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