
Gabriela Elfriede Berger[2], Anita Peerson[3]

Abstract

In the 21st century, cultural competence training of the clinical workforce has become a key approach in English-speaking countries to improve the health outcomes of its culturally and linguistically diverse (CALD) populations. Health care delivery has rests upon the shifting sands of migration, globalisation, environment, demography, morbidity and mortality. Core cultural competence training approaches from the disciplines of public health, allied health, nursing, medicine, psychology and psychiatry were reviewed. A new cultural competence model was developed due to these models: i) using numerous definitions; ii) describing different segments of the cross-cultural interaction between patients and health professionals; iii) lacking description, content and depth; and iv) conflating culture with race and ethnicity. The innovative Continuum Model advocates a 3-step approach to training the clinical health workforce that can be applied in any health care setting. The dynamics of health and ethnicity in the local CALD context are explored, then the mediating influences within and outside culture are examined, and finally strategies to achieving cultural competencies in the clinic are provided. This practical model, implemented since 2010, ultimately demonstrates on how providing patient-centred, culturally sensitive care at a health service in Queensland, Australia can be achieved in other cultural contexts and settings.

Keywords: Health Professional Training, Cultural Competence Model, Culturally and Linguistically Diverse (CALD) Populations, Patient-Centered Health Care, Australia

Introduction

In the 21st century, cultural competence training has become a principal means to address health inequalities and
improve health outcomes of culturally and linguistically diverse (CALD) populations in English-speaking parts of the world (Like, 2011). ‘Health inequalities’ refer to the differences in health status that can be measured and are preventable and unjust: this includes the environment, access to and utilisation of health services, and the quality of care (Baquet, 2002, p. 427). Patients’ health illiteracy, a pressing concern of CALD populations, is also rooted in the flaws of the health care system: research has shown that on the one hand the communication of scientific evidence is often incomplete and/or not transparent and on the other hand patients require better health literacy (Gigerenzer & Gray, 2011). Improved guidelines and procedures in health care systems and public education are deemed effective interventions. There is consensus regarding the treatment of patients from diverse cultural backgrounds: cultural competence training has been shown to heighten clinicians’ cultural awareness and enable them to translate their knowledge into skills thereby decreasing the risk for disparate care and poor health outcomes (Mostow et al., 2010).

‘Competence’ refers to the capacity of functioning within the context of cultural beliefs, behaviours and needs of patients and their families, and carefully considers the impact of ethnicity, culture and language of both parties: each health encounter is a unique cross-cultural encounter (Like, 2011, p. 202). ‘Cultural competence’ is broadly defined as creating a health workforce capable of delivering continuous, high level of care to all patients regardless of factors such as culture, ethnicity, gender, age, or language (Betancourt & Green, 2010, p. 583). Clinical outcomes which are compromised by poor adherence to medication, medical errors and lack of follow-up can be significantly improved when limited health literacy and cultural differences are addressed (Betancourt & Green, 2010). Culturally competent clinicians promote patient health outcomes when using communication models based on patient participation in health care decision-making: this boosts patient adherence to management plans and attracts higher patient satisfaction ratings during episodes of care (Epner & Baile, 2012; Mostow et al., 2010).

A Review of Current Cultural Competence Models in Health Care

While cultural competence training of the clinical workforce has become a professional imperative, the goal of integrating culture into clinical care remains largely elusive (Epner & Baile, 2012; Kleinman & Benson, 2006; Teal & Street, 2009). Culturally competent care is not visible in everyday practice. A recent Australian study revealed clinical supervisors were unable to define cultural competence and could not apply the concept to teaching junior doctors to become culturally competent in the hospital setting (Berger, Peerson, Conroy, & Brazil, 2014). Difficulties include: the fluid use of terminology as new terms are coined and used interchangeably. That is, the term ‘cultural’ is often followed by awareness, sensitivity, practice, safety, respect, security, diversity and humility, with a more recent emphasis on ‘competence’ (Grant, Parry, & Guerin, 2013; Thackrah & Thompson, 2013). Truong, Paradies & Priest (2014, p. 15) confirm ‘there is no uniform definition or framework of cultural competence that is accepted across the spectrum of health contexts/settings either within or between countries.’

Although most definitions embrace an aspect of culture, the meaning, application and focus vary. Cultural awareness training emphasises the positive aspects of diversity and activities focus on drawing attention to a culturally diverse population via cultural artefacts (e.g. food, beliefs, religious practices, dress). Cultural competence however focuses on how health professionals can incorporate strategies and collaborate to ensure the best health outcomes for all patients, regardless of cultural background and language, age and gender, education and income (Betancourt & Green, 2010; Epner & Baile, 2012).

Many cultural competence models are critiqued because they: i) conflate culture with ethnicity; ii) fail to consider the diversity of individuals within a single culture; iii) exaggerate cultural differences; iv) overlook biomedicine as a cultural system; v) view culture as static; vi) simplify culture as a ‘list of traits’; and vii) examine fragmented and out of context versions of the communication exchange in the clinic (Epner & Baile, 2012; Grant et al., 2013; Kleinman
Current trends in cultural competence training informed the concept of the Continuum Model which is symbolised as a tree (see Table 1). The Continuum Model serves as a practical training guide for health professionals in various cultural and organisational settings in Australia and overseas, by suggesting educational content and outcomes: thus linking theory to practice. The symbolic nature of a tree with roots of knowledge, leaves of change and fruits of wisdom is analogous. Entry level is fluid and can be at any theme, but this depends on participants’ previous knowledge: a bottom-up approach is suggested for novice clinicians and for each theme a workshop is suggested (Figure 1). Flipping the classroom (by delivering print, audio or video material prior to a workshop) is effective as it encourages active participation and deep level learning that can be further explored in face-to-face workshops. Each workshop can be shortened or expanded to address variations in training requirements. In particular, Theme 1 in ‘Roots of Knowledge - Population Health’ represents an innovative yet indispensable component not previously included in training models.

Theme 1: Roots of Knowledge –Population Health, explores the health of ethnic and marginalised groups; this approach provides a rich learning experience from which many lessons for clinical practice can be drawn. Discussion topics include the health of refugees, migrants, CALD and Indigenous people by examining recent trends in morbidity and mortality, equitable access to services for various urban and rural population groups by gender, age and education, as well as the predisposition of sub-population groups to high morbidity and premature mortality due to the social determinants of health. Migrant and Indigenous populations from around the world (e.g. United States, Canada, United Kingdom, New Zealand, Australia), have experienced marginalisation and health inequalities with regard to health insurance, access to care, life expectancy, and are affected by high rates of acute and chronic diseases (Australian Bureau of Statistics, 2016; Kagawa-Singer & Kassim-Lakha, 2003; Mortensen, 2010; Reading & Nowgesic, 2002).

In Australia for example, the incidence of chronic morbidity due to cardiovascular disease, diabetes, infectious diseases as well as health risk factors (e.g. smoking, alcohol use, physical activity, overweight and obesity) for indigenous people are significantly higher than for non-Indigenous people (Australian Bureau of Statistics, 2016). The provision of culturally competent health services for these vulnerable populations is critical. Current variable health outcomes are exacerbated by inadequate access to and variable understanding/affordability of medications, their efficacy and side-effects, low health literacy skills and English communication skills, poor instructions on labelling, medical terminology, and complex drug regimens. When medication and/or labelling advice is unclear or misunderstood, it can result in increased hospital re-admissions: this health risk behaviour of patients is often referred to as non-compliance. The use of this term is unsuitable as it assigns all responsibility to the patient for not ‘complying’ and masks variable standards of inadequate service provision at the point of care (Davidson, 2010; Hamrosi, Taylor, & Aslani, 2006, pp. 2-4).

Research has demonstrated that patients with the same illness have very different outcomes (Friel & Marmot, 2011). The aim of this workshop is to provide clinicians with an overview of the complexity of patients’ health experiences and alert them to health problems within their own practice and geographic region, to examine morbidity and mortality patterns among at risk groups, plus cross-cultural, language and communication factors, so that they can
modify their approach to patient-centred care (Epner & Baile, 2012; Fiscella & Epstein, 2008).

The issue of social justice is at the forefront of discussions, and practical activities focus on the social determinants of health. With increased awareness, clinicians can work more actively on reducing health inequalities and inequities (e.g. improved primary care by offering screening and intervention to at risk patients), recognising the need for clear communication, providing extra health information (oral, written and in multiple languages), increased use of interpreter services, more frequent referral to members of multi-disciplinary health care teams, and ensuring follow-up to reduce avoidable hospital re-admissions. Clinicians will also become cognisant that most determinants of health are outside the jurisdiction of the health system (e.g. income, education, private health insurance, transport, housing, the cost and availability of medicines, geographic isolation, accessibility to health services), and therefore recommend more realistic expectations on what can reasonably achieved for inpatients and outpatients.

In Theme 2: Leaves of Change - Cultural Concepts in the Context of Change, the dynamic nature of culture and its influence on health is explored. Culture shapes health-related beliefs, behaviours and values, and is relevant in the clinic with regard to diagnosis, treatment and care (Kleinman, Eisenberg, & Good, 1978). A richer, more nuanced conceptualisation of culture within the social context is essential to develop a more structural understanding of this concept; to avoid a simplistic equation of culture with ethnicity. In the health care context, patients belonging to a particular ethnic group may not share many commonly observed characteristics and therefore individual differences should not be dismissed as random, idiosyncratic and meaningless (Lo & Stacey, 2008).

Cultural labels which prescribe what to do and not to do for a particular group of patients (e.g. Japanese, Arab) in terms of treatment are not very helpful as they mask diversity and focus on similarity. This is demonstrated by Kleinman & Benson (2006) in the case of a Mexican HIV positive male patient with a 4 year-old HIV positive son who did not attend clinics to receive required care. Non-clinic attendance was not attributable to cultural differences (health beliefs, being Mexican) but rather to socio-economic factors such as lack of time (the need to work long shifts/hours) and low income from a job as a bus driver. Biomedicine is also a health belief model: every health care encounter is a cross-cultural encounter and clinicians need to become aware of their own beliefs and values (e.g. when patients request a complimentary medicine approach such as herbalism, homeopathy).

Theme 3: Fruits of Wisdom – Clinicians and Culturally Competent Care, offers pathways for clinicians on how to achieve culturally competent health care and optimal health outcomes for culturally diverse patients. Quality in clinical care involves recognising the patient's problem, diagnosis, management and follow-up. These are especially challenging where culture plays a role: differences in language, education, health literacy and health beliefs can affect communication and shared decision-making between clinician and patient, making it more difficult to grasp quickly what the problem is. Lack of problem recognition delays the provision of timely and appropriate care; when incomplete, subsequent diagnosis, management and follow-up will be inadequate (Fiscella & Epstein, 2008).

Vulnerable CALD populations experience a greater burden of disease, psychological distress and social problems; have higher risk factors (e.g., poor diet, physical inactivity, smoking); lack knowledge to access services in a timely manner; and are often unaware of health-promoting behaviours and preventive screening practices as these may not be formally practised in their countries of origin (e.g. applying sunscreen on sunny days, Pap smears, bowel cancer screening) (Australian Institute of Health and Welfare 2014, 2014; Dart, 2008; Harris & McDonald, 2009; National Preventative Health Taskforce, 2008).

Indigenous Australians continue to experience significant disadvantage such as high morbidity rates of preventable illness (due to smoking, alcohol/drug consumption, poor dietary choices, limited physical activity); low life-expectancy (9-12 years less than non-Indigenous Australians); poor access and utilisation of primary care services; socio-economic barriers (lack of income, high cost of health care, restricted public transport, lack of cultural
sensitivity by health professionals/services; rural and remote workforce shortages; and communication barriers such as English language, Indigenous status identification, lack of Indigenous staff, health literacy (Anikeeva, Katterl, & Bywood, 2012). ‘Closing the Gap’ initiatives at Australian health services have initiated strategies to enable Indigenous individuals to receive improved primary and hospital care for better health (Queensland Government, 2016). Indigenous Liaison Officers educate the workforce on Indigenous culture, and work with patients, community local elders and Indigenous health services at the grass roots level (Aboriginal and Torres Strait Islander Health Unit, 2015).

Clinicians caring for these patients require additional time to: elicit patients’ expectations and perspectives; complete an examination; give advice on primary health care and behavioural risk factors (e.g. nutrition, alcohol use); confirm patients’ understanding of their condition(s) and health care; address language barriers (e.g. using interpreters and translated health information); establish a rapport; reduce social and cultural distance by building trust and goodwill; coordinate and improve access to care; and encourage greater patient self-efficacy and follow-up visits (Fiscella & Epstein, 2008; Starfield, Gérvas, & Mangin, 2012). However, during periods of stress and time-pressure, clinicians are challenged to address patients’ complex needs and are more likely to resort to stereotypical thinking, conforming to preconceived notions and disconfirming data; and fostering miscommunication and misunderstanding. This situation arises due to disagreements about the illness, its treatment and the patient's role in health care, and may potentially compromise patient-centred care.

Clinicians are encouraged to: adapt their health service delivery at the point of care to each patient's individual needs in terms of their diagnosis, treatment and management; pay attention to their communication style; address any disparities in health literacy; and improve equitable access to services. Certain approaches that have been found helpful: ‘ask me three’ [questions] allows for an open, unstructured dialogue; the ‘teach back’ method involves asking patients to summarise and repeat information thereby laying bare any knowledge gaps; and practising cultural humility by developing a respectful partnership with patients, by exploring the goals and expectations they bring to the interaction.

The Implementation of the Continuum Model

The Continuum Model's 3- step approach offers a practical roadmap for continuous learning for health professionals, explores and reinforces key educational content, and through reflection, assists in the transition from cultural awareness to cultural competence. The bottom-up model commences with the big picture (the population), and drills down to cultures and sub-cultures to arrive at the individual: each interaction with a patient is a cross-cultural interaction. Organisational support for implementing cultural competence training has been provided by the Darling Downs Hospital and Health Service, Queensland, Australia, and remains embedded in the strategic plan and health policies to inform service delivery frontline service delivery (Queensland Government, 2016).

After piloting the Continuum Model in late 2010, the revised version was administered to junior doctors as part of their cultural competence training on a yearly basis from January 2011 onwards. By July 2016, around 322 junior doctors at different levels of training (interns, residents, international medical graduates) have received training and provided positive feedback in evaluations. Due to time pressures of busy clinical workloads, a blended delivery approach has been implemented with online learning (pre-workshop engagement) followed by a face-to-face workshop. The hospital’s online learning management system is accessible to all junior doctors, providing flexibility and ease of access. Pre-reading materials for each of the themes comprise of relevant journal articles, video clips, podcasts and quizzes. Each theme is then followed by a ‘flipped classroom’ where content is linked to clinical practice.
Conclusion

Cultural competence is defined by complexity: it moves seamlessly between different cultures, worldviews and health belief models, and regards each individual patient and health care encounter as a unique opportunity for clinicians to provide patient-centred care. The key outcomes of the Continuum Model are aligned with the Australian Safety and Quality Framework for Healthcare; including patient-centred care, access and equity to services, safety and quality, and workforce training (Australian Commission on Safety and Quality in Health Care, 2015). For the multi-disciplinary health care team, particular areas of action have been identified: increasing health literacy; addressing patient/family/carer input into shared decision-making; providing care which is culturally sensitive and respects cultures; and improving the continuity of care. It will remain a constant challenge for multi-disciplinary health professionals to incorporate the dynamics of cultural difference in patient-centred care and reduce health inequalities experienced by CALD patients. The Continuum Model focuses on how cultural competence skills can be acquired by clinicians to boost patients' trust, satisfaction and health outcomes.

Take Home Messages

Notes On Contributors

Dr Gabriela Berger is a medical anthropologist and public health specialist. She has been engaged in and passionate about the field of cross-cultural health since the completion of her PhD from Griffith University (1997), Brisbane, Australia. Her research interests include migrant and refugee health; health promotion; lifestyle and health; women's reproductive health; health literacy and medical education.

Dr Anita Peerson specialises in medical anthropology and public health. She has worked in various organisations addressing health workforce capacity-building and health service delivery issues, including ethnicity and culture. Her current work addresses health policy, research, health literacy, safety and quality, shared decision-making and community engagement aspects of patient-centred care.

Acknowledgements

Bibliography/References


http://dx.doi.org/10.1111/tct.12170


http://dx.doi.org/10.1097/ACM.0b013e3181d2b2f3


http://dx.doi.org/10.2471/BLT.08.020408


http://dx.doi.org/10.1016/j.hlc.2010.01.010


http://dx.doi.org/10.1001/archinte.168.17.1843


http://dx.doi.org/10.1146/annurev-publhealth-031210-101220


http://dx.doi.org/10.7551/mitpress/9780262016032.001.0001


http://dx.doi.org/10.1111/1753-6405.12067


http://dx.doi.org/10.3109/0142159X.2014.923821


http://dx.doi.org/10.1146/annurev-publhealth-031811-124528


http://dx.doi.org/10.1016/j.socscimed.2008.10.015


http://dx.doi.org/10.5694/mja13.10499


http://dx.doi.org/10.1186/1472-6963-14-99

Appendices
<table>
<thead>
<tr>
<th>Theme</th>
<th>Population Health</th>
<th>Core Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>At the Bottom: Roots of Knowledge</td>
<td>• Statistical data at the national, state and local level on trends in cultural diversity&lt;br&gt;• Population health patterns, morbidity and mortality, new and emerging trends&lt;br&gt;• Profiles of local CALD populations: migrants, refugees, newly emerging and Indigenous communities&lt;br&gt;• Health service indicators: equity and access to health services&lt;br&gt;• The social determinants and gradients of health&lt;br&gt;• The relationship between culture and health: implications for local health services</td>
<td>• Promote knowledge on regional cultural diversity and health profiles&lt;br&gt;• Explore health inequalities and access to health service are explored&lt;br&gt;• Examine the socio-cultural context of health inequalities&lt;br&gt;• Enable more complex, nuanced understanding and analysis of socio-economic and cultural barriers for patients&lt;br&gt;• Build awareness of social justice issues and how clinicians can use this information to improve health service delivery&lt;br&gt;• Connect with local communities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme</th>
<th>The Changing Nature of Culture</th>
<th>Core Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Middle: Leaves of Change</td>
<td>• Examination of core concepts central to the understanding of cultural competence&lt;br&gt;• Culture in context: clinicians and patients navigating the cultural chasm&lt;br&gt;• The mediating and changing nature of culture&lt;br&gt;• Moving away from cultural ‘facts’ and cultural ‘do’s’ and ‘don’ts’&lt;br&gt;• Valuing diversity: each health encounter is a unique cross-cultural encounter&lt;br&gt;• Exploring the role of health beliefs – when and how they are important</td>
<td>• Perform critical analysis of key concepts - essential for assessment and application&lt;br&gt;• Engage clinicians in cultural self-assessment at the individual level&lt;br&gt;• Examine the role of specific knowledge on cultures versus generic knowledge&lt;br&gt;• Alert clinicians to the over-simplification of culture for addressing bias, racism, prejudice and cultural stereotypes&lt;br&gt;• Undertake comparative analysis of patients’ and clinician’s health belief frameworks&lt;br&gt;• How health beliefs might affect treatment and care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme</th>
<th>Culturally Competent Care in the Clinical Setting</th>
<th>Core Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Top: Fruits of Wisdom In the Clinic: Clinicians &amp; Culturally Competent Care</td>
<td>• Patient-centred care in context: individualised health interventions&lt;br&gt;• Culture in the clinical encounter (e.g. health beliefs, religion, diet, physical activity)&lt;br&gt;• Intercultural and cross-cultural communication styles: power differentials&lt;br&gt;• The patient’s illness narrative&lt;br&gt;• CALD and indigenous patients with English as a 2nd 3rd or 4th language&lt;br&gt;• Health literacy&lt;br&gt;• Informed consent&lt;br&gt;• The social, psychological and economic impact of illness on patients, families, communities&lt;br&gt;• Empowering patients during consultations using these strategies: ‘Ask me 3’, ‘Tech Back’, ‘Cultural Humility’</td>
<td>• Adapt health service delivery to match each patient’s needs&lt;br&gt;• Implement communication strategies active listening and questioning skills, visual clues, differences in time allocation&lt;br&gt;• Develop strategies for the provision of health information at the right level&lt;br&gt;• Apply appropriate interpreter referrals&lt;br&gt;• Provide patient support, follow-up and collection of confidential patient feedback&lt;br&gt;• Ensure patient/care-family input in health care decision-making, offering culturally competent solutions&lt;br&gt;• Teach junior clinicians on how to become culturally competent&lt;br&gt;• Explore the impact of power/gender differentials between patients and clinicians</td>
</tr>
</tbody>
</table>
Declarations

The author has declared that there are no conflicts of interest.

This has been published under Creative Commons "CC BY 4.0" (https://creativecommons.org/licenses/by-sa/4.0/)