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Cross-Cultural Issues in Academic Palliative Medicine

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1. Introduction

1.1 The influence of cultural diversity in palliative medicine

The definition of culture, as an integrated pattern of learned beliefs and behaviors that include thoughts, styles of communicating, ways of interacting, values, practices, and customs has evolved, over time, but the underlying understanding is that culture is the lens through which people give the world meaning and which shapes their beliefs and behaviors. Culture is a system of shared ideas, concepts, rules and meanings that underlies the way we live — and approach death. Cultural diversity refers to more than ethnic diversity; age, gender, sexual preference, capabilities, education, place of residence, and occupation also contribute to diversity of culture. [Lickiss, 2003]. Cultures change or evolve over time and this affects many areas. In palliative medicine attitudes and practices regarding care of the incurable patient, of the dying (and dead) have changed, from unspeakable neglect common to the multiple contemporary patterns.[Kellehear , 2001]. The role of culture is significant in palliative care, and how it is conceptualized and applied has enormous consequences for patients, families and health care providers. It influences communication patterns, decision-making styles, responses to symptoms, treatment choices, and emotional expression at end of life [Valente, 2004; Werth et al, 2002]. Studies show that when cultural differences are inadequately addressed, inferior care occurs, affecting trust, and leading to patient dissatisfaction, nonadherence. [Betancourt & Green, 2010; Bruera et al., 2001; Ward et al., 2004]. The progress in palliative medicine requires balancing clinical art with science while paying due attention to cross-cultural differences that influence patients' and physicians' attitudes toward health care matters. The importance of cultural sensitivity for oncologists is now increasingly recognized and teaching and training in cultural competence are mandatory. [Betancourt & Green, 2010; Biasco & Surbone 2009].

1.2 Cross-cultural medical education and the need of cultural competence in the modern medical school

In the medical encounter of the multicultural universities, there is interaction between the culture of the medical students, the culture of the patients, and the medical culture that surrounds them. Physicians increasingly encounter patients of diverse racial, ethnic,

linguistic, and religious backgrounds, making effective cross-cultural communication skills essential. They should be sensitive to the diverse patients' health values that may be based on multiple cultures which they belong to (race, ethnicity. religion, gender, socioeconomic status, occupation, disability etc). The need for training in cultural competence is currently a requirement for medical schools. [Chun et al. 2010; Rodriguez et al. 2011]. Cultural competence refers to an ability to interact effectively with people of different cultures. It comprises four components: (a) awareness of one's own cultural worldview, (b) attitude towards cultural differences, (c) knowledge of different cultural practices and worldviews, and (d) cross-cultural skills.[Molinuevo & Torrubia, 2011]. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures.[Martin & Vaughn , 2007].

Cultural competency is something beyond the somewhat rigid categories of knowledge, skills, and attitudes: the continuous critical refinement and fostering of a type of thinking and knowing—a critical consciousness—of self, others, and the world. [Kumagai & Lypson, 2009]. As the european countries population and their universities become more diverse, racially and ethnically, demographic differences between physicians and patients increase, and the medical profession itself becomes more diverse, cross-cultural medical training takes on greater significance.[Rosen , 2004] .Cross-cultural education become important in preparing medical students in order to meet the health needs of the growing, diverse population. It has emerged because socio cultural factors are critical to the medical encounter.There are some medical universities which have been incorporated cross-cultural curricula into undergraduate medical education. [Betancourt, 2003; Betancourt, 2005; Davis & Smith, 2009].

The goal of these curricula is to prepare students to care for patients from diverse social and cultural backgrounds, and to recognize and appropriately address racial, cultural, and gender biases in health care delivery. Despite all changes, academic medical curriculums seldom prepare students for the realities of caring for patients with chronic progressive life threatening illnesses. An imbalance has been created in medical education which led to public concerns about poor communication and a perception that doctors lack care. [Taran, 2010]. The increasing attention to palliative medicine education has created major opportunities for improving education about care of the chronic progressive illnesses and for addressing multicultural issues in medical education. [Shanmugasundaram et al., 2009]. Medical schools offer some formal teaching about palliative and end-of-life care, but there is evidence that training is inadequate. [Lloyd-Williams & Macleod, 2004].

1.3 Motivating factors for cross-cultural medical education in palliative medicine

There are some motivating factors for cross-cultural medical education as folows:

- perception of chronic ,progressive illness, disease, causal factors, and treatment varies by culture
- diverse belief systems exist related to health, healing, and wellness
- culture influences attitudes toward health-care providers and motivations for seeking health care
- individual preferences and culture affect traditional and nontraditional approaches to health-care delivery and decision making

- communications between patient and health-care providers need to be clear and convey respect for individual beliefs and differences
- health-care providers in the delivery system are increasingly from culturally diverse and underrepresented minority groups
- patients have personal experiences of biases within health-care systems perceived as a reaction to their culture, ethnicity or religion

1.4 Spiritual dimensions of the health care in palliative medicine

Religious beliefs and practices are part of culture. Patients desire conversations with their health-care providers about spiritual and religious concerns. Physicians should ask about customs and practices, listen, explain and correct for their own cultural biases A good caring relationship is the greatest insurance against, and antidote for, the inevitable cultural mistakes.[Williams et al., 2011].

The advances of modern medicine increased life expectancy and this generated complex issues of the chronic progressive diseases' management. Increasing attention is being paid to the spiritual dimensions of the health care. The avoidance of the spiritual needs assessment in clinical practice and in the academic medical education may constitute a negligence and an important ethical issue. [Florea et al., 2008].

Palliative medicine and one of its core element, the spiritual care, provides a holistic patient-centered care applying a novel philosophy on living with incurable diseases and on death. Physicians, medical trainers mostly those using high medical technology and their students need special skills to communicate with patients and families. The compassionate care of the whole person-body, mind and spirit-has long been an ideal of medical education and practice. Many studies highlight the role that spirituality, culture, and end-of-life issues play in the future of medical education. [Azad, 2002; Betancourt, 2003; Betancourt 2006; Rosen et al. 2004].

Spirituality and religion, while often indistinguishable from culture, are beginning to be addressed in medical education, introducing palliative medicine module in medical schools curicula. A large segment of people claims belief in a higher being, and studies indicate that patients who have some religious commitment benefit in terms of stress reduction, recovery from illness, reduction of depression, and adjustment to disability. [Koenig et al., 2000 ; Lo et al., 2002; Williams et al., 2011 ; Wright, 2004] .

This evidence has provided the impetus among medical educators to include spirituality and health in undergraduate medical school curricula in order to increase sensitivity awareness about spiritual issues and to teach students communication techniques about different patients' spiritual beliefs, as they may affect their health and health care. Greater understanding of the diverse social, cultural, and spiritual contexts in which patients seek health care will facilitate more-favorable health outcomes and the cross-cultural medical education will have the potential to positively influence disparities in health. [Azad et al,.2002]. Some medical universities expand their students' and residents' education by integrating spirituality and medicine in the curriculum. Some of the europen and american medical schools, as our university, have been introduced courses in palliative medicine, including spiritual needs assessment and support, and many international hospitals have spiritual care initiatives.

Our university's undergraduate and postgraduate curriculum offer training in palliative care in a patient-centered model, including spiritual care and cultural diversity issues. Students are skilled in the understanding of human relationships, cultural sensitivity awareness in order to be able to integrate the personal meanings of values for both themselves and their patients, achieving a required cultural competence.

1.5 Obstacles to the inclusion of multicultural health content in the curricula of medical schools

To achieve the competence necessary to provide culturally appropriate education and culturally appropriate health care is a learning process that requires time, effort, practice, and introspection.

There are a number of obstacles to the inclusion of multicultural health content in the curricula of medical schools:

- difficulties in introducing new materials and experiences into an already overcrowded curriculum,
- lack of specialized teaching and learning resource materials,
- insufficient numbers of faculty prepared to teach the subject.

2. Methodology

The purposes of this study was to explore medical students' skills in cultural competence, their cultural sensitivity awareness, using 32 oncological outpatients with different cultural backgrounds, included in palliative care programs.

2.1 Recruitment process

2.1.1 Criteria for patients

Criteria for patients were a diagnosis of cancer and registration with a palliative care programme. The patient and family member had to be aged over 18 years, without obvious cognitive impairment as judged by referring health professionals. They had three different ethnicity (Romanian, Hungarian, German) and different religions (Orthodox, Catholic, Lutheran).

Patients designated the family member most involved in decision making regarding their illness (often but not necessarily the immediate carer) and from both of them formal consent was obtained.

2.1.2 Criteria for students

32 international students in the sixth year of their medical studies, from our university, were selected. They were from different cultural backgrounds: eight from United States, eight from Asia (two Chinese, four Indians, two Pakistani) eight from Africa (six Tunisian, two Moroccan) and eight from european countries (France, Germany, United Kingdom, Bosnia, Portugal).

Students attended the palliative medicine module as elective and all performed at least one summer practice in palliative care settings of their home countries.

The palliative medicine program included a number of six hours devoted to cultural sensitivity training. Methods that were used to integrate culturally sensitive topics into the curricula were: lectures, PBL (problem –based learning) cases with patients selected from three diferent romanian ethnic groups, creative teaching methods using simulated patients with diverse cultural backgrounds and small-group discussions.

All the students responded positively to our request to take part in an interview about palliative care, including spiritual care, even though most had before very limited knowledge of the subject.

2.2 Data collection and analysis

Students used a semistructured interview (one-to-one interview) (average one hour) with patients, focused on four basic dimensions in palliative medicine that vary culturally.

The four dimensions focused in the patients' interview were:

- communication of "bad news", eliciting detailed descriptions of patients' perceptions of their experiences of disclosure about the illness
- spiritual needs assessment: difficult subjects approach, recognizing symptoms and behaviors which may be related to spiritual pain and the relationship between pain and spiritual/psychological healing.
- locus of decision making
- attitudes toward advance directives and end-of-life care.

Semi structured interviews were selected because they are flexible, interactive, allow for deeper understanding of issues, and a greater exploration of cultural diversity issues. They are also dynamic and responsive to the language and concepts of individuals.

The students were divided into four focus groups. The focus groups were multi-cultural and included international medical students of different cultures to give a more diverse mix, palliative care professionals and medical teaching staff. Focus group discussions were effective in eliciting data on the cultural diversity of the patients and of the future physicians and in generating broad overviews of issues of concern to the cultural patient group.

A second interview was conducted with the same 32 international students in the sixth year of their medical studies, from our university, before and after they participated to palliative medicine module and group discussions.

All the students' interviews were personal meetings with teaching staff in palliative medicine that lasted about an hour and they took the form of a free and open discussion facilitated by a guiding questionnaire that had been drawn up in advance.

Some guidelines aimed at:

a. communication skills in different cultural environment :active listening,; common cultural variations regarding physician-patient communication; assess patients' knowledge of disease and prognosis; breaking bad news; strategies regarding ethnic, racial, and religious differences; common cultural variations regarding medical decision making; dealing with dificult questions ; eliciting and responding to patients' fears ; assessing spiritual needs as part of the initial assessment and ongoing care

b.   student perception of palliative medicine module
c.   student perception of cultural diversity, cultural sensitivity, cross-cultural issues integration in palliative medicine module

3. Results

3.1 Findings from patients' interviews

3.1.1 In the communication process with their patients, students appreciated:

*   what are the patient's needs, with specific focus on information needs, views of patients in palliative care and family members regarding their experiences of disclosure and information sharing during the course of the illness
*   how to identify common concerns or issues that might be used by students to shape and develop plans with respect to communication, with particular sensitivity to ethnic and cultural differences.

Patients and their relatives'need for sensitivity and respect for individual wishes in the communication process emerged as a central theme in the interviews. While this was especially important at the time of the initial disclosure, it recurred at all the different stages of information provision during the illness and affected the way in which content was perceived. The content needs most important to patients and families was related to prognosis and hope. Open communication regarding all aspects of the illness and its progress was reported as desirable by almost all participants, regardless of cultural backgrounds.

Almost all *patients,* 87% said they wanted to know the diagnosis of their illness. With four exceptions (in patients who shared information only in later stages) they thought it is important that information was fully shared with their families during all of the illness. A perception of insufficient information was reported to add stress, frustration, and uncertainty.

Of the respondents, 90% of the family members thought it was important for the patient to know the diagnosis. Three family members had requested that the patient must be not fully informed.

Students expressed different opinion: Bosnian, Indians, Pakistani and Chinese students expressed evasiveness regarding complete disclosure of the diagnosis to the cancer patients. They motivated their evasiveness with four reasons for nondisclosure:

*   Bosnian culture believes that open discussion of serious illness may provoke unnecessary depression or anxiety in the patient
*   Indians culture specifically views discussion of serious illness and death as disrespectful or impolite
*   Chinese culture believes that direct disclosure may eliminate hope;
*   Pakistani culture believes that speaking aloud about a condition, even in a hypothetic sense, makes death or terminal illness real because of the power of the spoken word.

In many Asian cultures, it is perceived as unnecessarily, cruel to directly inform a patient of a cancer diagnosis. Emotional reaction to news of serious illness is also considered directly

harmful to health. Indians, Pakistani, Chinese and Bosnian students preferred to act like "going around" the diagnosis and being indirect about serious illness in contrast to the emphasis on "truth telling" of the American students, whose directness they described as hurtful. Asian students' strategies commonly employed to minimize direct disclosure include using terminology that obscures the seriousness of a condition or communicating diagnostic and treatment information only to the patient's family members. Students agreed that, in certain cultures, while communication about serious illness and death may not be overt, information may be conveyed with subtlety. Facial expressions, voice tone, and other nonverbal cues may convey the seriousness of a patient's status without the necessity for explicit statements.

Most patients, 91%, wanted to know their prognosis, and family members respected their wish to know or not, although some would have wanted to protect the patient from details regarding prognosis.

All the students agreed to inform completely the patients and their relatives about prognosis in order to increase adherence to palliative care. They viewed information as a mechanism that enhanced decision making and keeping some control. Most patients wanted their family member present when they met health carers, although a small number expressed a desire to be the first to know or to control how much or when the family member should be told.

3.1.2 Spiritual needs assessment was a real challenge for the students

They used their spiritual-assessment skills (e.g., compassion, presence, and active listening) in understanding how spirituality affects health and appreciating the spiritual needs of patients from diverse cultural and spiritual backgrounds. Students identified as spiritual needs of their patients:

- to have the time to express true feelings without being judged,
- to speak of important relationships,
- to have hope,
- to deal with unresolved issues, to prepare for death.

They recognized spiritual pain as loss of meaning, loss of hope, loss of identity due to lost roles, lost activity, lost independence. Its characteristics identified by the medical students were: constant and chronic pain, insomnia, withdrawal or isolation, conflict with family members, friends or medical staff, anxiety, fear, mistrust of family, friends, physicians, hospice staff, depression, hopelessness, feeling of failure with life.

Despite most of the students considered themselves to be not religious or slightly religious and the heterogeneity in self-reported faith traditions: Christian (n = 7), Hindu (n = 4), atheist (n = 5), Catholic

(n = 6), Jewish (n = 2), Muslim (n = 8) they recognized the appropriate conditions which recommend clergy involvement. The specific situations identified to make referrals to chaplains as part of the interdisciplinary team were:

- when spiritual issues seem particularly significant in the patient's suffering,
- when spiritual/religious beliefs seem of particular help and support for the patient,

- when addressing the spiritual needs of a patient exceeds the physician's comfort level,
- when specific community spiritual resources are needed,
- when physician or nurse suspect spiritual issues which the patient denies,
- when the patient's family seems to be experiencing spiritual pain,
- when the medical staff (doctors, nurses, students) seems to be experiencing spiritual pain or is in need of support – multiple deaths, issues of injustice, particular attachment to a dying patient.

In the feedback gathered from patients, the majority of the participants (95%) felt their symptoms management needs and spiritual needs had been addressed and viewed their interaction with the students involved in palliative care positively. According to patients' responses, the majority wanted their doctor to be interested in their spiritual care.

3.1.3 Locus of decision making

With regard to decision making, american students emphasised on patient autonomy which contrasted with preferences for more family-based, physician-based, or shared physician- and family-based decision making among Indians and Tunisian students'opinion. Pakistani students shared that in their culture, physicians may be adopted into the family unit and addressed as parent, aunt, uncle, or sibling.

European students emphasised that in their culture patients prefer that physicians, because of their expert knowledge, make independent decisions to reduce the burden on patients and their families.

In group discussions, the students discussed choices regarding strategies for managing disease, approaches to symptom relief, or partnership in facing profound existential issues and facilitating personal growth. Decision making involved ethical principles (understood in the light of cultural sensitivity), with considerations of autonomy, justice, beneficence, and maleficence.

3.1.4 Attitudes toward advance directives and end-of-life care

Concerning the advance directive completion, this had lower rates among romanian patients of specific ethnic backgrounds, which may reflect distrust of the health care system, current health care disparities, cultural perspectives on death and suffering.

Chinese students emphasised that in their culture, people are less likely to sign their own do-not-resuscitate (DNR) orders because of its negative emotional impact on health.

By paying attention to the patient's values, spirituality, and relationship dynamics, students elicited cultural preferences. They actively developed rapport with ethnically diverse patients simply by demonstrating an interest in their cultural heritage.

3.2 Findings from students' interviews

3.2.1 Initial students' feedback, before palliative medicine module attendance

They discussed their self-perceived learning needs in dealing with patients with advanced diseases and different cultural backgrounds. Of the respondents 81 % students considered

that they were not prepared for all the skills/competencies needed to approach cultural diversity issues in palliative care. We identified many common themes and concerns emerged from students' interviews, including:

- lack of knowledge about palliative care and lack of understanding about spiritual care,
- confusion as to the difference between spiritual and religious needs,
- concern about how healthcare and social services would relate to spiritual care, finding a way to develop spiritual care and successfully integrate it into the general health and social services systems.

3.2.2 Interviews after students completed this module

They shared their educational and training experiences and made suggestions about cultural diversity issues in palliative care management and its influence in learning environment. Most students respondents (96%) thought that general communication skills, e.g. communicating with patients and patients' relatives, counselling skills such as dealing with difficult questions, eliciting and responding to patients' and relatives' fears, breaking bad news, crosscultural issues were well covered in the paliative medicine module and group discussion.

Focused was on:

- communication issues, including disclosure and consent;
- modes of decision making: how or when is the patient or family involved
- concepts of disease, meaning of pain and other symptoms;
- agree priorities with patients with different cultural backgrounds
- fulfil patients' needs for information about treatment
- attitudes to medication (especially opioid drugs and sedatives) and to nutrition
- ways of conceptualising death and dying in relation to the rest of life
- understand issues which surround euthanasia
- spiritual matters, as well as religious issues, including rituals.
- customs surrounding death, burial or cremation, and bereavement
- supporting a bereaved person, preparing family for bereavement.

According to students' responses after palliative medicine training the approach of spiritual care has had a positive and meaningful impact. Students identified two important facilitators of spiritual care: having time, unencumbered by competing clinical demands and effective communication with the patients and their family members. There were also identified the implications for medical care of the spiritual and religious issues:

- if the patient religion forbid any specific parts of medical care (transfusion, surgical therapies),
- barriers to patient-physician communication posed by religion/spirituality complex issues,
- the patient refuse to discuss spiritual or religious implications of his health care.

Students'evaluation before and after this module demonstrated improvement in students' abilities to assess patients' palliative care needs and spiritual needs and negotiate issues regarding complex treatments. They appreciated the interactive nature of palliative

medicine program and described it as relevant, balanced, and practical. Students were interested in finding out about new ways to enhance the lives quality of the patients and families in distress and they wanted better understand the challenges facing the development of palliative care. More attention may need to be directed towards the learning environment. The majority of respondents medical students showed that the patient's culture is an important issue when providing care (with 95 % of indicating "moderately important" or "very important"). In the interviews the students also explored educational issues in palliative medicine. They considered the attendance to palliative medicine module as an improved clinical experience and an opportunity for cultural sensitivity and cultural competence achievements. Medical students achieved interviewing skills, abilities to work in a multidisciplinary team, to pay attention to complementary treatments and ethical aspects of cross-cultural issues. Some critical attributes of good communication they identified as important: playing it straight, staying the course, giving time, showing you care, making it clear, and pacing information. They affect the quality of the relationship between health professionals and patients and their families and should be emphasised in the teaching of communication skills. Communication of prognosis to patients with cancer is a sensitive issue and therefore patients' needs for information should be individually assessed. Most students, 91% considered that poorly handled cross-cultural issues may have negative clinical consequences, including longer office visits, patient noncompliance, delays obtaining informed consent, ordering of unnecessary tests, and lower quality of care. A significant proportion of the respondents, 82% thought that they had developed some attributes fully through their work experience in palliative medicine module and group discussions and these were opportunities to consolidate what they had learned in the previous years. The teaching staff involved in this activities appreciated the open-mindedness attitudes, which made students especially receptive to our educational programme.

4. Discussions

The diversity of the cultural and racial orientations of the people means that those who provide health and social services increasingly interact with others of diverse cultural, social, racial, linguistic, and religious backgrounds.[*Green et al*, 2008]. The public is better informed and it has a better understanding of the complexity management of the chronic, life-threatening diseases. [Florea et al, 2008]. Given rapidly changing global demographic dynamics and the evidence regarding health outcomes attributable to cultural competence education, it is time to consider the approach to preparing medical students to reduce health disparities and care for ethnoculturally and socially diverse patients.

In an effort to provide health care professionals with the knowledge and skills to effectively care for diverse populations, an educational movement in "cross-cultural care" has emerged. This field has received a new emphasis during the past 10 years as a result of statements made by the American Medical Association (AMA) and the Accreditation Council for Graduate Medical Education, among others, that crosscultural training is necessary for the effective practice of medicine in this globalizing world.[Weissman, 2005]

The issue of cultural competence training is an evolving element of medical education curricula which must answer to the following questions:

- How can medical curricula be developed so that content is relevant and applicable to the workplace and graduates acquire the personal characteristics and skills required for medical practice?
- What are the obstacles to providing undergraduates with well-managed work experience, adequate exposure to the real world of medical practice and the necessary opportunities to apply knowledge and acquire essential skills, attitudes and personal attributes?

Tomorrow's physicians must be adequately trained to provide optimal care to patients from ethnic, social, spiritual and religious backgrounds different from their own. [Nelda &Valmi, 2011].

Cultural competence translate into improved health outcomes and reduction of disparities in health or health care. [Betancourt , 2006]. Improving student–patient communication is an important component of improving the quality of care generally, and addressing differences in quality of care that are associated with patients' race, ethnicity, or culture more specifically. Many students are unfamiliar with common cultural variations regarding physician-patient communication, medical decision making, and attitudes about formal documents such as code status guidelines and advance directives. End-of-life discussions are particularly challenging because of their emotional and interpersonal intensity. [Far, 2002; Kuin et al 2006; Mueller et al, 2001].

Introducing palliative medicine modules in undergraduate medical education is an important opportunity to enhance students with cultural sensitivity awareness and cultural competence. Despite recent progress and educational efforts, there are attitudinal barriers still thwart the successful integration of palliative care into general medical education. Medical students and residents are uncomfortable facing death and dying. The prevailing medical culture continues to view death as a medical failure. Palliative care, despite its growing scientific base, is often perceived as low-tech or ''soft.'' Many trainees do not view palliative care skills as core clinical competencies. They learn to prescribe antihypertensive and hypolipemiants drugs but they fail to master the use of opioids. These attitudes may contribute to practice patterns that tend to devalue the provision of palliative care even though the public increasingly asserts the importance of humane medical care at the end of life.

Previous efforts in cultural competence have aimed to teach about the attitudes, values, beliefs, and behavior of certain groups. There is no "manual" of how to care for patients from different racial, ethnic, or cultural groups; instead, a more effective approach is to learn about how social, cultural, or economic factors influence patients' health values, beliefs, and behaviors. [Gundersen, 2000; Hibnall & Brooks 2001; Hudson, 2006; Koenig, 2000].

In our study, group discussions were focused on the issues that arise most commonly due to cultural differences, cultural sensitivity. International students' curiosity, empathy, and respect, as well as an understanding of the romanian multiethnic patient's social context, motivated their interest in achieving cultural competence. We approached the concepts of cultural competence and"transnational competence" in medical education, which are not new concepts and have been argued previously, resulting in greater adoption of these principles among medical educators.[Gregg & Saha, 2006].

These principles have now become the blueprint for teaching medical students throughout the country, although adoption of this approach is slow but steady. [Koehn & Swick , 2006]. Training under this approach may be especially helpful in the care of patients who come from cultures different from the culture of the clinician. [Betancourt & Green, 2010]. Cultural competence aims to bridge the "cultural distance" that exists between medical providers and their patients.

Medical students and tomorrow's 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.

The field of cultural competence aims to assure that health care providers are prepared to provide quality care to diverse populations. There are evidence highlighting the fact that the failure of health care providers to acknowledge, understand, and manage sociocultural variations in the health beliefs and behaviors of their patients may impede effective communication and better patient care. [Betancourt & Green, 2010]. The diversity of the cultural and racial orientations of the people means that those who provide health and social services increasingly interact with others of diverse cultural, social, racial, linguistic, and religious backgrounds. Transnational competence in medical education offers a comprehensive set of core skills derived from international relations, cross-cultural psychology, and intercultural communication that are also applicable for medical education. [Koehn & Swick, 2006].

There is an effort to change the medical education systems. Moderate gains in cultural sensitivity training, such as inclusion of the topic in curricular objectives and content were made. These changes are part of an increased institutional commitment in some medical schools to improve students' abilities to provide culturally sensitive clinical care when they become practicing physicians. Gaps continue to exist in teaching this important skill. To achieve cultural competence, an organized and systematic approach of the objective development, curriculum planning, learning methods, and program evaluation is needed. [Betancourt & Green, 2010; Lie et al., 2006].

In some medical schools informal teaching of culturally sensitive topics have occurred. It is possible that medical students and faculties from different cultural backgrounds learn from each other using students' mobilities and teaching staff's professional mobilities and share their beliefs and attitudes with respect to health practices on an informal basis. Exposure to patients from other cultural backgrounds in practice, as our international students did, might bring culturally sensitive issues to the individual learner. Cultural competency involves an understanding and acceptance of cultural practices and is more than simply being able to speak the same language. Communicating effectively across cultures is a critical factor in providing quality health care to diverse populations. Becoming culturally competent is an ongoing process and a lifelong commitment.

Neglecting cultural issues in palliative medicine should be a possible source of tension in family and of confusion to health professionals. Sensitivity to the cultural nuances of communication (the breaking of bad news), family dynamics, decision making, interpersonal tensions and suffering may add value to attempts to care. Cultural gaps between health professionals and patients are expressed in many ways (from treatment preferences to concepts of spirituality). Bridging the gaps may require long time to be accomplished. This must begin in medical students' training.

As an effort to provide physicians training with the knowledge and skills to address cross-cultural challenges in the clinical encounter, curricula in "cultural competence" have emerged and been integrated into medical education. Cultural competence is a developmental process at both the student and university levels. With appropriate support, students can enhance their cultural awareness, knowledge and skills over time. Cultural strengths exist within our university and they will be better tapped in the training process of our 2800 international medical students, from 50 countries. A process of cultural competence assessment will be developped and students will benefit by heightening awareness, influencing attitudes toward practice, and motivating the development of knowledge and skills. This process also benefits the university by informing planning, policy-making, resource allocation and training/professional development activities. A growing literature delineates the impact of sociocultural factors, race, ethnicity and ethical issues on palliative care. [Florea et al., 2008; Shanmugasundaram et al., 2009; Williams et al., 2011].

Sociocultural differences between patient and physician influence communications and clinical decision making. Medical students and physicians aren't shielded from diversity, as patients present varied perspectives, values, beliefs, and behaviors regarding health and well-being. These include variations in patient recognition of symptoms, thresholds for seeking care, ability to communicate symptoms to a provider who understands their meaning, ability to understand the prescribed management strategy, expectations of care (including preferences for or against diagnostic and therapeutic procedures), and adherence to medical interventions and medications. Evidence suggests that provider-patient communication is directly linked to patient satisfaction and adherence and subsequently to health outcomes. [Betancourt, 2003]. Thus, when sociocultural differences between patient and provider aren't appreciated, explored, understood, or communicated in the medical encounter, patient dissatisfaction, poor adherence, and poorer health outcomes result.

The cultural competence, transnational competence approach will promote advances in preparing medical students to reduce health disparities among patients with multiple and diverse backgrounds, health conditions, and health care beliefs and practices. In palliative care this consistently directs attention to the policy and social factors, as well as the individual considerations, that can alleviate suffering and enhance health in a globalizing world.

Palliative and end-of-life care for a patient born and living in an Anglo-Saxon country may be different from that of a patient in a Latin or Islamic country, as patients' relationships with individual physicians and with institutions, preferences and practices of truth telling, attitudes toward screening, prevention and clinical trials, decision-making styles, and end-of-life choices are all subject to cultural variability. Additional research on how cultural diversity influences patients' and families' preferences in regard to palliative care is needed to meet the needs of different communities and individual patients.[Biasco & Surbone 2009].

Our study, like others, [Chun etal.,2010; Thompson et al, 2010] suggests that specific education, rather than individual experience of crosscultural interactions, which may not always be positive, is needed to improve the cultural competence of tomorrow's physicians and future palliative care professionals. The introduction of humanism, medical ethics and multiculturalism into medical education involves linking the professional training of students with human values, an orientation of education and practice towards addressing human needs and interests. [Kumagai & Lypson, 2009]. We need research to identify, assess,

and plan the care of all patients who are sick enough to die, and we need education that keeps alive our humanity and sense of vocation. This is an enormous challenge on the market of healthcare models, but one that will be useful to the chronic, life-threatening ill patients. [Florea et al, 2008].

5. Conclusions

The chapter describes the experiences of international medical students involved in palliative care programme, addressing cross-cultural issues, cultural sensitivity awareness. It draws attention to the complex relationships between different patients' and students' cultural background and palliative care issues and to the need of cultural competence in medical education.

Six-year international students at our medical school appreciated the level to which cultural competence instruction in palliative medicine occurred.

Our sudy also revealed that it is not only the patient's culture that matters; the students' and tomorrow's physicians' culture is equally important. Teaching about palliative care from a crosscultural perspective was favorably received by students and positively influenced students' attitudes.
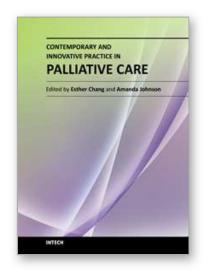
Palliative medicine training is a complex opportunity of cross-cultural medical education which must be approached and this will increase the cultural competence and standards of the academic medical education. Our findings indicate that multicultural medical education in palliative medicine is an important area for future research and curricular reform.

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