Preparing Future Physicians: A Reexamination of Communication and the Physician-Patient Relationship through the Lens of Culturally Sensitive Teaching and Learning Methodologies

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Abstract: Presently, we prepare future physicians to work with patients in a manner that makes distinctions between cross-cultural interactions and physician-patient communication in general. The authors argue that this distinction is an artificial one. Given that Biomedicine in and of itself can be considered a unique culture, all physician-patient interactions are cross–cultural by definition. To support this argument, the authors draw on the literature on culturally sensitive teaching and learning methodologies (CSTLM) in medical education to identify important elements of the culture of Biomedicine and underlying cultural assumptions out of which a physician's medical paradigm arises and through which the communication skills necessary for building effective physician-patient relationships are shaped. We use the CSTLM nomenclature to emphasize the active teaching and learning that occurs in the process of moving towards cultural competence. This re-examination of the CSTLM literature suggests a framework that delineates why an expanded view of physician communication as being cross-cultural is essential for building physician-patient relationships that are capable of meeting the health challenges of the 21st Century.

Keywords: Cultural competence, physician-patient communication, culture of biomedicine.

INTRODUCTION

Effective physician-patient communication is essential for improving patient health outcomes [1-5]. In medical education, the ability to communicate is recognized as a core skill and the medium through which medicine is practiced. It is estimated that 60-80% of diagnoses made are based on the history a physician elicits from a patient in the medical interview [6, 7]. Presently, we prepare future physicians to work with patients in a manner that makes distinctions between cross-cultural interactions and physician-patient communication in general. In this paper, we argue that this distinction is artificial. This argument is magnified in light of contemporary events that are impacting health and health care across the globe for example recognition of the need for a global movement for health equity [8]. Additional factors include 1) increasingly diverse national populations [9]; 2) persistent racial and ethnic health disparities [10-12]; 3) the growing number of people who are considered to be functionally illiterate [13] or limited English proficient [14]; and, 4) research linking doctor patient communication, including cross-cultural communication to patient satisfaction, adherence, and subsequently, health outcomes [15].

The idea that Biomedicine can be considered a unique culture has been noted in the literature repeatedly [16, 17]. Biomedicine is a system conveying strong authority which doctors are expected to obey [18]. It is also an institution of professional socialization of doctors that makes a life-long imprint on their identity [19]. These characteristics are compelling evidence that Biomedicine is a distinct culture into which medical students are ultimately inducted. In as much as Biomedicine is considered a distinct culture, it is our contention that all physician-patient interactions are cross-cultural by definition.

Given that all physician-patient interactions can be viewed in an expanded manner as cross-cultural, we believe that the time has come to integrate cultural competence, cross-cultural education, culturally sensitive teaching and learning methodologies (CSTLM) into the basic physician-patient communication curriculum rather than as an add-on or adjunct in medical education. To support our argument, we draw on the literature on CSTLM in medical education to identify important elements of the culture of Biomedicine and its underlying cultural assumptions out of which a physician's medical paradigm arises and through which communication skills necessary for building effective physician-patient relationships are shaped. We use the CSTLM nomenclature to emphasize the active teaching and learning that occurs in the process of moving towards cultural competence. Again, this focuses attention on the importance of learned communication skills. It is also important to define other terminology—such as culture, cultural competence, cultural sensitivity and communication—that is common to this literature and magnifies the idea that all physician-patient interactions are cross-cultural.

According to Geertz, "culture" is meaning encoded in symbolic forms (language, artifacts, etiquette, rituals, calendars, and so on) that must be understood through acts of interpretation [20,21]. Similarly, the U.S. Department of Health and Human Services [22] defines "culture" as the

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thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, and who should provide treatment. Anthropologist Janelle Taylor notes that recent approaches in anthropology provide a more dynamic perspective on "culture", viewing it as a process in which views and practices are dynamically affected by social transformations, social conflicts, power relationships, and migrations [23]. These definitions and perspectives on culture underscore a fundamental principle: in the physician-patient relationship, many of the noteworthy behaviors of both physicians and patients are determined by particularities of their cultural histories and experiences. Hence, in medical education, sensitivity to cultural issues is essential to the entire enterprise of knowledge generation and welfare promotion [24].

In addition to its cultural component, a common thread throughout definitions of the construct of cultural competence is communication. For example, Wachtler and Troein write that cultural competence can be understood as "those learned skills which help us to understand cultural differences and ease communication between people who have different ways of understanding health, sickness and the body "[25, p. 861]". Perloff and colleagues contend that movement towards cultural competence requires that providers must, at a minimum, avoid negative stereotypes about their patients (attitude), know something about the culture (s) of their patients (knowledge), and demonstrate skills in interacting with individuals from other backgrounds (behavior) [21]. Because cultural competence is often used interchangeably with cultural sensitivity, the definition of cultural sensitivity offered by Stewart *et al*. is instructive. Cultural sensitivity, they maintain, is the clinician's willingness to identify and incorporate into their care, patients' culturally based attitudes, values, and beliefs about their health and health care, expectations of the clinician's role, and preferred communication style [26].

Operational definitions of communication are more elusive. Stewart and colleagues offer an operational definition of communication that is embedded within a framework of interpersonal processes of care. In this framework, communication is distinguished from the other two dimensions that comprise the framework—decision-making and interpersonal style. They classify general clarity as a foundational element of communication along with elicitation of and responsiveness to patient concerns and expectations (the ability to learn from patients what is wrong), explanations and information (explanations about conditions, progress and prognosis; explanations about processes of care; explanations about self-care and empowerment (encouraging patients to assume personal responsibility for their health and imparting the idea that what patients do influences their health).

CULTURALLY SENSITIVE TEACHING AND LEARNING METHODOLOGIES AND PHYSICIAN-PATIENT COMMUNICATION: WHERE WE ARE AND WHERE WE NEED TO BE

Despite a proliferation of culturally sensitive teaching and learning methodologies in medical education in the last two decades, findings of a national survey of medical residents by Betancourt *et al*. revealed that few of them reported feeling unprepared in a general sense to care for patients who are racial and ethnic minorities and from diverse cultures. Yet, far more (one in five residents) felt unprepared to care for patients with specific cultural characteristics. The study's authors concluded that the gap between perceptions of preparedness in the general sense and preparedness for specific situations may itself be a marker of shortcomings in graduate medical education [27].

This conclusion suggests a need for re-examining the CSTLM literature, particularly, from the perspective that all physician-patient interactions are cross cultural. Such re-examination is necessary because this literature can provide valuable information on current instructional designs and approaches to cultural competence education that can be translated to physician-patient communication in general. It can shed light on key elements of the culture of Biomedicine and underlying assumptions that shape physician-patient communication. We can use markers of shortcomings in graduate medical education, such as those Betancourt and his colleagues identified, to draw attention to the value of and the need for greater emphasis on learned communication skills within the professional socialization of physicians. That is, the need to raise communication skills training to an equal level of importance, in the hierarchy of medical education, to basic science skills particularly in the first two years of training.

In medical education, cultural competence is frequently taught outside of the core curriculum. This is evident in the fact that most of the cultural competence literature is focused on curriculum content, development, implementation and evaluation and that only a limited number of specialties actually sponsor these courses. Current approaches to cultural competence education are described in one of two ways. In the first, authors describe these programs as they currently exist. An example of this type of description is that provided by Kripalani and colleagues [28]. They organize existing programs into two categories: (1) conceptual approaches (i.e. knowledge-based, attitude-based, and skill-based) and (2) pedagogies (the most common of which are classroom lectures, clinical clerkships, language training and immersion programs, small group discussions, role playing, faculty demonstrations, and videotaped feedback of real and standardized patients [4].

In the second type, authors suggest cultural competence programs as they ought to be. For instance, Rapp recommends the institutionalization of core curricula that provide for teaching of both fundamental concepts and more complex cultural themes [29]. To achieve this goal, he proposes a framework for cultural competency education that includes formalized instruction in basic principles of cultural diversity and clinical skill instruction *via* continued learning opportunities. Similarly, Betancourt and colleagues [14] advocate for a new framework for cultural competence that would include organizational, structural, and clinical interventions. The CSTLM literature shows that in teaching cultural competence as an adjunct, rather than an integral part of effective physician behavior and practice, medical education promotes cultural issues as a choice, not a requirement.

Cultural competence education is often provider-specific. In a literature review to identify educational programs for medical students on cultural diversity, in particular racial and ethnic diversity, Loudon *et al*. found that few specialties other than family medicine, community medicine, and psychiatry have reported sponsoring such courses for medical students [30]. Moreover, there is evidence to show that even when viewed from multiple curriculum perspectives, that is, intended curriculum (learning objectives), taught curriculum (teacher intention), and received curriculum (student experience), they were unable to clearly map physician-patient communication into the cultural competency curriculum [25] or perhaps more importantly, map cultural competence into physician-patient communication curricula. Given that clinical communication is a core skill in medical education as well as throughout the work life of physicians and Biomedicine is a culture itself, failure to integrate instruction in cross-cultural education and communication skills is another marker of the shortcomings of medical undergraduate education.

Biomedicine is underpinned by a Western medical paradigm in which two important assumptions are embedded. One is what is considered the necessary tension between the scientific and the personal dimensions of medicine, and the relative dominance of the former within the culture of medical school [31]. Dominance of the scientific dimension in medicine produces a particular kind of discourse, one that intimates 'distance', 'detachment', 'control', and 'neutrality' and assumes that the physician treats each patient objectively. Burgess, Fu, and van Ryn [32] demonstrate why medicine's claim of objectivity is impractical. In their paper, these authors outline and discuss implications of the robust evidence in social cognition research regarding provider unconscious bias despite dramatic endorsement of principles of racial equality. We provide two explanations for the discrepancy between clinicians' behavior and egalitarian attitudes, for their relevance to cultural competence education. First, according to Burgess, Fu and van Ryn, the evidence suggests that providers, when they are busy with other tasks, distracted, tired, or under pressure, tend to rely on cognitive schemata (i.e. the unconscious application of stereotypes) rather than conscious, effortful thoughts and feelings.

A recent study by Varkey *et al.* substantiates this claim. They surveyed clinic managers, physicians, and patients in order to explore the effect of workplace environment on health care disparities. They concluded that:

Adverse work environments may contribute to health care disparities by increasing the risk of provider biases and by stereotyping minority patients, especially in settings where medical complexity and clinical uncertainty compete with time pressure. Current efforts, such as provider-specific interventions to increase cultural competence and sensitivity, may not fully address these deeper systemic work environment issues [33, p. 248].

Research on provider bias demonstrates that physician behavior is fundamentally influenced by the clinical settings and the conditions under which physicians work. Given the adjunctive and provider-specific nature of cultural competence education, Varkey and colleagues make it clear that this approach may not fully address underlying systemic issues. The inability to address underlying systemic issues is one other marker of shortcomings of cultural competence education. The increasing complexity of medicine and the persistence of racial and ethnic disparities, which, according to Slavin are a manifestation of quality disparity that deserves our utmost attention [34], are two indicators that opportunities for provider bias will increase. This concept of provider bias, as well as health care system bias, is also prevalent in issues that relate to demographic differences between providers and patients such as gender, socioeconomic status and health literacy [35-37]. Again, the importance of integrating cultural competence education with general physician-patient communication skill curricula is evident.

The second explanation for the discrepancy between clinicians' behavior and egalitarian attitudes with implications for cultural competence education is summed up by Burgess, Fu and van Ryn. Simply put, we like and are more motivated to help people we think are like us [32]. This is exemplified in studies which show that physicians often underestimate the desire of minorities, poorly educated and lower socioeconomic status patients for information. The result is that the amount of information given to these patients may be inadequate [26]. This suggests that physicians, by categorizing particular kinds of patients and withholding information they need to make informed decisions about their care, may be inadvertently contributing to poorer health outcomes for these individuals.

The other assumption that is embedded in the Western medical paradigm is the centrality and importance of the physician-patient relationship. This relationship as a fundamental in medicine goes back to the beginning of medical practice. This relationship was exemplified by Sir William Osler, when he instructed: "Care more particularly for the individual patient than for the special features of disease" [38, p. 273]. This instruction on the physician-patient relationship is a window into how medical education can prepare physicians that are culturally responsive. On a micro level, there should not be a choice between a course on cultural competence and everything else necessary to be an effective physician. The CSTLM literature shows how this approach is failing to prepare physicians that can meet the health and healthcare challenges of the 21st Century.

On the macro level, there should not be a choice between scientifically and technically skilled physicians and physicians who are more humanist in their orientation and practice. In medical education, both technical skills and humanist skills are core dimensions of physician preparation. Failure in one dimension translates into delivery of poor health care and likely poor health outcomes. Osler's instruction on the physician-patient relationship is a reminder of the need for educating humanist physicians [39-42], and for shifting the emphasis from "instructing students on what they need to know and do to become skilled practitioners to [preparing them for] becoming skilled communicators and more humanistic practitioners" [43, P. 283].

CONCLUSION

We have presented evidence from the literature on culturally sensitive teaching and learning methodologies in medical education demonstrating that neglecting to integrate cross-cultural issues and communication into the core com-

munication curriculum results in failure on four basic levels. First, we are failing to prepare physicians who feel comfortable caring for patients with different specific cultural characteristics, as they relate not only to race and ethnicity, but also to the very nature of how medicine is practiced. Second, current efforts such as provider-specific interventions to increase cultural competence and sensitivity are not fully addressing deeper systemic clinical setting and communication issues. Third, provider bias remains a problem in the delivery of health care, despite the growing number of cultural competence programs. Finally, cultural competence education is having limited impact on physicians' learned communication skills in an environment that is cross-cultural by its very nature.

Because biomedicine is a unique culture in and of itself, all physician-patient interactions are cross-cultural by definition. Cultural competence is an integral part of becoming an effective physician, one who demonstrates competencies of a scientifically and technically skilled practitioner as well as competencies of a skilled communicator and more humanistic practitioner. In medical education technical skills and effective clinical communication skills, inclusive of cultural issues, are two sides of the same coin. Failure on any one dimension translates into delivery of poor health care. Both technical and humanistic skills are requisite to build the kind of physician-patient relationships necessary to meet the health challenges of the 21st Century.

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