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Cross-Cultural Care Training for Pediatric Hematology/Oncology Fellows

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Abstract

Introduction: Physicians are entrusted with the medical care of culturally and socially diverse patient populations. In addition, pediatric hematologists/oncologists are faced with the challenge of taking care of children with life-threatening and complex conditions. We implemented a cross-cultural care training curriculum for our pediatric hematology/oncology fellows with the goal of preparing them to handle complex clinical situations while navigating different social and cultural belief systems. **Methods:** The curriculum includes a precourse self-reflection; a learning module with a review of published literature; faculty-facilitated small-group role-play simulations; interactive sessions with language interpreters and physicians from different cultural, ethnic, and religious belief systems; and a postcourse reflection. **Results:** Fellows who participated in the curriculum strongly agreed that the module was helpful, indicating that it enhanced their communication skills, improved delivery of cross-cultural care, and had a sustained impact on their interaction with medical language interpreters. **Discussion:** Cross-cultural care training should be integrated into any pediatric hematology/oncology training curriculum. Sessions directed at addressing the perceived gaps between physician awareness and the patient's belief systems can increase awareness of personal biases in practice and improve interview techniques. Likewise, self-reflection can help physicians apply their medical knowledge and skills in the appropriate cultural and social context, thereby improving patient satisfaction, partnerships, and health care outcomes.

Keywords

Culturally Competent Care, Pediatric Hematology/Oncology, Health Care Disparities

Appendices

- A. Instructor Guide.docx
- B. Precourse Reflection.docx
- C. Learning Module.docx
- D. New Diagnosis - Case Scenario.docx
- E. Medication Noncompliance - Case Scenario.docx
- F. Limited Literacy Skills.docx
- G. End-of-Life Care - Case Scenario.docx
- H. Patient Communication Models.docx
- I. Course Feedback.docx
- J. Postcourse Reflection & Survey.docx

All appendices are peer reviewed as integral parts of the Original Publication.

Educational Objectives

By the end of this curriculum, learners will be able to:

1. Identify their own cultural beliefs and biases, as well as their potential impact on health care delivery.
2. Recognize the influence of language proficiency and health literacy on delivering optimal medical care.
3. Demonstrate an understanding of disparities in the diagnosis, treatment, and survival outcomes of children with hematologic and oncologic conditions.
4. Incorporate strategies to deliver culturally sensitive care in various clinical scenarios relevant to the field of pediatric hematology/oncology.

Introduction

Studies have shown that race and ethnicity disparities exist in both long-term health-related outcomes and survival outcomes of children diagnosed with cancer.^{1,2} Disparities in survival can be due to multiple factors. Economic factors such as the lack of medical insurance can result in poor access to health care and delays in treatment. Social and cultural factors, such as lack of education, as well as differing beliefs and attitudes towards medicine, can result in poor knowledge and noncompliance. In addition, both disease biology and genetic factors can affect treatment response and toxicity.²

Cultural differences among physicians and health care providers, coupled with diverse patient populations, can lead to poor communication with and poor understanding of individual beliefs about health and disease that affect patient care and outcomes. Cultural competency and sensitivity training among health care providers can reduce health care disparities and are important components of physician professionalism.³ Several groups and medical organizations have endorsed the need for educational awareness of cultural factors and issues in health care. Specifically, the Accreditation Council for Graduate Medical Education stresses the importance of cross-cultural understanding in the provision of health care and considers this a required element of competency during residency and fellowship training. In addition, the Liaison Committee on Medical Education requires that all students and faculty develop an understanding of the manner in which people of diverse cultural and belief systems perceive health and illness.⁴ The Institute of Medicine also recommends that medical schools integrate cross-cultural education into the training of all current and future health professionals.⁵

Studies have suggested that the participation of medical students in courses addressing cultural differences and awareness may both improve students' understanding of these differences and enhance cross-cultural communication skills.^{6,7} However, studies have shown that resident physicians' self-reported preparedness to deliver cross-cultural care lags behind preparedness in other clinical and technical areas. Although cross-cultural care is perceived to be important, there is little clinical time allotted during residency to address cultural issues, and little training in this area.⁸

Cultural competency, sensitivity, and awareness training are as essential as the clinical, procedural, and research training that residents and fellows receive. Providing pediatric hematology/oncology fellows with tools that help them get past their own biases and stereotypes increases their cultural awareness and promotes the application of clinical knowledge in the context of each individual patient and his/her needs and beliefs.

The American Academy of Pediatrics recognizes health care communication as a critical, but generally neglected, component of pediatric and pediatric subspecialty practice and training.⁹ Often, role-playing and informal feedback are used methods for health care communication skill building. Formal curricula in training programs are generally lacking.

We implemented a cross-cultural care training curriculum for our pediatric hematology/oncology fellows with the goal of preparing them to handle complex clinical situations while navigating through different social and cultural belief systems. There exists published curricula and programs focusing on communication skill building, delivery of bad news, dealing with difficult patients, and end-of-life care for pediatric oncology trainees.¹⁰⁻¹² However, there are very few published curricula for cross-cultural care training for medical students and residents.¹³⁻¹⁴ Likewise, there are no MedEdPORTAL publications focused on cross-cultural care training specifically for pediatric hematology/oncology trainees.

Our curriculum is also distinct from other curricula since it follows the framework of the experiential learning model. Throughout the course of the curriculum, trainees are able to build knowledge and awareness through reading, didactics, and tests (e.g., abstract conceptualizations). They undergo active experimentation through role-playing and practice skills in a safe, small-group setting with formal feedback. They also observe and participate in various simulated case scenarios that cover different aspects of pediatric hematology/oncology care such as determining a new diagnosis, treatment decision making, active treatment issues, and end-of-life care. Additionally, they self-assess through a narrative reflection process that occurs both before the course and at two points after (1 and 3 months, respectively). These two postcourse reflections allow students the chance to contemplate how they are integrating what they learned with active clinical experiences. The repetitiveness of the course, the utilization of different case scenarios crafted to reflect the 3 years of the training, and the longitudinal learning from precourse self-reflection to postcourse self-reflection further consolidate the students' experiences and help them grow over time.

Methods

Educators should consult the instructor's guide (Appendix A) for in-depth implementation advice. The pediatric hematology/oncology fellows should complete a precourse self-reflection (Appendix B) 1 month prior to the simulation-based learning activity.

Learning Module

For the learning module (Appendix C), the current literature on cross-cultural care in pediatric hematology/oncology has been reviewed and a comprehensive repository of articles and large clinical studies^{2,15-22} has been added to our learning management system, along with a test utilizing multiple-choice questions. Also, the census data on race/ethnicity for our county have been made available so fellows can get an awareness of the population we serve. This module is meant to create awareness among pediatric hematology/oncology fellows regarding (1) ethnic and racial differences in disease biology with several hematological and oncological disorders (e.g., glucose-6-phosphate dehydrogenase deficiency, hemoglobinopathies), (2) disease outcome differences due to various factors related to race, ethnicity, health beliefs (e.g., drug metabolism, knowledge, beliefs in alternative forms of treatment), and (3) barriers to differences in disease outcomes (e.g., noncompliance, health insurance and access to medical care, etc.).

This module is meant not only to create awareness but to promote self-directed learning and discovery. The articles and multiple-choice questions are available to the fellows for a month prior to the half-day workshop so they can review and answer the questions at their own pace. This online learning module is also made available for the pediatric hematology/oncology faculty as a means of promoting faculty development. If an educator does not have access to a learning management system, he/she can provide a list of articles to fellows and then administer a paper quiz based on the content in Appendix C sometime before the workshop.

Half-Day Workshop

The half-day workshop consists of interactive didactics and a simulation-based learning experience. An overview of the workshop is provided in Appendix A. The interactive didactics include a discussion with a language interpreter to help enhance skills in working effectively with interpreters. There is also a discussion with two physicians from different cultural, ethnic, and/or religious belief systems to create awareness and break biases and assumptions while developing skills and strategies that enhance cross-cultural patient care. In our case, we used one Hispanic and one Arab physician.

The simulation-based learning session should be facilitated by three faculty members. The sessions are small-group role-play simulations using standardized patients (SPs) of different cultural, social, and educational backgrounds. The sessions are recorded on video. Each fellow participates in one to two role-play exercises at 15 to 20 minutes each. The simulation scenarios cover a new cancer diagnosis in a Hispanic family with a language barrier (Appendix D), medication noncompliance in an African-American family with sickle cell disease (Appendix E), limited literacy skills with a parent who cannot read or write (Appendix F), and end-of-life care featuring a Middle-Eastern family of Islamic faith (Appendix G). The video-recorded sessions are followed by student self-reflection and debriefing with the facilitators, peers, and the SP. Faculty also discuss the use of patient communication models, such as LEARN (Listen, Explain, Acknowledge, Recommend, and Negotiate)²³ and RESPECT (Rapport, Empathy, Support, Partnership, Explanations, Cultural competency, and Trust),²⁴ as interview techniques (Appendix H).

The SP encounters are followed by small-group discussions facilitated by faculty and with participation of the SPs and peers. The fellows then provide course feedback (Appendix I). At 1 month and 3 months following the activity, fellows complete self-reflection surveys by providing responses to both open-ended questions and Likert-type items (Appendix J).

Results

Like many programs across the country, our pediatric hematology/oncology program is small, with one fellow per training year. This curriculum was well received by the two pediatric hematology/oncology fellows (in their second and third year of training, respectively) who took part in the curriculum.

The precourse reflection included questions regarding their perceptions of cross-cultural care and perceived barriers to providing culturally sensitive care (such as patient-related, physician-related, and health care systems–related barriers). The course feedback survey (Appendix I) included question about their perception of the course, using a Likert-scale response layout. The trainees agreed/strongly agreed that the curriculum, the self-reflection, the course materials, and the small-group simulation-based learning session components were helpful. The simulation-based learning session was rated as outstanding overall.

One month and 3 months after the simulation-based learning session, trainees were requested to complete a postcourse self-reflection survey (Appendix J) to determine if there was a sustained impact on their learning. The postcourse reflection indicated that the trainees learned valuable skills, such as interview techniques, working with interpreters, and increased cultural awareness, which they continued to apply in daily clinical practice.

The postcourse reflection had a twofold purpose. The first purpose was to determine if the trainees felt the training sessions had both enhanced their communication skills and impacted their delivery of cross-cultural care and work with interpreters. The trainees agreed/strongly agreed to the above at both 1 and 3 months postcourse.

The second purpose was to see if the training translated to clinical practice by improving the trainee's confidence when working with patients from different ethnic, racial, and cultural backgrounds. It also sought to measure their confidence when working with patients and families with limited or no English proficiency. The trainees felt confident/very confident at both 1- and 3-month intervals postcourse.

In response to the question regarding whether the cross-cultural simulation experience provided the trainees with additional tools to help them in clinical practice, one expressed that the following had been retained at the 1-month interval:

1. "Shared burden for disclosure of facts to patients—this was an invigorating discussion and very applicable to a few cases we have had in the past. I feel I will have a more inclusive and respectful approach towards a few families that may present the request of screening the information that we share with our patients and shielding them."
2. "Inclusion of interpreters in important discussions as team members to enhance communication."
3. "Learning a little about the culture's background before having particular conversations—like end of life customs. This is something I had not really thought about—but should in fact be an essential thing we should try to do in the end-of-life care scenarios."

At the 3 month interval from the course, the same trainee responded that

In situations where I used to feel more reluctant in discussing aspects of care that may not be welcomed by the patient/family, I have felt more confident as I know that I have taken the effort to explore about their hesitation and am more respectful of their culture. I am now working on increasing my efforts towards having families share their values and preferences in the decision making process.

Additional feedback included the following:

During Ramadan this year, I could take into consideration what they would anticipate as a family on the off-treatment days and helped the patient/family see our side of things and then agree on the best course of action. Also, in one situation where the patient and family

had seemed to misunderstand our plans towards timing of treatment completion, I felt better about having included the interpreters and identifying the reason for misunderstanding and the clarification.

The responses at the 1- and 3-month intervals demonstrate the effectiveness of the course. These responses also indicate the course's sustained impact even months after completion of the curriculum.

Discussion

The design and development of this cross-cultural curriculum for our pediatric hematology/oncology fellowship program were a learning experience for the faculty who developed and implemented it. We are a small fellowship program similar to many other pediatric hematology/oncology programs in the country with only one trainee per year. We are also a small team of faculty members from diverse backgrounds. Diversity is not exclusive to patients and families, and the treating physicians' own personal beliefs, unconscious biases, assumptions, and stereotyping can also significantly impact communication and care.

While it is a well-appreciated fact that physicians are constantly involved in communication with and care of very diverse populations where each patient has unique needs based on his/her cultural, racial, and ethnic backgrounds, training is typically focused only on clinical needs. Moreover, most of the training in cross-cultural care occurs early in medical school, with only some emphasis in residency. As physicians transition into fellowship and into the workplace, the focus is primarily on clinical care and research, with most of the cross-cultural care and communication training limited to faculty role-modeling, observation, informal teaching, and self-reflection.

Being a small program, we did not have a formal curriculum geared to meet the cross-cultural and communicative needs of a pediatric hematology or oncology patient prior to the implementation of this course. Though every field of medicine has some similarities with other fields, there are many areas that are unique to specific patient populations. Training obtained in medical school and residency can provide physicians with the necessary basic skills. However, these often require further continuous improvement and development to suit the specific needs of the patients that one sees in the daily practice of a particular specialty. In hematology and oncology, examples of such specific needs may include how to discuss enrolling a patient in a clinical trial when the patient has limited language proficiency or how to take cultural beliefs into consideration while discussing end-of-life and hospice care.

The primary goal of this curriculum is to improve the skills of both faculty and trainees in becoming skilled listeners who can learn to uncover their own unconscious biases and be open, supportive, and sensitive to the patient's core belief systems and background while building a trusting patient-physician partnership. A partnership built on trust and shared medical decision-making not only allows health care providers to deliver the best medical care, but also empowers the patients and their families, helping them engage more as they go through complex and life-threatening medical conditions and treatments. We wanted to build a structured curriculum encompassing all this and that would be easy to implement at the same time. The course was also built so we could learn what the trainees' perceived gaps in their own cross-cultural training were, which could help us further improve the course over time.

The precourse reflection gave the trainees an opportunity to think about their perception of cross-cultural care and consider any perceived barriers to providing culturally sensitive care, be they patient-related, physician-related, or health care system-related. As one of the trainees eloquently stated,

My perceptions of cross-cultural care are that I/we have a responsibility to educate ourselves to the point of understanding about the perspective of our patients, to try and know how they see the world, their health, medical care and their future. Ask questions and don't assume. But at the same time treat patients and families the same, children are children—they are innocent, intelligent, scared, and resilient. Parents are advocates for their children and want the best for them, but they too are scared.

The perceived barriers and struggles were the same for faculty as well. Their self-reflections further emphasized what we were already aware of as faculty, while also helping us identify additional areas to focus on as we continue to build the repository of learning materials to increase awareness, arrange didactics, and generate case scenarios. For example, some of the physician-centered barriers identified during self-reflections included lack of exposure or knowledge about different cultures; fear of offending if unfamiliar with patient and family core values/beliefs; frustrations with difficulties regarding communication and understanding; cultural differences with gender, age, social classes/groups; and personal unconscious biases. Health care system–related barriers identified included lack of interpreters or timely access to interpreters/language services, patient education materials not translated into different languages, medication prescriptions in English and not in native languages, health insurance or financial barriers for health care, and lack of food sources used by specific cultural and ethnic groups.

The didactics and simulation-based learning session brought together providers from different backgrounds and, when coupled with the SPs, opened up many learning opportunities for the trainees. These activities further highlighted how unique every individual is, even if from within the same cultural and/or social background. This experience also showed how cultural awareness, an open mind free of biases or assumptions, and relationships based on an understanding/acknowledgment of both similarities and differences can impact medical care.

The fellows and faculty felt the curriculum created an increased awareness of both known and unknown communication gaps when delivering cross-cultural care. In addition, the responses from the trainees at the 1-month and 3-month intervals from the course reflect the increased levels of confidence, awareness, and respect for the cultures, beliefs, and value systems of others. Further, the responses are indicative of the overall effectiveness of the curriculum and its sustained impact even months after completion. Future plans include adding more case scenarios so that each fellow can be exposed to variety of clinically relevant situations during their course of 3 years of training.

We do believe the curriculum can be implemented in larger programs with some modifications. The simulation-based learning session may need to be carried out differently based on the size of the program. A small-group session, limited to four to five participants, creates a nonthreatening and safe environment where even otherwise quiet trainees can express themselves. A suggested faculty-to-fellow ratio would be at least one faculty for every three to four fellows per simulation-based learning session group. In programs with a larger number of trainees, sessions can either be conducted as multiple half-day workshops or as a single half-day workshop with the group breaking out into multiple small groups of up to four learners per faculty for the simulation-based learning session. The rest of the curriculum can be carried out as outlined, without modifications other than those based on preference of faculty and perceived local needs. The learning module with articles and multiple-choice questions can be modified and updated as new literature becomes available.

Through the process of curriculum development and implementation, we also learned the importance of identifying champions within the division or outside of the team. One such champion is the office of diversity within the institution, as this office can be a useful resource if questions arise. Open-mindedness and self-reflection are fundamental for faculty as well since these sessions can bring out biases and beliefs that even the most culturally sensitive facilitator is not aware of. Since the module can serve as a faculty development tool, reaching out to all pediatric hematology/oncology faculty in the division and having as many of them as possible participate and rotate through sessions as facilitators is a consideration as well.

Since we are a small program, it will take many years before a large number of fellows complete pre- and postcourse surveys and we can gather data to analyze the impact of the course on their training. We will continue to conduct pre- and postcourse reflections and surveys over the coming years for future analyses. In addition, since we believe cross-cultural training should be part of any pediatric hematology/oncology fellowship training, a national cross-sectional needs assessment survey of all pediatric hematology/oncology fellowship programs directors and trainees has been completed, and the

data are currently being analyzed. We hope the results will shed some light on the current gaps in training, structure of training programs, and current methods of teaching cross-cultural care and comfort levels of trainees in treating culturally diverse populations.

We firmly believe an educational curriculum such as this is extremely essential and will help improve cultural awareness and increase physician self-reflection. Not only does this curriculum enhance physician and patient communication, it also helps physicians connect better among themselves as well and ultimately improves medical care through better understanding of our differences as culturally diverse individuals.

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Disclosures

None to report.

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Ethical Approval

Reported as not applicable

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