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Medical Cultural Competence. A Phenomenological Analysis

Ştefana Maria MOISĂ [1]
Lăcrămioara Ionela BUTNARIU [2*]
Laura Mihaela TRANDAFIR [3]

[1] Department of Pediatrics, Faculty of Medicine, "Grigore T. Popa" University of Medicine and Phar-macy, 700115 Iasi, Romania; stefana-maria.moisa@umfiasi.ro (S.-.M.M.), laura.trandafir@umfiasi.ro (L.-M.T.)
[2*] "Sfanta Maria" Clinica Emergency Hospital, Iasi, Romania
[3] Department of Medical Genetics, Faculty of Medicine, "Grigore T. Popa" University of Medicine and Pharmacy, 700115 Iasi, Romania; ionela.butnariu@umfiasi.ro (L.-I.B.)
*Correspondence to: Lăcrămioara Ionela Butnariu (ionela.butnariu@umfiasi.ro)

Abstract: *Medical clinical practice worldwide requires human interaction between the doctor and the patient, which can prove to be difficult because of many types of communication barriers, including cultural ones. In this context, it is becoming increasingly clear that doctors should be aware of their patient's cultural traits, that might influence their attitudes towards healthcare and the decision making process. This can prove to be difficult, especially in multicultural societies. This paper aims to highlight Romanian medical students' opinion on the importance of being aware of the cultural context the patient comes from in order to offer culturally competent healthcare. We conducted a focus group moderated by a group assistant, which included 10 fifth year medical students. Data was interpreted using a phenomenological interpretative approach. Romanian medical students are aware of some particular traits of social minorities in Romania regarding healthcare. They acknowledge the importance of cultural competence in medicine and can imagine several ways to protect human dignity at the end of life.*

Keywords: *medical students' opinion; healthcare attitude; cultural competence.*

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Introduction

Culture, defined as the "integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group" (Cross et al., 1989) is relevant to everyone's health care. Some minorities are characterized by higher prevalence of certain conditions and need to undergo thorough screening, therefore the doctor needs to be aware of his patient's populational background characteristics. Other populations may refuse to administer specific medications (blood, products manufactured using pork support; others may take traditional remedies that can interact with allopathic medicine. Health systems need to respond to these diverse linguistic and cultural needs by becoming "culturally competent". Cultural competence is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations"(Cross et al., 1989).

Cultural competence is fluid, as individuals can respond in diverse manners to cultural differences (Andrulis et al., 1999). Cultural competence is also a matter of social justice, a safeguard to the right to respect and nondiscrimination.

While patient autonomy has become a core principle of health care in the United States, some minority groups believe that family members should be involved in health care decision making (Bullock et al., 2016). For instance, Mexican Americans or Korean Americans seem to be more likely than Europeans or African Americans to involve families in the decision-making process (Blackhall et al., 1995). Involving families - and, in hierarchical societies, even community leaders may be crucial in obtaining consent for and adherence to treatment (Fadiman, 1997). Some patients may also seek advice from traditional healers, before of after being consulted by a medical professional (Druss & Rosenheck, 1999; Higginbotham et al., 1990; Kim & Kwok, 1998; Ma, 1999; Marbella, 1998) and substance interference must be taken into account.

There are no studies published yet on Romanian medical student perception on sensitive end of life situation or on race discrimination. Our study aims to address this literature gap, by highlighting their perception and degree of understanding of these aspects.

Materials and Methods

We have performed a focus group with 10 Romanian medical students regarding their opinion on the importance of cultural competence in medicine and on proper medical care at the end of life. The focus group duration was 2 hours. Participants were recruited from a Romanian speaking general medicine group of students, at the end of their training with the group teaching assistant conducting the focus group (after the final examination, therefore no form of coercion was involved). Informed consent was obtained from all participants.

The focus group guideline included 11 topics: Importance of patient autonomy, Types of autonomy, Paternalism in Romanian medical culture, Illness and disease, Patient cultural specificities, Roma beliefs regarding disease, Rroma minority discrimination, Romanian patient attitude towards disease, Communication of severe diagnosis or grim prognosis in Romanian patients, Meaning of dignified death, Religious coping in Romanian patients. Discussions were tape recorded and data was interpreted using a phenomenological interpretative approach (it was considered important to understand how medical students view these topics after 5 years of medical training and 3 years of clinical medicine and patient interaction. Also, focus was placed on students' personal perception and construct of compassionate and appropriate poor prognosis communication, dying with dignity and religious coping with death after their short experience with these concepts.)

The focus group was transcribed and data was coded in order to clearly delineate the directions identified by each respondent for each question. More than one respondent was sometimes found to follow one train of thought regarding one question, and sometimes all respondents agreed on something unanimously. On other occasions, each of them found a different response to a given question. The obtained response cathegories were then subdivided into sub-cathegories, such as physical or psychological autonomy, for instance. Finally, data was interpreted from a phenomenological point of view, keeping in mind individual experiences shape student views on specific topics.

The focus group guide included questions tailored to highlight participant's opinions on cultural particularities, dignity, discrimination and end of life situations:

Do you think at the end of life autonomy is important, or not?
Do you think a doctor should have basic notions about his patient's culture? Why and what are the notions you consider "basic"?
Do you think social minorities have particularities regarding health attitude?
Do you think the rroma are discriminated regarding the healthcare system?

Why do you think the rroma scream in healthcare settings? (Spontaneous, follow-up question)
Who should the poor prognosis be communicated to? To the patient? To the family?
In what order? Under what conditions?
Who is the prognosis of imminent death communicated to? The patient or the family?
Do you think religion is important to Romanians?
Do you think at the end of life religion is important to Romanians?
What type of coping pattern do Romanians adopt at the end of life?
What is end of life dignity?
How do you think a patient's dignity could be respected in the Romanian healthcare system?

Results

Student views on autonomy

Romanian medical students place an important accent on patient autonomy. In the absence of autonomy, they see no point to being alive. This may be due to their young age, as they cannot imagine living their lives "as a vegetable" at this time: "You don't want to be a vegetable for 10 years, do you? You can live without being autonomous, but that is no life". In their opinion, death is more easily accepted, maybe even welcomed by those who have lost physical autonomy. Students believe such patients gave up on even the hope or thought of fighting their condition and postponing death and just give in: ""That was it… I'm going… Why live for another month?" And they go in two weeks, not a month."

Psychological autonomy is also important: "When you have no psychological autonomy, everything is in vain". Thus, psychological autonomy seems to have greater value to Romanians than to other cultures. Students think Romanians prefer to make their own decisions, as opposed to other cultures. In Muslim families, there are the parents, elder brothers and husbands who have a greater decision-making power than the rest of the family members (Surbone et al., 2010). Being a burden to the family is not something that would preoccupy a patient as it goes without saying that the female members of the family will take care of the patient and that death will come at home (Wilson-Stronks et al., 2010).

In some communities, such as Hmong, the senior member of the family is the one to take decisions for his family members at the end of their lives (Surbone, 2011).

Student views on cultural particularities

Romanian medical students recognize the importance of being aware of patients' cultural specificities when it comes to dealing with illness and disease. Two students, however, mistook cultural particularities for education, as they thought a basic notion about patient culture was "to know how to explain to the patient what is going on depending on his level of training". Also, they thought a complicated treatment regimen was unlikely to be followed by patients, also a matter of education more than a matter of culture.

The others, however, recognized the fact that cultural particularities should be known by the doctors in order to "know how to guide the treatment". Also, they are familiar with Arabic culture prohibiting women to have male gynecologists and prohibiting all patients to accept medicines manufactured using pork-based technologies, such as Cerebrolysine. They also think about not making mistakes, such as administering Cerebrolysine to a coma Arab patient, as that would "isolate him from his own cultural environment".

Social minorities

When asked about social minorities having particularities regarding health attitude, students brought up two very different cultures: the Hungarian and the Rroma. One student admires the Hungarians: "Hungarians have a healthy attitude regarding health. They value their body and their diseases. They care about their health". The situation is different with the Rroma, who may have two types of reactions: the first is one where they do not believe their condition will have a very high impact on their lives: ""It will be ok like this" or "It will go away. I have been thru worse, I will get thru this, too".", the other is one where they overreact: ""I want to be cured right now"… for something really small". However, as a whole, students believe the Rroma care less about their health status.

In literature, opera and films, gypsies are often seen as people with free and mysterious ways of living, masters of romance. In real life, they are often labeled as causing social problems, are associated with a high rate of criminality and constitute an ethnic group that has problems with fitting into the dominant society.

Illness is perceived in the Rroma culture as a punishment from God, therefore it brings shame on the patient. This is why Rroma patients hide their disease from society, but the whole family is well aware of it, providing comfort and care.

Romanian medical students seem to be unaware of rroma beliefs regarding diseases. Still, they are fine observers of rroma behavior inside hospitals and examination rooms. They complain about Rroma aggressive behavior in emergency departments, where exhausted personnel cannot cope with this type of behavior. Students believe this behavior is caused by the fact that the Rroma think "they are entitled to everything" and respect is needed on both sides, as both sides (medical personnel and rroma patient) have equal rights and duties. Students believe aggression is motivated by the fact that "They feel left apart", but could also be a manipulation mechanism: "They come and scream and get in and have their problem solved and leave. I think they are advantaged many times.", leading to positive discrimination: "Many socially disadvantaged Romanian families have not been helped the way Rroma have".

In other situations, students think the Rroma are discriminated and disrespected inside the health system: "The way they [medical personnel] talk to them shows no respect.". And there is an explanation for this situation:" This is the attitude that society cultivates". However, this does not mean that their diseases are not treated, a fact that is unanimously agreed upon.

Disease and prognosis communication in Romanians

Romanian culture represents a mixture of different cultural traits. Romanians do not subscribe to the Muslim attitude, where the head of the family bears the responsibility of decision making alone (we are, in this respect, more like the Russian population, where anyone can make the decision), neither to the Roma minority attitude, defined by lack of open communication about the disease (for fear of calling evil spirits by the power of the word), but, on the other hand, the family or the patient himself leaves the decision to the doctor, ignoring the autonomy that is stated by the current legislation because of the lack of knowledge about his rights, because of the paternalistic tradition (that predates the communist period), or simply because of the fear of assuming the consequences of his own decision. In Romania, in current medical practice, an oncologic diagnosis is first communicated to the patient, then the family, whereas the news of poor prognosis or imminent death is communicated to the family only, and the family itself suggests to the doctor that the prognosis should be kept from the patient, in order to protect him from the psychological shock that this news might induce. We all believe that the bad news regarding the health status will harm the patient (he will die because of the sorrow the news will induce or, on the contrary, will get better sooner if hope is kept alive), and, indeed, many doctors keep the truth from the patient unless the patient has

the opportunity to choose from two therapeutic approaches with potentially different outcomes.

These aspects were also covered in the focus group. First of all, students recognize the difficulty of communicating poor prognosis and do not feel they receive proper education on this topic during their medical studies years: "During our medical studies we do not learn how to empathize with the patient. I think there is a gap in medical education in this respect." They recognize empathy to be of utmost importance in poor prognosis communication, but the doctor must remain firm and professional and not "absorb the patient's problems".

Regarding who the doctor should deliver the news to, students believe it would be ethical to tell the patient, but this does not happen in daily clinical practice, as the family finds out bad news first. Mental competence is also brought up by them: "I think that as long as the patient is mentally competent, he should receive the information about the prognosis". Many nuances exist, however, and it would be easier for the doctor to understand how much harm bad news would do to one specific patient if the doctor had more time to spend with that particular patient and assess his or her psychological status and strength: "maybe we shouldn't tell the truth directly to a person that has depressive tendencies". Students know that soon or imminent death is communicated to the family, but nuances exist here, too: "It should be communicated to the patient. Maybe he still wants to get things in order. He must know the approximate time he has left. Maybe he wants to connect to God during that time. Everyone wants to do something with the little time they have left."

Although, at first glance, hiding the poor and unchangeable prognosis from a patient might seem like breaking his right to autonomy, doing the opposite could be compared to communicating to a healthy man the exact time of his death. We all know we will die sometime, but we do not know when, and this existential uncertainty allows us, among other things, to be happy. In other words, Romanian attitude is similar to the ones in Albania, China, Korea, Mexico, Spain and Russia and, on a psychological level, the doctor that acts in this manner is bluntly lying to the patient, in order not to drive him to desperation and bring the end closer. Even if we all agree to the patient's right to autonomy, this consensus ends when it comes to communicating the vital prognosis, it only stands for communicating data about the disease and therapeutic options.

The perpetuation of the paternalistic attitude of the doctor can be an indirect consequence of the legislation. In countries where medical error is promptly punished, the right of the patient to autonomy is not only stated in

the law, but also strictly respected by the doctor, who tries to protect himself in this manner. On the contrary, in countries where legislation is being put together just now and patients are just beginning to know and exercise their rights, the doctor may allow himself to be the dominant decision maker for the patient for a while. Moreover, in oriental cultures, where the physical disappearance of a person is viewed in a more detached manner compared to occidental countries, the paternalistic attitude of the doctor might persist for a longer time. Also, in those cultures, the legislation regarding autonomy will probably be implemented later (Spector, 2000; Walter & Ross, 2014).

Dignity and religious coping in Romanian patients

Romanian medical students acknowledge the importance of religion for Romanian patients at the end of life. They think of religion as a state power, the most trusted institution and therefore used to manipulate masses: "If the priest says something, which becomes the law."

Religion is also deemed important at the end of life, when faith is the last resort. Students believe most end of life patients adopt a religious coping pattern. At the end of life, people "approach religion most, they try to grow spiritually, because they know physically they have no more…"

These findings are similar to some found in Turkey (Ahmadi et al., 2019). On the other hand, Swedes less often turn to religion in end of life situations (Ahmadi, 2006). Koreans feel a strong responsibility at the end of their lives (Ahmadi et al., 2016), while Muslims find the strength to be grateful worse did not happen yet (Ahmadi & Ahmadi, 1998) and thank God for good things.

Little is known about Romanian practicing physicians' views regarding the relevance and meaning of dignity or about the relationship between physicians' views about dignity, their religious characteristics, and their clinical practices. Romanian medical students have clearly defined views on this topic: "Dignity is the ability to say „no" at any time". "It's the right to have your intimacy and thoughts respected and your point of view heard.". "Dignity is the right to choose, the right to have options, the right to intimacy, the right to... I am the person, not the patient.". "The respect for self, to respect the ideas, the person...". The notion of dignity overlaps, in their opinion, with that of respect.

Students can identify several ways to respect a patient's dignity in the healthcare system: "First of all, by informed consent. Second, by respecting patient intimacy, especially during care maneuvers in terminally ill patients. And then, it's about the confidentiality of the information about the disease, the condition, the healthcare act. Dignity also means the patient's right to

not know what will happen, to prevent him from being scared. A man may simply not want to know. Or, more importantly, he does not want his family to know. If something is found, it should be kept confidential."

Dignity is different in different cultures: for the Chinese, one important aspect of dignity is advance care planning, to relieve the family from making painful decisions (Ho et al., 2013) for Americans, symptom control, independence and empathy are important (Kennedy, 2016), whereas for Indians an end-of-life stage heavily assisted by technology is considered to make dignified death impossible (Mani et al., 2012).

Discussion

Cultural competence

Rather than an end, cultural competence is better conceived as a journey. It refers to the process of actively developing and practicing appropriate, relevant, and sensitive strategies and skills in interacting with culturally different persons (Mollvik, 2021). It is a set of rules that eases work in a multicultural environment (Roley et al., 2008). Cultural competence means "understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system; and finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations"(Cross et al., 1989).

Cultural competence is key to effective therapeutic interactions and outcomes. It implies a heightened consciousness of how patients experience their uniqueness and deal with their differences and similarities within a larger social context. It enhances the doctor's knowledge of the relationship between sociocultural factors and health beliefs and behaviors. It enhances doctor-patient communication by allowing the healthcare provider to better understand factors causing their patients to make certain decisions.

Some ethical conflicts and dilemmas encountered in everyday clinical activity may have intertwined roots and causes. There are many doctor-patient interactions in which culture affects health, but they are not perceived as culturally or ethically related (Spector, 2000). Western bioethics places the "self" at the center of all decision-making (autonomy). However, there are many cultures that place the family, community, or society above the rights of the individual. The disclosing (truth-telling) of a diagnosis of serious illness or disability to the patient is not universally accepted. Many believe that the family, not the patient, should make important health care decisions. Some people believe that health is restored by using positive

language. This conflicts with the inherently negative language used when describing the risks of a certain approach or treatment, as a part of obtaining informed consent. Questions of race, ethnicity, and cultural beliefs have become part of the equation when resources are scarce (justice). Some cultures believe that it is the duty of the family to care for its sick member (self-independence). When the doctor promotes independence in self-care or activities of daily living, the role of the family may be negated (Betacourt et al., 2003). In other words, the opposition between the occidental and the oriental culture is synonym to the opposition between patient autonomy and family autonomy.

Ethical dilemmas can be further complicated by the unequal distribution of power in the relationship between the patient and the doctor. Patients and families faced with medical decisions are often subject to being over- or under influenced by the health care system and providers (power and dominance). The doctor-patient relationship is one wherein the doctor has the ultimate responsibility for drawing conclusions and proposing treatment. Respect for autonomy grants patients, who have been properly informed in a manner appropriate to the patient's beliefs and understanding, the right to refuse a proposed treatment (Nair & Adetayo, 2019).

Comparison between Different Cultural Patterns of Coping with Suffering and Decision-Making Processes

Culture is an adaptive, dynamic, responsive and comparatively coherent system that ensures the welfare and survival of its members. Culture explains what death is, why it happens and what its members should do to cope with it with integrity and honor and how the family and community should support the dying person (Surbone, 2011).

In some cultures, such as the Korean and Mexican minorities in America, it is customary to communicate the terminal diagnosis to the family only, not to the patient. In other cultures, while the patient is still consulted, there is a family-focused decision-making pattern and the clinician should not blindly adhere to the patient autonomy pattern (Wells, 2005; Krakauer et al., 2002; Sella et al., 2015). In these situations, it is normal that the families should contribute to decision-making and taking care of the patient while the disease progresses (Sarafis et al., 2014). The Roma culture is also part of this category and this is important in the social setting of today's Romania because Roma population represents is the third largest in Romania (2.46%), according to the last census.

Romanian students are aware of the importance the family has in patient making decisions, in both Romanian and Rroma cultures.

Medical paternalism

Paradoxically, the anti-paternalist vision promoting the patient's right to autonomy and self-determination may lead in some situations to cultural paternalism that may impact patients psychologically, since the antipaternalistic vision promotes patients' right to autonomy, even though some patients do not wish to make autonomous decisions or even to be informed about their condition (Rosenblatt, 1993; Lazcano-Ponce et al., 2020). In this situation, forcing a patient to make his own decisions and face his disease may have a negative psychological impact. On the other hand, the physicians' paternalist attitude persists in post-communist Romania although the patient right law states the patients' right to make their own decisions regarding healthcare.

In this context, we wonder: is benign paternalism such a bad thing?

The question originates in the uncertainty of whether a truly informed consent is obtained in some cases, given the patients' low level of understanding and education.

In some cultures, it is believed that the physician should always do everything in order to keep the patient alive and foster hope. From this point of view cultures may be classified as follows: death-denying (US), death-accepting (Hindu, some Asian groups) or death-avoiding (Navajo) (Baider & Surbone, 2010).

In other cultures, the mere act of talking about death is a taboo as the subject causes sadness and could accelerate the fatal outcome. In the Roma culture, talking about death is forbidden too as words are considered to have creating powers and a capacity to influence the future. The interviewed students proved to be fine observers of Roma behavior, but they do not yet understand deeper aspects, like Roma patient refusal to discuss terminal state. Knowing the patient's cultural peculiarities is key to respecting his/her dignity.

Illness and disease

The difference between "disease" and "illness" is important. The term "disease" refers to a pathological process disturbing the normal equilibrium of the body, whereas "illness" is a slightly broader term, taking into consideration the perception of the individual and family regarding that particular condition. (Machado & Hoff, 2012). Individuals seek health care because of their experience of illness, so it is important for physicians to recognize that a patient's experience with illness may vary from their professional interpretation of the disease and may be influenced by cultural and social factors (Gostin, 1995; Kleinamnn et al., 1978). Most individuals

develop their own explanations for the cause of the disease, its severity and the best treatment option. (Mainous et al., 2020). The goal of medical interviewing techniques is to "elicit" the patient's explanatory model of his or her sickness. A culturally competent physician must address both the disease and the illness and take the patient's perspective into consideration (Raus et al., 2018, Kleinman, 1980).

Culture influences the treatment seeking process in a profound manner (Ringstad, 2016; Arietta Valero, 2019; Pachter, 1994) and alternative medicine is not always the same as traditional health practices. Traditional methods of health care differ from alternative medicine in that they are based on traditional beliefs and practices that are integral to a person's culture (Arietta Valero, 2019).

In some situations, it may be beneficial for physicians to collaborate with traditional healers from the community to negotiate a treatment that best fits with the patient's health beliefs (Brach & Fraserirector, 2000, Cohen & Goode, 1999). This is also the case with certain Roma communities. This is not yet acknowledged by medical students. Their opinion is that the Rroma care less about their health status.

A Critique of the Concept of Human Dignity: is it an Outdated Concept?

In her article "Dignity is a useless concept"(Macklin, 2003), Ruth Macklin states that references to dignity are either vague statements of some other, more precise, notions, or mere slogans that add nothing to the attempt to understand the subject.

Discussions on human dignity originate in the early 70's and concerned the possibility to refuse the inappropriate prolongation of the dying process by applying maximal treatment to patients standing no chance of cure, treatment which led to an impaired quality of life and only resulted in making the dying process a technical one. In this context, respect for the patient's dignity was seen as respect for his/her wish not to be subject to such interventions, the notion being in this context equivalent to that of respect for patient autonomy.

In the social, economic and cultural context of today's Romania, respect for a patient's dignity seems to be more than that. The risk of inappropriately prolonging the dying process by invasive techniques which may not even be wanted by the patient is a fact; however, sometimes, the total lack of material resources that would allow such interventions prevents the application thereof. In post-communist Romania, with a severely underfinanced health system, respect for the patient's dignity may be defined

in terms of the medical professionals' manners, optimum hospitalization conditions, respect for the patient's privacy, provision of all necessary care after consultations with the patient and awareness of his/her wishes, allowing the family's presence by the dying person's side.

Death is a universal experience. Regardless of culture, religion, race or nationality, we all die. The way we approach death and suffering and what we believe will happen after we die varies based on our culture and religion (Macklin, 2003). Our spiritual beliefs mold the way we think of the end of our lives. Atheists and agnostics believe death is the end (Baggini & Pym, 2005). Christians believe that death is the beginning of eternity with God (Engelhardt & Iltis, 2005). Hindus believe death is the end of this life and the beginning of a new cycle (Hinduism Today, 2004). In this context, medical professionals should know what death is in each patient's culture, as well as what it represents in the patient's familiar background.

Today's multicultural reality necessitates recognition of the influence of culture influence on many aspects of health. In some countries, traditional healers are a well-recognized part of the official healthcare system.

Most conceptual frameworks of cultural competence emphasized the patient (and family when appropriate) as the focus of attention, rather than the person's cultural group characteristics or the disease (Carrillo et al., 1999; Leininger, 1978; Shapiro & Lenahan, 1996). This is in line with the modern concept of treating the patient in a holistic manner, not just their disease or illness. This scenario empowers the patient as the "expert" of his or her unique illness experience (Tervalon & Murray-Garcia, 1998).

The language of dignity is used by opposing sides in debates over the end-of-life care. Those who support assisted suicide in the terminally ill state that this ensures a dignified death for the patient, while those opposing death hastening argue that this would violate basic personal dignity altogether. Such debates highlight the fact that that "dignity" can have different meanings for different people.

The word dignity has been used by philosophers in three ways: attributive, intrinsic, and inflorescent dignity (Sulmasy, 2013). Attributed dignity refers to the value the individual has because of the circumstances he finds himself in or to the individual worth as a consequence of individual characteristics. Intrinsic dignity, on the other hand, is not a consequence of an individual's abilities, but is inborn, it is a consequence of just being human beings. Finally, inflorescent dignity is a term 'used by stoic philosopher to refer to "individuals who are flourishing as human beings," who demonstrate human excellence.

Romanian students have a good understanding of the concept of dignity and are able to identify ways of protecting their patients' dignity (informed consent, protecting patient privacy, confidentiality, psychological distress prevention).

Conclusions

Romanian medical students are aware of some particular traits of social minorities in Romania regarding healthcare. They acknowledge the importance of cultural competence in medicine and can imagine several ways to protect human dignity at the end of life.

People are different in many ways. Culture, religion, traditions and economic factors influence the moment and the reason patients seek for the doctor's help. Some people want to make their own decisions, some want nothing to do with decision making as long as the outcome will be pleasant, and some do not even get the chance to exercise autonomy because of the desire of the family to protect them from psychological harm. Doctors and families wish and can be paternalistic, while keeping the best interest of the patient at heart. At the end, is that a good thing, in an absolute sense? The answer to that question is never easy, since it depends on so many shades of gray.

Limitations

The main limitation of our study consists of the small number of students who were interviewed. Also, they were all enrolled in the fifth year of study of the Faculty of Medicine; therefore there is no way to know when their notions regarding cultural competence have developed. Further studies, involving younger and older students are required in order to elucidate this aspect. Furthermore, international studies on this topic should be performed, in order to better understand student cultural competence and evaluate the need to introduce this topic in the study curriculum of medical universities worldwide. This may prove especially important in multicultural societies.

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