

Enhancing Oncology Health Care Provider's Sensitivity to Cultural Communication to Reduce Cancer Disparities: A Pilot Study

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Abstract Under the auspices of a partnership grant to reduce cancer health disparities, Moffitt Cancer Center (MCC) partnered with the Ponce School of Medicine to identify the perceived cultural communication needs of MCC healthcare providers regarding Hispanic patients with limited or no English skills. Oncologists ($N=72$) at MCC were surveyed to identify the specific areas of cultural communication techniques for which they desired to

receive additional training. The majority of participants (66%) endorsed an interest in obtaining training to communicate difficult issues (terminal illness, controversial diagnosis) in a manner respectful to Hispanic culture. A workshop was conducted with providers ($N=55$) to improve cultural communication between Hispanic patients and families focusing on culture, terminal illness, and communication strategies. Findings from a pre–post test

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indicate an overall positive response to the workshop. Results from this study can help inform future efforts to enhance cultural competency among health providers.

Keywords Oncology · Health care provider · Cancer disparity · Cultural communication

Introduction

An alliance between a patient's cultural identity and a physician's cultural competency can improve patient–physician communication and ultimately reduce health disparities [1]. However, communication barriers in the patient–physician relationship contribute to health disparities in the cancer care setting [4]. Providers are often unaware of their communication skill level and biases and may perceive their skills that do not need improvement [4]. Culture, often defined as the set of attitudes, beliefs, and values that people and societies pass down between generations, can have a significant impact on patient's beliefs and expectations in the health care setting. Furthermore, these beliefs can influence their expectations and responses to information about diagnosis and disease treatment. Health care providers have their own medical culture as well as individual assumptions about cultural mores and values of specific racial and ethnic groups, including those of which they are a member. When patient and provider have separate and distinct cultural beliefs and expectations, cultural mismatch occurs. Cultural mismatch can negatively impact the quality and effectiveness of health care as well as patient satisfaction and the relationship with the health care institution and provider. It has been suggested that “cultural competency” and an initial investment in cultural sensitivity on the part of the provider can help to minimize misunderstanding or conflict later, ultimately resulting in improved patient and provider satisfaction, more effective service delivery, increased capacity, and cost savings [2, 5].

Studies of Hispanic populations indicate that there are unique and distinct perceptions of the value of healthcare, expectations about physicians, and beliefs about cancer. Furthermore, Hispanics seeking healthcare in the US report increased barriers from not only the mismatch between expectations and realities but also language barriers and the receipt of healthcare services brokered through an interpreter.

The Cultural and Linguistically Appropriate Service on Healthcare Standards (CLAS) was developed by the Office of Minority Health of the US Department of Health and Human Services. The CLAS standards focus on cultural competence, language access services, and organizational support for culturally competent healthcare. The American Medical Association and the National Medical Association have consistently called for improvements in the cultural

competency of physicians with CLAS standards providing a framework for the development of continuing medical education and medical school curricula. Additionally, the Joint Commission has recently released standards to encourage effective communication, cultural competence, and patient- and family-centered care, which will ultimately impact accreditation [7].

The Ponce School of Medicine and Moffitt Cancer Center (MCC) formed an institutional partnership funded by the U56 funding mechanism from the National Cancer Institute. This partnership provided an opportunity to implement outreach and research initiatives to study, understand, and address the unique barriers to cancer care services among Hispanics. The leading component of this joint venture is to identify strategies to reduce cancer health disparities. The current study presented here focused on developing and evaluating a brief intervention for oncology care providers at MCC to improve cultural communication related to Hispanic patients and families.

Methods

At a community outreach event focused on cancer prevention and education for survivors and their families, Spanish-only speaking patients completed a brief survey on their perceptions of the cultural competence of healthcare providers at MCC. Responses showed that 90% ($n=91$) felt it was “important to be able to communicate in their preferred language with their physician” and 75% felt they were viewed as “knowing less” because they did not speak English. As a result of this patient survey, we identified cultural communication as a key need for physician training and created a survey to identify specific areas of need within that domain. The purpose of the survey was to identify health care provider needs for assistance to improve the cultural communication skills of those caring for Hispanic patients with limited or no English skills. These findings are similar to previously published data where interpersonal skills and effective communication are among the indicators of culturally sensitive health care reported by patients [8].

A brief internet survey was administered to the in-house staff of 166 medical oncologists and surgeons at MCC. The survey consisted of questions based on the CLAS standards (Fig. 1). The nine-item survey asked questions about attitudes, preferences, and current use of institutional services.

Results

At least two physicians from each of the 11 MCC clinics responded to the survey. A total of 72 respondents completed the survey yielding a response rate of 43% ($n=72$). As

Fig. 1 Cultural communication needs assessment

Question	Response Option
I have used the interpreting services provided by Cancer Center	Yes/No
I would like more information about how to access Cancer Center's interpreters.	Yes/No
I would like more information on how to translate informed consents or other patient materials into Spanish	Yes/No
I am interested in receiving information on how to communicate difficult issues such as terminal illness and controversial diagnosis, in a way that is respectful to Hispanic culture	Yes/No
I am aware that prescriptions may be requested to be filled in Spanish.	Yes/No
Do you have health information materials in Spanish for your clinic area?	Yes/No
I am interested in receiving information on how to conduct an effective "triadic" interview. A triadic interview is one that involves provider, patient and interpreter.	Likert Scale (1-5)
How comfortable are you communicating directly or through an interpreter with patients who speak only Spanish?	Likert Scale (1-5)
How satisfied are you with the Spanish health information materials available in your clinic area to patients and families?	Likert Scale (1-5)
In what clinic is your primary practice?	Open-ended
How many years have you been in oncology practice	Open-ended
Language/s spoken?	Open-ended
On average, what percentage of the patients you see each month who are Hispanic with limited or no English skills?	Open-ended

Table 1 Cultural communication needs assessment results (N=72)

	Yes n (%)	No n (%)
Use of services at MCC		
Interpreting services	61 (84.7)	11 (15.3)
Aware prescriptions filled in Spanish	44 (61.1)	28 (38.9)
Have Spanish language materials in clinic	52 (72.2)	8 (11.1)
Satisfaction		
With Spanish health materials in clinic	30 (41.7)	16 (22.3)
With your communication skills with Spanish only patients	59 (81.9)	11 (17)
Interest		
How to use interpreters	14 (19.4)	58 (80.6)
How to have materials and consents translated	18 (25)	54 (75)
How to communicate difficult issues	48 (66.7)	24 (33.3)
How to conduct triadic interview	32 (44.4)	40 (55.6)

described in Table 1, 66% selected, “I am interested in receiving information on how to communicate difficult issues such as terminal illness and controversial diagnosis, in a way that is respectful to Hispanic culture.” Eighty-five percent had used the interpreting services at MCC and 19% reported desiring more information on how to access the interpreting services. Twenty-five percent selected they would like more information on how to translate informed consents and patient materials into Spanish.

Discussion

Since the most selected topic was for the receipt of information on how to communicate difficult issues, a workshop was developed to address these issues. Four weeks later, an interactive workshop was held for staff consisting of a didactic lecture from a Hispanic provider addressing culture, terminal illness, and communication strategies. A panel of interpreters, translators, and bi-lingual providers answered questions from the audience, and a group discussion was held. Fifty-five health care providers attended the workshop. A seven-item pre-test was administered prior to the workshop, followed by a three-item post-test. Sixty-two percent agreed that the panel discussion was helpful in developing techniques for communicating bad news to Spanish-only speaking patients. At baseline, 20% of participants felt very comfortable with their cultural communication skills; however, only 3% felt very comfortable after attending the intervention. At pre-test, 25% reported having very little knowledge about the cultural context of breaking bad news to Hispanic patients, yet at post-test, 0% reported having very little knowledge. These data suggest the training was successful overall, as well as aiding in identifying providers who previously had a high level of comfort based on misperceptions of good cultural communication. It seems that through the workshop, some providers realized they needed improvement. Our results appear to be unique to other institutional attempts to improve cultural communications.

Conclusion

One study suggested that the traditional notion of competence in training as mastery of a finite body of knowledge may not be appropriate in regards to multicultural education training and suggest as an alternative cultural humility, which incorporates a commitment to self-reflection and lifelong learning [6]. This may be worthwhile to consider in future efforts to improve communication and reduce cancer disparities. Additionally, as the findings from this research suggest a “one size fits all” approach to “cultural

competency training” may not be best to meet the varied needs of the diverse population impacted by cancer.

Though this was a relatively small sample size of both patients and providers and the results are not likely generalizable to all diverse patients seen at the Cancer Center, it is certainly a step toward improving sensitivity towards cultural communication and reducing disparities in this setting. Further research may include qualitative data collection (in-depth interviews or focus groups) with patients to ascertain not only perspectives of current care but also their priorities in the experience of illness and treatment [3] and to determine indicators of what they may consider to be culturally sensitive care. In addition, provider's perspectives regarding barriers to using current services as well as assessment of preferred learning styles (interactive format versus on line tutorial) may be considered before future curriculum is developed or training is planned.

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Ethical standards I confirm all human studies have been approved by the appropriate ethics committee and have been performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki. All persons gave their informed consent prior to their inclusion in the study.

Conflicts of interest The authors declare that they have no conflict of interest.

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