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“I'm worried about what I missed”: GP Registrars' Views on Learning Needs to Deliver Effective Healthcare to Ethnically and Culturally Diverse Patient Populations

H-O Pieper, A MacFarlane

*Discipline of General Practice, School of Medicine, National University of Ireland
Galway, Ireland*

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Pieper H-O, MacFarlane A

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A B S T R A C T

Introduction: It is widely accepted that medical undergraduate and postgraduate education should address issues related to human diversity. Despite the growth of guidelines and training resources, little is known about primary healthcare professionals' perceptions about their work with patients from diverse communities.

Objective: This research explored GP Registrars' views of their learning needs in relation to delivering effective healthcare to ethnically and culturally diverse patient populations.

Methods: The study was based on a naturalistic inquiry design, involving qualitative methods. Current GP Registrars of the postgraduate GP Western Training Programme, Galway, Ireland, were invited to participate in focus groups. Three different focus groups were conducted with a total of 31 GP Registrar participants. A thematic analysis following the principles of framework analysis was applied.

Results: GP Registrars reported considerable professional uncertainty and occupational stress when consulting with patients from diverse communities. They perceived their training in relation to healthcare for patients from diverse backgrounds as inadequate



and desired more training. They identified concrete learning needs, which were mainly related to factual knowledge, with less emphasis on communication skills and attitude awareness.

Conclusions: Educators should take GP Registrars' views into account in the development of diversity training in medical education. GP Registrars' attention to specific knowledge related to human diversity may, nonetheless, be too narrow. This training should also encourage acknowledgment of the doctor's professional uncertainty, awareness of the doctor's own attitudes, and development of generic skills such as a patient-centred approach to best meet the needs of diverse population groups.

Keywords: Cultural competence, cultural diversity, family practice, Medical education, needs assessment, qualitative research

Introduction

Globalization and movement of people from their countries of birth are occurring more rapidly than ever. Therefore, interest in cross-cultural issues in health, disease and medical care has increased immensely in recent years^{1,2}. Professional associations in the United States and Europe, including the United Kingdom and Ireland, emphasise that medical education should address issues related to human diversity, including the need to prepare doctors to work with patients from different cultural backgrounds³⁻⁶.

Regardless of general acceptance that cultural and social factors have a crucial role in healthcare, medical schools have been slow to change their undergraduate curricula to incorporate cultural diversity teaching⁷⁻⁹. For example, a recent survey found that 72% of medical schools in the United Kingdom and Ireland reported some teaching in cultural diversity, but found, overall, that teaching is fragmented and that there is uncertainty as to what actually constitutes 'cultural diversity' teaching¹⁰.

There is a growth in the availability of guidelines and training resources related to diversity training^{3,8,11-16}. Some educators have also stressed the importance of acknowledgement of professional uncertainty and disempowerment when dealing with cultural diversity, and suggest a shift away from a cultural expertise model toward a greater focus on patient-centred care^{17,18}. However, there is a lack of evidence about how primary healthcare professionals perceive their work with patients from diverse communities^{17,19-21}. Research, to-date, has predominantly focused on the views of medical students and residents^{18,22-29}. To our knowledge, there is only one study exploring GP Registrars' perceptions in relation to training about cultural and ethnic diversity in healthcare.

In the United Kingdom and Ireland the term GP Registrar is used to describe postgraduate doctors who are enrolled in their vocational GP training scheme, entailing training initially in hospital and later in the community. Kai et al²⁸. explored the views of 46 undergraduate medical students and 9 GP Registrars. They found that current teaching was perceived to be inadequate and most participants felt the need for more training. The authors recommended that medical educators pay attention to learners' views about how they should be taught successfully, and encouraged further research with learners in other settings. There are few studies internationally that explore doctors' perceptions of their work with culturally diverse communities, and there are no such studies in an Irish context. The present study addressed this gap in knowledge.

We explored current GP Registrars' views on their learning needs in relation to delivering effective healthcare to ethnically and culturally diverse patient populations. Specific objectives were to: document the experiences of GP Registrars; identify their specific learning needs; examine the extent to which these needs are met or not met in postgraduate training; and explore potential developments in postgraduate training to better inform the development of national education activities.



Traditionally, Ireland has been a country with high emigration. In the context of economic growth, this has reversed dramatically in the past two decades. Currently, one out of ten persons living in Ireland comes from a non-Irish background³⁰. From the mid 1990s to early 2000s, immigration was mainly driven by returning Irish nationals. Between 2002 and 2004, the numbers of non-European Union nationals and asylum seekers applications peaked. From 2004 to 2008, new highs of immigration were reached, driven by nationals of the enlarged European Union³¹. The Census 2006 identified the following top ten non-Irish nationals in Ireland: United Kingdom, Poland, Lithuania, Nigeria, Latvia, United States, China, Germany, Philippines and France. The non-Irish nationals were dominated by people in their twenties and thirties, with significantly more men than women. Although a high proportion of non-Irish nationals were married this was not reflected in their household composition where non-family households predominated. The non-Irish tended to belong to the lower social classes and their labour force participation rate was higher compared with the Irish, with fewer students, homemakers or retirees³⁰.

In terms of migrants' health needs and medical problems in Ireland, there has been focused research on the asylum seeking community. An asylum seeker obtains asylum if he/she meets the United Nation's definition of a refugee: someone who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of their nationality, and is unable to or, owing to such fear, is unwilling to avail him/herself of the protection of that country'³². Asylum seekers are a group with complex health and social care needs which are influenced by a myriad of factors including the experiences that led to their need for asylum (e.g. persecution and violence), the experience of being an asylum seeker in an unfamiliar country (e.g. language barriers, lack of knowledge of available services and supports, hostile responses from host communities) and the challenges inherent in that process of seeking asylum in their host country (e.g. long delays in the application process)^{33,34}. In Ireland, it was found that asylum seekers are frequent attenders of general practice, with high rates of diagnoses for psychological and psychiatric conditions³⁵.

Methods

Design: This study used a naturalistic inquiry design to attempt to better understand, describe and explain phenomena of interest³⁶. Similar approaches have been used in previous studies exploring learning needs in medical education in the area of human diversity^{18,24,27-29}. Ethical approval for the study was obtained from the Research Ethics Committee of the National University of Ireland, Galway.

Sampling and recruitment: Study participants were GP Registrars in the postgraduate Western Training Programme in General Practice, Galway - a four-year programme with 10 to 15 GP Registrars each year. Following the principles of purposeful sampling, current GP Registrars were invited to participate in the study, using combined email and face-to-face contact³⁷. All GP Registrars in years 1, 3 and 4 were invited to participate because they had scheduled classes in Galway at the time of data collection (March to July 2009), and therefore would be most available for the study. In contrast, GP Registrars in year 2 did not have scheduled classes at the time of data collection; therefore, only the Galway-based GP Registrars were invited for participation.

Data collection: Our study focus groups were homogenous, i.e. divided by year in training³⁸. The groups were conducted in seminar rooms of the Western Training Programme in General Practice, following tutorials, and lasted 30 to 60 minutes. Focus groups were facilitated by one of the study investigators, H.O. Pieper, a general practitioner, using a topic guide which had been developed based on study objectives, and consisted of open-ended questions.



One of the methods of needs assessment used in focus group discussion was to encourage 'reflection on action'^{39,40}. This involved asking participants to think back on relevant performances, identifying what was done well and what could have been done better. The latter was intended to provide an indication of the learning needs in this type of consultation. GP Registrars had had previously guidance on reflection on action during their training. The focus group interviews were audio-recorded with participants' consent, using a portable digital recorder device from which comments were later transcribed for analysis. Focus groups were conducted in the order year 4, 3, 1, with no changes of the topic guide because it was clear that it was eliciting data relevant to our aims and objectives.

Data analysis: We used thematic analysis, following the principles of framework analysis. This involved the four key stages of: (i) familiarisation; (ii) developing a thematic framework; (iii) indexing the material and charting and; (iv) mapping and interpretation to inform the key objectives of the research⁴¹. 'NVivo' software was used to facilitate this procedure. Following the principles of naturalistic inquiry, the primary focus of this study was not generalisability or external validity of study findings, but credibility and trustworthiness. Several methods were applied to enhance the accuracy or truth value of the interpretation³⁶, including:

- *Reflexivity:* This refers to the awareness and acknowledgement of the role of the researcher in the construction of knowledge⁴². In this research, one investigator is a general practitioner with a special interest in healthcare to serve ethnically and culturally diverse patient populations. He considered his own biases and personal perspectives by discussing and debating the research and its analysis in particular with the second investigator, a medical sociologist. Such interdisciplinary working is known to enhance reflexivity in qualitative health research projects⁴³.
- *Member checking:* This involves soliciting participants' views of the credibility of the findings and interpretations⁴⁴. In this research, the first investigator checked assumptions/interpretations of data with a subsample of informants. This was done verbally during focus groups and afterwards by e-mail. A subsample of participants agreed and provided feedback that they were satisfied with the findings and interpretations.
- *Peer debriefing:* This provides an external check of the research process by someone who acts as a 'devil's advocate' questioning methods, meanings and interpretations. The first investigator completed this work as part of a Masters in Health Sciences/Clinical Teaching, and the course director provided an external critique of the work around the research question and choice of methods.

Results

Responses from years 1, 3 and 4 were very good in contrast to year 2. Despite repeated efforts to contact and accommodate this group, there were no participants from year 2 in the study. Year 2 was the last group to be contacted, when it was the end of term without scheduled classes, which is likely to account for the lack of response. Three focus groups were conducted with a total of 31 GP Registrars from the 1st, 3rd and 4th year of the Western Training Programme (Table 1). All participants were Irish nationals and had completed their undergraduate training in medical schools in Ireland. There were 21 female and 10 male participants, reflecting the gender proportions in these years.

Table 1: Profile of GP Registrar participants by year and gender

GP Registrars	Year 1	Year 2	Year 3	Year 4	Total
Invited/ In training programme	15/15	6/15	10/10	10/10	41/50
Participants/ female; male	14/12;2	0/0;0	10/6;4	7/3;4	31/21;10



A thematic category system composed of four main themes was developed. Table 2 summarizes these themes and their sub-themes. Sub-themes are listed in ranked order of the perceived strength with which they were discussed in the focus groups. Following is an in-depth presentation of results by each of the thematic categories.

Table 2: Thematic category system emerging from focus group discussions

Theme	Sub-themes
1. Professional uncertainty	<ul style="list-style-type: none"> • Communication • Patient expectations and organizational issues • Clinical issues • Cultural and socioeconomic issues
2. Occupational stress	<ul style="list-style-type: none"> • Lack of confidence • Negative emotions (concern, anger, frustration, resentment, helplessness) • Positive emotions (reward, joy)
3. Perceptions of current training	<ul style="list-style-type: none"> • Training related to healthcare for patients from ethnically and culturally diverse backgrounds inadequate • Postgraduate communication skills and attitude awareness training beneficial
4. Desired training	<p><i>Perceived learning needs</i></p> <p><i>Knowledge</i></p> <ul style="list-style-type: none"> • Communication • Patterns of health and disease • Organizational issues • Cultural issues • Patient expectations • Ethnic diversity in social context <p><i>Skills</i></p> <ul style="list-style-type: none"> • Communication <p><i>Attitudes</i></p> <ul style="list-style-type: none"> • Awareness of one's own prejudices <p><i>Desired processes</i></p> <ul style="list-style-type: none"> • Teaching methods (lectures, videotaped consultation, role plays, involvement of community representatives) • Learning by doing (experience in General Practice) <p><i>Perceived problems with training</i></p> <ul style="list-style-type: none"> • Difficult area to teach • Danger of stereotyping

Professional uncertainty: Most participants had experiences of consulting with patients from ethnically and culturally diverse backgrounds, such as encounters with patients from Eastern Europe (particularly Poland), from the Far East such as the Philippines, from Brazil and from African countries such as Nigeria and Somalia. Some had worked with asylum seekers. While some participants talked positively about working with patients from different backgrounds, most participants discussed negative issues and described a plethora of challenges experienced by them when consulting. They were not always sure how to address these challenges, contributing to professional uncertainty.



A common issue in all focus groups was the issue of **communication**. Participants described that language was a barrier in many consultations with patients from diverse ethnic and cultural backgrounds. Many acknowledged that they had used informal interpreters such as family members and friends. They also revealed that they had been unaware of how to arrange for more 'appropriate' solutions, such as the use of a paid interpreter from a commercial agency, or that they thought these types of options were unfeasible. One participant said:

I had a case recently where I ended up having to do literally a gynaecological examination including high vaginal swabs and the whole lot on a female patient on the couch with the curtain pulled with a friend of hers who was male at the far side of the curtain translating ..., which was completely inappropriate. (Participant 6; Year 4)

The use of communication aids such as online dictionaries was mentioned. Some felt that information would be lost in translation with any form of interpreting, and that patients would receive substandard care as a result of this.

Another common topic was the struggle of dealing with **patient expectations and organizational issues**. Participants thought that patients from other countries were often disappointed with Irish healthcare in comparison to the healthcare systems in their home countries. For example, some participants had been told by their patients that there was faster access to specialist care in a lot of Eastern European countries. This sometimes caused tensions in their consultations, and participants complained that they lacked knowledge about these healthcare structures and practices in other countries. At the same time, they wished that migrant patients had better knowledge about structures and practices in Ireland. Participants were also critical about their own unfamiliarity with entitlements of migrants and asylum seekers.

Many participants stressed the complexity of **clinical issues**, such as treating patients who they felt were also receiving medication from their home countries, from other doctors or from relatives, resulting in possible interactions with medication prescribed in Ireland. They also pointed out how difficult it was to consult with patients who did not seem to be used to the concept of preventive care. Further, some participants were uncertain how to care for survivors of torture.

Cultural and socioeconomic issues were also identified as concerns. Participants had experienced patient encounters in which different health beliefs, gender and religious issues had emerged. Examples were given of a denied handshake by a Muslim female patient from Somalia, which the consulting male participant had perceived as rude, and of a female patient from the Philippines believing in bad spirits, which only emerged after repeated consultations with a female participant. Participants acknowledged their uncertainty around these issues. They also emphasised the difficulty of providing good care to socially-deprived people with few entitlements, such as migrant workers without free access to medical care and asylum seekers.

Occupational stress: The general consensus was that the challenges described often turned consultations with patients from culturally and ethnically diverse backgrounds into stressful encounters. Participants described a **lack of confidence** in the care they were providing. They were particularly concerned that they would miss something and that they might provide patients with substandard care compared to the good care they felt they provided patients native to Ireland. As a result, participants described a range of **negative emotions** towards cross-cultural consultations. These included feelings of concern, anger, frustration, resentment and helplessness. Nonetheless some participants also emphasised more **positive emotions** stating that their work with patients from ethnically and culturally diverse backgrounds had been very rewarding, such as a participant who enjoyed the challenge of working with patients from the Brazilian community. One participant said:



'I think part of the frustration though sometimes is that you feel like you are not giving them as good a service as you'd like to. Where you can get a bit of that heart sinking feeling at the start because you know when they come in you are not going to be able to communicate as effectively as you would with someone who has English as their first language and they're not going to get the service that you would like to give them because of that.' (Participant 4; Year 3)

Perceptions of current training: The majority of participants reported that their **training related to healthcare for patients from ethnically and culturally diverse backgrounds** had been **inadequate**, and they desired more of it. One said:

I'd like more [teaching], definitely I don't think there's adequate and I didn't like the concept of first learning about dealing with people from different cultural backgrounds when I was trying to be a doctor...I'm worried about what I missed....' (Participant 2; Year 3)

The most relevant training in the curriculum had been their **postgraduate communication skills and attitude awareness training**, which they had found **beneficial**. Apart from this, they perceived their current training about cultural diversity to be sporadic. In their view, the main learning had taken place outside the taught curriculum, by encounters with fellow students or in practice with patients from ethnically and culturally diverse backgrounds.

Desired training: The majority of participants identified concrete learning needs to care for patients from ethnically and culturally diverse backgrounds, and desired more training to address these. Particularly stressed was the importance of being taught specific *knowledge* in the areas of **communication, patterns of health and disease, organizational issues, nature of culture, patient expectations and ethnicity in the social context**. For example, in terms of communication, the emphasis was on gaining knowledge about how to access interpreting services. In terms of patterns of health and disease, the emphasis was on gaining knowledge about patterns of infectious diseases in the home countries of their patients.

Apart from valuing the *skills* training in **communication** which they had received, some participants also expressed their preparedness to develop bilingual or multilingual language skills by learning languages of key migrant groups such as Polish or French. Then again, the limitations of this approach were acknowledged, and some participants felt that the immigrant population should also make an effort to learn English. Finally, in terms of *attitude* awareness, a few participants thought it was important to receive teaching in this area. They acknowledged the impact which **awareness of one's own prejudices** can have on interaction with patients.

Participants also reflected on a number of **teaching methods** they thought would be useful. These included lectures, role plays and videotaped consultations. Some participants regarded ethnic community representatives in teaching sessions as helpful to improve understanding of the social context, such as asylum seekers describing their lives in the Direct Provision Accommodation. Direct provision is the term used to describe a specific accommodation policy for asylum seekers whereby they are accommodated in full-board accommodation centres run in an institutional style rather than private or self-catering accommodation. In Ireland, typically, accommodation centres are old hotels or hostels. Residents receive €19.10 per adult per week, and €9.60 per child. They often live in shared, crowded rooms with very basic facilities and amenities. It was stressed that teaching should be relevant to the local context. The importance of **learning by doing** in gaining practical experience in General Practice was emphasized.



In all groups, there was engaged debate, with more in-depth discussion and reflection among the 3rd and 4th year GP Registrars compared to those of the 1st year. All groups focused on patients from ethnically and culturally diverse backgrounds 'being different' from them, and particularly desired more related knowledge, while stressing the importance of seeing patients as individuals and applying a patient-centred approach. In addition, GP Registrars in the 3rd and 4th year considered the importance of reflecting upon oneself, such as on own prejudices and the culture of being a doctor. It was generally thought that healthcare to patients from ethnically and culturally diverse backgrounds is a **difficult area to teach**. Some participants were concerned that teaching might entail the **danger of stereotyping**. Also, some believed that related training would be more applicable to postgraduate than to undergraduate training, due to the fact that postgraduate course participants would have more contact with patients from diverse communities, and hence training would be more relevant.

Discussion

This study explored GP Registrars' views on their learning needs in relation to delivering effective healthcare to ethnically and culturally diverse patient populations. We observed that the vast majority of GP Registrars reported negative experiences, rather than positive ones, when consulting with patients from diverse backgrounds. GP Registrars were dealing with a plethora of challenges and, when doing so, they experienced considerable professional uncertainty and occupational stress, with predominantly negative emotions. They reported that training in relation to human diversity in healthcare had been inadequate, and desired more training. Most learning in this area had happened outside the taught curriculum. They identified concrete learning needs, which were mainly related to factual knowledge, with less emphasis on skills and attitudes.

Most GP Registrars focused on the concept of how people are different, with the more advanced 3rd and 4th year Registrars considering the importance of reflecting upon oneself. The difference in reflectiveness among GP Registrars may be related to varying experience with patients and exposure to postgraduate training in communication skills and attitude awareness. Also, the more advanced GP Registrars had known one another for a longer period than the 1st year GP Registrars. Length of time with each other and smaller focus groups may have impacted on the group dynamics during the focus group interviews.

We acknowledge that one author's perspective as a general practitioner, with a special interest in the area of cultural diversity, could have influenced the research. However, we did involve a peer, who was external to the research, at the outset to inform our methods. To enhance the accuracy of the researcher's interpretations, assumptions and data were checked with all participants during focus group interviews as well as with a sub-sample of three participants after data collection. Also, the second author, a social scientist, reviewed and discussed the analysis process and emerging interpretations.

Overall, this study was qualitative and findings cannot be simplistically extended to other populations⁴⁵, but the results do resonate with other published literature and can be used to develop postgraduate training in the study context. For instance, the GP Registrars' professional uncertainty and occupational stress while responding to human diversity in healthcare delivery are consistent with findings from other studies with other healthcare professionals^{17,18,46}. This is serious in the context of globalization and migration patterns, where general practitioners and other health professionals are increasingly required to work in cross-cultural consultations, and need to be skilled and confident to do so.

The perception of the GP Registrars related to inadequacy of current training is not confined to the Irish setting. Similar views have been reported from GP Registrars and medical students in the United Kingdom²⁸ and residents in the United States²². Additionally, our finding that the main learning of GP Registrars occurred outside the taught curriculum is consistent with findings from studies



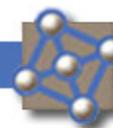
in Sweden²⁶ and the United States⁴⁷. This is a concern given wide national and international acceptance that medical undergraduate and postgraduate education should address issues related to human diversity³⁻⁶. It is important, in Ireland and elsewhere, to have a stronger connection between such *rhetorical* acceptance and the *actual* learning experiences in the development of learners' skills, knowledge and attitude awareness. This will benefit students and professionals in terms of reducing professional uncertainty and occupational stress as well as benefit patients from diverse backgrounds who are seeking quality healthcare.

The lessons learned from this research are that GP Registrars require training to enhance their skills to work with patients from diverse backgrounds. GP Registrars' perceptions regarding desired training to obtain more factual knowledge of different beliefs and practices and communication skills are consistent with the views of GP Registrars and medical students in an English study conducted by Kai et al²⁸. This issue of communication skills training is important. Our findings and those from other studies in the Irish and international context^{48,49} have shown that the use of informal strategies, such as the use of family members or friends as interpreters, to manage language barriers is very common in general practice consultations. This can be problematic because this type of interpreting involves errors which can interfere with the exchange of information and meaning between migrant service users and health professionals⁵⁰.

However, notwithstanding the importance of addressing specific knowledge, Kai et al. warn against the predominance of creating a 'difference' perspective, which may be emphasized if training is restricted to ethnic differences in disease and health behaviour. They argue that a narrow focus upon cultural difference and knowledge may restrain chances for self-reflection upon attitudes or for developing transferable skills such as a patient-centred approach, to respond to diversity. In our study and others^{28,29}, learners put less emphasis on the importance of this kind of self-reflection, and so the importance of listening to learners' views about what they should be taught needs to be balanced with attention to learning needs that they may not identify themselves. Also, some GP Registrars in our study believed that diversity teaching would be more applicable to later stages of their training. However, we feel that it is important to heed national and international guidance that medical education should address issues related to human diversity both at the undergraduate and postgraduate level³⁻⁶.

Therefore, our recommendations for training are that health educators should take into account issues in professional uncertainty, occupational stress and inadequacy of existing programmes in the development of diversity training in medical education. Such training should include specific knowledge, e.g. in the areas of communication, patterns of health and disease, organizational issues, nature of culture, patient expectations and ethnicity in the social context. However, to really reduce occupational stress, we believe it is important that diversity training in medical education should also encourage acknowledgment of the doctor's professional uncertainty, awareness of the doctor's own culture and attitudes, and development of generic and transferable skills such as a patient-centred approach to healthcare delivery.

Challenges to implementation are real; in particular it seems to be difficult that diversity training is fully integrated into busy curricula especially if this training is seen as an 'add on' rather than a core element of medical education. Teaching is often fragmented, and there is uncertainty as to what actually constitutes 'cultural diversity' teaching¹⁰. To address this, we agree with Kai et al. that diversity teaching should be integrated into existing established curricula, rather than offering 'stand alone' modules². Is there a way whereby core teaching about communication skills and attitude awareness that are attended to in spiral curricula⁵¹ can introduce teaching about cross-cultural consultations (and other areas of diversity) in later years as a way of advancing the level of sophistication of these skills? For example, the concept of active listening introduced early on, could be explored and practised using role play in later years in the context of interpreted consultations. These consultations are triadic in nature and, arguably, present specific challenges for the skill of active listening that are not present in the more usual dyadic



clinical encounter. Similarly, skills to work with a patient's agenda could be broadened in later years to explore and practise the management of cultural influences on the patient's agenda with due attention to the value of reflexivity on the part of the students about their own culture and its influences on the consultation. These ideas would certainly need to be further developed and would, also, have to be negotiated into existing curricula but as Betancourt aptly states: 'at the end of the day, physicians need a practical set of tools and skills that will enable them to provide quality care to patients *everywhere*, from *anywhere*, with *whatever* differences in background that may exist, in what is likely to be a brief clinical encounter'⁵².

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