Chapter 4
Health Workforce Development Interventions to Improve Cultural Competence

4.1 Background

Health professionals and the knowledge, attitudes, skills and behaviours they bring to the healthcare encounter have a major impact on patients' healthcare experiences. Research studies demonstrated how cultural and linguistic differences between health professionals and health service users can influence healthcare and patient experiences. Differences can result in issues such as miscommunication [1], loss of trust [2], decreased sense of satisfaction and feelings of disempowerment [3] among service users. Perhaps because of the central role of health practitioners in shaping patient healthcare experiences, improving health professionals' cultural competency is one of the oldest and most predominant cultural competency strategies [4, 5]. Intervention efforts to improve the cultural competence of the health workforce generally focused on providing education and training in the knowledge, attitudes and skills needed to work effectively in cross-cultural clinical encounters [5]. Key in these efforts are developing understandings of the role culture plays in shaping behaviour and increasing respect and acceptance of cultural differences. Education and training efforts also focused on increasing practitioner capacity to work effectively within cross-cultural contexts by teaching adapted and culturally specific approaches to providing healthcare. An ongoing process of developing awareness of one's own cultural influences, personal prejudices or biases, thoughts and sensations was also central to the types of cultural competence strategies in the health workforce [6–9].

One approach advocated in the early days of cultural competence was categorical approaches towards improving practitioner cultural competence. Categorical approaches involved providing information specific to particular cultural, ethnic or racial groups. This included things such as descriptions of common health beliefs, values, attitudes and behaviours among ethnic groups and suggested *do's*

and *don'ts* for the clinical encounter [5]. However, this approach was soon recognised as inadequate and problematic for several important reasons. First, the expectation that health practitioners could be familiar with all cultural perspectives that they might encounter especially given the extent of cultural, ethnic, religious and national diversity present in many countries was not feasible [5, 10, 11]. Second, categorical approaches are critiqued for oversimplifying and misrepresenting culture as a fixed and static phenomenon [12] without regard for its fluid and dynamic nature [11, 13, 14]. Evidence suggests that this approach can increase stereotyping and cultural misunderstanding [5, 10, 12] giving little attention to intra-group variability [14]. Lastly, categorical approaches are critiqued for failing to account for the impact of factors such as acculturation (see Chap. 2, p. 4) and socioeconomic status on individual experiences and expressions of culture [5].

The other key strategy used in cultural competency education and training is the cross-cultural approach. This approach addresses some of the key concerns associated with categorical approaches. It teaches generic knowledge, attitudes and skills that can be applied to any cross-cultural situation [5, 11]. The types of knowledge, attitudes and skills central to cross-cultural training and education strategies are outlined in the models created by pioneers in cross-cultural medicine such as Berlin and Fowkes [15], Kleinman [16] and Leininger [17]. These include developing an understanding of health and illness in its biopsychosocial context, skills for eliciting patients' explanatory models of health issues and their causes and teaching strategies for negotiating shared understanding and facilitating participatory decision-making in creating treatment plans [10, 11]. A significant amount of cultural competence training focuses on the development of awareness, sensitivity, attitudes and knowledge. However, these cross-cultural models share a focus on skills for health practice. The importance of going beyond knowledge and awareness to focus on practice-specific skills and their translation into informed, concrete behaviour applied in the practice setting is widely recognised as key to effective cultural competence training [4, 9, 13, 18].

In the US Government's report, *Unequal Treatment* revealed the pervasive and persistent disparities in healthcare quality and treatment received by ethnic and racial minorities [19]. Cultural competency training for healthcare professionals was established as a core strategy for addressing these critical disparities [11, 20]. As discussed in Chap. 2, factors such as patient mistrust of health practitioners and systems, discrimination and provider bias were integrated in the discourse and scope of cultural competency training [10, 11]. The training incorporated acknowledgement and critical reflection on practitioner perspectives brought to the clinical encounter, such as the 'medico-centric' perspective passed on through medical education and professional training, and reflection on issues of power and privilege in professional status [10].

This chapter extrapolates the key themes in intervention strategies, reported outcomes and measures used to assess outcomes. It is based on a journal article, which

was in press at the time of writing this book. The article was written by the authors reviewing 16 studies [21–36] that were published between 2006 and 2016 and that aimed to increase cultural competence in the health workforce [37].

4.2   Characteristics of Workforce Development Interventions

We found 16/64 (25%) papers that met the inclusion criteria as intervention studies that evaluated health workforce development and training interventions to increase cultural competence. Of these 16 evaluation studies, seven were from Australia [21, 22, 24, 25, 29, 33, 38]; all focused on improving cultural competence for the benefit of Indigenous Australians. Eight papers were published in the USA, with three of these aimed at improving cultural competence for Latino or Spanish-speaking patients [31, 32, 36] and a further five studies addressing general cultural competence rather than for a specified cultural or ethnic group [27, 28, 30, 34, 35]. A single study from Canada also addressed general cultural competence for working with ethnically diverse patient groups [23]. The included studies targeted a range of different health professionals. Six targeted various health professionals [21, 24, 25, 27, 31, 32], five targeted general practitioners/physicians and medical residents/registrars [22, 28, 29, 35, 36], and two targeted training for nurses [23, 34]. There were three other studies, each targeting pharmacists and Aboriginal health workers [33], alcohol and other drug workforce [38] and ethnic minority faculty [30], respectively. Interventions were delivered in diverse practice settings including hospitals [24, 34, 36], area health services (including hospitals and community health clinics) [21, 31], a general practice [29] and various other health settings such as for diabetes care, mental health, alcohol and other drugs and e-health [23, 25, 27, 28, 33, 35, 38].

A detailed overview of intervention strategies and outcomes is provided in Table 4.1. The symbol ✓ denotes evidence that the author(s) explicitly advanced adoption or support of the element of cultural competence; ~ denotes an implicit or inferred reference consistent with the intent of that element; and x denotes no evidence for that element.

4.3   Cultural Competence Workforce Development Intervention Strategies

The 16 studies reviewed reveal two primary intervention strategies which can be used to improve the cultural competency of the health workforce. The two primary strategies seen across cultural competence workforce development intervention studies were discrete cultural competency training courses and professional development interventions aimed at improving the cultural competency of practitioners.

Table. 4.1 Characteristics of health workforce interventions to improve cultural competence

First Author year Publication	Aim	Intervention Strategies							Intervention Outcomes											
		Cultural Competence training			Professional Development		Delivery mode		Practitioner cultural competence outcomes					Healthcare/health outcomes				Other outcomes		
	Increased cultural competency	Cross-cultural approach	Categorical approach	Minimal detail	Other training	Mentoring/Supervision	Multiple sites	Single sites	Knowledge	Attitudes/Beliefs	Skills	Behaviour	Confidence	Patient satisfaction	Patient trust	Practitioner satisfaction	Health outcomes	Research productivity	Training completion rates	Improved readiness to provide cc care
Aboriginal Workforce (2015)	✓	×	✓	✓	×	×	✓	×	×	×	×	×	×	×	×	×	×	×	✓	×
Abbott (2014)	?	×	×	×	×	✓	?	×	?	×	✓	✓	✓	×	×	×	×	×	×	×
Brathwaite (2006)	✓	✓	×	×	×	×	×	✓	✓	×	?	×	×	×	×	✓	×	×	×	×
Chapman (2014)	✓	×	✓	✓	×	×	×	✓	✓	✓	×	×	×	×	×	×	×	×	×	×
Dingwall (2015)	?	×	×	×	✓	×	✓	×	✓	×	✓	×	✓	×	×	×	×	×	×	×
Hinton (2012)	?	×	×	×	✓	×	×	✓	✓	×	?	×	✓	×	×	✓	×	×	×	×
Khanna (2009)	✓	✓	×	×	×	×	✓	×	✓	×	✓	×	✓	×	×	×	×	×	×	×
Kutob (2009)	✓	✓	?	×	×	×	✓	×	✓	×	✓	×	×	×	×	×	×	×	×	×
Liaw (2015)	✓	×	?	?	✓	✓	×	✓	?	✓	✓	✓	×	×	×	✓	×	×	×	✓
Lopez-viets (2009)	?	×	×	×	×	×	×	✓	×	×	✓	✓	×	×	×	×	×	✓	×	×
McElmurry (2009)	✓	×	✓	?	✓	×	✓	×	✓	✓	✓	?	×	×	×	?	✓	×	×	×
McGuire (2012)	✓	×	✓	×	×	×	✓	×	✓	×	✓	×	×	×	×	×	×	×	×	×
McRae (2008)	✓	×	✓	✓	✓	×	✓	×	✓	×	✓	×	✓	✓	×	✓	×	×	×	×
Salman (2007)	✓	✓	✓	✓	✓	×	✓	×	?	✓	✓	✓	✓	✓	✓	✓	✓	×	×	×
Thom (2006)	✓	✓	×	×	×	×	✓	×	×	×	?	×	×	✓	✓	?	✓	×	×	×
Wu (2006)	✓	×	✓	?	×	?	×	✓	×	×	×	×	×	✓	×	?	×	×	×	×

4.3.1   Cultural Competence Training

Of the studies reviewed, 11 (69%) provided discrete cultural competency training courses to the health workforce as the primary intervention. There was significant variation in training approaches, frequency and duration which makes comparisons of intervention effects difficult (see the paper by Jongen et al. 2017, for further details on intervention characteristics). There were, however, also important commonalities and themes across studies, which provide insight into the strengths and limitations of current cultural competency training approaches.

For well over a decade, the cultural competency literature presented research documenting the limitations of categorical approaches to cultural competence training. Yet despite this, six [21, 24, 31–33, 36] cultural competence training studies still used a categorical approach focused on teaching about characteristics, beliefs and behaviours of particular population groups [21, 24, 31–33, 36]. For example, McGuire et al. evaluated a training program focused on factors which might affect patient-practitioner communication and care process for Latino patients [32]. The training covered factors such as barriers in accessing healthcare in the USA, differences in healthcare systems in Latin America and the USA, expectations of Latino patients seeking care, social and cultural constructs of health and illness in Latino cultures and common health beliefs and practices such as the use of complementary medicine [32]. Two instances where a categorical approach to cultural competency training can be appropriate and effective have been identified [11]. One instance is when the focus of training is on learning about the cultures of local-level populations facilitated by the involvement of community members [11, 13]. In the six studies using categorical approaches, only two involved community members to help teach about local-level populations [21, 32]. The other instance is when knowledge taught has a specific, evidence-based effect on healthcare delivery or patient outcomes. It was difficult to determine whether any of the included studies taught this type of knowledge. Aside from these two cases, it is recommended that practitioners focus on learning directly from patients about their own sociocultural perspective and avoid generalisations about cultural beliefs or practices [11].

Five cultural competence training intervention studies used a cross-cultural approach focusing on general knowledge, skills and characteristics of culturally competent practice [23, 27, 28, 34, 35]. For example, the cultural competency training intervention reported by Brathwaite and Majumdar for health professionals in Canada [23] taught general knowledge and processes for providing culturally competent care, including (a) acknowledging intracultural diversity and the breadth and complexity of culture as something possessed by all, (b) conducting cultural assessments of service users, (c) learning from patients about their culture, (d) recognising the processes of acculturation and cultural diversity within individuals, (e) developing agreed-upon treatment plans and (f) accommodating non-harmful health beliefs and practices which can differ from practitioners personal and professional culture.

Case Study 1: Cultural Competence Training

Thom et al. [35] reported on a randomised control trial (RCT) assessing the impact of cultural competency training for primary care physicians providing diabetes care. The training was delivered to 53 primary care physicians across 4 diverse healthcare practice settings. The three training modules, which could be delivered as one half-day training or three separate sessions of 1–1.5 h addressed several core competencies. These included knowledge (such as knowledge of cultural identification and levels of agreement with respect to mainstream health beliefs), communication skills (including listening, explaining, acknowledging, providing recommendations and working effectively with interpreters) and cultural brokering (including negotiating a treatment plan with patient and family, understanding community resources available to patients and working with the healthcare system to meet the needs of culturally diverse patients). A RCT was employed to assess the impacts of training on Patient-Reported Physician Cultural Competence (PRPCC) score, patient satisfaction with and trust in physician and patient health outcomes of weight, blood pressure and glycosylated haemoglobin. While this study was rated strong in the study quality assessment, it was found that physician cultural competence training was not associated with any significant improvement on any outcome measure found for the intervention groups.

Despite the availability of established theoretical models that can be used to inform cultural competence training for health professionals [39], there was minimal use of these in the studies included in this review. The advantages of using such theoretical models are that they more readily allow for comparisons between studies using the same model and comparisons between studies using different models. This would help to determine whether certain models or approaches impact the effectiveness of interventions. One framework for cultural competency used in two studies [28, 35] was the LEARN model developed by Berlin and Fowkes [15]. This model focuses on teaching generic communication and negotiation skills applicable across all patient-practitioner encounters involving the negotiation of difference (cultural or otherwise). These same two studies drew upon Kleinman's explanatory model of disease [16] and involved experts in the development of the training method or framework. Further two studies [23, 34] evaluated training based on Campinha-Bacote's model of cultural competence [6]. All four studies that utilised pre-existing models evaluated training based on cross-cultural approaches.

Tools are needed to enable the comparison of cultural competency training interventions and help develop greater consistency in intervention approaches based on the evidence of what works. Such a tool was described by Dolhun et al. to assess the themes, concepts, methods and learning objectives of cultural competence education interventions [40]. In addition to the diversity and inconsistency in training approaches, the review of intervention strategies was made more difficult because of lacking detail in the training content and focus in several studies [21, 24, 33, 34, 36].

Additionally, many studies made no reference to the evidence base informing their cultural competency training approaches.

These issues, coupled with the widespread use of outdated cultural competence training approaches, demonstrate a lack of rigour and in-depth engagement with this complex field. This deficit was particularly evident in categorical-based interventions that focused on teaching about specific cultural or ethnic minority groups. The studies that adopted a cross-cultural training approach generally provided greater detail on the content of interventions; this assists with intervention assessment and comparisons. These cross-cultural interventions also demonstrated a more thorough grounding in theoretical frameworks and the evidence base than did interventions which took a more categorical approach.

An approach which prioritises self-understanding and critical reflection on one's own cultural backgrounds, beliefs, values, life experiences, behaviours and ways of communicating is considered crucial to cultural competence training and education [8]. Yet there is minimal research available that integrates this kind of self-awareness with cultural competence. In a review of reviews by Truong et al., only 4 out of 19 cultural competency literature reviews discussed the concepts of self-awareness and self-reflection on one's personal and professional culture [41]. In the studies included for this review, only one cultural competence training intervention for the health workforce assessed participants' cultural self-awareness [28].

Some suggest that cultural humility may be a better approach to embarking on the in-depth self-exploration and critical reflection needed to change practitioner attitudes, beliefs and behaviours which negatively impact patients [13, 46, 47]. Cultural humility training 'incorporates a life-long commitment to… redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships' (p. 117) [42]. Cultural humility addresses both the presence of cultural diversity in the broadest sense and the interconnected issues of power imbalances, represented in different forms of injustice and inequality [43]. Cultural humility might also be more aligned with the ongoing and developmental approach to cultural competency knowledge and skill building recommended in the literature [13]. The developmental, self-reflective approach of cultural humility can potentially help healthcare systems to avoid the trap of perceiving cultural competence as an easily demonstrable mastery of a finite body of knowledge [42] as opposed to an ongoing process of quality improvement.

4.3.2   Professional Development Interventions

To be effective, recommendations for the integration of cultural competence into all professional development endeavours across all levels of an organisation have been made [44]. This endorsement was reflected in the remaining workforce development interventions that utilised training and/or mentoring and/or supervision to increase the capacity and cultural competence of the health workforce.

These professional development strategies differ from more commonly utilised cultural competency training interventions. To the authors' knowledge, they have not previously been explored in the context of cultural competence.

The aforementioned strategies provide some insight into the range of approaches that can be employed to increase the cultural competence of health professionals. In some studies, training was concentrated on particular health issues or fields or on teaching certain skills sets for particular service-level interventions designed to improve the cultural competence of health practitioners [25, 26, 29, 31, 33, 34, 36]. For example, Dingwall et al. [25] evaluated the effects of training in a culturally adapted Indigenous e-mental health application on Indigenous and non-Indigenous service providers' awareness, perceived knowledge and confidence in using the app with Indigenous clients.

> **Case Study 2: Other Training to Improve Cultural Competence**
> Hinton and Nagel evaluated the effects of a culturally adapted 'Yarning about Mental Health' training for the Australian alcohol and other drug (AOD) workforce. Fifty-nine participants, including AOD workers and counsellors and mental health and allied health workers from two AOD workforce network agencies, attended four 1-day training workshops held over a period of 2 years. Pre-post questionnaires were administered to measure participant knowledge and skills in providing culturally appropriate strategies and tools for understanding mental health, promoting wellbeing and delivering brief, evidence-based interventions for Aboriginal and Torres Strait Islander service users. The qualitative evaluation found significant self-reported improvement in confidence and knowledge related to Indigenous mental health and wellbeing. This included improved knowledge of the warning signs and treatment of mental illness and increased confidence to assess, treat and communicate with Indigenous mental health clients. This study was rated as moderate in the study quality assessment [26].

Mentoring and supervision were identified as another common cultural competence workforce development strategy [22, 29, 30, 36]. Mentoring approaches were used to support the development of individual practitioners, whole health practices and minority research faculty and students with the aim of increasing cultural competence in the healthcare workforce. For example, Abbott et al. [22] evaluated an intervention to explore GP supervisors' and medical educators' attention to cultural competence when providing supervision to medical registrars. Participants viewed a simulated consultation between an Aboriginal patient and GP Registrar that highlighted inadequacies in communication and cultural awareness and documented teaching points to prioritise and use in supervision as a response to the video consultation.

Case Study 3: Mentoring to Improve Cultural Competence

Wu et al. [36] evaluated the reported satisfaction and healthcare experiences of 250 parents receiving care for children from a Paediatric Department of a large teaching hospital [40]. The intervention consisted of cultural education added to the role of Spanish interpreters in the hospital. Interpreters provided brief cultural competency training where residents were introduced to Latino cultural values and home remedies important to medical history taking. Residents were also taught Spanish expressions to help establish rapport with Spanish-speaking patients, and the training addressed techniques for optimising the use of interpreters in improving communication. In addition to this training, Spanish interpreters also worked as cultural mentors and provided individual cultural education sessions to residents where language or cultural issues that emerged during specific clinical encounters were reviewed.

Medical residents delivering care to Spanish-speaking parents in one large teaching hospital participated in the study. Each participant attended one 30-min group cultural workshop and two individual cultural mentoring sessions. The evaluation, which was given a strong study quality rating, used a comparative study design with historical control measuring parent reported satisfaction with interpreter service and healthcare experience. Parents' self-reported satisfaction with an in-person interpreter service compared to a telephone interpreter service and the impact of the additional cultural and language education on parent's satisfaction were assessed. The use of an in-person interpreter significantly increased Latino parents' satisfaction ($p < 0.001$) versus phone interpreter, but a program using an interpreter to educate residents in cultural and language issues increased parents' satisfaction even more [36].

Mentoring is an important and widely used tool for personal and career development in the workplace [45]. The inherently developmental and reflective focus of mentoring relationships [45, 46] places mentoring as a potentially powerful strategy for the development of health professional cultural competence. However, research on cultural competence mentoring and supervision has primarily examined supervision for minority practitioners by Caucasian supervisors [46–48]. It has focused on the provision of culturally appropriate supervision to health professionals of different backgrounds or identities to supervisors [49, 50] or as a strategy for the recruitment and retention of minority students [51]. Unfortunately, there is a scarcity of research exploring the role of mentoring and supervision in increasing the cultural competence of general health professionals. This is one intervention approach which could be further explored for its potential benefits on health provider cultural competence.

4.3.3 Delivery Mode

Interesting distinctions between reviewed studies in the delivery mode of interventions were evident. The majority of studies (69%) evaluated interventions specifically targeting a broad spectrum of health professionals across practice sites. Five interventions were delivered to health professionals across multiple sites in one geographical area [27, 29, 31, 34, 35]; three delivered cultural competency-focused interventions to professionals from diverse, unspecified practice settings [22, 25, 33]; and a further three delivered cultural competence training on a state or nationwide basis [21, 28, 32]. One example of a large-scale cultural competence workforce development initiative is described in the report by the Aboriginal Workforce [21]. This intervention aimed to provide cultural competence training to all staff of an Australian state government health service that employs approximately 100,000 people. In another study, McGuire et al. [32] evaluated a cultural competence training intervention in the USA utilising an education DVD delivered to healthcare professionals statewide through conferences, community meetings and clinic training. A live nationwide webcast and satellite conference were also offered, and the training was accessible online. Twenty-six American states were represented in the webcast. These large-scale interventions provide an example of the potential reach of cultural competency training and demonstrate the widespread recognition of cultural competence as a core component of quality healthcare.

Considering the key role that language plays in culture and the impact of language discordance on patient healthcare experiences as discussed in previous chapters, addressing linguistic competence should be commonplace in cultural competence workforce training and development interventions. Research evidence demonstrates the negative impact of language discordance on patient satisfaction and quality of care measures [52, 53]. While this review did not specifically search for studies on linguistic competence interventions for the health workforce, the lack of attention in the literature to issues of language in cultural competence training and professional development is discouraging. One study provided Spanish language courses and an integrated language immersion program alongside cultural competence training for health practitioners [31]. Another evaluated the impact of interpreter services as well as cultural education of medical residents on patient satisfaction [36]. The lack of attention to linguistic competence is consistent with previous research evidence, which showed that medical schools rarely teach about responding to language differences in healthcare practice, such as teaching about the use of interpreters in cultural competency course content [40].

4.4 Intervention Outcomes

Research studies on cultural competency interventions targeting the health workforce have demonstrated various positive practitioner and patient-related outcomes. Beach et al. found excellent evidence of improved knowledge and good evidence of

improved attitudes and skills among healthcare providers in response to cultural competence education. However, the evidence for the impact of cultural competence training and education on patient-related outcomes was less clear [54]. Several studies have found increased levels of practitioners' cultural competence to be positively associated with increases in patient satisfaction [55, 56], self-reported treatment adherence [57] and patient information seeking and sharing [56]. However, while Beach et al. found some evidence for effects of cultural competence education on patient satisfaction, poor evidence was found for patient adherence, and no evidence was found for improved health outcomes [54]. In a more recent review of cultural competence training interventions, including measures of health outcomes, Lie et al. found limited evidence of a positive relationship between cultural competency training initiatives and improved health outcomes [58].

In this review, we found significant heterogeneity in the outcomes reported across the intervention studies. The outcomes most commonly measured and reported across the reviewed cultural competency training and professional development interventions were related to health practitioner cultural competence. These included knowledge (9/16) [23–28, 31–33], attitudes/beliefs (5/16) [24, 29, 31, 33, 34], skills (7/16) [22, 25, 27–29, 31, 33], behaviour (4/16) [22, 29, 30, 35] and confidence (5/16) [22, 25, 26, 33, 34]. While these outcomes indicate some positive effects of workforce development initiatives on health practitioner cultural competence, there are some critical issues which need to be explored before assuming these results do in fact demonstrate improved practitioner cultural competence.

There is widespread recognition that assessments of knowledge and attitude are insufficient to demonstrate practitioner cultural competence. Firstly, knowledge- or fact-based evaluations can be problematic in cultural competency training given the complex, dynamic nature of culture and the diversity within all ethnic, racial and cultural groups [11]. Assessments focused solely on practitioners' knowledge of group characteristics run the risk of actually encouraging practitioners to stereotype people [11, 59]. Likewise, improved knowledge and attitudes, while arguably important in their own right, are not representative of subsequent changes in practitioner behaviour which is critical to cultural competence. Instead, a focus on teaching specific practice skills and assessing how these skills translate into demonstrable practitioner behaviour is needed [6, 13, 39]. The absence of reported behavioural outcomes, particularly in cultural competence training interventions, makes it difficult to comment. The studies reviewed did not generally provide any indication of the effects of cultural competency training on practitioner's behaviour. Only one training study assessed Patient-Reported Physician Cultural Competence behaviours but found that cultural competence training had no impact [35]. Two mentoring and supervision interventions assessed behavioural outcomes reporting increased research productivity [30] and changes in the practice settings to increase cultural appropriateness [29].

Other research studies found that cultural competency training that used didactic approaches and courses of shorter duration did not achieve behaviour change in practitioners [4]. A recent study found significantly improved knowledge, attitudes and comfort following cultural competence training. However, there were smaller

than anticipated improvements in practitioners' levels of comfort in using cultural competency strategies. The findings suggest that practitioners needed additional support to implement learned knowledge and skills in daily practice [60]. This concentration on knowledge, attitudes and skills, without assessment of their application in practice, is recognised as a core challenge in cultural competency workforce training interventions [41, 61].

The general heterogeneity across all factors in intervention content, duration and outcomes and measures makes comparisons of study effects very difficult. Similar to the findings of Beach et al., most of the reviewed training interventions reported positive outcomes independent of course duration and content [54]. Despite this, there was such variance between interventions in content and duration that a comparison of intervention impacts on outcomes was not possible. Furthermore, no studies compared the effects of training of longer or shorter duration on the same training curriculum and outcome measures. Likewise, there were no studies which compared the effects of different training approaches and content on the same practitioner cultural competence measures.

The lack of evidence for the impacts of cultural competence workforce training and development interventions on patient health outcomes [58] remains an ongoing limitation. Only a small number of studies evaluated healthcare outcomes, including practitioner satisfaction (4/16) [23, 26, 29, 33], patient satisfaction (2/16) [35, 36] and patient trust (1/16) [35]. Of the two studies which measured patient satisfaction, only one reported improvements in patient satisfaction following the intervention [36]. Considering that a major aim of cultural competence is to improve healthcare treatment and quality, patient experiences, as indicated by measures such as patient satisfaction, trust and healthcare access, deserve far greater attention in intervention evaluations. Health outcomes were assessed in only two studies [31, 35] with neither demonstrating significant changes as a result of intervention effects.

4.5   Measurement and Study Quality

The overall quality of studies evaluating interventions to improve the cultural competence of the health workforce was moderate to poor. Only two studies received a strong study quality rating [35, 36], and four were assessed as moderate (25%) [21, 24, 26, 28]. Ten of the sixteen studies (63%) were assessed as being weak in study quality. Study quality issues regarding the measurement of cultural competency training and workforce development intervention outcomes were common. For example, of the seven studies which measured practitioner cultural competency using some form of measurement tool, only four used existing validated measurement tools [23, 24, 29, 34], and one used a tool developed from existing validated instruments [28]. Similar to Beach et al., we found that no two studies used the same measurement tool [54]. A systematic review of 54 instruments to measure health professional's cultural competency by Kumas-Tan et al. also found that measures were rarely cited more than once [61].

   A significant lack of uniformity was found in the outcome measures of practitioner cultural competence even within the same outcome categories. This finding was also identified by Beach et al. [21]. For instance, while many studies assessed knowledge outcomes, none assessed the same type of knowledge using the same method of assessment. Furthermore, studies rarely accounted for practitioner variables such as gender, age, race and prior training or cultural competency levels. Another issue with many practitioner cultural competence measurement tools is that they have been developed without patient input and are normed on predominantly white, middle-class, English-speaking populations [61]. These measures are therefore of questionable reliability and validity when used with people who are not represented in this normative group [61, 62].

   The over-reliance on practitioner self-report measures of cultural competence is an ongoing limitation and concern [8, 41, 61]. This is demonstrated in the 16 reviewed studies, 69% of which relied on self-report to measure intervention outcomes. Because of the subjective nature of self-report, these measures are susceptible to a range of biases. For instance, higher levels of self-assessed confidence may be indicative of poorer insight and awareness on behalf of health practitioners [61]. The inherent issue of social desirability bias can also lead to participants selecting socially appropriate responses, which may not reflect their true beliefs [11, 61, 62]. Such responses are not predictive of resulting behaviour in clinical encounters [11]. The over-reliance on self-assessment is accompanied by a general lack in evaluations of patient perspectives. In this review, only one study evaluated patient perspectives by assessing the relationship between patient-reported physician behaviour and patient satisfaction and trust [35]. To develop a stronger evidence base for the effectiveness of interventions in improving the cultural competence of health professionals, more objective measures of intervention success beyond self-assessment are necessary [41]. There is also a great need to measure intervention effects over time. Only one study addressed the sustainability of intervention effects by completing a follow-up assessment at 3 months; it found that intervention impacts were sustained in this timeframe [23]. This is something which ought to be commonly measured in any workforce development interventions to improve healthcare cultural competence.

4.6 Conclusion

Interventions to increase the cultural competence of health professionals are common. Research studies demonstrate great diversity in approaches to address health practitioner cultural competency with some positive outcomes. However, it is apparent that there are some core issues which need attention to advance this intervention approach and build the evidence base for its effectiveness. Of particular concern is the lack of assessment of the impact of specific practitioner knowledge, attitudes, skills and behaviours on healthcare and health outcomes. This review, similar to others, demonstrates the strong need for studies of greater theoretical and

methodological rigour if we are to elucidate the true potential benefits of health workforce development interventions to improve cultural competence. Finally, consistent measures of practitioner, patient, healthcare and health outcomes are required.

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