Client views about cultural competence in primary health care encounters

David R. Thomas
Social and Community Health
School of Population Health
University of Auckland
Private Bag 92019, Auckland
New Zealand
email dr.thomas@auckland.ac.nz

August 2007

Abstract
Given the multicultural composition of many populations, it is important to assess the extent to which health and human services are appropriate for the cultural background of clients. The present paper reports a qualitative study of client-reported experiences in encounters with primary health care providers (such as general practitioners and nurses) in New Zealand. Using an inductive analysis, three themes associated with provider cultural competence were identified from semi-structured and open-ended interviews with participants from several non-dominant ethnic groups. These themes were: (a) feeling welcomed and acknowledged, (b) shared communication and understanding, and (c) provider strategies which address the cultural styles and ethnic status of clients. The findings are compared with previous studies investigating cultural competence in service provider communication. Developing broad dimensions relating to cultural preferences in communication style can provide useful information for assessing satisfaction with health and human services in multicultural communities.

Introduction
Most countries, including New Zealand and Australia, have ethnically diverse populations, particularly in the larger urban areas. Given this ethnic diversity, it is important for evaluators assessing the effectiveness of health and human services to address the extent to which services and programmes are suitable or appropriate for the multiple ethnic and cultural groups represented among clients. The Australasian Evaluation Society Guidelines for the Ethical Conduct of Evaluations, (Australasian Evaluation Society, 2002), includes the following guideline under the heading "Consider implications of differences and inequalities." While not specifically mentioning culture or cultural competence, this concept can be seen to be implicit in the guideline noted below.

> *10. Account should be taken of the potential effects of differences and inequalities in society related to race, age, gender, sexual orientation, physical or intellectual ability, religion, socio-economic or ethnic background in the design conduct and reporting of evaluations. Particular regard should be given to any rights, protocols, treaties or legal guidelines which apply.*

In New Zealand it is now common for evaluation *Request for Proposals* from government ministries to specify that an evaluation should determine whether the delivery of services is culturally appropriate for clients, and whether agencies, programs and services being evaluated meet the specific cultural and ethnic needs of the clients.

The assessment of cultural competence in health and human services has at least two requirements; (a) clear identification of the dimensions or attributes underlying cultural competence and (b) trustworthy indicators to measure cultural competence. In this context trustworthy is taken to mean quantitative indicators that are valid, reliable and directly relevant to the service or programme being assessed. A brief perusal of literature indicates very few measures are reported. Those which are described are often focussed on very specific types of services, with sparse information about validity or reliability.

The origins of cultural competence derive from a concern to ensure that programmes for clients from non-mainstream or multiple cultural backgrounds are effective and safe for clients. While a common context is to ensure that services provided by people from the dominant ethnic or cultural group are suitable for clients from a specific minority or non-dominant ethnic group (e.g., Maori people in New Zealand, Aboriginal people in Australia), increasingly other contexts are relevant. These contexts include organisations having both service providers and clients from multiple ethnic groups. This raises the issue, which will be discussed in more detail later, as to whether service organisations should endeavour to match providers with clients of

the same (or similar) ethnicity or language, or whether they should fosters generic skills among providers for working with people from diverse ethnic groups.

In relation to the research literature there are a considerable number of reports discussing the importance of cultural competence generally, or in relation to specific services or specific non-dominant ethnic groups (e.g., U.S. Department of Health and Human Services Office of Minority Health, 2001; National Health and Medical Research Council, Australia, 2005). However there are relatively few reports which go into details about the specific attributes associated with cultural competence (e.g., Lieu, Finkelstein, Lozano, Capra, Chi, Jensvold, et al., 2004) and many of these are specific to particular ethnic groups (e.g., Kim, Bean, & Harper; 2004). As well there appear to be few descriptions derived inductively from clients or service providers' perspectives. Many are derived from a general theory or framework relating to cultural competence. The study reported here used inductive methods to investigate client perspectives.

A search of the relevant literature indicates that multiple meanings and definitions have been used to describe cultural competence. In some cases the term is used in research reports without any description or definition of its meaning. In the United States, the Department of Health and Human Services website has compiled a list of definitions of cultural competence (US Department of Health and Human Services, 2007). This website notes that no single definition of cultural competence has been broadly accepted, either in human services practice or in professional education. Most definitions contain a common element focussing on the awareness of key attributes of one's own culture in order to understand differences between the service provider's culture and the culture of a patient.

A typical definition included in the US Department of Health and Human Services, web site noted above is the following:

> *… a set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations. It reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices and communication patterns of clients and their families to improve services, strengthen programs, increase community participation, and close the gaps in health status among diverse population groups.* http://bhpr.hrsa.gov/diversity/cultcomp.htm

Another description, included in a 2001 report on National Standards for Culturally and Linguistically Appropriate Services in Health Care, noted that

> *Cultural competence includes being able to recognize and respond to health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Examples of culturally competent care include striving to overcome cultural, language, and communications barriers; providing an environment in which patients/consumers from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options…* (U.S. Department of Health and Human Services Office of Minority Health, 2001, p. 7)

A more specific framework has been outlined by Reimann et al (2004) in their research among physicians treating Mexican-Americans with diabetes. They described cultural competence as comprising three general factors; cultural knowledge (a physician's familiarity with facts relevant to Mexican Americans with diabetes), cultural awareness (the manner of feeling and thinking that shows physicians' disposition or opinion toward cultural issues relevant to Mexican Americans with diabetes) and culturally appropriate behaviors (specific actions physicians reported taking). (p. 2198)

For the current project the working definition of cultural competence adopted was;

> *The delivery of programs and services so that they are consistent with the cultural identity, communication styles, meaning systems and social networks of clients, program participants and other stakeholders.*

In terms of identifying research needs for cultural competence, there is a need to identify key dimensions and develop suitable measures relevant for multiple types of health care services such as general practice, accident and emergency care, and nursing services. The dimensions are likely to be more robust if they are based on the perspectives of both service providers and clients and include accounts of clients from a range of non-dominant ethnic groups with both positive and negative examples. As well it will be useful to obtain health providers accounts of strategies they use with non-English-speaking clients.

The research described in this report was originally commissioned and funded by the New Zealand Ministry of Health in 2003. Its purpose was to gather information about consumer experiences and expectations of primary health care, consumers' knowledge about and responses to the restructuring of primary health care services into larger clusters, referred to as PHOs (primary health care organisations). The main report resulting from that study was completed in 2004 (Kerse et al, 2004). The objective of the additional analysis of the dataset reported here was to identify specific themes related to culturally competent service delivery for clients from non-dominant ethnic groups. A secondary objective was to relate the identified themes to any identified in previously published research on cultural competence.

Methods

Qualitative data-gathering procedures were used to explore client's experiences of primary health care. A qualitative design was used to obtain in-depth information and specific stories and experiences about primary health care. This method was intended to allow clients from diverse ethnicities, ages and health status to tell their stories in their own way. A purposive sampling frame was used. Health support agencies, community groups, primary health organisations as well as Māori and Pacific providers were used to contact participants. Multi-site ethics approval was obtained from the following regional health ethics committees; Auckland, Wellington, Otago, Canterbury and Nelson Marlborough.

Samples

Three specific types of samples included in the survey (a) 60 face-to-face interviews with individuals and couples (b) 22 focus groups involving a total of 128 people and (c) 63 computer assisted telephone interviews (CATI). The regions sampled included Northland, Auckland, Wellington, Nelson Marlborough, Otago and Canterbury. The telephone interviews were focussed on participants living in the South Island to ensure inclusion of people from this region. Potential participants were recruited with the assistance of health agencies such as the Arthritis Foundation, Stroke Foundation, Communicare, primary healthcare organisations and general practices. As it was important to include the views of clients from multiple ethnic groups, a specific focus was recruitment of Maori and Pacific participants for the face-to-face interviews and focus groups. The sample included 41 Māori, 45 Pacific people, 9 Asian and 170 Pakeha (New Zealand European) and other ethnic groups. The ethnic composition of participants across the three data-gathering methods is shown in Table 1. The ages of participants were between 16 and 90 years.

Table 1: Ethnic composition of samples

	Maori	Pacific	Other ethnic groups
Face-to-face interviews	12	8	40
Focus groups	4	6	12
Phone Interviews	2	0	61

Data collection methods

Data collection involved three methods which were; (a) face-to-face interviews undertaken in the participant's home or community hall, (b) focus group interviews undertaken in community centres and (c) telephone interviews undertaken with participants at their home. Interview guides were developed after consultation, key informant interviews and a literature review. The main section of the interview, relating to client experiences of primary healthcare, included the following prompts and questions:

- Tell me about a visit to your family doctor or other health service that went well for you.
- What made it go so well?
- Tell me about a visit that didn't go well.
- How could it have been improved?

Data Analysis

The general inductive approach (Thomas, 2006) was used to analyse the qualitative data to identify themes in the text data that were related to the research objectives. Once the data files were cleaned and put into a common format, the analysis commenced with a close reading of the text, which was carried out by two members of the research team. During the analysis, specific themes were developed, which in the view of the investigators, captured core messages reported by participants. The original analysis carried out by two members of the research team (Jeanne Reeve and Kay Mitchell). The findings were reported as core themes which captured core messages reported by interviewees (Kerse et al, 2004). A subsequent analysis was

carried out by the author to identify themes relevant to cultural competence. In this analysis the primary focus was on accounts provided by Maori, pacific and Asian participants in the face-to-face interviews and focus groups.

Findings

From the analysis of comments relating to experiences of primary healthcare services among the research participants, three broad themes were developed:

- Feeling welcomed and acknowledged
- Shared communication and understanding
- Provider strategies which address cultural styles and ethnic status of clients

Each theme is described in more detail below.

Feeling welcomed and acknowledged

The key attributes of feeling welcomed and acknowledged were the client being acknowledged as a person, being made to feel they have a right to receive the service and being included in ongoing social rituals (e.g. offered refreshments). Some examples of comments which illustrated this theme were:

> *The staff at the hospital go "hello aunty! How are you today?" You know, they make you feel like you're part of the family.*
>
> *I got in there, while they were examining me and they were taking a cup of tea around all the patients, and they asked me if I wanted a cup of tea and a piece of cake, and I felt so included in their area. I suppose it's about attitudes again.*
>
> *The doctor I have is very popular because of her approach and her user-friendly attitude. Just that extra care. She is not Maori but she is so friendly with Maori people.*

Sometimes respondent gave examples of what they had observed happen to other people, in this case a negative example:

> *The dental workers were not clear. They probably were [migrants]. They don't make things clear. Also when I was sitting there, a young Maori boy came into the clinic too. I don't like the way they confront him, the way they talk to him. Communication wasn't there…*

Shared communication and understanding

A key issue for many clients was the provider communicating effectively regardless of differences in ethnicity culture or language background. This often involved the provider taking extra time to allow for differences in cultural or communication styles and the provider getting to know the client as a person. In some instances the provider spoke the same (non-dominant) language as the client. In other instances the provider took additional effort or time to understand the client and to make sure the client understood what the provider had to say.

> *I think that there is more unhappiness from a lot of the Maori people. It is difficult to attract Maori health care providers for people who speak Maori. A really nice young doctor was very fluent in Te Reo. … And the patients loved him, some of the older patients could only explain their medical problems in Maori and when he left he left a huge gap.*
>
> *He has a very popular service because there are lots of Chinese migrants in the area. It is easy to communicate with him and easy for him to diagnose problems as he knows Chinese health problems. He is a good communicator and it is nice that he speaks the same language*

Provider strategies which address cultural styles and ethnic status of clients

The third general category referred to providers adapting their communication styles to be suitable for clients where the client's ethnicity, culture or social status was different from provider. This could involve taking additional time or special care with communication. Often there would be an indication of the provider's awareness of the possible influence of client's prior experiences of discrimination. As well, the provider was aware of and avoided culturally inappropriate behaviours for the client.

> *It is good because they understand the culture. The GP really makes effort to make sure I understand the message and that my mum understands from me what is wrong. [Mum doesn't speak English]. Gives us extra time because of the language barrier.*

In some cases negative examples were given, which illustrated providers not being sensitive to the cultural background of clients.

> *The services over the years for me have changed cause there are a lot of new people, and they don't know us, they've come from overseas and they don't know about Maori people, they don't know about their needs, they don't know how sensitive we are. And some of our people will stop going to the doctors because of that.*

> *For example, when I went to the doctors they stuck a thermometer in my mouth when I was in the foyer, being examined in the foyer this is not appropriate, many Maori are shy.*

One feature of note about the three themes was that many of the comments came from Maori respondents. Further investigations would be required to assess to what extent the three themes identified are generalisable across multiple ethnic groups.

Another point is that sometimes comments may include content that covers more than one theme. A quote in a doctoral dissertation, on clients' experiences with a mammography screening programme, reported the following comment from a participant:

> *When I first went for breast screening I was left in reception* [with] *no one to reassure me.* [I was] *then taken to a cubicle to strip off – still no reassuring words, taken in for the procedure, nothing reassuring there either.* [I was] *left in the cubicle again, then some time later told that I could leave. SURELY, a smile, a few reassuring words, even a bit of friendly banter couldn't hurt? It would certainly help me. It is difficult for some people to uncover parts of their bodies, let alone giving a stranger the opportunity to squeeze the heck out of them. Reassurance, a friendly smile and some friendly banter would go a long way to helping relieve the stress. TRY IT!!* (Brunton, 2000, p. 290).

The experiences reported in the above comment seem to cover all three of the themes identified, although the ethnicity of the client was not reported.

Discussion

The themes identified as underlying cultural competence are intended to be a contribution to the development of more detailed descriptions of cultural competence in health and other human services. Developing specific dimensions relating for example, to cultural preferences in communication style, can provide useful information for assessing satisfaction with health and human services in multicultural communities.

When compared to previous studies, the themes outlined here are generally consistent with previous research on cultural competence. A number of previous studies have highlighted the importance of shared communications and understanding between clients and providers. These include; the role of effective communication for patient satisfaction among American Indian older adults (Garroutte, Kunovich, Jacobsen, & Goldberg, 2004), and immigrant women and refugees from Middle Eastern and Sahel African backgrounds in Australia (Manderson, & Allotey; 2003).

The three themes described add to the existing knowledge about cultural competence in primary healthcare services. Further research could focus on the extent to which these themes are relevant across multiple cultural groups and across multiple types of services. A further area of application is in the training of health and human services staff who provide direct services to clients.

References

Australian Evaluation Society (2002). *Guidelines for the Ethical Conduct of Evaluations.* (URL: www.aes.asn.au). Accessed 23 August 2007.

Brunton, M. (2000). A changing dialogue within health communication in New Zealand. Doctoral thesis in Management Communication, University of Waikato, Hamilton.

Garroutte, E. M., Kunovich, R. M., Jacobsen, C., & Goldberg, J. (2004). Patient satisfaction and ethnic identity among American Indian older adults. *Social Science & Medicine, 59*, 2233–2244.

Kerse, N., Thomas, D.R. Neuwelt, P., Crampton, P., Dixon, R. Dyall, L., Reeve, J., Mitchell, K., O'fanoa, M., Mahony, F., Patrick, D. (2004) *Consumers' Views and Experiences of Primary Health Care in New Zealand: A Snapshot*. (Report on contract research for the Ministry of Health, Wellington). Auckland: School of Population Health, University of Auckland.

Kim, E. Y. K., Bean, R. A., & Harper, J. M. (2004). Do general treatment guidelines for Asian American families have applications to specific ethnic groups? The case of culturally competent therapy with Korean Americans. *Journal of Marital and Family Therapy, 30(3)*, 359-372.

Lieu, T. A., Finkelstein, J. A., Lozano, P., Capra, A. M., Chi, F. W., Jensvold, N., et al. (2004). Cultural Competence Policies and Other Predictors of Asthma Care: Quality for Medicaid-Insured Children. *Pediatrics, 114(1)*, 102 - 110.

Manderson, L., & Allotey, P. (2003). Cultural politics and clinical competence in Australian health services. *Anthropology & Medicine, 10(1),* 71-85.

National Health and Medical Research Council, Australia (2005). *Cultural competency in health: A guide for policy, partnerships and participation*. Canberra: Author. Online document. (URL: http://www.nhmrc.gov.au/publications/synopses/_files/hp19.pdf)
Accessed 27 August, 2007.

Reimann, J. O. F., Talavera, G. A., Salmon, M., Nunez, J. A., & Velasquez, R. J. (2004). Cultural competence among physicians treating Mexican Americans who have diabetes: a structural model. *Social Science & Medicine, 59*, 2195–2205.

Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation, 27(2),* 237-246.

U.S. Department of Health and Human Services Office of Minority Health. (2001). *National Standards for Culturally and Linguistically Appropriate Services in Health Care.* Washington, DC: Author.

US Department of Health and Human Services (2007). *Definitions of Cultural Competence*. Health Resources and Services Administration.
(URL: http://bhpr.hrsa.gov/diversity/cultcomp.htm). Accessed 23 August 2007