ANALYSIS OF BEST PRACTICES AND USED METHODS IN RESEARCH ARTICLES OF CULTURALLY COMPETENT CARE

Applied Systematic Literature Review

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ABSTRACT

Background: The ever-increasing multicultural population in the world creates a significant challenge to nurses providing individualized and holistic care to their patients. Finland is one of the countries that are facing these challenges. In between 1973 and 2003, 22 250 refugees immigrated to Finland and they started facing problems related to cultural differences. The social and health care system then needs to develop cultural competence care in immigration population. This final project is a part of Local and Global Development in Health Care, which is a joint project between social and health care.

Purpose: The purpose of this final project is to describe the best practices and used research methods in culturally competent care.

Method: Using an applied systematic literature review, the author appraise the methodological rigor of studies published in English from 2000-2009. These include: qualitative and quantitative study, full article for review, and targeted studies to describe the best practices and used research methods in culturally competent care. The most common reasons for exclusion were that the finding was not relevant to the study questions. The conceptual framework for this study is based on the Papadopoulos, Tilki and Taylor model for developing cultural competence.

Results: This study describes the best practices and used research methods in culturally competent care. This review confirms that there was uniformity of used methods in the articles. These are: interviews and questioners, and surveys from recorded or available data. These methods help to explore the minority's experience of culturally competent care in health care. This best practices analysis describe that racial and ethnic minority respondents were more likely to perceive bias and lack of culturally competent care when seeking treatment in the health care system overall than whites. Perceptions of racism and mistrust of whites had a significant negative effect on trust and satisfaction from received care. Patients' preferences for a same race or same ethnicity physician were also associated as a preferable encounter in patient-physician relationships.

Conclusion: This review confirms that there is uniformity in the data collecting methods such as focus group and telephone interviews, questioners and records or available method. These methods help to identify the minority's challenges in their health and illness needs. According to this review the minority patient were experiencing different challenges and bias. Some of the challenges were language barriers, language and racial discriminations, and communication problems. These kinds of problems lead the minority patients to dissatisfaction of their care and poor communication. Developing transcultural nursing practice is a key factor to minimize cultural challenges and to provide quality patient care.

Keywords

"Cultural competence", "culturally competent care", "ethnic minority perceptions

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Hyvien käytäntöjen ja tutkimusmenetelmien arviointi tutkimus artikkeleissa jotka menetelmana käyttävät kulttuuri toimivaltaista hoitoa: Soveltavaa järjestelmällinen kirjallisuuden arviointi.

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TIIVISTELMÄ

Tavoite: Tämän lopullisen projekttin tarkoituksena on kuvata hankkeen hyviä käytäntöjä ja tutkimusmenetelmia jotka käyttävät kulttuuri toimivaltaista hoitoa.

Menetelmä: käyttäen järjestelmällinen ja soveltavaa kirjallisuuden arviointi menetelma tutkimuksen laatija arvioi metodologian täsmällisyys vuosina 2000-2009 englanniksi julkaistujen tutkimuksien kirjallisuuden käyttäen. Näitä ovat: ne laadulliset ja määrälliset tutkimukset, kokonais artikkelit ja julkaisut, kohdennettuja tutkimuksia, ja hyviä käytäntöjä jossa käyttety kulttuuri toimivaltaisten hoidossa. Yleisin syy tutkimuksen pois jatto oli jos tutkimus ei ollut asianmukainen. Käsitteelliset puitteet tässä tutkimuksessa perustuu Papadopoulosin, tilki Taylorin kehittäma kulttuurisen mallin.

Tulokset: Tämä tutkimus kuvaa hyviä käytäntöjä ja käytetyjää menetelmiä kulttuuri toimivaltaisten hoidossa. Tämä tarkistus vahvistaa sen että käytettyn menetelmat ovat yhdenmukaisia. Nämä ovat: haastattelut ja kysyjät, tutkimukset, ja arkistot tai käytettävissä olevija tietoija. Nämä menetelmät auttaa tutkimaan vähemmistöjen kokemusta kulttuurisesti toimivaltaisten hoidossa. Tämä analyysi kuvaa että eri rotuun ja etniseen alkuperään vähemmistöjen vastaajien yleisesti ilmoittama puutelista kohtelua ja bias terveydenhuoltojärjestelmasta kun silloin pyritään kulttuuri toimivaltaista hoitoa, kuin valkoiset joiden parhaiden käytäntöjen todennäköisemmin mieltävät. Näkemykset rasismin ja epäluulo valkoisiin tuo merkittävää kielteistä vaikutusta luottamuksen ja tyytyväisyyta saadusta huoltoa vastaan. Potilas-lääkäri suhteissa potilaiden suosio saman rodun tai etnisen alkuperän lääkäri oli myös assosioitu tahan näkemykseen.

Päätelmä. Tämä arvio vahvistaa, menetelmien yhdenmukaisuuta tietojen kerämisestä keskittyä ryhmästa, kuten hastatteluja puhelimitse, kysyjät ja muita käytettävissä olevia menetelmä. Nämä menetelmät auttaa tunnistaa ja määrittää vähemmistöjen haasteisiin, niiden terveyteen ja sairauden tarpeisiin. Tämän tutkimuksen mukaan vähemmistö potilat olivat kokeneet eri haasteisiin ja bias. Joitakin nama haasteita olivat kieli esteet, kieli ja rotuun syrjintää, ja tiedonanto ongelmia.
Tällaisia ongelmia johtaa vähemmistön potilaiden hoidon tyytymättömyyttä ja niiden köyhien tiedonanto. Sairaanhoitohenkilöstön käytännön kehittäminen transcultural muotoon on ratkaisevan tärkeää minimoimaan kulttuurisiin haasteisiin ja tarjota laadukkaita hoitoa potilaille.

Avainsanat

"kulttuuri toimivalta" "kulttuuri toimivaltaainen huolto" "etnisen vahemmisto näkemykset"

CONTENTS

1 INTRODUCTION

Finland is one of the Nordic countries in the northern part of the world. The population of Finland is 5.1 million. Finns are 94% of the general population and in fact, they have no ethnic conflicts. The ethnic minorities are Sami (7000) and Roma (10 000). Foreigners (107 000) are mainly from Russia, Estonia and Sweden. Migrations from different countries are growing from year to year. For example, in between 1973 and 2003, 22 250 refugees immigrated to Finland. After that, the Finnish people started facing cultural differences and they believe that these new cultures need to be understood which helps to provide transcultural health and social care (Papadopoulos 2006: 204-208.)

There are different factors that make population move within or out of the country. Some of the reasons for leaving their homeland are war, political oppression, and economic conditions. Migration is one of the reasons, which brings the need for multicultural nursing practice to provide culturally competent care (Leininger 1995: 13). Finland is one of the countries that face challenges in providing culturally competent care in transcultural nursing practice.

Transcultural nursing is an essential aspect of healthcare today. The ever-increasing multicultural population in the world creates a significant challenge to nurses providing individualized and holistic care to their patients. This requires nurses to recognize and appreciate cultural differences in healthcare values, beliefs, and customs. Nurses must acquire the necessary knowledge and skills in cultural competency. Culturally competent nursing care helps ensure patient satisfaction and positive outcomes (Leininger 1995: 3.)

Local and Global Development in Health Care is a joint project between social and health care. This project is based on the model of the Papadopoulos, Tilki and Taylor model for developing cultural competence (2006: 11). The purpose of this final project is to describe the best practices and used research methods in culturally competent care.

These methods help to investigate culturally competent care in the immigrant population. It helps to identify how health care professionals understand minority

cultures, and how to develop the knowledge and attitudes of providers in transcultural nursing. The knowledge of trancultural nursing is a key factor to provide culturally competent care in immigrant population, which will help to satisfy their needs and to minimize complications caused by poor interpersonal relationship.

Cultural competence is a process born of a commitment to provide quality services to all. Providing culturally competent care in the nursing process is a crucial thing to satisfy the patient's needs. This requires to identifying and respecting cultural differences, the assumption of multicultural approach, self-awareness which includes knowledge of one's own culture and honesty in facing and dealing with personal prejudices and the influence of cultural shock for the minorities health problems.

The conceptual framework for this study is based on the Papadopoulos, Tilki and Taylor model for developing cultural competence. In this model cultural competence is viewed as "the process one goes through in order to continuously develop and refine one's capacity to provide effective health care, taking into consideration people's cultural beliefs, behaviors and needs" (Papadopoulos 2006: 11).

2 DEFFINITION OF MAIN CONCEPTS

This study is a part of the Local and Global Development in Health Care project. It is based on the model of the Papadopoulos, Tilki and Taylor model for developing cultural competence (2006: 11). This model explains that cultural competence is an ongoing process, which cannot be achieved in a short period. This process involves the combination of cultural awareness, cultural knowledge, and cultural sensitivity, which helps to provide culturally competent care, and to avoid discrimination and empowerment ideology in the transcultural nursing process.

2.1 Concepts of Model for Developing Cultural Competence

2.1.1 Cultural Awareness

The first stage in the model, cultural awareness, begins with an examination of personal values and beliefs. Before starting to assess other cultures, health care professionals need to know their own cultural background and understand how their cultural values, beliefs, attitudes and practices influence their interactions with others. This knowledge of cultural awareness helps to see cultural issues with minorities more sensitively.

If we compare different cultures´ value of love, life, justice, health, and family life, they have much in common but the interpretations of those values are different. This difference comes from life experience, difference in gender and age, and different cultural backgrounds. First, health care providers need to assess cultural identities, and to know their own cultural background and understand their cultural values, attitudes, beliefs and practices which come from an early age and their own family culture and social environment. Those cultural values and beliefs, affect their interaction with others. Therefore, self-assessment is important to avoid, evaluating other cultures according to the standards of one's own culture and stereotypes. It also helps to avoid ethnocentric tendency (Anderson and McFarlane 2008:122-123; Andrews and Boyle 2003: 18).

2.1.2 Cultural Knowledge

Papadopoulos (2006:13-16) explains that the second stage is a learning process which helps to understand other cultures. The understanding can be gained by making meaningful contact with different people who came from different cultural background, which in turn helps to improve knowledge about health beliefs and behaviors and raise understanding of the minority's problems. Cultural knowledge involves seeking and obtaining information about the various world-views of different cultures.

Health care providers need to develop the feelings of acceptance in interpersonal relationship in transcultural nursing. The first step to develop cultural competence is the willingness of knowing other cultural issues, such as needs to understand the minority's meaning and role of their culture, and knowing how to apply in health care. It needs commitment and adapting the cultural knowing process which helps to meet culturally unique needs. Cultural knowledge gives health care providers the practical understanding of how to work with others from different backgrounds in a culturally sensitive way (Anderson and McFarlane 2008:121).

2.1.3 Cultural sensitivity

According to Papadopoulos (2006:16) an important element in achieving cultural sensitivity, the third stage, is how professionals view minorities in their care. To develop cultural sensitivity, the health care professionals need to build up a good interpersonal relationship with their clients. Achieving equal partnership with clients is a crucial thing in cultural sensitivity, "Unless clients are considered as true partners, culturally sensitive care is not being achieved; to do otherwise only means that professionals are using their power in an oppressive way. Equal partnerships involve trust, acceptance and respect as well as facilitation and negotiation." (Papadopoulos 2006: 16.)

2.1.4 Cultural competence

Finally, as Papadopoulos explain (2006:18), the forth stage, Cultural competence is a developmental process that requires a long-term commitment. To be culturally competent, the health care professional should make an effort to be aware of cultural similarities and differences and needs to combine and apply the previous cultural knowledge, awareness, and sensitivities. The term cultural competence refers to the ability to work effectively with individuals from different cultural and ethnic backgrounds.

To work effectively one needs to assess patient's needs and problems that are related to health. In the process of assessment, the health care providers need to consider the patient's cultural values, beliefs, economic and social factors, political and legal factors, educational factors, and language and communication ability of the ethnic minorities. Other things that care providers need to be aware of are gender or class differences, communication needs, and interpersonal space (Andrews and Boyle 1999: 8, 2003: 15; Papadopoulos 2006: 18).

2.2 Data collection methods

According to LoBiondo and Haber (2006: 317-321) Data Collection is an important aspect of research study. Data collection methods are described as being both objective and systematic. By objective, the data must not be influenced by another who collects the information. By systematic, the data must be collected in the same way by every one who is in the data collection process. Data collection methods of a study provide the operational definitions of the relevant variables. There are five types of data Collection methods, such as physiological, observational, interviews, questionnaires and records or available data.

2.3 Best practices research

Research is the systematic process of collecting and analyzing information to increase our understanding of the phenomenon under study. It is the function of the researcher to contribute to the understanding of the phenomenon and to communicate that understanding to others. Best practices research is one of the research processes. It is a systematic way of identifying and analyzing data, and improving practices. "Best practices research is a systematic process used to identify, describe, combine, and disseminate effective and efficient clinical and/or management strategies developed and refined by practicing clinicians" (James, W. and Mark, E. 2003: 35(3), 131-4).

3 PURPOSE OF THE PROJECT AND RESEARCH QUESTIONS

The purpose of this final project is to describe the best practices and used research methods in culturally competent care.

What are the research methods used in research articles to describe culturally competent care?

What are the best practices in research articles to describe culturally competent care?

4 METHODOLOGY

4.1 Data collection

According to LoBiondo and Haber (2006: 88-89), traditional print resources do not need to be included in electronic database research. This final project was an applied systematic literature review, and used electronic databases were OVID, CINAHL, and PUB MED. The following key words were used to perform searches on each of the above databases: “Cultural competence”, “culturally competence care”, “ethnic minority perceptions”, “minorities” and “immigration population”. The key words were combined by “and” to get relevant information that helps to answer the research questions. The following criteria were used to include articles for further consideration:

1. The article is based on empirical research
2. The article is published in between 2000-2009,
3. The article is published in English
4. The article is in full text
5. The article is relevant to this final project’s topic

The exclusion criteria used was that the finding was not relevant to this final project’s research questions. Literature search and review process retrieved 36797 articles. Most studies were excluded after the title and abstract, and 10 articles passed the review process leaving scientific articles, which had relevant information that helps to answer the research questions.

Table 1 Database search and Relevant Hits

Date	Data base	Key words	Hints	Full articles	Title	Abstract	Relevant to study
25.10.2009	Pub med	Ethnic minorities perceptions AND cultural competence care	15	7	4	3	1
25.10.2009	Pub med	cultural competence care AND minorities	195	28	11	6	1
15.10.2009	Ovid	cultural competence AND immigration population	12082	1658	18	8	1
02.11.2009	CINAHL	cultural competence care AND Ethnic minorities perception	24505		10	4	2

4.2 Data analysis

The data analysis was reviewed in a deductive review process where the articles were read and reviewed. The articles were arranged in a table containing author, year, sample, data collection methods and analysis, and main findings (Appendix 1). The main findings of these articles were targeted to cultural competence care in

immigration population. Those findings of the articles were analyzed and certain themes emerged from the empirical data. (See table 2.) The themes were explored through concept analyses. These themes were categorizing, as a framework of the Papadopoulos, Tilki and Taylor model for developing cultural competence. (Figure 1)

5. FINDINGS

5.1 Used methods in research articles

This review confirms that there is uniformity in the methods that have been used to investigate culturally competent care in immigration population. Qualitative and quantitative research methods were used. In this review, four methods of data collection were used such as telephone interview, focus group interview, questionnaires, and recorded or available data. In this final project, most of the articles used interview as a data collecting methods, which can explore the individual experiences in culturally competent care. There are two types of interview methods used in these articles they were six telephone interviews and two focus group interviews. (Rachel, L. et al. 2004:19,101-110), (Quyen, N. 2004:19), (Janice, B. 2007:22, 1184-1189), (Ramona, B. 2006:98, 9), (Frederick, M. 2005:3, 2) and (Robert, W. 2003:38, 3) used telephone interviews, and (Anna, M. 2005:8, 4-17) and (Johanna, S. 2002:36:749-759) used focus group interviews. Other used methods were questionnaires and recorded or available data. These were: (Cynthia, T. 2005: 97, 8) used questionnaires and (Diane, S. 2006:44, 10) used recorded or available data.

These methods help to identify, the minority's challenges in their health and illness needs. It helps to make contact and gather relevant information concerning the minority's illness and cultural needs. Additionally these methods help to know new cultures and to identify the similarities and differences between cultures. This knowing process helps to develop and provide culturally competent care.

5.2 Analysis of best practices

This best practices analysis describe that overall racial and ethnic minority respondents were more likely to perceive bias and lack of culturally competent care when seeking treatment in the health care system than whites. Different articles have shown that for minority patients, racial concordance between patient and physician were associated with greater patient satisfaction and quality of care. Perceptions of racism and mistrust of whites had a significant negative effect on trust and satisfaction from received care. Patients' preferences for a same race or same ethnicity physician were also associated as a preferable encounter in patient-physician relationships. Additionally, this review explains that Racial/ethnic diversity patients in the health care were facing different challenges and bias.

According to the articles, racial and ethnic minorities have experienced multiple barriers to healthcare, such as language barriers (Robert, W. 2003:38, 3), language discrimination (Janice, B. 2007:22, 1184-1189) and (Rachel, L. et al. 2004:19,101-110), and racial discrimination (Rachel, L. et al. 2004:19,101-110), (Janice, B. 2007:22, 1184-1189) and (Frederick, M. 2005:3, 2) and age based discrimination (Anna, M. 2005:8, 4-17). Other barriers were dissatisfaction that caused by communication problems (Cynthia, T. 2005: 97, 8), negative effect on trust (Ramona, B. 2006:98, 9), lack of knowledge (Cynthia, T. 2005: 97, 8) and (Quyen, N. 2004:19), and disrespect (Rachel, L. et al. 2004:19,101-110).

These kinds of problems lead the minority patients to dissatisfaction of their care and poor communication. The problem with communication affected the effort to develop trust and equal partnership between patients and providers. Instead of developing trust, the minority patient's experiences were feeling of not respected, not belonging/mistrust, and discriminations. Developing trans-cultural nursing practice is a key factor to minimize cultural challenges and to provide quality patient care (Table 2).

Table 2 Cultural competence domains identified by authors of the articles

Cultural competence domains	Examples from the articles
Cultural competence: Prejudice, discrimination and inequalities	"They would have received better medical care if they belonged to a different race/ethnic group respectively" (Rachel, L. et al. 2004:19,101-110) "When asked about the last visit, they were more likely to report that their doctors did not listen, spend as much time, or involve them in decisions about care as much as they wanted." (Quyen, N. 2004:19) "Asians were less likely to report being treated unfairly because of race if in racially concordant relationships with providers than if in non-concordant ones"(Janice, B. 2007:22, 1184-1189) "Hispanics were also less likely to perceive unfair treatment because of language when in concordant relationships with staff as compared to non concordant relationships with staff" (Janice, B. 2007:22, 1184-1189) "Among African Americans, stronger beliefs about racial discrimination in health care were associated with preferring an African American physician" (Frederick, M. 2005:3, 2) "Latinos with stronger beliefs about discrimination in health care were more likely to prefer a Latino physician" (Frederick, M. 2005:3, 2)
Cultural sensitivity:	"Medical staff judged them unfairly or treated them with disrespect based on race/ethnicity respectively and how

Interpersonal/communication skills	well they speak English" (Rachel, L. et al. 2004:19,101-110)
Trust, respect	"The results of this study indicated that the majority of our respondents were satisfied with the care they received, but for a small percentage, language, communication, and/or culture contributed to dissatisfaction". (Cynthia, T. 2005: 97, 8) "Perceptions of racism and mistrust of whites had a significant negative effect on trust and satisfaction" (Ramona, B. 2006:98, 9)
Cultural knowledge: • Health beliefs and behaviors • understanding	"Some respondents did not think the provider was culturally competent, i.e., not sufficiently knowledgeable about their racial, ethnic and/or cultural background." (Cynthia, T. 2005: 97, 8)
• Similarities and differences	Language barriers (Robert, W. 2003:38, 3)
• Health inequalities	"Regular doctors did not understand their background and values" (Quyen, N. 2004:19) "social class based discrimination, ethnic concordance of physician and patient, and age-based discrimination" (Anna, M. 2005:8, 4-17)

6 VALIDITY AND RELIABILITY

This final project was an applied systematic literature review hence there was no direct data collection from participants during data collection process. The database searches were conducted only from reliable electronic database research such as OVID, CINAHL, and PUB MED, hence traditional print resources were not included. The

articles used in this final project were freely available data from the school electronic database. I read all articles and analysed the data according to my research questions and topic. Most of the articles were used qualitative research methods, which can explore the individual experiences in culturally competent care. These final project findings were based on the scientific articles and my personal view was not included. The results were assessed by reflecting on the content of the utilized articles after gathering the data. Ten articles were used; the results could not be generalized because of the limited number of articles used.

7 ETHICAL CONSIDERATION

The ethical considerations are based on the articles that I used to collect data. All of the articles followed ethical guidelines by ensuring that participant's anonymity and confidentiality was maintained and informed consent was obtained. The references for each data used are cited after the sentence or paragraph and in the reference page as well. These final project findings were based on the scientific articles and my personal view was not included.

8 DISCUSSION

The purpose of this final project was to describe the best practices and used research methods in culturally competent care. According to this review, four methods of data collection were used such as telephone interview, focus group interview, questionnaires, and recorded or available data. These methods help to make contact and gather relevant information concerning to the minority's illness and cultural needs. Additionally these methods help to know new cultures and to identify the similarities and differences between cultures. This knowing process helps to develop and to provide culturally competent care.

This best practices analysis suggests that the experience of interpersonal racism and perceptions of racism in wider society both have independent negative health consequences. The results of this final project show that racial and ethnic minority respondents were more likely to perceive bias and lack of culturally competent care when seeking treatment in the health care system overall than whites. Perceptions of racism and mistrust of whites had a significant negative effect on trust and satisfaction. This review reveals an association between patients' beliefs about discrimination in health care and specific preferences for the race or ethnicity of their physician. Patients' preferences for a same race or same ethnicity physician were also associated as a preferable encounter in patient physician relationships. Additionally most of this final project's articles indicated that language barriers, and language, age and racial discrimination were common findings that contribute to dissatisfaction in patient care.

Culturally competent care is a key concept in transcultural nursing practice. It needs to identify and recognize the culture differences and similarities, and knowing how to apply in nursing practice. To provide culturally competent care and satisfy the patient's needs, providers need to be aware of their own culture, willing to know new culture and apply their knowledge in nursing practice. Adapting to different cultural beliefs and practices requires flexibility and a respect for others view points. Culturally competent care provider needs to listen, to find out and learn about the patient's beliefs of health and illness. To provide culturally competent care they need to know and to understand culturally influenced health behaviors. Since the perception of illness and disease and their causes varies by culture, these individual preferences affect the approaches to health care. Culture also influences how people seek health care and how they behave toward health care providers. How health care providers care for patients and how patients respond to this care is greatly influenced by culture. Health care providers must possess the ability and knowledge to communicate and to understand health behaviors influenced by culture. Having this ability and knowledge can eliminate barriers to the delivery of health care. These issues show the need for health care organizations to develop guidelines, practices and procedures to deliver culturally competent care.

9 CONCLUSION

This applied systematic literature review helps to describe the best practices and used research methods in culturally competent care. There are different types of data collection methods, which can help to gather relevant information from different sources. This final project used ten articles to discus about culturally competent care in immigration population. Used methods in the articles were focus group interview, telephone interviews, questionnaires and records or available method. Those methods help to gather the information about minority's experience in culturally competent care. According to the finding of this final project, minorities have experienced different cultural challenges and bias. Some of the challenges were language /racial discrimination, cultural barriers, language barriers and communication problems. Additionally mistrust, feeling of not belonging leads them to prefer the same race healthcare professional. This final project concluded that providing culturally competent care is a key factor in transcultural nursing practice, which helps to satisfy patient's need.

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Ramona, B., Rosalind, M., Rodney, C. and Kathryn, K. (2006) Effects of Perceived Racism, Cultural Mistrust and Trust in Providers on Satisfaction with Care. *Journal of the National Medical Association* 98, 9.

Robert, W., Leo, S., Marc, E., Karen, S., Grant, M. and Ron, D. (2003) Race/Ethnicity, Language, and Patients' Assessments of Care in Medicaid Managed. *Health Services Research* 38, 3.

Table of utilized journals

Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Journal of General Internal Medicine					2			1		
Journal of the National Medical Association						1	1			
Annals of Family Medicine						1				
Medical Effectiveness Research Center						1				
Medical Education			1							
American Journal of Public Health				1						
Medical Education							1			
Total			1	1	2	3	2	1		

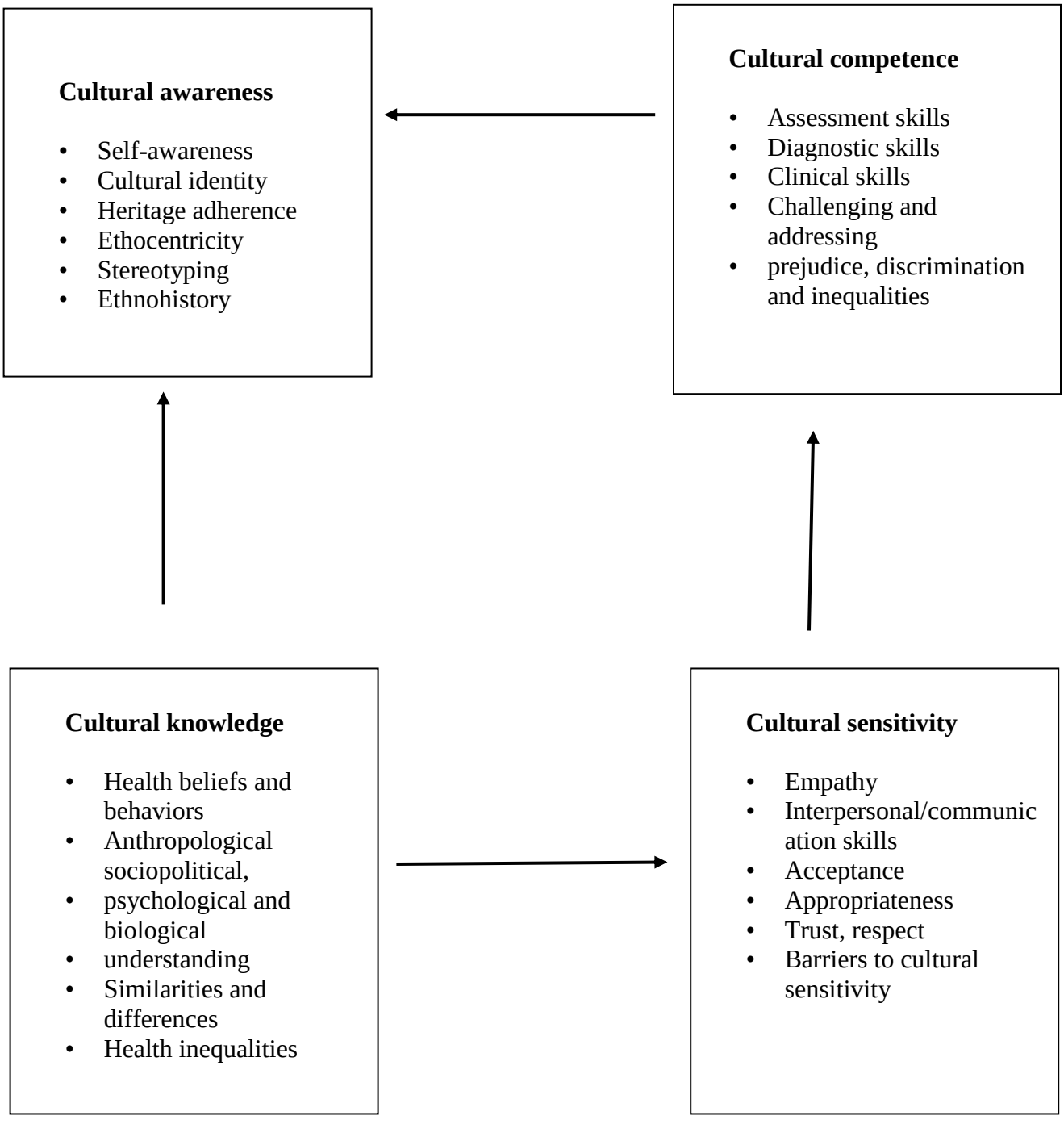

FIGURE 1 Model for developing 'Cultural Competence' (Papadopoulos, Tilki and Taylor, 2006: 11)

APPENDIX 1 Summary of the reviewed articles

Title	Authors & year of publication	Purpose of the study	Sample size	Data collection and analysis	Minority's experience related to cultural competence domains
Racial and Ethnic Differences in Patient Perceptions of Bias and Cultural Competence in Health Care	1. Rachel L. Johnson. 2004	To determine: 1) whether racial and ethnic differences exist in patients' perceptions of primary care provider (PCP) and general health care system–related bias and cultural competence; and 2) whether these differences are	A total of 6,299 white, African-American, Hispanic, and Asian adults	Telephone interview using random-digit dialing Data were weighted post-hoc.	They would have received better medical care if they belonged to a different race/ethnic group respectively Medical staff judged them unfairly or treated them with disrespect based on race/ethnicity respectively and how well they speak English

		explained by patient demographics, source of care, or patient-provider communication variables.			
Satisfaction with and Perceived Cultural Competency of Healthcare Providers: The Minority Experience	2. Cynthia T. 2005	To assess satisfaction of minority community members in Omaha with the care received and cultural competency of healthcare providers.	Respondents were 80. The sample was 43.8% male and 55% female.	Focus group interview Pilot-tested study	The results of this study indicated that the majority of our respondents were satisfied with the care they received, but for a small percentage, language, communication, and/or culture contributed to dissatisfaction. In addition, some respondents did not think the provider was culturally competent, i.e., not sufficiently knowledgeable about their racial, ethnic and/or cultural background. Some participants indicated that they preferred a provider of similar racial, ethnic, and/or cultural background, and/or thought some diseases were

					better treated by a provider of the same racial, ethnic, and/or cultural background
Asian Americans' Reports of Their Health Care Experiences	3. Quyen Ngo-Metzger 2004	To examine how Asian race/ethnicity affects patients' health care experiences and satisfaction with care.	White (*N* = ,205) and Asian-American (*N*= 521) adults respondents.	Telephone interview using random-digit dialing Bivariable analysis	Regular doctors did not understand their background and values. When asked about the last visit, they were more likely to report that their doctors did not listen, spend as much time, or involve them in decisions about care as much as they wanted.
Patient–Provider and Patient–Staff Racial Concordance and Perceptions of Mistreatment in the Health	4. Janice Blanchard, 2007	To determine what roles patient–provider and patient–staff racial concordance play on patients' perceptions within the health care setting.	Representative sample of 6,722 adults, age 18 and older.	Telephone interview using random-digit dialing Bivariate (chi-squared) analysis and multivariate logistic analysis	Asians were less likely to report being treated unfairly because of race if in racially concordant relationships with providers than if in non-concordant ones. Hispanics were also less likely to perceive unfair treatment because of language when in concordant relationships with staff as compared to non concordant relationships with staff

Care Setting					
Effects of Perceived Racism, Cultural Mistrust and Trust in Providers on Satisfaction with Care	5. Ramona Benkert 2006	To test a mid-range theoretical model entitled Perceptions of Racism and Mistrust in Health Care (PRMHC).	145 African-American in a group of low income in two primary care clinics	Structured interviews Structural equation modeling analysis	Perceptions of racism and mistrust of whites had a significant negative effect on trust and satisfaction. Perceived racism had both a significant, inverse direct effect on satisfaction as well as a significant indirect effect on satisfaction mediated by cultural mistrust and trust in provider.
Patients' Beliefs About Racism, Preferences for Physician Race, and Satisfaction With Care	6. Frederick M. 2005	Few studies have attempted to link patients' beliefs about racism in the health care system with how they use and experience health care.	1,479 whites, 1,189 African Americans, and 983 Latinos	Telephone interview using random-digit dialing Race-stratified analyses	Among African Americans, stronger beliefs about racial discrimination in health care were associated with preferring an African American physician. Latinos with stronger beliefs about discrimination in health care were more likely to prefer a Latino physician
Patients' perceptions of	7. Anna M. 2005	To identify key domains of	61 African–Americans,	Telephone interview using random-digit	Factors influencing the quality of medical encounters common to all ethnic groups included

cultural factors affecting the quality of their medical encounters		cultural competence from the perspective of ethnically and linguistically diverse patients.	45 Latinos and 55 non-Latino Whites.	dialing Chi-square analysis	sensitivity to complementary/alternative medicine (17%), health insurance-based discrimination (12%), social class based discrimination (9%), ethnic concordance of physician and patient (8%), and age-based discrimination (4%). Physicians' acceptance of the role of spirituality (2%) and of family (2%), and ethnicity-based discrimination (11%) were cultural factors specific to non-Whites. Language issues (21%) and immigration statuses (5%) were Latino-specific factors.
Primary care resident, faculty, and patient views of barriers to cultural competence, and the skills needed to overcome	8. Johanna Shapiro, 2002	To explore resident, faculty and patient attitudes and beliefs about what culturally competent doctor-patient communication means, what obstacles impede or	The participants were 33 male and 34 female.	Focus group interview A content analysis was performed to identify major themes.	These residents talked about cultural sensitivity (understanding cultural do s and don'ts') and specific cultural knowledge, such as understanding patient health beliefs. They also used phrases such as _being on the same page with the patient_ and _sharing common ground_, and stressed the importance of establishing a trusting relationship in describing cultural competence. Several residents expressed the belief that their own culturally different

them		prevent culturally competent communication, and what kinds of skills are helpful in achieving cultural competence.			backgrounds made them more sensitive to other cultures.
Immigrant Perceptions of Discrimination in Health Care	9. Diane S. Lauderdale, 2006	They examined whether foreign-born persons are more likely to report discrimination in healthcare than U.S.-born persons in the same race/ethnic group, whether the immigration effect	The participants were 42,044 adults	Interview Cross-sectional analysis	Respondent reports that there was a time when they would have gotten better medical care if they had belonged to a different race or ethnic group. Seven percent of blacks and Latinos and 4% of Asians reported healthcare discrimination within the past 5 years. Immigrants were more likely to report discrimination than U.S.-born persons adjusting for race/ethnicity. Speaking a language other than English at home increased discrimination reports regardless of

		varies by race/ethnicity, and whether the immigration effect is "explained" by sociodemographic factors.			birthplace; private insurance was protective for the U.S. born only.
Race/Ethnicity, Language, and Patients' Assessments of Care in Medicaid Managed Care	10. Robert, W. 2003	To examine whether consumer reports and ratings of care in Medicaid managed care vary by race/ethnicity and language.	The participants were 49,327 adults	Telephone interview using random-digit dialing Data were analyzed using linear regression models.	Racial/ethnic and linguistic minorities tended to report worse care than did whites. Linguistic minorities reported worse care than did racial and ethnic minorities.