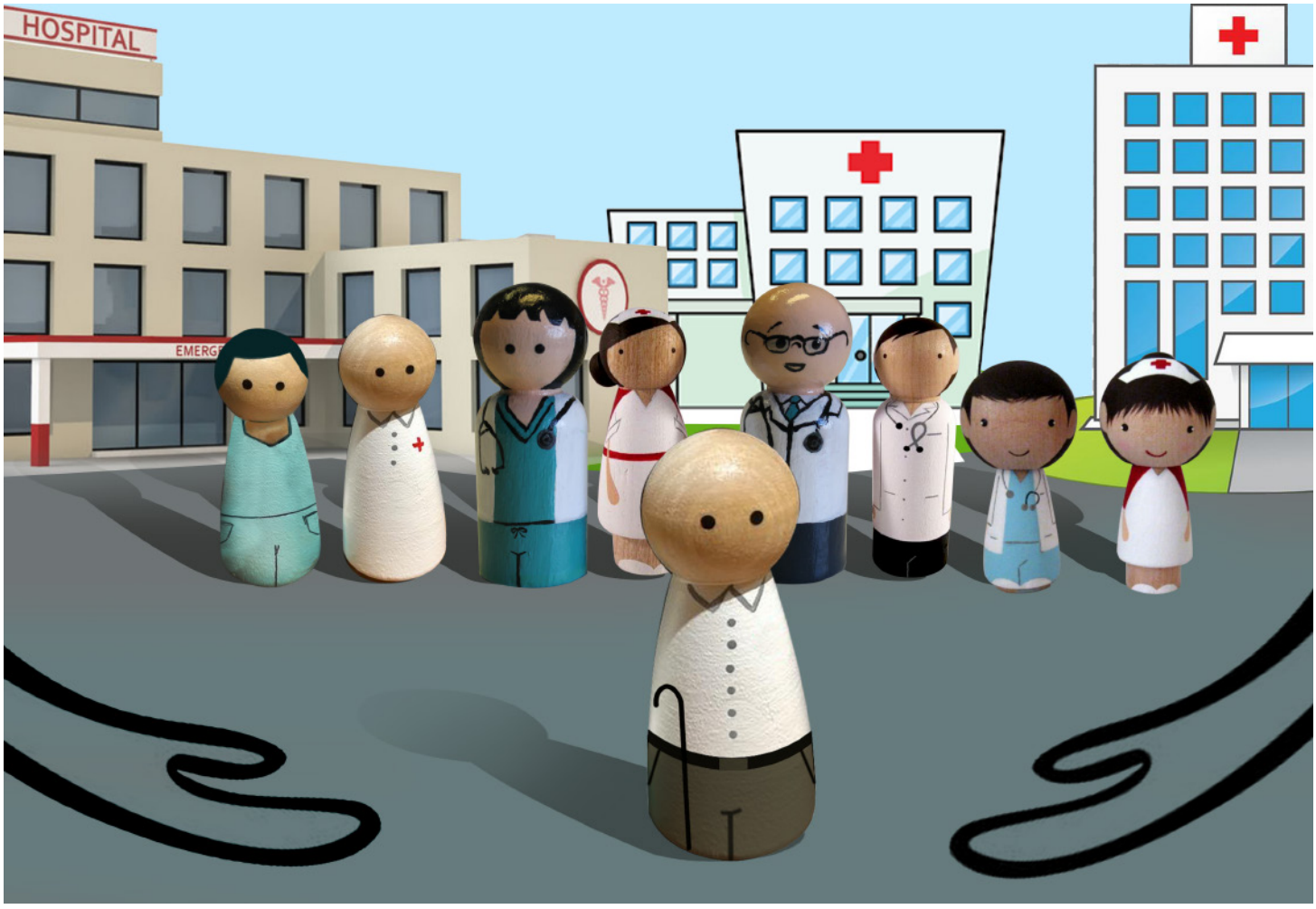
Cultural Competence In Patient Care : Challenges And Opportunities



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Cultural Competence In Patient Care : Challenges And Opportunities

ANCC Accredited NCPD Hours: 2.2hrs

Target Audience: RN/APRN

Need Assessment

Significant diversity exists on approaches to cultural competency training and assessment. Little evidence exists about whether existing cultural competency training leads to improved patient health outcomes and reductions in health disparity. A cross-cultural approach to cultural competence education and training is focused on teaching general knowledge, attitudes and skills relevant to navigating any cross-cultural situation. One key approach to improving overall cultural competence in health care is to develop the capacity of the health workforce to practice in a culturally competent manner. ***Health professionals play a key role in determining the nature of interactions and patient experiences in health care. Cultural and linguistic differences between healthcare providers and clients can results in significant miscommunication, mistrust, decreased satisfaction and disempowerment.***

Objectives

- Describe the General Focus of Culturally Competent Workforce Interventions
- Discuss the Effects of the Different Approaches of Cultural Competence
- Identify the Core Principles encompassing Cultural Competence
- Describe the concept of cultural safety
- Discuss the Complication of Narrow Understanding of Cultural Competency

Goal

The goal of this article is to discuss the idea of culturally competent care and latest research supporting it. It also discusses the pros and cons of culturally competent care, barriers for implementation and healthcare staff's concerns regarding implementation of such practices.

Introduction

The concepts of culture, cultural difference and cultural competence are complex and can be difficult to define. Many varied definitions are used to describe cultural competence. Cultural competence is defines as "a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals that enable that system, agency or professions to work effectively in cross-cultural situations". This definition accounts for a range of intervention approaches which are used to improve the cultural competence of healthcare systems. One key approach to improving overall health care cultural competence is to develop the capacity of the health workforce to practice in a culturally competent manner. [1, Rank 5]

Health professionals play a key role in determining the nature of interactions and patient experiences when accessing health care. Cultural and linguistic differences between healthcare providers and health service users can results in significant miscommunication, mistrust, decreased satisfaction and disempowerment. ***In contrast, care provider's increased cultural competence has been linked to increased patient satisfaction, treatment adherence, information seeking and sharing.*** It is perhaps due to the key role that health practitioners play in determining the health care experiences of patients. ***Improving health workforce cultural competency is one of the oldest and most predominant of cultural competence strategies. [3, Rank 3]***

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General Focus of Cultural Competence Workforce Interventions

The general focus of ***cultural competence workforce interventions has been on educating and training the health workforce in knowledge, attitudes, and skills needed to effectively respond to sociocultural issues arising in clinical encounters.*** Cultural competence training mainly include

- Understanding the central role of culture

in all lives and how it shapes behaviour

- Respect and acceptance of cultural differences
- Learning to effectively utilise culturally adapted and culturally specific practices
- Continuous development of ones aware ness of personal cultural influences and prejudices or biases.

Cultural competence training has mostly focused on developing knowledge, attitudes, awareness and sensitivity of those working in healthcare(As shown in fig.1). However, the literature emphasize the need to advance and focus on teaching the skills needed to translate knowledge and awareness into tangible practitioner behaviours, that can be consistently applied and assessed in healthcare encounters and settings.

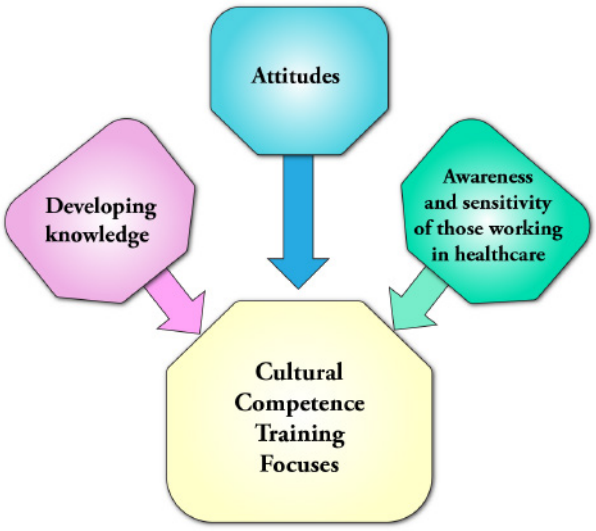

Figure 1 : Focuses of cultural training focuses

Different approaches to cultural competence training have been adopted over the years. Historically, there has been a

> **"One key approach to improving overall health care cultural competence is to develop the capacity of the health workforce to practice in a culturally competent manner "**

greater focus on ***categorical approaches that involve teaching health providers information about particular cultural, ethnic or racial groups. Such approaches describe common health beliefs, attitudes and behaviours of particular groups and offer prescriptive advice about what to do and what not to do in clinical encounters.*** However, it has been acknowledged that categorical approaches are insufficient and problematic for numerous reasons. [2, Rank 4]

Effects of the Different Approaches of Cultural Competence

To begin with, the ***categorical approach*** is critiqued for ***misrepresenting and oversimplifying the concept of culture as fixed and static rather than a fluid and dynamic phenomenon in a process of constant change and adaptation.*** Furthermore, the significant cultural, religious, ethnic and national diversity present in many countries means that it is not feasible

> **"A cross-cultural approach to cultural competence education and training is focused on teaching general knowledge, attitudes and skills relevant to navigating any cross-cultural situation."**

to be familiar with all cultural perspectives practitioners may encounter. ***Categorical approaches to cultural competence training may lead to stereotyping which can in fact increase cultural misunderstanding.*** Such approaches have also been criticised for giving little attention to intra-group variability and for failing to account for the ways in which acculturation and socioeconomic status effect different individual's ways of expressing and experiencing their culture.

Another key approach to cultural competence education and training which addresses some of the concerns identified with categorical approaches is the cross-cultural approach. A cross-cultural approach to cultural competence education and training is focused on teaching general knowledge, attitudes and skills relevant to navigating any cross-cultural situation. Some of these skills and attitudes were outlined by pioneers in cross-cultural medicine(As shown in fig.2) and include: eliciting patients' explanatory models of health issues and their causes; strategies for negotiating shared understanding and facilitating participatory decision-making in creating treatment plans; and understanding health and illness in its biopsychosocial context. Being applicable in clinical encounters with patients from varied cultural and ethnic backgrounds, such approaches have the advantage of being focused on specific skills that can be applied in healthcare encounters. [7, Rank 5]

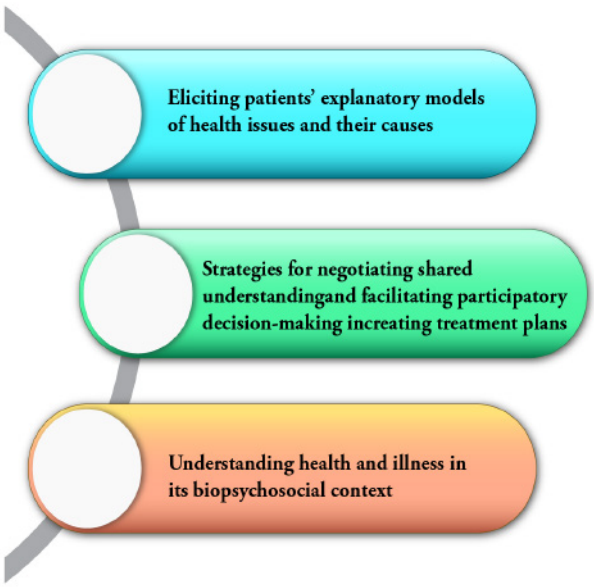

Figure 2 : Pioneers in cross-cultural medicine

Cultural competence interventions have come to be considered a key strategy towards addressing racial and ethnic healthcare and health disparities that exist across US. As a result, factors besides cultural differences and cultural barriers came to be included in the discourse and scope of cultural competence. These factors include

patient mistrust of health practitioners and systems because of historical and contemporary experiences of discrimination and provider bias towards minority groups. ***Cultural competence training can include developing an awareness of issues of gender, sexuality, and those such as racism, health practitioner and system bias and mistrust.*** Critical reflection on practitioner perspectives is also advocated. This includes critically reflecting on and acknowledging the limitations of "medico-centric" frameworks and the effects of dynamics of power and privilege associated with professional status.

Positive outcomes have been reported from cultural competency interventions targeting the health workforce, particularly for practitioner outcomes. A literature review on educational interventions to improve the cultural competence of health care providers showed excellent evidence of improved practitioner knowledge and good evidence of improved practitioner attitudes and skills . However, there is less evidence for the impacts of cultural competence education interventions on the patient's healthcare. [5, Rank 4]

Multiple studies delineating the efforts of integrating cultural competence showed interesting outcomes. Across the included studies, diverse intervention strategies were used to address cultural competence at the workforce level. The two primary workforce strategies were cultural competency training interventions and professional development interventions aimed at improving the cultural competence of health services and practitioners. There was a significant variation in focus, content, mode of delivery and duration of interventions within these two primary strategies. There was also heterogeneity in the outcomes reported across the studies. The most common outcomes were for practitioner related cultural competence, along with some healthcare process and health outcomes. [9, Rank 4]

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Reviewing Cultural Competency

Cultural competency is a broad concept that has various definitions drawing from multiple frameworks. ***Overall, this concept has varying interpretations within and between countries. Cultural competency has been described as a recognised approach to improve the provision of healthcare to ethnic minority groups with the aim of reducing ethnic health disparities.*** One of the earliest and most commonly cited definitions of cultural competency is sourced as:

Cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations.

Researchers contextualized cultural competency as part of a continuum ranging (As shown in fig.3)from the most negative end of ***cultural destructiveness*** (e.g. attitudes, policies, and practices that are destructive to cultures and consequently to the individuals within the culture such as cultural genocide) to the most positive end of ***cultural proficiency*** (e.g. agencies that hold culture in high esteem, who seek to add to the knowledge base of culturally competent practice by conducting research and developing new therapeutic approaches based on culture). Other points along this continuum include: ***cultural incapacity, cultural blindness and cultural pre-competence.***

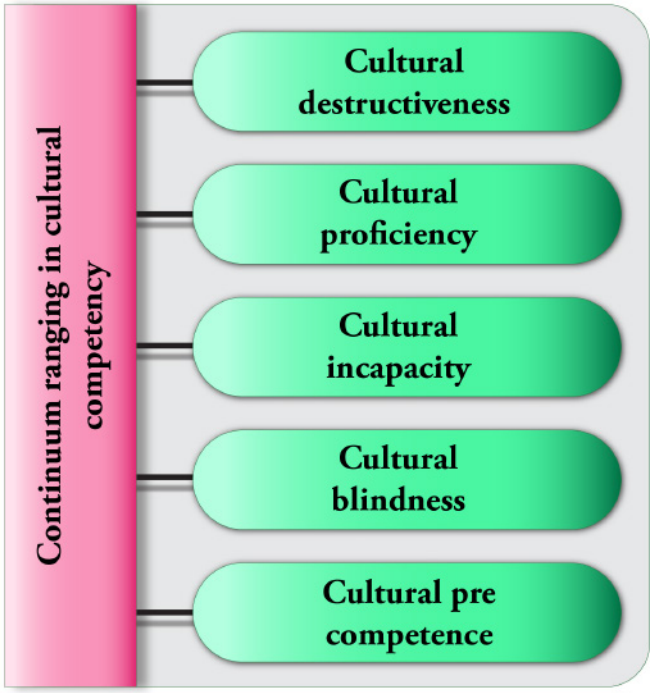

Figure 3: Continuum ranging in cultural competency

Over the years during the expansion of literature in this realm, a number of definitions, conceptual frameworks and related terms appeared in the landscape. ***Terms like cultural awareness, cultural sensitivity, cultural humility, cultural security, cultural respect, cultural adaptation,and transculturalcompetence or effectiveness are some of the concepts derived in the time frame.*** Unfortunately,

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this rapid growth in terminology and theoretical positioning(s), further confused by variations in policy uptake across the health sector, reduced the potential for a common, shared understanding of what cultural competency represents and therefore what interventions are required. [12, Rank 4]

The Concept of Cultural Safety

A key difference between the concepts of cultural competency and cultural safety is the notion of 'power'. There is a large body of work, developed over many years, describing the nuances of the two terms. Similar to cultural competency, this concept has varying interpretations within and between countries. Cultural safety foregrounds power differentials within society and the requirement for health professionals to reflect on interpersonal power differences (their own and that of the patient). The term also addresses how the transfer of power within multiple contexts can facilitate appropriate care for Indigenous people and arguably for all patients. [11, Rank 3]

Cultural safety is about acknowledging the barriers to clinical effectiveness arising from the inherent power imbalance between provider and patient. This concept rejects the notion that health providers should focus on learning cultural customs of different ethnic groups. Instead, cultural safety seeks to achieve better care through being aware of difference, decolonising, considering power relationships, implementing reflective practice, and by allowing the patient to determine whether a clinical encounter is safe.

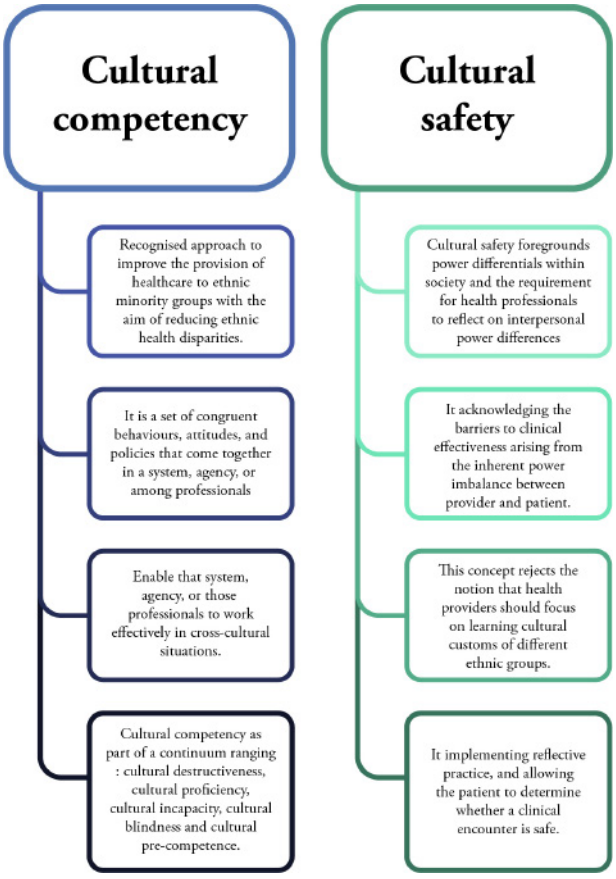

Figure 4 : Comparison of cultural competency and cultural safety

Cultural safety requires health practitioners to examine themselves and the potential impact of their own culture on clinical interactions. This requires ***health providers to question their own biases, attitudes, assumptions, stereotypes and prejudices that may be contributing to a lower quality of healthcare for some patients.*** In contrast to cultural competency, the focus of cultural safety moves to the culture of the clinician or the clinical environment rather than the culture of the 'exotic ' patient.

There is debate over whether cultural safety reflects an end point along a continuum of cultural competency development, or, whether cultural safety requires a paradigm shift associated with a transformational jump in cultural awareness. Researchers originally described the process towards achieving cultural safety in nursing as a step-wise progression from cultural awareness through cultural sensitivity and finally to cultural safety. [10, Rank 3]

It was clear that the terms cultural awareness and cultural sensitivity were separate concepts and that they were not interchangeable with cultural safety. Some authors interpret the original description of cultural safety as involving three steps along a continuum. Other studies view a move to cultural safety as more of a 'paradigm shift' where the movement from cultural competence to cultural safety is not merely another step on a linear continuum, but rather a more dramatic change of approach. This conceptualization of cultural safety represents a more radical, politicized understanding of cultural consideration.

Regardless of whether cultural safety represents movement along a continuum or a paradigm shift, commentators are clear that the concept of cultural safety aligns with critical theory, where health providers are invited to "examine sources of repression, social domination, and structural variables such as class and power" and "social justice, equity and respect". This requires a movement to critical consciousness, involving critical self-reflection: "a stepping back to understand one's own assumptions, biases, and values, and a shifting of one's gaze from self to others and conditions of injustice in the world."[15, Rank 4]

The Complication of Narrow Understanding of Cultural Competency

Unfortunately, regulatory and educational health organisations have tended to frame their understanding of cultural competency towards individualised rather than organisational/systemic processes. These

approaches focused on acquisition of cultural-knowledge rather than reflective self-assessment of power, priviledge and biases. There are a number of reasons why this approach can be harmful and undermine progress on reducing health inequities.

Individual-level focused positionings for cultural competency perpetuate a process of "othering", that identifies those that are thought to be different from oneself or the dominant culture. The consequences for persons who experience 'othering' include alienation, marginalization, decreased opportunities, internalized oppression, and exclusion. To foster safe and effective health care interactions, those in power must actively seek to unmask othering practices.

Figure 5 : Consequence of othering experience in person

"Other-focused" approaches to cultural competency promote oversimplified understandings of other cultures based on cultural stereotypes, including a tendency to homogenise Indigenous people into a collective 'they'. [22, Rank 2]

This type of cultural essentialism not only leads to health care providers making erroneous assumptions about individual, but also reinforces a racialised, binary discourse and destabilise Indigenous identity formations. By ignoring power, narrow approaches to cultural competency place responsibility for problems with the affected individuals or communities that overlook the role of the health professional, the health care system and broader socio-economic structures. The role of Inequities in social determinants of health have their foundations in colonial histories and subsequent imbalances in power, that consistently benefited some over others. Health equity simply cannot be achieved without acknowledging and addressing differential power, in the healthcare interaction, and in the broader health system and social structures (including in decision making and resource allocation).

An approach to cultural competency that focuses on acquiring knowledge, skills and attitudes is problematic because it suggests that competency can be fully achieved through this static process. Cultural competency does not have an endpoint, and a "tick-box" approach may well make practi-

tioners into a falsely confident space. These dangers underscore the importance of framing cultural safety as an ongoing and reflective process, focused on 'critical consciousness'. There will still be a need for health professionals to have a degree of knowledge and understanding of other cultures. However, this should not be confused with or presented as efforts to address cultural safety. Indeed, as discussed above, this information alone can be dangerous without deep self-reflection about how power and privilege have been redistributed during those processes and the implications for our systems and practice. [18, Rank 3]

By neglecting the organisational/systemic drivers of health care inequities, current efforts are fundamentally limited in their ability to impact on health inequities. Healthcare organisations influence health provider bias through the structure of the healthcare environment, including factors such as their commitment to workforce training, accountability for equity, workplace stressors, and diversity in workforce and governance. Working towards cultural safety should not be viewed as an intervention purely at the level of the health professional – although a critically conscious and empathetic health professional is certainly important. The evidence clearly emphasises the important role that healthcare organisations (and society at large) can have in the creation of culturally safe environments. Cultural safety initiatives therefore should target both individual health professionals and health professional organisations to intervene positively towards achieving health equity.

Perhaps not surprisingly, the concept of cultural safety is often more confronting and challenging for health institutions, professionals, and students than that of cultural competency. Regardless, it has become increasingly clear that health practitioners, healthcare organisations and health systems all need to be engaged in working towards cultural safety and critical consciousness. To do this, they must be prepared to critique the 'taken for granted' power structures and be prepared to challenge their own culture, biases, privilege and power rather than attempt to become 'competent' in the cultures of others. [20, Rank 5]

Core Principles Encompassing Cultural Competence

It is clear from reviewing the current evidence associated with cultural competency and cultural safety that a shift in approach is required. Researchers recommend an approach to cultural safety that

encompasses the following core principles:

- Be clearly focused on achieving health equity, with measurable progress towards this endpoint
- Be centred on clarified concepts of cultural safety and critical consciousness rather than narrow based notions of cultural competency
- Be focused on the application of cultural safety within a healthcare systemic/organizational context in addition to the individual health provider-patient interface
- Focus on cultural safety activities that extend beyond acquiring knowledge about 'other cultures' and developing appropriate skills and attitudes and move to interventions that acknowledge and address biases and stereotypes.
- Promote the framing of cultural safety as requiring a focus on power relationships and inequities within health care interactions that reflect historical and social dynamics.
- Not be limited to formal training curricula but be aligned across all training/practice environments, systems, structures, and policies. [16, Rank 3]

Studies recommend that the following definition for cultural safety is adopted by healthcare organisations:

" Cultural safety requires healthcare professionals and their associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery "

"Cultural safety requires healthcare professionals and their associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. This requires individual healthcare professionals and healthcare organisations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided. In doing so, cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness. This approach will hold themselves accountable for providing culturally safe care, as defined by the patient and their communities and measured through progress towards achieving health equity. Cultural safety requires healthcare professionals and their associat-

ed healthcare organisations to influence healthcare to reduce bias and achieve equity within the workforce and working environment". [13, Rank 5]

In operationalising this approach to cultural safety, organisations (health professional training bodies, healthcare organisations etc) should begin with a self-review of the extent to which they meet expectations of cultural safety at a systemic and organizational level and identify an action plan for development. ***The following steps should also be considered by healthcare organisations and regulators to take a more comprehensive approach to cultural safety:***

- Mandate evidence of engagement and transformation in cultural safety activities as a part of vocational training and professional development;
- Include evidence of cultural safety (of organisations and practitioners) as a requirement for accreditation and ongoing certification;
- Ensure that cultural safety is assessed by the systematic monitoring and assessment of inequities (in health workforce and health outcomes);
- Require cultural safety training and performance monitoring for staff, supervisors and assessors;
- Acknowledge that cultural safety is an independent requirement that relates to, but is not restricted to, expectations for competency in ethnic or Indigenous health. [27, Rank 4]

Issues Across Cultural Competence Literature

One of the key issues across the cultural competence literature is the lack of consistent terminology and an agreed upon definition of cultural competence and related concepts. Several researchers were interested to examine the definitions of culture and cultural competence used across studies as well as the understandings of cultural difference used to justify the need for cultural competence. Across the included studies, there was a general lack of reporting on definitions of cultural competence, culture and cultural difference.

The definitions of cultural competence that were provided in only three of the included studies were all different, confirming the lack of a consistent definition of cultural competence. The use of inconsistent terminology to describe approaches towards the goal of improving cultural competence seen across the literature was also seen in the included studies. Terms used included cultural awareness, cultural

respect, cultural safety, cultural understanding, and culturally appropriate healthcare. Furthermore, cultural differences are complex and varied within and across different cultural and ethnic groups. [32, Rank 3]

The interventions reported across the studies included in this review were varied. The primary intervention strategies used were cultural competence training and other professional development activities. Professional development activities included health issue/field or program-specific training, and mentoring/supervision approaches. These interventions represent a diversity of approaches taken to improve health workforce cultural competence across nations. This diversity can be considered a strength, demonstrating the many opportunities available to facilitate the ongoing process of improving the cultural competence of the practicing health workforce. However, the heterogeneity of intervention approaches, measures and outcomes makes analysis of interventions and their outcomes more difficult. For this reason, we focus our discussion on the general trends that are seen across studies, particularly those using similar strategies to improve health workforce cultural competence. [12, Rank 4]

Cultural Competence Training as an Intervention Strategy

Cultural competence training for the health workforce was the most frequently implemented intervention strategy reported across majority of the included studies. Cultural competence training interventions were delivered to a range of health professionals. Although some studies reported on training delivered specifically to physicians or nurses, more commonly, cultural competence training was provided to a diverse range of healthcare professionals together. There were no apparent differences in the training delivered to specific or mixed healthcare professionals in the strategies or outcomes reported. This indicates that ***many cultural competence training interventions are quite generic in nature, and do not necessarily target specific skills and knowledge, or types of care relationships that exist in health care.*** [24, Rank 5]

There were many commonalities across cultural competency training intervention strategies and outcomes. These commonalities help to shed light on some key strengths and limitations of common approaches to cultural competence training. For example, out of the eleven studies evaluating cultural competency training interventions, six utilised a categorical

approach and five implemented a cross-cultural approach. Interventions using either categorical or cross-cultural approaches reported positive outcomes around practitioner knowledge, attitudes/beliefs and reported skills and confidence. Due to the heterogeneity in measurement instruments and assessment methods, we were unable to discern whether either of these approaches to cultural competence training had a greater impact on particular learning outcomes. Despite this, there are some important issues pertaining to these approaches. [27, Rank 3]

Categorical approaches to cultural competence training can run the risk of increasing cultural misunderstanding if they do not account for inter-group variability. There are however certain instances in which categorical cultural competence training approaches can be effective or appropriate. For example, if the cultural competence training is teaching about cultures of local-level populations with the help of local cultural experts, this can help to build cultural competence. Two of the included studies using categorical approaches included a focus on local level populations in line with this recommendation.

The three remaining categorical cultural competence training studies either did not utilise such an approach, or did not report it. Another instance in which categorical approaches may be appropriate is when knowledge which has a clear, evidence-based effect on health care delivery or patient outcomes is being taught. Only one study utilising a cross-cultural approach to cultural competence training mentioned teaching such evidence-based knowledge. Aside from these instances, to avoid generalisations which may lead to cultural misunderstanding, a more suitable tactic is to learn as much as possible directly from patients about their own sociocultural perspectives and how they see this impacting their encounters with healthcare practitioners. [29, Rank 4]

Cultural Competence Education Models for Healthcare Professionals

Processes and skills for learning directly from patients is something that is commonly addressed in cross-cultural education models. For example, Kleinman's explanatory model of disease is a tool which can be used to facilitate cross-cultural communication, increasing understanding between patients and providers by eliciting patient's own explanation of their health and or/illness. This tool is designed to help

health providers better understand people's health beliefs, personal and social meanings attached to health issues, and expectations about the therapeutic process. [33, Rank 3]

Another key model for cross-cultural education is the LEARN (Listen, Explain, Acknowledge, Recommend, Negotiate) model. The LEARN model focuses on teaching generic skills for communication and negotiation that can be applied across all interactions when negotiating difference (cultural or otherwise) in the patient-practitioner encounter. Yet despite the existence and use of these models for many years, only two studies reviewed identified utilisation of both the LEARN model and Kleinman's explanatory model. [38, Rank 4]

To establish the relative impacts of different approaches to cultural competence training, comparative evaluations of interventions are needed to assess impacts using the same measurement instruments. Given the level of heterogeneity in cultural competency training interventions, a tool to assess the themes, concepts, methods and learning objectives of training interventions, would contribute greatly towards the comparison of outcomes between interventions. To facilitate greater analysis and comparison of cultural competency training approaches, it is important that evaluations provide sufficient detail on training approaches and content. This kind of detail was something that was lacking in many of the cultural competence training studies reviewed. Four of the cultural competence training studies using categorical approaches and one using a cross-cultural approach did not provide sufficient information to clearly ascertain the content and focus of the training. [39, Rank 5]

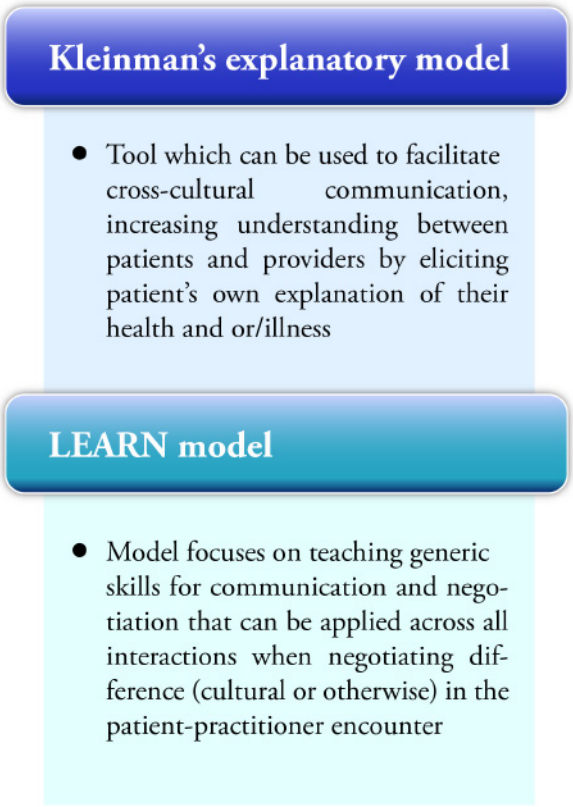

Figure 6: Key models of cross-cultural education

Despite the importance of issues of racism, discrimination and practitioner bias as issues to be addressed in culturally competent health care, none of the reviewed studies evaluating cultural competence training interventions explicitly discussed

issues of racism and practitioner bias or stated that these issues were addressed in cultural competence training. Only one intervention evaluated addressed distinguishing between cultural generalisations and stereotypes in a cultural competence training program.

The lack of attention to issues of racism and bias is consistent with the findings of other cultural competence reviews. [40, Rank 4]

Professional Development Strategies in Culturally Competent Healthcare

Researchers found two types of ***professional development strategies***(As shown in fig.7) reported in included studies that have not been commonly reported in cultural competence literature reviews. ***One such strategy was training interventions other than cultural competence training which also aimed to increase healthcare workforce cultural competence.*** These training approaches included training regarding specific health issues/fields (eg. Indigenous mental health and wellbeing and ethno-geriatric care) and training in particular service-level interventions.

It is recommended that a whole of organisational approach to be taken where efforts to improve cultural competence are integrated into all professional development endeavours within a healthcare service. These types of health issue or program specific training interventions are one strategy towards this goal. These training interventions demonstrate the different ways in which efforts to increase health professional cultural competence can be integrated into diverse professional development initiatives. [42, Rank 4]

Mentoring and supervision was another strategy found, with studies demonstrating the versatility and potential of this approach as a cultural competency workforce development strategy. Mentoring is a common and effective approach towards personal and career development in the workplace. Mentoring relationships are focused on mentee's learning and encourage a reflective dynamic where openness to feedback is embraced.

Figure 7: Professional development strategies

Therefore, mentoring strategies could encourage the kind of life-long learning processes needed to continuously strive towards cultural competence.

A significant focus of literature on mentoring and supervision in the context of cultural competence in the health workforce has been regarding supervision for minority practitioners by Caucasian supervisors. The potential of mentoring and supervision approaches to improve health practitioner cultural competence is a research area worth further exploration and testing for its efficacy and impact. [44, Rank 5]

Considering the evidence demonstrating the impact of language discordance on patient satisfaction and quality of care, the relative absence of efforts to address linguistic differences in most cultural competence workforce development interventions is discouraging. One of the reviewed studies provided language courses and an immersion program for health practitioners. Another study found that medical schools rarely addressed language issues in cultural competency course content, such as through teaching about the use of interpreters. Interventions to improve cultural competence in the health workforce in nations ought to address linguistic competence as a core aspect of cultural competence, particularly for populations who do not speak English as a first language. [43, Rank 3]

Behavioural Outcomes of Cultural Competence Interventions

Several studies assessed patient-reported physician cultural competence behaviours but found no changes following the intervention. The only behavioural changes reported in studies included increased research productivity and physical changes in practice settings to be more culturally sensitive. Hence, ***the majority of cultural competence training for the health workforce remains focused on building awareness and associated changes in attitudes. However, knowledge and attitude-based outcomes are not sufficient to demonstrate practitioner cultural competence.*** In order to build a stronger evidence base on the impact of cultural competency workforce interventions it is important that evaluations include assessment of practitioner behavioural outcomes.

Cultural competence training approaches should prioritise the teaching of practical skills and the application of these skills in practice, and their assessment

through demonstrable practitioner behaviour. Assessment of behavioural outcomes could also contribute to evaluation of workforce cultural competence training impacts on patient's healthcare and health outcomes. The assessment of healthcare and health outcomes are very important if we hope to demonstrate that cultural competence interventions do in fact impact on the healthcare disparities so frequently used to justify cultural competence interventions. However, only two of the reviewed studies reported healthcare outcomes with one reporting improvements in patient satisfaction and the other reporting no effect. [47, Rank 4]

Health outcomes were assessed in two studies however, neither reported significant changes as a result of interventions impacts. Studies outlined a potential approach to cultural competence education and training intervention evaluation which assesses behavioural outcomes related to knowledge and skills taught and their impact on healthcare and health outcomes. Cultural competence training and other workforce development interventions would greatly benefit from applying such an evaluation approach.

There are several key issues in the measurement and evaluation of cultural competence training and workforce development interventions which have been identified in previous literature and are mirrored in the studies reviewed. One concern is ***the lack of consistency in measurement instruments used to assess intervention outcomes,*** especially among cultural competency training evaluations. Similar to previous research studies reviewed, ***lack of uniformity across studies in measurement scales and outcomes were consistent problem observed. This lack of consistency in measurement tools makes it difficult to compare intervention outcomes and effectiveness across studies.***

The over-reliance of self-report measures is an ongoing limitation and concern across the cultural competency literature. Self-report measures were the most common method of evaluation, utilised in majority of included studies. However self-report measures are highly subjective and cannot be seen as predictive of resulting behaviour in clinical encounters. Due to the effects of social-desirability bias, participants might select responses seen as socially appropriate but which are not reflective of their true beliefs. To improve the evidence supporting their effectiveness, interventions aimed at improving health practitioner cultural competence need to move beyond the reliance on self-assess-

ment measures. [48, Rank 5]

Patient assessed practitioner cultural competence is one potential approach to evaluating the impact of cultural competency training interventions which could be used instead of, or in addition to, practitioner self-assessment. Patient assessed practitioner cultural competence has been associated with improved healthcare and health outcomes. However, there is less evidence linking patient-assessed practitioner cultural competence and associated positive outcomes to impacts of cultural competence training. In the reviewed studies, only one assessed patient reported physician cultural competence behaviours and its correlation with patient satisfaction and trust with no impacts reported. To increase the objectivity of the evidence base for the impact of cultural competency interventions, consistent assessment of patient perceived practitioner cultural competence, as well as healthcare and health outcomes, are needed.

Research exploring the comparative benefits of different approaches to cultural competence training as well as the benefits of other professional development opportunities such as mentoring and supervision would be of value to advance knowledge in this area. Although several positive outcomes were reported across the included studies, consistent evaluation approaches are needed to build the evidence base on intervention impacts. In particular, greater focus is needed on evaluating the application of knowledge, attitudes and skills in practice and the impacts of cultural competence interventions on specific practitioner behaviours and their subsequent impact on healthcare and health outcomes. [49, Rank 3]

Elements of Cultural Competence in Cultural Practice

Knowledge

In care providers, knowledge of the local context in which the patient and family is situated is vital, such that developing knowledge should focus on the local community in which the General Practitioner works. Knowledge of a patient's cultural context was thought to be important by General Practitioners, care providers, educators, patients and community members. Despite this, General Practitioners often reported accommodating differing cultural values and expectations only when they are explicitly stated by patients. At times they failed to recognise cultural expressions of distress and the effects of immigrant-specific issues on health, prefer-

ring to focus on individual interpersonal interactions.

Stereotyping can occur as a result of cultural training with a narrow focus and using generalisations without awareness of the uniqueness of the individual and the dynamic nature of culture. Medical learners have been reported to focus on differences and to want categorical information with high clinical relevance. General Practitioners and care providers were found to recognise and fear stereotyping as a potential consequence of cultural competence training, as do medical educators. In doing so, recognition of cultural difference was often conflated with stereotyping, with limited recognition of the need to test any assumptions held about a patient individually. [51, Rank 5]

General Practitioners commonly reported they lacked access to resources such as interpreters and other community health providers, language and culture-appropriate information, and knowledge of access to funding and specific health programs. This was noted to present barriers to culturally competent care and also to training. A lack of knowledge or skills in cross-cultural consultations was also reported to limit motivation to engage in these consultations and to increase stress particularly in care providers. care providers considered the use of bilingual community health workers to play an important role in mediating cross-cultural interactions, and prioritized this over the need to increase their own consultation skills. Training was associated with increased knowledge and use of appropriate resources. [50, Rank 3]

Attitudes

Unconscious underlying attitudes and assumptions of General Practitioners can alter their interactions with patients, and in turn the patients' response to GP cares. Addressing underlying racism, assumptions, prejudices and non-conscious bias is therefore a vital component of cultural competence and needs to be directly addressed during training.

Critical cultural self-reflection can be seen as the General Practitioner's ability to recognize the effect of their own position within the power structures of society and within their own culture, and how this affects their interactions. It also involves the ability to adapt in response to this reflection over time, including recognition of deficiencies in practice, recognition of their own assumptions, prejudices and non-conscious biases and their effect on the interaction and clinical decision-making. In care

providers, self-reflective professional development may occur without specifically addressing the General Practitioner's ethno-cultural identity or the influence of this on the consultation. For example General Practitioners may identify cross-cultural consultations as more stressful, but not see how the consultation could be done differently. The concerns some General Practitioners expressed about avoiding stereotyping may result in a failure to address cultural differences and existing biases and assumptions. [36, Rank 3]

Motivation of policy makers, medical educators, trainers and care providers was found to be a driving factor in cultural competence training. Lack of motivation of these stakeholders was shown to be a barrier to its implementation and effectiveness. In environments where non-compulsory training exists, cultural competence training was thought to be under-prioritised or overlooked, but where it is compulsory, resistance by health staff attending formal training was perceived to be very difficult to overcome. The 'buy in' was perceived to be critical because training directed at developing awareness of privilege/disadvantage, racism and prejudice was recognised as difficult and risking isolation or disengagement of the audience. [27, Rank 3]

Skills/Behaviours

Developing specific cross-cultural skills and behaviours should enable the General Practitioner to facilitate more effective and respectful health care. Communication was the most frequently cited barrier to effective cross-cultural interactions and at times had the potential to result in significant adverse outcomes for patients. In cross-cultural consultations, General Practitioners and patients may have less mutual understanding, which can be associated with poorer adherence. General Practitioners may have more retractive styles of consultation in the cross-cultural context involving patients less in decision-making and checking their understanding less often. Communication skills training alone does not necessarily lead to cultural competence and more training in cross-cultural communication skills was shown to be valued and desired by care providers.

Language differences pertain to a large part of communication difficulties and are associated with lower patient satisfaction and mutual understanding. General Practitioners and patients perceived language differences to be mostly overcome by the use of interpreters. However interpreter availability and lack of knowledge of how

to access them was sometimes a barrier. Using professionally trained interpreters was shown to reduce the risk of errors and improve outcomes, particularly in mental health scenarios. [19, Rank 3]

Despite this, use of untrained informal interpreters such as family members in care providers remains common. General Practitioners can be apprehensive about using interpreters, particularly with regard to the accuracy of the interpretation and about losing connection and rapport in both nonverbal cues and personal interaction. In one study, General practitioners did not see value in specific training in the use of interpreters and instead preferred to rely on other health workers being available to assist. Limited time and resources were frequently a barrier to cultural competence, especially as cross-cultural consultations were perceived to be more complex and require much longer consultations.

General Practitioners must also be trained to recognise and adapt to different cultural expressions of distress, cultural protocols that act as demonstrations of respect, and nonverbal cues and behaviours, including those produced by non-conscious biases in the General Practitioner. Many recognised patient-centred skills such as the ability to negotiate, build trust and rapport with patients etc. are all patient-centred techniques that are valuable in culturally competent practice. Being able to explore culture within the consultation in a respectful and effective way is something General Practitioners often avoid for fear of stereotyping or find difficult.

A lack of cultural competence of health services and systems is thought to impede the ability of an individual to provide culturally competent care. Proactively working to effect positive change not only in one's personal practice but in the wider health and societal systems was thought to be an important aspect of cultural competence [41, Rank 4]

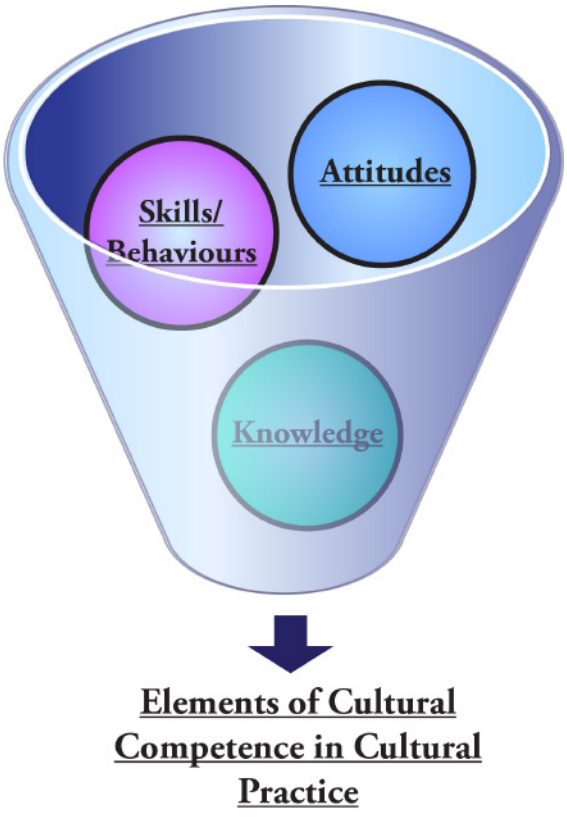

Figure 8 : Elements of cultural practice

The complexities of conceptualizing cultural competence

The complexities of conceptualizing cultural competence make assessment of attitudes, knowledge and skills difficult. Instruments and measures of what constitutes cultural competence often make assumptions or reflect biases. However, assessment of cultural competency amongst providers can drive motivation to learn and can be reflective of a supportive educational environment. care providers tended to interpret the lack of assessment in this area to mean it was a low priority for learning.

The importance of training evaluation cannot be understated, both in terms of ensuring quality and improvement of teaching practices and adding to evidence base. It has been noted that studies evaluating formal training interventions lack methodological rigour, do not adequately control for potential confounding variables (societal factors, external barriers), are difficult to generalize to other settings and tend not to assess patient perspectives or outcomes. Most evaluation studies of educational interventions were process-oriented, although evaluation of complex behaviours must be multi-faceted. Multiple confounders are often present and must be taken into account, such as other social and environmental determinants of health, access and other systemic barriers beyond the control of individual clinical interactions, and this makes evaluation even more difficult. A proposed algorithm for evaluation of educational interventions on patient outcomes exists to incorporate this understanding. [36, Rank 5]

Interventional studies evaluating formal training in the form of standalone workshops have shown such training improves awareness, knowledge and skills of participants, and that this can improve patient satisfaction and mutual understanding. However there is limited research to suggest it improves patient health outcomes. ***Formal workshops have the additional benefits of high participant satisfaction, efficacy for cost and time, and they can provide standardization of training amongst care providers, in a field where training environments can be very different.*** There were no particular features of formal training programs (such as length of training, content and curriculum and types of training methods used) that were associated with better outcomes. It was recognized however that standalone workshops and the improvements in individual participant knowledge, awareness and skills would not necessarily result in

long-term improvements in patient health without wider systemic and organizational changes and support.

Types of training suggested by care providers included videotaped consultations, role plays and case discussions, community-oriented project work and lectures and training led by representatives from those cultures. care providers also tended to desire more exposure to cross-cultural practice, more interpreters, and increasing diversity and awareness of faculty. However care providers in one study were ambivalent about formal training because of a fear of that training resulting in increased stereotyping. Cultural mentors and community members preferred informal settings and small group learning during training, as well as narrative and community site visits and cultural immersion [28, Rank 3]

Figure 9: Types of training suggested by care providers

Facilitating the development of Cultural Competency

The majority of interventional studies assessed standalone workshops led by trained medical educators. Experience and training specifically in cultural competence education was perceived to be required by educators given the complexity of the subject.

Cultural competency training is thought to risk perpetuating those myths, biases and stereotypes that exist within society already, particularly if it is done without the direct input and guidance by the cultural group under consideration. Therefore the value of cultural mentors is recognised by patients, educators and care providers across many studies. ***Cultural mentors are recognised as representatives from their community, able to share their expertise while facilitating partnerships with communities and health care providers.*** Ensuring cultural mentors and other community members play a central role in training also facilitate community ownership of cultural knowledge. Currently care provider's access to cultural mentoring is limited and needs to be expanded. [38, Rank 3]

Barriers to the involvement of com-

munity members in care providers training include having to manage negative attitudes of learners, conflicting family and community commitments, and lack of confidence and experience in training. There is however a desire within culturally diverse communities to engage in training with care providers and this should be supported. Having both a medical educator and community member present may improve engagement of care providers with the training session, by promoting its relevance and significance to clinical practice.

Staff diversity (including interpreters and allied health providers) within individual training practices has been shown to provide care providers with opportunities for cultural education. However, at times this may create a reliance on culturally diverse staff members to provide care for those patients, allowing other staff to avoid developing their own cultural competence. [47, Rank 5]

Views of Healthcare Practitioners Regarding Cultural Competence

Cultural competence is complex and multifaceted, requiring the care providers to have a combination of equally important knowledge, attitudes and skills, in order to produce a safe, respectful experience for the patient and better health outcomes. Studies exploring care provider's views and experiences of cross-cultural practice revealed that training in cultural competence was generally lacking, but desired and deemed important by care providers. This suggests there is general willingness for care providers to undertake further training, but they require more resources and support and facilitation of this training by clinical role models, medical educators and culturally diverse staff and community members. The central role of the supervisors in care providers training (through role modelling, mentoring and clinical supervision) suggests that supervisors do have a role in developing the cultural competence of their care providers, but that role needs to be further elucidated and developed

The educational environment can be either a facilitator or barrier to this training. This may be reflected in the motivation and skills of educational staff, as well as the use of assessment as a driver of learning. There appeared to be varying levels of critical self-reflection amongst care providers in general. ***Training in non-conscious bias, anti-racism training and cultural self-reflectiveness should therefore receive more***

focus. Consideration must be given to the complexities of teaching these particularly sensitive topics, and the potential to alienate audiences or inadvertently perpetuate stereotypes during training. Involvement of cultural mentors and experienced educators trained in this area may reduce these risks [11, Rank 3]

Person-Centered Definition of Cultural Competence

Person-centered definitions focused on customizing care for each individual. This understanding is consistent with the patient-centered movement across the health disciplines since the 1980s that has prioritized respect for patient wishes in clinical interactions. Person-centered definitions of cultural competence as fighting stigma also indicate that suffering from mental illness may be a more salient identity than "background" identities of race, ethnicity, or language. Indeed, hospital policies affirm this person-centered definition by noting that diversity is "internal and external." The list of "factors" for diversity includes "internal" traits that cannot be determined by prioritizing "external" appearance.

Discrepancies between hospital policies and actual practice raise questions over how to align priorities around cultural competence. For example, current policies do not specify best practices for clinicians on how to conduct a comprehensive cultural assessment. Some clinicians and administrators undergoing hospital training may have advocated group-based models of cultural competence based on their personal experiences than implementing an institutionally-endorsed alternative. [20, Rank4]

Most administrators defined cultural competence through group-based, demographic traits compared to person-centered definitions. Some administrators and clinicians treated traits particular to specific groups as targets of clinical intervention. Those who believe in the model of cultural competence may not think that clinicians can deliver culturally-competent care when patient and clinician backgrounds and identities differ. This tendency emerged among administrators who recommended patient-clinician matching by perceived cultural similarities as a model for cultural competence.

Clinicians and administrators typically define patient identities by making assumptions about physical appearance based on racial or ethnic backgrounds rather than asking patients directly about

their cultural identities. Taken to the extreme, a group-based understanding among administrators and clinicians may approach the definition for "stereotype" in hospital policies of applying experiences with an individual to an entire group [49, Rank 3]

Several studies also mentioned that clinicians should share similarities with patients as techniques for achieving cultural competence, but patients and clinicians wanted clinicians to relate personal experiences whereas an administrator warned against professional boundary violations. Role expectations may explain differences. Administrators supervising clinicians may want to avoid breaking institutional rules whereas clinicians may be willing to experiment with different forms of interactions with patients since they ultimately are responsible for treatment.

Psychologists have shown that US racial and ethnic minorities respond positively to therapist self-disclosures related to cultural identities. In this regard, our clinician sample exhibits notable differences from a study of psychiatry residents who complained about a cultural sensitivity course since instructors did not discuss how clinicians' personal experiences with race and ethnicity affected their approaches to patient care.

> **" Understand and respect individual differences. "**

Patients want to be treated as equal partners in treatment planning whereas clinicians and administrators viewed explanations as opportunities for psychoeducation. The growth of managed care has led to patients seeing themselves as consumers and clinicians as consultants rather than older models of clinicians as omniscient and omnipotent. Respecting patient wishes matches hospital policies to "understand and respect individual differences." However, patients and clinicians may view medical communication differently: patients tend to evaluate clinicians based on expressions of respect and empathy whereas clinicians focus on information gathering for diagnostic and treatment planning. Limits on the consultation model appear during acute illness when clinicians may need to treat patients against their preferences. One solution may be to ask patients how they wish to be treated during times of acute illness such that patient preferences and the range of clinician responses are discussed in advance of clinical emergencies. [37, Rank 4]

Hospitals remain understudied despite being preeminent domains that

refract mainstream society's core values and beliefs. The hospital in our study represents the challenges of a broader American society struggling to redress injustices for historically disadvantaged minorities, provide services for diverse immigrants, and balance market efficiency with consumer satisfaction. Staff meetings, employee orientations, and other hospital settings can illuminate how multiple stakeholders create and debate everyday knowledge and practice that may diverge with institutional standards. Social science research in health care settings can illuminate our understanding of how people construct institutional culture by comparing what people say with what they think they do. Researchers have adopted this orientation in analyzing how patients, clinicians, and administrators construct the institutional culture of one hospital by comparing their perspectives on cultural competence (what they say) as stakeholders against actual hospital policies (what they think they do) to improve clinical practice.

Social scientists have since identified numerous understandings of culture in cultural competence trainings. In the absence of a consensus definition for culture in the medical field, administrators have implemented cultural competence in various ways, from low-cost celebrations of patient festivals to the high-cost hiring of translators. Many trainings treat culture as a negative set of group traits that prevents minority patients from adhering to treatments recommended by clinicians rather than as a dynamic process through which all people make meanings of health and illness. Clinicians may view these trainings as required forms of political correctness that can be practically removed from patient care, reinforced by the use of exotic cases that may stereotype patients. [16, Rank 4]

The literature suggests that much of the development of cultural competence in care providers occurs informally, as fits with the work-place based training common to most programs. However, best practice delivery of cultural competence training in this setting has not been well explored. As many studies suggest, ***cultural competence training is a lifelong process*** and formal training, such as workshops, is only an introduction. Development of cultural competence in care providers requires use of a range of strategies, integrated within the curriculum and facilitated by cultural mentors and medical educators experienced in this area.

Many of the ***training approaches*** described in the literature are likely to be useful in care providers vocational training.

For example, community visits and cultural immersion may correspond to nursing home and home visit consultations during training. Case discussions and role plays form part of the current training approaches, however discussion regarding culture and its impact on the consultation tends to be ad hoc and confined within a framework of the patient-centred model. How training should and does proceed from there, how integration should occur into the general curriculum, and where the focus should lie at different stages of training has not been explored. An exploration of racism and its prevalence and impacts on patient care within care providers will also help in understanding what other influences exist on care providers training in this area. [48, Rank 4]

Further exploration is required of the integration of patient-centred and culturally competent approaches in care providers. The ***patient-centred model is well developed in general practice, and although there are many overlapping, possibly synergistic learning skills, between the two paradigms, the focus is ultimately different.*** Further exploration is required to determine whether a patient-centered approach incorporating elements of cultural competency provides a culturally safe experience for the patient and assist in reducing health inequalities. Studies further recommend that cultural competency development of care providers should receive more focus, particularly training in non-conscious bias, anti-racism training and critical self-reflectiveness.

Cross-cultural consultations can be stressful and complex for care providers. Formal cultural competence training in care providers is generally lacking, despite the recognition that it is of vital importance and that care providers generally desire this. There is a need for further exploration of how cultural competence training is delivered via the informal curriculum, and whether this is effective. Increased training focus on non-conscious bias, anti-racism training and self-reflectiveness is required. The ultimate end point of developing cultural competence in any clinician should be not only to provide quality and respectful care to patients across cultures, but also to reduce racism, discrimination and remove the health inequities that exist between cultural groups. [23, Rank 30]

Future Directions

Cultural competency, cultural safety and related terms have been variably defined and applied. Unfortunately, regulatory and educational health organisations have tended to frame their understanding of cultural competency towards individualised rather than organisational/systemic processes, and on the acquisition of cultural-knowledge rather than reflective self-assessment of power, priviledge and biases. This positioning has limited the impact on improving health inequities. A shift is required to an approach based on a transformative concept of cultural safety, which involves a critique of power imbalances and critical self-reflection. [36, Rank 3]

Conclusion

Health practitioners, healthcare organisations and health systems need to be engaged in working towards cultural safety and critical consciousness. To do this, they must be prepared to critique the 'taken for granted' power structures and be prepared to challenge their own culture and cultural systems rather than prioritise becoming 'competent' in the cultures of others. The objective of cultural safety activities also needs to be clearly linked to achieving health equity. Healthcare organisations and authorities need to be held accountable for providing culturally safe care, as defined by patients and their communities, and as measured through progress towards achieving health equity. [35, Rank 5]

***Important information for post-test are highlighted in red letters, boxes and diagrams.**

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