Cultural competence and diversity responsiveness: how to make a difference in healthcare?

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The increasing ethnic diversity of Western societies poses new challenges to healthcare. Healthcare that is responsive to diversity has often been referred to as 'culturally competent healthcare'. This thesis aims at contributing to a scientific basis for healthcare that effectively responds to patients' diversity at various levels. First, the studies presented offer insight in the knowledge, attitudes and skills that individual healthcare providers should possess to provide good quality care to ethnically diverse patient populations. Second, it addresses the development, content and assessment of cultural competence in medical education. Finally, this thesis provides insight in the policies and actions healthcare organisations should implement to guarantee equitable access and quality of care for all patients.

This work shows that responding effectively to patients' diversity seems to come down to a balance between working in a patient-centred way, thereby acknowledging the uniqueness of patient experiences, and taking into account the characteristics of specific groups (e.g. ethnic minority groups) that make them particularly vulnerable. The findings emerging from this work contribute to the systematic development and implementation of equitable, culturally competent and diversity-responsive healthcare.

Cultural competence and diversity responsiveness
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Conny Seeleman

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Cultural competence and diversity responsiveness: how to make a difference in healthcare?

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Contents

1 Introduction

Introduction

Patient populations in the Netherlands show increasing ethnic diversity. International research has demonstrated the existence of ethnic inequalities in accessibility and quality of healthcare. Similarly, over the years, research in the Netherlands has also shown ethnic inequalities in both health and healthcare.

In the Netherlands, various initiatives have been taken to improve healthcare for ethnic minority patients. However, because these initiatives (usually local) have seldom been evaluated, they have hardly contributed to a systematic development of evidence-based culturally competent healthcare (1). Research does not seem to have kept pace with the need experienced in everyday practice to develop healthcare that effectively responds to the diversity of present-day patient populations.

This thesis aims to contribute to a scientific basis for healthcare that effectively responds to patients' diversity. For several decades, healthcare that is diversity responsive has been referred to as 'culturally competent care'. The research presented here focuses on operationalisation of the concept of culturally competent/diversity responsive healthcare and on the application of these concepts in medical practice and education. First of all, this introductory chapter provides some background information about ethnic inequalities in healthcare and about the concept of cultural competence.

Ethnic diversity in the Netherlands

Settlement of migrants from various migration flows to the Netherlands and their children has resulted into an ethnically diverse society. In 2012, 3.5 million people (around 20% of the Dutch population) was from non-Dutch background[*] (2). In the Netherlands, ethnic groups are broadly divided into Western (mainly from Europe and northern America) and non-Western groups. In the largest Dutch cities, about 33% of the population is from non-Western ethnic background. The largest 'non-Western' groups originate from Surinam, Turkey, Morocco and the Dutch Antilles/Aruba. The largest groups classified as 'Western' are from Indonesia and Germany.

Based on the reason for migration, various migrant groups can be distinguished. First, there are those from the former Dutch colonies (Indonesia, Surinam, the Dutch Antilles and Aruba). Although the Surinamese and Antillean populations are ethnically highly diverse, most of the migrants from the former Dutch colonies have at least a basic understanding of the Dutch language.

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[*] Non-Dutch background: classified as such by their country of birth and the countries of birth of their parents

Second, labour migrants have immigrated to the Netherlands since the 1960s; the largest groups of such migrants originate from Turkey and Morocco. Turkish and Moroccan men came to the Netherlands as labour migrants in the 1960s and 1970s mainly to perform unschooled jobs; neither group originally spoke Dutch. Nowadays, many labour migrants come from Eastern Europe. For example, Polish migrants are now the largest group of labour migrants in the Netherlands; most of them have not yet mastered the Dutch language (2).

A third migrant group consists of refugees applying for asylum in the Netherlands. The composition of this group is very diverse, and its origin reflects conflict zones around the world. Large groups of refugees that have settled in the Netherlands originated from Iraq, Iran, Afghanistan and Somalia.

A fourth group of migrants results from family reunification, i.e. those who arrive in the Netherlands to get married or to join their partners; for example, the families that followed the Moroccan and Turkish labour migrants in the 1970s. In 2012, family migration was the most frequent motive for people from Turkey, Morocco and Surinam to migrate to the Netherlands (2).

These motives for migration, and the various countries of origin, imply that the composition of the Dutch population is highly ethnically diverse. Also within the ethnic groups themselves, differences exist that might influence healthcare provision; for example, differences in socio-economic status, acculturation, migrant generation (first, second or third-generation migrant), or mastery of the Dutch language. As a consequence, the Dutch healthcare must respond to highly diverse patient populations.

In this thesis we focus on the ethnic diversity of patients. Ethnicity is a complex concept, which can be defined as "*the social group a person belongs to and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry, and physical features traditionally associated with race*" (3). Different measures are used to operationalise ethnicity. In the United States, ethnicity is referred to as 'race/ethnicity' and defined by racial group (e.g. African-American, Caucasian). In the UK, self-identified ethnicity is preferred (e.g. Afro-Caribbean, Pakistani). In the Netherlands, as in other countries in continental Europe, the country of birth of an individual and his/her parents is used as the basis for the classification of ethnic groups (e.g. Turkish, Moroccan, Surinamese) (4).

Ethnic diversity in healthcare

Internationally, the body of evidence concerning ethnic inequalities in healthcare is growing (5,6). Also in the Netherlands, insight into the process and outcomes of healthcare among ethnic minority patients has broadened.

Ethnic diversity among patients affects healthcare provision in various ways and care providers do not always respond adequately (7). An obvious issue of importance is language. Although the added value of using professional interpreters in the medical setting has been documented (8), professional interpreters are underused by Dutch healthcare providers (7,9). Inadequate response to a language barrier will hamper adequate information exchange. For example, Fransen et al. revealed ethnic inequalities in informed decision-making about participation in prenatal screening, due to underuse of interpretation services and translated information materials (10). Additionally, various Dutch studies showed ethnic differences in other aspects of medical communication. Compared with Dutch patients, for example, they found shorter consultations with ethnic minority patients, less patient participation, and a lower level of empathy shown by general practitioners (11-13).

Furthermore, difficulties might arise from differences in illness perceptions or expectations between patients and care providers. Ethnic differences in illness perceptions were found for both hypertension (14) and asthma (15), which may influence patients’ decisions regarding their treatment. Differences in patient expectations may also result in misunderstandings. If care providers behave in ways that are different from patients’ expectations this might result in lack of trust (9), as has been reported in oncology care (16). Finally, providers’ (unconscious) bias regarding ethnically diverse patients may play a role. For example, Begeer et al. showed an ethnic bias among paediatricians that led to ethnic differences in the diagnosis of autism in children (17).

If, when and how these difficulties in the patient-care provider interaction influence the outcomes of healthcare for ethnic minority patients is not completely clear due to a lack of studies in this area. However, it is known that various healthcare outcomes are worse for ethnic minority patients. For example, studies show a higher risk for adverse perinatal and maternal outcomes in ethnic minority groups (18-20); less asthma therapy adherence among ethnic minority children (21) as well as worse outcomes for paediatric asthma care (22); and higher drop-out rates from rehabilitations programs among ethnic minority patients (23). These studies, however, do not provide insight into how underlying variables that account for inequalities in outcomes influence the care process.

Taking all this evidence into account, barriers in the healthcare process provided to ethnic minority patients, that could negatively influence healthcare outcomes, have been demonstrated. Cultural competence is a strategy that has the potential to improve the healthcare process provided to patients from ethnically diverse backgrounds.

Cultural competence

Culturally competent care is considered an important strategy to decrease inequities in healthcare outcomes for ethnic minority patients (5,24,25). The term ‘cultural competence’ derives from the United States and started to appear in the literature during the 1990s. Originally, cultural competence programs stemmed from an urge to overcome cultural and linguistic barriers experienced between immigrant patients and their care providers. These programs focused on teaching about beliefs and characteristics of specific cultural and ethnic groups. Over the years, the concept of cultural competence has expanded beyond culture, and now addresses a broad array of topics relevant to (ethnic) inequalities in healthcare quality. Additionally, cultural competence has extended from focus on the patient-provider interaction to encompassing the level of healthcare organisations and health systems (25-27).

Cultural competence at the level of individual care providers

Cultural competence at the level of individual care providers is generally defined as the knowledge, attitudes and skills necessary to provide good quality of care for ethnic minority patients. With the proper knowledge, attitudes and skills (i.e. cultural competence), individual healthcare providers should be able to more effectively manage and solve barriers in the patient-provider interaction. Although there are reports describing what ‘cultural competence’ is comprised of, a practical and concrete translation of the often abstract terms (e.g. for the purpose of developing training), is still lacking.

Meanwhile, in the Netherlands as well as elsewhere, many initiatives have been launched to improve cultural competence of care providers, mostly by providing training. However, evaluation of cultural competence training programs on students’ and physicians’ behaviour is lacking, and the effect of healthcare provider’s level of cultural competence on healthcare outcomes of diverse patients has not been well investigated (28,29). This is partly due to the lack of thoroughly evaluated instruments to measure providers’ cultural competence (29,30).

Cultural competence in medical education

Preparing all physicians to respond to the ethnic diversity present in modern societies should start during medical education. In various countries, licensing bodies and curricular objectives require medical curricula to address cultural competence (31-33). In spite of this, teaching of cultural competence has remained mostly unsystematic, non-uniform and fragmented (34); moreover, cultural competence training programs are not yet structurally implemented in medical schools (31,35,36).

Also in the Netherlands, the document that describes the objectives of medical curricula, the so- called ‘Raamplan’ (General Plan) (33) addresses issues related to cultural competence. It clearly states, for example, that students must be able to “*take into account ethnic backgrounds and contextual characteristics that might influence the provision of healthcare to individuals in society*” (Raamplan, p.37 (33)); or: “*to signal when an interpreter is necessary and be able to call in an interpreter*” (Raamplan, p.29 (33)). Despite these objectives, also in the Netherlands, teaching in cultural competence is not a structural part of the medical curricula (35,37). Internationally, several barriers for implementing cultural competence teaching in medical education have been identified, such as the lack of clarity about what the concept of cultural competence means, how it should be framed, how it should be assessed, and how it should be implemented throughout the curriculum. Other identified barriers were a lack of faculty support, a lack of expertise of staff, and students who do not experience a need for cultural competence training (34). In the Netherlands, implementation of cultural competence teaching has not yet been investigated; however, it is likely that some of these barriers will play a role here as well. For example, although the ‘Raamplan’ includes objectives related to cultural competence, these objectives are not clearly specified.

Cultural competence at organizational level

Some barriers experienced in healthcare by ethnic minority patients have their origin in the way various organisations are structured (e.g. unavailability of interpreter services). By putting into place certain key elements in service policies and management, organisations can improve accessibility and create conditions for individual healthcare providers to provide culturally competent health care (25,38,39).

Various institutions have developed guidelines and standards that provide insight into their views on organisational cultural competence. Probably the best known approach is the CLAS standards: ‘National Standards for Culturally and Linguistically Appropriate Services in Health Care’ developed by the U.S. Department of Health and Human Services Office of Minority Health (40,41). These standards were launched in 2001 and have served as the foundation for a large number of initiatives to improve quality of care for ethnic minority patients (42,43). Within and outside the United States other approaches have been developed to guide healthcare organisations in becoming responsive to patients’ ethnic diversity, such as the ‘interculturalisation approach’ in the Netherlands in the early 2000s (43,44). It has remained unclear, however, to what extent various approaches relate to each other: is there consensus between them in the aspects that healthcare organisations should implement, or do they all differ in their views on organisational diversity responsiveness?

Aim and research questions

The main aim of the research in this thesis is to operationalise the concept of cultural competence and to provide insight into the application of this concept in medical practice and medical education. The studies presented here address cultural competence at two levels: the level of individual healthcare providers and the level of healthcare organisations. At both levels we focus on the operationalisation of the cultural competence concept and, second, on the application of these concepts in everyday medical practice, in medical education and in healthcare organisations. The studies are arranged according to three themes:

I. Cultural competence at the level of individual health care providers

Within this first theme of the thesis we aim to operationalise the concept of cultural competence *at the level of the individual healthcare provider*. With qualitative studies based on experiences of care providers and patients in medical practice in various healthcare settings, we explore care for ethnically diverse patients and cultural competence from a broad perspective. The aim of the first three studies presented here is to specify the broad concept of cultural competence into specific competencies to develop the general idea into a useful concept for medical practice and medical education, in different settings and for different types of patients.

The following research questions were addressed:

1) What cultural competencies are necessary for healthcare professionals to provide good quality care to ethnic minority patients? (*Chapter 2*)
2) What mechanisms characterise the care process for ethnic minority patients, and what competencies for the care provider can be derived from these mechanisms? (*Chapter 3*)
3) According to care providers working with asylum seekers, what cultural competencies are required specifically for medical contact with asylum seekers? (*Chapter 4*)

II. Cultural competence in medical education

Within this theme we explore the application of the concept of cultural competence at the level of individual healthcare providers to *medical education*. The aim is to find concrete entry points for cultural competence curriculum development by exploring the level of cultural competence of students and physicians and by consulting experts in the field of teaching about ethnic diversity in medical education. We addressed the following research questions:

4) What are the outcomes of a cultural competence assessment among students and physicians? How are the assessed cultural competence domains

(knowledge, reflection ability and consultation behaviour) associated with subjective (self-perceived) cultural competence? And to what extent can the results of this assessment be applied in developing a cultural competence training program? (*Chapter 5*)

5) According to experts in diversity in medical education, what recommendations can be made for the development of training for medical students in communication with ethnically diverse patients? (*Chapter 6*)

III. Cultural competence at the level of healthcare organisations

The third theme of this thesis aims to operationalise the concept of cultural competence *at the level of healthcare organisations*. We chose to analyse existing approaches that provide recommendations or guidance for healthcare organisations to increase their organisational responsiveness to ethnic diversity.

The research question we addressed was:

6) According to the various approaches, what are the essential elements in providing care that is responsive to the needs of diverse patient groups, and how much consensus is there between these various approaches? (*Chapter 7*)

Overview of this thesis

Table 1.1 presents an overview of the studies presented in this thesis.

Chapters 2-4 discuss the operationalisation of cultural competence *at the level of individual healthcare providers*. We chose to use qualitative studies within medical practice in various healthcare settings to explore care for ethnic minority patients and cultural competence from various perspectives.

Chapter 2 describes a conceptual framework that outlines the specific knowledge, attitudes and skills that are necessary for care providers to deliver high-quality care to ethnic minority patients. The framework is based on personal interviews with patients and physicians, which were held as part of the development of educational material for medical students: i.e. the case study book entitled ‘Een arts van de wereld’ (Physician of the world) (45), and key literature on cultural competence.

In Chapter 3 we explore the healthcare process for ethnic minority patients in a specific context: specialist paediatric asthma care. For this qualitative study, paediatricians and nurses were interviewed to explore mechanisms which lead to deficiencies in culturally competent care. The interviews were analysed according to the cultural competence framework presented in Chapter 2, and findings were compared with literature.

Chapter 4 focuses on the provision of health care to asylum seekers living under specific conditions in a host country while awaiting the decision about their request for asylum. Based on questionnaires and group interviews, we explored those particular cultural competencies that nurse practitioners working with asylum seekers consider important. The findings are placed in the perspective of the conceptual cultural competence framework (*Chapter 2*).

In Chapters 5 and 6 we explore the application of the concept of cultural competence at the level of individual healthcare providers to *medical education*. We used both a quantitative assessment method and a qualitative survey.

Chapter 5 describes the assessment of cultural competence of medical students and physicians to identify gaps in the curriculum regarding cultural competence training. We developed an assessment instrument based on our conceptual cultural competence framework (*Chapter 2*) which we distributed among medical students and physicians.

Chapter 6 presents ten recommendations for the development of training in communication skills for consultation with ethnic minority patients in medical curricula. The recommendations emerged from a questionnaire sent to the members of a Dutch special interest group on diversity in medical education, and represent the views and experiences of these respondents.

The final theme of this thesis aims to operationalise the concept of cultural competence *at the level of healthcare organisations*; document analysis was used for this part. In Chapter 7 we developed an over-arching analytic framework within which different approaches for organisational responsiveness to patients' diversity are compared and contrasted. To develop the framework, we selected six approaches from the USA, Australia and Europe, and used qualitative analysis to categorise the content of each approach into domains (conceptually distinct topic areas) and, within each domain, into dimensions (operationalisations). The resulting classification framework was used for comparative analysis of the content of the six approaches.

Chapter 8 (General discussion) deals with answers to the research questions, discusses aspects of the methodology of the various studies, presents an interpretation of the findings in the light of current literature, and closes with implications for further research and practice.

Table 1.1 Overview of the studies presented in this thesis

	Ch	Topic	Study methods	Study population	Focus of study
INDIVIDUAL HEALTHCARE PROVIDERS	2	Operationalisation of individual healthcare provider's cultural competence	- Personal interviews - Literature review	Patients from diverse ethnic background (n=20); Physicians of diverse specialties (n=23)	Developing a conceptual framework
	3	Operationalisation of individual healthcare provider's cultural competence in paediatric asthma care	- Personal interviews - Literature review	Paediatricians (n=13); Nurses (n=3)	Exploring mechanisms leading to deficiencies in care provision and the cultural competencies that result from these
	4	Operationalisation of individual healthcare provider's cultural competence in healthcare for asylum seekers	- Questionnaires with open-ended questions - Group interviews	Nurse practitioners (n=89 for questionnaires; n=36 for interviews)	Exploring cultural competencies considered important according to nurse practitioners
MEDICAL EDUCATION	5	Assessing cultural competence	- Web-based questionnaire	Medical students (n=86); Youth healthcare physicians (n=91)	Assessing cultural competence to identify gaps in the curriculum
	6	Developing training	- Questionnaire with open-ended questions	Group of experts (n=23)	Recommendations for teaching skills in communication with ethnically diverse patients
ORGANIZATIONS	7	Operationalisation of cultural competence at the level of healthcare organisations	- Document review	Approaches for organisational responsiveness to diversity (n=6)	Insight in essential elements for organisational cultural competence/responsiveness

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2 Cultural competence: a conceptual framework for teaching and learning

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Abstract

Objectives

The need to address cultural and ethnic diversity issues in medical education as a means to improve the quality of care for all has been widely emphasised. Cultural competence has been suggested as an instrument with which to deal with diversity issues. However, the implementation of culturally competent curricula appears to be difficult. We believe the development of curricula would profit from a framework that provides a practical translation of abstract educational objectives and that is related to competencies underlying the medical curriculum in general. This paper proposes such a framework.

Methods

The framework illustrates the following cultural competencies: *knowledge* of epidemiology and the differential effects of treatment in various ethnic groups; *awareness* of how culture shapes individual behaviour and thinking; *awareness* of the social context in which specific ethnic groups live; *awareness* of one's own prejudices and tendency to stereotype; *ability* to transfer information in a way the patient can understand and to use external help (e.g. interpreters) when needed, and *ability* to adapt to new situations flexibly and creatively.

Discussion

The framework indicates important aspects in taking care of an ethnically diverse patient population. It shows that there are more dimensions to delivering high-quality care than merely the cultural. Most cultural competencies emphasise a specific aspect of a generic competency that is of extra importance when dealing with patients from different ethnic groups. We hope our framework contributes to the further development of cultural competency in medical curricula.

Introduction

In societies that are rapidly becoming multicultural, doctors deal increasingly with patients from a variety of ethnic backgrounds. Hence, ‘cultural competence’ has been suggested as an instrument that can be used to prepare doctors and to support them in dealing with issues such as ethnic diversity. Cultural competence is generally defined as a combination of knowledge about certain cultural groups as well as attitudes towards and skills for dealing with cultural diversity (1). However, as a concept or strategy, cultural competence is not yet fully developed. For example, the terminology of the concept suggests that culture and ethnicity, two different notions, are equivalent or interchangeable (2). In addition, although it is clear that cultural competence is a combination of attitudes, knowledge and skills, it is not evident how and when the right balance between these elements can be achieved.

The need to address cultural and ethnic diversity issues in medical education as a means of improving quality of care for all and of eliminating ethnic and racial disparities has been widely emphasised. In several countries, educational objectives that address cultural or ethnic diversity in one way or another have been outlined for medical faculties (e.g. in the UK (3), Sweden (4) and the Netherlands (5)). However, the practical implementation of these objectives appears to be problematic. In particular, it seems to be difficult to ensure that cultural competency is fully integrated into the curriculum. Frequently, teaching about this subject is fragmented (3,5). In addition, for teachers and curriculum developers unfamiliar with the subject, it is not always clear what should be taught (5,6).

We believe the development of culturally competent curricula would profit from a framework that provides a practical translation of the vague and abstract terms used in the outlined learning objectives. This paper proposes such a framework. It draws upon what is already known in the literature and is related to competencies that underlie the medical curriculum in general. Two basic assumptions are fundamental to the conceptual model. Firstly, we use a broad conceptualisation of cultural competence, which relates not only to cultural issues, but also to other elements that pertain to care for patients from various ethnic backgrounds, including epidemiological differences, patients’ social contexts, and prejudice and stereotyping. Secondly, we do not assume that doctors are culturally and ethnically neutral, but we start instead from the premise that the learning environment of most medical students is predominantly ‘White’ and ‘Western’. ‘By embedding cultural competence information within the typical problems clinicians grapple with daily’, as Vega (7) puts it, we will specify which aspects are important in an ethnically and culturally diverse health care setting. This results in a conceptual framework of cultural competence that is based on the competencies of medical doctors in general. It also provides specific focal points for the integration of cultural competency in medical education.

The framework presented here is based on our experiences in developing educational material for medical students. It was developed over a 3-yearperiod, during which we studied national and international literature extensively. We began to identify and to analyse difficulties (experienced by doctors as well as patients) that arise in providing health care in an ethnic or culturally diverse setting. We then defined competencies that are necessary to solve or to manage these kinds of difficulties. These competencies were compared with the literature on cultural competence. Initially, we operationalised the term ‘cultural competence’ very broadly as representing the attitudes, knowledge and skills necessary to deliver high-quality care to an ethnically and culturally diverse patient population. (Attitudes include a cognitive [knowing what is important] and an evaluative [an individual’s affective evaluation of this knowledge] component. We describe attitudes in terms of ‘awareness’, but we would like to stress that after becoming aware of, for example, the influence of culture on individual behaviour, the next step within this competency is to appreciate and value the importance of this influence.)

We arranged the competencies accordingly (Box 2.1). In the next section we will specify each competency and show why it is important in everyday practice because this framework focuses on patient-doctor interaction. The competencies are illustrated with cases from educational material that we have compiled (8). These cases are based on real-life medical situations, and the material was gathered by interviewing doctors from several specialties and patients from a number of ethnic backgrounds.

Box 2.1 Cultural competencies

Knowledge
- Knowledge of epidemiology and manifestation of diseases in various ethnic groups
- Knowledge of differential effects of treatment in various ethnic groups

Attitudes
- Awareness of how culture shapes individual behaviour and thinking
- Awareness of the social context s in which specific ethnic groups live
- Awareness of one’s own prejudices and tendency to stereotype

Skills
- Ability to transfer information in a way the patient can understand and to know when to seek external help with communication
- Ability to adapt to new situations flexibly and creatively

Conceptual framework of cultural competencies

Knowledge of epidemiology and manifestation of diseases in various ethnic groups

From a prescriptive perspective, doctors should base their clinical decisions on two components: namely, the symptoms presented and the probability of a disease (9). Ethnic background might influence this in two ways. Firstly, the presentation of symptoms can be influenced by a patient's culture, as in the case of schizophrenia (10), or clinical presentation may differ, such as in dermatological diseases, which may present differently in people with darker and lighter skin colours (11). Secondly, the incidence of a disease may vary between ethnic groups: a well-known example is diabetes mellitus, which has a high prevalence among South Asians (12). This affects the probability of a diagnosis in the presence of certain symptoms. In order to promote a timely diagnosis for all patients, it is necessary for doctors to be aware of these kinds of differences in the presentation and epidemiology of diseases (1), as illustrated in Case 1 (Box 2.2).

Box 2.2 Knowledge of epidemiology and manifestation of diseases in different ethnic groups: Case 1 (8,37)

Mrs Ismael, a 45-year-old woman, moved from Somalia to the Netherlands 5 years ago. She wears a headscarf because she is a Muslim. She visits her general practitioner (GP), complaining of tiredness and difficulty in walking, getting up out of a chair and climbing stairs. The doctor confirms that Mrs Ismael is indeed walking somewhat stiffly and with difficulty and he prescribes painkillers. He believes her vague complaints probably have a psychosomatic cause, like homesickness or adaptation problems. Later, he learns about the pain that can accompany vitamin D deficiency and that resembles Mrs Ismael's complaints. Causes of the deficiency can be a lack of exposure to sunlight or a lack of vitamin D in food. The GP checks Mrs Ismael's vitamin D level during her next visit and the test confirms this deficiency.

In the Netherlands, the prevalence of vitamin D deficiency is higher among women from certain non-Western ethnic groups than among the general Dutch population. If the doctor had known about this unequally distributed prevalence and the complaints that accompany this deficiency (which would probably be better known if the prevalence among the general population were higher), he could have given this woman proper treatment earlier.

Knowledge of differential effects of treatment in various ethnic groups

Although research in this area is still quite recent, it suggests that biological differences can be related to genetic differences that may influence the ways in which certain drugs are metabolised. Until now, this kind of research has focused primarily on psychotropic and antihypertensive agents (13). However, this research focuses mainly on racial rather than genetic differences. Thus, it should be viewed with caution because research has also shown that genetic differences are greater within socially defined racial groups than between groups (14), which implies there is no biological basis for ‘race’ (15). Therefore, it is important for doctors to stay abreast of developments in this area, yet to view them critically at the same time (16).

Awareness of how culture shapes individual behaviour and thinking

Culture is defined in many different ways, but most definitions agree that culture constitutes a set of behaviours and guidelines that individuals use to understand the world and how to live in it (17). Nevertheless, culture should not be seen as homogenous or static. Culture may differ for members of the same ethnic group (e.g. according to differences in age, gender, class, religion, personality (18)) and it changes over time.

Illness is culturally shaped in the sense that how we perceive, experience and cope with disease is based upon our explanations of sickness. These explanations are specific to the social positions we occupy and to the systems of meaning we employ (19), as shown in Case 2 (Box 2.3). Culture may influence many other aspects of the patient-doctor relationship, such as mutual expectations or ethical norms.

When we make contact with people from other cultural backgrounds, it is easy to attribute differences to the other person’s culture. This also accounts for how doctors treat patients from other ethnic backgrounds: they tend to ascribe difficulties primarily to cultural differences (20). Clearly, this is not always justified. Doctors also have their own cultural backgrounds - personal and professional - which influence the way they interpret their patients’ behaviour as well as the medical and other decisions they make, as seen in Case 3 (Box 2.4).

Clearly, cultural background, among other factors such as religion, influences peoples’ perceptions of health and health care, their frames of reference, and their expectations. Awareness of how this might be of influence - instead of mere knowledge about the cultural practices or beliefs of specific ethnic groups - and an appreciation of this factor helps doctors deal effectively with cultural issues. The same applies to doctors’ awareness of their own cultural frames of reference.

Box 2.3 Awareness of how culture shapes individual behaviour and thinking: Case 2 (8)

An 8-year-old girl of Moroccan descent visits the emergency room. Over a 1-month-period, the girl had experienced speaking difficulties, walking disturbances, problems with writing, and moments of being mentally absent. The physical examination does not show any abnormalities. The conclusions from the neurological examination are ‘no signs of meningeal irritation, walking disturbed, and muscle tone diminished’. Several additional examinations provide no further information and the doctor decides to do a lumbar puncture to exclude encephalitis. The child’s mother refuses, but the reason for this refusal is unclear to the doctor. Therefore, they request the assistance of a doctor of Moroccan descent. She asks the mother, ‘What do you think is wrong with your daughter?” The mother answers, ‘I think it is a djinn [a spirit in Islamic folk *belief]. That is what the imam told me.' She believes that if her daughter is given a puncture or a drip, it will upset the djinn and her daughter will become more seriously ill.*

Although in this case it remains unclear why the mother took her child to the hospital when she had already sought help elsewhere, it does show how the cultural-religious background of this mother influenced her decision-making with regard to her daughter's health.

Box 2.4 Awareness of how culture shapes individual behaviour and thinking: Case 3 (8,38)

Mrs Tünay, a 26-year-old woman of Turkish descent, has diabetes that is difficult to regulate. She has just told her internist she is 5 weeks pregnant, which came as a surprise to the internist. Although she knew that for the last 4 years Mrs Tünay has wanted to have a baby, the internist thought it was better to regulate her diabetes first. After all, Mrs Tünay is young enough.

In this case, the doctor's reasoning comes from her medical background, and she believes the medical risks for mother and child are more important than the patient's wish to have children. Furthermore, because the average Dutch woman is 29 years old when she has her first child, although the average Turkish woman is aged 21 years, the internist is also reasoning from a 'Dutch' perspective when she claims that Mrs Tünay is still young enough to postpone a pregnancy.

Awareness of the social context in which specific ethnic groups live

According to Green et al. (21), most cultural competency initiatives underemphasise the importance of social factors in providing health care to diverse populations. Addressing only cultural factors may lead doctors to think that culture can explain issues that are fundamentally social (21). Green et al. (21) distinguished four domains of social context that are particularly important for ethnic minority patients: social stressors and support networks; change in environment; life control, and literacy. Generally, in Western European countries and the USA, all these domains are less favourable for ethnic minority patients than for the host population. For instance, the income and educational levels (which are lower on average) of ethnic minorities (22), higher vulnerability to discrimination (23) and the process of becoming familiar with a new society may all serve as stressors, as may distress caused by the migration itself. In Excerpt 1 (Box 2.5), a Moroccan woman we interviewed speaks about her limited options when it comes to her children's health.

The final domain distinguished by Green et al. is literacy; minorities have disproportionately high levels of illiteracy (21,24). Difficulties in reading prescriptions and understanding instructions or appointment reminders are some of the possible consequences.

The rules and regulations that might be challenged with regard to caring for ethnic minority patients also directly influence health care. Three important issues in this regard are care for undocumented patients, legislation about residence permits on medical grounds, and informed consent.

All these factors indicate the importance of taking patients' social contexts into account. If a doctor is unaware that ethnic minority patients have fewer opportunities in life compared with the host population, he or she may interpret a particular situation as reflective of unwillingness on the part of the patient, rather than as indicative of circumstances where certain responses are impossible. If a doctor is not aware of the stress related to a patient's position as a migrant (e.g. as a result of discrimination), he or she may not recognise or acknowledge this distress and will thus ignore it.

Box 2.5 Attitudes. (A) Awareness of the social contexts in which specific ethnic groups live. (B) Awareness of one's own prejudices and tendency to stereotype

(A) Excerpt 1

Many migrant patients also have less ability to influence the direction and course of events in their lives. We interviewed a Moroccan mother of a child with asthma for the development of our educational material. She lives in a small, damp house and she says:

'And our doctor says you have to move. If you do not move, your son may stay this ill. And if we find a good home I want to move. […] Yes, but if I look in the paper, the houses are expensive. My husband has little money; he is on welfare, so it is expensive. That is difficult.'

Although this woman is willing to move, her options are restricted by limited finances, lack of awareness of possible subsidies or financial support, unfamiliarity with the Dutch health care system, and her inadequate Dutch.

(B) Excerpt 2

In the next quotation, the consequences of stereotyping are devastating. It is an excerpt from an interview with an intern who talks about the contact between an Afghan refugee and her general practitioner (GP):

'The patient had continuous physical symptoms and she went to see her GP about them. And she had the feeling he didn't take her seriously. […] She complained of terrible headaches and the GP said, "Go and take some painkillers, don't think, don't worry, then everything will be alright."[…] But her symptoms suddenly got worse, and she had different symptoms, vomiting, bad vision, and double vision too. She went to her GP with these symptoms as well […]. And in the end the GP said, "Well, don't come back with these symptoms because there's nothing wrong with you."[…] It wasn't long before she had an epileptic seizure and had to go to the emergency room; she had a CT scan and there turned out to be an enormous tumour at the front of her brain.'

In this case, the GP's diagnosis was biased by his stereotypes about refugee patients, specifically that they suffer from a traumatic past. Therefore, he placed the patient's complaints within this frame of reference and failed to diagnose a brain tumour.

Awareness of one’s own prejudices and tendency to stereotype

Stereotyping is a mechanism by which we give structure to the world that surrounds us (25). Patients with different ethnic or cultural backgrounds can more easily invoke bias as a result of stereotyping or prejudice. For the doctor, several mechanisms may influence this (26). For example, doctors may have lower regard for, or even prejudice against, certain ethnic groups. Clinical uncertainty can also play a role: doctors must make judgements about patients’ conditions under time pressures and resource constraints. It can be more difficult to obtain the necessary information or to interpret the given information when a patient has a different ethnic background. The doctor’s a priori attitudes (e.g. about ethnic background, socio-economic position, age or sex) may then shape his or her interpretation of the information provided by the patient. In the case of stereotyping, doctors use social categories (e.g. race, sex or class) to acquire, process and recall information about others (Excerpt 2, Box 2.5). As a first step towards avoiding this pitfall, it is essential to be aware of one’s own prejudices and tendency to stereotype. This concerns obvious prejudice as well as subtle stereotyping, as reflected in patronising or avoiding patients.

Ability to transfer information in a way the patient can understand and to know when external help with communication is needed

Nowadays, although good doctor-patient communication is accepted as an important condition for quality of care (27), it is not always self-evident. Problems in this regard may result in incorrect diagnoses, noncompliance with treatment, or inappropriate use of health services. Problems in communication and mutual understanding occur more often between doctors and migrant patients than with native-born patients (28). These difficulties can be caused by a number of factors. The most obvious is language, but cultural differences and level of knowledge can also play a role (Case 4, Box 2.6).

Because of the negative consequences of inadequate information, the ability to transfer information in a way the patient can understand is essential for doctors. Formal training in intercultural communication competence may support doctors in this (29). Additionally, because it is both impossible and undesirable for doctors to master the native languages of all their patients, it is important that doctors acknowledge the limits of their competency. It has been proved that external help such as medical interpreting services improve the quality of care for patients with limited language proficiency (30), but these services are not consistently used in practice (31). Doctors should know how to call in this external help and should be able to use it constructively.

Box 2.6 Skills. Ability to transfer information in a way the patient can understand and to know when to seek external help with communication: Case 4 (8)

This dialogue was transcribed from an actual consultation on videotape:

A Moroccan man and woman visit a general practitioner (GP). The man nervously speaks to the doctor and explains that he and his new wife are going to have intercourse for the first time. She is still a virgin and he wants a tablet so that she doesn't get pregnant. The GP explains about contraceptives.

GP: 'But these tablets, she has to start with them on the first day she has a loss of blood, you know?'

Man: 'Yes, only, so she is still a virgin. I know first the blood will come but I think before the blood comes she has to eat tablets? I think so?'

GP: 'Well the, ummm, no you have to start the first day the blood comes, then she has to start; then she has to take the first tablet.'

Man: 'Before the blood comes or after?'

GP: 'No, the first day, blood always comes 4 days 5 days but the first day she has to start and must take the first tablet.'

Man: 'An example, I'm sorry I go sleeping with her at night, yes? She goes taking a tablet before?'

The language barrier makes it difficult for both parties to express themselves. A misunderstanding arises when the man and the GP attribute different meanings to the word 'blood' (as a synonym for menstruation versus the blood that is apparent at the loss of virginity). Furthermore, this man has scarcely any knowledge of contraceptives or the menstrual cycle, so he cannot place the doctor's information within his own frame of reference.

Ability to adapt to new situations flexibly and creatively

The competencies described thus far emphasise the importance of certain knowledge, awareness, and skills, but these are not ready-made solutions for difficult or unfamiliar situations. When handling new situations, doctors cannot always fall back on standard solutions. Sticking to usual habits and principles, or disapproving of certain preferences (including cultural ones), may create conflicts or frustration, or may damage the doctor-patient relationship. Instead, doctors have to find new and versatile solutions, and this requires creativity and flexibility. This can be seen as part of patient-centredness, the approach advocated today in medicine (32). The literature and the interviews we used to develop our educational material illustrate that patients are usually highly appreciative when doctors are prepared to think along with them, to step outside their usual way of doing and to demonstrate versatility in dealing with ethnic minority patients (8,33).

Discussion

In this paper, we have presented cultural competencies we believe are essential for medical practice in an ethnically diverse setting. A versatile conceptualisation is a prerequisite if we want to use cultural competence as a means to improve quality of health care for all, to eliminate health disparities in general and as a strategy to educate future doctors as culturally competent practitioners.

Our framework anticipates two important criticisms of the concept of cultural competence. Firstly, the term ‘cultural competence’ incorrectly suggests that the concepts ‘ethnicity’ and ‘culture’ are interchangeable. This does not do justice to the complex sociocultural context in which patients live (17), and which we must acknowledge if we are to care for an ethnically diverse patient population. Therefore, the competencies we distinguished in our conceptual framework also relate to elements other than cultural, such as epidemiological differences, patients’ social contexts, and prejudice and stereotyping. Secondly, it has been noted that cultural competence tends to focus on the ‘otherness’ of patients as the cause of experienced problems, while assuming doctors to be culturally neutral human beings (2). Therefore, the framework acknowledges that not only patients, but also doctors and health care systems, are culturally influenced.

When describing the competencies, we distinguished between the elements of knowledge, attitudes and skills. Yet it is the integration of these that make up a competency (34), described by Betancourt as a three legged stool (1). Thus, for instance, if a doctor is knowledgeable about epidemiological differences, he or she must also possess the appropriate disposition and value system and must be skilled in order to apply this knowledge in practice. In our description, we emphasised the most important aspect of a competency, but it is fully constituted by the interaction between knowledge, attitudes and skills. Developing such competencies requires an educational design that balances and continuously shifts between the acquisition of knowledge, attitudes and skills, and that offers opportunities to integrate these aspects (34).

It might appear that the competencies described represent a striving for an ideal situation. Indeed, we believe it is necessary to aim for this in order to assure high-quality care (e.g. doctors should never rely on their stereotypes). However, this is more complex in terms of skills in communication and flexibility because, although a doctor may have highly developed abilities in this regard, the provision of care always involves interaction with the patient. Both are responsible for the outcome of the interaction, but a doctor has to act within the limits of his or her profession and organisation. Sometimes there may be no solution other than to accept an unsolvable or unsatisfactory situation.

If we take a close look at the cultural competencies defined, it becomes clear that they are not very different from those competencies every doctor already needs to possess. Most of the cultural competencies emphasise a specific aspect of a certain generic competency that is of extra importance when dealing with patients from different ethnic groups. Interaction with ethnic minority patients magnifies problems that already exist, although communication difficulties are more obvious when neither partner speaks the other's language. However, it does not mean these kinds of problems do not exist with other patients. Therefore, cultural competencies might be expected to benefit health care in general (1).

The framework of competencies could be interpreted as a list of educational goals, which suggests that if one has 'completed' the list, one is culturally competent. We do not consider cultural competence to be an end in itself, however, but a means to the provision of a better quality of care. Like any other medical competency it needs continuous attention. In this manner, the framework fits the concept of reflective practice, the importance of which is increasingly recognised within medicine. Reflection helps professionals and students to make sense of complex situations and enables them to learn from experience (35). When a doctor reflects on his or her medical performance, the aspects of cultural competency should be a recurring focal point.

We believe this framework can be used by teachers and curriculum developers to examine whether all these aspects of cultural competence are being given proper attention and to find out whether there are any blind spots to, or underemphasised aspects of, cultural competence in medical education (18). In order to assess students' cultural competency, the competencies need to be developed further. For example, they might be expressed in terms of measurable behaviour and they should inform learners about what is expected from them (36). However, like Govaerts (34), we want to stress that competencies derive meaning in practice and that the foremost concern of education and assessment should be to facilitate the understanding of practice and understanding in practice. We hope our framework can contribute to the further development of an integrated approach to cultural competence in medical curricula.

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3 Deficiencies in culturally competent asthma care for ethnic minority children: a qualitative assessment among care providers

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Abstract

Background

Asthma outcomes are generally worse for ethnic minority children. Cultural competence training is an instrument for improving healthcare for ethnic minority patients. To develop effective training, we explored the mechanisms in paediatric asthma care for ethnic minority patients that lead to deficiencies in the care process.

Methods

We conducted semi-structured interviews on care for ethnic minority children with asthma (aged 4-10 years) with paediatricians (n = 13) and nurses (n = 3) in three hospitals. Interviews were analysed qualitatively with a framework method, using a cultural competence model.

Results

Respondents mentioned patient non-adherence as the central problem in asthma care. They related non-adherence in children from ethnic minority backgrounds to social context factors, difficulties in understanding the chronic nature of asthma, and parents' language barriers. Reactions reported by respondents to patients' non-adherence included retrieving additional information, providing biomedical information, occasionally providing referrals for social context issues, and using informal interpreters.

Conclusions

This study provides keys to improve the quality of specialist paediatric asthma care to ethnic minority children, mainly related to non-adherence. Care providers do not consciously recognise all the mechanisms that lead to deficiencies in culturally competent asthma care they provide to ethnic minority children (e.g. communicating mainly from a biomedical perspective and using mostly informal interpreters). Therefore, the learning objectives of cultural competence training should reflect issues that care providers are aware of as well as issues they are unaware of.

Background

Asthma outcomes are generally worse for children from ethnic minority backgrounds (1-3). A recent study in the Netherlands showed that ethnic minority children have poorer asthma control and more complaints than their Dutch peers (4). This reflects a significant, avoidable burden of illness, because asthma prevalence is as high as 5% to 10% among children in Western societies (5), and ethnic diversity has increased among young Western populations (6,7).

Low adherence to preventive treatment with daily inhalation corticosteroids (ICSs) is an important barrier to achieving optimal asthma control (8,9). Paediatric asthma care focuses on parents' self-management of their children's asthma. Rather than parents having full responsibility, an effective partnership between the care provider and the child's parents is considered a key component for effective self-management (10). Therefore, care providers are also responsible for this. However, research has found more misunderstandings and less patient satisfaction in medical consultations with ethnic minority patients. Problems arise from cultural differences, linguistic barriers, and perceptual bias (11).

Cultural competence is regarded as an instrument for improving quality of care for ethnic minority patients, and is generally defined as the combination of knowledge, attitudes, and skills necessary for delivering high-quality care to an ethnically diverse patient population (12,13). Training can make care providers aware of ethnic differences and improve their cultural competence. However, to develop effective, informative training, we first have to gain insight into the daily practice of specialist paediatric asthma care for ethnic minority patients. Based on such insights, learning objectives can be defined for cultural competence training targeted specifically at such care.

The aim of this qualitative study was to explore those mechanisms in paediatric asthma care that lead to deficiencies in the care process for ethnic minority patients. The results will be used to develop cultural competence training for specialist paediatric asthma care providers.

Methods

Design

We conducted semi-structured qualitative interviews with care providers in specialist paediatric asthma care that focussed on their own experiences and reported concrete behaviour with children from ethnic minority groups with asthma (aged 4-10 years) and their parents. We defined "children from ethnic minority groups" as children who had at least one parent who was born abroad (14).

We chose to conduct individual, qualitative interviews because of its appropriateness to provide an in-depth understanding of the care process for ethnic minority children with asthma. Although Dutch law (the Medical Research Involving Human Subjects Act) did not require ethical approval for this interview study, each respondent was adequately informed of the aims and methods of the study and we took every precaution to guarantee the respondents' anonymity.

Respondents

We established a purposive sample of nine paediatricians (two male, seven female) and four paediatric pulmonologists (three male, one female) in three hospitals in Amsterdam (two paediatric university hospitals, one general inner-city teaching hospital). Their experience in working as paediatricians varied between <10 years (n = 7), 10-20 years (n = 3) and >20 years (n = 3). We chose Amsterdam because over 50% of its young population (aged 0-15) is from non-Western ethnic minority backgrounds (7). Although over 170 nationalities live in Amsterdam, the largest ethnic groups are Moroccans and Turks (both ethnic groups have a history in labour migration), and Surinamese (Suriname is a former Dutch colony in South America) (15).

Eight physicians worked in an academic setting, and five in the general hospital. We chose these different settings to ensure variation in ethnic patient population, provider population, asthma severity, and type of healthcare organisation. Additionally, an asthma nurse was interviewed in each hospital (all female). Respondents were selected because they worked at one of the three hospitals' paediatrics department at the time of the study. They were approached by the first author (CS). Three care providers declined an interview: two because of time constraints and one because of illness. We stopped approaching care providers when interviews revealed no new information (saturation of data).

Data collection

We used a semi-structured topic list based on issues of specific importance in asthma care in an ethnically diverse healthcare setting (Table 3.1). We asked respondents to elaborate on a specific case from their own daily practice. Interviews were conducted by CS who is an independent researcher and not involved in patient care, and took between 40 and 75 minutes. All interviews were audiotaped and transcribed verbatim.

Data analysis

We used a framework approach to analyse the transcripts (16). After familiarising ourselves with the data, we (CS and MLE-B) identified a coding framework based on Seeleman's cultural competence model (13). Seeleman's model identified the important aspects in providing care to ethnic minority patients, including the influence of culture on the care process, patients' social context, stereotyping and prejudice, and communication barriers. These issues were all identified within the coding framework. Transcripts were coded by CS according to this framework. Subsequently, the data was charted according to two parallel charts: 1) What are the care provider's experiences? and 2) What actions does he or she take in such situations? These charts were used to explore mechanisms in the care process that may lead to deficiencies in culturally competent asthma care for ethnic minority children. For further refinement, CS and MLE-B discussed this analysis extensively until consensus on interpretation was reached.

Table 3.1 Topic list

Topic	**Interview**
Provider's experience	Experience in caring for children from ethnic minorities in general
A specific case	Elaboration of a specific case ("Please think of a case of a patient with asthma from an ethnic minority background (aged 4-10) that did not go smoothly in your opinion.") - Case background - Medication - Advice other than on medication - Self-management - Consultation *(The interview focused on "What happened?" and "What did you do/how did you react?")*
Themes related to culturally competent care	- Working with interpreters - Eliciting patients' perception on asthma/medication - Influence of social context
Improving care	Respondents' ideas about specific requirements for improving care for children from ethnic minority backgrounds with asthma

Results

Central problem: non-adherence

Non-adherence (especially to daily preventive ICSs but also to lifestyle recommendations) is generally known to be the major problem in paediatric asthma care, and respondents in our study identified issues that add on non-adherence in asthma care to ethnic minority children.

The first section describes three factors of influence on adherence in patients from ethnic minority backgrounds as mentioned by the respondents: social context, illness perception, and language. The second section describes the respondents' reported reactions to patients' non-adherence. Quotes are presented throughout the results to illustrate the findings.

Factors of influence on adherence in ethnic minority patients

Social context

Respondents related children's adherence to families' social context. Several respondents described multi-problem families in which various problems coexisted: a sick parent, problems in the parents' relationship, and parenting problems. These problems affected children's adherence in different ways. Sometimes the responsible parent was so caught up in his or her own problems that there was barely any attention left for the child's asthma. Or a parent had difficulties getting a child to take the medication, while other parents shifted too much responsibility onto the child. The following case, described by one of the respondents, illustrates these issues:

> *"Well, the family has three children, of which two suffer from a severe allergy and asthma, exercise-induced asthma and allergic asthma. <. . .> divorced parents of, well they actually are very lively boys. The mother gives an impression of being overburdened. Youth care and pedagogic support has been offered in the past and it seems to be going better now. And then you have the oldest, he is kind of entering puberty and he believes it is nonsense that he has to use inhalation steroids. He just is not motivated himself so the mother tries to do encourage him, but it just does not work." (A6)*

Illness perception: chronicity of asthma

Respondents also ascribed non-adherence to different illness perspectives. Some respondents merely said that parents from ethnic minority backgrounds "perceive their child's illness differently"; others had more concrete ideas of differences in illness perception. They expressed more difficulties explaining the chronic nature of asthma to parents from ethnic minority backgrounds, and found it harder to get them to understand the consequences this has for daily life. The following respondent related these differences to culture:

> *"I think that might be the biggest problem, letting parents and patients know the disease can last a lifetime and cause lots of symptoms, and that the doctor can't cure the disease, but can relieve symptoms. I think that might be the cultural difference, I don't know exactly." (A9)*

This was also explained as a “phase” difference – a phase Dutch society (and patients) have already gone through, and patients from minority backgrounds have not:

> *“Here we’ve already gone through all of that, we’re talking about 25, 30 years back, gone from, say, the acute illness concept and getting better to a concept of, it’s a chronic disorder, you have to take care of it in the meantime.” (A4)*

Furthermore, respondents indicated that differences in perceiving the chronic nature of asthma create the unmet expectation that asthma can be cured:

> *“Well, there is a cultural difference, insofar as particularly in the Moroccan community, quick diagnosis, treatment, [is expected] and everything has to be alright again, they want to see a plan, a course of action.” (A12)*

Language

Although respondents did not label language barriers as a large problem, at the same time “language difference” was described as a factor that hindered parents’ understanding of asthma and its treatment. Respondents explained that the message they generally communicate (which they described as “what asthma is and what do you have to do about it”) was a complex one.

Care providers also mentioned that a language barrier made it more difficult for them to assess whether their information was well understood:

> *“And I think if you speak in your own language it’s much easier to know whether something has really gotten through or if we just have to do it again, or do it differently.” (A4)*

Reported reactions to patients’ presumed non-adherence

In this section we describe the reactions reported by respondents to patients’ non-adherence, including retrieving information, providing information, occasionally providing referrals for social context issues, and using informal interpreters.

Retrieving additional specific information

Care providers need to get a clear picture of what is going wrong, and therefore expressed a need for specific information from patient and parents on the child’s health situation and the extent of and reasons for non-adherence. Respondents experienced more barriers in gathering such information from ethnic minority patients due to two mechanisms: communication barriers and a discrepancy in care providers’ information needs and patients’ daily lives.

Communication barriers

Respondents described various strategies for retrieving information, including additional questioning, asking questions in an empathic way ("It's very difficult to get a child to take his medication every day – how is that for you?"), or asking children directly instead of parents. These techniques did not always yield the desired information. Respondents recognised specific communication patterns with ethnic minority parents, including "yea-saying", i.e. socially desirable response behaviour. In their eyes, these patterns hindered information retrieval. Keeping an asthma diary as an alternative source of information also caused difficulties because of functional illiteracy and language barriers.

Discrepancy in care providers' information needs and patients' daily lives

Sometimes the type of information care providers required did not seem to be in keeping with patients' daily lives. Respondents expressed the feeling that their questions did not yield the "right" information. A respondent explained that the information physicians are looking for is very concrete: how often and how much medication was used during which time span? Whereas Dutch parents are usually able to answer these questions, with ethnic minority patients this kind of information seems harder to retrieve. This respondent believed that giving medication in ethnic minority families is something that blends into the day rather than something that happens according to a schedule and that can easily be reproduced when a care provider asks for it.

Some respondents explained that in cases where they lacked insight into home situations, they tried to monitor the patient more closely (e.g. by being more prescriptive in their treatment recommendations instead of stimulating self-management).

Providing biomedical information

Providing information was our respondents' strategy of choice for improving adherence. They focused on transferring biomedical knowledge (sometimes repeatedly) to help parents understand their child's medical situation.

> *"Yes, I explain it again, sometimes I look like a fool but yes, I make another drawing, your windpipe is constricted, how can you prevent this. And I explain the risks again, particularly to the mother. That we see children in the ICU, on the respirator, just because they're not compliant." (A6)*

Some explained that they tried to connect with what parents put forward during the consultation:

> *"If someone consistently finds these attacks distressing, that you follow this with your information, like, yes, but this is especially to prevent these attacks." (A12)*

The respondents explained they use drawings or anatomical models to visualise the information for parents. Or they compared the “invisible” (inflammation of lung tissue) with something “visible” (like eczema on the skin). Almost all paediatricians mentioned a preference for referring patients to an asthma nurse for more detailed asthma education. Which patients were actually referred differed per healthcare organisation (e.g. all new patients, patients with uncontrolled asthma, or patients who had been prescribed new medications).

One care provider used a specific metaphor to get information across:

> ***The story of the cowboy*** *A cowboy has two things. He has a horse, which is reddish brown (a colour similar to the corticosteroid inhaler) and he has a pistol, which is steel blue (a colour similar to the Ventolin inhaler). A good cowboy looks after his horse twice a day and only shoots when he has to. If the cowboy only wants to take care of his horse when he really needs one, you can imagine the horse will be dead by then. That doesn’t work. And that doesn’t work for the medicine either. (A10)*

Social context issues: occasional referrals

In cases where social context issues such as a parent’s illness or parenting problems influenced a child’s adherence, respondents explained they find it important to acknowledge the problem to parents, but they doubted the extent to which they could support them in these issues. Although in some cases they referred parents for psychosocial support, these referrals were not formalised in protocols.

Using informal interpreters

Often, respondents associated patients from ethnic minority backgrounds with language barriers. Although respondents regarded language barriers as posing a risk to transferring and gathering information and therefore posing a risk to adherence, the general opinion was that “the language problem wasn’t so bad.” In daily practice, respondents seldom used formal interpreters (which was free of charge in the Netherlands). Respondents mentioned several barriers that hampered communication when using formal interpreters: it takes too much time to request an interpreter, the conversation gets impersonal with an interpreter on the phone, and the conversation is reduced to one-liners. The respondents regularly used informal interpreters (like family and friends) brought in by parents. These conversations proceeded naturally, and informal interpreters were given no instructions on how the respondents would like them to translate the conversation. Respondents were aware of risks that may arise from using informal interpreters, but saw little danger in using them in standard asthma care:

> *“Usually it <the patient bringing an informal interpreter> is just convenient. It depends on the type of conversation, but the type of conversation we have here in the outpatients’ clinic, that is rarely so emotionally charged that it would be a problem.” (A12)*

Discussion

In this study we showed that mechanisms in paediatric asthma care that lead to deficiencies in the care process for ethnic minority children were mainly related to non-adherence. It seems that most factors our respondents discussed (such as influence of social context factors and difficulties in understanding asthma as a chronic disease) are not related to ethnic minority patients in particular. Rather, they emphasise certain aspects of asthma care that are likely to create problems in the general patient population.

Educational literature describes different stages of competence. In the stage “conscious incompetence,” care providers recognise mistakes and difficulties in their actions, and will be able to report them. However, this stage is preceded by the stage of “unconscious incompetence”: a stage in which learners (or care providers) are unaware of their incompetence (17) and therefore cannot report them. If applied to our study, this theory means that apart from the difficulties care providers reported (and were aware of), difficulties they were unaware of might also complicate the care process.

A first difficulty the respondents seemed unaware of is related to providing information. Providing information was our respondents’ strategy of choice in case of non-adherence, with the intention of increasing parents’ knowledge on asthma. Studies have shown that medical information is generally not easily understood by patients due to such things as unfamiliarity with medical technical terminology (18,19). Low health literacy (the degree to which individuals have the capacity to obtain, process, and understand basic health information (20)) complicates patients’ understanding: low parental literacy has been associated with poorer asthma outcomes (21). For effective communication, it is recommended that care providers make their own language accessible by avoiding technical jargon and using plain language instead (22). Low health literacy is more prevalent in minority populations (23); however, our respondents did not reflect on their own use of technical jargon and how that might impede communication.

A second difficulty respondents seemed unaware of is related to language. Respondents recognised language difficulties as a barrier to information transference. Respondents explained that language barriers were overcome by using informal interpreters instead of formal ones. However, research has shown that using professional interpreters in healthcare has added value over the use of informal interpreters (24) and is therefore preferred if there are language barriers.

Respondents indicated that different illness perspectives were related to non-adherence. Kaptein et al. (25) showed the importance of patients' perceptions of disease and treatment for asthma outcomes. The idea of "no symptoms, no asthma" (when patients consider asthma to be an acute rather than a chronic illness) is found repeatedly, irrespective of ethnicity (25,26). Parents who do not perceive asthma as a chronic disease are more likely to administer medication only when the child experiences symptoms. Our respondents did not seem to regard discussing illness perceptions as a standard part of consultations. In cultural competence literature, though, exploring patients' illness perspectives is considered a central aspect of culturally competent care (27), because culture has a strong influence on illness perspectives (28). Rather than a biomedical communication style, a patient-centred one helps to get information about cultural differences, expectations, and influence of social context factors out in the open (27).

Self-reflection receives much attention in the literature on multicultural care (29). This acknowledges the importance of reflecting on one's own cultural background and assumptions, biases, and values, especially when taking care of people from other ethnic or cultural backgrounds (29,30). The respondents reflected little on their own cultural and professional backgrounds. However, care providers did seem aware of the existence of stereotyping. During the interviews, statements like "The same goes for Dutch patients" or "This does not apply to all patients from that ethnic background" were made regularly.

To develop effective, meaningful cultural competence training for specialist paediatric asthma care providers, we have to turn our findings into learning objectives that reflect both the issues care providers were aware of as well as the issues they were unaware of. For care providers to adequately identify reasons for non-adherence in children with asthma from ethnic minority backgrounds, and to effectively act on these, we identified the following objectives:

- Ability to use patient-centred communication skills in giving and retrieving information;
- Awareness of different illness perceptions and ability to communicate effectively about this;
- Ability to effectively overcome language and health literacy barriers;
- Ability to reflect on one's own background and stereotyping in intercultural contexts (Table 3.2).

Table 3.2 Difficulties in paediatric asthma care for ethnic minority children

Providers were aware of	a) complex social contexts b) difficulties in explaining the chronic nature of asthma and its consequences c) gathering information about the child
Providers were unaware of	d) communicating from a biomedical perspective (mainly providing knowledge) e) not giving attention to illness perceptions f) not using formal interpreters g) not adapting their own language (plain language instead of medical jargon) h) the impact of providers' own backgrounds on the consultation
Cultural competence	- Ability to use patient-centred communication skills in giving and retrieving information *(issues a,b,c,d,e,g)* - Awareness of different illness perceptions and ability to communicate effectively about this *(issue e)* - Ability to effectively overcome language and health literacy barriers *(issues f,g)* - Ability to reflect on one's own background and stereotyping in intercultural contexts *(issue h)*

Evaluation of care provided to ethnically diverse patients often showed a "magnifying glass effect" (31): difficulties in the care process are revealed that are not unique to patients from these groups but are more intense expressions of general paediatric care problems. For instance, if care providers communicate from a biomedical perspective, it is hard for all patients with low health literacy to understand the information they receive. Since health literacy skills in ethnic minority patients are generally lower, and language barriers might further complicate the communication, the negative effect on patients from ethnic minority backgrounds is larger. Because of the accumulation of characteristics that complicate care, ethnic minority patients experience more disadvantages from suboptimal care. The magnifying glass effect explains why the learning objectives we defined are not so "cultural" either. For the most part they are specifications of competences care providers should already possess. The most striking example is the importance of the ability to use patient-centred communication skills.

By using a qualitative research method, we obtained insight into issues respondents themselves related to adherence in children from ethnic minority backgrounds. By putting respondents' experiences in the context of the general literature on asthma care and cultural competence, difficulties respondents were unaware of also became apparent.

Research on care providers' cultural competence commonly uses instruments to measure their self-perceived cultural competence (32-34). However, because care providers cannot report explicitly on things they are unaware of, some issues will go unnoticed. Although our interviews showed an extra dimension in the care process, other methods such as direct observation will provide added value in gaining full insight into the relationship between care providers and patients. Now we had to rely on care providers' recall. Respondents were asked to elaborate on a specific case from their own practice in which they had experienced difficulties, to get insight in care providers' concrete experiences. The examples discussed might not be representative for every day practice and therefore not reflect a general need for cultural competence training among these providers. Although during the interviews the issues discussed were placed in broader context ('was this case exceptional or do these issues happen more often?'), methods like direct observation would provide a more detailed, objective insight into what actually happens during a consultation. Additionally, insight into patient experiences would provide information from their perspective.

A limitation of this study is the small number of interviewed respondents (n = 16). This was due to rapid saturation of the data. An explanation for limited variation in data and rapid saturation might be homogeneity of the respondent group. Although gender, years of experience and setting (academic/non-academic) did vary between respondents, we did not verify respondents' country of birth. Based on their last names, mastery of Dutch language, and appearances, we assume they all had a Western/an ethnic majority background. It might be that care providers from ethnic minority background would have put forward different experiences or communication styles during the interviews that would have diversified the data.

Developers of cultural competence training can use our findings as input for developing learning objectives. Although it is important to meet the educational needs of care providers when developing cultural competence training, we have shown it is equally important to take into account issues care providers are unaware of. However, care providers must first become aware of their "incompetence" before they will recognise their need to learn about these issues. We therefore recommend that creating awareness of providers' "incompetence" should become a part of the training itself or a separate learning activity before the actual training.

Our study was limited to cultural competence at the level of care providers (35). For providers to be able to provide culturally competent care, the healthcare organisation should provide the conditions necessary to enable care providers to work in a culturally competent way (36).

Conclusions

This study provides keys to improve the quality of specialist paediatric asthma care to children from ethnic minority backgrounds. Importantly, we showed that care providers do not consciously recognise all the mechanisms that lead to deficiencies in culturally competent asthma care they provide to ethnic minority children ("unaware incompetence"). Therefore, the learning objectives of cultural competence training may need to start with issues that care providers are aware of, to get their interest. Once having them inside, cultural competence training should address unaware incompetence issues and change these into "awareness" and then into "competence" (e.g. the use of formal interpreters to overcome language barriers). Fortunately, our results also give reason to believe that if care providers continue to improve on the patient-centred skills they learn during medical training, they already "come a long way."

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4 Cultural competence among nurse practitioners working with asylum seekers

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Abstract

Asylum seekers often have complex medical needs. Little is known about the cultural competences health care providers should have in their contact with asylum seekers in order to meet their needs. Cultural competence is generally defined as a combination of knowledge about certain cultural groups, as well as attitudes towards and skills for dealing with cultural diversity. Given asylum seekers' specific care needs, it may be asked whether this set of general competences is adequate for the medical contact with asylum seekers. We explored the cultural competences that nurse practitioners working with asylum seekers thought were important. A purposive sample of 89 nurse practitioners in the Netherlands completed a questionnaire. In addition, six group interviews with nurse practitioners were also conducted. A framework analysis was used to analyse the data of the questionnaires and the interviews. From the analysis, several specific competences emerged, which were required for the medical contact with asylum seekers: knowledge of the political situation in the country of origin; knowledge with regard to diseases common in the country of origin; knowledge of the effects of refugeehood on health; awareness of the juridical context in the host country; ability to deal with asylum seekers' traumatic experiences; and skills to explain the host country's health care system. Apart from these cultural competences specific for the situation of asylum seekers, general cultural competences were also seen as important, such as the ability to use interpretation services. We conclude that insight into these cultural competences may help to develop related education and training for health care providers working with asylum seekers.

Introduction

Asylum seekers are a heterogeneous and culturally diverse population living under specific conditions in a host country while awaiting the decision on their request for asylum. It is a population with a high prevalence of both physical and mental health problems (1). The medical needs of asylum seekers are often complex because of multiple medical problems, language and cultural barriers, lack of familiarity with the health care system, and general health illiteracy (2). Furthermore, the relatively poor health care systems in countries of origin, the war-related chaos and subsequent hardships, the difficulties associated with the flight (3), and the impact of a long asylum procedure (4) may all contribute to asylum seekers having different health needs compared to other immigrants.

Health care professionals often do not feel competent to deal with these needs (5) because they feel they lack adequate skills (6) or a comprehensive knowledge of health conditions unique to refugees (2). It is also noted that health care providers working with asylum seekers apply strategies that are developed individually rather than professionally (7), and that much is left to professionals to discover through trial and error. Even though studies exist that highlight the importance of cultural competence in several areas, such as the skill to develop a trustful relationship with asylum seekers (8,9) or the ability to explain the host country's system of health care (10,11), cultural competence has not been studied in a systematic and integral way in relation to this specific patient group. To date, no research exists that describes cultural competences — which will be explained in the next section — specific for the medical contact with asylum seekers. Yet, a systematic description of cultural competences may facilitate the development of training and education for care providers. On the basis of questionnaires and interviews, we explore in this paper those particular cultural competences that nurse practitioners working with asylum seekers consider important. A nurse practitioner is a registered nurse who has completed specific advanced nursing education (generally a master's or doctoral degree) and training in the diagnosis and management of common as well as a few complex medical conditions. Nurse practitioners are common in the Netherlands, but also in the United States, Canada, Australia, and the UK.

Cultural competence

In societies that are rapidly becoming multicultural, nurses deal increasingly with patients from various ethnic backgrounds. Hence, ‘cultural competence’ has been suggested by scholars to be an instrument that can be used to prepare care providers and to support them in dealing with issues of ethnic diversity (e.g. 12-15). The idea is that with culturally competent health care providers, health care for patients of different ethnic backgrounds will improve and health disparities may decrease (5,16-18).

Cultural competence has been a concept of interest in nursing for the past forty years, and has been addressed internationally in the United States, Canada, New Zealand, the United Kingdom, and Korea (19). It is assumed that with culturally competent health care providers, health care for patients of different ethnic backgrounds will improve and disparities will decrease (generally, models of cultural competence include a combination of awareness, knowledge, and skills to deal with ethnic diversity). Awareness refers to self-examination and to an in-depth exploration of one's own cultural and professional background, including one's own biases. Knowledge is the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups, such as disease incidence or prevalence and treatment efficacy. Skill refers to the ability to collect relevant cultural data regarding the client's presenting problem, such as the ability to elicit the patient's perspective or to use interpreter services effectively. The three concepts of awareness, knowledge, and skills have an interdependent relationship with each other (13), and each of them needs to be addressed by the care provider. It is the integration of these concepts that makes up a competence (20), and it is therefore described by Betancourt (14) as a three-legged stool.

Despite the popularity of the concept of cultural competence, two important criticisms exist. Firstly, it is assumed that the concepts of ‘ethnicity’ and ‘culture’ are interchangeable (21). However, this does not do justice to the complex sociocultural context in which patients live (22), and which needs to be acknowledged in the care for an ethnically diverse patient population. Hence, a broad conceptualisation of cultural competence needs to be applied, which relates not only to cultural issues but also to other elements that pertain to care for patients from various ethnic backgrounds; this includes epidemiological differences, patients' social contexts, and prejudice and stereotyping (15). Secondly, the concept of cultural competence tends to focus on the ‘otherness’ of patients as the cause of experienced problems, and suggests that care providers are culturally neutral human beings (21). Therefore, models of cultural competence need to acknowledge that not only patients but also care providers and health care systems are culturally influenced.

Cultural competence is said to be relevant in all areas of medical practice (13), but given asylum seekers' specific care needs, it may be asked whether this set of general competences is adequate for the medical contact with asylum seekers. Asylum seekers and refugees may confront care providers with all kinds of challenges, demanding not only a sufficient level of cultural competence (23,24) but perhaps also different kinds.

Methods

Questionnaires were used to collect general data on the intake experiences of nurse practitioners, but questions about cultural competences were also included. In addition, semi-structured group interviews were conducted to obtain a more detailed insight into the daily experiences of nurse practitioners. Thus data from different sources were synthesized, a method called ‘triangulation,’ as a way to improve the likelihood that qualitative findings would be found credible (25).

Setting

Asylum seekers stream to the Netherlands from different parts of the world, and in 2007, the largest groups had come from Iraq, Somalia, Afghanistan, and Iran (26). While awaiting the decision on their application for refugee status, they live here in asylum seeker centres. At the time of the study, nurse practitioners were working at these centres, and the health care was organised as follows: 1) to assess the health needs, within six weeks after the asylum seekers' arrival, nurse practitioners undertook an intake procedure in which main health issues were discussed. This was usually the first contact between an asylum seeker and a nurse practitioner; and 2) to deal with asylum seekers' medical and mental problems, nurse practitioners provided daily care, and referred as necessary to mainstream service professionals such as GPs, social workers, or dentists. An interpretation service, in all languages and generally by telephone, was available. At the time of the study, there were approximately fifty different asylum seeker centres divided into six clusters throughout the Netherlands. For about 40% of the applications for asylum, the Naturalisation Service Agency (the Organisation for entry into the Netherlands) takes a decision within three to five days. For some 60% of the applications, however, more time is needed, and in these instances the Naturalisation Service Agency strives towards taking a decision within about a six-month period, during which the asylum seeker stays temporarily in an asylum seeker centre (www.ind.nl).

Participants

In each cluster, a coordinator was approached who distributed the questionnaires to nurse practitioners in different asylum seeker centres. Nurse practitioners could fill in the questionnaire at their own convenience, and they returned it by post to the researchers.

For the group interviews, coordinators in all six clusters were asked to approach nurse practitioners, from one centre per cluster, who were willing to participate in a group interview. Thus, we conducted a purposive sampling of nurse practitioners from centres in the different clusters, to ensure representation from all clusters and to maximise variation in experience with asylum seekers.

Data collection

Data from the questionnaires and group interviews were collected over a four-month period in 2007. In total, 89 questionnaires were returned, but because it is not known how many questionnaires were distributed we are not able to give a response rate. Four open-ended explorative questions with regard to cultural competences were asked: 1) Did you receive specific education or training with respect to cultural competences and, if so, what is your educational background? 2) Do you feel culturally competent: why or why not? 3) What kind of cultural competences are important for the intake? 4) How may cultural competences be improved? In addition, personal information about years of experience in providing health care to asylum seekers was requested. As an introduction to these questions, we provided a broad and generally accepted definition of the concept: 'Cultural competence can be defined as a composite of knowledge, awareness, and skills necessary to provide adequate care to an ethnically diverse patient population.' This definition was included in order to give all respondents the same general idea about what we understand cultural competences to be.

Subsequent to the questionnaires, a group interview with nurse practitioners was planned in all six clusters: in total, seven group interviews were conducted, and were held either after a professional meeting or were organised separately. All together, 36 nurse practitioners were interviewed in groups of between two and nine persons. In the interviews, a topic list was used that contained items such as problems experienced with providing medical care, the specific role of the nurse practitioner in the system of medical care, perceived expectations of asylum seekers, and what was seen as an ideal situation in which to provide high-quality care. No specific questions about cultural competences were asked, but participants spontaneously considered it while discussing the above-mentioned topics. Questions were open-ended and efforts were made to engage all present in the group. The interviews were conducted by two researchers (IR and CS) who took turns interviewing and making notes. All interviews — which took about 1.5–2h each — were recorded on tape and transcribed.

Ethical considerations

According to the Medical Research Involving Human Subjects Act, medical–ethical approval of this study was not required in the Netherlands. Firstly, only care providers and no patients were involved. Secondly, this was not an intervention study, and respondents were only interviewed. Nevertheless, we made a great effort to deal adequately with ethical considerations such as anonymity of all the collected data and informed consent of the involved care providers. The anonymity of respondents was guaranteed by using codes to designate them. Information about the study was given in the form of a flyer as well as in a letter accompanying the questionnaire, in which the researchers also guaranteed anonymity. Group-interview participants were assured of confidentiality, informed consent was obtained and this was tape-recorded a priori the interviews. Finally, approval was obtained from the Community Health Services for Asylum Seekers, the employer of the nurse practitioners.

Data analysis

A framework approach was used to analyse data from the questionnaires (27,28), and after familiarisation with the data, a coding framework was identified. The questionnaires were then systematically coded using this framework. Data were subsequently charted (29) and three major charts were constructed: educational background (combining questions 1 and 2), important cultural competences in connection with asylum seekers, and ideas about how cultural competences may be improved. The group interviews were not developed to collect data on cultural competences, although interesting related themes arose from the interviews. It was therefore decided to include the group interviews data in the study, albeit merely to illustrate further what was found in the questionnaires. The transcription of each group interview was read carefully to gain an overall impression before being coded and analysed. One chart was designed on the basis of different cultural competences that were mentioned in the interviews. Using this chart, patterns and connections could be described (30).

The questionnaires as well as the interviews were qualitatively analysed. This means that we were interested in exploring how nurse practitioners understood or managed their day-to-day competences in relation to asylum seekers (29). Rather than to quantify this process and answer questions such as “how often” or “how many,” we wanted to understand what was going on, in order to provide a comprehensive description of cultural competences.

Results

Training and education in cultural competence

Nurse practitioners had an average of nine years' work experience in health care for asylum seekers. In the questionnaires, a majority of the nurse practitioners explained they had received some form of training or education in cultural competences (Table 4.1). This was generally during their study period, such as doing a master's degree in transcultural nursing and/or in special courses organised by the employer or previous employers (e.g. a course regarding intercultural communication skills or sexually transmitted diseases and PTSS). Most nurse practitioners answered that they felt culturally competent, and added that this was largely because of their experience working in the asylum seeker centre or because of their training or education. In Box 4.1, the cultural competences that nurse practitioners described in the questionnaires are presented. Mainly these are competences specific for the contact with asylum seekers, whereas a few competences can be seen as general competences useful in all intercultural medical contacts. In the following paragraphs, each competence specific for the medical contact with asylum seekers is further illustrated with information from the interviews. The excerpts show how these competences are put into practice, and occasionally demonstrate how difficult they may be to apply. We leave the general cultural competences unexplained in this paper because they have already been addressed elsewhere in more detail (e.g. 12-15).

Table 4.1 Education in cultural competence and feeling culturally competent.

Educational background with respect to cultural competence	88%
Education/training during study (e.g. intercultural nursing) or specific courses (e.g. in intercultural communication skills, knowledge of sexually transmitted diseases and PTSS)	81%
Education/training because of former experience (e.g. working in an asylum seeker centre; working in a developing country)	34%
Nurse practitioners feeling culturally competent	88%
Feeling culturally competent because of previous work in an asylum seeker centre	15%
Feeling culturally competent due to education or training	11%

Percentages do not add up to 100%, as it was possible to give more than one answer to these questions and an answer was not always provided.

Box 4.1 Cultural competencies for nurse practitioners working with asylum seekers.

Knowledge

- *Knowledge of the political and humanitarian situation in countries of origin.*
- *Knowledge of epidemiology and the manifestation of diseases in asylum seekers' countries of origin.*
- *Knowledge of effects of refugeehood on health.*

Attitudes

- *Awareness of the juridical context of the host country in which asylum seekers live.*
- Awareness of how culture shapes individual behaviour and thinking (related to being respectful, open-minded, empathic, and so on).
- Awareness of one's own prejudices and tendency to stereotype (related to being open-minded, respectful, and so on).

Skills

- *Ability to develop a trustful relationship with an asylum seeker.*
- *Ability to ask delicate questions about traumatic events, personal problems.*
- *Ability to explain what can be expected from health care (in order to develop a trustful relationship.*

- Ability to transfer information in a way the patient can understand and to know when external help with communication is needed.
- Ability to adapt to new situations flexibly and creatively.

Specific cultural competencies related to the contact with asylum seekers are in italics.

Knowledge of the political and humanitarian situation in the country of origin

Most nurse practitioners saw it as essential to be aware of the political situation in the patients' home countries, and to have an insight into the way medical problems may be a direct result of the political situation. A nurse practitioner has to decide which specific information is relevant for groups of asylum seekers coming from different political situations. As a nurse practitioner explained in an interview:

> *'It is different, for example, if you were part of the army of Saddam Hussein, and you are a young Iraqi man, who, oh well, had to do awful things, and were abused with rifle butts or something like that. Or that for a long time you had very little to eat and were wandering through the desert of Sudan […] and have become very skinny, yes, had very limited food.' [R1]*

Knowledge of epidemiology and the manifestation of diseases in asylum seekers' countries of origin

Nurse practitioners mentioned that it was useful to have knowledge of the prevalence of diseases such as malaria, worms, infectious diseases including HIV and other sexually transmittable diseases, dental problems, chronic diseases, vaccinations, and haemopathologies such as sickle cell disease or thalassemia. Knowledge concerning the prevalence of female circumcision and possible medical complications was also seen as relevant.

Knowledge of the effects of refugeehood on health

Nurse practitioners generally made a difference between health issues with regard to different stages of the refugee's flight. It was important to know about health issues that had existed before the flight (e.g. knowing that bone fractures may be the result of torture), that emerged during the flight (e.g. knowing that there may be health differences between someone who had arrived by plane or after a long and arduous journey), or after the flight (e.g. knowing that the asylum-seeking procedure and living conditions in the centres may influence asylum seekers' mental health).

Awareness of the juridical context in which asylum seekers live

Several nurse practitioners stressed the importance of explaining very clearly that the medical staff had nothing to do with officially organising entry to the Netherlands. For instance, they pointed out to asylum seekers that all information would remain confidential and would not be used in the application procedure for a residence permit. Or they told asylum seekers that they would like to know the story with regard to the flight in order to assess their health condition, but stressed that they were not interested in every detail. Thus, they strove to avoid causing the asylum seekers to feel they were being interrogated in connection with their refugee status. Nurse practitioners took great pains to make it clear that this was not the case, because if asylum seekers erroneously believed it to be so, it was seen as highly disruptive in the development of a trustful relationship.

Skills to develop a trustful relationship with an asylum seeker

Building a trustful relationship was generally seen as pivotal, and should be initiated as early as possible in the contact with asylum seekers, as is explained in the following excerpt:

> *'I think it is a trustful relationship. Because people need a long time before they will disclose things. Especially painful things. And the fact that someone has been seen in the intake creates a bond, a starting point from which to continue. I myself think this is often neglected. It is so important to see the same faces, the same people, a familiar face.' [R5]*

Having a trustful relationship helped the asylum seeker to talk about mental problems, but it also enabled the nurse practitioner to ask sensitive questions about traumatic events or about personal problems. Good communication skills, such as listening, were seen as crucial.

Ability to ask delicate questions about traumatic events and personal problems

Although nurse practitioners considered it important to detect whether asylum seekers suffered from mental problems or psychological trauma, the topic was experienced as a difficult one to raise.

Some nurse practitioners tried to sense whether the asylum seeker wanted to talk about traumatic experiences. For example, they prefaced questions with a remark such as 'I am going to ask some questions that may be painful.' However, even the 'neutral' administrative questions that nurse practitioners also have to ask — such as 'Are you married' or 'Do you have children,' when the partner and/or children may be dead or left behind — may result in the asylum seeker feeling loss and pain. Several nurse practitioners added that the presence of an interpreter also made it more difficult to ask these kinds of questions of someone you had never seen before.

Furthermore, nurse practitioners stressed the importance of referring in good time to other professionals when they felt they themselves were not capable of dealing adequately with mental problems presented by asylum seekers.

Ability to explain what can be expected from health care

This skill has to do with explaining the Dutch health care system. On the one hand, it was seen as important because nurse practitioners saw it as their job to explain to asylum seekers what they could expect from the medical care, in order to do away with any unrealistic expectations about the medical care in the host country (e.g. thinking that a leg crippled by polio would be healed) [R5]. On the other hand, the medical system was explained because it is known to be different from many systems in the rest of the world (e.g. thinking one could buy antibiotics in a shop or could go to a paediatrician whenever one felt like it) [R4]. Nurse practitioners acknowledged that not only for asylum seekers but for all newcomers to the Netherlands the health care system is new and needs to be explained. Nevertheless, it was seen as particularly important for the contact with asylum seekers, mainly because if the system was not explained well, asylum seekers may have felt excluded from care, and this was seen as disruptive in the development of a trustful relationship.

Improving cultural competence

Finally, from the analysis of the questionnaires, it emerged that nurse practitioners believe cultural competence can be improved. The majority thought more education was needed (40%). For example, skills such as listening, being able to construct a confidential relationship, and knowledge of the countries of origin, of body language, and of differences in the presentation of complaints were seen as important cultural competences that need regular attention in education and training. Other nurse practitioners believed that cultural competences can be improved through the concrete experience of working in an asylum seeker centre (24%). For instance, discussing complex cases with colleagues, talking to asylum seekers about what they feel is important, or working with interpretation services were all seen as valuable experiences and as ways to improve cultural competence.

Discussion

According to nurse practitioners in this study, the following areas of competence are important: knowledge of the political situation in the country of origin; knowledge of how refugeehood influences health; specific knowledge with regard to diseases common in the countries of origin; awareness of the juridical context; and specific skills such as the ability to ask delicate questions about traumatic events and to explain the health care system. Even though we explored cultural competences of a specific group of care providers — namely, nurse practitioners — we believe that our results are relevant for other care providers who work with asylum seekers.

These results add more specific competences to the cultural competences that have been described in other studies (e.g. 12-15). The future education of nurse practitioners or other care providers may be focused on acquiring this set of specific knowledge, attitudes, and learning skills in specific courses. However, this study also shows that it is not merely education or training that helps nurse practitioners feel culturally competent. Equally significant is the concrete experience of working with asylum seekers. This suggests that ‘learning in action’ (31) by way of adequate supervision, mutual peer supervision, and systematic feedback on the work floor may also be a key teaching instrument. Thus, experiential and didactic learning may be integrated in order to develop relevant cultural competences (32).

We believe that the care providers' cultural competences may benefit the quality of medical care to asylum seekers. However, care providers do not work in a juridical and social vacuum, but in a context of policies and politics, which to a large extent are beyond their control. For example, care providers may experience feelings of powerlessness after having to terminate contact with an asylum seeker whose application is rejected and who will be deported to the country of origin. Thus, even if care providers are very culturally competent, they have to work with restrictions to their possibilities of providing medical care. Care providers from different countries have to deal differently with the juridical and social context of their own country, as every country has its own asylum seeker policies and policies of medical care (33). This may demand country-specific non-medical competences, such as the ability to work within a certain juridical context.

Finally, cultural competences should not be seen as a list of skills that are acquired and ticked off one at a time, resulting in a person who is culturally competent. Acquiring cultural competence is an ongoing process, driven by the practitioners' self-reflection (13,34). This is perhaps especially true for nurse practitioners working with asylum seekers, a group of patients that by definition changes due to new wars and conflicts in home countries, or due to a change in host-country politics with regard to refugees.

Study limitations

Although the interviews revealed interesting topics that could be used to illustrate the questionnaire data, more information may have been revealed if we had asked specifically about cultural competences in the interviews. Another limitation is that we only asked about cultural competences in relation to the intake and not to regular contacts. Thus, specific cultural competences necessary for the contact with asylum seekers who have already been a long time in the asylum seeker centre may not have been found. Still, because the intake is seen as an important starting point for the relationship with asylum seekers, we believe that cultural competences relevant for the intake will also apply for subsequent contacts.

Conclusion

As far as we know, this is the first empirical study that describes cultural competences with regard to the contact between care providers and asylum seekers. The results of our study can be used for the training and education of different health care professionals, describing as it does cultural competences unique to the contact with asylum seekers.

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5 Cultural competence assessment as a basis for identifying gaps in the medical curriculum

This chapter has been submitted as:

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Cultural competence assessment as a basis for identifying gaps in the medical curriculum.

Abstract

Purpose

Cultural competence assessment of students that have completed a large part of the curriculum, to evaluate effectiveness of that curriculum and to guide the development of a cultural competence program.

Methods

392 medical students, Youth Health Care (YHC) Physician Residents and their Physician Supervisors were invited to complete a web-based questionnaire that assessed three domains of cultural competence: 1) general knowledge of ethnic minority care provision and interpreter services; 2) reflection ability; and 3) culturally competent consultation behaviour. Additionally, respondents graded their overall self-perceived cultural competence on a 1-10 scale.

Results

86 medical students, 56 YHC Residents and 35 YHC Supervisors completed the questionnaire (overall response rate 41%). On average, all groups scored low on general knowledge (mean 46% of maximum score) and knowledge of interpreter services (mean 55%) and much higher on reflection ability (80%). The respondents' reports of their consultation behaviour reflected moderately adequate behaviour in exploring patients' perspectives (mean 64%) and in interaction with low health literate patients (mean 60%) while the score on exploring patients' social contexts was on average low (46%). The associations between overall self-perceived cultural competence and assessed knowledge, reflection ability and consultation behaviour were weak.

Conclusion

Assessing the cultural competence of medical students and physicians identified gaps in knowledge and culturally competent behaviour. Such data can be used to guide improvement efforts to the diversity content of educational curricula. The weak associations between overall self-perceived cultural competence and assessed knowledge, reflection ability and consultation behaviour supports the hypothesis that measuring perceived cultural competence is insufficient to assess actual cultural competence.

Introduction

Culturally competent care has been proposed as an important strategy to combat ethnic inequities in quality of care (1,2). Cultural competence is commonly defined as the combination of knowledge, attitudes and skills necessary for care providers to effectively interact with culturally and ethnically diverse patient populations (3). Although conventionally labelled 'cultural', the concept of cultural competence has expanded,[1] encompassing a broad array of topics relevant to ethnic inequalities in healthcare quality (4,5).

In various countries, licensing bodies and curricular objectives require medical education curricula to address cultural competence (6-8). In spite of this, content analysis of medical curricula shows that cultural competence training has rarely been systematically implemented in undergraduate and postgraduate medical education (6,9-11). In addition to content analysis, equally important and under-studied is an evaluation of whether culturally competent learning objectives are met.

While preparing the development and implementation of a cultural competence educational program in two curricula (an undergraduate medical curriculum and a postgraduate curriculum for Youth Health Care (YHC) physicians), we intended to assess the cultural competence level of students who completed most of the present regular curriculum. This would allow pinpointing the domains of cultural competence that the current curriculum is able to deliver, in the absence of a comprehensive cultural competence program, and the potentially remaining gaps.

Various measures exist to evaluate healthcare providers' cultural competence (e.g. IAPCC-R, CCHPA, CCCQ) (12-14). However, these measures have a strong reliance on self-perceived cultural competence rather than more objective indicators (15,16). A literature review demonstrated that in most studies, there is little, none, or an inverse relationship between self-perceived and objectively measured medical competence (17). Other evidence showed that care providers are unconsciously incompetent regarding care provision to an ethnically diverse patient population (18,19).

We performed an assessment of the level of cultural competence of students who had already completed the majority of the curriculum, using a newly developed instrument. We chose for a self-assessment questionnaire but we aimed to assess cultural competence more objectively than with self-perception measures. We assessed

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[1] Also other labels have been given to training that addresses proving health care in an (ethnically) diverse context, such as cultural humility, diversity sensitivity or diversity responsiveness. For clarity reasons we keep to the term cultural competence.

knowledge with a multiple choice test; and we assessed culturally competent behaviour with items referring to the respondent's actual behaviour in specific situations. We assessed reflection ability with a validated instrument (the Groningen Reflection Ability Scale, (20)).

In this paper we outline the outcomes of the assessment and the association between self-perceived overall cultural competence and assessed knowledge, reflection ability and consultation behaviour. Finally we discuss how assessing cultural competence can support the development of a cultural competence training program.

Methods

Participants

The study population consisted of three groups: medical students in the clinical phase of their education, Youth Health Care Physician Residents in training (YHC Residents) and Youth Health Care Physician Supervisors (YHC Supervisors). We selected these groups because we planned to implement cultural competence training in the curricula of these medical students and physicians. In the Netherlands YHC physicians are public health physicians, specialized in assessing, monitoring, interpreting and promoting the mental and physical health at an individual and population level of all children (0-19 years of age) while taking the children's environment (family, social network, events etc) into account.

We recruited the YHC respondents at the Netherlands School of Public & Occupational Health. Of the 163 individuals registered (95 residents, 68 supervisors), 13 refused and 32 did not react to the request of using their e-mail address, bringing the total sample at 118 YHC respondents. We randomly selected a sample of 274 medical students of the University of Amsterdam Medical School in the 2nd, 3rd and 4th phase of their rotation-program for participation.

Recruitment

The students and YHC respondents were invited to participate via e-mail. The invitation emphasized voluntary participation, that participation and outcomes would not influence study progress, and responses would be confidential. Two follow-up reminders were later sent. Two rewards of 200 Euro each were raffled off to the medical students who completed the questionnaire. There was no incentive for the YHC respondents.

According to Dutch law, formal ethical approval was not required, but we took every effort to effectively inform the respondents and protect their privacy.

Development of the questionnaire

The cultural competence framework of Seeleman et al. (21) provided the theoretical basis for developing the web-based questionnaire to assess respondents' cultural competence. The initial item pool was screened by expert researchers and pilot-tested with 31 public health physicians. A debriefing with these experts provided support for the relevance, acceptance, and feasibility of the items. A few that were considered ambiguous were excluded from the final questionnaire (not shown). The final questionnaire comprised three domains. Appendix 5.1 provides insight in the operationalisation of the framework into questionnaire domains (see appendix 5.1 at the end of this chapter).

The three cultural competence domains were:

1) General Knowledge: We developed eight multiple choice items to assess the 'general knowledge of ethnic minority care provision', and six multiple choice items to assess respondents' 'knowledge of interpretation services' (see appendix 5.1 for examples). For both dimensions, the score was calculated as the sum of correct answers ('correct' = 1 point, 'not correct' and 'do not know' = 0 points; general knowledge range 0-8; knowledge of interpreter services range 0-6). For reasons of comparability of scores across the various domains, all scores are presented as percentage of the maximum possible score. For example a mean score of 5 correct knowledge item responses out of 8 equals a score of 5/8x100= 63%. The scores on the knowledge domains showed a normal distribution.

2) Reflection Ability*:* Reflection is needed to gain insight into one's own understanding of prejudice and cultural frames of reference (22). We used the Groningen Reflection Ability Scale (GRAS) in the questionnaire, a validated measure of personal reflection (20). The GRAS consists of 23 statements and respondents rate their level of agreement with each statement on a five point Likert scale (1=totally disagree, 5=totally agree; see appendix 5.1 for examples). We transformed the scores (23-115) into a scale between 1-10 by dividing by 23. Cronbach's alpha was 0.79 for the GRAS in this study. High scores indicate higher reflection ability.

3) Culturally Competent Consultation Behaviour: This was defined as applying a patient-centred communication style with a focus on issues of specific importance in the care of an ethnically diverse patient population. In this domain we ask respondents to report their behaviour in terms of what they do and/or how often, rather than the respondents' own rating of their capability or confidence of culturally competent

behaviour (as commonly used in self-perceived measures). We developed two short case scenarios to assess respondents' behaviour in a) exploring patient perspectives, and b) interaction with patients of low health literacy level (see appendix 5.1 for an example). Normative answer categories were determined, following recent literature (23,24). Scores for these items ranged from 0-3 (summing the culturally competent answers). We also developed an 11-item scale to assess how respondents explored patients' social contexts. This score was summed (<25%=0; 25-50%=1; 50-75%=2; >75%=3) and divided by 11 (range 0-3). In the results, all scores are also presented as a percentage of the maximum scores. Cronbach's alpha for the social context scale was 0.86 in this study.

Additionally, we asked respondents about the frequency and type of interpreter used in the six months prior to this survey (e.g. professional interpreter, informal interpreter, patient's child older than 16; patient's child younger than 16). Because medical students during their internships are not allowed to decide about professional interpretation without approval from their supervisors, we did not ask what they did, but rather focused on their preference for type of interpreter.

Furthermore, we measured respondents' own grading of their overall cultural competence on a 1-10 scale (i.e. self-perceived overall cultural competence). We described cultural competence in this single item as: 'the knowledge, attitudes and skills required to provide adequate healthcare to patients of non-Dutch background'. Other variables in the questionnaire included 'ethnic origin of participants', assessed by country of birth of the respondents' parents and classified as Dutch, Western ethnic origin (Europe, North America, Japan) and non-Western ethnic origin (25); 'Professional experience with minority patients', assessed by asking the respondents to estimate the proportion of ethnic minority patients in their current rotation/practice (5 categories: <5%; 5-10%; 10-25%; 25-50%;>50%), and by classifying the current location of the practice as 'urban' (Amsterdam, Rotterdam, The Hague, Utrecht) or 'non-urban', because the proportion of the population of non-Western ethnic origin is much higher in these cities compared to other places in the Netherlands.

Analysis

Descriptive statistics were used to summarize characteristics of the respondents, and the scores on the various domains of cultural competence. We used one-way analysis of variance (ANOVA) to compare the average scores between the respondent subgroups. Post-hoc procedures were performed with the Bonferroni correction. We compared the results with a priori expectations about the direction of the differences to find support for the validity of the questionnaire. For example, if there was a significant difference in consultation behaviour, we expected the YHC respondents to perform better than the medical students. The relation between self-perceived overall cultural competence and assessed knowledge, reflection ability and consultation behaviour was analysed with Pearson correlation.

Results

Response and population background characteristics

The overall response rate was 41% (n=177), with lower participation among medical students (25%) than among YHC physician groups (56%). In total 86 medical students, 56 YHC Residents and 35 YHC Supervisors completed the questionnaire. The comments reported by the respondents at the end of the questionnaire were generally positive and did not point at a negative attitude towards the subject of culturally competent care, neither at a low acceptance or unclear structure of the questionnaire. Table 5.1 presents the characteristics of the study participants.

Assessed cultural competence

Table 5.2 displays the scores for the three cultural competence domains.

Average scores on ‘general knowledge of ethnic minority patients’ were low, with on average only 46% of the items answered correctly. We found differences in scores between various knowledge items. For example, 81% of the respondents knew the correct response to an item on Vitamin-D deficiency in migrant women, while only 15% knew the ratio of Western to non-Western ethnic minorities in the Dutch population. Scores on ‘knowledge of interpreter services’ were low as well. Whereas 80% of respondents knew that professional interpreters are preferred in medical practice, only 15% knew that professional interpreters in the Netherlands are not trained to provide information about cultural issues. These response patterns (e.g. items that were responded correctly or not) were comparable among all respondent groups.

The average score on ‘reflection ability’ was 8.0 (on a scale 1-10), indicating high reflection ability in general. Scores on culturally competent consultation behaviour varied among the different items and among respondent groups. While all respondents scored adequately on ‘interaction with low health literacy’ (the average score being 60% of maximum score), medical students scored low on ‘exploring patient perspectives’ and ‘exploring social context’ (52% and 38% of culturally competent answers, respectively), while these scores were better among the YHC groups. Within the social context scale we saw that most respondents explored country of origin, composition of the patient’s family and patient’s work/daily routines. The least explored aspect pertained to patients’ healthcare uses in countries of origin.

Regarding use or preference for type of interpreter, most YHC respondents indicated making use of informal interpreters brought in by their patients in the past six months. Medical students also preferred this type of interpreter. Least used and preferred were children under 16 years old, although 61% of YHC Residents and 49% of YHC Supervisors had used children younger than 16 for interpretation, and 38% of the medical students found a child younger than 16 sometimes preferable. Such practices differ from the literature and in Dutch professional practice guidelines, in which formal interpreters are preferred, and the use of children below 16 years is strongly discouraged (26).

Table 5.1 Demographic characteristics of the study population (gender, age, ethnicity) and clinical experience with ethnic diversity in patients

		All	**Medical students**	**YHC Residents**	**YHC Supervisors**
		N=177	**N=86**	**N=56**	**N=35**
		N (%)*	**N (%)**	**N (%)**	**N (%)**
Demographics					
Gender	Male	29 (16)	21 (24)	2 (4)	6 (17)
	Female	148 (84)	65 (76)	54 (96)	29 (83)
Age	*Mean (sd)*	36 (12.4)	26 (2.3)	39 (9.5)	54 (6.3)
	range	22-64	22-35	26-59	40-64
Ethnicity	Dutch	144 (81)	68 (79)	47 (84)	29 (83)
	Western	16 (9)	9 (11)	3 (5)	4 (11)
	non-Western	15 (9)	8 (9)	6 (11)	1 (3)
	missing	2 (1)	1 (1)	-	1 (3)
Experience with ethnic diversity					
Practice in one of the four largest cities†	Yes	65 (37)	47 (55)	11 (20)	7 (20)
	No	112 (63)	39 (45)	45 (80)	28 (80)
Estimated part of patients from non-Dutch background	Less than 5%	20 (11)	4 (5)	11 (20)	5 (14)
	5-10%	40 (23)	10 (12)	17 (30)	13 (37)
	10-25%	51 (29))	24 (28)	16 (29)	11 (31)
	25-50%	43 (24)	36 (42)	4 (7)	3 (9)
	Over 50%	23 (13)	12 (14)	8 (14)	3 (9)

* except for 'Age'

† the largest cities are: Amsterdam, Rotterdam, Utrecht, The Hague

Table 5.2 Cultural competence scores on knowledge, reflection ability, culturally competent consultation behaviour, self-perceived cultural competence per respondent group presented as mean scores and mean score as percentage of maximum score

	All **N=177**	**Medical students** **N=86**	**YHC Residents** **N=56**	**YHC Supervisors** **N=35**	**Interpretation of mean scores**§
Assessed cultural competence domains					
Knowledge					
General knowledge of ethnic minority care provision (score 0-8)					Low level of *general knowledge* in all respondent groups
Mean score (95% CI)	3.7 (3.5-3.9)	3.5 (3.2-3.9)^{b}	3.6 (3.2-3.9)^{c}	4.4 (3.9-5.0)^{b,c}	
% of maximum score	46%	44% ^{b}	45% ^{c}	55% ^{b,c}	
Knowledge on interpretation services (score 0-6)					Low level of *knowledge on interpretation services* among medical students, and moderate level among YHC Residents and YHC Supervisors.
Mean score (95% CI)	3.3 (3.1-3.5)	3.0 (2.6 -3.3)^{a,b}	3.6 (3.3-3.9)^{a}	3.7 (3.4-4.1)^{b}	
% of maximum score	55%	49% ^{a,b}	60% ^{a}	62% ^{b}	
Reflection ability					
GRAS score (score 1-10)					High *ability to reflect* in all respondent groups.
Mean score (95% CI)	8.0 (7.9-8.1)	8.0 (7.8-8.1)	7.9 (7.8-8.1)	8.1 (7.9-8.3)	
Culturally competent consultation behaviour					
Exploring patient perspective (score 0-3)					Low score on *exploration of patient perspectives* in medical students, moderate among YHC Residents and YHC Supervisors.
Mean score (95% CI)	1.9 (1.8-2.1)	1.6 (1.4-1.7)^{a,b}	2.3 (2.1-2.5)^{a}	2.1 (1.8-2.5)^{b}	
% of maximum score	64%	52% ^{a,b}	77% ^{a}	71% ^{b}	
Interaction with low health literacy (score 0-3)					Moderate score on *interaction with low health literacy* in all groups
Mean score (95% CI)	1.8 (1.7-1.9)	1,9 (1.7-2.0)	1.8 (1.6-2.0)	1.7 (1.4-2.0)	
% of maximum score	60%	62%	60%	56%	
Exploring social context (score 0-3)					Low score on *exploration of social context* among medical students and YHC Residents and moderate among YHC Supervisors.
Mean score (95% CI)	1.4 (1.3-1.5)*	1.1 (1.0-1.3)†^{a,b}	1,5 (1.4-1.7)^{a}	1,8 (1.5-2.0)^{b}	
% of maximum score	46%	38%	50%	59%	

	All N=177	Medical students N=86	YHC Residents N=56	YHC Supervisors N=35	Interpretation of mean scores[§]
Self-perceived cultural competence					
Self-perceived cc (score 1-10)					Moderate *self-perceived cultural competence* among all respondent groups.
Mean score (95% CI)	6.8 (6.6-6.9)	7.0 (6.7-7.2)[a]	6.4 (6.1-6.7)[a]	6.9 (6.5-7.2)	

Significant differences in scores between respondent groups (p<0,05);represented by

a: indicating a significant difference between medical students and YHC Residents

b: indicating a significant difference between medical students and YHC Supervisors

c: indicating a significant difference between YHC Residents and YHC Supervisors

§: interpretation: <60%=low; 60-80%=moderate; >80%=high

* N=176 (1 student missing)

† N=85 (1 student missing)

Association between self-perceived and assessed cultural competence

Table 5.2 also shows the scores for overall self-perceived cultural competence. The average rating of self-perceived cultural competence was 6.8 (on a scale 1-10). Medical students and YHC Supervisors perceived themselves as equally culturally competent (7.0 and 6.9 on average, respectively). Residents perceived themselves significantly less culturally competent than medical students (6.4 on average). Table 5.3 shows the associations between self-perceived overall cultural competence and assessed knowledge, reflection ability and consultation behaviour. The significant associations were all positive, but weak.

Table 5.3 Correlations overall self-perceived cultural competence and assessed knowledge, reflection ability and consultation behaviour

	All (n=177)	**Medical students (n=86)**	**YHC Residents (n=56)**	**YHC Supervisors (n=35)**
Knowledge				
General knowledge of ethnic minority care provision	0.16*	0.10	0.19	0.32
Knowledge on interpretation services	-0.01	-0.02	0.21	-0.13
Reflection ability				
GRAS score	0.23**	0.11	0.39**	0.28
Culturally competent consultation behaviour				
Exploring patient perspective	-0.06	0.02	0.05	-0.04
Interaction with low health literacy	-0.07	-0.06	-0.08	-0.12
Exploring social context	0.10	0.13	0.20	0.16

* Sign 0,05

** Sign 0,01

Discussion

We assessed cultural competence with a questionnaire survey among medical students, YHC Residents and YHC Supervisors and identified gaps in ‘general knowledge of ethnic minority care provision’ and ‘interpreter services’, whereas ‘ability to reflect’ seemed adequate. Scores on ‘consultation behaviour’ varied between respondent groups: reported exploration of patients’ perspectives and interaction with low health literacy suggested moderate culturally competent behaviour, whereas reported exploration of patients' social contexts seemed inadequate. The associations between self-perceived overall cultural competence and assessed knowledge, reflection ability and consultation behaviour were weak.

Until now, cultural competence training was not structurally implemented in the curricula of these respondents. This possibly explains their generally low scores on the knowledge domains. Low knowledge among physicians and medical students regarding the use of interpreter services were found in other studies as well (19,27).

In the current curriculum of both medical students and YHC Residents, education about reflection is well implemented, which probably explains these high scores. In the literature about assessing reflection, a distinction is made between the process of reflection (e.g. ability to formulate learning goals) and the content of reflection (e.g. what situation is reflected upon) (28). The scores on the GRAS suggest that general reflection skills seem well-developed, but they do not provide insight in actual reflection around one's own prejudices or cultural values.

Variation in scores on reported culturally competent consultation behaviour might be explained by the strong relation between cultural competence and patient centred communication (5). Patient centeredness is increasingly regarded as the norm in communication skills training (29), therefore some aspects of culturally competent behaviour (e.g. exploring patients' perspectives) might to some extent already be covered in the current curricula. Although, patient centred attitudes were reported to decline when medical students progress through medical school and transfer to clinical practice (30), the YHC respondents in our study scored higher on most aspects of culturally competent consultation behaviour than the students. YHC professional activity is characterized by a focus on patients' social contexts, and the YHC physicians in our sample were strongly embedded in an educational context.

We found a weak association between self-perceived overall cultural competence and the assessed cultural competence domains. This is coherent with the study reported by Hudelson et al. for competence in working with a medical interpreter (19) and highlights the additional value of assessing cultural competence beyond self-perception (15,16). Taking the 'conscious competence learning model' in mind (31), self-perceived competence will provide insight in incompetence of which respondents are aware of. However, a more objective indicator also shows incompetence of which respondents are unaware.

Limitations

The response rate among medical students was quite low (25%). The comments reported by respondents at the end of the questionnaire were generally positive and did not indicate a negative attitude towards the subject of cultural competence, neither a low acceptance nor unclear structure of the questionnaire. Generally, students who were more interested in the area of cultural competence are more likely to have participated. Therefore we cannot assume that our results are fully representative of the local medical student population.

We used a self-developed questionnaire. Validation of any measure is a permanent process (32). The strong base of the items in theory supports the content validity of the measure. The differences in average scores between various domains of cultural competence in the three respondent groups were mostly concordant with a priori expectations and support the construct validity of the questionnaire. For example, the average scores of YHC Residents on exploring social context were significantly higher than those of the medical students. This is in line with expectations, because YHC physicians are specifically trained to address social determinants of health.

We chose to develop a web-based questionnaire because this allows for data collection at a large scale at relatively low costs. We believe that this questionnaire allows for getting insight in the level of cultural competence of large groups in a relatively easy way. However, despite the fact that we tried to assess cultural competence as objectively as possible, the use of a questionnaire implies that we had to rely on self-reported behaviour. The relationships of the domain scores with real behaviour in medical practice remains to be investigated by, for example, by observing clinical practices. However, by testing knowledge with a multiple choice test and by questioning respondents’ past or intended behaviour we have developed a questionnaire that goes beyond respondents rating their own level of knowledge and behaviour.

Although we used a normative framework describing the required domains of cultural competence, the interpretation of the scores for the various dimensions of cultural competence in terms of ‘sufficient’ or ‘insufficient’ may be less straightforward as we have presented. It is likely that the requirements regarding cultural competence are context dependent; for example, the context of providing care to asylum-seekers requires more specified cultural competence than the context of paediatric asthma care (18,33).

Guidance for development of a cultural competence training program

Assessing cultural competence of medical students and physicians allows for the identification of gaps in knowledge and appropriate behaviour that reflect specific areas for improvement of the diversity content of their educational curricula. Low scores on knowledge of the context and processes that influence health and healthcare of minority patients suggest gaps in the curricula in delivering contextual knowledge. Although reasonable scores were found with regard to exploration of patients’ perspectives (64%) and on interaction with low health literate patients (60%), addressing these issues in the curriculum would be valuable to improve these scores.

The outcomes of the questionnaire provide guidance for curriculum improvement, but need to be supplemented by a curriculum-scan (for example by means of the TACCT (34)) to provide concrete indications for what needs to be improved and what are didactically the most natural places to address the missing issues.

Conclusions

Assessing knowledge of issues relevant for care provision to ethnic minority patients, ability to reflect, and culturally competent consultation behaviour enabled us to identify gaps regarding cultural competence training in the current curricula of medical students, YHC Residents and professional education of Youth Health Care Supervisors. In combination with a curriculum scan, the results of such an assessment will provide the basis for concrete recommendations of what diversity-related issues should be addressed where in the curriculum. At the same time the assessment outcomes could serve as a baseline score that can be used as a benchmark in a subsequent assessment later on, after curriculum improvements have been realized. We believe this cultural competence assessment is a valuable addition to existing curriculum assessments and measures of self-perceived cultural competence.

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Appendix 5.1 Development of the questionnaire

The cultural competence framework			
Competencies defined in the framework (21)	**Knowledge** 1. Knowledge of epidemiology and manifestation of diseases in various ethnic groups 2. Knowledge of differential effects of treatment in various ethnic groups	**Attitudes** 3. Awareness of how culture shapes individual behaviour and thinking 4. Awareness of the social contexts in which specific ethnic groups live 5. Awareness of one's own prejudices and tendency to stereotype	**Skills** 6. Ability to transfer information in a way the patient can understand and to know when to seek external help with communication
Operationalisation for questionnaire			
What we want to measure *(the numbers between brackets refer to the competencies defined in the framework)*	Knowledge of: - the context and processes that influence health and health care of minority patients (such as ethnic inequalities in health, ethnic composition of the population) (1,2); - interpretation services (e.g. when and how to use professional interpreters in medical practice) (6)	Ability to reflect on how a care provider's own frame of reference (e.g. cultural), and prejudice and stereotypes, influences his practice (3,5).	Behaviour showing that the care provider effectively takes patients' social context and culture into account (3,4), and applies the appropriate communication strategies in diverse contexts (6).
What we measure			
Domain	**Knowledge** a) general knowledge of ethnic minority care provision b) knowledge of interpretation services	**Reflection ability**	**Culturally competent consultation behaviour**
Type of assessment	Multiple choice items a) 8 items on general knowledge of ethnic minority care provision (4 response options, including 'do not know') b) 6 statements on knowledge of interpretation services (true/false/do not know)	GRAS (Groningen Reflection Ability Scale) Self-assessment measure: 23 statements with 5 point Likert scale (20)	- Case based questions with 'correct' (culturally competent) and 'incorrect' (culturally incompetent) response options (2 items) - 11-item scale on knowledge of patients' individual social context - asking preference for (students) or actual use in past months of (YHC respondents) different types of interpreters (1 item)

Examples	- *General knowledge of ethnic minority care provision* 1. In 2010, 20% of the Dutch population had a migrant (non-Dutch) background. What was the proportion of Western vs. non-Western migrants? a) 30/70 (Western/non-Western) b) 50/50 (Western/non-Western)* c) 70/30 (Western/non-Western) d) Do not know 2. During Ramadan, religious Muslims are not allowed to eat and drink between sunrise and sunset. Do Muslims in the Netherlands apply these fasting rules to medication as well (i.e., they will not use medication between sunrise and sunset)? a) Yes: many Muslims in the Netherlands apply these fasting rules to medication use.* b) No: Muslims in the Netherlands seldom apply these fasting rules to medication use. c) Partly: these fasting rules are applied to alternative medication, but not to medication that is prescribed by physicians. d) Do not know - *Knowledge about interpretation services* 1. Patients are responsible to take care for an interpreter (true/false*/do not know) 2. A professional interpreter (in the Netherlands) is trained to explain cultural issues, in addition to translation (true/false*/do not know) **correct answers*	- *Statements from the GRAS* To what extent do the following statements apply to you? • I take a closer look at my own habits of thinking • I am aware of the emotions that influence my thinking • I can see an experience from different standpoints • I am aware of the cultural influences on my opinions • I am able to understand people with a different cultural/religious background *Answers on 5-point scale (1 meaning ‘totally disagree’ until 5 ‘totally agree’)*	- *Culturally competent consultation behaviour* 1. Which communication techniques do you apply in a consultation with a migrant patient that only has finished primary education? (there is no language barrier)(maximum of 4 answers) • I am concise in my information • I use laymen's language* • I check the patients’ knowledge level before I start my information* • I start a next consultation repeating the information • I provide written information as much as possible • I limit the number of new subjects I introduce* *scored as culturally competent answers 2. Take in mind the newly registered migrant patients of the past two months. Of which part of these patients you know the following background characteristics: • country of origin • composition of family • patient’s social network • work/daily routine • years education *Answers on 4-point scale (<25%; 25-50%; 50-75%; >75%)*

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6 Teaching communication with ethnic minority patients: Ten recommendations

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Abstract

Introduction

Culturally competent communication is indispensable for medical practice in an ethnically diverse society. This article offers recommendations to teach such communication skills based on the experiences of members of a Dutch NMVO Special Interest Group on ‘Diversity’.

Method

A questionnaire with three open-ended questions on recommendations for training in culturally competent communication was sent to all members (*n*=35). Returned questionnaires (*n*=23) were analysed qualitatively with a thematic coding framework based on educational themes emerging from the data.

Recommendations

All students need to be educated in culturally competent communication. Teachers should stimulate awareness of personal biases and an open attitude. Teach the three core communication skills, listening, exploring and checking, and offer practice with a professional interpreter. Knowledge content should focus on mechanisms relevant to various ethnic groups. Offer students a variety of experiences in a safe environment. All involved should be aware that stereotyping is a pitfall.

Discussion

Training in communication skills for consultation with ethnic minority patients cannot be separated from teaching issues of awareness and knowledge. The shared views on the content of these communication trainings are in line with general patient-centred approaches. The development of proper training in this field demands specific efforts of those involved.

Introduction

With the increased number of immigrants into the Western world, medical students must prepare for their roles as physicians in a diverse patient population. In the Netherlands, 11% of the population have a non-Western ethnic background (1). This percentage is based on country of birth and comprises first generation migrants and their children (2,3). A relatively large group within this non-Western population were originally labour migrants (mainly from Turkey and Morocco), others came as refugees (e.g. from Afghanistan and Iran) or immigrated from former colonies (e.g. Surinam). The composition of the ethnic minority population is dynamic and ever changing, as exemplified by the recent arrival of labour migrants from Eastern Europe (1), the distribution of first and second generation migrants or the degree of acculturation.

Common causes of communication problems with ethnic minority patients are language barriers, cultural differences in explanatory models of illness, health illiteracy and racism or perceptual biases (4-6). In general, physicians behave less affectively with ethnic minority patients (5,7,8) and check less often whether patients have understood their message (9) than is the case with majority populations.

Cultural competence is generally defined as the combination of knowledge, attitudes and skills necessary for care providers to deal effectively with cultural and ethnic diversity (10). The need for education in cultural competence is widely recognised, but it has not yet been implemented structurally in Dutch medical schools (11) nor in other European countries (12,13). Neither is there consensus on how to implement medical communication training that focuses on patients from an ethnic minority background (culturally competent communication). Many of the existing frameworks and visions on cultural competence describe the contents of the concept at a meta-level (10,14,15). These frameworks can be helpful in defining general objectives of communication training, but do not specify what to teach and how.

Practice points

- Despite recognition of the importance of teaching culturally competent medical communication, there has been little consensus on what to teach and how.
- Culturally competent communication training should not merely focus on skills, but must be part of a larger set of cultural competences.
- All those involved in culturally competent communication training should be prepared to examine their own stereotypes
- Teachers should create a safe teaching environment, stimulate students' self-reflection, and be able to cope with reluctance and resistance in students.
- The assessment of cultural competence in medical students deserves more attention and debate.

In this article, we offer recommendations for the development of medical communication training with respect to patients from ethnic minorities. These are based on an investigation of experiences and views of the members of the NVMO Special Interest Group (SIG) on Diversity and will be presented in the context of the available literature. We define ethnic background by country of birth because this is a common practice in The Netherlands and Belgium (2), but our recommendations also relate to communication difficulties resulting from differences in socioeconomic status, cultural background, degree of literacy, religious backgrounds or from discrimination experienced.

Method

Design

We sent out, by e-mail, a questionnaire to all members of the SIG (N=35) to elicit their ideas about, and experiences in, teaching culturally competent communication in an ethnically diverse context. The questionnaire consisted of the following open-ended questions:

What are your recommendations regarding communication with ethnic minority patients, to: 1. *students*, 2. *educational designers* who are designing training in such communication and 3. *teachers* who teach such communication?

Each of these three items had five information entering fields as response options. Additionally, we asked general items about background (education), academic position, working field, medical institution and demographic characteristics.

As the SIG collaboratively decided on this project, e-mail was used to survey opinions and experiences. Consequently, the identity of the respondents was not anonymous, but in the data-analysis all personal information was left out.

Respondents

Thirty-five members (all except CS and VS) were sent the questionnaire and a maximum of two personal reminders in case of non-response, upon which 23 colleagues returned a completed questionnaire. All eight Dutch medical schools and one Belgian medical school were represented (Table 6.1).

Data analysis

We used a framework approach (a content and thematic analysis strategy) to analyse the data (16). After having familiarised with the data, VS and CS derived educational themes, which provided a coding framework. Main themes were: educational view, place in the curriculum, teaching objectives, materials and methods, classroom level and danger of stereotyping. All recommendations were independently categorised by VS and CS into these educational themes. Within these broad themes, clusters of recommendations appeared, which were categorised into subthemes. Recommendations that could not be categorised in a subtheme were assigned to 'rest' categories. No qualitative research software was used.

Results of this categorisation process were compared, and differences discussed, until VS and CS reached consensus. We then discussed the recommendations with four other members of our group in order to check the categorisation and search for possible omissions or contradictions in the data. A summarising document, including the recommendations and a short description of every point made was then e-mailed to all our members, inviting them to indicate omissions and information they disagreed with.

All members had the opportunity to react by e-mail, telephone or in person at the next meeting of the SIG. Comments from our members were thoroughly discussed in the meeting and by VS and CS separately, and incorporated into the final recommendations if relevant.

Table 6.1 Socio-demographic characteristics of respondents

		%	(n)
Gender (*n* = 22[a])	Female	68%	(15)
	Male	32%	(7)
Country of birth: outside Netherlands (n = 22[a])	Respondent	23%	(5)
	Respondents' mother	9%	(2)
	Respondents' father	23%	(5)
Educational background (*n* = 22[a])	Medicine	36%	(8)
	Social sciences	55%	(12)
	Other	9%	(2)
Current function (*n* = 22[a])	Professor	13%	(3)
	Associate professor or university teacher	57%	(13)
	Researcher	13%	(3)
	Other	17%	(4)
Involved in diversity education (*n* = 23)	Yes	87%	(20)
	No	13%	(3)
Involved in communication teaching (*n* = 23)	Yes	61%	(14)
	No	39%	(9)

Note: [a]One respondent left this page blank.

Recommendations

All 10 recommendations were structured according to the general educational themes that emerged in the data and that were used for the categorisation process, as follows: educational view (recommendation 1), place in the curriculum (recommendation 2), teaching objectives (recommendations 3-7), materials and methods (recommendation 8), classroom level (recommendation 9) and stereotyping (recommendation 10).

(1) Develop a clear view on the content of the training

The first step is to develop a ‘view’ on what culturally competent medical communication consists of. This view may then function as a starting point for the development of the actual educational programme. The view shared in our group is that communication skills should be part of a larger set of cultural competences and not be taught isolated from awareness and knowledge issues (see recommendations 3-7).

General medical communication and communication with individuals from an ethnic minority background have many similarities. However, some issues are more frequent in or specific for communication with minority patients, e.g. language barriers or expectations for treatment based on health care experiences in the patient’s country of birth. Clarifying these similarities and dissimilarities helps to distinguish what can be taught in regular communication training and what should be addressed in a specific training in culturally competent communication.

(2) Teach all students

The group considers culturally competent communication a basic competency for each physician. Therefore, it should be taught in the standard medical curriculum, at all levels and to all students.

By frequently addressing cultural competence issues in communication training, awareness of diversity will become something ‘natural’. Special courses can be developed for students with a specific interest in cross-cultural care.

(3) Stimulate awareness of cultural and personal biases

Two awareness issues are especially important in culturally competent communication training. First, teachers have to stimulate students to become aware of their own cultural backgrounds and perspectives. The training must make them aware that culture is not something that only belongs to others, for example by exercises that question students about their own personal and cultural backgrounds. Students are invited to exchange their views and feelings on issues that are not usually part of daily conversations (such as religion or important values in their families) (see Box 6.1 for a practical exercise). This awareness is essential to enable reflection on their communicative behaviour within an intercultural setting.

Second, students must be aware of their personal attitudes (including stereotypes) towards individuals from ethnic minority backgrounds. To raise students’ awareness, they might take an online Implicit Association Test[1] (IAT: https://implicit.

harvard.edu/implicit/), the outcomes of which may serve as starting points for a reflective learning group. Box 6.1 describes an educational session in which students are invited to state and examine their own prejudices.

(4) Stimulate an attitude of openness, interest and respect

For effectively applying acquired communication skills, a triad of specific attitudes is a prerequisite, namely openness, interest and respect. These attitudes are essential to understand patients' perspectives and to prevent students from judging too quickly. Students can practise this 'respectful curiosity' by asking questions, even difficult or delicate ones, to their peers or simulated patients.

Students should learn to deal with feelings (such as irritation or powerlessness in case of misunderstandings and language barriers) that might interfere with their openness towards patients. Reflection on these kinds of emotions should be a regular part of the closing discussion after communication exercises.

Box 6.1 Examples of practical exercises.

Example 1 – Reflection on diversity and professional growth:
A multicoloured card game

A *set of reflection cards* (in English, Spanish, Dutch) was designed to stimulate reflection on diversity and professional growth in small groups of medical students. This 'card game' is an exercise in listening, asking explorative questions and in understanding one another's background, values and views. By sharing experiences and views, participants may gain insight into their own personal and professional 'culture' and development.

The set consists of over 70 cards with challenging reflection questions, in five categories: 1. personal roots, 2. cross-cultural communication, 3. professional development, 4. death and dying and 5. taboos.

Some illustrative questions per category:

1 Name one rule or moral value you were brought up with that you have now discarded.
2 Have you ever felt discriminated? If so, on what grounds?
3 Name a personality trait of yours that may be a problem in your medical profession.
4 At my funeral, I hope people will say that ... .
5 In your opinion, should a doctor try to avoid crying in front of a patient?

Participants are invited to take turns, answering one of the questions (e.g. by picking a random card or choosing from an open stack).

Three *rules* should always be respected:

1 Safety and privacy: the 'interviewee' may decline any question without reading the card aloud and without explaining why.
2 The 'interviewers' show real interest by asking explorative questions, and by not interrupting with their own experiences.
3 No discussion!

Designed by Benno Bonke (Erasmus Medical Center) and Veronica Selleger (VU Medical Center)

Example 2 – Awareness and impact of stereotyping

In a first year course on communication and medical problem solving, one session in small groups addresses stereotyping and prejudices in cross-cultural medical communication. The aim is to challenge students to face their prejudices in order to prevent these from unconsciously affecting their communication with (minority) patients.

1. Students explore their personal cultural backgrounds. Who (according to current definitions) belongs to an ethnic minority? What are the students' opinions on these 'labels'?
2. Students engage in a short brainstorm on possible pitfalls in communication with minority patients.
3. The teacher provides some theoretical information on communication with minority patients, stereotyping, and prejudices.
4. Students express and examine some of their personal stereotypes and prejudices freely and uncensored. First, they are invited to come up with labels of (sub) groups in Dutch society, like farmers, 'Turks', gays, doctors, women, etc. Then, they are prompted to express their prejudices about some of these groups. Students belonging to a specific group state their prejudices about their own group. Students and teacher compare prejudices and discuss reasons for prejudice.
5. In a roundup, the students and the teacher discuss the possible impact of these prejudices on medical communication. These exercises are followed by a training session with simulated patients.

Designed by Naomi Ehrlich (VU Medical Centre)

(5) Listen, explore and check: The three core skills

Preventing misunderstanding when physicians and patients are from different ethnic backgrounds is all the more important because such confusion is then more prevalent than otherwise (17). The most obvious level of potential misunderstandings is language: do both parties understand the words spoken? (see recommendation 6). A next level has to do with interpretation: do both parties give the same meaning to the words used. Due to culturally based differences in expectations, illness-based experiences or different emotions, misunderstanding may also occur.

Students can be taught the necessary skills for preventing misunderstandings such as questioning, listening and observing attentively and checking. The teacher must stimulate awareness that confusion can occur both ways: they can misunderstand their patients and patients may misunderstand them. By asking additional, exploring questions, they may find out whether they were really understood. At the same time, they may discover what is of importance to patients themselves. Transparent communication can prevent confusion: explain the rationale for the questions that you want the patient to answer.

(6) Practise with a professional interpreter

Students should learn why and when working with professional interpreters is important and be taught specific skills to communicate well with a patient through interpreters. This may be addressed in a session that discusses the pros and cons of working with professional interpreters and where students practise a simulated conversation with an interpreter.

(7) Acquire knowledge at a meta-level

It is an issue of debate as to what kind of knowledge is relevant for culturally competent communication in health care. Knowledge of specific characteristics of cultural groups can easily result in stereotyping, as emphasised in literature and by our members. Nevertheless, our group considers some knowledge aspects important to be taught in communication training, mostly those at a higher level, such as on theories on mechanisms that influence health and health care in patients form ethnic minorities (e.g. Kleinman's explanatory models (18), migration history of ethnic groups, dynamics of culture). For example, understanding that patients may have particular cultural explanations for their symptoms helps physicians to pick up the cues patients provide during a consultation about their illness perspectives. Qualitative research on patient perspectives and experiences from different ethnic groups as well as books or films on these subjects might serve as valuable input (19,20).

It remains difficult to determine exactly what kind of knowledge of specific cultures should be taught. For students to become sensitive for 'cultural views', these should be illustrated with examples of specific groups. Obviously, physicians must be familiar with Ramadan, for example to anticipate risks for diabetic Muslim patients. In order to avoid reinforcing stereotyping, however, it is always important to stress the limitations of this wisdom in the communication with individual patients.

(8) Offer a variety of educational experiences

In working with simulated patients when teaching communication skills, one must make sure that role-plays and communication exercises reflect reality and do not promote stereotypes. The pitfalls of focusing merely on psychosomatic complaints or of providing examples of traditional cultural ideas only instead of showing dynamics in a culture had better be avoided. Cases must have clear learning objectives without all kinds of communication aspects being intertwined, like language barriers as well as cultural and literacy issues. It is considered wise to choose simulated patients from a variety of ethnic backgrounds.

Apart from practising in simulated settings, students may also be offered other examples of educational methods and materials, such as: real-life experiences where they can observe other professionals and meet patients from ethnic minority backgrounds, assignments to write reflection papers, as well as supportive materials such as films and books.

(9) Conditions at classroom level: Safety is crucial

Safety is an important condition for teaching diversity issues. Students should feel comfortable to reflect on their own assumptions and moral values, and to go 'deeper' than merely giving politically correct answers.

When one addresses diversity in class, students from ethnic minority backgrounds may have interesting and valuable contributions to what is practised or discussed. They should not be addressed merely because of their ethnic backgrounds, as this might put them in an awkward position. One of our members explained a subtle approach:

> *I always start to approach background issues broadly and safely. I may ask: 'Who comes from a rural background?' And then I move closer to ethnicity or religion related themes.*

Reluctant students pose yet another challenge. Some may be unwilling either to reflect on their own backgrounds and behaviours or to modify their regular behaviours when a patient is of an ethnic minority background. Such reluctance might be caused by an unsafe learning environment, and prevented if safety conditions are met, but the political and social context in which this topic is taught might also cause reluctance. Addressing cultural competency as part of the basic competencies that every physician should possess may diminish student resistance. Teachers can be supported in their educational efforts by a specific teach-the-teachers programme.

(10) Stereotyping is a persistent pitfall

Our members frequently warned for stereotyping, which should be in the back of the minds of all involved in developing and teaching medical communication in an ethnically diverse context. This pertains to obvious prejudice as well as subtle stereotyping. Everybody has stereotypes, even unconsciously or unwillingly, and these affect communication negatively (5). Teachers must enable students to examine, and learn to deal with their own stereotypes. Accordingly, teachers should also be prepared to reflect on their own perspectives and assumptions on ethnic diversity.

Discussion

Training in communication skills for health care professionals working with patients from an ethnic minority background cannot be separated from education in issues of awareness and knowledge. The content of such communication training should focus on skills to prevent misunderstandings and on exploring patients’ contexts. Students must be encouraged to develop their own communication repertoire. Designers, teachers and students involved in these communication trainings should be open to exploring their own attitudes on diversity issues and avoiding reinforcing stereotypes.

Our investigation has its limitations. The recommendations in this article only represent the views of the members of the SIG. Although the SIG represents most of the Dutch expertise in ethnic diversity-related education as well as in medical communication, the views of non-members are not present. The members of the SIG are mostly from ethnic majority background. It might be that teachers from ethnic minority backgrounds have useful recommendations from a different point of view that were not taken into account due to the composition of our group.

Our recommendations result from Dutch and Flemish contexts with regard to medical education, health care organisation and society itself (e.g. regarding ethnic minorities), as well as from our own cultural views. Although the general concepts of culturally competent communication are broadly relevant across contexts, the specific contents of communication training must be adapted to the specific needs of each educator’s context.

The proverbial three-legged stool described by Betancourt (10) as a symbol for the importance of the combination of attitudes, skills, and knowledge in cultural competence education is also reflected in our recommendations on communication training. Our members emphasised that attitudes like openness and respect, and awareness of one’s own background are part and parcel of communication in an ethnically diverse context.

The attitudes and skills described, such as asking explorative questions, listening attentively and being aware of patients’ contexts, are not unique for communication with ethnic minority patients but are important elements of any patient-centred communication approach (21,22). The potential complexity, however, of communication with patients from an ethnic minority group – due to language barriers, cultural distance or influence of stereotypes – asks for distinct qualities (22) or a ‘PLUS’ in the generic patient-centred approach (4,23). It is important for students to explore their expectations about patients as well as their own professional standards and personal ethical limits in order to decide to what extent they can meet their patients’ expectations.

In our recommendations, we have approached the topic of communication very broadly. Medical communication has various functions, ranging from history taking to the breaking of bad news. Influence of patients’ cultural and ethnical backgrounds varies for these functions, and therefore provides different focus points for communication training. In history taking, it is important that physicians are well informed of ethnic differences in the prevalence of diseases (15); in breaking bad news exploring patients' cultural views when talking about health issues is vital.

This article does not discuss recommendations about assessing cultural competence. Probably due to the phrasing of our questionnaire, this issue remained underexposed. Within the cultural competence literature, assessment is a neglected subject (24, 25). Assessment may bring about several pitfalls if not dealt with adequately such as reinforcing a one-dimensional notion of cultures or using assessment tools that lack authenticity (26). To get more insight into the views on assessment, future research with a particular focus on assessment is necessary.

Education in culturally competent medical communication demands specific efforts of both education designers and teachers (more specifically, their willingness to examine their own perspectives regarding diversity issues and their own biases and prejudices). We hope that our recommendations and the pitfalls mentioned provide some guidance and encouragement for those who consider developing education in this field, and contribute to the further development of culturally competent care.

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The NVMO SPECIAL INTEREST GROUP ON DIVERSITY was started in 2004, and has since met approximately three times yearly to exchange ideas and experiences related to all kinds of diversity aspects in medical education. The majority of the members are employed by one of the eight Dutch medical schools; two members are from Belgian medical schools in Flanders. All have a special interest in the subject of diversity in medical education, but not all members actually teach diversity-related subjects.

Note

1. The IAT was designed to assess the degree to which an individual implicitly associates certain members in the society (e.g. ethnic minority groups, women, the handicapped, obese individuals, etc.) with certain personal characteristics.

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7 How should health service organizations respond to diversity? An analytic framework based on a comparison of six approaches

This chapter has been submitted as:
Conny Seeleman, Marie-Louise Essink-Bot, Karien Stronks, David Ingleby. *How should health service organizations respond to diversity? An analytic framework based on a comparison of six approaches.*

Abstract

Context

Health care organizations need to be responsive to the needs of increasingly diverse patient populations. We developed an analytic framework based on a comparison of six approaches for organizational responsiveness to diversity. The central questions addressed in this paper are: what are the essential elements of health services that are responsive to the needs of groups differing from the majority population? How much consensus is there between various approaches?

Methods

We selected six approaches from the US, Australia and Europe and used qualitative analysis to categorize the content of each approach into ‘domains’ (conceptually distinct topic areas) and, within each domain, into ‘dimensions’ (operationalizations). The resulting classification framework was used for comparative analysis of the content of the six approaches.

Findings

We identified seven domains that were represented in most or all approaches: ‘organizational commitment’, ‘empirical evidence on inequalities and needs’, ‘a competent and diverse workforce’, ‘ensuring access for all users’, ‘ensuring responsiveness in care provision’, ‘fostering patient and community participation’ and ‘actively promoting responsiveness’. Variations in the conceptualization of ‘responsive care’ reflected different assumptions about the type of diversity that should be responded to. For example, approaches that focus on ethnic diversity refer mostly to cultural and language differences; approaches that broaden their target populations to (e.g.) ‘vulnerable’ groups adopt a more multidimensional approach, also paying attention to such factors as socio-economic status and gender.

Conclusions

According to current conceptualizations, organizational responsiveness to diversity in health care means ensuring access and providing appropriate care. The analytic framework also defines several preconditions, such as demonstrating organizational commitment, developing a competent and diverse workforce, and fostering patient and community participation. Despite differences in the way different approaches are labeled, this comparative study reveals a broad consensus among different approaches concerning the way in which health service organizations should respond to diversity.

Introduction

Health service users belonging to groups that differ in certain respects from the majority population, such as migrants, ethnic minorities and other groups sometimes referred to as 'vulnerable', often receive poorer care than majority users. Variously described as 'health care disparities', 'inequalities' or 'inequities', these problems in healthcare have been well documented in the United States (1,2) and are increasingly being recognized in other countries (3-5).

The existence of these problems implies that health services may need to be adapted in order to increase their accessibility and quality for service users who differ from assumed norms. Such responsiveness to diversity has for several decades been referred to as 'culturally competent care'. This concept was first developed in the USA in relation to ethnic minorities, but in recent years there has been a growing realization that many other groups are also not optimally served by standard services. In the USA, the response has been to retain the label of 'cultural competence' but to broaden the definition of 'culture' to reflect such attributes as migrant status, socioeconomic position, geographical location, gender, religion, age, sexual orientation or disability (6,7). In other countries, however, widening the range of target groups has been seen as a shift *away from* the focus on 'culture'. Rather than speaking of 'cultural competence', advocates of responsiveness to diversity have used terms such as 'promoting equitable health care', or 'protecting vulnerable groups' (8). Despite the differences in terminology, we will argue in this paper that these disagreements are to a large extent a question of semantics.

Whichever approach is adopted, promoting responsiveness to diversity requires interventions at several levels of the health system. At the level of *individual caregivers,* three elements of responsive care have been emphasized: knowledge, skills and attitudes (9,10). At the level of *health service organizations*, promoting responsiveness involves putting into place certain key elements in service policies and management (8). Some approaches address the level of entire *health systems,* in which case interventions at national (or state) as well as organizational or individual levels are discussed.

In this article we will examine only recommendations that have been put forward at the organizational level, while recognizing that responsiveness to diversity also has important implications for the other two levels. Approaches differ according to the target group for which they were principally intended and the assumptions that underlie them. In the USA, 'cultural competence' has been promoted at the organizational level through the CLAS standards (Standards for Culturally and Linguistically Appropriate Services) (11). In Europe, recommendations have been published referring to goals such as ‘migrant friendliness’ (12), ‘intercultural opening’ (13), ‘transcultural competence’ (14) or ‘difference sensitivity’ (15).

So far no systematic analyses have been carried out to establish whether there are important differences in content between these approaches. To what extent does consensus exist about the measures that organizations should take in order to adapt health services to the needs of diverse patient populations? Without such consensus, no general principles can be laid down for improving responsiveness, nor can general criteria for measuring progress towards this goal be defined.

In this paper we have developed an over-arching analytic framework within which different approaches can be described, compared and contrasted. The paper examines six approaches and addresses the following questions:

1. On which aspects of health service provision (‘domains’) do the different approaches focus?
2. How much agreement is there concerning the domains that are important?
3. How much agreement is there in the way the tasks within each domain are operationalized in ‘dimensions’?

The answers to these questions will shed light on our central question: what are the essential elements in providing care that is responsive to the needs of groups differing in certain important respects from the majority population, and how much consensus is there between various approaches?

Method

Choice of approaches

In recent years many guidelines or recommendations for increasing organizational responsiveness to diversity have been published by both public and private bodies. To compare all these approaches would have been an impossibly large task, so we selected six approaches using the following criteria:

- the approach was developed for widespread (more than local) use;
- it was developed by an organization with some authority; and
- it was publicly available.

In addition, we wanted to compare approaches from US, Australian and European sources.

The following approaches were selected: 1) CLAS Standards - National Standards for Culturally and Linguistically Appropriate Services in Health Care (further referred to as: CLAS) developed by the Office of Minority Health, part of the U.S. Department of Health and Human Services (11); 2) Advancing Effective Communication, Cultural Competence, and Patient- and Family Centered Care: A Roadmap for Hospitals (further referred to as JCR), developed by the Joint Commission (16); 3) Cultural Responsiveness Framework. Guidelines for Victorian health services (further referred to as CRF) developed by the Victorian Government, Department of Health (17); 4) Recommendation of the committee of ministers to member states on mobility, migration and access to health care (further referred to as COER) of the Council of Europe (18,19); 5) The Equality Delivery System (further referred to as EDS) for the NHS (20); 6) Standards for Equity in Health Care for Migrants and other Vulnerable Groups (further referred to as EQS) developed by the Task Force on Migrant-Friendly and Culturally Competent (21). Box 7.1 briefly describes each approach and clarifies our reasons for including the approach in our study.

In May 2013 the Enhanced CLAS Standards were published, entitled “National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice” (7). A comparison of the new Standards with the original version showed that the underlying ideas were virtually identical to those which informed the first edition. Indeed, the accompanying texts made clear that the aim of the revision was mainly to increase the effectiveness of the Standards, by explaining them more clearly, ensuring that they reflected recent developments, and aligning them with other initiatives such as the Affordable Care Act and the work of the Joint Commission. Some differences of emphasis are described in Box 7.1. The version of CLAS used in this paper is the original one: we do not feel the changes made in the enhanced version are extensive enough to warrant a separate analysis.

Box 7.1 Description of the six approaches on responsive health care that were included.

CLAS Standards - National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) (11). These standards were developed by the Office of Minority Health, part of the U.S. Department of Health and Human Services. Some of the standards have the status of mandates, meaning that they are Federal requirements for all health care organizations that receive Federal funds; others are purely recommendations. We included the CLAS standards because they are probably the most comprehensive and influential approach in use. In May 2013 the Enhanced CLAS Standards were published (7). Although largely similar, there are some differences of emphasis between the original and the Enhanced CLAS Standard appeared of which we would like to mention:

A broader definition of “culture” was adopted. In the original version, culture was defined as being “associated with racial, ethnic or linguistic groups”. In the new definition, this was expanded to include “religious, spiritual, biological, geographical, or sociological characteristics”, thus extending the relevance of CLAS standards beyond racial and ethnic minorities to a wide range of types of diversity. Although many new groups are now intended to fall under the scope of CLAS, the only feature of these groups which is taken account of is still their culture (defined as an "integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions"). Other features such as social position, material limitations or legal situation are not mentioned.

In the vision on responsive care some slight changes of emphasis could be found, such as a shift from regarding diversity as a 'group' characteristic to 'appreciating the diversity of individuals'. The enhanced CLAS also places more emphasis on the importance of 'patient- and family centred care', thus bringing it more into line with the JC Roadmap

Advancing Effective Communication, Cultural Competence, and Patient- and Family Centered Care: A Roadmap for Hospitals (JCR) (16). This 'Roadmap' has been developed by the Joint Commission (JC), an independent, not-for-profit organization which accredits and certifies health care organizations in the United States. The Roadmap was developed in addition to existing JC requirements "to inspire hospitals to integrate concepts from the fields of communication, cultural competence, and patient- and family-centered care into their organizations." We included the JC Roadmap because of the global influence of JC and the Joint Commission International (JCI) accreditation program on health care organizations through their accreditation programs (applied in over 50 countries). Although attention to healthcare for ethnic minority patients within the JC started after a 'gap' analysis between the CLAS standards and the JC's accreditation standards in 2003, the JC has developed its own framework of recommendations on issues of effective communication, cultural competence, and patient- and family-centered care. Therefore we consider the Roadmap to be related to the CLAS standards, but distinct from them. It is important to note that 1) existing JC requirements also include issues related to those issues discussed in the Roadmap, and 2) that the national Joint Commission Standards are different from the Standards of the Joint Commission International.

Cultural Responsiveness Framework. Guidelines for Victorian health services (CRF) by the Rural and Regional Health and Aged Care Services, Victorian Government, Department of Health (Australia) (17). The CRF was developed to replace the Health Service Cultural Diversity Plans (HSCDPs) which since 2006 have required all Victorian health services to develop and implement policies for ethnic diversity in care. The intention of the CRF is to consolidate multiple requirements for reporting on cultural diversity initiatives within health services. All Victorian health services are required to submit plans and achievements according to the standards and measures in the CRF to the Statewide Quality Branch. We included the CRF because it has been disseminated and made compulsory in a large health care system in Australia.

Recommendation of the committee of ministers to member states on mobility, migration and access to health care (COER) of the Council of Europe (18,19). The Council of Europe is an international organization set up "to achieve a greater unity between its members for the purpose of safeguarding and realizing the ideals and principles which are their common heritage and facilitating their economic and social progress" (32). We included the COER because it has been endorsed by the Health Ministers of the 47 member states of the Council of Europe. The document is aimed at ministerial level, therefore it includes recommendations that have consequences for the whole health system. To make comparisons possible we have only included the recommendations at organizational level in our analysis.

Equality Delivery System (EDS) for the NHS (20). EDS originates from the Equality and Diversity Council within the British National Health Service (NHS). It is designed to help NHS organizations to comply with the 'Public Sector Equality Duty' (PSED) of the Equality Act. This act "requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees" (33). EDS is made available to the NHS as an optional tool. It was included because it is a European instrument which has been disseminated in a large health care system.

Equity Standards (EQS) of the Task Force on Migrant-Friendly and Culturally Competent Healthcare (21,25). These Standards were developed by a group of mainly European experts set up within WHO's Health Promoting Hospitals network. The Equity Standards are a self-assessment instrument to enable health care organizations to carry out an 'equity evaluation' against a set of standards. The instrument was piloted in 10 European countries, as well as in two non-European ones. The Equity Standards were included because of the broad international context in which they were developed.

Developing the Framework

The following stepwise approach was used to develop the analytic framework.

A. Encoding of content

1. The first approach analyzed was CLAS. The different CLAS standards were grouped into 'domains ', i.e. conceptually distinct topic areas. Within each domain, different 'dimensions' were distinguished in order to show how the domain was operationalized.
2. A second approach was selected and its content was subsumed under the domains and dimensions identified in Step 1, new ones being created where necessary.
3. The four remaining approaches were treated in the same way.
4. The resulting system of domains and dimensions was critically reviewed by three of the authors in order to remove ambiguities and overlap.

B. Comparison of content

Categorizing the content of the approaches in this over-arching classification system enabled us to see at a glance whether certain domains were unique to, or absent from, particular approaches. Within each domain, it revealed the differences in the ways in which approaches operationalized the domain. In order to compare the six approaches, we listed the differences between them as well as their similarities.

Results

This section starts with background information on the six approaches. We then provide an overview and analysis of their content, classified according to the domains and dimensions of the framework that we developed. We then describe the similarities and differences between the six approaches.

Background information

Table 7.1 provides background information on the six approaches, listed with their acronyms (Table 7.1: see end of this chapter).

As their *aim*, the approaches refer to reducing or eliminating existing inequalities in health and quality of care between different populations (CLAS, COER, EQS), as well as improving outcomes for patients (JCR, CRF, EDS). Although all approaches aim at improving the quality of care, the motives underlying this goal are different. Some approaches (CLAS, COER, EQS) start from human rights principles, regarding inequalities between groups as injustices which should be eliminated. JCR considers equality as an indicator of performance, assuming that outcomes should be equal for all patients, while CRF and EDS combine both starting points. Two unique aims (not mentioned in other approaches) also emerge: CRF aims to enhance the cost-effectiveness of health service delivery, and EDS aims to create better working environments for staff.

In their *vision* on responsive care, three approaches directly invoke the concept of ‘cultural competence’. CLAS refers to the classic definition of cultural competence (Cross et al. 1989 (34)); at the same time, the term ‘culturally and linguistically appropriate services’ places separate and explicit emphasis on language issues. For JCR, cultural competence is one of three fundamental concepts on which the Roadmap elaborates (the other concepts being ‘effective communication’ and ‘patient and family centered care’). JCR operationalizes cultural competence in a similar way to CLAS. CRF introduces another concept: ‘culturally responsive care’. Although this term is chosen in preference to ‘cultural competence’, the vision implied is very similar to that of CLAS and JCR. A common characteristic of the first three approaches is therefore their emphasis on ‘culture’, at least in the labeling of their vision.

In the other three approaches the emphasis is not on ‘culture’ (as the presumed cause of problems) but on ‘equity’ or ‘equality’ (as the hoped-for result of efforts to tackle them). COER refers to “equitable access to health care of appropriate quality”: in relation to service delivery, it speaks of “improving the adaptation of health service provision to the needs, culture and social situation of migrants”. EDS does not provide a definition of its concept of equality, but relates it to the pursuit of quality, which in turn is defined as recognizing the needs and circumstances of *all* (both patients and staff) and ensuring accessibility, appropriateness, safety and effectiveness for patients. EQS explicitly distances itself from the concept of 'cultural competence', instead highlighting Whitehead's definition of equity in health: "equal access to available care for equal need; equal utilization for equal need; equal quality of care for all" (22).

The *target population* of each approach refers to the user groups envisaged by the authors as beneficiaries. CLAS, JCR and CRF refer to the target population in terms of race, ethnicity, culture or language, while EDS and EQS also include gender, age, disability, religion, sexual orientation, transgender status (both EDS and EQS); marriage and civil-partnership, pregnancy and maternity, nationality (only EDS); socio-economic status and aboriginal status (EQS). COER focuses explicitly on migrants, a category that is not mentioned explicitly in CLAS, JCR, CRF or EDS. However, COER uses the term migrant "in a very broad sense, referring not only to those who change their country of residence voluntarily but also to asylum seekers, refugees and victims of human trafficking. Since the consequences of migration may also extend beyond the first generation, second and later generations are also discussed. In the case of Internally Displaced Persons, internal migrants are also included". There is thus considerable overlap between the category of 'migrants' as defined by COER and the term 'ethnic minorities' used in other approaches.

'Horizontal' analysis (according to domains) (see table 7.2 at the end of this chapter)

1. Organizational commitment

Elements of the various approaches were classified in this domain if they mentioned commitment at management level to responsiveness to diversity. Two dimensions were found: *policy and leadership* and *measurement of performance*.

Policy and leadership

All six approaches maintain that organizations must make an explicit commitment to developing responsive care, rather than merely permitting individual initiatives that are not structurally imbedded in the organization. In COER this requirement is implied by insistence on a 'whole organization approach'. Commitment can either take the form of an explicit plan (CLAS, EQS), which sets out how the organization intends to organize and guarantee responsiveness, or a policy of good leadership (JCR, EDS), or both (CRF).

'Good leadership' is explicitly committed to achieving responsive care and promotes this within the organization (JCR, EDS): leaders take responsibility for reaching this goal (CRF). All approaches emphasize that plans for change should be integrated in existing organizational policies and processes. EQS additionally promotes a 'proactive' approach: in *all* its plans, the organization should anticipate the effect the plans will have on accessibility and quality of care for vulnerable groups.

Measuring and improving performance

All approaches regard it as essential that organizations measure their performance in providing responsive services (e.g. outcomes of treatment for different groups), with the aim of identifying necessary improvements, taking action, and assessing the organization's progress in providing responsive care. CLAS, EDS and EQS further emphasize that performance measurement should be a continuous activity, incorporated in regular performance measurement systems. The approaches differ in the variables which they suggest should be measured: some focus on quality of care, some on accessibility, and some on both (see also the domain 'collecting data' for the data-sources to be used in measuring and improving performance). CRF is the only approach stipulating mandatory indicators for measuring organizational cultural responsiveness. These have to be submitted by affiliated organizations and are also used for benchmarking.

2. Collecting data

The second domain we identified concerns the collection of data, not as an end in itself but because these data are necessary to measure equity of access and quality of care and to identify special needs or opportunities for improvement (see also the domain 'measuring and improving performance'). Two types of data are distinguished: one concerns *the population at large;* the other concerns *the organization's own users*.

Data on the population at large

Five approaches (CLAS, JCR, CRF, EDS, EQS) recommend assembling data on the community or catchment area in order to adapt services to the needs thus identified. Organizations can use information that is already available, but CLAS and EDS also give organizations an active role in collecting these data themselves. Such data include demographic variables (e.g. age, gender, ethnicity), characteristics potentially affecting service use (e.g. language proficiency, health literacy), health status and exposure to health risks. In COER the importance of empirical evidence is strongly emphasized: governments are urged to collect it "in partnership with relevant organizations".

Data on the patient population

Patients' files can serve as a source of data on ethnicity, race, language and other characteristics considered relevant for quality of care. For CLAS, JCR, CRF, and EQS these data are considered important in order to identify and monitor health and health care inequalities. For CLAS, JCR and EQS, information in patients' files on individual characteristics associated with ethnic minority status (e.g. proficiency in the majority language) also enables adaptation of care to the needs of an individual patient. Additionally CLAS, JCR, CRF, EDS and EQS emphasize that outcome measures and patient feedback systems must be able to analyze results according to diversity characteristics. The approaches differ in the types of data they recommend organizations to collect.

3. Staff/Workforce

The third domain concerns the staff or workforce of the organization. Two dimensions can be distinguished: *staff competencies* and *diversity in the workforce*.

Staff competencies

Staff competencies in delivering responsive care, and the importance of education and training, are central themes in all approaches. CRF and EDS describe a comprehensive approach to improving confidence and competence among staff, for example through personal development programs (EDS) and adapted HRM policies (CRF). CLAS, CRF, COER and EQS emphasize that *all* staff should be trained (CLAS even includes affiliated and subcontracted staff); CLAS, CRF and EQS also recommend monitoring the effects of training. CLAS recommends separate training in the provision of responsive care, JCR recommends the incorporation of such training in the existing curriculum, while COER and EQS support both. The approaches vary in the amount of information they provide on the content of training.

Diversity in the workforce

According to CLAS, JCR and COER, diversity among staff members is desirable for furthering responsiveness to patient diversity. Two arguments are given for the importance of staff diversity. The first is general: the workforce should be representative of the general population (CLAS, COER). The second is more specific: staff diversity is considered to further equity by making possible a higher degree of linguistic and ethnic concordance between patients and staff (CLAS, JCR). EDS and EQS discuss this issue from the perspective of equality among staff and include objectives for inclusive Human Resource policies relating to issues such as recruitment. CRF does not address the issue of staff diversity.

4. Ensuring access

All issues relating to barriers to entering the healthcare organization were classified under this heading. The dimensions that emerged concerned *entitlement to care*, the provision of *understandable information*, and issues concerning *geographical* and *other aspects* of accessibility. Some issues discussed in this domain reappear in the domain of ‘care provision’, because they are also relevant to the caregiving relationship.

Entitlement to care

Entitlement to care (i.e. whether patients are insured or are allowed to use national health services) is not mentioned in CLAS, JCR, CRF and EDS. This is understandable to the extent that entitlement is an issue covered by legislation and insurance rules, rather than by the policies of service providers. If service providers choose to give care outside the framework of formal entitlements, this is left to their own discretion. However, EQS goes a step further and charges organizations with a responsibility for patients who are not eligible for care: it urges that at the very least, steps should be taken to help them find appropriate care elsewhere. COER, which includes recommendations at health system level, makes a plea for "adequate entitlements to use of health services": concerning the role of service providers, it stresses that these must ensure that legislation is implemented properly and that all care providers are aware of existing rights.

'Understandable' information

Three approaches (CLAS, COER and EQS) stress that organizations should provide 'understandable' information in order to facilitate accessibility. This means providing information which is translated where necessary and is adapted to the health literacy level of the targeted populations.

Geographical accessibility

The importance of reducing geographical barriers to accessibility is briefly discussed in COER and EQS.

Other aspects of accessibility

In EDS and EQS two unique dimensions related to accessibility appeared. Firstly, EDS mentioned specific types of care (public health, vaccination and screening programs); secondly, EQS discussed the accessibility of organizations for specific 'disadvantaged' target groups such as HIV/AIDS patients, disabled patients, and homeless people.

5. Care provision

Issues in this domain relate to the quality of care patients receive within an organization. Topics mentioned in the six approaches include: care that is responsive to the needs and wishes of patients, patient participation in the care process , overcoming communication barriers, providing 'understandable' patient information materials, trust, and patients' rights.

Care responsive to needs and wishes

All approaches underline the importance of this issue. The interpretation of this dimension is related to the different visions the approaches have concerning the nature of responsive care. 'Needs' are discussed in various ways:

- CLAS and CRF focus on the *cultural* needs of patients, in accordance with their respective visions on responsive care ('culturally competent' and 'culturally responsive').

- JCR refers to *'additional'* and *'unique'* needs that should be integrated in the clinical process: "it is important for hospitals to be prepared to identify and address not just the clinical aspects of care, but also the spectrum of each patient's demographic and personal characteristics".
- COER focuses on the needs of *migrants* (broadly defined)*,* going beyond cultural factors to consider social position, migration history and legal situation.
- EDS and EQS focus on needs resulting from patients' *individual* characteristics.
- Apart from identifying needs, JCR also discusses the points in the care continuum at which they should be taken into account. Although all approaches emphasize the importance of taking patients' needs and wishes into account, they leave it up to the professional to reconcile the demands that patients or their relatives may make with the dictates of their professional conscience.

Patient participation in the care process

Five approaches (JCR, CRF, COER, EDS) explicitly refer to the importance of patient participation or involvement in the individual care process, for example in shared decision making about treatment and care planning (23). CLAS and EQS do not refer explicitly to patient participation in this context; however, the standards they provide show that they too consider patients as active participants in their treatment.

Overcoming communication barriers in patient-provider contact

All approaches except EDS emphasize that organizations should systematically tackle language barriers in the service delivery setting, placing the onus on the organization to provide patients with language assistance where necessary. Various types of interpreting are recommended such as professional interpreters, bilingual staff or intercultural mediators; approaches differ according to which type they prefer. CLAS, JCR and COER explicitly advise against using untrained, informal interpreters such as family members. CLAS, JCR, CRF and EQS assert that organizations are responsible for ensuring the quality and competence of language assistance that is offered. CLAS and JCR mention that patients should be informed about their right to language assistance. JCR and EQS also discuss support to patients with other communication barriers (e.g. hearing or speech impairments).

Understandable patient information materials

With the exception of EDS, all approaches stress that patient information materials should be understandable for all patients, in terms of both language and level of health literacy. When suitable materials are not available, CLAS asserts that patients have a right to orally translated information. These points concern not only patient folders providing information about specific medical problems or treatments, but also consent forms and labeling of medicines.

Trust

The approaches discuss several issues related to building trust between users and service providers. The first of these is related to the environment within the health care organization: CLAS, JCR and EQS stress the importance of making this welcoming and inclusive. Some approaches include statements underlining the security of patients, stressing that patients should not be exposed to any dangers and mistreatment that might arise from their vulnerability. Phrases used include “patients are free from abuse, harassment, bullying, violence” (EDS); and “the patient has the right to be free from neglect, exploitation, and verbal, mental, physical and sexual abuse” (JC Requirements (see Box 7.1), p.54 (16)).

A second issue related to trust concerns conflict and grievance procedures. CLAS and JCR recommend that these procedures should be capable of identifying issues that concern organizations’ responsiveness to diversity, and that such conflicts should be dealt with in a respectful manner (CLAS, JCR, and EDS). The issue of access by minority patients to grievance procedures is also discussed (CLAS, JCR), including the need for personnel dealing with complaints and grievances to receive proper training (CLAS).

Patients’ rights

CLAS and JCR discuss the importance of informing patients about their rights. This concerns (among other things) the right in the US to receive language assistance (CLAS, JCR) and not to experience discrimination (JCR). JCR and EQS also note the importance of adapting informed consent procedures to the patients’ needs (e.g. health literacy level).

6. Patient and community participation at organizational level

The sixth dimension identified in the approaches concerns the involvement of users and communities in health care at the organizational level. In this domain one dimension appeared: involving patients *in the development of services.* Patient participation *in the care process* was not subsumed under this domain.

Involving patients and communities in the development of services

The issue of participation at the organizational level is discussed by all approaches. The first argument put forward in favor of such participation is that it results in better responsiveness and quality of care (CLAS, JCR). Another advantage named is that patients and communities can contribute to the implementation of changes (EDS). The approaches explicitly (CLAS, CRF, COER, EDS, EQS) or implicitly (JCR) assume that their target populations often belong to disadvantaged groups that may normally be less likely to take part in participation processes. The approaches therefore pay attention to the challenge of creating inclusive participation processes.

Four approaches explicitly mention patient as well as community participation (CLAS, JCR, CRF, EDS; COER speaks of migrant participation). The important difference between patient (or user) and community participation is that the latter brings in the voice of people who did not get into treatment. However, only CLAS and EDS explicitly regard it as important to build partnerships (e.g. with community representatives or organizations) in the community served by the health care organization. Their argument amounts to the following: a health care organization serves a community; therefore the community has to be enabled to exert influence on what happens in the organization through a collaborative process. In the other approaches patients and community members are regarded as complementing each other (usually in the same sentence), without making clear the additional value of community participation.

7. Promoting responsiveness

Issues were classified in this domain if they concerned the promotion of responsive health care in the wider society. We identified one dimension, 'sharing information on experiences' in improving care for ethnic minority patients.

Sharing information on experiences

All approaches except CRF mention the importance of sharing experiences in promoting responsiveness with the general public and the community. This is proposed with different aims in mind: to increase support for responsive care from the general public (COER), to demonstrate an organization's commitment (CLAS, JCR), or to enable organizations to learn from each other (CLAS, EQS). CRF and EQS take this theme a step further, by proposing that organizations should enter into active partnerships with others that promote equity within the health care system (e.g. in research and other collaborative activities).

8. Unique issues

Two issues were unique to particular approaches. JCR repeatedly mentioned the identification and addressing of patients' mobility needs (e.g. using a cane, guide dogs). EDS emphasized "supporting the workforce to remain healthy", which is in line with its focus on equality in the workforce.

'Vertical' analysis (comparing approaches)

In the foregoing section we have discussed findings in terms of the domains which form the rows of the matrix in Table 7.2. In what follows, we analyze differences between the approaches represented in the columns, in order to obtain insight into the specific nature of each approach.

1. As its name implies, CLAS focuses mainly on cultural and linguistic issues. The linguistic issues have a legal basis in the Civil Rights Act of 1964, which requires "entities that receive Federal financial assistance to take steps to ensure that limited English proficient individuals have meaningful access to the health services" (11), p. 10). Issues related to patients' position in society are viewed in CLAS as aspects of culture, which is sometimes confusing. CLAS has a very explicit vision on responsive health care, for example in the details provided about the content of training or the types of data that should be collected. Although unequal access is mentioned as a problem which might be reduced by providing appropriate services, the separate CLAS standards discuss only linguistic barriers to access.

2. JCR follows the steps in the clinical care process, which is explained by its origin in the Joint Commission standards for hospitals. JCR was developed as a *supplement* to existing standards, so it may have left out some issues already covered by existing Joint Commission standards. The standards do not embody an elaborated vision on 'responsiveness' beyond the general terminology of cultural competence, communication, and patient- and family-centered care. Accessibility is not operationalized in JCR. Interestingly, we see that the international branch of the Joint Commission does consider accessibility as an important aspect of health care: in their international accreditation standards there is a specific standard on access to care and continuity of care. For example they have defined the following standard: "the organization seeks to reduce physical, language, cultural, and other barriers to access and delivery of services" (p.42 (24)).

3. CRF focuses, like CLAS, mainly on cultural and linguistic issues. Other issues affecting access to care are not mentioned. CRF offers quantitative and qualitative indicators (standards and measures) for measuring organizational responsiveness to diversity. In contrast to other approaches, it offers process indicators. The indicators provide organizations with relevant information for improving their services, and are also meant to yield information enabling health services to be compared with each other.

4. COER is at a different level, being addressed to governments rather than individual health care organizations. Governments are assumed to be ultimately responsible for everything that goes on in the health system. Issues concerning organizational responsiveness to diversity are discussed without specifying precisely the division of responsibilities between levels. In keeping with the Council of Europe's historical role, COER is primarily concerned with the ethical and human rights dimensions of social and health issues.

5. EDS addresses issues concerning both accessibility and quality of care, but its vision of responsive care for ‘protected groups’ remains rather implicit. The implementation strategy elaborates on steps such as ‘engage with local interests’ and ‘analyze performance’. The content of responsive care is only briefly described in terms of goals such as ‘better outcomes for all’ and ‘improved patient access and experience’ (see Table 7.1). EDS does not provide an explicit definition of equality in care or a specification of how this should be realized in practice.

One of the main objectives of EDS was to provide a tool for NHS commissioners to comply with the UK’s ‘Public Sector Equality Duty’ (PSED). This is reflected in the envisaged target groups of EDS (the chosen ‘protected groups’ are the same as those to which the PSED applies), as well as in the unique focus of EDS on equality among staff (e.g. equal career changes, no harassment on the work floor) which is in line with the aim of the PSED to eliminate discrimination and enhance equal opportunities *throughout* the public sector. The issue of language is not discussed at all, as it is not discussed in the PSED. Also unique in EDS is the clear role that has been described for engagement of patients and communities within the whole implementation strategy.

6. EQS focuses on quality of care and access, which are both aspects of healthcare equity. Its emphasis is on the vulnerability of certain patients, which can result from many factors – ‘culture’ being hardly mentioned as one of these. The focus is on patients’ individual needs and characteristics, rather than their membership of specific ethnic, cultural or other groups. This approach seems to view ‘patient centered care’ as the best way to respond to diversity in care provision. Although EQS defines its target group as ‘migrants and other vulnerable groups’, most of the standards focus on issues relevant to migrants, which is explained by the Task Force’s origin in the Migrant Friendly Hospital network (25).

Variations in the orientation of different approaches

Looking at the differences between approaches, we see that only the European ones address issues of access to health care in the sense of entitlement. A common feature of the non-European approaches is their emphasis on ‘culture’. On closer examination, this seems to be mainly a question of how factors are labeled: sometimes it turns out that factors such as socioeconomic or legal status are regarded as ‘cultural’ ones. In the European approaches the issue of culture receives less emphasis: EQS, for example, hardly mentions it as a topic of importance. Here the focus is on individual characteristics, which brings EQS close to the approach known as ‘patient centered care’ (26) (Saha, Beach, and Cooper have discussed the relation between ‘patient centered’ and ‘culturally competent’ care (27)). A possible shortcoming of this individualistic perspective is that the social position that characterizes members of certain vulnerable groups (e.g. asylum seekers, irregular migrants) may be overlooked. However, COER and EQS are the only approaches that explicitly refer to ‘migrants’ and take into account the vulnerability that results from having different kinds of migrant status (asylum seeker, irregular migrant, labor migrant etc.).

Discussion and conclusion

Through a qualitative analysis of six current approaches to organizational responsiveness to the diversity of users, we developed an over-arching framework and subjected the content of different approaches to a comparative analysis. It emerged that the following ‘domains’ were almost universally regarded as important for creating responsive organizations: organizational commitment, collecting data to provide empirical evidence on inequalities and needs, development of a competent and diverse workforce, ensuring access for all users, ensuring responsiveness in care provision, fostering patient and community participation, and actively promoting the ideal of responsiveness. Almost all these issues could be recognized to some extent in all the approaches that were analyzed.

With the exception of EDS and EQS, all approaches are primarily oriented to the needs of ethnic minorities and/or migrants. Differences of language and culture play a prominent role, especially in CLAS, JCR and CRF. Nevertheless, all approaches recognize that many aspects of an individual’s social position can give rise to inequalities in health care. EDS was specifically developed for a wide range of target groups (those covered by the UK Equality Act). EQS explicitly aimed to address diversity from a broader perspective; its vision seems heavily influenced by the notion of ‘superdiversity’ (28), resulting in a strong emphasis on individual differences.

We also analyzed the extent to which the six approaches studied used the same domains and dimensions. There were relatively few empty cells in the matrices shown in Tables 2 and 3, which suggests a broad consensus regarding the essential issues. There were, however, differences regarding the important ingredients of responsive care and the measures regarded as necessary to improve accessibility. Variations in the conceptualization of ‘responsive care’ reflect in part different assumptions about the type of diversity that should be responded to. CLAS and CRF address the issue of racial or ethnic groups differing in terms of language and/or culture. Patients tend to be identified as members of a group, with little attention being paid to differences within groups. EDS and EQS, on the other hand, adopt a more individualistic and multidimensional approach; though aiming at ‘inclusiveness’, they steer away from definitions of diversity in terms of group membership. For example, CLAS states that “care should be compatible with cultural health beliefs and practices, and preferred languages”, whereas EQS states that “individual characteristics, experiences and living conditions are considered”. COER is explicitly focused on migrants (broadly defined) as a group, while mentioning a wide spectrum of issues that may be relevant to the provision of accessible and appropriate care.

The non-European approaches focus on improving quality of care and improving *linguistic* accessibility in the fight against health disparities, while the issue of ‘entitlement to care’ is overlooked. This is remarkable since (lack of) health insurance coverage explains substantial proportions of disparities in health care in the US (29). The National Health Interview Study 2012 found that while 7.6% of white respondents had been uninsured for more than one year, this percentage was 23.6 in the Hispanic population, 11.7 in the black population, and 11.3 in the Asian population (30). Although entitlement to care is a matter of health systems, approaches that aim to reduce disparities in health and health care should at least acknowledge the influence of this issue on disparities.

Our analysis has its limitations. First of all we based it on six approaches to organizational responsiveness to diversity. It was not our aim to compare all existing approaches, because too many have been developed. However, the six approaches that we included in this framework showed considerable consensus regarding the important elements of care that is responsive to diversity. The framework can be used to describe and compare other approaches. Secondly, the level of detail provided by the approaches varied. Classifying them in our framework might not fully do justice to the visions or ideas behind the approaches. For example, EDS is very concise in its conceptualization of responsiveness, but it may be that within the NHS other documents elaborate this concept in more detail.

Conclusion

To our knowledge this is the first systematic comparison of the content of approaches for organizational responsiveness to diversity in health care. Our framework showed that organizational responsiveness to diversity in health care means ensuring access and providing appropriate care. This in turn is dependent on meeting the following preconditions: demonstrating organizational commitment, collecting and using evidence on inequalities and needs, developing a competent and diverse workforce, fostering patient and community participation, and advocating for responsiveness.

Our analysis shows that there is considerable consensus among approaches concerning the way in which health service organizations should respond to diversity. There are differences between the approaches, but many of these do not so much reflect differences of viewpoint as variations in the emphasis that is placed on the concept of ‘culture’. On closer inspection, this variation reflects different definitions of the concept: in some approaches it is linked to a wide range of attributes such as socioeconomic position, education, or sexual orientation. This enlarged concept of culture is particularly pronounced in the Enhanced CLAS Standards (7). However, we believe that stretching the concept of culture in this way is confusing (31), and the discussion on providing diversity-responsive health care would win in clarity if the various social dimensions of importance were clearly distinguished from each other.

The approaches included in the comparison are all to a greater or lesser extent focused on diversity in migrant and ethnic minority groups. Nevertheless, diversity is a characteristic of the population as a whole. The focus on responsiveness to diversity should be extended to *all* health service users (8). The concept of ‘patient centered care’ is a step in the right direction of acknowledging diversity among all patients. However, patient centeredness focuses on acknowledging the uniqueness (diversity) of patients, and is thus individualistic. The most serious inequities in health care are strongly associated with differences in group membership and social situation. For example, being an asylum seeker or undocumented migrant is neither a cultural characteristic nor a personal one – it is a social position, with important consequences for health and access to health care.

All in all this paper suggests a high degree of agreement between approaches (countries, institutions) on how health service organizations should respond to diversity. There is enough consensus in the field to enable us to move ahead in adapting health services to diversity with the aim of reducing health care inequities. This consensus creates the opportunity to move forward, to resolve issues regarding terminology and to help health care organizations to respond to the diversity that is present in modern societies. At the same time, we need to work as hard as possible to underpin these recommendations with research.

Table 7.1 Background information on the six approaches

	CLAS Standards (CLAS)	**Joint Commission Roadmap (JCR)**	**Cultural Responsiveness Framework (CRF)**	**Council of Europe Recommendations (COER)**	**Equality Delivery System (EDS)**	**Equity Standards (EQS)**
ORIGIN	US dept of Health and Human Services; Office of Minority health (U.S.)	The Joint Commission (U.S.)	Victorian Government; Dept. of Health (Australia)	Council of Europe; The committee of ministers (Europe)	The National Health Services (NHS); The Equality and Diversity Council (U.K.)	Health Promoting Hospitals; Task Force on Migrant-Friendly and Culturally Competent Health care (Europe)
YEAR	2001	2010	2009	2011	2011	2013
AIM	*ensure equitable and effective treatment in a culturally and linguistically appropriate manner *correct inequities *more responsive services *elimination of racial and ethnic health disparities *inform, guide and facilitate culturally and linguistically appropriate care	*improve overall safety and quality of care *integrate concepts from communication, cultural competence and patient-centered care fields into hospitals	*better links between access, equity, quality and safety *better health outcomes for culturally and linguistically diverse (CALD) populations *enhance cost effectiveness of service provision *track organizations' improvement; align cultural responsiveness (CR) with existing standards; develop benchmarks	*equitable access to health care of appropriate quality	*better outcomes for patients and communities, better working environments for staff *improve equality performance *review equality performance *a tool to comply to the 'public sector Equality Duty'.	*ensure equitable and accessible health care *reduce disparity in health care *an Equity self-assessment by health care organizations
VISION	*cultural and linguistic competence *culturally and linguistically appropriate services (CLAS)	*effective communication (EC) *cultural competence (CC) *patient- and family-centered care (PFCC)	*cultural responsiveness (CR)	*improving the adaptation of health service provision to the needs, culture and social situation of migrants	*equality for patients and staff *personal, fair and diverse services and workplaces	*promoting equity
TARGET POPULATION	*inclusive of all patients *especially racial, ethnic, and linguistic populations that experience unequal access	*no target group, recommendations address 'issues' in health care (e.g. language, culture etc.)	*culturally and linguistically diverse populations (CALD)	*migrants	*protected groups	*migrants and all other vulnerable groups

	CLAS Standards (CLAS)	Joint Commission Roadmap (JCR)	Cultural Responsiveness Framework (CRF)	Council of Europe Recommendations (COER)	Equality Delivery System (EDS)	Equity Standards (EQS)
TARGET ORGANIZATION-TYPE	*health care organizations *policymakers, accreditation agencies, purchasers, patients, advocates, educators, health care community in general	*hospitals	*all Victorian health services	*governments of CoE member states	*NHS commissioners and providers	*health care organizations
STRUCTURE	*14 standards in three types: mandates (4), guidelines (9), and recommendations (1) *3 themes: culturally competent care, language access services, and organizational supports for cultural competence	*54 recommendations structured around main points along the care continuum *aspects of the care continuum: admission; assessment; treatment; end of life care; discharge and transfer; organization readiness	*6 standards across four domains, divided in measures and sub-measures (both quantitative and qualitative) *Standards: a whole organization approach; leadership; interpreters; inclusive practice; consumer/community involvement; staff. *4 domains: organizational effectiveness; risk management; consumer participation; effective workforce	*14 recommendations, specified in 31 sub-recommendations.	*18 outcomes grouped into four goals; nine steps for implementation *EDS goals: better health outcomes for all; improved patient access and experience; empowered, engaged, and well-supported staff; inclusive leadership at all levels	*5 main standards, divided in sub standards and measurable elements *main standards: equity in policy; equitable access and utilization; equitable quality of care; equity in participation; promoting equity

Table 7.2 The approaches inserted in the analytic framework

DOMAINS & dimensions	**CLAS**	**JCR**	**CRF**	**COER**	**EDS**	**EQS**
ORGANIZATIONAL COMMITMENT						
Policy and leadership	*a written strategic plan to provide culturally competent care *strategic plan is integrally tied to the organization's mission, principles, service focus	*demonstrate leadership commitment to effective communication (EC), cultural competence (CC), and patient- and family centered care (PFCC) *integrate concepts of EC, CC, PFCC into existing policies	*implement a Cultural Responsiveness (CR)-plan addressing the standards *integrate CR-plan into existing services' plans and processes *demonstrate leadership *have an advising structure with participation of culturally and linguistically diverse (CALD) populations *allocation of financial resources *employ a cultural diversity staff member when CALD population > 20%	*organization as a whole must be 'culturally competent' *implement the recommendations in a sustainable, coordinated and evidence based way	*leaders conduct and plan business so that equality is advanced *managers support and motivate staff to work culturally competent *recruit, develop and support strategic leaders to advance equality outcomes *integrate equality objectives into mainstream business planning	*a specific plan to promote equity, integrated with existing accountability systems *all organization plans promote equity
Measuring and improving performance	*initial and on-going self-assessment of CLAS-related care *integrate CLAS-related measures into regular quality improvement programs (e.g. internal audits) *use data on individual patients for needs assessment, service planning and quality improvement	*a baseline assessment whether organization meets unique patient needs	*obligatory reporting on CR performance (on defined measures) *perform research in outcomes (e.g. emergency presentations) for CALD patients' care needs *analyze quality/risk management data for CALD patients *report on CR performance in organization's regular performance reports *include CALD stakeholders in performance review	*evaluate existing services, identify existing problems, develop good practices *conduct research to identify problems, determine actions and evaluate interventions	*analyze performance, agree (with stakeholders) on results, and prepare equality objectives	*continually identify and monitor access and barriers in access, and evaluate interventions for reducing access barriers (e.g. communication support services) *use data on equity performance to improve equity in accessibility and quality

DOMAINS & dimensions	**CLAS**	**JCR**	**CRF**	**COER**	**EDS**	**EQS**
COLLECTING DATA						
Data *on the population at large*	*maintain a current demographic, cultural and epidemiological profile, and a needs assessment of the community	*use available population-level demographic data of surrounding community	*monitor community profile and demographics	*governments (in partnership with other relevant organizations) collect background data and epidemiological data on migrants	*assemble evidence drawing on existing information systems (incl data *on population level*)	*collect or have access to data on health status and health inequalities of catchment area
Data *on the patient population*	*collect data on individual patient's race, ethnicity, spoken/written language in health record *integrate CLAS-related measures into patient satisfaction assessments	*develop a system to collect patient-level data *collect data on patient race and ethnicity in medical record *collect data on patient's language and additional patient-level information (e.g. cultural, religious) *collect feedback from patients, families	*develop appropriate information strategies for data collection, reporting and sharing *collect CALD patient satisfaction data		*assemble evidence including surveys of patient experiences	*organization's systems can measure equity performance *identify patients' needs according to characteristics (health records include information on demographic characteristics e.g. language, health literacy level, ethnicity)
STAFF/WORKFORCE						
Staff competencies	*all staff receive on-going education in providing CLAS	*new and existing training addresses issues of EC, CC, PFCC	*provide staff at all levels with opportunities to enhance their CR *train staff *CR references included in HRM policies and practices (e.g. position description) *communication systems for sharing information on CR	*care professionals at various levels should be trained in accessibility issues and in cultural competence	*enable staff to be confident and provide appropriate care with support by training, personal development and performance appraisal	*all staff is aware and competent to address inequities due to education *specific training on equity issues *include equity issues in organization's core education

DOMAINS & dimensions	**CLAS**	**JCR**	**CRF**	**COER**	**EDS**	**EQS**
Diversity in workforce	*strategies to recruit, retain and promote diverse staff, representative of demographic characteristics of service area *diverse staff at all levels, including diverse leadership	*recruitment efforts to increase a diverse workforce that reflects the patient population *diverse workforce can increase ethnic and language concordance, which may improve communication		*recruitment policies should ensure that the diversity of general population is reflected in the workforce *(mentioned as an example)*	*fair selection processes to increase diversity of all workforce *equality in levels of pay *staff can work in a safe environment (e.g. free from abuse, harassment etc.) *flexible working options	*fair and equitable workforce policies and practices *promote respect for dignity of all staff and volunteers
ENSURING ACCESS						
Entitlement to care				*legislation concerning entitlement is properly implemented *professionals at all levels are aware of eligibility rights		*monitor situations of people that are ineligible for care *ensure health care to people ineligible for services by providing appropriate support
'Understandable' information	*patient related materials and post signage essential for access should be made easily understood *offer and provide language assistance services to all patients with LEP, at all contacts, in a timely manner during all hours of operation			*programs for migrants should include knowledge on health and illness, the way the health system works, and entitlements to health services *promote interpretation and translated materials to improve accessibility		*in communicating with people and providing information on access issues, health literacy and language needs are taken into account
Geographical accessibility				*inconvenient locations should be reduced as far as possible		*minimize architectural, environmental and geographical barriers to facilities

DOMAINS & dimensions	CLAS	JCR	CRF	COER	EDS	EQS
Other aspects of accessibility				*remove accessibility barriers and reduce practical difficulties (e.g. inconvenient opening times)	*patients, carers and communities can readily access services *public health, vaccination and screening programs benefit all local communities/groups	*ensure access to care for disadvantaged people *provide outreach information to disadvantaged people on outreach services
CARE PROVISION						
Care responsive to needs and wishes	*patients receive effective (positive outcomes), understandable and respectful (patients values taken into account) care *care should be compatible with cultural health beliefs and practices, and preferred languages	Throughout the care continuum: *ask for additional needs (e.g. cultural, religious) *communicate information about unique patient needs to relevant providers *start patient-provider interaction with an introduction *identify and accommodate cultural, religious, spiritual beliefs/practices that influence care *incorporate EC, CC, PFCC concepts into care delivery	*inclusive practice in care planning (including dietary, spiritual and other cultural practices) *implementation and revision of policies for provision of appropriate meals *use feedback/evaluation from patients to improve CR *develop and use suitable instruments for assessment (e.g. clinical diagnosis) which incorporate cultural considerations	*improve relevance and appropriateness of health services *offering the same services to everybody may result in users receiving lower quality of care *services should be culturally competent (matched to needs of migrants from diverse backgrounds) *culturally competent care goes beyond cultural factors, e.g. social position, history, legal situation should also be taken into account *adapt existing diagnostic and therapeutic procedures or invent new ones if necessary	*assess individual patients' health needs and provide appropriate and effective services *discuss changes across services with patients and make transitions smoothly *strive for positive treatment experiences: being listened to, being respected, privacy and dignity are prioritized	*in needs assessments, delivery of care and at discharge, patients' individual, family characteristics, experiences and living conditions are taken into account (incl. psychosocial needs) *workforce is able to take into account individual patients' ideas and experiences of health and illness in clinical practice and at discharge *care is considerate and respectful of patients' dignity, personal values, knowledge and beliefs regarding health care

DOMAINS & dimensions	CLAS	JCR	CRF	COER	EDS	EQS
Patient participation in the care process		*Involve patients, families, support persons in the care process along the care continuum.	*inclusive practice in care planning (including dietary, spiritual and other cultural practices)	*promote participation of migrants in all activities concerning the provision of health services, including decision making processes	*involve patients as they wish during the care continuum	
Overcoming communication barriers in patient-provider contact	*offer and provide language assistance services (including bilingual staff, interpreter services) at no costs to all patients with LEP, at all contacts, in a timely manner during all hours of operation *inform patients of their right to receive language assistance *assure competence of language assistance by interpreters and bilingual staff	*identify patient's preferred language or other communication needs during admission *identify and monitor patient communication needs/status during care continuum, document this in patient record *ensure competence of language assistance *develop a system to provide language services *inform patients of their rights for an interpreter	*implement language services policy *policies include directions about role of interpreters and family *provide accredited interpreters to patients who need one *match employment of in-house interpreters to community demographics *evaluate interpreter services	*high quality interpreting should be promoted *consider all available methods to reduce language barriers		*have a policy on overcoming language barriers *make professional interpreting services available and promote it *accommodate communication needs of patients with e.g. hearing, speech impairments *monitor quality of interpreting services/ communication support *ensure staff ability to work with interpreter/ communication support staff

DOMAINS & dimensions	**CLAS**	**JCR**	**CRF**	**COER**	**EDS**	**EQS**
'Understandable' patient information materials	*provide easily understood patient related materials (applications, consent forms) and post signage in diverse languages incl. directions to facility services *(diverse language: languages of commonly encountered groups/groups represented in the service area)* *take into account culture and health literacy levels *persons from small language groups have the right to oral translation	*provide patient education materials and instructions that meet patients' needs (health literacy, language) during assessment, treatment and discharge *support patient's ability to understand/act on health information *determine needs for assistance with admission forms (health literacy)	*have appropriate translations of signage, patient forms, education materials for predominant language groups using services	*promote high quality translated written information		*provide easily understood written material and signage taking health literacy and language needs into account
Trust	*Conflict & grievance* *conflict/grievance procedures are culturally sensitive *conflict/grievance procedures can identify, prevent, resolve cross-cultural conflicts/complaints *staff handling complaints should receive cultural competence training *monitor culturally or linguistically related complaints *Atmosphere* *create a welcoming and inclusive environment	*Conflict & grievance* *accessible complaints system (language, non-writing) *complaints are not being subjected to coercion, discrimination, reprisal, or unreasonable interruption of care *Atmosphere* *create an environment that is inclusive of all patients *patient has the right to be free of neglect, exploitation and abuse *(regular JC standards, chapter: Rights and Responsibilities of the Individual)*	*Conflict & grievance* *monitor number of complaints lodged by CALD consumers/patients.		*Conflict & grievance* *complaints should be handled respectfully and efficiently *Atmosphere* *create a safe environment, without threat of dignity of denial of individual identity	*Atmosphere* *create a safe environment, with respect for patient's dignity and identity *create an environment inclusive for all patients

DOMAINS & dimensions	CLAS	JCR	CRF	COER	EDS	EQS
Patients' rights	*provide notices in diverse language of a variety of patients' rights (including right for language assistance)	*inform patients of their rights (interpreter, accommodation for disability, be free from discrimination, etc.) *tailor the informed consent process to meet patient needs (related to low HL)				*accommodate patients' diverse needs in informed consent procedure
PATIENT AND COMMUNITY PARTICIPATION AT ORGANIZATIONAL LEVEL						
Involving patients and communities in the development of services	*utilize a variety mechanisms to facilitate community and patient involvement in designing and implementing services *develop participatory, collaborative partnerships with communities	*be involved and engaged with patients, families and the community to identify needs for new/modified services *collect feedback from patient, families and communities	*CALD consumer, carer and community members are involved in the planning, improvement and review of programs and services on an on-going basis *advice of participation structures is taken into account *facilitate different degrees of participation from CALD consumers, carers, community *develop partnerships with ethno-specific community organizations	*promote participation of migrants in designing, evaluating, and carrying out research on migrant health and health care *promote participation of migrants in developing and implementing new measures	*identify local interests (including patients, communities) that need to be involved in implementing EDS *share assembled information with local interests so they participate in analyzing performance and setting objectives *agree roles with local authority (e.g. services that share the same clientele)	*identify service users at risk for exclusion from participatory processes, promote their participation *identify and overcome barriers to participation *monitor and evaluate participatory processes *use feedback to improve services and share results of participation with public

DOMAINS & dimensions	**CLAS**	**JCR**	**CRF**	**COER**	**EDS**	**EQS**
PROMOTING RESPONSIVENESS						
Sharing information on experiences	*make information available to public on progress and innovations in implementing CLAS *inform community, own organization (for institutionalizing CLAS) and other organizations to learn from each other	*share information with surrounding community about efforts to meet unique patients' needs to demonstrate commitment	*undertake research to develop new and improved initiatives and resources for CR	*inform public adequately about issues concerning migrant health	*share assembled evidence on equality performance with local interests (e.g. patients, communities), so they can take part in analysing performance and set goals *publish accomplishments (grades) and equality objectives so they are accessible for local interests	*be a participant in networks, research initiatives which promote equity *disseminate results of research/practice related to equity *build solid relationships/ networks with community-based service providers *ensure that equity is reflected in all partnership and service contracts
UNIQUE ISSUES						
		*identify and address mobility needs (e.g. cane, guiding dogs)			*support workforce to remain healthy, focus on major health and lifestyle issues that affect individual and wider population	

Table 7.3 Description of classified domains and dimensions, and coverage of domains/dimensions by the six approaches (shaded cells visualize that this dimension is not covered by the approach)

DOMAINS & Dimensions	**CLARIFICATION OF THE DOMAINS AND DIMENSIONS**	**CLAS**	**JCR**	**CRF**	**COER**	**EDS**	**EQS**
ORGANIZATIONAL COMMITMENT	The obligations health care organizations impose on themselves about providing diversity responsive care.						
Policy and leadership	Organizations' explicit commitment to provide diversity responsive care, demonstrated in policies and leadership and integrated in regular policies.						
Measuring and improving performance	Measuring organizations' performance related to diversity responsive care and improving performance based on the findings.						
COLLECTING DATA	Collecting data to provide evidence on equity of access and of quality of care for diverse populations.						
Data collection on *the population at large*	Data collection on demographics, characteristics relevant for service use, and health of the population living in the geographical area served by the health care organization.						
Data collection on *the patient population*	Data collection of the patients being served by the health care organization.				▨		
STAFF/WORKFORCE	Issues related to the care providers, the management and support workers, that work at a health care organization.						
Staff competencies	Improving competencies of staff working at a health care organization to provide responsive care (e.g. by training and other support).						
Diversity in workforce	Creating a demographically diverse workforce of a health care organization and ensure equal opportunities among all.			▨			
ENSURING ACCESS	People that need healthcare can access health care services in a timely manner and without barriers.						
Entitlement to care	Implementation of legislation on entitlements for the use of health services for specific groups (e.g. undocumented migrants).	▨	▨	▨		▨	
'Understandable' information	Providing information adapted to language and health literacy needs of diverse patient populations to facilitate access.		▨	▨		▨	
Geographical accessibility	Reducing geographical barriers to access.	▨	▨	▨		▨	
Other aspects of accessibility	*Issues on ensuring accessibility not discussed in the dimensions above*	▨	▨	▨			
CARE PROVISION	Providing good quality health care in the context of patients' diversity.						
Care responsive to needs and wishes	Providing care that is responsive to diverse patients' needs and wishes.						
Patient participation in the care process	Patient participation or involvement in the individual care process.	▨					▨
Overcoming communication barriers in patient-provider contact	Removing communication barriers in the patient-provider contact.					▨	
'Understandable' patient information materials	Removing barriers in understanding patient information materials (with regard to language and health literacy level).					▨	
Trust	Building trust between service users and service providers with regard to patient diversity.				▨		
Patients' rights	Inform patients of their rights.			▨	▨	▨	

DOMAINS & Dimensions	**CLARIFICATION OF THE DOMAINS AND DIMENSIONS**	**CLAS**	**JCR**	**CRF**	**COER**	**EDS**	**EQS**
PATIENT AND COMMUNITY PARTICIPATION AT ORGANIZATIONAL LEVEL	The process that enables patients and/or communities to participate in planning, developing and delivering health services at organizational level.						
Involving patients and communities in the development of services	Efforts to include all patients and communities (including those of risk to be excluded) in participation activities for development of services.						
PROMOTING RESPONSIVENESS	Furthering responsive health care in the society to which a health care organization belongs.						
Sharing information on experiences	Disseminating experiences with providing diversity responsive health care to stakeholders/society.						

(shaded cells visualize that this dimension is not covered by the approach)

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8 General Discussion

General Discussion

This thesis aims to contribute to a scientific basis for healthcare that effectively responds to patients' ethnic diversity, summarised here as 'culturally competent' care. We addressed three themes: cultural competence at the level of individual healthcare providers; cultural competence in medical education; and cultural competence at the healthcare organisation level.

This chapter discusses the main findings of the studies presented in this thesis. Part 1 summarises the studies; Part 2 deals with methodological issues; Part 3 considers the findings in the light of current debates on cultural competence; Part 4 makes recommendations and discusses implications for further research, practice and policy; and Part 5 presents the conclusions of this thesis.

Part 1 Summary of the main findings

Cultural competence at the level of individual healthcare providers

The aim of the first three studies presented in this thesis was to outline the broad concept of cultural competence into a useful concept for medical practice and medical education. In Chapter 2 we developed a conceptual framework of cultural competence for individual healthcare providers. This framework, based on the literature and personal interviews with physicians and patients, distinguished between the following cultural competencies: knowledge of epidemiology and the differential effects of treatment in various ethnic groups; awareness of how culture shapes individual behaviour and thinking; awareness of the social context in which specific ethnic groups live; awareness of one's own prejudices and tendency to stereotype; ability to transfer information in a way the patient can understand, and to use external help (e.g. qualified interpreters) when needed; and ability to adapt to new situations in a flexible and creative manner. The results show that more dimensions are involved in delivering high-quality care than merely the cultural one. Most cultural competencies emphasise a specific aspect of a generic competency that is of particular importance when dealing with patients from different ethnic groups.

The study in Chapter 3 addressed cultural competence in specialist paediatric asthma care. In this study we interviewed paediatricians and nurses and explored the mechanisms that characterise the care process for ethnic minority children with asthma, and the cultural competencies that emerged from that. We found competencies necessary for effective communication. Although we specifically addressed the paediatric asthma care setting, the emerged competencies are comparable to the general cultural competencies found in our first study (*Chapter 2*). The focus on communication is in line with the finding that patient non-adherence was the central problem in asthma care. We found some evidence that if care providers would improve the patient-centred skills that are now considered the ‘norm’ in medical training, then they would already make good progress. This strengthens the hypothesis that most cultural competencies are specifications of generic competencies that healthcare providers should already possess. This study also showed that care providers do not always consciously recognise all the mechanisms that lead to deficiencies in culturally competent asthma care that they provide to ethnic minority children (e.g. communicating mainly from a biomedical perspective, and using only ‘informal’ interpreters).

In Chapter 4 we addressed cultural competence in care provision in a specific healthcare setting: i.e. asylum seekers living in asylum-seeker centres whilst awaiting the decision concerning their request for asylum. Through a survey and group interviews we explored the particular cultural competencies that nurse practitioners working with asylum seekers considered to be important. In this healthcare setting we found a more specific elaboration of some of the general cultural competencies from the framework. Especially the knowledge component was further distinguished from the general cultural competence framework (e.g. knowledge with regard to diseases common in a patient’s country of origin; knowledge on the effects of refugee-hood on health). The more highly specified cultural competencies were related to the various (and often difficult) migration histories of asylum seekers and the unique circumstances in which this patient group lives in the Netherlands. Apparently, when providing care in a healthcare setting with such a specific patient group, the general cultural competencies described in the framework need to be further specified for the particular care context.

Cultural competence in medical education

In this part of the thesis we changed the focus from the conceptualisation of cultural competence at the individual healthcare provider level, to the development, content and assessment of cultural competence in medical education. In Chapter 5 we assessed the cultural competence of medical students and Youth Health Care physicians. For this, we used a newly developed instrument based on the conceptualisation of cultural competence as reported in Chapters 2 to 4. It was shown how the results from the assessment could be used to support the development of an educational cultural competence program. We found that, on average, respondents scored low on the knowledge domains, low to moderate on the behaviour domains, and high on reflection ability. Based on this study, we conclude that curriculum development should focus on increasing knowledge and improving behaviour. We found a weak association between self-perceived cultural competence and assessed knowledge, reflection ability and consultation behaviour. Assessing cultural competence using this assessment instrument enabled us to identify gaps related to cultural competence training in the current curricula of our respondents.

Chapter 6 presented ten recommendations for the development of training in culturally competent medical communication, based on a qualitative survey among experts in the field of diversity in medical education. The recommendations that emerged were that: the content of training should be based on a clear ‘view’ on culturally competent communication; all students need to be educated in culturally competent communication; teachers should stimulate awareness of personal biases and an open attitude; three core communication skills should be taught, i.e. listening, exploring and checking; practice should be provided with a professional interpreter; knowledge content should focus on mechanisms relevant to various ethnic groups; students should be offered a variety of experiences in a safe environment; and that all persons involved should be aware that stereotyping is a pitfall. Training in communication skills for consultation with ethnic minority patients cannot be separated from teaching issues of awareness and knowledge. Comparable to the study on asthma care (*Chapter 3*), the shared views on the content of these communication trainings are in line with general patient-centred communication approaches. However, the potential complexity of communication with patients from an ethnic minority group (due to language barriers, cultural distance and/or influence of stereotypes) requires explicit qualities or a ‘PLUS’ in the generic patient-centred approach.

Cultural competence at the healthcare organisation level

The third part of the thesis addressed cultural competence at a level beyond that of individual care providers, namely the level of healthcare organisations. In Chapter 7 we developed an analytical framework for organisational responsiveness to ethnic diversity. The framework is based on a qualitative document analysis of six approaches for organisational responsiveness to diversity. We identified seven domains that were represented in most or all approaches: ‘organisational commitment’, ‘empirical evidence on inequalities and needs’, ‘a competent and diverse workforce’, ‘ensuring access for all users’, ‘ensuring responsiveness in care provision’, ‘fostering patient and community participation’ and ‘actively promoting responsiveness’. Variations in the conceptualisation of ‘responsive care’ reflected different assumptions about the type of diversity that should be responded to. For example, approaches that focus on ethnic diversity mostly refer to cultural and language differences; approaches that broaden their target populations to (e.g.) ‘vulnerable’ groups adopt a more multidimensional approach, also paying attention to such factors as socio-economic status and gender. Despite differences in the way different approaches are labelled, this comparative study revealed a broad consensus among different approaches concerning the way in which health organisations should respond to diversity.

Part 2 Methodological considerations

Strengths and limitations of the studies

A strength of this thesis is the combination of methods used in the various studies. Most studies were explorative in nature, in line with our objectives, and made use of qualitative research methods. Qualitative research is the appropriate research approach to gain in-depth understanding of the nature and context of complex phenomena, and provides understanding of respondents' personal experiences (1). Additionally, in Chapter 2 we studied various healthcare settings in breadth (e.g. general practice, internal medicine, occupational medicine), while in Chapters 3 and 4 we studied two specific healthcare settings in depth. Therefore, our operationalisation of cultural competence is based on a variety of perspectives and healthcare settings. The explorative studies and operationalisation of the cultural competence concept also enabled us to subsequently perform a quantitative assessment of the level of the individual care provider's cultural competence.

Although we studied different and diverse healthcare settings, the total picture of cultural competence in healthcare is still patchy. Although we have no reason to assume that our findings would not be valid in other healthcare settings, we recommend specific healthcare settings to examine whether it is necessary to further specify the generic cultural competencies we have defined in this thesis.

Amongst our studies, the least explored perspective is that of ethnic minority patients. While we did explore the process of health care from their perspective (*Chapter 2*), we did not explicitly ask them about the cultural competencies of healthcare providers or organisations. Therefore, we might have missed competencies that ethnic minority patients regard as important. For example, in a qualitative study among patients with limited English proficiency, these respondents expressed the importance of family involvement in health care (in roles such as patients' advocate, carer, mediator) and the researchers defined the resulting cultural competency as 'negotiating family involvement' (2), an issue that was not emphasised in our studies.

A limitation of our data might be the influence of social desirability. Although we took several precautions to diminish this kind of bias, (e.g. anonymity of questionnaires used in Chapters 3 to 5; guaranteeing anonymity when reporting the data), in the case of 'taboo' issues, such as influence of provider bias on the healthcare process, social desirability might have played a role. On the other hand, the study among asthma healthcare providers offered the insight that respondents were 'unaware incompetent':

they freely reported ‘non-desirable behaviour’ (in this case cultural incompetence) because some respondents were simply not aware of the desirable behaviour.

From a professional viewpoint, the researcher did not have any shared experiences as a healthcare provider, because she does not have a medical background; nor does she share a professional perspective with the respondents. However, she was able to offer the perspective of an ‘outsider researcher’ on the provision of health care (3). Advantages of being an outsider researcher were that she was able to question issues that might be self-evident for respondents; or the researcher could hide behind a ‘cloak of ignorance’ (4). In these situations she could ‘force’ care providers to explicitly explain why they, for example, did things in a certain way rather than assuming that she had understood. A disadvantage is that the researcher may have overlooked specific issues of importance in the healthcare process (things only other care providers would know about), simply because she was not aware of their existence.

From a more personal viewpoint, the researcher being a white Dutch female meant that she shared the ethnic background of almost all of the care providers that were interviewed. This may have helped healthcare providers to not be overly sensitive about difficulties they had experienced with ethnic minority patients. For example, if the researcher had been a veiled Muslim woman, respondents might have been hesitant to share possible negative experiences with Muslim patients.

Fortunately, the studies performed in this thesis involved researchers from different disciplines (medicine, psychology, sociology, epidemiology, medical education). Together they represented and bring a breadth of professional perspectives to this research. However, considering the ethnic perspective, most of the researchers were from a Western ethnic background.

Internal validity

Several factors may have threatened the internal validity of our studies; below we discuss each study separately.

The conceptual framework we developed in Chapter 2 was based on analysis of real-life case studies and existing literature. However, we did not perform a systematic review of the conceptualisation of cultural competence in the literature. Since the publication of this framework (in 2009) the literature on cultural competence has expanded and the concept has evolved. Therefore, our conceptual framework should be adopted with some caution, bearing in mind that new domains may have to be added to our conceptualisation.

In Chapter 3 we interviewed only a small number of healthcare providers (n=16) due to the rapid saturation of the data. This might be explained by the ethnic homogeneity of the respondent group. Although the ethnic homogeneity in our respondents reflects the low rate of ethnic diversity among medical specialists in the Netherlands, it is possible that care providers from ethnic minority background would have provided different experiences and insights. In this study on asthma care, the conceptual framework of cultural competence (*Chapter 2*) was used in the analysis of the interview data, according to the ‘framework method’ (5). The guidance of our conceptual framework in the analysis could explain why the cultural competencies of our conceptual framework were comparable to those we defined in the paediatric asthma care setting. On the other hand, our framework also served as a ‘spotlight’: the theory used (i.e., our conceptual framework) had a clarifying effect on the analysis, revealing difficulties in the care process to ethnic minority children with asthma that would otherwise have remained unnoticed (6). For example, the respondents hardly discussed illness perceptions with their patients, while the conceptual framework describes the importance of gaining insight into illness perceptions and how this might influence patients’ behaviour and thinking.

In the study presented in Chapter 4 we used questionnaires to gain data. In these questionnaires the nurse practitioners were asked for the cultural competencies that they regard as important in providing care to asylum seekers. The use of questionnaires meant that we missed the opportunity to detect important issues in providing care of which respondents were not aware, as we did in the asthma care setting.

In Chapter 5, the low response rate among the medical students may have caused some selection bias. In general, students who are more interested in the area of cultural competence are more likely to have participated. This might have resulted in an overestimation of the cultural competence scores of the medical students (assuming that more interested students would also be more culturally competent). Still, among these respondents we were able to identify gaps in the curriculum. In this study the cultural competence assessment instrument was used for the first time. The validation of this instrument is an ongoing process. Findings regarding the validity of the instrument in this modest study were positive; nevertheless, future research needs to analyse the relations between scores on the various domains and actual provider behaviour in medical practice.

In Chapter 6 experts of the Special Interest Group (SIG) on Diversity showed considerable consensus in their recommendations for developing cultural competence training. This consensus could be a result of the SIG meetings, rather than the views of individual respondents. However, respondents that did not attend meetings also participated in the study.

The analytic framework in Chapter 7 that addresses cultural competence at the healthcare organisational level was based on six approaches to organisational responsiveness to diversity. Although the six approaches showed considerable consensus regarding the important elements, it is possible that other approaches would add to this framework. Future studies should provide more insight into the 'completeness' of this framework.

External validity of the findings in this thesis

The generalisability of the findings presented in this thesis might be considered limited, because the ethnic composition of the Dutch population is different from that of other countries. In our research though, we focused on the healthcare process and the competencies to effectively provide care to an ethnically *diverse* patient population, rather than the provision of health care to specific ethnic groups. The use of the conceptual framework on cultural competence at the level of healthcare providers (*Chapter 2*) in studies from the UK, Israel, Germany and Denmark (7-10) suggests that our conceptualisation of cultural competence is also recognisable in populations with a different ethnic composition.

In addition, the specific Dutch healthcare system might have influenced our findings. The system in the Netherlands is characterised by universal access. In our studies, the issue of access does not seem to be an issue among our respondents and, subsequently, did not receive much emphasis among the defined cultural competencies (except for the analytical framework of organisational diversity responsiveness that was developed by comparing international approaches). Thus, from country to country the emphasis on specific cultural competencies may vary. This is particularly true in the case of care for asylum seekers. Care providers from different countries have to deal with the legal and social context of their own country, while every country has its own asylum-seeking policies and policies of medical care (11).

Part 3: Reflections on the main findings

Cultural competence and diversity responsiveness

At the start of our research we focused on healthcare provision to ethnic minority patients. Exploration of the mechanisms and difficulties in the care process for ethnic minority patients in a general context (*Chapter 2*) and in the context of paediatric asthma care (*Chapter 3*) revealed a 'magnifying glass effect': the issues we found were not in fact unique to patients from these groups but seemed to be more intense expressions of the general difficulties in healthcare. Many difficulties experienced in healthcare in a multi-ethnic population are not a result of the patient's ethnicity, but result from universal determinants such as low socio-economic status or low health literacy. This raises the question: to what extent is cultural competence different from generic ‘care provider’ competence (12,13)?

In the first studies that focused on the operationalisation of cultural competence at the healthcare provider level, we found that if physicians would communicate and act in a patient-centred way, some of the barriers related to care provision to ethnic minority patients would be reduced. This hypothesis was acknowledged and supported by the experts in the diversity education field. The generic concept of ‘patient-centred care’ does help in acknowledging diversity among all patients; however, if we draw the parallel with patient-centred care to the organisational level, it becomes apparent that the concept of patient centredness is not the only solution for healthcare inequalities. Patient centredness focuses on acknowledging the uniqueness (diversity) of patients and is, therefore, individualistic. However, serious inequities in health care are strongly associated with differences in group membership and social situation (14,15). For example, being an undocumented migrant is neither a cultural characteristic nor a personal one – it is a social position, with important consequences for health and access to healthcare.

Considering all these factors together, at the level of healthcare systems and organisations we feel it is more correct to speak of ‘diversity responsiveness’ than of cultural competence. Firstly, because healthcare should be responsive to universal ‘diversity’ determinants (such as socio-economic position) in *all* patients. Secondly, because in healthcare provision to ethnically diverse patients many variables *other* than merely ethnicity and culture (such as immigration status, religion, gender, and age profiles) are of considerable importance. Vertovec discusses the importance of the interplay of these factors - which he describes using the notion of ‘super-diversity’ (16). With diversity responsive care, societies can prepare for the ‘diversification of diversity’ which is seen in many Western populations. Diversity responsiveness seems to come down to a balance between working in a patient-centred way and thereby acknowledging the uniqueness of patient experiences, and taking into account the group characteristics which make certain groups of patients, such as ethnic minority groups or asylum seekers, particularly vulnerable.

At the level of individual healthcare providers, however, we suggest to stay with the term ‘cultural competence’ for the time being. This term has been widely employed in the literature, and the abilities of professionals are best described with the word ‘competence’ because it encompasses the integration of knowledge, attitude and awareness and skills. Therefore, we place emphasis on the word *competence*, and want to stress that the word ‘culture’ does not fully describe the competencies necessary to provide diversity-responsive healthcare.

Diversity responsiveness and non-discrimination

The studies in this thesis emphasise the importance of preventing stereotyping and bias from influencing healthcare provision in an ethnically diverse context. This is in line with the current discourse on cultural competence (17,18). At the same time, diversity responsive care explicitly requires care providers to differentiate between patients, if relevant, for quality of care and to optimise chances of optimal healthcare outcomes. However, the criteria justifying differentiation by ethnicity or ethnicity-related characteristics in healthcare have not been fully investigated, and it remains unclear in which contexts and on what grounds it is relevant to differentiate between ethnic groups. Moreover, it is known that this uncertainty makes care providers hesitant about differentiating in their treatment, i.e. their fear of prejudice and stereotyping may lead to suboptimal care (19). We need to be aware of the duality of our message of diversity responsive healthcare.

Unaware incompetent

The study among care providers in specialist asthma care (*Chapter 3*) showed that care providers are not always aware of the mechanisms that characterise the care process for ethnic minority children. When we assessed the cultural competence of medical students and physicians we found that the rating of their own cultural competence was only weakly related to the scores on assessed knowledge, reflection ability and consultation behaviour (*Chapter 5*). This is in line with other studies that have demonstrated little, none, or an inverse relation between self-perceived and more objectively measured clinical competence (20). Care providers will not always be aware of their learning needs in cultural competence. Therefore, the assessment of cultural competence in education and research must go beyond merely relying on self-perceived measures.

Cultural competence in medical education

Our research revealed that cultural competence training must be systematically integrated in the medical curriculum and addressed in a longitudinal approach. This will allow to develop training that is cumulative in complexity (12). Teaching cultural competence as a recurrent theme will serve to reinforce this in students. Assessing the level of cultural competence on various competency domains (e.g. knowledge, behaviour) of students that have completed a major part of the curriculum, combined with a curriculum scan (e.g. the TACCT (21)), seems useful to identify gaps in the curriculum regarding cultural competence training.

Within cultural competence it is the integration of knowledge, attitudes and skills which make up a competency (*Chapters 2 and 6*); this is not different from other medical competencies. In the literature on cultural competence, most debate focuses on the importance of teaching knowledge. Whereas in earlier days cultural competence training focused on teaching cultural knowledge about specific ethnic groups (12,22), nowadays emphasis is on the danger that providing knowledge might reinforce stereotyping (17,23). The type of knowledge that is relevant for the provision of diversity-responsive care remains an ongoing issue of debate. The study among experts in the diversity education field showed that they consider teaching knowledge at a 'meta level' to be important, e.g. about theories on mechanisms that influence health/health care in patients from ethnic minorities such as Kleinman's explanatory models (24), migration history of ethnic groups, dynamics of culture, or background information on religions. For example, care providers can only anticipate the risks of Ramadan for a diabetic Muslim patient if they are aware of such religious traditions.

Diversity responsive healthcare organisations

The results of comparing the approaches for organisational responsiveness showed considerable consensus among the approaches of how health service organisations respond to diversity, despite differences in terminology. It seems that most differences between the approaches reflected differences in the definition of the concept of culture. In some approaches the concept of culture is enlarged and linked to a wide range of attributes such as socio-economic position, education, or sexual orientation. However, we believe that the discussion on providing diversity-responsive healthcare would gain clarity if the various socio-cultural dimensions of importance were clearly distinguished from each other.

The consensus we found for organisational responsiveness, paves the way to structurally implement diversity-responsive healthcare, for example in the Dutch healthcare system. But how does one start? In the Netherlands we pilot tested one of the approaches that appeared in the comparison presented in Chapter 7, the Equity Standards of the TF-MFCCH (25). These standards are based on Whitehead's definition of equity in healthcare: "*equal access to available care for equal need; equal utilization for equal need; and equal quality of care for all*". Additionally, Whitehead suggests that equity is concerned with equal opportunities for health (26). Rather than treating all patients alike without making any distinctions, the equity concept emphasises equal opportunities for all in which patients' needs are central - this is exactly what diversity-responsive healthcare is all about.

Equity is an acknowledged performance indicator of healthcare systems, and seems a promising concept to enhance organisations' diversity responsiveness. It avoids the political sensitivity of paying attention to ethnic groups, because it focuses on equity among the total population. However, when pilot testing the Equity Standards in the

Netherlands we found that representatives of the various organisations that participated in our study were not familiar with the equity concept. Moreover, it seemed that the representatives had different ideas about and associations with the equity concept. The fact that we could not properly translate the word ‘equity’ into Dutch may have played a role in this respect. We believe the concept of equity could serve as a stepping stone for the improvement of diversity-responsive healthcare.

Part 4: Implication and recommendations

Implications and recommendations for research, clinical practice, medical education and healthcare policy are based on the findings emerging from this thesis.

Implications for further research

- Analyse the current level of cultural competence of individual healthcare providers and determinants of the development of cultural competence.
- Identify existing inequities in healthcare and assess the diversity-responsiveness of healthcare organisations.
- Evaluate the effects of diversity responsiveness on the accessibility, quality and outcomes of healthcare for ethnically diverse patient groups.
- Explore the limits of diversity-responsive care in relation to non-discrimination, and investigate in which contexts and on what grounds it is relevant to differentiate between ethnic groups.

Implications for clinical practice and medical education

- Structurally implement compulsory cultural competence training in the curricula of healthcare professionals, and implement staff training in healthcare organisations.
- Support medical teachers that actually deliver cultural competence training and clinical teachers that influence students as role models, in staff development programs. Not all teachers feel competent and supported to address diversity-related issues in their own teaching (27,28).
- Register patients’ country of birth and other variables that are relevant in the context of diversity-responsive healthcare. This is needed to facilitate taking healthcare needs into account in the care process at the individual patient level, as well as to monitor outcomes at the patient group level (29). We are aware of the sensitivity of this issue (30,31); therefore, it should be recognized that registration of patient characteristics in the patient record requires strategies to adequately inform patients and staff, and careful regulation of data handling to protect and guarantee the patient’s right to privacy (32).

Implications for healthcare policy

- Monitor equity as a performance indicator of healthcare. Indicators of accessibility and quality of care should be analysed according to ethnicity and other relevant diversity characteristics such as socio-economic position.
- Implement clear legislation regarding registration of country of birth and other variables that are relevant in the context of diversity-responsive healthcare. Legislation should provide for legitimate data processing and also guarantee patients’ right to privacy.
- Incorporate diversity responsiveness and attention for ethnically diverse patients in all policies that aim to improve the responsiveness of healthcare in general (e.g. patient safety initiatives that address the importance of professional interpreters in the patient-provider context; initiatives to improve patient participation emphasise the importance of diversity among patient representatives, etc.) to create synergy among activities.

Part 5: Main conclusions

This thesis contributes to the conceptualization of culturally competent or diversity-responsive care. At the level of *individual healthcare providers* cultural competence means knowledge of epidemiology and the differential effects of treatment in various ethnic groups; awareness of how culture shapes individual behaviour and thinking; awareness of the social context in which specific ethnic groups live; awareness of one’s own prejudices and tendency to stereotype; ability to communicate in a patient-centred way taking into account patients’ language, health literacy and other communication needs; and the ability to adapt to new situations in a flexible and creative manner. We found that cultural competencies elaborate on generic care provider competencies, but specific healthcare contexts might need a more specific operationalisation of cultural competence.

At the level of *healthcare organisations* diversity responsiveness means ensuring access and providing appropriate care. This, in turn, is dependent on meeting the following preconditions: demonstrating organisational commitment, collecting and using evidence on inequalities and needs, developing a competent and diverse workforce, fostering patient and community participation, and advocating for responsiveness. We found considerable consensus among the six approaches for diversity responsiveness that we analysed, which is promising to further diversity-responsive care.

In medical education it is important to structurally implement cultural competence training using a longitudinal approach. With respect to the content of training, all dimensions of cultural competence (knowledge, awareness, and skills) should be covered. At the same time it should be taken into account that medical students and physicians can be culturally *in*competent and unaware of their learning needs.

Further research should focus on the effects of diversity responsiveness on patients' experiences and outcomes of healthcare. Rather than merely using diversity responsiveness as a reactive response to known inequities in health care, strategies should be integrated proactively to prevent inequities developing in the future. We should focus on equity of care as a basic principle to guarantee that the healthcare system is accessible and provides good quality of care to all patients. We hope that the findings emerging from the work presented here will provide useful leads to achieve this.

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Summary

Summary

Introduction

In the Netherlands, various initiatives have been taken to improve healthcare for ethnic minority patients. This field could profit from a systematic development of evidence-based culturally competent healthcare. The research presented here focuses on a number of steps in such a systematic development, including the operationalisation of the concept of culturally competent healthcare and on the application of these concepts in medical practice and education.

Healthcare must respond to highly diverse patient populations that are present in modern Dutch society. Ethnic diversity among patients affects healthcare provision in various ways. Many difficulties between care providers and ethnic minority patients have been shown. Communication problems are the most prominent; these types of problems arise from language barriers, socio-cultural differences in explanatory models of illness, and differences in health literacy levels. It is also known that stereotyping and biases impact the care process.

Cultural competence is a strategy that has the potential to improve the healthcare process provided to ethnically diverse patients. Cultural competence at the level of individual care providers is generally defined as the knowledge, attitudes and skills necessary to provide good quality of care for ethnic minority patients. During medical education all physicians can be prepared to respond to adequately to ethnic diversity. However, teaching of cultural competence has not yet structurally been implemented in medical schools. Additionally, cultural competence encompasses the level of healthcare organisations. By putting into place certain key elements in service policies and management, healthcare organisations can improve accessibility and create conditions for individual healthcare providers to provide culturally competent health care.

The main aim of this thesis is to operationalise the concept of cultural competence at the level of individual healthcare providers and the level of healthcare organizations, and to provide insight into the application of this concept in medical practice and medical education. The studies are arranged according to three themes, namely cultural competence

I. *at the level of individual health care providers*
II. *in medical education*
III. *at the level of healthcare organisations*

Cultural competence at the level of individual health care providers

The aim of the first three studies is to specify the broad concept of cultural competence into specific competencies to develop the general idea into a useful concept for medical practice and medical education, in different settings and for different types of patients. In the study presented in Chapter 2 we developed a conceptual framework on cultural competence for healthcare professionals. The framework is based on personal interviews with patients and physicians and on the literature. Our research question was:

What are the cultural competencies necessary for healthcare professionals to provide good quality care to ethnic minority patients?

The framework distinguished between the following cultural competencies: knowledge of epidemiology and the differential effects of treatment in various ethnic groups; awareness of how culture shapes individual behaviour and thinking; awareness of the social context in which specific ethnic groups live; awareness of one's own prejudices and tendency to stereotype; ability to transfer information in a way the patient can understand and to use external help (e.g. qualified interpreters) when needed, and ability to adapt to new situations in a flexible and creative manner. The results show that more dimensions are involved in delivering high-quality care than merely the cultural one. Most cultural competencies emphasise a specific aspect of a generic competency that is of particular importance when dealing with patients from different ethnic groups.

The study in Chapter 3 addressed cultural competence in specialist paediatric asthma care. In this study we explored mechanisms that characterize the care process for ethnic minority children with asthma and the cultural competencies that result from that. For this study we conducted semi-structured interviews with paediatricians and nurses in three hospitals. Our research question was:

What mechanisms characterize the care process for ethnic minority patients, and what competencies result from that?

Our respondents mentioned patient non-adherence as the central problem in asthma care. The cultural competencies we found were: the ability to use patient centred communication skills in giving and retrieving information; awareness of different illness perceptions and ability to communicate effectively about this; the ability to effectively overcome language and health literacy barriers; and the ability to reflect upon one's own background and stereotyping in intercultural contexts. Although we specifically addressed the paediatric asthma care setting in this study, the competencies that resulted from the insight into paediatric asthma practice are comparable to the general cultural competencies found in our first study (*Chapter 2*). We found some evidence that if care providers would improve the patient-centred skills that are now considered the 'norm' in medical training, then they would already make good progress in cultural competence. This strengthens the hypothesis that most cultural competencies are specifications of generic competencies that healthcare providers should already possess. This study also showed that care providers do not always consciously recognise all the mechanisms that lead to deficiencies in culturally competent asthma care that they provide to ethnic minority children (e.g. communicating mainly from a biomedical perspective, and using only 'informal' interpreters). Consequently, they are partly unaware of their learning needs in this respect.

The study in Chapter 4 addressed cultural competence in care provision in a specific healthcare setting: i.e. asylum seekers living in asylum-seeker centres whilst awaiting the decision concerning their request for asylum. For this study we explored those particular cultural competencies that nurse practitioners working with asylum seekers considered important, through a survey with open-ended questions and group interviews. Our research question was:

What, according to nurse practitioners working with asylum seekers, are cultural competencies specific for the medical contact with asylum seekers?

In this healthcare setting we found a more specific elaboration of some of the general cultural competencies from the framework: knowledge of the political situation in the country of origin; knowledge with regard to diseases common in the country of origin; knowledge of the effects of refugeehood on health; awareness of the juridical context in the host country; ability to deal with asylum seekers' traumatic experiences; and skills to explain the host country's health care system. More general cultural competencies that were considered important were: awareness of how culture shapes individual behaviour and thinking; awareness of one's own prejudices and tendency to stereotype; ability to transfer information in a way the patient can understand and to know when external help with communication is needed (e.g. a qualified interpreter); and ability to adapt to new situations in a flexible and creative manner.

The more highly specified cultural competencies were related to the various (and often difficult) migration histories of asylum seekers and the unique circumstances in which this patient group lives in the Netherlands. Apparently, when providing care in a healthcare setting with such a specific patient group, the general cultural competencies described in the framework need to be further specified for the particular care context.

Cultural competence in medical education

In this part of the thesis we changed the focus from the conceptualisation of cultural competence at the individual healthcare provider level, to the development, content and assessment of cultural competence in medical education. The study in Chapter 5 addressed the evaluation of two medical curricula, based on a cultural competence assessment of medical students and Youth Health Care (YHC)-physicians who had completed a large part of the curriculum (chapter 5). We described the development of a new cultural competence measure and showed how the results from the assessment can be used to support the development of a cultural competence training programme. The research question were:

What are the outcomes of a cultural competence assessment in groups of students and physicians? What is the association between self-perceived overall cultural competence and assessed knowledge, reflection ability and consultation behaviour? And to what extent are the results of this assessment applicable in the light of developing a cultural competence training programme?

We found that on average, our respondents scored low on general knowledge and knowledge of interpreters and much higher on reflection ability. The respondents' reports of their consultation behaviour reflected moderately adequate behaviour in exploring patients' perspectives and in interaction with low health literate patients, while the score on exploring patients' social contexts was on average low. Based on this study, we conclude that curriculum development should focus on increasing knowledge and improving behaviour. We found a weak association between self-perceived cultural competence and assessed knowledge, reflection ability and consultation behaviour. Assessing cultural competence using this assessment instrument enabled us to identify gaps related to cultural competence training in the current curricula of our respondents.

The study in Chapter 6 provides insight into the development and content of cultural competence education. It presents recommendations for the development of training in culturally competent medical communication, based upon a survey among experts in the field of diversity in medical education. The research question was:

According to experts in diversity in medical education, what recommendations can be made for the development of training for medical students in communication with ethnically diverse patients?

The recommendations that emerged were that: all students need to be educated in culturally competent communication; teachers should stimulate awareness of personal biases and an open attitude; three core communication skills should be taught, i.e. listening, exploring and checking; practice should be provided with a professional interpreter; knowledge content should focus on mechanisms relevant to various ethnic groups; students should be offered a variety of experiences in a safe environment; and that all persons involved should be aware that stereotyping is a pitfall. Training in communication skills for consultation with ethnic minority patients cannot be separated from teaching issues of awareness and knowledge. Comparable to the study on asthma care (Chapter 3), the shared views on the content of these communication trainings were in line with general patient-centred communication approaches. However, the potential complexity of communication with patients from an ethnic minority group (due to language barriers, cultural distance and/or influence of stereotypes) requires explicit qualities or a ‘PLUS’ in the generic patient-centred approach.

Cultural competence at the healthcare organisation level

The third part of the thesis addressed cultural competence at a level beyond that of individual care providers, namely the level of healthcare organisations. In the study in Chapter 7 we developed an analytical framework for organisational responsiveness to ethnic diversity. The framework is based on a qualitative document analysis of domains (conceptually distinct topics) and dimensions (operationalisations) of six approaches for organisational responsiveness to diversity. The research question was:

What, according to various approaches, are the essential elements in providing care that is responsive to the needs of diverse patient groups, and how much consensus is there between various approaches?

We identified seven domains that were represented in most or all approaches: ‘organisational commitment’, ‘empirical evidence on inequalities and needs’, ‘a competent and diverse workforce’, ‘ensuring access for all users’, ‘ensuring responsiveness in care provision’, ‘fostering patient and community participation’ and ‘actively promoting responsiveness’. Variations in the conceptualisation of ‘responsive care’ reflected different assumptions about the type of diversity that should be responded to. For example, approaches that focus on ethnic diversity mostly refer to cultural and language differences; approaches that broaden their target populations to (e.g.) ‘vulnerable’ groups adopt a more multidimensional approach, also paying attention to such factors as socio-economic status and gender. Despite differences in the way different approaches are labeled, this comparative study revealed a broad consensus among different approaches concerning the way in which health organisations should respond to diversity.

General discussion

In Chapter 8, the general discussion, we discussed the main results and the strengths and limitations of the studies. We placed the findings in perspective and we end with recommendation for research, practice and policy.

Findings of Chapter 2 and 3 revealed that many difficulties experienced in healthcare in a multi-ethnic population are not unique to ethnic minority patients and that these difficulties often result from universal determinants such as low socio-economic status. This raised the question: to what extent is cultural competence different from generic ‘care provider’ competence. We conclude that it is more correct to speak of ‘diversity responsiveness’ than of cultural competence. Firstly, because healthcare should be responsive to universal ‘diversity’ determinants (such as socio-economic position) in *all* patients. Secondly, because in healthcare provision to ethnically diverse patients many variables *other* than merely ethnicity and culture (such as immigration status, gender) are of considerable importance. Diversity responsiveness seems to come down to a balance between working in a patient-centred way and thereby acknowledging the uniqueness of patient experiences, and taking into account the group characteristics which make certain groups of patients, such as ethnic minority groups or asylum seekers, particularly vulnerable.

The studies among care providers in specialist asthma care (Chapter 3) and the assessment of cultural competence of medical students and physicians (Chapter 5), showed that care providers might be ‘unaware incompetent’. They will not always be aware of their learning needs in cultural competence, which should be taken into account when teaching and assessing cultural competence.

The results of comparing the approaches for organisational responsiveness showed considerable consensus among the approaches of how health service organisations should respond to diversity, despite differences in terminology. This paves the way to structurally implement diversity-responsive healthcare, for example in the Dutch healthcare system. The concept of equity could serve as a stepping stone for the improvement of diversity-responsive healthcare. It avoids the political sensitivity of paying attention to ethnic groups, because it focuses on equity among the total population.

We recommend that further research should evaluate the effects of diversity responsiveness on the accessibility, quality and outcomes of healthcare for ethnically diverse patient groups. In clinical practice and medical education we recommend the structured implementation of cultural competence training in medical education and to support teachers in providing culturally competent medical education. Lastly, healthcare policy needs to focus on monitoring equity as a performance indicator of healthcare. We hope that the findings emerging from this work will contribute to a systematic development of diversity-responsive healthcare.

Samenvatting

Samenvatting

Inleiding

In Nederland is met verschillende initiatieven geprobeerd de gezondheidszorg aan mensen van niet-Nederlandse herkomst te verbeteren. Een systematische ontwikkeling van evidence-based cultureel competente zorg kan deze praktijk ondersteunen. De studies in dit proefschrift zetten een aantal stappen van zo'n systematische ontwikkeling, waaronder de operationalisatie van het concept cultureel competente zorg en de toepassing van dit concept in de medische praktijk en het medisch onderwijs.

De gezondheidszorg moet om kunnen gaan met de grote diversiteit in patiëntenpopulaties in de huidige Nederlandse samenleving. Etnische diversiteit van patiënten speelt op verschillende manieren een rol in de zorg. Er zijn veel knelpunten aangetoond tussen zorgverleners en patiënten van niet-Nederlandse herkomst. Communicatieproblemen springen het meest in het oog; deze kunnen ontstaan door taalbarrières, sociaal-culturele verschillen in modellen voor de verklaring van ziekte, en lage gezondheidsvaardigheden. Ook stereotypering en vooringenomenheid (ook wel 'bias' genoemd) kunnen invloed hebben op het zorgproces.

Culturele competentie wordt beschouwd als een strategie die het proces van zorg aan patiënten uit diverse etnische groepen kan verbeteren. Culturele competentie op het niveau van individuele zorgverleners wordt meestal gedefinieerd als de kennis, attitudes en vaardigheden die nodig zijn om kwalitatief goede zorg te verlenen aan een etnisch diverse patiëntenpopulatie. Het medisch onderwijs biedt de gelegenheid om alle artsen voor te bereiden op adequate zorgverlening aan etnisch diverse patiëntenpopulaties. Echter, onderwijs in culturele competenties is nog niet structureel geïmplementeerd in het medische curriculum. Naast culturele competentie op het niveau van individuele zorgverleners onderscheiden we ook culturele competentie op het niveau van zorgorganisaties. Door het implementeren van specifiek beleid en aandacht in het management kunnen zorgorganisaties hun toegankelijkheid verbeteren en voorwaarden scheppen voor individuele zorgverleners om cultureel competente zorg te verlenen.

De doelen van dit proefschrift zijn het operationaliseren van het concept culturele competentie op het niveau van individuele zorgverleners en op het niveau van zorgorganisaties en inzicht geven in de toepassing van het concept culturele competentie in de medische praktijk en het medisch onderwijs. De onderzoeken zijn verdeeld in drie thema's, namelijk:

I. *Culturele competentie op het niveau van individuele zorgverleners*
II. *Culturele competentie in medisch onderwijs*

III. Culturele competentie op het niveau van zorgorganisaties

Culturele competentie op het niveau van individuele zorgverleners.

Het doel van de eerste drie studies is het operationaliseren van het brede concept van culturele competentie in specifieke competenties. Meer specifiek is het doel om het algemene idee te vertalen naar een concept dat bruikbaar is in de medische praktijk en in het medisch onderwijs; voor verschillende zorgcontexten en voor verschillende typen patiënten. In hoofdstuk 2 hebben we een conceptueel raamwerk ontwikkeld van de culturele competenties van individuele zorgverleners. Het raamwerk is gebaseerd op persoonlijke interviews met patiënten en artsen en op de literatuur. De onderzoeksvraag was:

Welke culturele competenties hebben zorgverleners nodig om kwalitatief goede zorg te verlenen aan een etnisch diverse patiëntenpopulatie?

In het raamwerk onderscheiden we de volgende culturele competenties: kennis van epidemiologie van ziekten en verschillende effecten van behandeling in verschillende etnische groepen; bewustzijn van de manier waarop cultuur invloed kan hebben op individueel gedrag en ideeënvorming; bewustzijn van de sociale context waarin specifieke etnische groepen leven; bewustzijn van je eigen vooroordelen en neiging tot stereotypering; vaardigheid in het overbrengen van informatie op een voor de patiënt begrijpelijke manier en om externe hulp te gebruiken indien nodig (bijvoorbeeld gekwalificeerde tolken); en de vaardigheid om flexibel en creatief om te gaan met nieuwe situaties. De resultaten van deze studie laten zien dat bij het leveren van goede kwaliteit van zorg veel meer dimensies een rol spelen dan alleen de culturele dimensie. De meeste culturele competenties benadrukken een specifiek aspect van een meer algemene competentie die van extra belang is in de omgang met patiënten uit diverse etnische groepen.

Hoofdstuk 3 richt zich op culturele competentie in de pediatrische astmazorg. In dit hoofdstuk exploreerden we de mechanismen die het zorgproces voor kinderen van niet-Nederlandse herkomst met astma kenmerkten en de culturele competenties die daaruit voortkwamen. Voor deze studie hebben we semi-gestructureerde interviews met kinderartsen en verpleegkundigen in drie ziekenhuizen gehouden. De onderzoeksvraag was:

Welke mechanismen karakteriseren het zorgproces voor patiënten met een niet-Nederlandse herkomst, en welke competenties komen daaruit voort?

Onze respondenten benoemden therapieontrouw als het centrale knelpunt in de astmazorg. De culturele competenties die we vonden waren: vaardigheid in het toepassen van patiëntgerichte communicatie bij het geven en verkrijgen van informatie; bewustzijn van verschillende ziektepercepties en de vaardigheid om daar effectief over te communiceren; de vaardigheid in het effectief omgaan met een taalbarrière en met lage gezondheidsvaardigheden van patiënten; en de vaardigheid in een interculturele context te reflecteren op je eigen achtergrond en stereotypen. Hoewel we ons in deze studie specifiek hebben gericht op de context van de pediatrische astmazorg zijn de competenties die we vonden vergelijkbaar met de algemene culturele competenties die we in het raamwerk van hoofdstuk 2 presenteerden. Als zorgverleners zich verder zouden bekwamen in de vaardigheden voor het verlenen van patiëntgerichte zorg zouden hun culturele competenties al een stuk beter worden. Patiëntgerichte zorgverlening wordt op dit moment als norm beschouwd in het medisch onderwijs. Dit versterkt de hypothese dat de meeste culturele competenties nadere specificaties zijn van algemene competenties die zorgverleners al behoren te bezitten. Deze studie laat ook zien dat zorgverleners niet altijd bewust de mechanismen herkennen die kunnen leiden tot tekortkomingen in cultureel competente astmazorg aan kinderen van niet-Nederlandse herkomst, zoals de nadruk op communicatie vanuit een biomedisch perspectief en het gebruik van informele tolken. Het gevolg is dat zorgverleners zich onvoldoende bewust zijn van hun leerbehoeften op dit gebied.

Hoofdstuk 4 beschrijft culturele competentie in een specifieke zorgsetting: de zorgverlening aan asielzoekers die in een asielzoekerscentrum wonen in afwachting van de beslissing over een verblijfsvergunning. In deze studie exploreerden we de culturele competenties die belangrijk worden gevonden door praktijkverpleegkundigen die werken met asielzoekers. Voor deze studie maakten we gebruik van een survey met open vragen en groepsinterviews. Onze onderzoeksvraag was:

Welke culturele competenties zijn, volgens praktijkverpleegkundigen die werken met asielzoekers, specifiek van belang in de medische zorg voor asielzoekers?

In deze bijzondere medische context vonden we meer specifieke uitwerkingen van algemene culturele competenties uit het raamwerk van Hoofdstuk 2, namelijk: kennis van de politieke context in het land van herkomst; kennis over veel voorkomende ziekten in het land van herkomst; kennis van de invloed van het vluchteling-zijn op gezondheid; bewustzijn van de juridische context in het gastland; vaardigheid in het omgaan met traumatische ervaringen van asielzoekers en vaardigheid in het uitleggen van het gezondheidszorgsysteem in het gastland. Meer algemene culturele competenties die praktijkverpleegkundigen belangrijk vonden, waren: bewustzijn van de manier waarop cultuur invloed kan hebben op individueel gedrag en ideeënvorming; bewustzijn van je eigen vooroordelen en neiging tot stereotypering; vaardigheid in het overbrengen van informatie op een voor de patiënt begrijpelijke manier en om externe hulp te gebruiken indien nodig (bijvoorbeeld gekwalificeerde tolken); en de vaardigheid om flexibel en creatief om te gaan met nieuwe situaties. De specifieker uitgewerkte competenties hadden betrekking op de bijzondere en vaak moeilijke migratiegeschiedenis van asielzoekers en de unieke omstandigheden waarin deze patiëntengroep woont in Nederland. Bij het verlenen van zorg aan een dergelijke specifieke patiëntengroep blijkt het noodzakelijk te zijn om de algemene culturele competenties zoals beschreven in het raamwerk verder uit te werken voor de specifieke zorgcontext.

Culturele competentie in medisch onderwijs

In dit deel van het proefschrift verleggen we de focus van de operationalisatie van het concept culturele competentie op het niveau van individuele zorgverleners naar de ontwikkeling, inhoud en meting van culturele competenties in het medisch onderwijs. In hoofdstuk 5 evalueerden we twee medische curricula, door de culturele competenties te meten van medisch studenten en jeugdartsen die een groot deel van die curricula hadden doorlopen. We beschreven de ontwikkeling van een nieuw meetinstrument voor culturele competentie en lieten zien hoe de resultaten van de meting gebruikt kunnen worden om de ontwikkeling van een onderwijsprogramma over culturele competenties te ondersteunen. De onderzoeksvraag was:

Wat zijn de uitkomsten van een culturele competentie meting in een groep studenten en artsen? Wat is de associatie tussen de eigen inschatting van algemene culturele competentie en gemeten kennis, reflectievaardigheden en consultvoering? En in welke mate zijn de resultaten van deze meting behulpzaam bij het ontwikkelen van een onderwijsprogramma over culturele competenties?

We vonden dat onze respondenten gemiddeld laag scoorden op algemene kennis en kennis over tolken, terwijl ze hoger scoorden op reflectievaardigheden. Het zelf-gerapporteerde consultgedrag was matig in overeenstemming met cultureel-competente consultvoering voor het exploreren van het patiëntenperspectief en voor wat betreft het omgaan met patiënten met lage gezondheidsvaardigheden. De score op het exploreren van de sociale context van patiënten was gemiddeld laag. Gebaseerd op deze resultaten concludeerden we dat de ontwikkeling van het curriculum zich zou moeten richten op het verhogen van kennis en het verbeteren van consultgedrag. We vonden een zwakke associatie tussen zelf-ingeschatte culturele competentie en de gemeten kennis, reflectievaardigheden en consultvoering. Het meten van culturele competentie met dit instrument maakte het mogelijk om hiaten in onderwijs over culturele competenties te identificeren in de huidige curricula van deze respondenten.

De studie in hoofdstuk 6 richtte zich op het ontwikkelen van onderwijs over culturele competenties. We beschrijven aanbevelingen voor de ontwikkeling van training in cultureel competente medische communicatie. Deze aanbevelingen zijn gebaseerd op een survey onder experts op het gebied van diversiteit in medisch onderwijs. De onderzoeksvraag was:

Welke aanbevelingen kunnen volgens experts op het gebied van diversiteit in het medisch onderwijs worden gegeven voor de ontwikkeling van training voor medische studenten in communicatie met patiënten van etnisch diverse herkomst?

De aanbevelingen die naar voren kwamen, waren:

- Verplicht onderwijs over cultureel competente communicatie;
- Docenten stimuleren bewustwording van persoonlijke vooringenomenheid en een open houding bij studenten;
- Onderwijs in de drie kerncommunicatievaardigheden (luisteren, exploreren, checken);
- Oefenen met een professionele tolk als standaard onderdeel van het curriculum;
- Onderwijs over kennisaspecten richt zich op mechanismen die relevant zijn voor verschillende etnische groepen;
- Studenten kunnen verschillende ervaringen opdoen in een veilige omgeving;
- Alle betrokkenen bij dit onderwijs zijn zich bewust van de valkuil van stereotypering.

Onderwijs in communicatievaardigheden voor consultvoering met etnisch diverse patiënten kan niet los staan van attitudeonderwijs of onderwijs over kennis aspecten. Vergelijkbaar met onze studie over de astmazorg (hoofdstuk 3), zijn de door de respondenten gedeelde ideeën over de inhoud van communicatietraining in lijn met algemene benaderingen voor patiëntgerichte communicatie. Echter, de potentiële complexiteit van communicatie met een etnisch diverse patiëntenpopulatie vereisen expliciete vaardigheden vanwege taalbarrières, culturele afstand en/of de invloed van stereotypen, oftewel een 'PLUS ' in de algemene patiëntgerichte benadering.

Culturele competentie op het niveau van zorgorganisaties

Het derde deel van dit proefschrift richt zich op culturele competentie op het niveau van zorgorganisaties. In dit hoofdstuk spreken we van diversiteits-responsieve zorg. In hoofdstuk 7 ontwikkelden we een analytisch raamwerk voor diversiteits-responsieve zorg op het niveau van zorgorganisaties. Het raamwerk is gebaseerd op een kwalitatieve analyse van domeinen (conceptueel verschillende onderwerpen) en dimensies (operationalisaties binnen een domein) van zes modellen die het concept diversiteits-responsieve zorg hebben uitgewerkt. De onderzoeksvraag was:

Wat zijn, volgens verschillende modellen, de essentiële elementen op het niveau van gezondheidszorgorganisaties in het leveren van zorg die responsief is voor de behoeften van diverse patiëntengroepen, en hoe veel consensus is er tussen de verschillende modellen?

We identificeerden zeven domeinen die in de meeste of alle modellen voorkwamen: 'organisatorische commitment', 'empirisch bewijs van verschillen in toegankelijkheid en kwaliteit van zorg en in zorg behoeften', 'een competent en divers personeelsbestand', ‘gegarandeerde toegankelijkheid voor alle cliënten, ‘gegarandeerde responsiviteit in de zorgverlening’, ‘bevorderen van participatie door patiënten en de gemeenschap (community), en het actief uitdragen van het belang van diversiteits-responsieve zorg’. Variaties in de uitwerkingen van het concept ‘responsieve zorg’ weerspiegelden verschillende aannames over het type diversiteit waar de zorg op zou moeten reageren. Bijvoorbeeld, modellen met een focus op etnische diversiteit verwijzen voornamelijk naar verschillend in taal en cultuur; modellen die een bredere doelgroep voor ogen hebben, bijvoorbeeld ‘kwetsbare groepen’ gaan uit van een multidimensionale benadering, waarin ook aandacht wordt besteed aan factoren zoals sociaaleconomische status en gender. Ondanks verschillen in de terminologie die de verschillende modellen hanteerden waar het gaat om diversiteit en responsiviteit, laat deze vergelijkende studie zien dat er een brede consensus is over de manier waarop zorgorganisaties moeten reageren op diversiteit.

Discussie

Hoofdstuk 8 begint met een beschrijving van de belangrijkste resultaten en een discussie van de sterke en zwakke punten van de beschreven studies. We plaatsen de bevindingen in een breder perspectief en eindigen met aanbevelingen voor onderzoek, praktijk en beleid.

De bevindingen van hoofdstuk 2 en 3 lieten zien dat de meeste knelpunten die worden ervaren in de zorgverlening aan etnisch diverse populaties niet uniek zijn voor patiënten met een niet-Nederlandse achtergrond en dat die knelpunten veelal voortkomen uit universele determinanten zoals lage sociaaleconomische status. Dit bracht ons bij de vraag: in welke mate zijn culturele competenties anders dan algemene competenties van zorgverleners? We concludeerden dat het correcter is om te spreken van ‘responsiviteit voor etnische diversiteit’ dan van culturele competentie. Ten eerste omdat de gezondheidzorg responsief moet zijn voor universele diversiteitsaspecten (zoals sociaaleconomische status) van *alle* patiënten. Ten tweede omdat in de zorg aan etnisch diverse patiëntenpopulaties veel meer aspecten van belang zijn dan alleen etniciteit en cultuur (zoals immigratiestatus, gender, sociaaleconomische status, geletterdheid). Responsiviteit voor diversiteit lijkt neer te komen op een balans tussen werken op een patiëntgerichte manier waarbij de uniciteit de ervaringen van patiënten worden erkend, en het rekening houden met groepskarakteristieken die bepaalde patiëntengroepen, zoals patiënten met een niet-Nederlandse herkomst of asielzoekers, extra kwetsbaar maken.

De studies bij de zorgverleners in de pediatrische astmazorg (hoofdstuk 3) en de culturele competentie meting van medische studenten en artsen (hoofdstuk 5) lieten zien dat zorgverleners ‘onbewust incompetent’ kunnen zijn. Ze zullen zich niet altijd bewust zijn van hun leerbehoeften op het gebied van culturele competentie. Het is belangrijk om daarmee rekening te houden in onderwijs over en het meten van culturele competenties.

De resultaten van de vergelijking van modellen voor responsiviteit van organisaties lieten, ondanks verschillen in terminologie, aanzienlijke consensus zien tussen de benaderingen over hoe zorgorganisaties moeten reageren op diversiteit. Dit maakt de weg vrij om diversiteits-responsieve zorg structureel te implementeren, bijvoorbeeld in het Nederlandse gezondheidszorgsysteem. Het concept ‘equity’ zou kunnen dienen als een opstap voor het bevorderen van diversiteits-responsieve zorg. De term equity staat los van de politieke gevoeligheid die heerst als het gaat om het besteden van aandacht aan etnische groepen, omdat equity zich richt op de totale populatie.

We bevelen aan om in toekomstig onderzoek aandacht te besteden aan de effecten van diversiteits-responsieve zorg op de toegankelijkheid, kwaliteit en uitkomsten van de zorg voor etnische diverse patiëntengroepen. Voor de medische praktijk en het medisch onderwijs bevelen we aan dat onderwijs in culturele competenties structureel wordt geïmplementeerd en dat docenten effectief worden ondersteund in het geven van onderwijs hierover. Tenslotte is het noodzakelijk om equity te monitoren als een prestatie-indicator van de gezondheidszorg. We hopen dat de bevindingen uit dit proefschrift zullen bijdragen aan een systematische ontwikkeling van diversiteits-responsieve zorg.

Dankwoord

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Dit proefschrift was nooit tot stand gekomen zonder belangrijke bijdragen van anderen. Heel veel mensen zijn de afgelopen jaren op allerlei verschillende manieren bij dit werk betrokken geweest. Op deze plaats wil ik iedereen daar heel erg voor bedanken. In het bijzonder wil ik de volgende mensen noemen:

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Robert, Sietse en Koen: fijn dat jullie in mijn leven zijn! (het rijmt dus het is waar, toch Sietse en Koen?)

About the author

PhD Portfolio

Name PhD student: Conny Seeleman
PhD period: September 2010 – December 2013
Name PhD supervisor: prof. dr. K. Stronks and prof. dr. M.L. Essink-Bot

1. PhD training

	Year	Workload (ECTS)
General and specific courses		
AMC Graduate School:		
- PubMed	2010	0,1
- Project Management	2010	0,6
- Practical Biostatistics	2011	1,1
- Scientific Writing in English for publication	2011	1,5
EpidM:		
- Klinimetrie: het ontwikkelen en evalueren van meetinstrumenten	2011	1,2
(Inter)national conferences and presentations		
Congres Nederlandse Vereniging Medisch Onderwijs - NVMO; Egmond aan Zee/Maastricht	2010-2013	2,0
- Het aanleren van tolkenvaardigheden in het medisch onderwijs (workshop)	2010	0,5
- Culturele competenties van artsen en coassistenten: de ontwikkeling van een meetinstrument (poster presentation)	2012	0,5
- Vrouwelijke genitale verminking, een noodzakelijk onderwerp in het basiscurriculum? (workshop)	2013	0,5
Conference on Migrant and Ethnic Minority Health in Europe, 3rd edition Pecs, Hungary; 4th edition Milan, Italy	2010, 2012	1,5
- Measuring cultural competence – an essential prerequisite towards equitable care for ethnic minority patients (oral presentation)	2012	0,5
- Cultural Competence in paediatric asthma care (oral presentation)	2010	0,5
- Solving language and cultural barriers during interviews with immigrants – experiences with interpreters, ethnic matching, and 'getting by' (workshop)	2010	0,5
Quality in Health Care for Culturally Diverse Populations -Diversity RX; Baltimore, USA	2010	0,75
- Cultural Competence in paediatric asthma care (electronic poster)	2010	0,5
Nederlands Congres Volksgezondheid (NCVGZ), Amsterdam	2011	0,25
- Omgaan met taal- en cultuurbarrières in interviews (workshop)	2011	0,5

	Year	Workload (ECTS)
Academische Werkplaats Diversiteit, Pharos (Utrecht)		
- Diversiteit in Medisch Onderwijs (oral presentation, discussion)	2012	0,5
Studiedag Diversiteit in Zorg, Universiteit Antwerpen		
- Het ontwikkelen van een curriculum rondom diversiteit (workshop)	2012	0,5
Congres Cultuurverschillen in de kliniek, UMCG		
- Ethische kwesties in de interculturele praktijk (workshop)	2012	0,5
COST-ADAPT meeting, Amsterdam		
- Organizational responsiveness to ethnic diversity: a comparison of approaches (oral presentation)	2012	0,5
Sarphati initiatief, Amsterdam		
- Ongelijk behandelen: discriminatie of cultureel competente zorg? (oral presentation, discussion)	2012	0,5
21st International Health Promoting Hospitals Conference, Gothenburg, Sweden	2013	0,25
- Pilot testing the preliminary standards in health care organisations (workshop)	2013	0,5
Other		
- Co-chair of the Special Interest Group 'Diversity' of the Dutch Association for Medical Education (NVMO)	2010-present	4
- Member of the Task Force on Culturally Competent and Migrant Friendly Health Care	2011-present	3,5
- Member of COST Action 'Adapting European health systems to diversity (ADAPT)'	2012-present	0,2

ECTS=European Credit Transfer and Accumulation System; 1 ECTS credit=28 hours

2. Teaching

	Year	Workload (ECTS)
Lecturing		
- Developing of, and teaching in training ‘Effective care for ethnic minority children with asthma’ (total 1,5 day) for paediatric residents and paediatricians	2010	3
- Developing of, and teaching in the elective course ‘Ethnic Diversity in Medical Practice’ for 2nd and 3rd year medical students	2010, 2013	6
- Assessing papers and teaching in the ‘practical nursing course at a health care institute’ (verpleeghulpstage)	2011, 2012	3
Tutoring, Mentoring		
- Tutoring medical students in writing papers for the elective course ‘Ethnic Diversity in Medical Practice’	2010, 2011, 2013	0,75
Other		
- Co-developer of the longitudinal thread on Diversity in the medical curriculum	2011-present	3

ECTS=European Credit Transfer and Accumulation System; 1 ECTS credit=28 hours

3. Parameters of Esteem

	Year
Grants	
- Funding obtained from ZonMw for following-up research project ‘Evidence-based cultureel competente zorg’.	2013
Awards and Prizes	
- ZonMw Parel voor project ‘Evidence-based cultureel competente zorg’.	2013

Curriculum Vitae

Conny Seeleman was born on June 19, 1976 in Amstelveen the Netherlands. After completing her secondary education at the Hermann Wesselink College in Amstelveen in 1994, she started studying Dentistry at the ACTA in Amsterdam. This study did not meet her expectations, so she stopped and spent four months in Tanzania as a volunteer. In 1998 she started the MSc program Nutrition and Health at Wageningen University and Research Center. In 2002 she obtained her Master's degree, and finished her studies with a master thesis on 'Health care needs of Chinese elderly': Conny's first introduction in the field of ethnic diversity in healthcare.

In 2003 Conny started working at the Department of Public Health of the Academic Medical Center (AMC-UvA) in Amsterdam. The first project she worked on was the development of the case study book 'Een arts van de wereld' ('a physician of the world'). In retrospect, this was the start of her PhD-trajectory. From 2008 to 2013 she conducted the other studies underlying her PhD-thesis, including a project on pediatric asthma and the project Evidence – based culturally competent care. The latter project was awarded a ZonMw 'Parel' in 2013 (http://www.zonmw.nl/nl/over-zonmw/parels/culturele-competentie-in-de-zorg/). During her projects, Conny has been involved in many cultural competence teaching activities, in which she developed trainings and taught medical students. Currently she is working as a postdoc researcher at the Department of Public Health of the AMC, conducting a qualitative study on ethnic differences in quality of care for colorectal cancer (funded by the Dutch Cancer Foundation/KWF Kankerbestrijding) and an implementation study aimed at the improvement of the diversity-content of medical curricula (funded by ZonMw).

Conny is married to Robert van der Boon, and they have two children: Sietse (2006) and Koen (2008). They live in the small village Bilderdam, at the edge of the 'Green Heart' in the Netherlands.