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Walden University

College of Health Professions

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Wayne M. Boatwright

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Walden University
2021

Abstract

Perspectives of Physicians Mandated to Complete Cultural Competence Education

by

Wayne M. Boatwright

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy in Health Services

Walden University

May 2021

Abstract

Studies show that ethnic and racial disparities continue to exist in health care delivery. The economics of today's multicultural world along with changing demographics and persistence of inequality in healthcare have challenged healthcare professionals to consider cultural competency (CC) training to assist in eliminating health disparities. The purpose of this study was to identify the perspectives of physicians who were mandated to complete CC education. The conceptual framework used the Purnell model for cultural competence. For this single case qualitative study, data were collected using semi structured interviews.. The study involved a descriptive examination of 10 physician's perceptions and experiences who had privileges at one hospital system in New Jersey and were mandated to complete 6 hours of CC education. Data analysis involved digitizing records and cutting them into pieces using Microsoft Word and Microsoft Excel and as a result, four themes were generated. All study participants revealed a lack of CC education early in their career and medical school. Participants generally found less of a need to enroll in CC elective courses in medical school. During clinical rotations, CC importance was difficult to ascertain. Furthermore, CC education had varying degrees of importance with each specialty in residency and fellowship. Overall, all participants agreed that CC education was important to patient outcomes and their practice and should be mandated. The findings positively impact social change by supporting the continued mandating of CC education as a means of enhancing physician-patient relationships.

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Dedication

I dedicate this work to two of the most important women in my life. First, my mother Alethia Washington-Boatwright who passed away before she was able to see the work completed. Mother was my biggest supporter and understood the value and impact of this journey and the importance of commitment and never let me forget my responsibility to give to others.

I also dedicate this work to my wife Carol Gene Bragg-Boatwright. I am thankful for Carol's endless support, belief in this work and her selfless commitment of financial support, patience love and understanding during this very long and often challenging journey. I could not be more in love and grateful to anyone in my life.

Acknowledgement

First a foremost, thank you to Dr. Jamuir Robinson who is my chair. She provided endless supporter during our time together. She was always professional, encouraging, and available for any of my needs during this incredible journey. I could not be more grateful. Another special thanks goes out to Dr. Dixon- Lawson, an important member of my committee. Her expertise in helping me complete this work has been invaluable.

I also want to give a very special recognition to Fatima Khan who was our Research Assistant at work – she has been a voice of reason over the last few years. There is no way I could complete this work without your support, so thank you! I have been blessed by knowing you. In addition, thank you to the rest of my team at work—Tracey, Darryl, Barbara, Avonia, Nyrie, Arlene, Mercedes, and Jessica. When I was tired you became my strength, and truly saw my success as your success. You understand greater than most, the value of cultural competence in healthcare. Finally, I want to acknowledge my incredible family for their support, and always providing the feedback that I can do this and need to do this!

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Chapter 1: Introduction to the Study

Introduction

Racial and ethnic minorities make up at least 30% of the U.S. population. Steady changes in the demographics of the U.S. highlight the demand for cultural awareness and sensitivity in the clinical environment. The percentage of minorities in America is projected to exceed 50% by 2056, with a far less proportionate rise in the number of minority physicians and medical students (Bernstein, 2012). Cultural competence (CC) has become increasingly concerning and a national concern due to greater concerns on racial and ethnic health disparities and the need for health care systems to include diverse patient populations. Providing culturally competent services is proposed as a key strategy to help lower racial and ethnic disparities in health care (Like, 2011). Training physicians to care for diverse populations is essential.

Currently CC is among the interventional offerings in healthcare that has been explored to address this demographic shift. Healthcare professionals are expected to understand and be sensitive to patients with different cultural backgrounds. Various universities and medical schools have developed programs that explore and examine cultural competency.

One such university, Wake Forest University has developed a culture and diversity course, which is theoretically based, and is a yearlong cultural competency-training program for second year medical students (Crandall et al., 2003). The program is

based on 27 core competences outlined in the American Medical Student Association's Promoting, Reinforcing and Improving Medical Education project (AMSA PRIME). A key strategy to reduce health disparities and promote health equity is to integrate education and training that prepares future physicians to provide culturally responsive care.

Other universities that developed programs on cultural competency include: (a) University of Massachusetts Medical School, which has an ongoing cultural competency faculty development program to directly and indirectly elevate the quality of faculty teaching through behavioral modeling; (b) University of Sydney, which has integrated Personal and Professional Development (PPD) as one of their four themes of their longitudinal medical training program; and (c) Wellington School of Medicine and Health Sciences, which created an immersion model designed to promote learning about other cultures and providing opportunities for students to learn principles linked with cultural safety (Hobgood, 2007). These instructional efforts regarding cultural competency were underway, and medical schools were benefitting from topics presented by their colleagues. These trainings aimed to prepare physicians to be ready to work and offer services in any area they are assigned with the confidence to promote health equity and cultural sensitivity.

The Association of American Medical Colleges (AAMC) staff and panels reviewed more than 100 general studies on CC published between 1995 and 2013. Some studies attempted to establish instructional effectiveness by implementing existing scales,

surveys, and exams to measure learning—others developed new instruments. The panel identified issues on cultural competency education provided in the published literature and strategies to support future work in CC. For example, they found a lower level of evidence abound in the literature evaluating CC education and training. There were also difficulties measuring learning outcomes and objectives with varied teaching formats.

There are several mandates that still support CC education and training of physicians. Researchers are working tirelessly on factors that affect training and CC education that involves the outcomes of patients (Betancourt, 2003; Crampton, 2003). According to researchers, nurses, health professionals and physicians, all realized that CC is crucial in providing awareness, skills, and knowledge and provides a greater opportunity to participate in health matters of their patients (Allen et al., 2009).

In this study, I specifically detailed physician perceptions of the CC training efforts in New Jersey. Cultural competency is at the core of high quality, patient-centered care, and it directly impacts how care is delivered and received (Lehman et al., 2012). Again, it is important that health providers seek to understand the community and socio-cultural environments that influence patients' beliefs about illness and disease, and the values that patients assign to various elements of the health system (Betancourt & Green, 2010). This chapter covers background and statistical information on cultural competency education, presents a statement of the research problem, describes the purpose and nature of the study, discusses assumptions, defines the scope and delimitations, and presents the significance of the study.

Background

Over the past decade, medical schools have been weaving disparities-related issues into required courses to assist in developing culturally competent physicians (Jeffereys, 2010). This approach has led medical schools to focus on broadening students' understanding of the impact of stereotyping in medical decision-making and helping them to devise strategies that counteract bias in clinical practice (Dy & Nelson, 2011). Accrediting bodies and state laws that require cultural competency to be incorporated into curricula of state-run medical schools has helped to fuel this insertion into the curriculum (Jeffereys, 2010).

In 2005, New Jersey began requiring physicians to take continuing medical education courses that provide grounding in culturally competent patient care, in addition to all other CME courses needed to maintain their licenses (American Medical News, 2005). California took a different approach with its 2006 law and deemed that all courses, including CME courses, taught to physicians must contain clinically relevant cultural and linguistic information (American Medical News, 2005). The Patient Protection and Affordable Care Act (ACA) of 2010 includes important provisions related to CC education, health disparities elimination and research, workforce diversity, and related minority health initiatives (Andrulis, 2013).

In addition to ACA's provisions requiring cultural competency education, some state legislatures are now developing laws and policies to close the health disparities gap, and therefore are requiring continuing cultural competency education as a condition of

professional licensure. Furthermore, national accrediting bodies including the Joint Commission, National Committee for Quality Assurance (NCQA), and National Quality Forum (NQF) provided best practices and required healthcare organizations to show improved communication, patient- and family-centered care, CC, and language access within hospitals, and throughout managed care plans (Like, 2011). The Liaison Committee on Medical Education initiated a requirement in 2000 that faculty and students should display “an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness, and respond to various symptoms, diseases and treatments” (Dy, Nelson, 2011).

Attitude of physicians Being Mandated to Complete CC Training and Education

Over the past decade, medical schools have been weaving disparities-related issues into required courses to produce culturally competent physicians. Accrediting bodies and state laws that require cultural competency to be incorporated into curricula of state-run medical schools has fueled the move (Venturin et al., 2013). A wealth of research and studies has shown that ethnic as well as racial disparities exist in healthcare. It is unclear how to address these disparities, which remains one of the most debated and researched topics among medical professionals. An approach that continues to gain momentum is the idea of mandating CC training for physicians (Chun et al., 2010).

Researchers, authors, and supporters of mandated training continue to point to many quality studies that show that patients from minority groups have worse outcomes in the healthcare system than white patients (Crandall et al., 2003). There continues to be

a great deal of controversy over the issue of mandated CC training with members of the medical community mounting the strongest opposition to increased mandatory education. There are also leaders in healthcare that have been passionately in favor of mandatory education (Adams, 2005).

Statement of the Problem

Although, there is little to no literature indicating a positive change in the patient relationships when their physician has been mandated to complete cultural competency training, lack of CC in healthcare can have life-threatening implications (Saha, 2008; Lie, 2011). However, with appropriate training and guidance from cultural competency providers, many of these issues can be both addressed and overcome. Paez et al., (2009) found that patients of physicians who were more motivated to learn about cultures within their practice and society were more satisfied with the medical visit, perceived their physicians to be more facilitative when their physicians shared more about their culture. This study was one of the first to examine the association of physician self-reported CC with regards to the quality of the patient-physician relationship and patient participation in care (Paez et.al., 2009).

The review of the literature on disparities and possible improvement through cultural competency education provides encouraging reason to believe that careful and appropriate implementation of sound CC practices are important to consider. The field of CC had been developing in recent years as part of the strategy to overcome cultural

differences in health services. The signs of a difference in cultural perceptions between patients and medical staff can be difficult to detect.

In addition, we still did know how physicians perceive mandated CC education. A physician who had been mandated to complete CC education may resent the implication that they may not understand what the best cultural and clinical approach is for their ethnically diverse patient. Ignoring diversity and providing culturally incongruent care can adversely affect patient outcomes and jeopardize patient safety (Berger et al., 2011). This research study investigated CC training and its impact on patient interactions from the physician's perspective. To achieve this, this study looked at the role of physician's knowledge and experience in shaping their competence and skills. Additionally, this study looked at the perceived cultural gap that the physicians feel exist between them and their patients.

Purpose of Study

The purpose of this study was to understand the attitudes about CC education and its possible effects among physicians who were mandated to complete cultural competency education and training. This study used a phenomenological approach and case study design to examine the experience of physicians who have undergone CC education and training efforts in New Jersey. The study looked at the role and importance of this training and education to physicians. The study delved into whether physicians felt there was improvement in physician and patient communication and collaboration since being educated in CC. The aim was to engage in a robust discussion around whether the

physician felt CC increases patient satisfaction, enhances adherence, and if they felt CC improves clinical outcomes will occur during the interviews.

Research Questions

Research Question 1: What are physicians' perspectives on the experiences of completing mandated CC training?

Research Question 2: What are physician's perspectives of self-directed CC training?

- How do physicians feel it impacts their experiences with their patients?
- How do physicians feel it impacts their confidence when dealing with patients from other cultures?
- What are physician's perspectives about CC training being employed as a part of the health care customer-oriented reforms?

Research Question 3: What are physicians' perspectives on the impact their CC training has had on the clinical outcomes of their patients?

Research Question 4: What are physicians' perspectives on having the CC training be mandated instead of voluntary?

Theoretical Framework/Conceptual Model

The Purnell model of cultural competence is proposed as an organizing framework to guide CC among multidisciplinary members of the healthcare team in a variety of primary, secondary, and tertiary settings (Purnell, 2005). On a micro level, the model has an organizing framework consisting of 12 domains, constructs, and their concepts, which are common to all cultures, subcultures, and ethnic groups. These 12 domains are

interconnected and have implications for health. This organizing framework stems from its concise structure, which can be used in any setting and applied to a broad range of empirical experiences to assess cultural domains. They can be used to formulate questions and statements for conducting research. Once cultural data are analyzed, the practitioner can fully adopt, modify, or reject healthcare interventions and treatment regimens in a manner that respects the client's cultural differences. These adaptations improve the quality of the client’s healthcare experiences and personal existence. The circle’s dark center is the unknown phenomena. The jagged line on the bottom is the nonlinear concept of cultural consciousness.

The 12 cultural domains include: overview/heritage (country origin, residence, topography effects, economics, politics, education); communication (language and dialects, paralanguage variations, willingness to share thoughts, nonverbal communication); family roles and organization (head of household and gender roles family roles, age roles, extended family members, social status); workforce issues (autonomy, acculturation, assimilation, gender, ethnic communication type, individuality); bicultural ecology (variations such as skin color, physical differences in body stature, genetic, heredity, endemic, and topographical diseases); high-risk behaviors (tobacco, alcohol, drugs, low physical activity); nutrition (proper food; food meaning; food preferences, rituals, and taboos); pregnancy (fertility, birth control practices, pregnancy views, and taboo methods); death rituals (perception of death, death cultural rituals and behaviors, and burial methods); spirituality (religious methods, prayer, life

meaning, basis of strength); health care practices (acute or preventive; traditional, religious, and biomedical views, health responsibility, self-medication methods, and opinions on mental illness and organ donation); and health care practitioner (status, use, and perceptions of traditional, or religious, and allopathic biomedical health care providers). These 12 cultural domains (constructs) provide the organizing framework of the model. Healthcare providers can use this same process to understand their own cultural beliefs, attitudes, values, practices, and behaviors (Purnell, 2005).

The Purnell model offers a structure for healthcare providers to learn culture concepts and characteristics. It outlines circumstances affecting one's cultural worldview according to historical perspectives. It also interrelates characteristics of culture to promote congruence and to facilitate the delivery of consciously sensitive and competent health care (Purnell, 2005).

I utilized the Purnell model (see Figure 1 below) in my interview questions to assess the physicians' cultural worldview in the context of historical perspectives, their motivation and intentionality, and their awareness of culture and how it continues to expand from person to family, to community, and to the global community (the circles or rings within model). In addition, I assessed changes and evolution in the individual's CC that include occupation, religion, education, politics, ethnicity and nationality, and gender (the 12 subsections inside each ring).

Nature of Study

This study followed a phenomenological qualitative research approach, involving the use of the semi-structured interview as the primary method. The semistructured interview was beneficial in that it allowed the interviewer to follow the guide of prewritten questions and allows the interviewer to address topical trajectories in the conversation that may stray from the guide (Bernard, 1988). The study involved a preliminary descriptive examination of the perceptions and experiences of physicians with their own mandated cultural competency education who were in practice in New Jersey and had been mandated to complete 6 hours of cultural competency education. The sample was selected from physicians who had privileges at The large New Jersey healthcare system located in Monmouth and Ocean counties in New Jersey. This healthcare system was selected since it was the largest healthcare organization in New Jersey. The large healthcare system had 12 hospitals and offered privileges to over 4100 physicians with the majority of these physicians completing the training over the last 5 years. I conducted 10 interviews.

Data were initially planned to be analyzed using a special tool used for preparing the recorded data for analysis without the need for transcribing. Firstly, the records were to be digitized, cut into pieces, and organized in terms of the time-markers with every part of the interviews. Secondly, a clickable table of contents (C-TOC) through use of the Altas.ti application was to be created (Hauptmann, 2005). The data was to be stored on a computer through notes/transcripts, and the computer would be password protected to

ensure no one else had access to the data files. The next step in data analysis was to interpret the interviews by matching whether they were valuable or related to answer the research question or gave any new direction to the existing outline of the research process. Eventually, the data was to be interpreted by its relation to RQs, connecting the CC training with the experiences of physicians and their perceived value of the CC training for their own confidence and comfort of their clients.

Definitions

Culturally linguistic appropriate services (CLAS): The National CLAS Standards in Health and healthcare are for advancing health equity, improving quality, and eliminating healthcare disparities by creating a blueprint for health care organizations.

Continuing medical education (CME)- refers to a specific form of continuing education (CE) that helps those in the medical field maintain competence and learn about new and developing areas of their field. These activities may take place as live events, written publications, online programs, audio, video, or other electronic media (Morse, 1994).

Concordance - In clinical care, agreement between physician and patient.

*Cross Culture***-**combining, pertaining to, or contrasting two or more cultures or cultural groups.

Cultural Competence-. Level of knowledge-based skills required that provides effective clinical care to patients from a particular ethnic or racial group (Pacheco, 2011).

Culture Humility-willingness to suspend what you know, or what you think you know, about a person based on generalizations about their culture. Rather, what you learn about your clients' culture stems from being open to what they themselves have determined is their personal expression of their heritage and culture.

Diversity- can be defined as the sum of the ways that people are both alike and different. The dimensions of diversity include race, ethnicity, gender, sexual orientation, language, culture, religion, mental and physical ability, class, and immigration status.

Employee Resource Group (ERG)- This is a group of employees who come together, especially in their working area depending on their experiences in life, and features. The main objective of this group is to provide career support.

Health equity- refers to the study of differences in the quality of health and healthcare across different populations.

Inclusion- Refers to the situation of being included in a group or to a structure formed by individuals. E.g. Inclusion of specific racial or ethnic group.

Institute of Medicine (IOM)-A nonprofit organization made in 1970 as a part of US National Academy of Sciences that works outside the framework of government to offer evidence-based research and proposals for public health and policy.

Health Provider- A term used by managed care organizations, referring to anyone rendering medical care, including physicians, nurse practitioners, physician assistants, and others.

Junior Doctors-In the United Kingdom (UK) and Ireland are qualified medical practitioners who are working whilst engaged in postgraduate training to become a consultant or a General Practitioner (GP). The period of being a junior doctor starts when they qualify as a medical practitioner following graduation with Bachelor of Medicine, Bachelor of Surgery degrees, and culminates in a post as a Consultant, a GP, or some other non-training post, such as a Staff grade or Associate Specialist post. Individuals are from the UK.

Limited English Proficient (LEP)- is a term used in the United States that refers to a person who is not fluent in the English language, often because it is not their native language. Both LEP and English-language learner (ELL) are terms used by the Office for Civil Rights, a sub-agency of the U.S. Department of Education.

Mandates- To authorize or decree (a particular action), as by the enactment of law

Millennial- Also referred to as echo boomers meaning an individual who do not have exact dates when cohort life begins or ceases.

Mindful Way- Bearing in mind; regardful; attentive; heedful;

Office of Minority Health (OMH)- The mission of the Office of Minority Health is to improve the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities (Morse, 1994).

Patient-centered care-Patients and their families are actively involved in the design of new care models and in decision-making about individual options for treatment.

Unconscious Bias (UB)-is defined as discrimination and incorrect judgments because of stereotyping. These can occur automatically and without the person being aware of it (Pacheco, 2011).

Unfunded mandate- a regulation that obligates a state or local government to conduct certain actions without money provided to meet the requirements. Public individuals or organizations can also be required to fulfill public mandate.

Assumptions of the Study

Assumptions are aspects of a study that are accepted as true. This study was based on the assumption that the physicians would be cooperative and punctual for all sessions. It was also assumed that the physicians would be able to recollect their training adequately and accurately. They will be able to communicate their thoughts properly and completely. In addition, it is assumed that all physicians will have some basic similarities and/or consistencies in their training.

Scope and Delimitations

The scope of the study includes all things that was covered in a research project. It clearly defined the extent of content that will be covered by the means of the research in order to come to more logical conclusions and give conclusive and satisfactory answers to the research. The scope of this study only included physicians who had completed CC training in their past experience. I explored physician’s perspectives on the mandated CC training, and their feelings and experiences of the training.

Elements outside of scope of this study included observing physicians to determine whether or not they are culturally competent. In addition, I although I had racially diverse group of physicians, the culture and ethnic background of physicians was not a determining factor in selecting them for interview as I was not be exploring patient-physician racial congruence. I was not studying methodologies of CC research (i.e., standard metric evaluations). In addition, CC, from the perspective of patients, was critical to the quality of their care and their satisfaction with the medical treatment received. However, I was not studying the mechanisms through which CC affects health and medical treatment.

Threats to Validity and How They Would Be Potentially Addressed in the Study

A fundamental concern in any research study is to put in place mechanisms that will assure the researcher and reader of the quality of the research, the findings and the process used. I assured that as a researcher I was neutral by listening to all my interviewees and taking individuals' information seriously without bias. Another threat to quality was the possibility that physicians may be concerned that their words would be misused (i.e., used against them) or used somewhere else without their permission. I made it very clear during the informed consent process that participants would remain anonymous and information collected for this study would be used the researcher for research on CC education. The data obtained during the interviews may have been impacted if the interviews were conducted in a busy area where background noise and people coming in and out might be a distraction. Therefore, I planned to reserve a room

ahead of time and make sure the room was sound-proof and that there was no background noise.

Limitations of Study

Potential Design and/or Methodological Weaknesses of the Study

Many cultural competency and diversity scholars note that CC is a process rather than an ultimate goal and is often developed in stages by building upon previous knowledge and experience (Gravlee, 2014). The qualitative approach tends to focus on the context and details that are unique to each research situation and usually involves only a small data set. Weaknesses in the design include the sampling of physicians who were interviewed. For example, I had no more than 10 physicians located in Monmouth and Ocean counties instead of a wider pool of physicians from all over New Jersey. In addition, I did not focus on having a racially diverse group of physicians—their culture and ethnic background was not be a determining factor in selecting them for interview. Another weakness was asking physicians to recall their training from years ago that may have differed over the time each physician took it. Therefore, I asked physicians to recall as much as they could and to be as descriptive as possible. The focus was on their perceptions of the training and its effects rather than on the content of the training.

Another concern may have been that some of the physicians when interviewed may be unwilling to give correct information. This may have affected the findings and caused the research to be inaccurate. Thus, when something was unclear, I asked them to verify or repeat their claims in order to have them provide consistent and clear

information.

Significance of the Study

The purpose of this study was to assess the views of physicians who were mandated to receive cultural competency training and used this as a benchmark for other physicians to learn about the positive and negative aspects of cultural competency education. This could raise the level of awareness on diversity and the various cultures that hospitals and healthcare organizations serve. This study can make medical schools and teaching facilities aware of the benefits and limitations of their cultural competency education so they can tailor it for increased satisfaction of the students. Medical schools can review the results of this study to better understand physician's perceptions on mandated CC education, validate their recommendations on medical school curriculum content, identify major areas or domains of CC education that need to be incorporated into their programs, and develop assessment tools for the student's CC educational experience throughout the medical school curriculum.

Summary

Over the past decade, medical schools have been integrating disparities-related issues into required courses to assist in developing culturally competent physicians. Accrediting bodies and state laws that require cultural competency to be incorporated into curricula of state-run medical schools has helped to fuel this insertion into the curriculum. To date there is a lack of empirical data on how physicians perceive mandated CC education. The

purpose of this study is to understand the attitudes of physicians who are mandated to complete cultural competency education and training. The proposed study followed a qualitative research approach, involving the use of the semi-structured interview.

Chapter 2: Literature Review

Introduction

Chapter 2 provided an extensive review of the literature and research related to the importance of CC education in health care. The literature review also provided a historical perspective of CC's important role in non-healthcare, non-profit and for-profit businesses as a leadership attribute and a developmental skill for employees. Finally, the literature review addressed the issue of state mandated CC education for physicians as a matter of continued licensure, and their attitudes around this mandate.

Search Strategy

I used the Walden Library and Research Center, to support my search strategy. The specific databases I utilized were Med Line with full text, Pro Quest Nursing, and Allied Health Source and PubMed open access – a database that provides unrestricted access to peer and non-peer reviewed journal articles, books, and dissertations. Walden's research center also offered evidence and clinical reviews, as well as test and instruments, which provided over 2,000 contemporary testing instruments. However, I could find very few instruments that tested cultural competency in healthcare. I focused my search on articles that were peer-reviewed, those with abstracts and those that provided full texts. I searched key words, such as CC for physicians, mandated CC in education, and mandated education for healthcare providers.

This combined search of databases produced over 8,500 results. I then narrowed my search to a range date of 2011-2018, which reduced the number of articles available

by 50% or less than 4,000, I further narrowed the search to medical schools and hospitals, which indicated results of 800 articles. I further narrowed the search by indicating United States as the country that the studies were conducted. The clinical practice focus was primary care physicians and teaching hospitals. From this list of articles, I then sorted all references again, from most recent to oldest. The final step in my strategy was to sort all references by the subtopics of my literature review, such as CC in various industries, CC in medical schools, and CC as mandated by states. Unfortunately, the last subtopic and the main area of my study "mandated CC training" produced very few results and even less updated information. To identify more relevant information, I broadened the clinical practice search term not to limit it to specific specialties, since relevant articles either covered nursing or physicians' contribution to increase of CC awareness, and I specifically researched states (CA, WA, NM, AZ, GA, KY, OH, and NY) that were trying to pass similar legislations.

Theoretical Foundation

Much of the focus of my study was to identify the impact that the cultural competency of health practitioners has on patient health and the potential impact on health disparities. Through this review, I provided a review of the effect that CC education even has on various non-healthcare industries. Although my study focused on the impact of CC education in clinical and medical settings in terms of the physicians' and nurses' improved qualification, it also explored physicians' perception and attitudes toward mandated CC education. Some physicians suggested that the clinical success that

their practices experience with their diverse patients was somewhat impacted by their "CC" knowledge however others feel that they have more important things to worry about than cross-cultural issues. Despite these differences in opinion among physicians, hospitals that train many health practitioners often identified themselves as culturally competent organizations and had a positive perspective regarding the value of CC.

A culturally competent hospital uses its understanding of the patient's worldview (gained by obtaining cultural knowledge about the patient's health-related beliefs and values) and applies it in delivery of treatment in a manner that is sensitive to the wishes and needs of the individual patient (Grosse, 2011, p. 307). Since the modern healthcare system makes hospitals and other health care facilities take a business approach in managing their operation to ensure safe yet effective delivery of healthcare services, administrators and managers also need to take CC education as a priority and a tool to improving their quality. As identified by Grosse (2011), awareness of the cultural differences makes a great difference in providing goods and services to a culturally diverse population (p. 310). In other words, cultural awareness adjusts strategies of assessment, communication, and interventions for patients and their families to fit the needs and understanding of patients.

One solution that the medical community has come up with to address this challenge in healthcare delivery is to offer continuing education for physicians (in addition to nurses and others inside the field) that are specifically related to CC. Some states have gone to mandatory CC education as a condition of continued employment

(Bustillos & Darling, 1993). A great deal of controversy exists over these measures, with some members of the medical community fiercely opposed to more mandatory education while other are passionately in favor of the decision (Bustillos & Darling, 1993). However, in the modern climate, the attitude appears to move towards mandatory CC education with fierce arguments and debates across the country occurring in both historically conservative and historically liberal states. For instance, Betancourt et al. (2005) assessed the phenomenon of CC emergence with regard to its perception by the major stakeholders on the professional side. Since the present paper does not evaluate CC as an indicator of quality care from the patients' angle, medical staff members, policymakers, educators, and insurers are considered stakeholders.

Value of CC Education as a Strategic Imperative for Various Industries

Aside from the importance of CC in healthcare, various industries have expressed the importance of CC as being good business and an important strategy in providing education and development for their employees (Abrams & Gibson, 2007). This is important for those businesses that plan to compete and conduct business globally. Today cross-cultural competency training is a necessity for many businesses. As businesses expand their relationships and operations across the globe, many of their employees and executives find themselves dealing with people from many different cultures. The differences in behavior and expectations that arise from differences in cultural backgrounds make interactions fraught with possibilities for misunderstandings and breakdowns in communications. CC training helps improve global performance. Cross-

cultural training will make corporate communications more effective leading to improved customer satisfaction, the avoidance of costly errors, increased employee morale, and reduce turnaround time in processing orders (Tiberio, 2016). Just as many businesses invest in addressing the language requirements of prospective customers and partners, they must invest in addressing the cultural differences that may interfere with communication.

When reviewing organization's efforts to become more culturally competent, five developmental stages are consistently identified regardless of the industry. As defined by Rozas (2007), the stages may have different names while the progression appears to be similar, including the following components: 1) organizations work to value diversity; 2) organization has usually developed a self-assessment regarding culture; 3) awareness of the dynamics that appear consistent when interaction occurs between cultures; 4) cultural knowledge is institutionalized; and 5) service delivery is developed and adapted showing an understanding of diversity within and between cultures (p. 8). In reviewing the dialogue on cultural competency's impact on businesses, consistently the message is that CC is a developmental process that occurs along a continuum and does not happen immediately.

Many organizations have difficulty trying to institute CC because of several areas of resistance expressed as cultural destructiveness- having actual policies and procedures that negatively affect and are often destructive to cultures and the members of that culture. This approach gives the impression that one race is more superior to another

(Pecukonis et al., 2008). Cultural incapacity is not intended to be culturally destructive; however, there is the lack of working with minorities and there is still belief in racial superiority of the group that is considered “dominant” (Pecukonis et al., 2008). Blindness to culture is the next element, which is an important step in moving down the continuum and is often seen as a mid-point to cultural proficiency, however, this approach indicates that culture, color, race makes no difference and that the dominant culture approaches everything equally and is universally applicable (Pecukonis et al., 2008). The next element is the precompetence to culture, which brings about the understanding that there is a weakness that the organization has in working with minorities.

The struggle occurs when knowledge is increased and practices are put in place and tokenism occurs (Pecukonis et al., 2008). Cultural competency occurs when there is an acceptance for differences and a respect for those differences. In this step the individual as well as the organization participates in self-awareness and assessment and pays attention to the dynamics of differences (Pecukonis et al., 2008). Being proficient around culture is defined as holding culture in high esteem and demonstrating this esteem through various approaches to conducting business because of culture, and disseminating culturally sensitive research and assessments (Pecukonis, Doyle & Bliss, 2008). Cultural proficiency is the goal that individuals and organizations strive for.

Cultural competence has served as an effective strategy for many businesses and is often reflected through the organization’s communication and marketing efforts. Many organizations have now built CC education into the development goals of their

employees and more importantly their leaders (Jeffreys, 2010). In this respect, Jeffreys (2010 suggested a similar approach of how healthcare institutions collaborate and connect to each other, involving interpersonal, institutional, unit (site) levels, and supplementary resources to achieve culturally congruent care, which is built on such premises as CC confidence, experience and observation, transcultural self-efficacy appraisal, and transcultural nursing skills (cognitive, practical, affective) (p. 244). In this case, Jeffreys (2010 promotes the need for all individuals to receive formalized preparation in transcultural nursing for "promoting cultural competency development in others" (p. 244). By reviewing current evidence through the literature review and providing an assessment of the Magnet Recognition Program and CC tools, Jeffreys (2010 develops an illustration of CC education, showing how it affects all levels of health care institutions, emphasizing the number of challenges that the latter face and offering a number of tools, such as self-assessment and Magnet Recognition Program (pp. 247-253). Additionally, such assessment of potential value of CC educational tools is evident in the study by Like (2011). Although CC education effectiveness may be difficult to perceive, its impact on all levels of healthcare institutions shows its importance for all stakeholders, especially at a formalized level. In a similar attempt to ensure diverse perspectives and feedback, many organizations developed diversity committees that later became affinity groups, and today are often identified as Employee Resource Groups (ERGs). These groups are voluntary, employee-led, and serve as a resource of cultural integrity for members and organizations by fostering a diverse, inclusive workplace

aligned with organizational mission, values, goals, business practices, and objectives (Jeffreys, 2010). The development of ERGs is indicative of an organization that is moving along the continuum of CC and approaching culture proficiency. The organization has to create changes itself through policies and procedures, while developing cultural education to help the employee make the change (Pollack, 2004). An overarching criticism of the CC framework for businesses was identified through a social work educators guide and appears to be relevant in other businesses. The identified concern is that CC does not reach far enough in addressing systemic and institutionalized oppressions (Pollack, 2004). According to Potocky-Tripodi and Tripodi (2005), organizations have to distinguish between the anti-oppression model, which is systemic and the "cultural sensitivity' model which can impact change at the individual's level. As stated by Callender et al. (2007), CC theories often emerge from philosophical angles, limited empirical evidence, "preached to the choir," which can often affect the credibility of the theory of CC.

Models and Frameworks of Cultural Competency in Healthcare

Millennials, who number 83.1 million, have now surpassed Baby Boomers at 75.4 million and are the most diverse generation in history (U.S. Census Bureau, 2015). Demographers predict the U.S. will be majority-minority for the first time by the mid-2040s (U.S. Census Bureau, 2015). This aggressive change has caused providers and health systems to seriously consider the varied perspectives of their patients as well as the patient's beliefs, values and behaviors about their health and well-being (Betancourt et

al., 2005). The inability to manage and understand differences that occur in sociocultural situations can significantly affect patients and minority patients. The focus around CC especially in healthcare has become prominent as one effort to address disparities in health care (Betancourt et al., 2005). Research has shown that provider-patient communication is linked to patient satisfaction, adherence to medical instructions, and health outcomes (Betancourt et al., 2005). Thus, poorer health outcomes may result when some sociocultural differences between patients and providers are not reconciled in the clinical encounter (Betancourt et al., 2005).

When health systems can provide care to patients that is diverse in its values, beliefs and behaviors, the system is considered culturally competent. This definition includes the healthcare system's ability to tailor their delivery of care to meet the linguistic, social and cultural needs of the patient (Elliot, 2006). The objective is to have a healthcare system and workforce that can provide the best quality of care to every patient, regardless of their background, race, ethnicity, or language (Betancourt et al., 2005). Several studies have been conducted with results indicating the value of CC education in many healthcare arenas.

In the United States, with increased diversity both racially and ethnically, the challenge becomes more critical for health care organizations in ensuring that culturally competent services are provided to meet the diverse population (Elliot, 2006). It is essential to provide cultural competent care in healthcare institutions, as there is a strong indication that it may be an effective tool in eliminating health disparities among

minorities (Like, 2011). Health care organizations will be better able to address the unique needs of minorities by removing barriers to CC and placing a stronger emphasis on culture in health care (Elliot, 2006). To gain greater cultural knowledge, and provide CC training and deliver high-quality services, organizations should assess cultural differences. As reported by U.S. Department of Health and Human Services (HHS) (2001), one model used to help assess cultural differences is the CLAS (Culturally Linguistic Appropriate Services) standards established by the Office of Minority Health.

The CLAS standards are intended to advance health equity, improve quality, and help eliminate health care disparities. The CLAS standards acts as a blueprint for health organizations, which enables them to provide quality care, that is equitable, respectful as well as responsive to the needs of the diverse patient (HHS, 2001). Although there were 11 standards developed, they are divided into 3 areas of focus. Standard 1 sets the mission of all standards, which is to provide effective, equitable, understandable and respectful quality care and provide services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs (HHS, 2001, pp. 49-54). Standards 2-4 focus on governance leadership and workforce (HHS, 2001, pp. 54-70). Standards 5-8 focus on communication and language assistance (HHS, 2001, pp. 70-88). Standards 9-11 focus on engagement, continuous improvement, and accountability (HHS, 2001, pp. 88-102). Standards 12-14 focus on continuous improvement and accountability (HHS, 2001, 102-113).

When the standards were first announced in 2001, diversity leaders were eager to adopt the CLAS standards for their organizations as they were seen as a viable and valid action plan for instituting CC and diversity training (Winkelman, 2009). The CLAS standards serve as a guide to ensure quality health care and CC by professional staffs to meet the need of diverse populations. However, as of today they are still “standards” and not requirements. The only standards “required” are standards 5-8 with a focus around communication and language services primarily because they are government mandated, although an unfunded mandate. Unfortunately, this unfunded approach speaks to the inconsistent quality of language services initiatives throughout hospital systems (HHS, 2001). Organizations that provide accreditation standards like the Joint Commission are criticized for creating “crosswalks” (agreements) with the CLAS standards versus adopting the CLAS standards as policies and requirements and holding hospitals accountable as they would for other hospital errors that directly affect patient care (HHS, 2001).

The Purnell Model

The Purnell model was another effort developed to provide consistent standards of care in healthcare. The Purnell model was developed in 1991, when the author was teaching undergraduate students and discovered the need for both students and staff to have a framework for learning about the cultures of their patients and families (Purnell, 2002). The Purnell model of CC is proposed as an organizing framework to guide CC among multidisciplinary members of the healthcare team, which includes primary,

secondary, and tertiary settings (Figure 1 below). Many scholars who have researched the area of CC have utilized the Purnell model. As stated in the study by Schim, Doorenbos, Benkert, and Miller (2007), Purnell "described 12 domains of culture that influence health care, including heritage, communication, family roles and organization, workforce issues, biocultural ecology, high-risk behaviors, nutrition, pregnancy and childbearing practices, death rituals, spirituality, health care practices, and the role of health practitioners" (p. 106) in his CC model, enabling other researchers to develop and improve it. In this case, Schim, Doorenbos, Benkert, and Miller (2007) integrated the Purnell model to build the puzzle model, using cultural domains and dimensions of the former to serve as the client-level of the latter, showing the interrelatedness of all levels, resulting in culturally congruent healthcare.

Additionally, the study by Jirwe et al. (2009) evaluated the CC education and its effectiveness for nurses from the Swedish perspective, showing how the Purnell model contributes to the improvement of culturally sensitive delivery of care along with retrieval of various CC-related components from other CC models. The findings by Jirwe et al. (2009) are based on interviews conducted with 24 nurses, researchers and lecturers particularly knowledgeable in CC education and their rating of various components and dimensions associated with CC collected in a questionnaire. The questionnaire reflected 137 terms, issues, and concepts associated with cultural and multicultural competence, and further rating of them by 24 experts, with the 118 of those concepts reaching the rating of 75% assessed for their importance (Jirwe et al., 2009).

The description of the model is a circle, with the outer rim showcasing global society, a second rim being community, a third is family, and inner rim is the person (Soulé, 2014). The inside of the circle is divided into 12 domains and their concepts (communication, spirituality, family roles, health practitioners, and others). The model is one of the more thorough and visible that can help healthcare providers understand their own cultural beliefs, attitudes, and behaviors (Soulé, 2014).

The 12 domains with organizing framework are briefly explained with primary and secondary characteristics of culture, thereby determining differences in values, beliefs, and practices of one's cultural heritage (Purnell, 2002). Healthcare providers in any setting can use this model, thereby making it more desirable in the present team-oriented environment. The Purnell model similar to other CC frameworks in healthcare, talks about the continuum of change, more specifically; CC is a continuous process not an endpoint. Purnell's (2002) intercultural competency model addresses steps to achieving cultural proficiency.

The cultural proficiency continuum is a model introduced by Lindsey et al. (2003), discussing the range of values and behaviors of an individual and/or the policies and practices of an organization reflecting their response to diversity. The model identifies cultural destructiveness, incapacity, blindness, and pre-competence, competence to finally cultural proficiency (Lindsey et al., 2003). Again, these are the five stages identified earlier that organizations go through to become culturally proficient. This cultural proficiency goal aligns with Bennett's approach as well as the Purnell

model. As mentioned earlier the process required for various industries to eventually become culturally proficient is very similar to the approaches adopted in healthcare. The model in healthcare encourages the organization and person to become unconsciously conscious, whereas in non-healthcare models the term is to become culturally proficient.

Figure 1

Purnell Model

The Bennett Model

The Bennett model, also referred to as Developmental Model of Intercultural Sensitivity (DMIS), is another intercultural competency model that helps to demonstrate how an individual could move from denying they have unconscious bias to putting strategies in place to mitigate the influence of unconscious bias during their interactions with their patients (Bennett, 1986). The steps of the Bennett model reflect the steps a person must accomplish to become unbiased similar to many organizations. The concept of unconscious bias will be discussed throughout the literature review and will have specific focus under the section the role of CC in medical education.

Table 1

Explanation of the Bennett Intercultural Competency Model

Bennett Stage	Definition of stage in intercultural competency	Proposed definition of stage for bias awareness and unconscious bias (UB)
Denial	No awareness of cultural differences between self and others, or differences among cultural subgroups	Unawareness of other cultures Inability to differentiate between conscious bias and UB
Defiance	Recognition of differences Denigration of cultural others Perception of cultural superiority	Recognition that UB may exist Failure to accept UB in oneself
Minimization	Recognition of differences with minimization of importance Expectation that human behaviors and values can be interpreted in a universal manner	Recognition of UB in others Perhaps recognition of the possibility of UB in oneself Trivialization of potential impact Belief that one can treat all patients objectively
Acceptance	Acknowledgement of and respect for cultural differences	Recognition that UB exists Recognition of UB in oneself Ability to see potential impact on interaction with patients

Cultural competence continues to receive attention in healthcare. Although it appears clear that many industries including healthcare has a vested interest in eliminating health disparities and providing quality care (Betancourt et al., 2005). For instance, the study by Anderson, et al. (2006) utilized Bennett's DMIS model for assessing the intercultural and cross-cultural sensitivity in students to show benefits of study abroad programs for increase of their CC level. In this context, the CC of students of different specialties can be increased using cross-cultural experiences, as measured with the Bennett model by Anderson et al. (2006), indicating that cross-cultural sensitivity is improved with the involvement of students into short-term study abroad programs.

Cultural Competency Education in Policymaking Efforts

All segments of healthcare are not motivated by the same issues or have the same urgency in quickly establishing a rule or policy to mandate the education of CC (Like, 2011). Experts from various sectors have participated in interviews specifically to discuss their perspectives on the subject of CC and health care disparities (Soulé, 2014). Each industry expressed their interest in the importance of CC. Managed care saw the advantage of CC as a business and quality imperative that links to addressing disparities. Academe's perspective is that in the process of standardizing educational programs, the curriculum should reflect CC education as an attempt to educate today's healthcare workers. Government weighs in on the advantage of CC as the ability to access high quality care for the vulnerable and using purchasing power to advance CC (Soulé, 2014).

Although motivations differ for the reasons to advance cultural competency, many synergies are in place to allow for the continuing development of CC in health care. CC is moving from marginal to mainstream policy issues and being identified as a potential strategy to improve quality and address disparities (Like, 2011). Steps being created inside healthcare institutions are critical in moving healthcare initiatives forward, however, healthcare policies, legislative, accrediting and professional initiatives need to weigh in. Aside from the focus healthcare has in addressing enhancements in CC, some state legislatures as well as policy strategist close to the health disparities gap are enacting laws (Like, 2011). State legislatures are also requiring continuing education in cultural competency as a condition of professional licensure.

Presently five states (Connecticut, Washington, California, New Mexico, and New Jersey) have attempted to mandate cultural competency training for physicians (Like, 2011). Also involved in this effort are health system accrediting bodies which include the National Quality Forum (NQF), National Committee for Quality Assurance (NCQA) and the Joint Commission. These agencies have published reports that serve as benchmarks and “best and promising” practices. To improve patient centered care, communication and access to language services, these agencies have issued requirements that address these areas (Jeffreys, 2010). CC has also been the focus of medical specialty groups and these groups have published policies and guidelines that specifically relate to the elimination of health disparities and the care of culturally diverse populations

(Hoffman, 2011). Included in these specialty groups is the AMA/NMA/NHMA Commission to End Healthcare Disparities.

The subject regarding the need for CC training have been addressed by professional organizations representing nurses, physician assistants, dentists, pharmacists, psychologists, social workers, and other allied health professionals. When continuing medical education (CME) courses are taught, the students are able to make an impact on this issue by increasing their use of social media to foster connections, encourage participation and facilitate dialogue among other students who may be interested in promoting culturally competent service delivery and eliminating disparities (Like, 2011). A study by Like (2011) integrates a comprehensive review of current literature to show the healthcare disparities caused by lack of cultural education to physicians and other healthcare professionals. In this respect, Like (2011) emphasizes the role of continuing medical education (CME), providing overview of health care policy, and various initiatives, including legislative, accreditation, and professional relating to multicultural education programs. Meanwhile, Like (2011) not only reviews the studies in multicultural education programs, online courses, and curricular resources, but also criticizes their effectiveness, and evaluates CC training in terms of its impact on elimination of healthcare disparities.

A principle that emphasizes openness, sharing, integrity, interdependence and collaboration is called the wikinomic principle. These “communities of practice” utilizing this principle can generate a type of continuing education that is transformative and lead

to clinicians and patients being empowered to greater justice and equity in health care (Brennan & Cotter, 2008). Finally, there is help needed administratively to assist those who facilitate the teaching of CC education. CC is at the core of attitudes and beliefs of health care professionals. For value to occur in healthcare for providers, patients and clients, "those who get the right care, at the right time, to the right patient, for the right price, calls for culturally competent providers who continue their endeavor towards cultural proficiency (Musolino et.al, 2010).

The reviewed frameworks show the variety of perspectives of how CC and relevant CC education can be perceived by physicians and other medical staff members when applied in their professional work. While the perception of change may depend on various factors, such as personal resistance to change, effectiveness of education, subjective assessment of the relevance of education, and others, it is of paramount importance to evaluate physicians' attitudes toward the mandated CC education via evidence-based practice, ensuring complete integration of the research material. On the one hand, such an assessment shows that the reaction to CC education might change the cultural horizons of physicians, making them more sensitive to needs and interests of their patients, and such a reaction may be predicted via the suggested frameworks. On the other hand, the change might occur in the physician's approach to work without being reflected in his/her conscious attitude toward the results of education.

CC Training in Medical Education

The decision to include CC in the curriculum of medical schools has been readily accepted, however, the specific models to be used in the curriculum for the medical student's education has varied (Kripalani et al., 2006). The challenge is that before students begin to learn and dispense care for other cultures, they need to be comfortable with their own culture and understand the stereotypical perceptions their patients and colleague may have about their culture (Dy & Nelson, 2011). In an effort to plan patient care that is culturally sensitive and individualized to the need of the patient a health care provider must have self-awareness of one's own beliefs and biases. A problem often occurs when health care providers assume a bias that is superior that does not align with the patient's health beliefs or practices (Dy & Nelson, 2011). The patient-provider relationship can be negatively affected by miscommunication or mistrust when this happens (Dy & Nelson, 2011). When a provider is educated in CC, there is sensitivity and at least awareness that their health beliefs may differ from their patients. CC education strives to help create empathetic care if not sympathetic care from providers. In this section of the literature review, I present several models that are being introduced in the curriculum of medical schools. Several of the models being researched claim their motivation to achieve cultural competency is because of the desire to create a patient centered care environment. Being educated in culture is critical to the approach of patient centered care (Mirsu-Paun, Tucker, Herman, & Hernandez, 2010).

Mirsu-Paun et al. (2012) examined if there is a need to customize CC training for medical students based on the specific cultural subgroups of patients. The participants in the study were from four medical schools and totaled 217 medical students in their third and fourth year (Mirsu-Paun et al., 2012). According to Mirsu-Paun et al., the students self-reported what level of engagement and knowledge they had in regard to providing culturally sensitive care. They could report this information by using the Tucker-Culturally Sensitive Health Care Inventory Provider Form, which was completed on-line.

Most of the students indicated high engagement with regards to providing patient centered culturally sensitive care but not high engagement in all the behaviors and attitudes when providing this care. Meanwhile, a “post hoc analysis” indicated that students with previous higher level of experience with multicultural patients also served as the indicator of their post-educational higher CC responsiveness compared to students that reported lower or average level of prior experience with multicultural patients, (mean difference, 1.9, $p < .05$). Additionally, when rating patients’ gender, race/ethnicity and fluency in a language other than English, and experience in providing health care to minority patients, the student’s self-ratings differed. They were less confident in their ability to effectively communicate with Limited English Proficient (LEP) patients (Mirsu-Paun et al., 2012).

Mirsu et al.’s study concluded that some medical students need training in patient-culturally sensitive health care. Additional recommendations of the training were that it should be assessment-based and customized to address areas where there are low self-

ratings of engagement in patient-centered culturally sensitive health care (Mirsu-Paun, Tucker & Hardt, 2012.

Tucker et al. (2005) studied communicating or displaying CC in ways that make patients feel that their culture is respected, which helps the patient feel comfortable with and trust the health care that they receive (Tucker et al., 2005). CC embraces the view that patients are the experts on culturally sensitive health care; not their providers (Tucker et al., 2005). Moreover, it consists of recognizable behaviors of health care providers and staff, and health environment characteristics (Tucker et al., 2005).

The study by Tucker et al. was aimed at determining if the concepts of CC and cultural sensitivity overlap or whether they differ completely. Therefore, the major hypothesis was that CC and cultural sensitivity are not correlated or have insignificant correlation, demonstrating that they differ. The research was conducted using self-administered self-assessments from 93 providers from local healthcare facilities, measuring their perception of CC and cultural sensitivity (Tucker et al., 2005).

The results obtained by Tucker et al. indicated that cultural sensitivity was highly correlated to CC only in two of eight subscales (Staffing ($r = -.464$, $p < .05$) and Service Delivery and Practice ($r = .585$, $p < .05$)). In other words, corresponding training on CC should integrate training on cultural sensitivity to reduce disparities in healthcare (Tucker et al., 2005).

A major implication of this research is that the level of patient-centered cultural sensitivity experienced by primary care clinic patients can be assessed and used to

determine the need for, culturally sensitive clinic-based training in health care settings. The findings of the Tucker et. al. provide empirical support for the potential usefulness of the Patient-Centered Culturally Sensitive Health Care Model for explaining the linkage between the provision of patient-centered, culturally-sensitive health care, and the health behaviors and outcomes of patients who experience such care.

Similar to Tucker et al., Beach et al. (2006) evaluated the cultural sensitivity in approaches utilized by healthcare providers. The specific goal of the study by Beach et al. was to focus on the medical students and empirically assess their need to be trained in serving patients in a culturally sensitive manner (Beach et al., 2006). The overall research purpose presented by Beach et al. was to compare and contrast two models of patient-centeredness and CC in spite of these two approaches to healthcare delivery originating from different traditions. In this case, the methods utilized by this study were limited to comparison and contrast of tools and approaches evaluated through the qualitative research implemented in patient-centeredness and CC with regard to benefits for patients and healthcare professionals.

The research findings by Beach et al. show that although patient-centeredness and CC are different constructs that require comprehensive integration of each other when delivering health care services, they still have several differences. The main objective of patient centeredness is to individualize quality, add value to healthcare quality, focus on process measures and performance goals, and emphasize personal relationships and patient service. As such, patient centeredness aims to elevate quality for all patients. The

main goal of CC movement is to balance quality, improve equity, and lower disparities by improving care for people of color and other minority populations. Because of these different emphases, patient centeredness and CC have targeted different aspects of healthcare delivery (Beach et al., 2006).

Mirsu-Paun et al. (2010) relates to the previous research on CC and cultural sensitivity measured through self-perceived values. This study indicated that patient-centered care is a version of interaction between the patient and physicians, and specifically a way of obtaining feedback on the provider's cultural sensitivity. Patient centeredness is a way to assess training to promote patient cultural sensitivity among providers.

Mirsu-Paun et al. used data like those used by Mirsu-Paun, Tucker and Hardt (2012), including 217 medical students from 4 medical schools. The tool that was used to describe patient-centeredness, Tucker-Culturally Sensitive Health Care Inventory (T-CSHCI) ((T-CSHCI)-Provider Form) is very practical and designed to promote CC (Mirsu-Paun et al., 2010). Using the T-CSHCI-Provider Form, they found slight deviation of data from a normal distribution evaluated with the Pearson's coefficient of skewness being .105, the kurtosis indicating the heavy-tailed distribution compared to normal with the coefficient of -1.27, and the Kolmogorov–Smirnov coefficient Z showing 1.47, p.05. An additional benefit of this study was in helping health care providers and veteran physicians overcome challenges that stood in the way of their own

sensitivity and cultural competency knowledge and its assessment (Mirsu-Paun et al., 2010).

This study found that the T-CSHCCEI-PF instrument is a reliable and valid inventory for culturally diverse patients to provide feedback to the administrators at their health care centers regarding the degree to which these centers have characteristics that are reflective of patient-centered culturally sensitive health care.

The approach of providing CC in medical school's curricula varies from one school to another and many approaches are based on the priorities and demographics of the individual school's service area and student population. Medical institutions and providers have their own culture and ignoring their cultures and only focusing on the culture of the patients are believed to contribute to health disparities (Smedly et al., 2002).

Educators that focus on CC education in medical schools are addressing how bias affects medical encounters and are searching for strategies that can be inserted in the education that may help to reduce this bias (Rapp, 2006). Some providers and medical institutions have met these strategies with resistance.

Hannah and Carpenter-Song (2013) created a course aimed at faculty development that intends to reduce bias and avoid the problem of blame. Many of the medical school courses that focus on CC and the behaviors of the patient, intends to bring conscious awareness to the bias of the provider, whereas the course developed by Hannah

and Carpenter-Song acknowledge that the provider's culture is as important as the patient's culture in the delivery of medical care. The course recognizes that the best-intentioned individuals have conscious and unconscious attitudes when it comes to issues of race, gender, nationality, sexual orientation, and even social class. Another interesting component of the course has been this safe space environment that is created (Hannah & Carpenter-Song, 2013).

The safe space approach allows individuals to discuss shameful past experiences without fear of being blamed or criticized. The conclusion is that based on participant-observation in all course sessions and eight in-depth interviews, the approach was moderately successful, although the course has a voluntary structure for individuals to freely participate (Hannah & Carpenter-Song, 2013).

The voluntary environment and the focus on introspection indicate that prior ignorance not malice contributes to actions of bias. This approach allows for the perpetrators of bias to escape blame for their actions and allows the underlying causes of their behavior to go unaccounted for (Hannah & Carpenter-Song, 2013).

The opportunity for the learner to speak openly and safely regarding their perceptions and feelings about CC, and to admit to their own biases without being shamed is a critical component. Another critical component in some CC models that is not evident in Hannah's model is the inability to assess and help eliminate the underlying causes of this unconscious or conscious bias.

CC in medical schools continue to have challenges because it is often not seen as important as “basic sciences’ and is not consistently addressed in the student’s curriculum. However, the article by Lim et al. (2008) has identified some important issues with student’s approach to CC. The study indicates the possibility of having a positive impact on first year medical students regarding CC (Lim et al., 2008). This is an important observation because previous assessments have shown success of students that receive CC training in their later years (Leamon & Fields, 2005). This means that if the CC study is carefully and thoughtfully constructed, the information can be beneficial and relevant later in the student’s curriculum; however, it seems the earlier the better. (Leamon, Fields, 2005).

A limitation of this study was the use of self-report evaluations of the learning objectives immediately following the presentations (Leamon & Fields, 2005). This study is one of the few measures that were developed to demonstrate the possibility of having an impact on first-year medical students with only a 2-hour presentation, if done with the focus of the importance on cultural issues in patient care (Lee & Coulehan, 2006). This level of success occurring with first year medical students creates encouragement toward the development of a CC curriculum for medical students that could be taught each year (Lee & Coulehan, 2006). The curriculum or lecture could be enhanced as the student’s knowledge grows.

Kerdijk et al. (2013) recommended that future studies evaluate students on the retention and application of the learning objectives at intervals after the presentation,

such as their cultural knowledge on a formal exam, their attitudes on culture and interpreting, or the demonstration of interpreting skills in a clinical setting or even an observed structured clinical examination.

Unconscious Bias in Healthcare

Many health care educators have recognized that although there is growth and recognition of CC and diversity at many levels, at the root of this is the need for medical students and residents to understand the impact of unconscious bias (Metzl & Hansen, 2014; Teal et al., 2012). These types of biases are often so ingrained in culture and society they go unnoticed by many people. This is most common in gender, age, and race stereotyping (Teal et al., 2012). Issues such as influence on treatment decisions, or behaviors from the physician that appears preferential against or toward certain patients and even doctor and patient relationships can be impacted by unconscious biases (Levine & Ambady, 2013).

Researchers have explored unconscious bias (UB) in two related but distinct areas of medicine involving patients' race and understanding their unique nonverbal communication. When considering clinical reasoning, researchers have examined how cognitive shortcuts, or heuristics, can contribute to clinical decision-making, whether it ends up being for better or worse. Levine and Ambady (2013) conducted a literature review on cultural sensitivity, biases, and perceived discrimination in relation to two major aspects. The two aspects they studied were (a) the way minority patients' race affects the physicians' non-verbal communication, and (b) the difficulty faced by white

physicians when delivering care to non-white patients in understanding the non-verbal cues of the latter. The findings suggested that white physicians interacting with minority group patients are likely to behave and respond in ways that are associated with worse health outcomes.

The discussion by Levine and Ambady integrated analysis of possible reasons for such difficulties and the overall causes of stereotyping and prejudice in healthcare. The practical implications of the findings by Levine and Ambady suggest that CC education should be mandated to healthcare providers at all levels, not limiting it to verbal communication but extending it to non-verbal cues.

Unconscious bias shows up in clinical care when a physician without thinking, automatically identifies or classifies a patient as a member of a specific group and then stereotypically applies certain characterizations of that group. These stereotypes can be positive or negative and are more likely to be put in place when cognitive resources are pressured by stress or time limitations (Levine et al., 2013). Unfortunately, stress and limitations are often faced by physicians or training doctors daily when trying to manage complex clinical interactions.

Doctors may underestimate how much their biases impact their behavior, because it is an area that is often outside their consciousness. When it comes to race, ethnicity, gender and even disparate care, there is a wealth of data that highlights how doctors contribute to bias (Staats, 2014). These biases may take the form of discrepancies in how aggressive they advocate for some treatments, pain management and transplant decisions

and how long the wait time is for diagnostic testing (Levine & Ambady, 2013). A model illustration developed by Van Ryn and Fu (2003) showed how a provider's unconscious and conscious beliefs are the foundation of their interpersonal behavior toward a patient during a medical encounter. The study also displayed proposed mechanisms through which health and human service providers can influence race and ethnicity disparities in treatment (Van Ryn & Fu, 2003, p. 250).

This belief affects how the provider interprets or forms opinions about the patient's symptoms, and subsequent decision-making (Stone & Moskowitz, 2011). As indicated by Stone and Moskowitz, nonconscious stereotyping causes increase of racial and ethnic disparities in healthcare. Culturally and Linguistically Appropriate Services (CLAS) do not specify how to specifically reduce racial and ethnic disparities, and common approaches like stereotype suppression are ineffective in reducing non-conscious bias. The provider's bias beliefs of the patient added to the beliefs of the patient's characteristics and presentations can produce treatment in a way that unconscious bias can be highlighted (Stone & Moskowitz, 2011). Unconscious bias, when inappropriately managed and un-recognized can lead to health disparities.

Unfortunately, the research regarding unconscious bias in medical schools is very scarce. However, the illustration developed by Van Ryn and Fu (2003) – although not specifically medically focused – shows how learners can move in and out of stages of development and become more aware of UB and can even bring UB into "consciousness" and better manage clinical encounters.

The authors believe that multiple and diverse educational experiences will help to move the learner through stages of developmental awareness about UB and eventually include this new learning into regular practice in a meaningful way (Van Ryn & Fu, 2003). The authors indicate that learners should have the opportunity to learn of their own biases, while continuing to receive education about the topic of implicit versus explicit biases (Van Ryn & Fu, 2003).

It may be difficult for learners to come to grip in recognizing the concept of implicit biases, because it is bias without awareness. It may be even more difficult to learn how mindful, intentional practice is needed when bias is activated (Burgess, Fu & Van Ryn, 2004) To have success, the authors believe that educators of UB must have skills and be deliberate when they teach or have discussions about the issue and show the relevance to clinical practice (Van Ryn & Fu, 2003). Although not all educators agree, research suggests that UB can be altered when the learner becomes aware and is motivated to change.

Teal et al. (2012) explained the development of one's conscious choices via education, "Multiple and diverse educational experience are necessary to progress through the developmental stages and integrate unconscious bias into regular practice in a mindful way" (p. 84). There were several very important themes that emerged from the study by Berger et al. (2011) and were similar to results of study by Teal et al. (2012). The latter was conducted in the United States regarding CC training and assessments of physicians' skills in the area of CC.

Berger et al. and Teal et al. have in common the focus of CC education targeted toward the medical students and interns. The reviewed studies concluded that education in CC is important and beneficial in caring for the diverse patient. An interesting discovery by Berger et al. was the relationship with the junior doctor and their attending physician. The attending physician's personal approach to the diverse patient had a greater influence on the students than the specific information that was taught through the CC education modules.

Finally, Green et al. (2007) used semistructured interviews with 22 second-year medical students in Harvard after undergoing CC course and completing objective structured clinical examination (OSCE) to test whether physicians show implicit race bias and whether the magnitude of such bias predicts thrombolysis recommendations for black and white patients with acute coronary syndromes. According to Green et al., students perceived CC education differently, indicating at least one of the learning objectives, and some of them reporting lack of readiness to deal with a standard medical workup when being in their second year, while others perceived the CC education as stereotypical.

At the same time, some students in the study by Green et al. were not confident about the CC aspects of education, revealing their concern on the artificial nature of the standardized patient (SP). The research findings by Green et al. represent the first evidence of unconscious (implicit) race bias among physicians, its dissociation from conscious (explicit) bias, and its predictive validity, suggesting that physicians'

unconscious biases may contribute to racial/ethnic disparities in use of medical procedures such as thrombolysis for myocardial infarction.

Providing Cultural Competency Education for Physicians

The issues normally discussed by cultural competency educators (Levine & Ambady, 2013; Like, 2011) as the reasons for health disparities, such as relationships between the physician and the patient and poor access to healthcare, are not seen as the only valid issues facing providers. Even when minority patients gain access to a care system, poor communication with their providers creates patients that are less actively engaged which may contribute to health disparities (Williams & Sternthal, 2010).

The patient–provider relationship remains key, and issues like trust of the physician or being treated with respect continue to be issues experienced by the minority patient (Smith et al., 2007). This focus on respect has shown positive impact on patient's adherence to treatment and following recommendation of care from their physician. CC education is suggested as an initiative to fill this gap. When CC is identified at the physician-patient-level of care, the goal is to create the ability to establish effective interpersonal working relationships that supersede cultural differences (Smith et al., 2007).

There has been a limited amount of knowledge detailing the improved outcomes of patient-physician relationships as it relates to CC, but some quality studies have been done. Lie et al. (2011) hypothesized that patients who had culturally competent physicians would experience greater satisfaction from their physicians around the areas

of respect, and trust which would result in the patient having greater involvement in their care. Cultural competency training was provided to physicians, and they received feedback based on their aggregated cultural competency scores compared to other physicians in the practice. The primary outcome at 6 months was change in the Patient-Reported Physician CC (PRPCC) (Thom et al., 2006).

Other researchers conducted a regression analysis to explore the relationship between CC and the ratings of the patient (Paez et. al., 2009). The results of this study indicated that patients of physicians reported more motivation to learn about other cultures when they perceived their physicians were more facilitative.

The results also indicated that the patient was more willing to share cultural information when the physician themselves shared information about their culture (Paez et al., 2009). Conclusions from this study showed that behavioral and attitudinal goals of CC are important to the development of higher quality and higher participative relationships between the physicians and their patients (Paez et al., 2009). To date, there have been few studies assessing the possible association between health disparities and cultural competency of healthcare providers.

Lie et al. provided feedback on several assessments and studies that were conducted on the topic of CC and made suggestions for a framework in the future. Lie et al. specifically attempted to determine if culturally sensitive physicians could have a positive impact on clinical outcomes of their patients. In their review, seven of the studies met the criteria of inclusion; all seven of the studies had various healthcare professionals

involved, such as physicians, mental health professionals and multiple health professionals and students (Lie et al., 2011).

Three of the studies were pre/post field studies, two were quasi-randomized and two were cluster randomized. Of the seven studies, three of the studies reported beneficial (positive) effects; none of the studies demonstrated a negative (harmful) effect (Lie et al., 2011). The conclusion of the study indicated that there is limited research that shows a positive relationship between training in CC and improved patient outcomes, and there is a limited amount of research that is high quality around the issue of CC.

Despite the skepticism and opposition to cultural competency studies, some physicians have been surprised by the knowledge they've gained through these studies. Some physicians feel that closing the culture gap between doctors and their patients could reduce the racial and ethnic health disparities that persist in the health care system (Orenstein, 2015). A culturally sensitive lens will allow a provider to frame the patient's presenting problem in a way that makes more sense for the patient, and this will allow for a treatment plan that will consider the strengths and barriers that a patient is facing (Orenstein, 2015).

Patients will be apt to adhere to the treatment plan if they believe their provider understands their perspective and experience, and this may also result in less no-shows to appointments, greater probability of the patient seeking care in the future, and overall enhanced health outcomes. With the striking disparities that exist in mental and health outcomes, we as providers are obligated to implement state-of-the art clinical guidelines

in a manner that takes into consideration patient's cultural identities and experiences (Orenstein, 2015). Our own cultural identities affect how we view our patients and their presenting issues and response to treatment. How our patients view us can affect the clinical encounter and their connection to and understanding of the treatment plan. In addition, our cultural backgrounds can expose us to certain experiences which may shape some unconscious biases and influence the way we interact with our patients (Orenstein, 2015).

Another study proposed that to aggressively demonstrate the impact on health disparities and patient outcomes, an algorithm should be created to help educators navigate the development and evaluation of CC curriculum (Lie, et al., 2011). Physicians are being held more accountable for their patient outcomes and therefore want proof that cultural competency works (Coye & Alvarez, 1999). Rigorous research on cultural competency would both enable the testing of cultural competency's theoretical premises and provide health systems with constructive information about which techniques are most successful and under what circumstances (Coye, Alvarez 1999).

The topic of CC's impact on physicians and their relationships with their patients is a global concern. A critical study was conducted in Australia to determine how junior doctors provide feedback on cultural issues and their reactions to their patients. The method was a qualitative study that was conducted in a regional hospital and twenty clinical supervisors were recruited for the study (Berger et al., 2011). These data was from semi-structured interviews and were analyzed thematically. In Australia, CC is

mandated training for junior doctors during their prevocational years; however, at Queensland's hospitals, CC is a mandated component of all doctor's orientation (Berger et al., 2011). Although CC was mandated through all Australia's physicians' orientation, the skill is not emphasized consistently through the medical training.

The concept of CC was a vague concept for the junior doctors' supervisors (Berger et al., 2014). When supervisors were asked how they transmitted their skills to the junior doctors regarding communicating to diverse health professionals and culturally diverse patients, they provided very few responses and no detailed responses (Berger et al., 2014). The training doctors said they used role modeling when the opportunity arose to enhance their communication with their patients and modified their language when necessary, but did not teach the interns how to do this (Furness, 2005).

In as much as the senior physicians who participated in Berger et al. (2014) also conducted in Australia, agreed that CC education was important, the majority of senior physicians struggled in providing examples to the students in ways to handle language and cultural issues. In regards to language proficiency, the supervisors recognized the need for CC when the junior doctors and the patients spoke limited English; again, the supervisors had no strategies on enhancing transfer of information (Tiberio, 2016).

Berger et al. found supervisors underestimated the amount of hospital patients from culturally diverse backgrounds, which may give an incorrect perception of the need of CC training. Even the indigenous Australian patient was not mentioned as a group that needed special assistance, in health beliefs or a focus on their ethnic background (Berger

et al., 2014). Supervisors reported miscommunication coming from medical jargon and low competence around languages (Berger et al., 2014). As mentioned throughout the area of training physicians in CC, there was little awareness by most physicians on how their culture differed from those of their patients and the impact this has on their patient's health outcomes.

The results indicated that some supervisors lacked awareness of the impact that culture has on health (Berger, et al., 2014). Every health care requires specific skills in communication, as well the understanding of the clinician's own cultural beliefs versus their patients cultural belief and values (Betancourt, & Green, 2013).

The study by Berger et al. was designed to include results from semi-structured interviews collected from 20 clinical supervisors recruited in a regional hospital in Queensland, Australia. The conclusion of this study shows that CC training of health professionals improves knowledge and skills, and more specifically the clinical supervisors themselves needs this training in order to support the junior/training doctors. The findings that clinical supervisors at a major regional hospital being unable to describe these clinical practice skills suggest that they are a key target for CC training (Berger et al., 2014).

The findings by Campbell et al. (2011) was re-enforced through the research by Berger et al. (2014), reporting on the impact of caring for diverse patients by residents, when they have not had education or experiences supported by education in cultural competency.

In this respect, Campbell et al. compiled results from 19 self-administered surveys by members of the program one year after the mission in CC experience. The hypothesis of the research by Campbell et al. was that international surgical mission can be not only an effective educational tool, but also serve for improving surgical residents' cultural competency. As indicated by Campbell, Sullivan, Sherman, and Magee (2011), all participants evaluated their participation in an international surgical mission and its effect on their lives as highly positive, while 94.7% of respondents marked such an experience as contributing to personal growth (p. 125), based on Regan Fellowship survey results.

CC Training for Practicing Physicians

Numerous studies have been conducted that examine the benefit of CC training for physicians; however there is still debate regarding the efficacious approaches to this training (Salas-Lopez et al., 2007). Very little focus has been placed on cultural training and evaluation of practicing physicians. More CC education has been taught to physicians that treat chronic issues reflected in minority populations and/or medical residents being introduced to CC. A skill-based course was developed and tested that focused on culturally competent care for diabetes (Kutob, et al., 2013).

The course was tested in a trial that was controlled for primary care physicians caring for patients in an identified state's Medicaid program (Kutob, et al., 2013). The hypotheses was that physicians who completed the course would show a higher level of self-reported CC and would be measured by a CC Assessment Tool (CCAT) than those that were in the control group. Ninety physicians completed the study and divided into

control (*n*=41) and intervention groups (*n*=49). The average age of the sample was 44 years and had been in practice for an average of 12 years and 66% of them were female. The results based on CCAT score showed no significant difference between the control (212.7 ± 26.7) and intervention (217.2 ± 28.6, *p*= .444) groups in CC between the control group and the intervention groups (Kutob, et al., 2013).

One puzzling issue identified in the intervention group was the low level of self-awareness; as seen in one of the interviews, it was inability to describe one's own ideas about illness and health in relation to other people who had diverse backgrounds. Some explanations of this lowered self-awareness could be the diverse case mix and the broadened definition of culture, which included culture of medicine. This broadened definition may have caused the participants to question their previous ideas about their own racial culture. In turn, this realization may have lowered their confidence in assessing a patient's culture without feedback from the actual patient (Kutob, et al., 2013). The finding from this study was that a skills-based course on CC, delivered via the Internet, could be an effective educational strategy for practicing physicians.

Similar to other research, the result of the study by Shaw and Armin (2011) comes back to the issue that remains a highly debated issue regarding CC – the definition. A recent result of continuing medical education (CME) calls for culturally competent programs to have more aggressive self-reflection, critical thinking and cultural humility (nonjudgmental behaviors). This CME is different from other culturally based training

ideals because it focuses on cultural-humility rather than achieving a state of knowledge or awareness (Shaw & Armin, 2011).

The reports from this study points specifically to non-judgmental behaviors and the elicitation of patient's explanatory models that a course such as this could target (Shaw & Armin, 2011). The conclusions were that rather than just focusing on increasing specific cultural knowledge regarding target ethnic groups, cultural humility also needs to be a desired outcome. Improving healthcare disparities remains a question of how to teach clinicians about cultural components of ethnicity. An argument can be made that a skill based approach to CC does create the potential for improved relationships between the physician and patient.

New Jersey Education System

In as much as states and medical schools have made aggressive efforts to mandate CC education for physicians and students, as of this writing New Jersey is the only state that has passed such a bill into law. In New Jersey, aside from the Continuing Medical Education (CME) courses that have to be completed for physicians to maintain their license, New Jersey also passed a bill requiring physicians to complete cultural competency education (Adams, 2005).

The bill was passed in 2005 and required physicians to earn six hours of CC education that had to be completed over 2 years (Bustillos & Darling, 2003). The topics that the state specified to be covered were definitions common in healthcare such as race, CC, ethnicity and culture, a focus around traditional beliefs of patient populations that are

diverse, and some understanding of stereotyping that can negatively impact medical decision-making (Adams, 2005). Additional topics included strategies for recognizing and creating objectives for eliminating health disparities; and ways to address language services issues by working with interpreters.

Several states that were aggressive in their efforts took different approaches with its laws. California indicated that all courses that were taught to physicians had to include a focus around language services and relevant cultural information. Ohio considered introducing a similar bill in 2006; however, their State Medical Association opposed the mandate. The state of Maryland took a voluntary approach to cultural competency training, and their bill was designed to help all healthcare professionals identify cultural competency courses (National Consortium for Multicultural Education for Health Professionals, 2009). There has been little progress in getting cultural competency training mandated for states through legislation since the initial push in 2005-2008.

The National Consortium for Multicultural Education for Health Professionals (2009) provided an update on Medical Cultural Competency Legislation and Regulation, since California introduced a Bill called the Health Care Language Assistance Act which makes health plans accountable for providing language services and required all insurers and plans to provide those who enrolled with interpreter services, translated materials, and to collect data on race, ethnicity, and language to address health inequities. In 2006, the Bill required associations that accredited physicians to develop standards for CME courses that would include cultural and linguistic coursework that impacts patient care.

Several states were aggressive in their efforts to push mandated training through their legislature. Unfortunately, a lot of activity with very little results as identified in this summary.

- New Jersey passed the Bryant Law that required all New Jersey medical students to complete CC training as a requirement of licensure. This law was enacted and passed in March 2005.
- New York attempted to pass a similar bill as New Jersey for medical graduates, however the bill is still pending.
- Ohio's CC bill, would require physicians renewing or collecting registration to practice medicine, surgery, or osteopathic medicine to finish training before state board exam admission. However, this bill is presently pending language change.
- Washington's bill indicated that by 2008 all educational programs for health professionals would integrate multicultural health into their curriculum. This consortium is still pending (National Consortium for Multicultural Education for Health Professionals, 2009).

Although the New Jersey bill was introduced in 2002, and passed in 2005, it was the spring of 2008, which the New Jersey legislature began requiring cultural competency instruction for licensed physicians and mandated 6 hours of cultural competency continuing education for physicians (Like, 2011). The requirements indicate that all license renewals occurring after March 24, 2008 must include 6 hours of cultural competency CME, and that the training must occur prior to June 30, 2009 (Like, 2011).

The impact of this mandate on participation in cultural competency training was assessed through data from OMH Think Cultural Health's (Like, 2011). This feedback assessment illustrates the value of cultural competency mandates to improve care for all. The curricula design had three courses within the program and the answers were pre- and posttests which provided immediate feedback. Individuals that completed the course could participate in self-assessment exercises. There were over 40,000 participants.

In another study, a comprehensive, mixed-methods evaluation was conducted after the program launched to determine its impact on physicians' knowledge, attitudes and skills regarding culturally competent care (Chapman et al., 2013). The evaluation examined qualitative and quantitative data from over 2,000 physicians who participated in the program from 2004 to 2006. Data sources included pre- and posttests, registration questionnaires, self-reflection surveys, and nationwide focus groups. Curriculum participation results in development of knowledge, awareness and skills related to cultural competency. The curriculum shows the potential for improving health outcomes and potentially mitigating racial and ethnic health disparities.

New Jersey mandated 6 hours of cultural competency continuing education for physician being relicensed. OMH Think Cultural Health, sought to determine the effect of this State mandate on provider attitudes toward cultural competency (Like, 2011). Self-reflection components of the curriculum were compared among mandated and non-mandated individuals. The data analysis indicated little to no difference in responses to

attitudinal questions. Both groups demonstrated a culturally competent outlook (Like, 2011).

Concerns that mandating cultural competency will negatively affect physician attitudes appear to be unfounded based on these initial results. Data from this physician cultural competency program was analyzed to determine the impact of the New Jersey mandate (Like, 2011). This research set out to examine what, if any, differences in attitudes about cultural competency exist between individuals who self-select to take the physicians' cultural competency curriculum and those who take it to fulfill a mandate. The results revealed the positive value of increasing awareness of cultural competency amongst physicians through policy initiatives. In addition, mandating cultural competency training in New Jersey as a part of physicians' licensure renewal led to huge increases in physician participation in the OMH's cultural competency continuing education program for physicians (Like, 2011).

Whereas the number of New Jersey physicians participating in the program one year prior to the mandate was 156, the number of physicians participating in the year following the mandate was 9,078 (Like, 2011). This investigation found that physician attitudes toward cultural competency were consistent regardless of having self-selected or being mandated to take the training. Given the similar cultural competency attitudes expressed by both mandated and self-select physician curriculum participants, overall educational outcomes from the program may be generalized to both categories (Like, 2011).

As a recap from the *A Physician's Practical Guide* evaluation, providers can take the first step to improve the quality of health care services given to diverse populations. By learning to be more aware of their own cultural beliefs and more responsive to those of their patients, providers can think in ways they might not have before. That can lead to self-awareness and, over time, changed beliefs and attitudes that can translate into better health care. Data indicates that program completions result in an increase in cultural competency knowledge and a positive impact on practice behavior (DHS, 2013).

Therefore, the benefits of completing the program are applicable to mandated and non-mandated individuals. This negates criticism that mandatory cultural competency training is ineffective because mandated providers will show reluctance in grasping cultural competency concepts (Like, 2011). In addition, the large number of individuals who participated in the physicians' program due to legislative requirements – over 9,000 participants as compared to less than 200 the year before the mandate – indicates that mandatory training may be an ideal way to promote cultural competency as an effective strategy to reduce and eliminate health disparities (Like, 2011).

Cultural competency education results in positive attitudinal and behavioral outcomes for health providers including nurses. Therefore, mandates that boost the participation rates in such trainings are a crucial way to help improve care and ultimately help eliminate health disparities (Like, 2011). Culturally competent care is a vital strategy to mitigate the health inequities faced by the diverse communities. Following the provisions of the national health care reform law, culturally competency continuing

education programs are an important way to improve health for all. *A Physician's Practical Guide to Culturally Competent Care* is designed to equip health providers with the knowledge, skills, and abilities needed to provide culturally and linguistically appropriate services to all individuals (Like, 2011).

The competent care study was one of the first of its kind in regard to measuring the feedback of physicians that completed mandatory training and an evaluation of those who completed similar training on their own. Some of the gaps in the literature were the physician's feedback or their "attitude" about CC was at the end of an approved, free guide tool that was approved by the board of medical examiners. The completion of this guide would also count towards their needed 6 hours of credit.

I am not sure if bias was tested for through in the utilization of this study. The physicians had to complete this education as a means of continued employment. Therefore, when the number grows from 156 to 9078, the increase is likely due to the requirement and may not necessarily be an indication of how the physicians felt about the training. I am concerned that the timing of the assessment was too close to the actual time that the education was completed for the feedback to be "non-biased". Normally positive feedback will occur when information that is mandated, is also free.

Summary

CC relates to the quality of the day-to-day interactions and relationships between health care providers and patients. Unlike workforce diversity training, which affects patients indirectly, CC affects patients directly. Working with a diverse patient

population requires ongoing training that provides workers with specific knowledge, abilities and skills. For example, health care workers must understand the common cultural barriers that get in the way of preventing and treating conditions or disease. When interacting with patients, an ability to ask questions tactfully and respectfully and negotiate between a patient's cultural interpretation of a condition or disease and treatment expectations and options is crucial to good patient care and ultimately good outcomes. The next chapter involves the research methodology, including research design and rationale, role of researcher, methodology, and data analysis process.

Chapter 3: Research Methodology

Introduction and Overview

The notion of "cultural competency" in healthcare has gained attention in recent years. Health professionals are expected to be sensitive to the cultural backgrounds and language of their patients. Courses on cultural competency are now routinely offered to others working in health fields. Although the rhetoric of cultural competency has been applied to clinical contexts, my focus is on the physicians that were mandated to become educated in cultures and their attitude regarding this mandate. A key strategy to reduce health disparities and promote health equity is to integrate education and training that prepares future physicians to provide culturally responsive care. These instructional efforts regarding cultural competency are underway, and medical schools can benefit from leveraging the work of colleagues that are published in the literature regarding this topic and studies that have evaluated learning outcomes.

To facilitate identification of curricular strategies and evaluation tools for reuse or enhancement, the AAMC (Association of American Medical Colleges) commissioned an expert panel to review CC studies that measured learner changes in attitudes, knowledge, and skills. The panel and AAMC staff reviewed more than 100 studies published between 1995 and 2013. Some studies attempted to establish instructional effectiveness by implementing existing scales, surveys, and exams to measure learning—others developed new instruments. The panel identified deficits in the published literature and strategies to

support future work in this area. While several mandates supporting CC education and training exist, the research on the effects of CC education and training on patient outcomes still is evolving.

Systematic reviews of educational interventions for physicians, nurses, and other health professionals found that overall CC had a positive influence on provider knowledge, skills, and attitudes, but more rigorous research is necessary (Beach et al., 2005; Lie et al., 2010). My study was intended to answer this question of the physicians' attitude towards mandated CC training by receiving feedback from physicians as to their beliefs and attitudes of mandated cultural competency education and the impact it had on their patient population.

Study Design: Case Study

One type of qualitative research involves doing case studies, or comprehensive analyses between a single person, group of people, or situation and a phenomenon over time. Case studies are often done in the subject's real-world context, which gives researchers a good view of what they are really like. Documents, observations, and interviews can all be sources of information for a case study. There are generally three reasons that people perform case studies: as pilot research; to develop new theories; or to challenge traditional theories (citations). For this study, I planned on using a single case study design. The data was to be obtained only from New Jersey, and there are no cases available to replicate. This case study design was being used to develop a new theory—

attitudes and beliefs on CC education for physicians has not been studied in the past (Zainal, 2007).

To conduct the case study, I employed a qualitative methodology. The main purpose of qualitative research was to provide in–depth description, understanding, and eventually interpretation of the human experience. In qualitative research, participants' words/voices are honored over numbers, and so direct quotes are used in order to better describe the findings and honor the participants' involvement (Denzin and Lincoln, 2011). As stressed by Sipe and Constable (1996), maintaining a dialogue between researcher and participant(s) is critical; only through a dialectical process can a deeper understanding of the social world is achieved. A qualitative research design is most appropriate for my proposed study as it enables me to assess mandated CC education from the perspective of the physicians who undergo the training. Collecting data via semi-structured interviews seems most appropriate for capturing the views and experiences of the participants in their own words. This enables the researcher to bring something new to the interviews if anything worthy comes up during the data collection process.

Research Questions

Research Question 1: What are physicians' perspectives on the experiences of completing mandated CC training?

Research Question 2: What are physician's perspectives of self-directed CC training?

- How do physicians feel it impacts their experiences with their patients?

- How do physicians feel it impacts their confidence when dealing with patients from other cultures?
- What are physician's perspectives about CC training being employed as a part of the health care customer-oriented reforms?

Research Question 3: What are physicians' perspectives on the impact their CC training has had on the clinical outcomes of their patients?

Research Question 4: What are physicians' perspectives on having the CC training be mandated instead of voluntary?

Role of the Researcher

As a qualitative researcher, I served as an instrument to retrieve useful information from situations, contexts, literature, and respondents. Methodologically, I asked why, how, what, when, and where questions. Since I was interested in meaning and interpretation, I did not use or test hypotheses (Fink, 2000). Another important role of mine was identifying myself, which assumed an importance that it might not have in quantitative research. To clarify my identity to the participants, I planned to include such markers as gender, color, ethnicity, and socioeconomic status.

Depending upon the purpose of the study and the population under study, I thought it may be useful to identify myself linguistically and culturally (Stake, 2010). Finally, I named the degree of insider-outsider status, or detailing the amount of experience or lack thereof I have, with the target population. In other words, I thought it may be important to my participants to know that I was from the health care industry and

serve as an administrator for a large matrix health system (Holloway, Wheeler, 2010). My role in this study as the researcher was to conducting the interviews, reviewing the transcripts to identify themes and coding of the data.

My professional role as the Vice President of Diversity and Inclusion may have impacted the study, as I had a bias that CC training was vital and should be mandated. However, I strictly adhered to the interview guidelines in order to not pass judgment and remain objective when interviewing the participants. I did not have any previous working relationship with these physicians, and thus their responses for the interviews should not be impacted. However, there may have been a concern about physicians who knew me and my role as a Diversity and Inclusion leader. Will they be open and forthcoming with me since they knew me and had assumptions about my views on this topic?

Since CC was one of the integral parts of the physician's work in the modern era due to increased cultural diversity and need to adopt a customer-oriented approach in healthcare, learning about the overall involvement of respondents with cultural diversity of their target customer populations seemed reachable only by close engagement to them during the interviews.

I was not an instructor for the mandated CC training, and therefore there should have been no conflicting interests for participants who knew my role. If participants felt there was a bias, I explained to them I was interviewing objectively and would not persuade them in their responses.

Methodology

This section identifies the population, sampling strategy, criteria on which participants were selected, number of participants and rationale, procedures for identifying, contacting and recruiting participants, instrumentation, data collection procedures, data analysis plan, and protection of human subjects.

Sampling Approach

The sample for this study was selected using purposive sampling. The main goal of purposive sampling was to focus on particular characteristics of a population that are of interest, which can best enable you to answer your research questions. The sample being studied was not entirely representative of the population, but for researchers pursuing qualitative or mixed methods research designs, this is not considered to be a weakness (Black, 2010). Rather, it is a choice, the purpose of which varies depending on the type of purposing sampling technique that is used (Black, 2010). For example, in homogeneous sampling, units are selected based on their having similar characteristics because such characteristics are of particular interested to the researcher.

More specifically the type of purposive sampling is called maximum variation sampling, also known as heterogeneous sampling, is a purposive sampling technique used to capture a wide range of perspectives relating to the thing that you are interested in studying. In this research, a wide range of perspectives will be taken from the physician's attitudes around mandated CC education. Maximum variation sampling is performed by searching for a variation in perspectives, ranging from those conditions that are

considered to be typical to those that are more extreme in nature (Saunders, Lewis, Thornhill, 2012). Conditions are defined as the units (i.e., people, cases/organizations, events, pieces of data) that are of interest the researcher. These units may exhibit a wide range of attributes, behavior's, experiences, incidents, qualities, situations, and so forth (Saunders et al., 2012). The basic principle behind maximum variation sampling is to gain greater insights into a phenomenon by looking at it from all angles. In this respect, all of the physicians I will interview completed a cultural competency education module that was mandated by the state of New Jersey as a condition of continued employment and licensure. Presently New Jersey is the only state that has mandated 6 hours of CC education.

This sampling approach can often help the researcher to identify common themes that are evident across the sample. My research questions were designed to determine the feelings and attitudes physicians experienced in being mandated to complete CC education and would those feelings be the same if they were self-directed in receiving this feedback. The sampling approach allowed me to answer these research questions as I heard directly from the physicians whether this mandated training had an impact on their comfort with CC and if they have had greater cultural interactions with their patients.

Maximum variation sampling was reflected in my research questions since the physicians in this study were from various backgrounds, ages, and fields of practice/clinical environments, and had taken cultural competency education at varying times. Maximum variation sampling was most appropriate since all "units" have similar

characteristics (i.e., physicians), and the units exhibited a wide range of attitudes, behaviors, and experiences required to answer my research question on attitudes and feelings on CC education being mandated. Maximum variation sampling was useful for addressing my research questions since I wanted to gather a variety of feelings and attitudes of physicians across the board on CC education, in order to accurately determine its clinical impact and outcomes for diverse patients.

Participants

This study involved a descriptive examination of the perceptions and experiences of physicians who are in practice in New Jersey and have been mandated to complete 6 hours of cultural competency education. It was limited to no more than 10 physicians who had some privileges at The large New Jersey healthcare system but not employed there. The physicians came from hospitals located in Monmouth and Ocean counties in New Jersey. Characteristics of participants included men and women, of all ethnic backgrounds. I retained permission to conduct this research in several hospital locations. My plans were to interview at least two physicians from each of the five sites.

I developed a list of physicians that I knew but had not previously worked with over the course of my career and used their publicly available contact information to send the letters of invitation. In addition, I asked my participants to recommend additional physicians for participation.

Inclusion Criteria

The sample for this study consisted of five women and five men physicians. Inclusion criteria included: (a) practicing medical physician; (b) had previously worked at The large New Jersey healthcare system (not currently employed) but now with some privileges at the organization; and (c) completed a mandatory cultural competency training from 2009 onwards. Including physicians who completed CC training from 2009 to present allowed me to have a larger participant pool while only including physicians who received training after it was mandated. In terms of diversity, the ethnicity and religious denomination of physicians did not seem to be important for drawing any meaningful conclusions, since the focus was on physician perceptions and it was the difference between the physicians' and clients' cultures that made the CC training so urgent and important.

Although my focus was on feedback regarding mandated CC training, my main research question asked: What are physician's perspectives of self-directed CC training?

Rationale for Hospital Selection

My rationale for recruiting physicians independent from the large New Jersey healthcare system but still with privileges at the organization is that I would not need permission from the organization to get contact information and reach out to them. Most physicians I was looking for used to work at The large New Jersey healthcare system and had completed the mandated CC training over the last 7-8 years. The makeup of the physician relationship with the large New Jersey healthcare system helped to reduce bias

in the study in that most physicians had independently owned practices and had surgical privileges at the sites. Although the selected physicians may have worked for The large New Jersey healthcare system in the past, they were currently not employed by the system and others served as instructors because one of the sites (Jersey Shore University Medical Center) is a teaching hospital. These different roles allowed the physicians to encounter their patients differently and express the impact of CC education based upon these various encounters.

Recruitment of Physician Participants

My plans for recruiting physicians were fully independent from the large New Jersey healthcare system organization. I identified and obtained contact information of participants by asking physicians that I already knew to recommend their colleagues that completed the training in 2009. I used my prior physician contacts to identify physicians. Hospital organizations only had data from 2013 forward, so they did not have a list of those that completed the training in 2009. The majority of the physicians I interviewed were in private practice. Although they had privileges at the large New Jersey healthcare system, they were not employed by the organization. I emailed them personally asking for participation and attaching a flyer to that email (Appendix A).

Once I received potential participant's contact information, I sent one email then possibly a second email two week later as a follow-up. I tried to have this process to be three to four weeks, and I tried to maintain five to six email contacts with participants. In addition, I posted fliers in the physician's lounge for maximum three weeks and

specifically on their bulletin board providing my contact information and a brief paragraph describing the purpose of the study. Interested individuals contacted me via email with the time and date of their availability and were also able to call me directly if they had any questions. The letter of Invitation is provided in Appendix A and the Recruitment Flier is provided in Appendix B.

Data Collection

I conducted interviews virtually—via video conferencing or phone—with participants at a date and time of their choosing. Prior to the start of the interview I provided the informed consent form and an overview of my research study, goals and objectives. I began by informing the interviewees that the aim of this study was to learn more about their mandated CC training, and the physicians' attitude towards mandated CC training by receiving feedback from physicians as to their beliefs and attitudes of mandated cultural competency education and the impact it had on their diverse patient population.

I informed the participants that their specific quotes/feedback would be used, but their names were not to be identified when presenting the quote. I informed the participants that the interviews should last 45 minutes with 15 minutes for questions or discussions that did not come up through the questions. Although, I was conscious of the time, I was flexible with this schedule if the interviewee wanted to have a conversation longer than the scheduled time. I took notes and recorded the information if participants indicate they were comfortable with me using a digital recorder. At the conclusion of the

interview, I left them with my contact information so that they could provide any additional comments that was not discussed during the interview if they have any. I also informed them that each participant would be provided with a short summary of the findings at the conclusion of the study.

Setting

The research setting refers to the place where the data was collected. In this study, the interviews was conducted virtually. I encouraged the interviewee to select the mode of interview—either phone or video conferencing—to allow them to most comfortably answer questions “uninterrupted”, regarding their experience in completing the mandated CC training. I ensured that no one was around me and interviewee during interviewing to preserve privacy of information discussed. My goal was to reduce barriers to participation in order to increase the respondents’ willingness to participate. Therefore, conducting interviews with each respondent in the specified time should have increased the chances of having an uninterrupted interview. Even if our time together was interrupted, the questions were divided into specific sections so that rescheduling could be easily accomplished and easy to “pick up where we left off”.

Instrument

For the purposes of this research, I used semi-structured interviews, whose aim was to identify participant’s emotions, feelings, and opinions regarding the particular research subject. More specifically, the main advantage of semi-structured interviews was that this type of interview involved personal and direct contact between interviewers and

interviewees, as well as eliminating non-response rates (Fisher, 2005, Wilson, 2003). A semi-structured interview does not limit respondents to a set of pre-determined answers (unlike a structured questionnaire). However, the interviewer has to be careful that the "questioning" does not deviate from the prespecified research aims and objectives (Gill & Johnson, 2002).

Semistructured interviews were a widely used technique in development of research. Unlike formal interviews, which follow a rigid format of set questions, semi-structured interviews focus on specific themes but cover them in a conversational style. They are often the best way for learning about the motivations behind people's choices and behavior, their attitudes and beliefs, and the impacts on their lives of specific policies or events. I was confident that the interviews would create rich discussions from the physicians and that they often provided valuable information that wasn't anticipated by the researcher (Magrath & Walsh, 2012). The Interview Guide is presented in Appendix C.

Interview Guide

The conceptual framework was used in this study to develop the interview guide. The interview guide was developed through my conceptual framework—my goal to understand physician's perceptions on mandated CC training to understand clinical and patient outcomes. The Purnell model was utilized during the interviews to assess the physicians' cultural worldview in the context of historical perspectives, their motivation and intentionality, and their awareness of culture and how it continued to expand from

person to family, to community, and to the global community (the circles or rings within model).

Along with asking about the physician's awareness of culture based on community, family, and person, I used the 12 domains of the Purnell model to ask about physician's awareness of individuals (i.e., one's overview/heritage, communication, family roles/organization, workforce issues, biocultural ecology, high-risk behavior, nutrition, pregnancy and childbearing practices, death rituals, spirituality, health care practices, and healthcare practitioners). This led to my research questions of physicians' attitude towards mandated CC training by receiving feedback from physicians as to their beliefs and attitudes of mandated cultural competency education and the impact it had on their diverse patient population. What were physicians' perspectives on the experiences of completing mandated? CC training? I had very few questions, however they were succinct, straightforward and free of jargon. I structured my questions so they were easy for the participant to understand and that the respondents felt comfortable throughout the interview process.

I contacted physicians Dr. Robert Like from Robert Wood Johnson and Dr. David Kountz from Hackensack Meridian to request their assistance in reviewing the interview guide as well as the questions for validity. Both physicians were well respected for their knowledge around diversity cultural competency and medical education. Both physicians had agreed and express their willingness to help.

Interview Guide Questions

Question 1: What were your experiences with cultural competency education?

Question 2: Where did you receive your CC education? How long ago was your training and education? Which location was the training covered at?

Question 3: What impact if any did you feel your CC training has had on your approach to practice and the patient population you treat?

Question 4: If you have not completed CC education, from what you know about CC do you think it would have made an impact to patient care?

Question 5: What were your feelings about state mandated CC education for continued employment?

Data Analysis

Interviews were recorded using a voice recorder on a smartphone, which was also to be used as one device to store the records. I also took hand-written notes during the interviews using a simple pen-and-paper format, which allowed me to take notes and leave brief comments, since some responses could have provoked new ideas, resulting in the shifts in the original topic or even design of the research. I presented the transcripts of the interviews to the participants to ensure accuracy prior to analysis.

Once the data was collected, it was categorized into themes and sub-themes to be able to be compared. Next was the coding process, or analysis of the data. A main advantage of analyzing data obtained through in-depth interviews was that it helped in data collected being reduced and simplified, while at the same time producing results that

may then be measured using qualitative techniques. As suggested by Hauptmann (2005), a special tool was to be used for preparing the recorded data for analysis without the need for transcribing. Firstly, the records would be digitized, cut into pieces, and organized in terms of the time-markers with every part of the interviews. Secondly, a Clickable Table of Contents (C-TOC) through use of the Altas.ti application will be created (Hauptmann, 2005). The data was stored on a computer through notes/transcripts, and the computer will be password protected to ensure no one else could access to the data files.

The next step in data analysis was the interpretation of interviews by matching whether they were valuable or related to answer the research question or brought any new direction to the existing outline of the research process. Eventually, the data was to be interpreted by its relation to RQs, connecting the CC training with the experiences of physicians and their perceived value of the CC training for their own confidence and comfort of their clients.

Protection of Human Subjects

Prior to recruiting form my study, I obtained approval from the Institutional Review Board of Walden University. Once approval was been granted I began each interview by obtaining consent from participants prior to conducting the study. Participants were able to refuse to answer any questions and withdraw from the study at any time. I conducted the interviews in a secluded room to reduce the chance that sensitive information may be overheard.

Much of the materials I collected were not stored on digital devices. However, I

still handled these materials in a secure manner. Items such as research journals, paper surveys, writing samples, and other materials collected for research-purposed were stored on my computer's hard drive, manual folder and an off-site storage disc. I collected and reviewed these materials. In addition, the Institutional Review Board (IRB) (APA §1.11) needed to understand who had access to the data, regardless of how it was stored. Generally, the Board required that only the individuals listed on the protocol as part of the research team had access to the data.

Summary

Attention to CC is crucial to the success of primary health care approaches. CC is a growing and dynamic field of study, generating a substantial body of literature. To boost CC of the healthcare delivery system, health professionals need to learn how to offer services in a culturally competent way. Although many different types of training courses have been developed across the country, these efforts have not been standardized or incorporated into training for health professionals in any consistent manner. Training courses vary greatly in content and teaching method, and may range from three-hour seminars to semester-long academic courses. Important to note, however, is that CC is a process rather than an ultimate goal, and is often developed in stages by building upon previous knowledge and experience. Using a qualitative approach in data collection and analysis should provide additional information for understanding CC perspectives on CC training. While CC training is perceived as beneficial for both physicians and their patient, it is not clear how physicians feel about their CC training and the extent to which

it has impacted their experiences with their patients. My research served as one of the few empirical studies that inquired about the attitudes that physicians had toward mandated cultural competency education.

The next chapter (Chapter 4) is the results, including the setting, demographics, data collection, data analysis, findings, and summary.

Chapter 4: Results

Introduction

The purpose of this study is to identify the effect of varying types of CC training on patient-level outcome. This study detailed physician perceptions of the CC training efforts in New Jersey. This research study was geared toward answering the following research questions: (a) What are physicians' perspectives on the experiences of completing mandated CC training; (b) What are physician's perspectives of self-directed CC training; (c) What are physician's perspectives on the impact that CC training has on the clinical outcomes of their patients; and (d) What are their perspectives on having CC training being mandated instead of voluntary.

This chapter will cover the study setting, participant's demographics, actual data collection method, data analysis process, detailed results, impact of executive order on diversity training, and summary.

Setting

The interviews in this study were conducted virtually because there is a COVID-19 pandemic during this time. The interviewee selected the mode of interview—either phone or video conferencing—and answered questions regarding their experience in completing the mandated CC training. I ensured the interviews were "uninterrupted" and privacy was maintained. The interviews were conducted in a specified time.

Demographics

This study involved participants of varying demographics and characteristics. After receiving the Walden University IRB approval, I was able to secure 15 physicians who practiced in New Jersey (Monmouth and Ocean counties) and were mandated to completed 6 hours of cultural competency education. I secured these participants rather quickly, and they were all open to providing information regarding their perspectives on mandated CC. I ended up interviewing 10 physicians. Although the demographic make-up of the participating physicians was not a necessary component for participation in this study, I was encouraged by the make-up of the physicians i.e., five were men and five were women. In regard to race and ethnicity, 6 were African American, 4 were Caucasian, 3 were Latinx and 2 were Asian/Pacific Islander. They had all been in practice for over 15 years (see Table 2 below).

Table 2

Participant Demographics

Participant #	M1	M2	M3	M4	M5	F1	F2	F3	F4	F5
Race / Ethnicity	AA	AA	AA	Caucasian	Caucasian	Latin	Latin	Asian	AA	AA
Gender	M	M	M	M	M	F	F	F	F	F
Years of Practice	18	25	20	16	31	20	28	32	22	30
NJ County (Monmouth / Ocean)	M	O	M	M	M	O	O	O	O	O

Data Collection

The state of New Jersey had just reopened from the COVID-19 shutdown. Therefore, data was collected between Aug 2020 to Sept 2020. The virus has been devastating for the communities of color and many of these physicians have often expressed concern for diverse patients regarding health disparities, and during my interviews, several expressed their concerns as to how COVID- 19, (although not a racist disease) still racked havoc on individuals that had compromised immune systems, which many were from communities of color. Also, many of these physicians were working virtually, so the opportunity to connect through Zoom or the Blue Jeans platform virtually was easy to set up and create a time to meet.

Another critical issue occurring throughout our nation during my scheduled interview was the police violence on African American males and as I was collecting data about CC the world was still reeling from these atrocities. The network, The large New Jersey healthcare system that the physicians are a part of has strongly stood against racist behavior, had a day of solidarity (white coats against racism) and developed a listening campaign called “listening to understand.” These listening campaigns are permanent focus group for all level team member to express the impact that racism has had on them, their families and communities. Many of these physicians have volunteered to be a leader to listen, understand and begin to address action items that will begin the healing and elimination of racism in medical settings. All of the physicians interviewed, feel that

racism is a public health issue. Many of my sessions with the physicians lasted longer than the hour slated, because many of them “needed to talk.”

Data Analysis

Interviews were recorded via voice recorder on a smartphone along with taking hand-written notes during the interviews to ensure accuracy of responses and transcription. The data was stored on a computer through notes/transcripts. Once I collected the data from the participants via online video-conferencing and phone calls, I was able to digitize it. Initially I planned to use a special tool to prepare the recorded data for analysis, involving digitizing the records, cutting them into pieces, and organizing the interviews by time-markers. I also planned to use a Clickable Table of Contents to derive codes (i.e., tagging them with a “code” to make them searchable and countable and “evolving the codes” or merging and breaking them down). However, I instead used Microsoft Word and Excel to oversee, arrange, and analyze the data.

Once all the data were collected, transcribed, and verified each member’s responses for accuracy, I read the raw data entirely to gain a better understanding of each participant’s experiences and beliefs on CC training. During the primary analysis, the data were gathered into many tables on Microsoft Excel, with each spreadsheet containing differing data sets (i.e., Participant Demographics, Male Experiences, Female Experiences), thus allowing me to create direct quotes from the interviews. Next, important descriptions and recollections from participants were recognized, emphasized, and labeled into meaningful units on Microsoft Word. I analyzed the interviews by

determining whether they were valuable or related to answer my research questions or bringing any new direction to the existing outline of the research process. Thus, I was connecting the CC training with the experiences of physicians and their perceived value of the CC training for their own confidence and comfort of their patients.

The significant phrases or “units” were examined closer to find and merge similarities, thereby having thematic categories begin to develop. Further analysis of the thematic categories allowed me to identify the final significant meanings and themes relevant to the study.

During the final analysis of the data, the all-encompassing details of physician’s experiences produced several emergent themes and subthemes (see Table 3 below).

Table 3

Study Themes & Subthemes

#	Theme / Subtheme
1	CC in Medical Education
1a	Faculty Recruitment
1b	Administration & Leadership
1c	Student Motivation & Time Constraints
2	CC Education After Medical School
2a	Rotations & Clinicals
2b	Residency & Fellowship
3	CC Education on Physician’s Approach to Practice and Patient Population
4	Feelings about State Mandated CC Education for Continued Employment

Further descriptions of the above themes and subthemes are given in the findings section.

Findings

The overarching research question guiding this study was: What are the perspectives of physicians who were mandated to complete CC education? The interview questions were formed to answer the research question and to gather comprehensive descriptions of the physician's experiences, beliefs, and interpretations.

Themes 1: CC Education in Medical School

The theme of "CC Education during Medical School" primarily focuses on the experiences of physician's in the beginning of their medical journey. It also explains how CC education impacted them. Furthermore, this theme discusses why cultural competency was not taught during their time in medical school (i.e., barriers to CC training in medical school), including: a) faculty recruitment, b) administrative support and leadership, and c) student motivation and time constraints.

Nine out of the 10 physicians I interviewed agree that doctors should be trained in understanding how culture plays a role in health and health-care delivery. Sometimes, however, believing in the benefits of change and implementing them are two different concepts. Few studies have systematically documented or explained how this "understanding" is translated into a practical application.

Many of the physicians I interviewed indicated that they had little to no CC education in medical school and that it created a disadvantage for them when going into

their residency programs where they interfaced with patients of different race and ethnicity. Participant F1 mentioned: “I was taught nothing to interest me in medical school I had to learn how to think on my own feet.” Similarly, Participant F4 described, “I went to medical school in the late 80s, and there was no CC education. However, I took religion as a minor in college, so I developed and appreciation for differences.”

The physicians in some cases described that although there was visible diversity and cultural differences while attending medical school there was no formal course or lesson that addressed their differences as students or the patients they would be caring for. Participant M3 stated, “I did not learn anything about CC through my medical education. As students, we knew there were differences, but there was no discussion of disparities.”

In addition, Participant M4 said, “I am biracial – my mother is Filipino, and father is African American. My brother and I were the only black students in school. At UC California, I represented only 6% minority, only 5% of minority in medical school, and only person of color during residency. During high school, many of the students were not culturally sensitive and were intrinsically racist.” Participant F10 added “People don’t know they are racist.” Several of the physicians said they were encouraged to interact with each other who were of different race and ethnicity with the hopes that they would become more culturally sensitive or aware through “osmosis”.

Participant M1 mentioned, “In medical school, I was told African Americans were hypersensitive, but never told why.” Some of the African American physicians

became members of specific cultural medical groups on campus they could join such as the National Medical Association (NMA). Praising the group, Participant F1 said, "NMA used to create weekends for African American students."

Many non-minority physicians that I interviewed indicated they were often made aware of people of color predisposition to certain illnesses, reactions to medicines and chronic issues, but never explained why those outcomes occurred or why individuals were predisposed to these issues. Many of the physicians stated that in their early training, they delved into the molecular worlds of disease and therapeutic interventions along with medical practice and medical culture. They also learned proper behaviors that are accepted in society, including the way to speak, listen, and relevancy to the clinical task. However, as Participant M3 stated, "As a medical student, other students and I had difficulty trying to learn the heart and caring of medicine."

Students are also encouraged to learn about social and economic needs in healthcare; some begin to appreciate the social medicine perspective while in the medical world. These medical students delve into projects involving international and urban health and volunteer to provide basic healthcare to poor and minority groups. These social medicine projects become less important in students' education when they are going into clinical clerkships and are now managing patient's clinical care. So those students that want to spend more time in developing cultural competency are not encouraged by the administration and often time not by their instructors, again creating less importance on the value of CC. Participant F3 said, "CC needs to start as early as

college. It is too late if it starts in medical school." Participant F2 noted, "Black students are not talking about all the atrocities because people are listening but not hearing."

Faculty Recruitment

One of the initial challenges in implementing a new course or curricular activities is securing the faculty's commitment. Some faculty members do not see the relationship between culture and what they are currently teaching. Even when faculty members are committed to introducing the concepts of culture and diversity as they relate to health-care delivery, the work of preparing for an extra course is burdensome—and often not reimbursed. Regarding importance of proper recruitment, Participant F1 said, "A person cannot teach CC until they have walked in your shoes. I truly believe that someone who hasn't experienced some of the things that people of color experience, they will not be able to empathize or understand the situation. Therefore, it is important to recruit diverse faculty members to teach CC courses."

Administrative Support & Leadership

It is essential to institutionalize cultural competency into the educational system, not just the curriculum; but to do this, support from the school administration is crucial. Cultural competency training should be made an integral part of strategic planning at all levels. Sustainable support funding for all involved, including staff training and other activities related to an initiative, should be provided. And collaboration from all aspects of the medical school is necessary to integrate the importance of teaching culture in the

curriculum. Participant M1 said, “The problem is medical leadership – there is no voice at the table.”

Student Motivation & Time Constraints

Some students choose to take elective courses because of personal interest and others because of educational requirements. Participant F4 said, “Students won’t take a CC course on their own because it is a disincentive.” In addition, Participant F5 said, “There is a lot of resistance to the course and a level of offense taken.” Unfortunately, when culture and diversity courses are offered as an elective, there is no real educational need created for the students to enroll. Often, students who participate in cultural competency elective courses have previously shown an interest in culture and diversity, having spent time in other countries or underserved communities in the United States or they are members of ethnic minority groups. And even when the interest is high, many students are anxious about taking on extra coursework during their second year, before boards, and student enrollment or dropout levels can be disappointing as a result.

Theme 2: CC Education After Medical School

The theme of “CC Education After Medical School” narrates physician’s experiences on receiving CC education after medical school. More specifically, this theme discusses physician’s experiences during various stages, including a) rotations and clinicals, and b) residency and fellowship.

Eight of the ten physicians that I spoke with received their exposure to CC and if any training, after they graduated from medical school and took on certain voluntary

assignments during their medical rotations or assignments. The exposure to CC they received was not mandated and for most the learning of CC was never formalized. Two of the physicians who received exposure to CC was through their volunteer work in different communities and organizations than were different than their own. Participant F10 said, “Many CC courses appear to be punitive.” Similarly, Participant F5 said, “I am the only pediatrician woman of color at work. There was no mention of CC during my third and fourth year of medical school, and no focus on CC as an attending or resident.” Furthermore, Participant M1 stated, “Philosophy of inclusion is not taught as a core value.”

One physician spoke of his work on a Native American reservation. He expressed that it was the first time he had been in a community or exposed to people who did not think or prioritized their life the way that he did. Participant M2 said, “I learned CC from working with native Americans. Before this, I was unempathetic to my own culture.” Furthermore, Participant F10 said, “I became more culturally competent by taking care of people in my community. Programs like Peace Corps teach CC.” He expressed how critical it was to learn the culture and how much the native American community needed to understand “his values” before providing and confiding in him about their health issues.

Participant F10 felt that CC education often is defined as learning the culture of the “majority minorities”, like African American and Latinx, but often feels that the smaller cultures are not “mainstreamed”, and often overlooked and their health disparities

are not often publicized or given priority. As an example, American Indians and Alaska Natives continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases. Given the higher health status enjoyed by most Americans, the lingering health disparities of American Indians and Alaska Natives are troubling. He stated, "Black infant mortality is an example of structural racism." In trying to account for the disparities, this physician expressed that policymakers, and tribal leaders are looking at many factors that impact upon the health of Indian people, including the adequacy of funding for the Indian health care delivery system.

Participant M2 talked about how critical it was to put yourself in the role of the community member, but also in the role of hierarchy that you were in the family. In many respects, the history of the past has influenced and helped to shape the structure, roles, and meaning of family to American Indians today. Participant M2 said, "American Indians describe family as blood- and non-blood related, extended family, outer tribe, and entire nation of American Indians. Therefore, no one is ever alone; they always have family or a kinship network."

Furthermore, Participant M2 discussed participating in a curriculum that was developed in 2014. He said, "A handful of U.S. medical schools offer electives related to Native health. In September 2013, Lewis' team spent several months studying what to teach, a process she wrote about in Academic Medicine. A year later, UMMSD launched

a seven-hour block of lectures for first-year students, embedded within an existing course on rural health. I was one of the first students to complete the course."

The majority (9 out of 10) of the physicians that I interviewed had completed the mandated CC course that was offered by The large New Jersey healthcare system in 2008. The bill was passed in 2005 but was not enacted until 2008. Medical students and practicing doctors in New Jersey had to undergo cultural competency training to keep their licenses under a new state law. Medical students were required to complete cultural competency training before receiving their diplomas, and practicing doctors needed to make such coursework part of their continuing education to renew their licenses. At the time, similar measures were under consideration in Arizona, California, Illinois and New York, according to news reports.

The physicians that I interviewed indicated that they and their peers did not have a favorable response to the decision of mandated education. Participant F1 stated, "The curriculum included common definitions, appreciation for traditions and beliefs of patients, impact of stereotypes, patterns of health care disparities, cross-cultural skills, and dealing with language barriers. However, my issue was that it actually stated we treat all the same." In addition, Participant F3 said, "CC education in 2009 did not include importance of capturing race and ethnicity data."

Two of the participants (M3 and M5) did not agree with the title of the Bill "CC." Participant M5 said, "Seeing the title of CC made me feel I was "incompetent" around the area of culture. It made me feel like I had to "correct" my approach with patients."

Others felt that they did not need to be mandated to provide the best care for their patients. For example, Participant F4 stated, “When I knew of the CC course, I did not think it was necessary to be a good doctor or provide quality care.” Participant M2 added, “I initially saw it as insignificant in my line of work. I did not see the relation between CC and patient care.” Many felt that it was an infringement on their time. Participant F3 stated, “I had to log in 6 hours and the course was not initially offered on line. I did not have that much time to complete this.”

Most participants, including Participant M1 and F3, attended the course in the afternoon because they were practicing physicians and most saw patients until 5PM, therefore they had to attend the sessions in the evening or weekend courses when available. They felt this took time away from their already personal life. Most training was delivered in 3-hour increments. Participant F5 said, “I took the CC course through Meridian and it was very good. However, it should have been 6 to 12 hours instead of the 3 that was mandated.”

CC During Rotations & Clinicals

All of the physicians I interviewed discussed the difficulty of attempting to focus on cultural competency during their rotations and clinicals. They expressed that some people assume that CC means perfecting the nuances of every culture and using their factual knowledge of different cultural beliefs to seamlessly navigate different contexts. Participant F2 said, “Everyone’s culture and customs are so different, and no two people are the same. One cannot assume that all people within a group are the same” Participant

M4 stated, “It may seem like a daunting task for someone to have to learn about every cultural belief and custom. I know now that it is okay to not know everything and to ask for clarification.” Participant M5 expressed, “While we were encouraged to learn about the views and beliefs of different cultures during rotations, it is impossible for anyone to be well-versed in every culture.”

Three of the 10 physicians were specific about competency at this level of practicing and expressed that competent care is not about reading patient’s physical characteristics and indiscriminately applying what “experts” tell you about a population, nor is it about employing static stereotypes about social identities. Participant M2 stated, “Competent physician-patient interaction is about respect. It is about deferring to the expertise of the patient in order to ascertain what it is that they believe and desire. Every clinical interaction is inherently cross-cultural.” Participant F2 added, “We cannot continue to conceptualize attention and efforts to this dilemma as a “competency,” as if a certain level of consideration is sufficient for our needs as clinicians”. “It is an ever-present challenge that requires deference — humility — rather than proficiency.”

CC During Residency & Fellowship

Another theme that was often mentioned was the physician’s knowledge and expertise in cultural competency during their residency. Participant M1 said, “Cultural competency needs to continue through residency and there should be Diversity and Inclusion rotations.” Similarly, Participant M2 said, “CC needs to be hard baked into the residency programs.”

The physicians indicated that even when CC was discussed in medical school that this report further indicated that there was inconsistency in medical education regarding the importance of CC, and the reason it is not mandated at all levels of medical education. Participant M4 said, “All medical school curricula do not address knowledge, attitude, and skills related to working with ethnically diverse patients.” Participant F3 stated the issue is “residencies never write race in the outcomes.” Participant F2 added regarding his residency experience, “I came from a different background and did not grow up in this country. Therefore, it was hard to apply or understand other’s backgrounds.”

Theme 3: Physician’s Approach to Practice and Patient Population

This theme “Physician’s Approach to Practice and Patient Population” focuses on the impact of CC training to physician’s practice of medicine and patient outcomes. The participants had varying answers on whether CC education makes a difference to patient outcomes and practicing medicine. Although all of the physicians I interviewed did not have formal CC education, they all felt it was and remains very necessary and important to include in the medical student’s curriculum.

CC is an integral part of excellence in healthcare delivery. People with chronic conditions coming frequently in the healthcare system are especially concerned about healthcare quality and satisfaction. Improving CC with medical professionals and organizations can help enhance healthcare quality for all. Participant F2 said, “CC impacts minority patients differently. We do not want to admit it but we all have biases. Biases are not equally detrimental. Many go through the ‘doctor knows everything

syndrome.'

The participants agreed that CC education is importance to prevent provider bias or entitlement. Participant F5 added, "There is an arrogance of the 'doctor' title. Doctors can feel they are above everyone else." Participant M1 said, "You impact the patient when you think you have to be right all the time. This can be detrimental to the doctor-patient relationship as the patient can become closed off." Participant M3 said, "I am no expert and try to be open to my own biases. However, doctors are a tough group to teach. They sometimes feel they are superior in terms of education and credentials. This perception is something that needs to change. No matter your rank or level of expertise, one should always be open-minded to learn about others and accept feedback."

Furthermore, the participants agreed that CC education is key in-patient outcomes. Participant F3 said, "While working in palliative care you really get to know the patient. End of life matters greatly." In addition, Participant M1 said, "I believe that the impact of stereotyping is important on medical decision-making. That's why I take every patient case by case, and try to learn about each patient individually." Furthermore, Participant M4 added, "Receiving CC education has affected my way of history-taking, problem solving, and promoting patient compliance. I can feel more connected to my patients."

The physicians also mentioned the current times were are in and how it affects them in providing care to patients. Participant F3 said, "People are so scared to hurt others and are trying to be politically correct." Participant F5 also said, "It has been hard

to function at work because of all the civil unrest."

Theme 4: State Mandated CC Education

Finally, the theme of "State Mandated CC Education" describes physician's views of being mandated to receive the New Jersey CC training for continued employment. As stated earlier most of the physicians I interviewed were initially opposed to the mandated CC training that was offered at The large New Jersey healthcare system. I asked all of the physicians if they would have completed a self-directed course or taken training on their own if their patient demographics became more diverse and was a way of enhancing their relationship. All of the physicians said they would not have attended or taken a course on their own. They indicated that this decision would generate a loss of finance and they feel the time could be better spent at the office providing better care to their patients and families. Participant M1 stated, "I typically complete only mandated courses or to receive CME credits." Participant F3 added, "As a physician I am so busy trying to balance work and family time, so it's difficult for me to find time to take extra courses."

All physicians were in agreement that CC education should be mandated for continued employment. Participant F1 said, "CC should be mandated quarterly for 2-3 hours." Participant F4 and 8 agreed, saying, "I am in favor of mandating CC." Participant M2 emphasized bias, stating, "CC is important but should focus on implicit bias and provider bias." Additionally, Participant F10 said, "Anyone getting federal dollars should be mandated to teach CC."

All in all, each physician agreed that CC training is necessary and should be

mandated in medical school and during residency. They also agreed that physicians should be mandated to review the course every 5 to 7 years and should be a condition of employment and re licensure.

Executive Order on Diversity Training

Throughout my study and specifically the information in my chapters on data collection (chapter 4) and analysis (chapter 5) has emphasized the difficulty in consistently teaching CC in medical schools. In September 2020, then President Donald Trump instituted an executive order that made it even more difficult for all type of diversity training to be taught in “for profit and not for profit organizations”. This was especially difficult because it put all businesses on notice that was receiving governmental contracts. As the Diversity, Equity and Inclusion (DE&I) executive for my network, I had to halt all training for our over 38,000 employees (including roughly 2000 physicians) and conduct a cross walk of our training goals and the specifics of the executive order (EO).

The two areas that were most concerning for my organization was the order’s specific resistance to unconscious bias training and historical teachings regarding the impact of slavery in the United States. We also have a medical school as a part of our network and a major part of the student’s curriculum focuses on the importance of CC in the effort to eliminate health disparities. Our review indicated no violation of our diversity training and we partnered with our state agency and the American Hospital Association to protest this order.

I am including this information to further express the challenge in mandating CC in medical education when the political world takes an issue with the importance of this education.

On September 22, 2020, the President (Trump) issued an Executive Order ("EO") titled "Combating Race and Sex Stereotyping" that rejects trainings that address concepts such as implicit and unconscious bias, institutional and structural racism, and privileges associated with dominant culture traits (male privilege, white privilege). According to the EO, these types of trainings promote "divisiveness in the workplace" and are "contrary to the fundamental premises underpinning our Republic: that all individuals are created equal and should be allowed to an equal opportunity under the law to pursue happiness and prosper based on individual merit."

Implications for Federal Contractors

The EO requires that all federal government contracts effective after November 21, 2020, include a provision that during the performance of the contract, the contractor shall not use any workplace training that inculcates in its employees "any form of race or sex-stereotyping or any form of race or sex scapegoating[.]" The term "race or sex stereotyping" is defined as "ascribing character traits, values, moral and ethical codes, privileges, status, or beliefs to a race or sex, or to an individual because of his or her race or sex." The term "race or sex scapegoating" is defined as "assigning fault, blame, or bias to a race or sex, or to members of a race or sex because of their race or sex."

The EO specifically prohibits training on "divisive concepts" that include:

- One race or sex is inherently superior to another race or sex.
- An individual, by virtue of his or her race or sex, is inherently racist, sexist, or oppressive, whether consciously or unconsciously.
- An individual should be discriminated against or receive adverse treatment solely or partly because of his or her race or sex.
- Members of one race or sex cannot and should not attempt to treat others without respect to race or sex.
- An individual's moral character is necessarily determined by his or her race or sex;
- An individual, by virtue of his or her race or sex, bears responsibility for actions committed in the past by other members of the same race or sex;
- Any individual should feel discomfort, guilt, anguish, or any other form of psychological distress on account of his or her race or sex; or
- Meritocracy or traits such as a hard work ethic are racist or sexist or were created by a particular race to oppress another race.

There was tremendous pushback on the order and an early decision by now President Biden was to rescind the order. On President Biden's first day in office, he signaled a major shift in the administration's approach to racial issues, signing an executive order ending the Trump White House's policies that denied the existence of systemic racism in the United States and ordering agencies to "root out" systemic racism

and other forms of discrimination both in the workplace and in their public-facing programs.

Biden’s executive order, one of 15 he signed Wednesday January 20, 2021, rescinds the diversity training order in its entirety and launches what the White House called a “whole-of-government initiative to advance racial equity,” according to a summary. It directs all federal agencies to conduct an internal review and devise plans to “address unequal barriers to opportunity in agency policies and programs.” The review should also ensure equity based on sexual orientation, gender identity, religious minorities and people with disabilities.

The order also instructs the Office of Management and Budget to work to ensure that federal government spending more equitably invests in communities of color and ensure that federal programs are available to people for whom English is not their first language. It launches a new “equitable data working group” to ensure federal data “reflects the diversity of America.”

Summary

The present study was conducted to explore the experiences of physicians on CC education. All participants in the study revealed lack of CC education early on in their career and medical school. They also discussed some barriers as to why CC education was not taught in medical school, including lack of faculty members, leadership support, and student motivation. Although it is deemed important, it is difficult to create a curriculum due to money and time constraints. Not only is it important with medical

professional, but with administrative personnel as well. Medical students generally found less of a need to enroll in CC education courses as an elective. In addition, the importance of CC was difficult to convey or ascertain during clinical rotations. Furthermore, CC education has varying degrees of importance with each specialty in residency and fellowship. Overall, all participants agreed that CC education was important to patient outcomes and their practice, and it should be mandated. Chapter 4 provided a detailed report of the study results, including main themes and subthemes.

The next chapter includes a detailed interpretation of the findings, with limitations, future research recommendations, social implications, and conclusions.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to identify the effect of varying types of CC training on patient-level outcome. This study detailed physician perceptions of the CC training efforts in New Jersey. This research study was geared toward answering the following research questions: (a) What are physicians' perspectives on the experiences of completing mandated CC training; (b) What are physician's perspectives of self-directed CC training; (c) What are physician's perspectives on the impact that CC training has on the clinical outcomes of their patients; and (d) What are their perspectives on having CC training being mandated instead of voluntary.

This chapter will cover the interpretation of the findings, study limitations, recommendations, implications, and summary.

Interpretation of the Findings

This section describes in the ways the findings confirm, disconfirm, or extend knowledge on CC education by comparing them with what has been found in peer-reviewed literature. In addition, the findings are analyzed and interested in the context of the theoretical or conceptual framework.

Data Collection Process: Purnell Model

The Purnell Model of CC was used to guide the study (e.g. analysis, interpretation of findings), since it is an organizing framework to guide CC among

multidisciplinary members of the healthcare team, which includes primary, secondary, and tertiary settings (Purnell, 2002).

I found it interesting that each physician that I spoke with reflected (on their own admission) an area of “growth” regarding CC that I was able to identify through the model. In some cases, I have highlighted that growth to emphasize that becoming competent does not have an end point. Many of the physicians I interviewed were very aware of the CC they experienced at each level of their career. Healthcare providers in any setting can use this model, thereby making it more desirable in the present team-oriented environment. The Purnell model similar to other CC frameworks in healthcare, talks about the continuum of change, more specifically; CC is “again” a process not an endpoint (see Figure 1). The model in healthcare encourages the organization and person to become unconsciously conscious, whereas in non-healthcare models the term is to become culturally proficient. Again, the model has a specific focus on healthcare practitioners.

Theme 1: Cultural Competent Education in Medical School

Many of the physicians I interviewed indicated that they had little to no CC education in medical school and that it created a disadvantage for them when going into their residency programs where they interfaced with patients of different race and ethnicity. The physicians in some cases described that although there was visible diversity and cultural differences while attending medical school there was no formal course or lesson that addressed their differences as students or the patients they would be

caring for. Several of the physicians said they were encouraged to interact with each other who were of different race and ethnicity with the hopes that they would become more culturally sensitive or aware through "osmosis". Some of the African American physicians became members of specific cultural medical groups on campus they could join such as the National Medical Association (NMA), which is the nation's oldest and largest organization representing African American physicians and health professionals in the United States (National Medical Association, 2020).

Black Americans were subjected to all of the injustices inherent in a dual medical care system. However, there was the need to support African American students in medical school so the Student National Medical Association (SNMA) was founded in 1964 as a sub-division of the National Medical Association (NMA), largely through the effort and support of W. Montague Cobb, MD, an NMA member (and, later, NMA President), who spearheaded the initiative to include medical students in the association's ranks (National Medical Association, 2020).NMA recognized the need to give active support to medical students and encourage them in the pursuit of careers as physicians. The SNMA's founding chapters were Meharry Medical College and Howard University College of Medicine. However, the education and support of the NMA was more focused on supporting African American students with coping with schools that did not welcome them versus providing CC education or how to care for patients different from them (National Medical Association, 2020).

Many non-minority physicians that I interviewed indicated they were often made aware of people of color predisposition to certain illnesses, reactions to medicines and chronic issues, but never explained why those outcomes occurred or why individuals were predisposed to these issues. For example, some diseases are more prevalent in some populations identified as races due to their common ancestry. For example, people of African and Mediterranean descent are found to be more susceptible to sickle-cell disease while cystic fibrosis and hemochromatosis are more common among European populations.

Many of the physicians stated that in their early training, they delved into the molecular worlds of disease and therapeutic interventions along with medical practice and medical culture. They also learned proper behaviors that are accepted in society, including the way to speak, listen, and relevancy to the clinical task. However, medical students had difficulty trying to learn the heart of medicine (Somayeh A, Meena C, 2016). So those students that want to spend more time in developing cultural competency are not encouraged by the administration and often time not by their instructors, again creating less importance on the value of CC (Somayeh A, Meena C, 2016).

No physician should leave medical school today without the knowledge about the role culture plays in health care and the tools to understand patients whose backgrounds are different from their own. Those tools— called cultural competency—are lacking from current curricula (Gonzalo et al., 2017). And change only comes with action. 9 out of the 10 physicians I interviewed stated that doctors should be trained in understanding how

culture plays a role in health and health-care delivery Sometimes, however, believing in the benefits of change and implementing them are two different concepts. Few studies have systematically documented or explained how this “understanding” is translated into a practical application. (Vaughn **&** Krenz, 2013). The physicians agreed with researchers and authors who have written that cultural competency can be taught in a course, class or series of classes, taking the form of lectures and interactive sessions: workshops; student clerkships; electives; immersion programs; month-long rotations; cultural teaching OSCEs (objective-structured clinical examinations); and language (Vaughn**,** Krenz, 2013).

Theme 2: CC Education After Medical School

CC during rotations and clinicals

All the physicians I interviewed discussed the difficulty of attempting to focus on cultural competency during their rotations and? clinicals. They expressed that some people assume that CC means perfecting the nuances of every culture and using their factual knowledge of different cultural beliefs to seamlessly navigate different contexts. The physicians expressed that while you are encouraged to learn about the views and beliefs of different cultures, it is impossible for anyone to be well-versed in every culture.

Three of the 10 physicians were specific about competency at this level of practicing and expressed that competent care is not about reading patient’s physical characteristics and indiscriminately applying what “experts” tell you about a population, nor is it about employing static stereotypes about social identities. Competent physician-

patient interaction is about respect. It is about deferring to the expertise of the patient in order to ascertain what it is that they believe and desire. Every clinical interaction is inherently cross-cultural (Mandana et al., 2020). It is important for physicians to have humility rather than competency or proficiency, "It is an ever-present challenge that requires deference — humility — rather than proficiency." (Mandana et al., 2020).

CC during Residency & Fellowship

Another theme that was often mentioned was the physician's knowledge and expertise in cultural competency during their residency. Three of the physicians interviewed referred me to a study that discussed how CC education often differed by specialties, since they believed the degree of CC importance varied by specialty. A nationwide survey of 2047 residents (internal medicine, surgery, pediatrics, obstetrics/gynecology, emergency medicine, psychiatry, and family medicine), attempting to assess preparedness to provide cross-cultural care, found that most residents viewed a patient's culture as an important factor when providing care (moderately important = 26%; very important = 70%) (Lanting et al., 2019).

For example, surgical and emergency medicine residents were less likely to deem cultural issues as "very important" (43% and 47%, respectively), compared with the other specialties, of which 67–94% felt it was "very important." (Lanting et al., 2019). Similar findings were presented in a related qualitative study on residents' perceptions of their experiences learning cross-cultural care (Lanting et al., 2019).

The physicians indicated that even when CC was discussed in medical school that this report further indicated that there was inconsistency in medical education regarding the importance of CC, and the reason it is not mandated at all levels of medical education.

Theme 3: Physician's Approach to Practice and Patient Population

The majority of physicians (80%) that I spoke with received their exposure to CC and if any training, after they graduated from medical school and took on certain voluntary assignments during their medical rotations or assignments. The exposure to CC they received was not mandated and for most the learning of CC was never formalized. Two of the physicians who received exposure to CC was through their volunteer work in different communities and organizations than were different than their own.

One physician (Participant M2) spoke of his work on a Native American reservation. He expressed that it was the first time he had been in a community or exposed to people who did not think or prioritized their life the way that he did. He expressed how critical it was to learn the culture and how much the native American community needed to understand "his values" before providing and confiding in him about their health issues. This physician felt that CC education often is defined as learning the culture of the "majority minorities", like African American and Latinax, but often feels that the smaller cultures are not "mainstreamed", and often overlooked and their health disparities are not often publicized or given priority.

As an example, American Indians and Alaska Natives continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases (Sanderson, Teufel-Shone, Baldwin, 2010). Given the higher health status enjoyed by most Americans, the lingering health disparities of American Indians and Alaska Natives are troubling. In trying to account for the disparities, this physician expressed that policymakers, and tribal leaders are looking at many factors that impact upon the health of Indian people, including the adequacy of funding for the Indian health care delivery system (Sanderson, Teufel-Shone, Baldwin, 2010).

Participant M2 talked about how critical it was to put yourself in the role of the community member, but also in the role of hierarchy that you were in the family. In many respects, the history of the past has influenced and helped to shape the structure, roles, and meaning of family to American Indians today. American Indians define their family as blood, non-blood related, extended, tribal community, and the entire nation of American Indians. Thus, they are never alone and always have family and kinship (Sanderson, Teufel-Shone, Baldwin, 2010).

Participant M2 made me aware of his participating in a curriculum that was developed in 2014. A handful of U.S. medical schools offer electives related to Native health. In September 2013, Lewis' team spent several months studying what to teach, a process she wrote about in Academic Medicine. A year later, UMMSD launched a seven-

hour block of lectures for first-year students, embedded within an existing course on rural health (Schutt RK, Woodford ML, 2020). He was one of the first students to complete the course. I found it interesting that many of the experiences this physician expressed and his own personal growth in CC was expresses on the Purnell model that focused on community, family and then the role of the healthcare worker which states: Focus on traditional practices, often regarding religious beliefs.

Theme 4: Physician's Views on State Mandated CC Education

As stated earlier, most of the physicians I interviewed were initially opposed to the mandated CC training that was offered at the large New Jersey healthcare system. I asked all of the physicians if they would have completed a self-directed course or taken training on their own if their patient demographics became more diverse and was a way of enhancing their relationship. All of the physicians said they would not have attended or taken a course on their own. They indicated that this decision would generate a loss of finance and they feel the time could be better spent at the office providing better care to their patients and families.

Each physician agreed that CC training is necessary and should be mandated in medical school and during residency. They also agreed that physicians should be mandated to review the course every 5 to 7 years and should be a condition of employment and re licensure.

Although all the physicians I interviewed did not have formal CC education, they all felt it was and remains very necessary and important to include in the medical

student's curriculum. Chronic patients frequently visiting the healthcare system are especially concerned about health care quality and satisfaction. Improving CC with medical professionals and organizations can help enhance healthcare quality for everyone. Studies find that increasing respect and understanding between patient and provider leads to mutually beneficial levels of trust and responsibility for all. Furthermore, it encourages community participation and involvement in health issues (Julene R, 2019).

The majority (nine out of 10) of the physicians that I interviewed had completed the mandate CC course that was offered by a large healthcare system in Northeast US in 2008. The bill was actually passed in 2005 but was not enacted until 2008. Medical students and practicing doctors in New Jersey had to undergo cultural competency training to keep their licenses under a new state law. Medical students were required to complete cultural competency training before receiving their diplomas, and practicing doctors needed to make such coursework part of their continuing education to renew their licenses. Most of the physicians that I interviewed indicated that them and their peers did not have a favorable response to the decision of mandated education.

Some indicated that the title of the Bill "CC" made them and their peers feel that they were "incompetent" around the area of culture. Others felt that they did not need to be mandated to provide the best care for their patients. Many felt that it was an infringement on their time because they had to log in 6 hours and the course was not initially offered on line. Most attended the course in the afternoon because they were

practicing physicians and most saw patients until 5PM, therefore they had to attend the sessions in the evening or weekend courses when available. They felt this took time away from their already personal life. Most training was delivered in 3-hour increments.

Limitations of the Study

This section describes the limitations to trustworthiness that arose from execution of the study. Many cultural competency and diversity scholars note that CC is a process rather than an ultimate goal, and is often developed in stages by building upon previous knowledge and experience (Gravlee, 2014). The qualitative approach tends to focus on the context and details that are unique to each research situation and usually involves only a small data set.

Weaknesses in my study design include the sampling of physicians who were interviewed. For example, I had no more than 10 physicians located in Monmouth and Ocean counties instead of a wider pool of physicians from all over New Jersey. Another weakness was asking physicians to recall their training from years ago that may have differed over the time each physician took it. However, this limitation was minimized by focusing on their perceptions of the training and its effects rather than on the content of the training.

Another concern is that some physicians could have been unwilling to give correct information due to the nature of interviewer/interviewee relationship. This may have affected the findings and caused the research to be inaccurate. I minimized this by using physicians who I had no direct working relationships with.

Furthermore, the setting of this interview was a limitation of this study. Due to the COVID-19 pandemic, we were not able to have in-person interviews, which could have affected the physician's comfort level and answers. All interviews were conducted via zoom and telephone.

Recommendations

This section describes recommendations for further research that are grounded in the strengths and limitations of the current study as well as the literature. The physicians I interviewed provided feedback as to why cultural competency was not taught during their time in medical school, including: (a) Faculty recruitment, (b) administrative support, (c) student motivation, and (d) training.

Faculty Recruitment and Time Constraints

One of the initial challenges in implementing a new course or curricular activities is securing the faculty's commitment. The findings of this study suggest that some faculty members do not see the relationship between culture and what they are currently teaching. Even when faculty members are committed to introducng the concepts of culture and diversity as they relate to health-care delivery, the work of preparing for an extra course is burdensome—and often not reimbursed (McElmurry, McCreary, Park, 2009). As a result of my study findings, future recommendations would be to add diverse faculty members and new job roles in medical schools to teach CC education.

Administrative Support

It is essential to institutionalize cultural competency into the educational system, not just the curriculum; but to do this, support from the school administration is crucial. Cultural competency training should be made an integral part of strategic planning at all levels. Sustainable support funding for all involved, including staff training and other activities related to an initiative, should be provided. And collaboration from all aspects of the medical school is necessary to integrate the importance of teaching culture in the curriculum (Jandorf, Cooperman, Stossel, 2013).

Student Motivation and Time Constraints

Some students choose to take elective courses because of personal interest and others because of educational requirements. Unfortunately, when culture and diversity courses are offered as an elective, there is no real educational need created for the students to enroll. Often, students who participate in cultural competency elective courses have previously shown an interest in culture and diversity, having spent time in other countries or underserved communities in the United States or they are members of ethnic minority groups. (Fiscella, Sanders, 2016). And even when interest is high, many students are anxious about taking on extra coursework during their second year, before boards, and student enrollment or dropout levels can be disappointing as a result (Fiscella, Sanders, 2016). Future recommendations include incentivizing CC courses so it can be interesting and highly considered by medical students.

Importance of CC Training

There is a strong need for CC curriculum in medical schools, elective rotations, and post-medical school training. Medical schools need to evaluate student's cross-cultural education. They should also develop a curriculum assessment tool to identify and monitor CC educational experiences throughout the medical school curriculum.

Participant Demographics

I did not emphasize the racial or ethnic background of the physicians—focusing on their culture and ethnic background could be a determining factor for future studies. I believe that each physician's racial/ethnic background and their personal experiences with bias (i.e., being judged unfairly and treatment with disrespect) can affect their perceptions, importance of other cultures, and the way they provide care to others. It may be important to focus on physicians of various racial and ethnic minorities and examine their likelihood of perceiving bias and importance of CC in the health system.

Although culture can be defined in many different ways, it is important to note that any patient's encounter with a physician can be considered cross-cultural. The physician has different beliefs, values and practices about medicine and health care that can be different from what any patient may believe, value or practice concerning his own illness. However, it has become more important in today's society to formally educate medical students about the tools needed to understand patients whose cultural background is different from their own (Vaughn**,** Krenz, 2013).

Implications

This section describes the potential impact for positive social change at the appropriate level (individual, family, organizational, and societal/policy). It then describes methodological, theoretical, and/or empirical implications, as appropriate. Finally, it describes recommendations for practice as appropriate.

The implications of this study include enhanced relationship between physician and patient. It also includes new perceptions of physicians in not having biases and prejudice. This study is significant because it assesses physicians' views on mandated cultural competency training and uses it as a benchmark for other physicians to learn about the positive and negative aspects of cultural competency education. This could raise the level of awareness on diversity and the various cultures that hospitals and healthcare organizations serve.

This study provides information on diversity and the various cultures that hospitals and healthcare organizations serve. This study provides information that suggest the need to assess the education being provided at medical school institutions so they are aware of the benefits and limitations of their cultural competency education and can tailor it for increased satisfaction of the students. Medical schools will be able to review the results of this study to better understand physician's perceptions on mandated CC education, identify major areas or domains of CC education that need to be incorporated into their programs, and develop assessment tools for the student's CC educational experience throughout the medical school curriculum.

Conclusion

In conclusion, this study assessed the views of physicians who were mandated to receive cultural competency training. This study was conducted to explore the experiences of physicians on CC education. All participants in the study revealed lack of CC education early on in their career and medical school. They also discussed some barriers as to why CC education was not taught in medical school, including lack of faculty members, leadership support, and student motivation. In addition, the importance of CC was difficult to convey or ascertain during clinical rotations. Furthermore, CC education has varying degrees of importance with each specialty in residency and fellowship. Overall, all participants agreed that CC education was important to patient outcomes and their practice, and it should be mandated. CC education is a necessary part of the medical field, and is beneficial for physicians, patients, healthcare team, administrative personnel, and the community at large.

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Appendix A. Email for Physician Recruitment

Email Subject: MANDATING CC EDUCATION?

Hello Physicians of [Insert Partner Organization Site / Hospital Name],

My name is XXXX, and I am currently enrolled in the School of Health Administration as a PhD candidate at Walden University and am in the process of writing my dissertation. I am also the XXXX for XXX. However, this study is separate from my role as a Vice President.

I am inviting you to participate in a brief 1-hr interview for your beliefs and attitudes towards mandated CC training/education and its impact on your diverse patient population. You are being invited because you have already attended and completed the NJ CC mandated training for physicians. Please note, your specific quotes/feedback will not be used.

If interested, please contact me at XXXX@waldenu.edu with Date/Time of availability. ***Due to the mandates from COVID-19, we will be conducting interviews virtually (i.e. via phone, online video conferencing, etc.).*

Any questions? Please call me at XXX-XXX-XXXX. Hope to hear from you soon! ☺

Appendix B: Flyer for Physician Recruitment (Attached in Email)

MANDATING CULTURAL COMPETENCE FOR PHYSICIANS?

Hello Physicians:

Feeling frustrated with cross-cultural interactions between health services, clinicians, and patients? Do you feel cultural competence training should be mandated?

Please join me and participate in a brief 1-hr interview for your beliefs and attitudes towards mandated CC training/education and its impact on your diverse patient population. Please note, your specific quotes/feedback will not be used.

If interested, please email me at wayne.boatwright@waldenu.edu with Date/Time of availability. Due to the mandates from COVID-19, we will be conducting interviews virtually (i.e. via phone, online video conferencing, etc.).

Any questions? Please call XXX-XXX-XXXX. Hope to hear from you soon! 😊

Appendix C: Interview Guide

Interview Questions:

1. What experience have you had in receiving culturally competent education?
2. Where did you receive your CC education and was it mandated? How long ago was your training and education? Where was the training covered?
3. If you received training; what impact has it made on your approach to your practice and patient population?
4. If you have not completed CC education, from what you know about CC do you think it would make a difference?
5. What are your feelings about state mandated CC education for continued employment?