding list that you have a new 3-year-old patient from the United Arab Emirates, a country in the Middle East, admitted overnight for a week of fever. What will you/ the resident do to prepare to see the case?
2	You have just received a complaint of a mother whose 1-month-old has just been admitted to the Children's Intensive Care Unit (CICU) for sepsis. The family is Malay Muslim. This 1-month-old child was just discharged 12 hours before readmission, from your ward, against medical advice as parents refused lumbar puncture for infantile pyrexia. You were the last doctor to see this patient prior to discharge. How would you feel and what would you do?	You have just received a complaint of a mother whose 1-month-old has just been admitted to CICU for sepsis. The family is Malay Muslim. This 1-month-old child was just discharged 12 hours before readmission, from your ward, against medical advice as parents refused lumbar puncture for infantile pyrexia. You have just told the paediatric resident who is the last to have seen this child prior to discharge. How would the resident likely react to this? How would you counsel the resident about dealing with this situation?	You realise that the ward team has just received a complaint of a mother whose 1-month-old has just been admitted to CICU for sepsis. The family is Malay Muslim. This 1-month-old child was just discharged 12 hours before readmission, from your ward, against medical advice as parents refused lumbar puncture for infantile pyrexia. You are asked to speak about the last doctor who saw the case. What do you think were the problems that may have happened at that time? How would the resident most likely react?
3	You have been asked to supervise a new house officer who is a foreign graduate. He has recently graduated and is working in Singapore for the first time. The nurses have been complaining to you that he is rude and curt towards them and the patients. How would you feel and what would you do?	You notice that there is a new house officer who has just graduated from a foreign university and is working in Singapore for the first time. The nurses have been complaining to you that he is rude and curt towards them and the patients. You have asked the paediatric resident to speak to this new staff – how would the resident likely react to this and how would you counsel the resident about dealing with this situation?	You notice that there is a new house officer from a foreign university who has never worked in Singapore before. He is rude and curt to nurses and patients and you have informed the ward resident of this matter. How would the resident react to this? How would you escalate this matter?

Table 1. Clinical vignettes

E. Data Analysis

Thematic analysis was performed on by hand through interview transcriptions by two independent reviewers (CC and RS) to identify emerging themes through descriptive phrases utilised by participants during interviews. Both reviewers analysed all transcripts individually prior to further discussion of the themes. Themes between sources were compared to determine the presence of convergence or divergence. The final themes emerged were synthesised to more clearly elucidate the phenomenon of cultural awareness among

paediatric residents. Any discrepancy in opinions by the two independent reviewers proceeded with a further discussion with a third reviewer (FS).

III. RESULTS

In this section, the results are arranged according to the main themes derived from the research, based on issues and concerns that arose from the interviews.

A. Residents' Awareness of Cultural Differences

In general, residents' awareness of cultural differences among patients is present but limited to specific aspects.

1) Linguistic needs of patients: In the first clinical vignette, most residents made an initial assumption that this non-local patient would be able to speak English. A resident also shared about the patient's responsibility in obtaining a translator, instead of this being the initiative of healthcare providers.

Time was also mentioned as a major factor in not being able to meet the patients' linguistic needs, as waiting for a translator was time-consuming.

Faculty expressed their concerns that residents are often not aware of the importance of the source of history from a non-native language-speaking family and may avoid interacting with the family altogether:

"...what I have seen is that (residents) would have just gone in and examined the patient as per usual and... not really speak to the family."

All residents were able to identify that despite usage of translators, information can get lost in translation. They were also aware of their limitations in speaking to patients who preferred a language the residents themselves were not fluent with, and hence tried to overcome this through finding appropriate translators wherever possible.

2) Sociocultural needs of patients: Resident seniority in training and own sociocultural background had an impact on their awareness of cultural differences. Senior residents were more likely to discuss self-prejudices and reflect upon how cultural background can result in patients having gender and racial bias. A resident of a minority race was concerned that increasing ethnic segregation has resulted in poorer inter-cultural awareness.

The majority of residents did express empathy when responding to the second clinical vignette, *"Try to understand where the parents are coming from"*, and attempted to accommodate parental requests. However, all residents, and most nurses, did not identify cultural factors as having a role in the parent's refusal of the lumbar puncture. The exceptions were a resident and nurse of Malay ethnicity, who were able to mention cultural influences in the caregiver's decision. A non-ethnic Malay resident said:

"I often wondered to myself too... so actually more often than not I do realise it's with Muslim patients, but when you ask them why, they cannot really say why actually."

This reflects her genuine curiosity in whether a cultural influence was present, which is a key feature in developing cultural competence.

Most faculty consistently felt that residents tended to put more emphasis on the medical aspects rather than the sociocultural aspects of patient care. Similarly, nurses felt that doctors may not actively seek out cultural backgrounds of patients, and perceived that nurses are more aware of cultural concerns compared to doctors.

Caregivers did not explicitly mention that residents were insensitive to their cultural needs, but were more affected by residents' lack of ability to identify parental struggles. A mother shared:

"They will keep on asking me, 'Oh the medications... did he really take?' Ah, so... we were like, OK, we are like bad parents like that we never give him medication,"

This reflects her perception of residents' insensitivity in their history-taking approach. She also felt that although residents took the time to speak to her about her son, they tended to be unnecessarily technical and overly apologetic.

3) Sociocultural background of colleagues: In discussing the final clinical vignette, faculty and residents did not feel a significant difference in professional behaviour between locally and non-locally trained doctors.

Consistently, faculty, residents and nurses felt that locally-trained junior doctors tend to be superior with regards to their understanding of systems-based practice but not professional behaviour. To residents and nurses, seniority, experience in the local system and personality were more important than the sociocultural background of junior doctors.

B. Impact of Cultural Differences on Interpersonal and Group Interactions

There are two group interactions emerged from this data. First is the interactions between paediatricians and caregivers and second is the cultural differences on interpersonal and group interactions. The first four sub-themes are more prevalent to the interactions between paediatricians and caregivers while the last sub-theme is related to interprofessional relationships.

1) *Cultural and ethnic bias of caregivers towards doctors:* While working in a multi-cultural hospital environment, some faculty and residents have experienced racist encounters and blatant complaints.

A non-local paediatric resident from another culturally diverse country observed:

"I feel that there's still bias among different ethnicities... for example, 'I want to see a Chinese doctor', 'I want to see an Indian doctor', 'I don't want to...'"

A paediatric resident recounted an uncomfortable experience:

"The parent actually said, 'Oh why is there a Malay doctor looking after my child.'"

This has also resulted in her questioning the impact of her own ethnicity on others:

"Sometimes I do worry whether people accept me... because especially the... people's, the public's perception of my religion and all that and you know... things that have nothing to do with me but you sometimes feel like, OK, do they judge me..."

Both faculty and residents experienced patients making requests to see doctors of a particular ethnicity, usually, but not always, to facilitate communication in a familiar language. A non-local resident questioned:

"So does that mean that, a Chinese doctor will provide better care for a Chinese patient, because they can relate to each other better?"

To deal with patient requests for doctors from specific ethnicities, faculty were firm that they will not accede to them. However, if the problem was communication due to language barriers, an appropriate translator would be sought.

2) *Conceptualising "difficult parents" and attitudes towards them:* Throughout the interviews with faculty, residents and nurses, a common emerging theme was the concept of "difficult parents". A resident shared:

"The making of a difficult parent, I don't feel it's like, any race or culture, I feel like it's different things... it's like how the parents were raised, and then, what their views are on life... because I mean you have difficult

parents from across all races... I don't even think it's related to education."

Although this was echoed by most healthcare staff, there were certain subgroups of parents who were perceived to be more "difficult". For example, residents identified some of these parents to be parents of newborn babies, parents of chronically ill patients who were familiar with navigating the healthcare system, and parents who were resistant to any healthcare intervention. Some residents also highlighted experiences with parents from certain countries and of certain ethnicities who tended to be more "difficult" and would mentally prepare themselves for the encounter.

A resident, while not explicitly mentioning his own bias, tended to explain certain negative behaviours through the caregivers' backgrounds by using certain descriptive terms such as "one was a professor in (a university)" and "one is from... (specific country)". However, a senior resident self-reflected about being cautious in over-labelling "difficult parents":

"Personally, I think we have to ask ourselves, whenever someone is perceived to be difficult... whether at that time... in that situation, whether we would have done the same..."

In response to these "difficult parents", faculty expressed concerns that residents may sometimes shy away from communicating with them. They may also not be keen to find out the underlying reason why the parents are behaving in a particular way, and use the term "difficult" to simply explain the behaviour. Residents may not be aware that parents actually do notice this avoidant behaviour.

Caregivers collectively did not mention that they preferred doctors of a specific ethnicity, unless it was to facilitate communication. There was also no specific concern about being served by healthcare staff of a different ethnicity.

Caregivers were aware that foreign doctors (i.e. international medical graduates not originally from Singapore) may do things differently, and some preferred local doctors as they "could communicate more effectively". A parent perceived that local doctors were more passionate about their work compared to foreign doctors, especially with regards to addressing parent or patient needs rather than just completing the consultation. Despite this, parents would accept foreign doctors who are knowledgeable, caring and sincere.

3) *Communication*: Faculty and nurses unanimously felt that residents, especially those with less experience, were not able to pitch conversations with parents at the right level. According to faculty:

“Typically they’ll follow a cookie cutter checklist as opposed to tailor the advice to the individual patient”.

A junior resident also acknowledged her limitations in doing this effectively, as she mentioned:

“I would... approach the parents as I would with any parents... I would pretty much give the same package of information to everybody...”

In a similar manner, a parent raised a concern about residents not being spontaneous in providing detailed information, such as investigation results, even though both parents were well educated.

Additionally, caregivers felt that with residents there tended to be a lack of *“human interaction”*. A caregiver also compared nursing behaviour to doctor behaviour,

“The doctors will only call (my child’s) name when they need to do the examination, or some investigation, but for nurses, usually when we walk by... they will call “Hey, (name of child), Hi! How are you today?”... it’s different.”

4) *Impact on patient care*: Faculty and residents were aware that healthcare staff can form their own judgments and bias about patients. As mentioned by a faculty:

“There’s some element of judgment, that’s very clear, a lot of times... I can see my staff judging people for the way they speak for where they might come from... clearly everybody judges here.”

However, all faculty and residents agreed that patient care was the same regardless of the sociocultural background of the patient.

Interestingly, a non-local parent felt that there may be a possible disparity of care between local and foreign patients,

“Maybe if the patients are local... (the healthcare staff) look like want to take care more... maybe the way they... talk to us or behave to us maybe a bit different.”

5) *Inter-professional relationships*: Being foreign or from a minority race had an impact with regards to developing inter-professional relationships with colleagues. Language was identified as a barrier, if colleagues spoke a language not understood by non-locals.

A Muslim resident found non-Halal out-of-hospital dinners a personal struggle to attend, which compromised team bonding. These were not concerns of those from majority ethnic groups.

C. Learning Experiences

Most residents’ learning about cultural differences was from personal experiences, rather than from formal training. This was reflected in the following phrases from residents, *“I think a lot of my learning is best done informally like at clinically, on the ground”*, *“it’s more a sum of your experiences”* and *“clinical experience comes in, dealing with people from different backgrounds”*.

Residents were able to reflect upon patient complaints made against them, experiences of miscommunication, having their opinion rejected by caregivers, and with *“difficult”* parents. They also learnt that when dealing with a challenging conversation, *“bring(ing) the focus back to the child”* was critical.

Residents also mentioned the importance of role-modelling by seniors,

“... what I really like is watching the registrar or the consultant... then I learn it for the next time.”

1) Role of a formal cultural competency curriculum:

Residents trained in Western medical schools shared their experiences with cultural competency modules. Residents trained in Asian medical schools, however, claimed they had not received such prior training. However, all residents, regardless of training institution, shared their concerns about the limitation of a structured cultural competency curriculum. A resident shared,

“I don’t think there’s anything really teachable... even if you had to sit in a course, I don’t know how much everyone would actually learn...”

Faculty had mixed views about the implementation of such a curriculum – those who had experienced one were keen for structured teaching, while those who did not, remained sceptical. The main reason for this was that

experiential learning appeared to be more important than a formal cultural competency curriculum.

IV. DISCUSSION

This study provided insight into aspects of cultural awareness among healthcare staff and was able to address the study's research questions to a large extent.

Some proposed recommendations based on the themes derived from issues and concerns raised in the interviews are presented in Table 2. These suggestions on programmatic interventions in the clinical context could supplement on-the-job experiential learning of cultural awareness, addressing the current literature gap in this area.

Issues	Suggestions	Components
Addressing the tension between residents' instrumental and expressive behaviour in patient care	Empowerment of other healthcare staff to speak up to doctors about cultural issues through faculty facilitation and interprofessional ward rounds	FD, L, P
	Purposeful observation of clinical encounter by faculty to provide residents with specific feedback on addressing parental concerns	FD
	Provision of cultural competent healthcare as a hospital key performance indicator	P
Addressing cultural and ethnic bias of caregivers towards doctors	Firm, transparent policies in the hospital against discrimination towards healthcare staff and patients	P
	Engaging residents into hospital policies against discriminatory practices	P
	Faculty development on supporting residents who are victims of discrimination	FD
Addressing residents' concerns about communicating with "difficult patients"	Facilitation of residents' on-the-job learning through demonstrating and encouraging culturally competent communication (through the 'LISTEN' mnemonic)	FD
	Complaint debriefing sessions including faculty development on facilitating these sessions	FD
Facilitating residents' understanding of the patient's perspective	Utilise patients or caregivers as educators	IC
	Obtain patient or caregiver feedback about the team's care	IC
Addressing bias within interprofessional relationships	Leadership training and faculty development in cultural sensitivity	L, FD
	Ensuring team diversity	L, P
	Role-modelling of faculty behaviour to encourage team cohesion and inclusivity	L, FD

Note: Components are characterised as follows: FD – Faculty Development; L – Leadership; P – Policy; IC – Involve Caregivers

Table 2. Recommendations for integrating cultural awareness into existing residency programs

In addressing the study's research questions, firstly, although paediatric residents were aware of their culturally diverse work environment, they were lacking in addressing some fundamental patient needs. With a few exceptions, they tended to have an instrumental rather than expressive view on patient care – getting their job done rather than exploring the patient's perspective, as described in a study on paediatrician communication (Wassmer et al., 2004). In similar studies in Western contexts, residents acknowledged the importance of cross-cultural factors in medical care (Park et al., 2005; Park et al., 2006), but no studies have been done specifically exploring faculty or nursing observations of actual resident behaviour for comparison. Park et al.'s (2006) study discusses the same barriers that were raised by residents to providing culturally competent care, including time, language and availability of interpreters. To manage this tension between instrumental and expressive behaviour, in this study residents often deferred to nurses to address issues such as getting a translator, or finding out more about the patient's background, while focusing their limited time on primarily medical aspects – vital parameters, prescriptions and therapy. Hence, nurses, being more culturally aware, should be empowered to highlight

issues to doctors where appropriate. This can be done via faculty encouraging nurses to speak up during ward rounds, or having interprofessional ward rounds. Furthermore, observed clinical encounters of residents with patients on ward rounds often help faculty provide feedback to residents on their sensitivity in addressing parental concerns. Observed clinical encounters have been supported, but with a specific mention of interactions with patients from diverse backgrounds, which is more clearly understood in Western rather than in this study's context (Park et al., 2006).

Secondly, cultural differences in interpersonal relationships can result in cultural and ethnic bias of caregivers towards doctors, and bring about the concept of "difficult parents".

It is unfortunate, but not surprising, that there exists an ethnic bias in the hospital setting. Much of this bias is unconscious and a reflection of harmful ignorance, rather than an intention to offend. While the association of doctors' bias and healthcare disparities have been discussed in the literature, with a recent survey showing 40% of doctors practising in the United States reporting bias towards specific patient groups (Peckham, 2016),

patients' bias against doctors has not been studied. On the flip side, in this study, doctors' bias was not deemed to result in poorer patient care. Similarly, studies have shown that implicit bias in healthcare has not shown to negatively influence clinical judgment, though it has been associated with poorer physician-patient relationships (Blair, Steiner, & Havranek, 2011). An Israeli study also found that ethnicity significantly affected the patient's perception of the cultural competence of the physicians and their satisfaction with their medical care, possibly reflecting the cultural bias associated with historical conflict and recent migrant influx (Ohana & Mash, 2015). For residents who may be victims of cultural or ethnic bias, faculty should address these experiences in a sensitive, professional manner, and firm policies against discrimination should be reinforced. Engaging and involving residents in formulating these policies may also emphasise the importance of the issues of cultural and ethnic bias to healthcare leadership.

The concept of "difficult parents" emerged from many interviews. Healthcare staff believed that the "making" of a "difficult parent" stemmed from sociocultural upbringing, and some residents were also forthcoming in identifying certain patient groups whom they felt were more consistently "difficult". While the avoidant behaviour of residents is understandable due to fear and inexperience, faculty are indispensable in facilitating residents' uncovering the hidden meaning behind a child's illness, understanding the reciprocal nature of partnerships, and defining the physician's and parent's goals, roles and expectations (Sunde, Mabe, & Josephson, 1993), through provision of culturally competent communication, which involve (using the mnemonic 'LISTEN'): Listen, Interest, Sincerity, Trust, Empathy, and Neutrality (F. Stevens, personal communication, March 2, 2017). Through the intentional process of facilitated feedback, residents can also be more aware of their own unconscious biases and cultural assumptions. Although communication courses are rampant in medical education, these resource-consuming courses may often teach "desirable" behaviour rather than focus on relationship-building. Hence, integrating the 'LISTEN' mnemonic into facilitated on-the-job learning by faculty is likely to be more beneficial for residents longitudinally.

Additionally, there appears to be a role for parents as teachers, to educate residents about the importance of family-centred care for the young patients and their families (Blasco, Kohen, & Shapland, 1999). However, this requires caregivers to be comfortable with speaking about their experiences, as some may be shy or worried about opening up to their doctors. This can be integrated

into on-the-job training through asking caregivers and patients about what concerns them the most and giving them time to provide feedback about the team's care after the clinical encounter.

There is also a need to increase cultural sensitivity within the workplace, to improve inter-professional working relationships and enhance team interactions. Focusing on inter-professional teams, through implementation of the team management theory, can help counter exclusion, distrust and fear by creating bonds through working and interacting together (Schreiber, 1996). Ensuring that teams are diverse can encourage team members to learn from each other and breakdown sociocultural barriers. Although Pololi, Cooper and Carr's (2010) study mentioned about under-represented minority faculty members experiencing difficulties with cross-cultural interprofessional communication, this did not appear to be a concern in this study's findings. Buddy and mentorship systems, leadership training in cultural sensitivity and faculty development in providing and assessing cultural competent communication are possible interventions. These aspects were also emphasised in Pololi et al.'s (2010) study, with an additional mention of the danger of devaluing research in health disparities, which is a problem that conservative multicultural societies like Singapore may also face.

The last research question explores learning experiences, which often arise from residents' personal experiences and observations, but this learning is incomplete without adequate reflection and discussion as described in the experiential learning theory (Kolb et al., 2001). Physician self-reflection, self-knowledge, and self-critique have been identified as critical components of cultural competence (Tervalon & Murray-Garcia, 1998). Therefore, through challenging patient encounters and patient complaints, faculty have to encourage these processes for residents to develop deeper cultural awareness and sensitivity towards others. Some recommendations include complaint debriefing sessions and provision of culturally competent healthcare as a hospital key performance indicator. Leadership and role-modelling also serves as an important tool to facilitate residents' learning of culturally sensitive behaviours, based on the social learning theory, reinforcing the importance of faculty development in this area (Dauvrin & Lorant, 2015). Interestingly, in Park et al.'s (2005) study exploring residents' experiences in learning cross-cultural care, residents perceived that attendings were not consistently supportive or knowledgeable in cross-cultural care, hence role-modelling by faculty was not deemed to be particularly helpful in their learning. In this context, however, culture was interpreted largely as race and ethnicity, rather than other aspects of culture that

become more evident through interpersonal interactions which this study also explored. Mixed faculty and resident perceptions on the role of a structured cultural awareness and competency curricula are also present in studies done in Western contexts, with a unanimous agreement that cultural awareness training goes beyond courses, as on-the-job experiences are essential for impactful learning (Beagan, 2003; Park et al., 2006; Shepherd, 2018). Similarly, while the assessment of cultural awareness should be attempted, it has to be multifaceted and not dependent on conventional assessment methods such as Objective Structured Clinical Examinations (Dogra & Wass, 2006).

As the majority of studies involve homogeneous groups of Western-based health professionals interacting with non-Western patients (Horvat et al., 2014; Renzaho et al., 2013), this study's inclusion of heterogeneous, non-Western health professionals provides a broader perspective on cultural awareness. Furthermore, a paediatric study provides the additional caregiver viewpoint, which can be more holistic and sensitive compared to an adult patient's viewpoint as the focus is on the quality of another person's care and not oneself. The limitations of this study are a small sample size, given some homogeneity in the themes that emerged, and that only a single institution was studied, as institutional culture also has an impact on resident training and behaviour.

V. CONCLUSION

Resource-intensive cultural competency curricula may not always be feasible to be integrated into busy residency programs. Based on the broad issues developed in this study, there are small but significant evidence-based practical methods to integrate cultural awareness into the clinical context of postgraduate training, to ensure longitudinal reinforcement of the importance of cultural sensitivity.

Notes on Contributors

Cristelle Chow and Raveen Shahdarpuri are general paediatricians with an interest in clinical education. Fred Stevens is an Associate Professor with Maastricht University and his research includes medical education and culture.

Ethical Approval

This study was approved by the SingHealth Centralised Institutional Review Board with CIRB reference number 2016/2648.

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Declaration of Interest

The authors do not have any conflict of interest to declare.

References

- Beagan, B. L. (2003). Teaching social and cultural awareness to medical students: "It's all very nice to talk about it in theory, but ultimately it makes no difference". *Academic Medicine*, 78(6), 605-614.
- Betancourt, J. R., Green, A. R., & Carrillo, J. E. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches*. Retrieved from <https://www.commonwealthfund.org/publications/fund-reports/2002/oct/cultural-competence-health-care-emerging-frameworks-and>
- Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong II, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, 118(4), 293-302.
- Blair, I. V., Steiner, J. F., & Havranek, E. P. (2011). Unconscious (implicit) bias and health disparities: Where do we go from here? *The Permanente Journal*, 15(2), 71-78.
- Blasco, P. A., Kohen, H., & Shapland, C. (1999). Parents-as-teachers: Design and establishment of a training programme for paediatric residents. *Medical Education*, 33(9), 695-701.
- Britton, C. V., & American Academy of Pediatrics Committee on Pediatric Workforce. (2004). Ensuring culturally effective pediatric care: Implications for education and health policy. *Pediatrics*, 114(6), 1677-1685.
- Brotanek, J. M., Seeley, C. E., & Flores, G. (2008). The importance of cultural competency in general paediatrics. *Current Opinion in Pediatrics*, 20(6), 711-718.
- Carpio, B. A., & Majumdar, B. (1993). Experiential learning: An approach to transcultural education for nursing. *Journal of Transcultural Nursing*, 4(2), 4-11.
- Conrad, C., & Poole, M. S. (2012). *Strategic organizational communication: In a global economy* (7th ed.). Chichester, England: John Wiley and Sons Ltd.
- Culhane-Pera, K. A., Reif, C., Egli, E., Baker, N. J., & Kassekert, R. (1997). A curriculum for multicultural education in family medicine. *Family Medicine*, 29(10), 719-723.
- Dauvrin, M., & Lorant, V. (2015). Leadership and cultural competence of healthcare professionals. *Nursing Research*, 64(3), 200-210.
- Dogra, N., & Wass, V. (2006). Can we assess students' awareness of cultural diversity? A qualitative study of stakeholder's views. *Medical Education*, 40(7), 682-690.

- Frykman, J., & Gilje, N. (2003). Being there: An introduction. In J. Frykman & N. Gilje (Eds.), *Being there: New perspectives on phenomenology and the analysis of culture* (pp. 7-52). Lund, Sweden: Nordic Academic Press.
- Gornick, M. E. (2000). Disparities in Medicare services: Potential causes, plausible explanations, and recommendations. *Health Care Financing Review, 21*(4), 23-43.
- Gregg, J., & Saha, S. (2006). Losing culture on the way to competence: The use and misuse of culture in medical education. *Academic Medicine, 81*(6), 542-547.
- Horvat, L., Horey, D., Romios, P., & Kis-Rigo, J. (2014). Cultural competence education for health professionals. *Cochrane Database of Systematic Reviews, 2014*(5), CD009405. <https://doi.org/10.1002/14651858.CD009405.pub2>
- Javier, J. R., Hendriksz, T., Chamberlain, L. J., & Stuart, E. (2013). Cross-cultural training in pediatric residency: Every encounter is a cross-cultural encounter. *Academic Pediatrics, 13*(6), 495-498.
- Kolb, D. A., Boyatzis, R. E., & Mainemelis, C. (2001). Experiential learning theory: Previous research and new directions. In R. J. Sternberg & L. F. Zhang (Eds.), *Perspectives on thinking, learning, and cognitive styles* (pp. 227-247). New York, NY: Routledge.
- Kumagai, A. K., & Lyson, M. L. (2009). Beyond cultural competence: Critical consciousness, social justice and multicultural education. *Academic Medicine, 84*(6), 782-787.
- Kumas-Tan, Z., Beagan, B., Loppie, C., MacLeod, A., & Frank, B. (2007). Measures of cultural competence: Examining hidden assumptions. *Academic Medicine, 82*(6), 548-557.
- Lockhart, J. S., & Resick, L. K. (1997). Teaching cultural competence: The value of experiential learning and community resources. *Nurse Educator, 22*(3), 27-31.
- Macdonald, M. E., Carnevale, F. A., & Razack, S. (2007). Understanding what residents want and what residents need: The challenge of cultural training in pediatrics. *Medical Teacher, 29*(5), 444-451.
- Ohana, S., & Mash, R. (2015). Physician and patient perceptions of cultural competency and medical compliance. *Health Education Research, 30*(6), 923-934.
- Park, E. R., Betancourt, J. R., Kim, M. K., Maina, A. W., Blumenthal, D., & Weissman, J. S. (2005). Mixed messages: Residents' experiences learning cross-cultural care. *Academic Medicine, 80*(9), 874-880.
- Park, E. R., Betancourt, J. R., Miller, E., Nathan, M., MacDonald, E., Ananeh-Firempong II, O., & Stone, V. E. (2006). Internal medicine residents' perceptions of cross-cultural training: Barriers, needs, and educational recommendations. *Journal of General Internal Medicine, 21*(5), 476-480.
- Peckham, C. (2016, January 13). Medscape lifestyle report 2016: Bias and burnout. Retrieved from <https://www.medscape.com/slideshow/lifestyle-2016-overview-6007335>
- Pololi, L., Cooper, L. A., & Carr, P. (2010). Race, disadvantage and faculty experiences in academic medicine. *Journal of General Internal Medicine, 25*(12), 1363-1369.
- Renzaho, A. M., Romios, P., Crock, C., & Sønderlund, A. L. (2013). The effectiveness of cultural competence programs in ethnic minority patient-centered health care – A systematic review of the literature. *International Journal for Quality in Health Care, 25*(3), 261-269.
- Schreiber, E. J. (1996). Muddles and huddles: Facilitating a multicultural workforce through team management theory. *The Journal of Business Communication (1973), 33*(4), 459-473.
- Seeleman, C., Suurmond, J., & Stronks, K. (2009). Cultural competence: A conceptual framework for teaching and learning. *Medical Education, 43*(3), 229-237.
- Shepherd, S. M. (2018, January 22). Cultural awareness training for health professionals can have unintended consequences [BMJ Opinion Blog]. Retrieved from <https://blogs.bmj.com/bmj/2018/01/22/stephane-m-shepherd-cultural-awareness-training-for-health-professionals-can-have-unintended-consequences>
- Stevens, F., & Goulbourne, J. S. (2014). Medical education, cultural competence in. In W. C. Cockerham, R. Dingwall, & S. R. Quah (Eds.), *The Wiley Blackwell encyclopedia of health, illness, behavior and society* (1st ed., pp. 1355-1339). Chichester, England: Wiley and Sons.
- Sunde, E. R., Mabe, P. A., & Josephson, A. (1993). Difficult parents: From adversaries to partners. *Clinical Pediatrics, 32*(4), 213-219.
- Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117-125.
- Wassmer, E., Minnaar, G., Abdel Aal, N., Atkinson, M., Gupta, E., Yuen, S., & Rylance, G. (2004). How do paediatricians communicate with children and parents? *Acta Paediatrica, 93*(11), 1501-1506.

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