Cultural competence and communication: medical students' experiences during hospital observerships.

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Background

Cultural competency training in medical and public health curricula is limited. It is rare for students to learn about the importance of effective communication[1-3], or ways to remediate the effects of paternalistic linguistic schemas[1] that perpetuate stigma for vulnerable groups or sub-populations. Additionally, discriminatory attitudes or implicit biases against minority healthcare workers[4] by both peers and patients alike remain understudied.

Aims

The purpose of this analysis was to examine how doctor-patient encounters deteriorate due to lack of cultural competence, particularly as it manifests in communication ineffectiveness. Potential gaps in cultural competency training were identified for further research and applications to medical curricula.

Methods

The experiences of nine second-year medical students from one urban clinical learning site (Southside Learning Community, The University of Queensland) were collected through informal group-based interviews over three sessions. The participants were asked to provide examples of or reflect on complex communication situations that arose during their observerships in outpatient departments at a medium-sized public hospital in Brisbane over 16 weeks. Their experiences were analyzed using case-based and thematic techniques. A cultural competency framework was broadly applied to the cases to extract relevant themes.

Results

The participating medical students were conveniently sampled and were nationals of Australia, USA and Canada with an incidental mix of ethnic backgrounds. Four students were visible minorities (Black, Southasian). Two students had self-identified as having Asian-European backgrounds while one student had self-identified as Aboriginal. All had limited exposure to patients at their current level of training. A case-based and thematic analysis of their experiences using a cultural competence framework demonstrated the 'negative effects of linguistic barriers' (theme 1) and limited interpretative techniques on the quality of the therapeutic alliance as well as patient outcomes. In addition, 'inappropriate terminology' (theme 2) used by doctors for addressing undesired patient behaviour (e.g. non-compliance vs adherence) was regarded as stigmatizing or prejudicial. The 'bias against healthcare workers' (theme 3) was also noted as being disruptive for healthcare provision.

Conclusion

Cultural competence is a product of optimal communication strategies and evolving schemas that produce a stronger therapeutic alliance and an ethical healthcare ecosystem. Inappropriate language and communication techniques by physicians with ethnically diverse patients results in sub-optimal management, negative health outcomes or dissatisfaction. Cultural competence training for medical students and trainees in public health must go beyond a focus on language barriers. It must include a greater emphasis on understanding the implicit biases and stigmatizing attitudes integrated in medical language while also addressing cultural discrimination as it is encountered by both patients and providers.

References:

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