

Cultural Competency in the Primary Health Care Relationship

Thesis submitted to the Faculty of Graduate and Postdoctoral Studies (FGPS) in partial fulfillment of the requirements for the M.Sc. degree in Epidemiology degree

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Acknowledgements

Writing this thesis has been a journey for me; one that I would not have been able to embark let alone complete without the endless guidance and support of my thesis supervisors. Thank you, Dr. Ron Labonté, for showing me how to transform an idea I was passionate about into a complete thesis project, a skill that will accompany me always. Thank you also, Dr. Kevin Pottie, for your invaluable insight on this complex subject, encouraging me to consider alternative perspectives and think “outside the box”.

I would also like to thank the Canadian Institutes of Health Research (CIHR) for their support by awarding me the Frederick Banting and Charles Best Graduate Scholarships-Master’s Award. In addition, a special acknowledgement goes to the South-East Ottawa Community Health Centre and the Somerset West Community Health Centre for opening their doors to me during the recruitment process, as well as Connie Castaño for allowing me to participate in various community activities through the Ibero American Organization, Projenesis.

My sincere appreciation goes out to my family, particularly my partner Rodrigo, my sister Alice and my father Eduardo, for their patience, support and input in the early phases of this research study.

Most importantly, I would like to thank the participants of this study, who shared with me their struggles and successes while reliving their experience of migrating and settling in Canada in hopes of improving health care for all Canadian immigrants.

Abstract

Cultural competency is theorized as the sensitivity of practitioners from the dominant culture towards the diverse cultural backgrounds of their patients. Less attention is placed on how communication between providers and patients can enable patients to share their health care beliefs.

An evidence review of the literature around the conceptualization of cultural competency in health care was performed, and interviews were conducted aiming to understand what immigrant patients perceive as culturally competent care and its effect on the relationship between them and their providers.

Definitions of cultural competence varied, and no conclusive studies linking cultural competence to improved health outcomes were found. Findings from the participant interviews helped to address gaps in the literature by confirming a preference for a patient-centred approach to culturally competent care, in addition to identifying pre-existing expectations for the health care encounter and patient-dependent factors as additional elements influencing the physician-patient relationship.

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CHAPTER 1 INTRODUCTION AND OBJECTIVES

Cultural Competence and Patient-Centredness in Primary Health Care

Cultural competency has been commonly defined as a set of congruent behaviours, attitudes and policies that come together as a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations (1). Betancourt et al. have further defined cultural competency in health care by highlighting that health care professionals should provide effective and high-quality care to patients regardless of their socio-cultural backgrounds, while clarifying that diversity not only includes race and ethnicity but also gender, sexual orientation, religion, and country of origin among other characteristics (2).

Traditionally, cultural competency has been taught according to the specific attitudes, traditions, values and beliefs of individual cultural groups. However, because this method combined patients with similar cultures and generalized their values and beliefs, it led to stereotyping and oversimplification (3). In addition, it is impractical and probably impossible for a health practitioner to learn every aspect of individual cultural groups, since these groups tend to be dynamic with varying ranges of acculturation. This has led to the development of the 'patient-centred' approach to cultural competency, where emphasis is placed on the individual sociocultural factors that can influence a person's health (2-5).

This approach relies heavily on what is known as the patient's *explanatory model* described initially by Arthur Kleinman in 1978. He theorized that patients' understanding of health and illness is determined not only by their culture but also by the environment in which they live and the way health is conceptualized in their society, otherwise known as

“medical culture” (6). Some authors, such as Saha et al., have drawn several comparisons between patient centeredness and cultural competency, in terms of improving quality of care. They indicate that these two concepts overlap, especially when it comes to exploring and respecting patients’ beliefs and understanding of illness and disease (5).

Eliciting a patient’s explanatory model allows the health care provider to become familiar with the patient’s understanding of sickness aetiology, symptoms, course of illness, treatment options, and encounter expectations. Failure by health practitioners to understand these core concepts may lead to patient dissatisfaction, misdiagnosis, and errors in communication, as well as negative health outcomes due to non-adherence and lower preventive behaviours (2). Using the patient-centred approach allows providers to further elicit a patient’s beliefs and medical preferences through questions such as: “What do you think has caused your problem?” or “What kind of treatment do you think would work?” (6,7). This approach also allows a deeper understanding of the patient’s social context, which includes socioeconomic status, social networks, migration history, and health literacy among others.

The concept of cultural competency is very broad and it is present at several levels of the primary health care system. For example in terms of access, cultural differences may create difficulties in navigating the Canadian health care system, which is usually very different from the immigrant patients’ country of origin. Examining all the aspects of cultural competency is beyond the scope of this thesis research, and as such the focus will be on factors that affect the communication component of the physician-patient relationship and the quality of care received, once health care has already been accessed.

Immigration and Health in Canada

Over the recent years, an important number of studies across all disciplines have been focusing on the effect of migration on health. This has been particularly noticeable in countries where immigrants¹ account for a large percentage of the population, such as in the case of Canada where immigrants make up approximately 20% of the total population (8). Each year, around 250,000 immigrants arrive in Canada and according to the 2006 Statistics Canada Census, two-thirds of the population growth between 2001 and 2006 was due to net international migration (+5.4%), helping to make Canada the country with the highest rate of population growth compared to the other G8 countries over this period (9,10) (see Figure 1 below). Ontario, in particular, had a growth rate of +6.6%, higher than the national average. Data from Citizenship and Immigration Canada indicates that more than 600,000 immigrants settled in Ontario between 2001 and 2006, representing half of those who immigrated to Canada during that time.

¹ The term “immigrant” in this thesis research refers to both voluntary and involuntary migrants. Involuntary migrants, or refugees are defined as a person who “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country...” as outlined in the 1951 Geneva Convention.

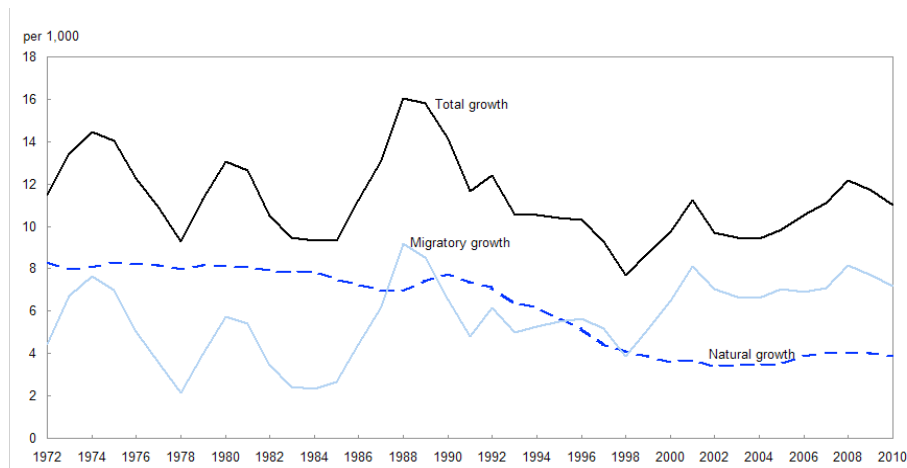


Figure 1. Total, natural and migratory population growth rates, Canada, 1972 to 2010 ²

The demographic composition of the arriving immigrant population is changing as well. Immigrants from Asia and Pacific, Africa and the Middle East, and Central and South America have been steadily increasing, with China, India, Philippines, Pakistan, Korea, Colombia and Iran among the primary source countries (8). The majority of these new arrivals fall within the ages of 15-44 and report an official language different than English or French (11). The three main cities where immigrants choose to settle are Toronto, Vancouver and Montreal. In 2006, there were approximately 2,320,165 immigrants living in Toronto, 831,265 in Vancouver, and 740,355 in Montreal. The greatest proportion of immigrants living in Toronto and Vancouver come from Asia and the Middle East, while in Montreal immigrants are mostly of European origin. Ottawa-Gatineau ranks fifth in terms of percentage of immigrant population, with approximately 202,730 immigrants representing almost 18% of the total Ottawa population (11). This number has been

² Source: Statistics Canada, Demography Division (Notes: Final data from 1972 to 2007, updated data from 2008 to 2009 and preliminary data for 2010. Emigration, returning emigration, temporary emigration and non-permanent residents: Final data from 1972 to 2006, updated data from 2007 to 2009 and preliminary data for 2010. Immigration: Final data from 1972 to 2009 and preliminary data for 2010.)

steadily increasing and, according to the City of Ottawa Growth Projections, by the year 2031 almost all of Ottawa's population growth is expected to be from immigration (12). The characteristics of Ottawa's immigrant population also somewhat differ from those of other cities. In 2001, for example, more than half of recent immigrants aged 25-54 had a university degree, making Ottawa the highest recipient of immigrants with a university degree among all other large Canadian cities (12) In terms of country of origin, while most large Canadian cities receive a significant amount of immigrants of European origin, this population ranks only as the fifth largest group in Ottawa, surpassed by Chinese, African, Middle Eastern and Indian immigrants.

The scale of this migration has been of considerable health policy interest for some time, and research has focused on identifying the most effective ways of addressing the needs of this diverse population. Regardless of country of origin or reason for migration, several studies have confirmed that immigrants tend to be healthier than their Canadian-born counterparts upon arrival. This phenomenon is known as the "healthy immigrant effect" and is well documented in the literature (13-16). Factors such as a healthy diet, optimal levels of physical activity, socio-cultural differences around lifestyle, and a comprehensive health screening process prior to immigration mainly account for this effect (15). Despite this initial advantage, however, the effect is lost over time resulting in a gradual decline in health (17). This is particularly evident in certain immigrant subgroups such as refugees, low-income immigrants, and recent non-European immigrants. While there are some genetic factors that may account for an increase in certain medical conditions among specific immigrant population groups, other conditions appear to be attributable to environmental, educational, socio-economic and cultural factors (18). Issues

around accessibility and navigation of the Canadian health care system also seem to play an important role (13,15).

From the health service provider perspective, caring for this population presents unique challenges. Lack of familiarity with patient's country of origin and corresponding disease prevalence may result in under or over-testing of certain conditions, leading to inefficient use of resources and sometimes, suboptimal care. In response to this issue, the Canadian Collaboration for Immigrant and Refugee Health recently developed a set of evidence-based clinical preventive guidelines to assist primary care physicians caring for this population (18). It is expected that the use of these guidelines will improve health outcomes related to preventable and treatable diseases.

Physicians are not only encouraged to refer to resources such as guidelines, but are also advised to consider contextual factors such as patients' cultural background and preferences, and to tailor the medical encounter accordingly (4,19). While there are multiple studies on this dimension of the physician-patient communication relationship, evidence is still unclear as to its exact influence on health outcomes and patient satisfaction. Most of these aspects are part of what is known as 'cultural competency' and 'patient-centredness', which will be described in detail in Chapter 3- *Literature Review Findings*.

Research Objectives

The following objectives are designed to address the main overarching research question: How do new immigrant patients conceptualize cultural competency? New immigrants in this thesis are defined by persons who migrated to Canada and have been living in Canada for ten years or less.

1.1.1 Research Objective One: Evidence Review on Cultural Competency and Primary Care

The first objective of this thesis is to perform an evidence review of the literature around cultural competency in health care, and the communication relationship between providers and immigrant patients. By conducting a rigorous, structured review of the literature, the following questions were addressed:

- a) What is the historical development of cultural competency in primary health care?
- b) How is cultural competency in health care conceptualized?
- c) What is the evidence linking cultural competency to improved health outcomes?

There are various definitions of cultural competency in the literature, each varying depending on the context. Some of these definitions have been modified and applied to the health care field, with the goal of providing high quality care to culturally diverse populations. Even within the health care field, the abundant literature around this subject has led to a multitude of definitions with no clear consensus. Moreover, it appears

providers and patients conceptualize cultural competency in different ways, creating confusion as to how to best incorporate cultural competency in primary health care.

1.1.2 Research Objective Two: Qualitative Study on Immigrant Perspectives on Cultural Competency

The second objective of this thesis was achieved by conducting interviews with participants identified as immigrants living in Ottawa. The aim was to understand what immigrant patients perceive as adequate culturally competent care and how this affects the communication relationship between them and their providers. The interview was designed to answer the following questions:

- a) How do immigrant patients conceptualize culturally competent care?
- b) What provider attitudes and behaviours do patients believe affect the communication relationship?
- c) What aspects of the medical encounter influence patients' decisions to adhere to medication, follow medical instruction and access preventive services?
- d) What do patients believe could improve cross-cultural communication?

Cultural competency can be explored on several different levels. The majority of studies on immigrant health have focused on understanding the barriers that immigrants face when accessing health care. While this research has produced valuable knowledge, there is limited focus on exploring the immigrant patient's experience once health care has already been accessed. Addressing this knowledge gap may assist in understanding why some

immigrant patients continue to have sub-optimal health outcomes or report lower levels of satisfaction in relation to the health care encounter, despite having adequate access to health care.

CHAPTER 2 METHODOLOGICAL APPROACH

Evidence Review

The approaches for conducting literature reviews may vary greatly depending on the research objectives. In terms of levels of evidence, systematic reviews are considered the gold standard to answering a specific clinical question. By aggregating all evidence in a systematic manner using a research question and pre-specified eligibility criteria, these types of reviews improve reliability, minimize bias and facilitate the decision-making process.

The Cochrane Collaboration, for example, is an internationally recognized group focusing on evaluating the evidence for a certain clinical intervention by identifying a specific population, the type of intervention and comparison, and the outcome of interest (20). Most Cochrane systematic reviews examine interventions in the areas of treatment, prevention and rehabilitation. The rigorous process involves formulating a research question, gathering all primary research addressing the topic, selecting the research that meets the inclusion criteria, synthesizing and analysing all information using stringent guidelines, and finally concluding whether or not the intervention is effective. Many systematic reviews also include meta-analyses, which can improve the accuracy of estimates of the effect of an intervention by using statistical methods to synthesize the results of various studies (20).

The Campbell Collaboration, a sister organisation to the Cochrane Collaboration, also conducts systematic reviews following the same guidelines, yet focuses on different areas such as social policy, social welfare, criminal justice and education, among others. These reviews differ from other systematic reviews by ensuring the inclusion of a systematic

search for unpublished reports as a measure to minimize publication bias. Whenever appropriate and possible, Campbell systematic reviews also conduct meta-analyses.

Cochrane and Campbell reviews focus exclusively on analysing the evidence for a specific intervention. While the rigorous methodology minimizes bias and produces reliable results, it is not applicable in situations where research is conducted in the absence of an intervention, as in the case of this thesis research. As such, different approaches for conducting systematic reviews in health care have been developed, allowing for a broader exploration of research questions. The Evidence for Policy and Practice Information and Coordinating Centre (EPPI-Centre)³ in particular, builds upon the model of systematic reviewing to “address a wider range of questions and methodologies relevant to public policy research such as statistical, narrative and conceptual synthesis” (From <http://eppi.ioe.ac.uk/cms/Default.aspx>).

A systematic review, as defined by the EPPI-Centre, is characterized by the following:

- Explicit and transparent methods are used (a priori research question)
- It is a piece of research following a standard set of stages
- It is accountable, replicable and updateable
- There is a requirement of user involvement to ensure reports are relevant and useful

³ The EPPI-Centre is part of the Social Science Research Unit- Institute of Education at the University of London, and has collaborative partnerships with the Cochrane Collaboration and the Campbell Collaboration among others. For more information, go to <http://eppi.ioe.ac.uk/cms/Default.aspx>.

These key features outlined by the EPPI-Centre highlight the importance of ‘User Driven Evidence’ and incorporate the views of policy-makers, practitioners and other providers, as well as the perspectives of those receiving the service or affected by the services being provided. In addition, this type of systematic review can address questions such as *“how does it feel to receive this intervention? Why does this phenomenon occur”* (21), as well as analyse information in the form of qualitative data.

Taking into consideration the qualitative nature of this thesis, as well as the phenomenon being examined, the evidence review conducted for this thesis research is based on the guidelines described by the EPPI-Centre. The method of review and the type of studies included in the review were guided by the overarching research question: *How do new immigrant patients conceptualize cultural competency?* By following a qualitative approach to the literature review, different types of evidence were identified, mainly in the form of what the EPPI-Centre refers to as “free-text narrative data”, which include summaries, key concepts and themes identified by the authors of primary studies. A qualitative approach was also used during the synthesis stage, taking the form of a “narrative empirical synthesis”, where empirical research is combined and presented in a structured narrative. Involving both stakeholders actively involved in providing care to immigrant patients and the immigrant patients themselves ensured the “user driven” component.

Given the qualitative nature of this evidence review, quantitative concepts such as generalizability were replaced with other measures of validity such as transferability. Whereas generalizability focuses on being able to replicate results in a different setting,

transferability consists of describing the setting and population in enough detail to allow other researchers to compare to another population of interest (22-24).

Informant Interviews

Qualitative research methods are typically used to obtain an in-depth understanding of a certain issue that has not fully been explained through other research methods. Creswell further expands on the need for qualitative methods to address certain research questions by stating:

“We ... conduct qualitative research because we need a complex, detailed understanding of the issue. This detail can only be established by talking directly with people, going to their homes or places of work, and allowing them to tell their stories unencumbered by what we expect to find or what we have read in the literature. We conduct qualitative research when we want to empower individuals to share their stories, hear their voices, and minimize the power relationships that often exist between a researcher and the participants in a study.” (24)(p. 40)

The factors affecting cultural competency, especially within the context of the physician-patient communication relationship, is indeed a complex issue, which can initially be best explored by employing qualitative methods.

The purpose of this qualitative component was to derive a conception of cultural competency from the immigrant patient perspective. As such, this exploratory study did not attempt to test any theories but rather to contribute to the understanding of cultural competency in primary health care. The iterative and cyclical nature of the qualitative

research process allows for ongoing refinement during the data collection and analysis stages, resulting in a deeper understanding of the issue being studied (see Figure 2).

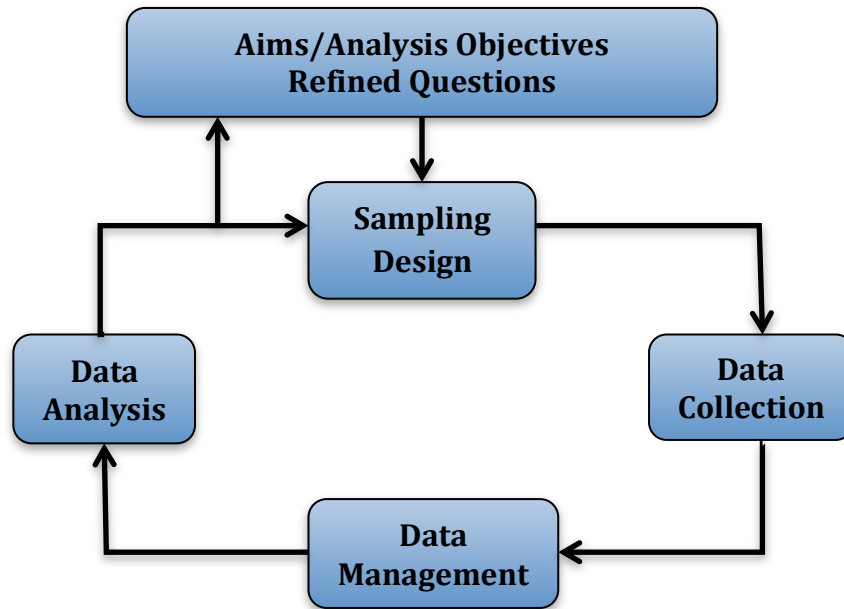


Figure 2. Simplified Diagram of the Iterative Qualitative Research Process⁴

Five main approaches to qualitative inquiry were initially considered to address the research question: phenomenology, narrative research, case study, ethnography and grounded theory. Narrative research is an appropriate approach when the aim of the study is to explore the experiences of a single person or small group of people. It requires the researcher to gather participants' stories through various streams such as field notes, discussions with friends or family members of the participants, and photographs among others. Similarly, ethnographic research also requires the examination of participants, yet usually involves a large group of individuals, such as an entire cultural group. The

⁴ From Crabtree & Miller (1999)

researcher is typically *immersed* in the world of the group under observation, with the intent of understanding common beliefs and behaviours shared by the group. Case studies, on the other hand, rely on clearly defined cases and seek to obtain an understanding of a particular situation. One or multiple cases may be selected, yet typically no more than four or five, as the objective is to achieve a deep understanding rather than yield generalizable results. This thesis research does not attempt to understand an entire cultural group, nor does it focus on the experiences of one or two people or cases. As such, these first three approaches to inquiry were not considered appropriate to address the research question and were excluded as options.

Phenomenology was initially considered, as it aims to describe the meaning of a concept or phenomenon as understood by several individuals. The researcher explores the commonalities in all participants do develop a “description of the essence of the experience for all individuals” (24) (p.58). For the purpose of this thesis, this approach was considered as a way to explore how participants understood the “phenomenon” of cultural competency. However, this presented cultural competency as a phenomenon to be experienced, and as such, required an existing definition or understanding of the concept. In addition, it was uncertain whether or not the study participants had actually experienced cultural competency as a “phenomenon”.

As opposed to understanding a predefined phenomenon, the grounded theory approach “moves beyond description ...to generate or discover a theory, an abstract analytical schema of a process...” (24) (p. 63). This approach was initially developed in 1967 by sociologists Barney Glaser and Anselm Strauss, who felt that theories should be “grounded” in the data gathered from participants, to create a theory. This theory is comprised of

actions, interactions, or processes, all within interrelating categories based on the information gathered from participants. In its original formulation, it was a fairly structured methodology yet eventually both authors disagreed on the rigidity of the procedure, with Glaser preferring a more flexible methodology, and Strauss adhering to more systematic, analytical procedures.

The grounded theory approach, as described by Strauss and Corbin (25), is recommended when the researcher aims to understand or construct a theory or framework for a certain phenomenon. In some cases where a theory already exists, the researcher may consider it incomplete because it fails to address potential variables being studied, or because it is not applicable to a specific situation or sample of interest (24). This approach requires the investigator to set aside any previous notions or concepts as to allow for the development of a theoretical construct, yet Strauss and Corbin “emphasize that it is not possible to be free of bias” (26) (p.97).

Of all qualitative approaches, this is the most systematic, usually following a step-wise method of data-analysis consisting of open coding, axial coding and selective coding, described in detail in Chapter 4.

2.1.1 The Role of the Researcher

Contrary to quantitative methods, where a researcher’s influence is discouraged as it may result in bias, qualitative research requires the researcher to consider their own culture, personal history and beliefs among others, when interpreting findings as long as this is openly stated. Being both an immigrant to Canada and a primary care practitioner, I

documented my personal impressions through memoing. Memoing allows a researcher to record their ideas about the evolving theory during the data collection and analysis phase.

CHAPTER 3 EVIDENCE REVIEW: METHODS AND FINDINGS

Methods

The methodology described above guided the methods used for this study. What follows is a description of the evidence review component of this thesis.

3.1.1 Data Sources and Search Strategy

The electronic search for the evidence review was conducted through the OVID interface and included searches through MEDLINE/PubMed, Embase and PsycINFO, to address the overarching research question: How do new immigrants conceptualize cultural competency? By identifying key search terms and using Medical Subject Headings (MeSH), a search template was developed and applied initially to MEDLINE/PubMed, and later applied to the other databases (see Appendix A for Search Strategy). The databases were searched for articles in English, French or Spanish, published between 2000 and 2011. This time period was selected because a broader time frame produced an unmanageable amount of results. In addition, it was expected that modern literature would be more relevant and would reference back to previous literature.

The search strategy was also expanded to include articles found in the bibliography of key review publications, as well as hand-searched articles deemed important for the evidence review. Certain authors and field experts were consulted as well, to ensure inclusion of additional relevant studies.

3.1.2 Study Selection

Articles found through the electronic and bibliographic search were selected based on the relevancy of their titles and abstracts, using established inclusion and exclusion criteria (see Appendix B for Relevance Appraisal Guideline). To allow for comprehensive review of the literature around cultural competency in primary health care and its effect of the communication relationship, no restriction was placed on type of study design, place of publication or health care setting, such as those based on countries other than Canada. Eligible studies had to focus primarily on cultural competency and primary health care⁵, and had to include immigrant population. Studies mentioning patient-centredness or cross-cultural communication were also included, as these were considered closely related to the literature review objectives. Articles focusing on allied health professions⁶ and certain medical subspecialties irrelevant to primary care were excluded, as were those mentioning cultural competency in a brief manner not examining this concept as their primary focus. Also excluded, were studies focusing on a particular medical condition, unless these articles appeared to carry a heavy communication component. For the purposes of this study, articles mentioning cultural competency in the context of indigenous or aboriginal health were not included. For articles not providing an abstract and containing a title providing insufficient information on the content of the study, the full text of the article was read to make a final decision.

⁵ The 'primary health care' inclusion criteria was broad and included publications based on primary health care providers/users, processes of care, certain health care systems, or services that may be delivered at the primary care level in the Canadian context.

⁶ There is abundant literature on cultural competency in the field of nursing. The majority of these studies focused on developing nursing competencies, and as such were excluded. Only studies with significant crossover into the field of primary care or which were relevant to the literature review objectives were included.

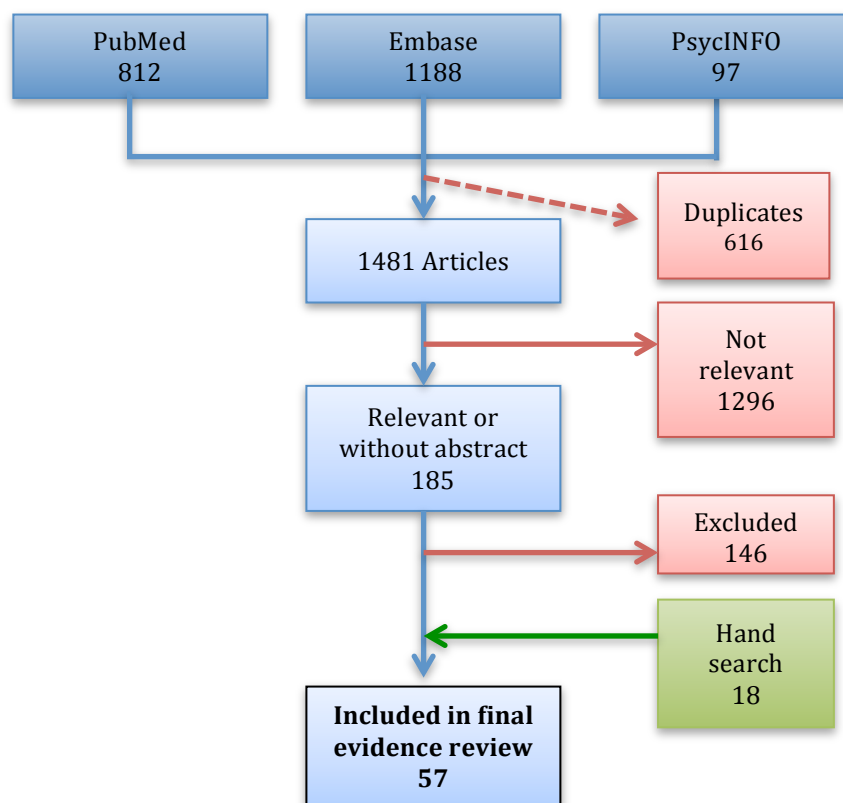


Figure 3. Study Selection Flow Chart

The initial literature search generated 2097 results. After the elimination of duplicates, there were 1481 studies remaining. Based on the initial evaluation of article titles and abstracts, 185 results were retained. A more in depth secondary review of these results was conducted. At this stage, all studies including those found through article bibliographies were assessed for relevancy to determine their inclusion (see Figure 3 above for study selection flow chart). Editorials and commentaries were only included if they provided new information regarding the research questions. Similarly, only original articles were included, as there were some instances where an article was based on a

previous one. A total of 57 studies were included in the final evidence review (see Appendix C for list of included studies).

The Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach was used to assess the quality of evidence when applicable (27). This approach is being used by multiple organisations such as the World Health Organization, the Ministry of Health and Long-Term Care (Ontario), the Canadian Task Force on Preventive Health Care, the Canadian Collaboration on Immigrant and Refugee Health and the Cochrane Collaboration, among many others. The quality of evidence grading is defined as: High, meaning it is very unlikely that further research will change the grader's confidence in the estimate of effect; Moderate, where there is a possibility that further research can affect confidence in the estimate of the effect or even change the estimate; Low, meaning further research is very likely to change confidence in the estimate of the effect as well as likely to change the estimate and; Very low, where there is great uncertainty of any estimate of effect. As evidence quality may vary, using this systematic approach can help minimize bias and assist with the interpretation of information.

Considering the significant amount of qualitative studies addressing the topic of cultural competency in health care, in addition to the GRADE approach a separate quality appraisal guideline, the McMaster Critical Review Form for Qualitative Studies, was used (23). This guideline was developed by the McMaster University Occupational Therapy Evidence-Based Practice Research Group, revised by Letts et al. It was selected among other guidelines due to its comprehensiveness and versatility, as well as its focus on four main components of trustworthiness: credibility, transferability, dependability and confirmability. Credibility can be achieved by using multiple methods of data collection,

conducting member checks, and including several participants, all with the goal of ensuring an accurate understanding of the phenomenon. Transferability, (described in Chapter 2, section 2.1), refers to whether or not the findings could be transferred to another setting or population. Dependability deals mainly with consistency between the information gathered and the reported findings, usually achieved by keeping an audit trail or conducting peer reviews. Finally, confirmability consists of communication with colleagues, participants and experts as a way to ensuring optimal interpretation of data (23). While this guideline does not have an actual scoring system to grade qualitative studies, it guides the reader through a series of questions after which a subjective decision can be made regarding the quality of the study.

3.1.3 Data Analysis/Synthesis

A data extraction template was designed and populated with categories including study objectives, study design, target population, conclusions and quality of study when applicable. As described in Chapter 2, the varied nature of the literature findings prevented aggregate quantitative assessments or pooling of the data. The results of this review are therefore presented as a 'systematic narrative review', defined by the EPPI-Centre as the classification and description of available literature on a subject. This method is particularly useful when the scope of a review is broad, and when the primary objective is to synthesize information arising from a wide variety of studies. This method allowed for the inclusion of what is described by the EPPI-Centre as 'free-text narrative data', which includes information that usually cannot be placed in a particular category or analysed numerically.

Evidence Review: Findings

This section of the chapter presents the historical development of cultural competency in health care, leading to a description of how cultural competency is currently conceptualized in the medical literature. Through the discussion of existing frameworks, the different components of cultural competency are explored, compared and analysed. Emphasis is placed on the communication component and as such, other aspects contributing to the physician-patient relationship are also examined.

3.1.4 Conceptualization of Cultural Competency in Health Care

Key terms such as ‘culture’, ‘ethnicity’, ‘diversity’ and ‘multicultural’ are not consistently defined in the literature, leading in turn to difficulties in understanding what cultural competency entails. The Oxford English dictionary defines ‘culture’ as the “attitudes and behavior characteristic of a particular social group” and defines ‘competence’ as “the ability to do something successfully or efficiently” (28). In the context of health care, however, these terms can adopt a different meaning. In 1989, Cross et al. published a key monograph, which greatly contributed to today’s understanding of cultural competency in health care. According to the authors, the word ‘culture’ “implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group”. This broad definition demonstrates how one cultural group may have overlying characteristics with another group, despite differing in racial or ethnic characteristics. It also demonstrates the complexity of the word ‘culture’ and supports the opinion that it is impractical to make assumptions of a person’s belief based only on cultural background.

Based on this understanding, Cross et al. defined cultural competence as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work efficiently in cross-cultural situations” (1).

At the time of publication, the authors acknowledged this was a somewhat idealistic definition, and therefore presented ‘cultural competence’ as a goal to strive towards, through a developmental process. To represent this process, the authors developed a continuum ranging from ‘Cultural Destructiveness’ to ‘Cultural Proficiency’ (1) (see Figure 4 below).

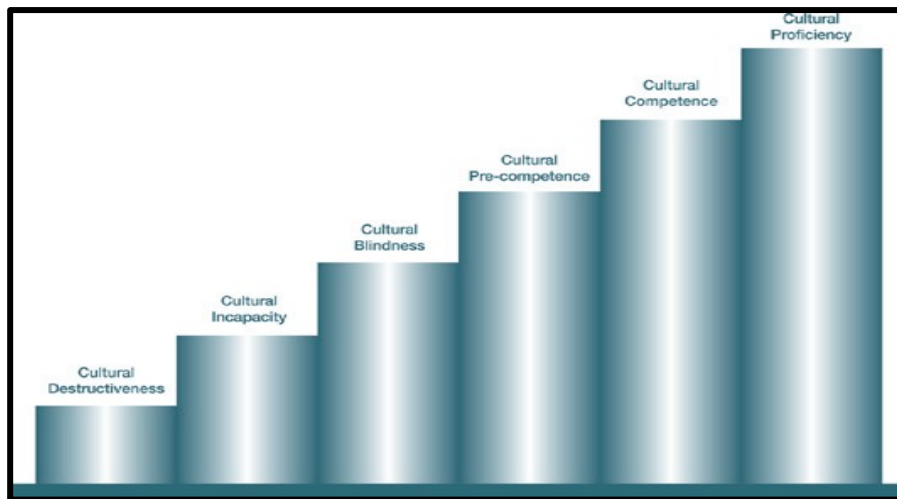


Figure 4. Model of Cultural Competency Continuum (1)

The spectrum begins at the negative end with ‘Destructiveness’ where there is a complete disregard for cross-cultural awareness, and is represented by attitudes, policies and practices which are destructive to cultures. Next is ‘Cultural Incapacity’ indicating that while the system or organization may not necessarily intend to be destructive, it fails to respond to the needs of culturally and linguistically diverse groups. Towards the midpoint

of the continuum is 'Cultural Blindness', where systems provide services with the intention of being unbiased. While the systems are well intentioned, they fail to recognize cultural strengths or unique needs, and rather encourage assimilation. Next in the continuum is 'Cultural Pre-competence', which recognizes that systems possess the desire to deliver quality of services to diverse populations, and take measures such as hiring diverse personnel or undergoing cultural sensitivity training. The authors highlight that while these are important steps to becoming culturally proficient, systems at this level may lack the knowledge or information on how to proceed. 'Cultural Competence' follows on the continuum, and is characterized by systems involved in seeking consultation from the communities they serve, performing regular self-assessments, taking necessary measures to support staff working in cross-cultural environments, and being aware of new and existing knowledge and resources around cultural competency. At the final and most positive end of the continuum is 'Cultural Proficiency', also known as 'Advanced Cultural Competency'. Culturally proficient systems take an active role in conducting research to contribute to the existing knowledge of providing quality care in cross-cultural settings, and participate in the dissemination of this knowledge. This model is meant to be applicable at all levels of a system or agency, including administrators, policy-makers and practitioners among others.

This model has been extensively used and alluded to in subsequent work (5,29-31) . In 2001, for example, the U.S. Department of Health and Human Services, Office of Minority Health employed these key concepts when launching a series of standards in response to increasing evidence of racial and ethnic disparities in health care. These standards, known officially as the 'National Standards for Culturally and Linguistically Appropriate Services in

Health Care' (CLAS), were developed over a three-year period and involved a thorough review and analysis of existing standards and measures, as well as incorporated contributions from various stakeholders, health care organisations and professionals, patient advocates and consumers, among others. This process produced fourteen standards organised by the themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7) and Organisational Support for Cultural Competence (Standards 8-14) (32)(See Box 1 below).

Of particular relevance to this thesis are Standard 1, which states that patients should receive culturally competent care in their language of preference from all staff, and Standard 3, which states that staff should receive ongoing training on how to provide culturally and linguistically appropriate service delivery. Unfortunately, these standards are somewhat broad and unspecific, which can lead to varying degrees of interpretation. While individual health care organizations in Canada may also be striving to provide culturally and linguistically appropriate care, there is currently no Canadian equivalent to these standards.

**National Standards for Culturally and Linguistically Appropriate
Services in Health Care
U.S. Department of Health and Human Services, Office of Minority Health**

Standard 1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery

Standard 4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Box 1. National Standards for Culturally and Linguistically Appropriate Services in Health Care

Another model, developed by Borkan et al. in 1991, also presents cultural competence as a process. Based on previous work by Bennett in 1986, who developed a framework for personal growth to achieve “intercultural sensitivity”, Borkan et al. developed a model ranging from “Ethnocentric” to “Ethnosensitive” (33,34)(see Figure 5).

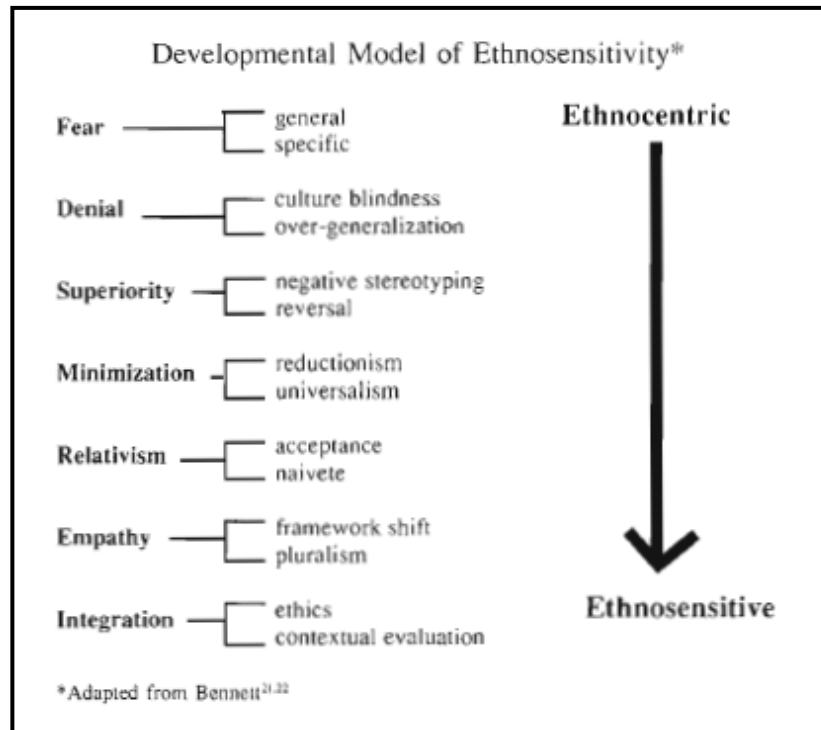


Figure 5. Developmental Model of Ethnosensitivity (Borkan, 1991)

Ethnocentric refers to the evaluation of other cultures based on preconceptions of one’s own culture (28) as opposed to ethnosensitive which refers to the “ability to appreciate values and behaviors within the context of specific cultural norms” (34). Each stage of this model is accompanied by specific goals and strategies to assist physicians in transitioning to the following stages on the path to ethnosensitivity. While this model was

originally developed to train and assess family physicians' cross-cultural skills, it has been referred to in general health encounter settings and applied to other health care disciplines addressing cross-cultural communication (5,35-37).

The model begins with the initial stage of 'fear', where the practitioner has a general mistrust or fear of a certain group. The authors highlight the negative consequences that fear may have in caring for a population group, providing the example of how fear of HIV may lead to fear of treating groups generally associated with this disease. Practitioners at this stage can benefit from addressing those fears through education and understanding of different cultural groups. Strategies such as participating in Balint groups⁷ or using desensitizing techniques may be employed.

The second stage is 'denial', which consists of 'cultural blindness' or generalization. Examples of this stage include behaving as if cultural differences are not important or are inexistent. To address these behaviours, practitioners in this stage are encouraged to recognize and value cultural diversity. This can be achieved by attending educational cultural events or participating in experiential learning.

Next on the continuum is 'superiority', which is best exemplified by negative stereotyping. Practitioners at this stage are aware of cultural differences, yet tend to place their own culture as superior. However, the authors clarify that this not only refers to regarding one's cultural group as superior, but may also refer to the denigration of one's group believing in the superiority of another cultural group. Actions at this stage involve

⁷ Balint groups, named after Hungarian psychoanalyst Michael Balint, is a form of therapy group consisting of doctors presenting cases, with a specific focus on the physician-patient relationship component. The groups are typically moderated by two leaders, usually a physician and psychologist or psychiatrist, who facilitate the process. This approach has been identified as a way of understanding and developing empathy for patients. For more information, please refer to <http://americanbalintsociety.org/>.

identifying and promoting similarities between cultural groups, as well as highlighting specific ethnic values. The authors also suggest using the technique of “demystification”, where Western biomedicine assumptions are examined, particularly those based on empirical evidence. The goal is to understand how many medical practices are accepted in the Western biomedical model despite the lack of evidence, in the same way non-Western medicine is traditionally practiced.

The next stage is ‘minimization’, which is characterized by reductionism and universalism. In medicine, reductionism places emphasis on “biochemistry and pathophysiology models while de-emphasizing the medical effects of personality, family structure, and socio-cultural factors” (34). Universalism refers to the belief that universal laws apply equally to all groups. At this stage, it is important to highlight the unique individual and group characteristics, promoting bio-psychosocial awareness, as opposed to a strictly biomedical model. The authors also suggest viewing the patient as a unique individual, and using Kleinman’s explanatory model questions, which are discussed in detail later on.

The fifth stage is ‘relativism’ and is characterized by both awareness and acceptance of diverse cultural groups, yet without understanding the clinical implications of these differences. This limitation can be addressed through additional education about culture-specific needs. The authors suggest experiential learning at this stage, yet they caution that practitioners may become overwhelmed as they feel the need to master all cultural knowledge. Kleinman’s Explanatory Model Approach is once again suggested as a

technique to address this challenge, as well as following the LEARN guidelines⁸ developed by Berlin and Fowkes (38). These techniques allow practitioners to effectively communicate in cross-cultural situations, without necessarily possessing in-depth knowledge of a cultural group.

The sixth stage, 'empathy', involves seeing things through the patient's worldview to better understand their values. The authors consider this an important aspect of the communication relationship, leading to improved adherence and patient satisfaction. A particular challenge at this stage is the capacity to make ethical decisions. The authors argue that it becomes difficult for the practitioner to know how to weigh different cultural issues when making a decision. This obstacle may be addressed through additional education around ethical issues, as well as working through culturally complex ethical scenarios.

The final stage on the continuum to ethnosensitivity is 'integration', where the practitioner "stands both inside and outside a culture, having both deep understanding and a critical viewpoint." (34). Practitioners at this stage can make ethical clinical decisions taking into consideration both cultural and individual contextual factors. Although this is the final stage of the continuum, it is an open-ended stage and the practitioner is expected to refine the skills previously acquired.

Both models described above present cultural competence as a goal to be reached, whether defined as being culturally proficient or ethnosensitive. By presenting the steps as

⁸ The LEARN guidelines were developed as a tool to enhance communication and assist practitioners during a cross-cultural encounter. The LEARN mnemonic stands for: *Listen* with sympathy and understanding to the patient's perception of the problem, *Explain* your perceptions of the problem, *Acknowledge* and discuss differences and similarities, *Recommend* treatment, and *Negotiate* agreement.

a continuum, practitioners can assess the level at which they find themselves and follow the necessary measures to improve their cultural competency skills. Although theoretically it may be useful to have a continuum where practitioners can assess their skills and determine where they find themselves on the continuum, these approaches are linear and one-dimensional in nature. A practitioner proficient in certain aspects of one stage yet lacking in another, may have difficulty assessing their place on the continuum. Borkan et al. agree the cross-cultural communication process is more complex than what is represented in their model, indicating that a practitioner may be 'ethnosensitive' when caring for one population group yet not with another. The example they present is that of a practitioner being ethnosensitive when caring for South-east Asians yet remaining ethnocentric when caring for Haitians. As such, they believe the developmental stages depicted in the model are not mutually exclusive.

In 1991, Campinha-Bacote developed a visual framework to describe the different components of cultural competence. Similar to the models discussed above, this framework was initially linear in nature and included four constructs of cultural competency, which the author identified as cultural awareness, cultural knowledge, cultural skills, and cultural encounters. Realizing the significant overlap between these constructs, the author revised the model and in 1998 developed a Venn diagram representation of cultural competence (39). In this new model, the author maintained the original four constructs, yet added 'cultural desire' as a fifth construct. When describing the construct of 'cultural awareness', the author also refers to the concept of ethnocentricity, indicating it is important for practitioners to be aware of their own culture and beliefs and how these may affect their practice to avoid "cultural imposition". Also part of this construct is the concept of

becoming aware of the culture, beliefs and practices of others and being sensitive to these during the clinical encounter.

The 'cultural knowledge construct' refers to becoming knowledgeable about the worldviews of different cultures by seeking education and training in these areas. This involves learning how various cultures understand the world around them, and as result, understanding patient's behaviour. This construct also includes being aware of the biological variations within various cultural groups, such as the way the body metabolizes certain drugs, or a group's pre-disposition to certain diseases.

Sharing some characteristics with this construct is the 'cultural skill' construct, which consists of conducting a "cultural assessment" by taking a culturally relevant history and performing a culturally appropriate physical exam. A culturally relevant history involves understanding a patient's perception of illness and disease, as well as exploring accepted treatment options. Cultural skills are also required to perform a physical assessment, considering ethnically diverse patients may vary biologically and physiologically. The author suggests making use of tools and guidelines to assist during the assessment, yet cautions to avoid simply asking questions on a checklist, as this has to be conducted in a culturally sensitive manner.

The 'cultural encounters' construct encourages practitioners to "engage directly in cross-cultural interactions with clients from culturally diverse backgrounds". The author argues that three or four encounters with individuals from a certain cultural group is insufficient to grasp a true understanding of a particular culture due to "intra-ethnic" variation, where people from a same cultural group may have different characteristics. The author suggests addressing this issue by increasing a practitioner's exposure to various

groups through experiential learning, where the practitioner might adjust or modify their belief about a particular group. The author also emphasizes the importance of verbal and non-verbal cues during the experiential encounters, advising practitioners to be aware of their communication style and how this may be interpreted during a cross-cultural encounter.

The final construct of 'cultural desire' was incorporated to the model to represent a true desire to work with culturally diverse patients. The author highlights the importance of this concept by quoting John Maxwell who said: "...people do not care how much you know, until they first know how much you care", highlighting that despite being proficient in the other four constructs, lack of proficiency in this construct translates to poor quality of care, as perceived by patients. This construct is clearly immeasurable and the author advises to seek immediate help and guidance if a practitioner has negative feelings about working with culturally diverse groups.

As opposed to the models previously discussed, the author presents each of the five constructs as interdependent, meaning that regardless of where the practitioner enters the process all aspects of cultural competence should be addressed equally. In addition, the model avoids linearity by using overlapping constructs demonstrating the interaction of the different aspects of cultural competence in health care. Despite this advantage, the description of each component of the model is limited making it difficult to understand how each construct should be conceptualized in practice. Unlike Borkan et al.'s model, which presents each stage with clear accompanying strategies to address each challenge, Campinha-Bacote's model provides few suggestions as to how to become proficient in each construct. Nevertheless, Campinha-Bacote's model incorporates components essential to

cultural competence, such as cultural desire, even if it is unclear as how to best achieve it. This model is in the process of being revised once again, where the construct of ‘cultural encounters’ is placed at the centre representing the main drive that puts all the other constructs into action⁹.

While there are other models and frameworks for cultural competence in the early literature, the three described above have been frequently used when implementing cultural competence guidelines, designing activities, or conducting assessments.

These models, although quite comprehensive, fail to fully address the issue of understanding the social and contextual factors that shape a person’s worldview, regardless of ethnicity or cultural background. The Campinha-Bacote model partially addresses this issue when mentioning “intra-ethnic variation” as part of the ‘cultural encounters’ construct, yet does so by implying that with sufficient exposure to cultural encounters, one may obtain an understanding of a cultural group. Cross et al. also address this issue in their monograph, acknowledging the existence of subgroups within cultures, and caution against possible stereotyping. This presents a limitation, especially with today’s degree of migration and acculturation, making it challenging to determine a person’s cultural beliefs and preferences in medicine, based only on the cultural group they belong to.

To address this limitation, aspects of these models have been adapted and combined with concepts of what is known as the patient-centred method, leading to a new conceptualization of cultural competence in health care. The patient-centred approach, where emphasis is placed on understanding the patient’s perspective of illness and disease,

⁹ Personal communication with the author

has been identified as a way to enhance cross-cultural communication. Aside from acquiring basic knowledge relevant to cultural groups likely to be encountered in their practice, health care providers are also encouraged to develop certain attitudes and skills that can be applied in any setting(3,5,40) .

These “universal” attitudes and skills rely heavily on what is known as the patient’s “explanatory model”, described initially by anthropologist, Arthur Kleinman in 1978 (6). He theorized that patients’ understanding of health and illness is determined not only by their culture but also by the environment in which they live and the way health is conceptualized in their society. Eliciting a patient’s explanatory model allows the health care provider to become familiar with the patient’s understanding of sickness aetiology, symptoms, course of illness, treatment options, and encounter expectations. For example, patients suffering from a chronic disease who believe in fatalism may be convinced that their outcome cannot be influenced by medical intervention. This in turn may lead to hesitancy to seek care or difficulties adhering to treatment (36,41,42). Religion and spiritual beliefs also play an important role in illness perception, and it is not uncommon for immigrants to hold several viewpoints while transitioning through belief systems (36). A practical and effective way to better comprehend a patient’s understanding of illness and disease may be achieved by asking these questions developed by Kleinman:

- 1) *What do you think has caused your problem?*
- 2) *Why do you think it started when it did?*
- 3) *What do you think your sickness does to you? How does it work?*
- 4) *How severe is your sickness? Will it have a short or long course?*
- 5) *What kind of treatment do you think you should receive?*

Kleinman suggests that if at this stage there is still some doubt as to the patient's therapeutic goals or psychosocial/cultural understanding of their illness, these additional questions may be added:

- 6) *What are the most important results you hope to receive from this treatment?*
- 7) *What are the chief problems your sickness has caused for you?*
- 8) *What do you fear most about your sickness?*

By asking these questions, the practitioner is able to elicit a patient's understanding of illness and disease, regardless of the cultural group they belong to.

This early work by Kleinman has been referred to extensively, both by proponents of cultural competency and of patient-centred care. Stewart et al., for example, developed a patient-centred clinical method with six interactive components, sharing some of the concepts identified by Kleinman (7). This approach encourages physicians to shift traditional power relationships, which in turn can lead to patient empowerment resulting in a more balanced physician-patient relationship. The six interactive components, as described by Stewart et al. include a) exploring both the disease and the illness experience, b) understanding the whole person, c) finding common ground, d) incorporating prevention and health promotion, e) enhancing the patient-doctor relationship, and f) being realistic (7).

The first three components of this model are particularly relevant during a cross-cultural encounter. In addition to conducting the necessary medical investigations, the first component, 'exploring both the disease and the illness experience', focuses on eliciting the patient's perception of illness and disease. This involves assessing patients' feelings and

ideas, as well as understanding the effect on function and expectations. In patients who hold beliefs that differ from the Western bio-medical model, this component becomes important giving practitioners the opportunity to ascertain what the patient believes is causing their illness.

The second component, 'understanding the whole person', encompasses three dimensions: the person, the proximal context, and the distal context. Considering these contextual factors, such as the patient's personal life story, family dynamics, social support, cultural environment and community setting allows for a more comprehensive understanding of the patient's world. This particular component assures an individualized approach to the clinical encounter, avoiding generalizations and stereotyping merely based on the patient's cultural background.

The third component, 'finding common ground', focuses on establishing a mutual understanding between the patient and the physician, mainly in reference to identifying the problem, deciding what the goal of the treatment or management should be, and defining the roles of the patient and physician. During a cross-cultural encounter, addressing this component may increase adherence to treatment, as physicians have the opportunity to learn of the patient's expectation of management. The remaining three components, while equally important, are less specific to the cross-cultural encounter, yet interact with the first three components described above to provide patients with patient-centred care.

Stewart et al. present this approach as "patient-centred" yet there is an evident overlap with the concepts of cultural competence previously discussed. Some authors have specifically explored the relationship between patient-centredness and cultural

competency, arguing that both are necessary and in fact, complementary to providing quality of care (3,5,30,40,43). Herman et al. for example, combined these two concepts to create what they describe as 'Patient-Centered Culturally Sensitive Health Care' (43), characterized by a) *Cultural Competency Plus*; b) the patient-centered patient-provider relationship; c) patient empowerment; and d) measureable provider and staff behaviours and attitudes, and clinic environment. *Cultural Competence Plus* refers to the fact that while some providers are highly trained in providing culturally competent care, this does not necessarily translate into behaviours or attitudes considered to be culturally competent or sensitive. The authors highlight that an additional effort must be made to elicit patients' needs and understanding of culturally competent care.

The 'patient-centered patient-provider relationship' refers to the creation of a partnership between the two, where providers are empathic, compassionate and responsive to the needs of patients (44). Using a patient-centred approach increases the probability that patient needs and preferences will be taken into consideration when making clinical decisions. Also related to clinical decision-making is 'patient empowerment', which encourages patient assertiveness and personal and interpersonal control to influence the health care system to meet their needs. The authors suggest training personnel on skills that enhance patient empowerment as well as the use of suggestion boxes where patients can provide their feedback on the type of care they wish to receive.

The final component, 'measureable provider and staff behaviours and attitudes and clinic environment', involves being responsive to what patients have identified as respectful and trust-promoting behaviours and attitudes. The authors suggest that

fostering these behaviours could increase satisfaction with care leading to improved health outcomes. These four components of 'Patient-Centered Culturally Sensitive Health Care' are discussed in further detail by Tucker et al., who describe the relationship between patient-centred culturally sensitive care and improved health outcomes, along with an intervention program to address these components (45).

Researchers in the field of medical education have also employed the combination of the patient-centred approach with cultural competence. Based on previous work by Carrillo et al, Betancourt et al. developed what they refer to as a 'patient-based approach to cross-cultural primary care (3,40). The authors argue that it is becoming increasingly challenging for physicians to care for patients from various cultures, especially considering language barriers, varying levels of acculturation and the effect of socioeconomic status, among others. These factors can affect the communication relationship, which may in turn impact health outcomes. To address these challenges, the authors developed a "patient-based approach to cross-cultural care and communication", consisting of: assessing core cross-cultural issues, exploring the meaning of the illness, determining the social context, and engaging in negotiation (3,40).

Sharing some of the characteristics from the models previously described, the authors make reference to items such as the patient's explanatory model and negotiating the treatment or management plan. However, by presenting 'social context' as a component in itself, the authors emphasize the influence of an individual's social environment on illness and health status, such as the experience of migration or social support. In terms of culture-specific issues, the authors believe there is benefit in understanding "core" issues, which tend to be present in most cultures. These five "core" issues include: styles of

communication; mistrust and prejudice; decision-making and family dynamics; traditions; customs and spirituality; and sexual and gender issues. If a “core” issue is identified, patients can be further asked about their preferences around the particular issue as opposed to making general cultural assumptions.

Both approaches described above include components of patient-centredness and cultural competence, yet do not specify which components belong to which concept. Some authors believe it is important to acknowledge the areas where they overlap, while maintaining them as two separate concepts(5). The benefit of keeping these two concepts separate lies in the fact that there are some non-overlapping aspects to each which can independently contribute to the improvement of health care quality.

Saha et al. have developed a conceptual model to visually represent this overlap, along with examples of what each component entails(5). (See Figure 6).

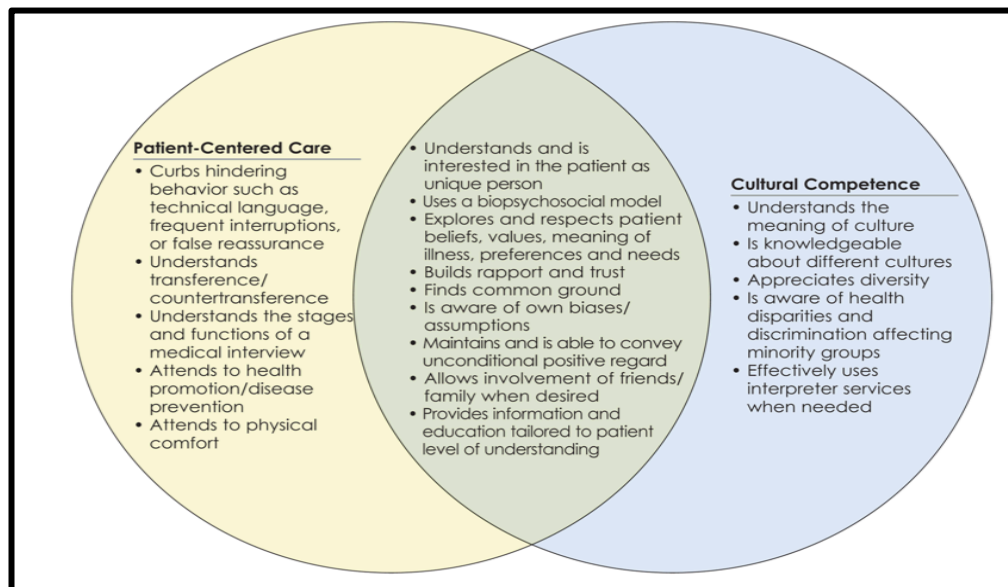


Figure 6. Overlap between Patient-Centred care and Cultural Competence at the Interpersonal Level (Saha et al., 2010)

In this model, the authors demonstrate the overlapping role of cultural competence and patient-centredness in improving health outcomes. These two concepts can influence the delivery of care both at the interpersonal level as well as at the systems level. In the overlapping section of the diagram, the authors mention concepts also present in models previously discussed, such as the importance of seeing the patient as an individual and finding common ground (described by Kleinman as the 'explanatory model' and by Stewart et al. as the second and third components of the patient-centred clinical method). The diagram also clearly represents what the authors consider to be exclusive aspects of patient-centred care or cultural competence.

The models presented above provide examples of how the concepts of cultural competence and patient-centredness are increasingly being used to complement each other and enhance the physician-patient relationship. While beneficial when caring for patients in general, these approaches may be particularly helpful during cross-cultural encounters(5,40).

3.1.5 Operationalizing Cultural Competency in Health Care

Based on the prevailing definitions of cultural competence presented above, researchers have conducted studies aiming to understand how cultural competence is operationalized in health care. These studies employ both quantitative and qualitative methods, and include surveys, literature reviews and participant interviews, among others.

In a report prepared for the Commonwealth Fund, Ngo-Metzger et al. present the results of a comprehensive literature review to ascertain patient perspectives of cultural competency and how it affects quality of care (4). By adapting an existing framework for

measuring health care quality, the authors depict the main components of culturally competent care, focusing specifically on the overlapping region (see Figure 7).

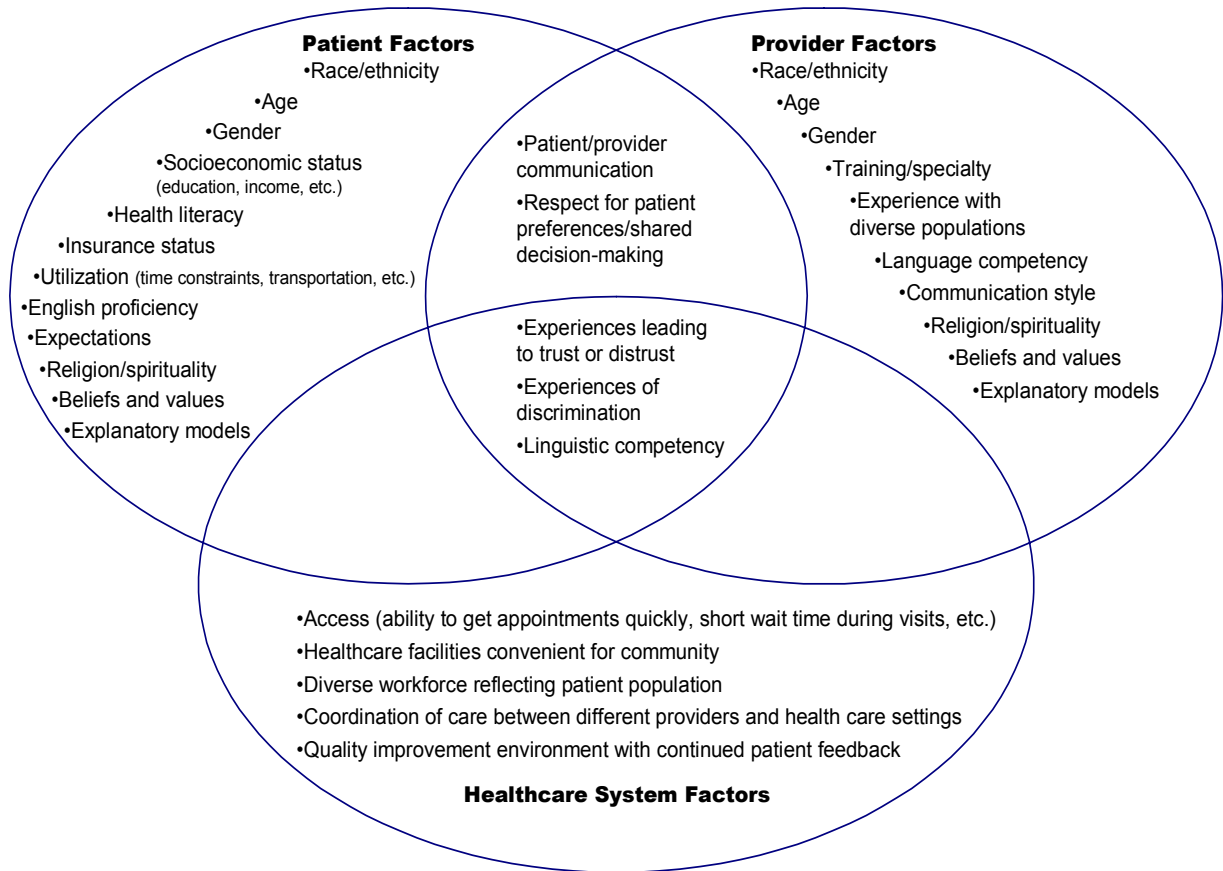


Figure 7. Conceptual Framework of Culturally Competent Care from the Patient's Perspective (Ngo-Metzger 2006)

The five domains in the overlapping region included: 1) patient-provider communication; 2) respect for patient preferences and shared decision-making; 3) experiences leading to trust or distrust; 4) experiences of discrimination; and 5) linguistic competency. The authors determined these five domains could be best explored through the patient's perspectives, which were used to guide the literature review. Although the

authors agreed there were other components related to quality of care, such as access and coordination, they considered these aspects part of 'patient-centredness' and did not include them in their report. The review focused on studies conducted in the United States between 1990 and 2005, and included people from various ethnicities such as African Americans, Latin Americans, Asians and Pacific Islanders, and Native Americans.

Overall, the authors identified the patient-provider interaction as the key component of quality of care, emphasizing the importance of verbal and non-verbal communication styles, as well as eliciting the patient's explanatory model. This is in keeping with the definitions of cultural competency and patient-centred care presented in the previous section, corroborating the value that patients place on this particular component. A unique finding of this literature review was the idea that physician-patient communication is bidirectional, meaning that the degree of patient expressiveness can also influence physician behaviours. The authors provide examples of studies demonstrating how patients' communication style may influence the amount of information physicians give the patient. In the studies reviewed, patients with higher education and showing involvement in their own care received more health and diagnostic information. This is interesting considering that patients with lower education are likely in greater need of this type of physician-patient interaction. This finding has not been identified as a significant component of communication in any of the cultural competency models, suggesting that 'communication' is more complex in practice than in theory.

Other significant findings were culture-specific, such as studies indicating that Latin American and Asian patients place particular importance to listening and allotting sufficient time during the health encounter. In addition, Asians and Pacific Islanders

considered ordering of tests and giving referrals particularly important. These findings were based on studies using primarily survey data, and focused mainly on race/ethnicity (without considering migration) in the context of the U.S. health care system. As such, caution should be taken when interpreting these findings to avoid stereotyping and generalizations in the Canadian context.

The authors also identified linguistic and health literacy as a component of cultural competency, highlighting that unlike language barriers that can be addressed through language-concordant physicians or interpreters, health literacy can be a barrier even when communicating in the same language. The report also presented recommendations to reduce language and literacy barriers, such as limiting the use of medical jargon, asking patients to “teach back” the instructions they were given, make use of audio-visual aids, arrange language-concordant medical encounters when possible, and limit the use of ad-hoc interpreters.

While the findings from the literature review described above are based on the U.S. health care system, similar findings are also present in the Canadian literature. A paper by Zanchetta and Poureslami, based on a literature review and on the Second Canadian Conference on Literacy and Health held in 2004, also emphasizes the importance of health literacy within ethnocultural diversity (46). They indicate that upon arrival to Canada, newcomers have difficulty navigating the health care system and identify four main reasons for these difficulties: 1) Barriers to access and services use; 2) Lack of information about certain health services available; 3) Use of herbalists and other alternative health providers for their own and their family members’ health issues; and 4) Lack of culturally sensitive or acceptable health services available for ethnic communities.

Among the strategies to address each of these challenges, conference attendees suggested incorporating literacy profiles and language preferences into the patient profile section of medical files, encouraging providers to use plain language especially with multicultural patients, and increasing cultural competency education in medical education programs.

Because of the significant influence the communication component has on the medical encounter, some studies have focused on exploring patient preferences for practitioners from their own cultural background (19,47-49). A study by Wang used a mixed methods approach to examine the gaps and barriers faced by Mainland Chinese immigrants when accessing primary care in the Greater Toronto Area (50). By conducting a telephone survey and seven focus groups, Wang found that participants had a significant preference for ethnically and linguistically concordant physicians. Participants identified 'language' as the primary factor for choosing a physician, and 88% of the 104 survey participants reported choosing a Chinese-speaking family physician. Through the focus groups, the study also found that patients were able to use vocabulary such as *yin/cold* and *yang/hot* when communicating with their physicians, as well as discuss the use of traditional Chinese treatments.

A similar study by Wiking et al. conducted in Sweden, examined immigrants' experience and reflections about the medical encounter. Using a mixed methods approach, the authors administered a survey with open and close-ended questions to fifty-two participants from Chile, Iran and Turkey. Due to the relatively small sample size, the authors agree that findings from the quantitative component must be taken with caution, yet findings from the open-ended portion of the study revealed that although 85% of the

participants felt their physician understood their medical problem, many still commented on the physician's inability to listen. Like findings from studies described above, language barriers and the importance of having an interpreter present, were identified as factors affecting patients' perception of quality of care received (51).

Overall, it appears that the majority of the examples of how cultural competency is operationalized in health care are based on addressing language barriers and addressing health literacy issues, in addition to exploring patients' preferences for complementary and alternative medicine. Although authors agree regarding the importance of the "communication" component in providing culturally competent care, examples of how this is operationalized in practice are lacking.

3.1.6 The Effect of Cultural Competency on Health Outcomes

No conclusive studies directly linking cultural competence to improved health outcomes were found during the literature review for this study. It is possible this was due in part to the lack of consensus when defining cultural competence, yet also due to difficulty determining ideal endpoints to properly measure a change in health outcomes. Wide arrays of study design and approaches have been developed to understand the effect of cultural competence on health outcomes, yet the quality of evidence remains low to moderate at best.

One hypothesis, which has been considered by some authors as the pathway through which cultural competence may affect health outcomes, relies on the patient satisfaction component of the health care encounter (2,42,52,53). Some have taken this concept further and argued that it is specifically the communication aspect of cultural competency that

influences this outcome (54-56). For example, Betancourt et al. conducted a systematic review of the literature to identify sociocultural barriers to care. The authors proposed a framework through which health outcomes may ultimately be affected (See Figure 8) (54). The authors suggest that cultural and linguistic barriers during the health care encounter have a negative impact on communication and trust. This leads to lower levels of patient satisfaction and adherence to treatment (or preventive interventions), which in turn leads to suboptimal health outcomes.

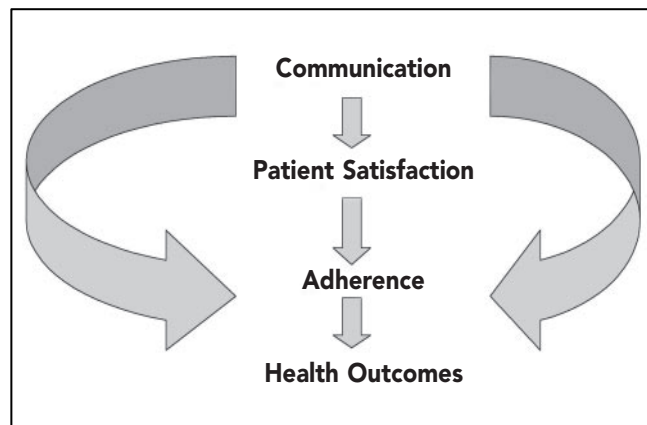


Figure 8. Linking Communication to Health Outcomes (54)

Other authors have reached a similar conclusion, arguing that lack of cultural competency tends to disproportionately affect health outcomes in certain population groups, therefore leading to health inequities in several areas such as preventive medicine (57-62). Even studies focusing on providers' perspectives of care delivered indicate that differences in language and culture make it challenging to deliver the same quality of care they would normally provide to a non-immigrant patient (63-66). This concept is also supported in the 2002 Institute of Medicine report entitled *Unequal Treatment*, where racial and ethnic disparities were identified across various health care settings, even when controlling for confounding factors (44). Brach et al., for example, conducted a thorough

literature review in which they determined that even when there are no differences in socioeconomic status or health insurance coverage, racial and ethnic disparities still persist (57). To address this issue, the authors depict nine areas of cultural competency where these inequities can be reduced: interpreter services; recruitment and retention of minority staff; cultural competency training; coordinating with traditional healers; use of community health workers; culturally competent health promotion; including family and/or community members; immersion into another culture; and administrative and organisational accommodations. The exact mechanism through which these factors may impact health outcomes is shown in Figure 9 below.

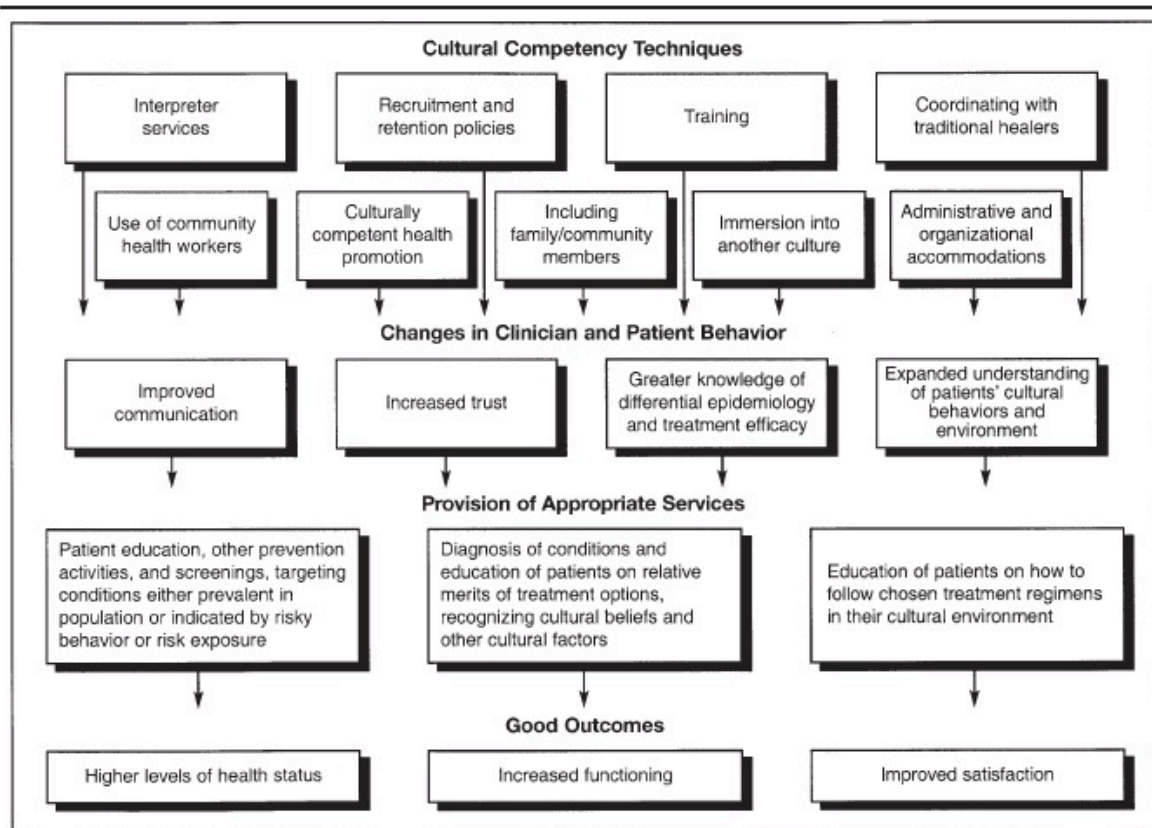


Figure 9. Cultural Competence Techniques (57)

Despite encountering multiple studies supporting this logic model, the authors note that rigorous research around this area is lacking, with the exception of the role of language barriers in reducing health inequities. As such, it is difficult to make recommendations and request health care institutions and professionals to adhere to proposed guidelines without the evidence to support it.

A similar conclusion was reached by Lie et al., who conducted a systematic review to assess the effectiveness of cultural competency training in improving health outcomes (67). While the overall findings supported a positive relationship between cultural competency training and improved health outcomes, the authors considered the included studies to be of low to moderate quality, suggesting more research could significantly impact the estimates of effect.

To address this limitation, some authors have focused on one particular medical condition, such as diabetes, hypertension and asthma, in one population group at a time (2,41,68-70). Studies taking this route have identified subtle pathways through which cultural nuances may affect the physician-patient relationship, impact patient satisfaction, influence adherence to treatment, and ultimately affect patient outcomes. For example, in the Latin American population, some authors have identified cultural-specific factors which might affect health outcomes. Examples of these include: *simpatía*, Spanish for pleasantness and kindness; *personalismo*, also known as formal friendliness where physician's interest in the patient extends to inquiring about personal non-medical issues; *familismo*, which refers to the involvement of family members in the care of the patient and; *fatalism* which is the belief that there is little that can be done to alter fate. All these are believed to influence the physician-patient relationship to the point that it may affect health outcomes in a negative

way when they are absent (41,58,68). While being aware of these factors may be useful during a clinical encounter with a Latin American patient, the relationship between these cultural traits and health outcomes is merely anecdotal.

Studies attempting to quantify the impact that cultural competency can have on health outcomes have yielded somewhat similar results. Ailinger et al., for example, conducted a study to determine the effect of a cultural intervention on adherence to latent tuberculosis infection treatment among immigrant Latin Americans in the United States(71). In this case, patient's adherence was measured by the amount of pills taken. One group was provided with a cultural intervention and compared to a demographically similar group that did not receive the cultural intervention. Both groups were required to attend nine monthly clinic visits, which coincided with the duration of treatment for latent tuberculosis. The cultural intervention consisted of five components: having the same nurse present during each appointment, as opposed to one of five different nurses working in the program which addressed the issue of personalismo due to increased rapport; having the intervention nurse inquire and show interest regarding other members of the patient's family, and referring to them by name (familismo); using a familiar Latin proverb at the start of each visit; using Latino-tailored educational materials written in a basic-level Spanish and finally; using bicultural or bilingual nurses as opposed to an outreach worker translating for the nurse, which included non-verbal communication such as gestures or physical contact with the patient. The authors found a statistically significant difference in the amount of pills taken by each group, by almost a month's worth of medication. While this study was able to quantify the relationship between cultural competency and a specific health behaviour, an actual comparison of final health outcomes was never conducted

making it difficult to establish a definite connection between the two. In addition, the authors cautioned the results might not necessarily be generalizable due to the use of a nonrandomized sample.

Another study by Field and Caetano focused on ethnic matching as a means to ensure a culturally competent health encounter (47). The authors recruited five hundred and thirty-seven patients of Latin American background from a trauma centre who suffered an injury in the context of alcohol abuse. Participants were randomly assigned to either routine assessment and treatment, or to the intervention group with a “Brief Motivational Intervention” (BMI) where physicians engaged in a deeper discussion with the patient regarding their drinking. In the BMI group there was 71% ethnic matching between patient and provider, which at a 12-month follow-up resulted in a significant reduction in drinking outcomes. The authors concluded that ethnic-specific perceptions regarding alcohol abuse, along with certain cultural scripts might explain this finding. It is difficult to assume that ethnicity alone was responsible for the favourable outcomes, as opposed to the actual level of cultural competence of the health care professional. The assumption that communication barriers will disappear if the patient and physician share the same ethnic background does not take into consideration other factors such as socioeconomic status or education level, which may account for an even greater discordance than ethnicity alone.

Although there are only a few quantitative studies attempting to understand this association, there are several qualitative studies suggesting a relationship between cultural competence and various endpoints such as patient satisfaction, adherence and in some cases, health outcomes. For example, in a study by Donnelly, the health care practices of Vietnamese-Canadian women were explored focusing specifically on breast and cervical

cancer screening. After interviewing fifteen Vietnamese-Canadian women and six health care providers, the author found that although the majority of patient participants' ideas regarding illness and disease corresponded to the Western biomedical model, the relationship with their physicians influenced their degree of participation in cancer-screening programs (72). A further analysis of the physician perspective demonstrated significant hesitancy to discuss breast and cervical cancer screening, especially when the physician was male (73). However, this study did not ascertain how many of the "un-screened" participants eventually presented with breast or cervical cancer, once again making it difficult to confirm an association between cultural competence and health outcomes.

Julliard et al. conducted a similar study with Latina women to understand how culture and background can affect what patients choose to disclose to their physicians. In this study, twenty-eight Latin American women were interviewed and asked about factors affecting the physician-patient relationship. The authors found that lack of physicians' awareness of what were considered sensitive issues contributed to decreased patient disclosure, along with time constraints and language barriers. Conversely, because of the emphasis on building strong relationships, caring and compassion were associated with an increase in disclosure of important health information which may affect management and health outcomes (52).

Other qualitative studies exploring the provider perspective of culturally competent care have produced varying results. One Montreal-based study by Rosenberg et al, for example, focused on understanding strategies used by physicians during a cross-cultural encounter (74). The authors found that physicians used three main strategies: insisting on patient

adaptation to the local norm, physician adaptation to what they believed the patient wanted and negotiation of a plan that was acceptable to both. While use of these three strategies depended on each situation, overall it appeared physicians used a patient-centred approach to care yet lacked a clear approach to elicit details about patient's culture. An earlier study also by Rosenberg et al. used videotaping of cross-cultural physician-patient encounters to explore communication challenges during the consultation (75). Participants were then asked to review the tape during an open-ended interview, where they could share their thoughts on how the interview went from a cross-cultural perspective. Once again, the authors found that physicians were highly motivated to provide quality care using a patient-centred approach, yet lacked the knowledge and skills to understand the role that culture and ethnicity was playing in the medical encounter. These findings suggest that a patient-centred approach, although useful, is not sufficient without considering patient's culture, a conclusion reached by other qualitative studies as well (76).

Overall, however, most authors agree further research is needed to fully understand the effect cultural competence has on health outcomes and addressing health disparities. There is no consensus on which research approach is best to understand this association, yet it appears that a mixed-method approach may be useful given the complex nature of cultural competency in health care.

CHAPTER 4 INFORMANT INTERVIEW RESEARCH: METHODS

Methods

4.1.1 Study Design

In order to understand patients' perspectives on what constitutes culturally competent care, data collection for this exploratory study was obtained by conducting one-on-one, semi-structured, open-ended interviews. Interview participants consisted of immigrants who had been living in Canada ten years or less, who had visited their primary care provider at least three times during that time, and were willing to discuss their experience during these health care encounters.

The decision to conduct one-on-one interviews as opposed to other qualitative data collection methods, such as focus groups, was made based on the assumption that some participants may have irregular immigration status, and may feel uncomfortable sharing their experiences in a group setting. In addition, as the study design allowed for the inclusion of participants from diverse cultural backgrounds, it was suspected that experiences during health care encounters would vary, making it difficult to capture these subtleties during a focus group session.

4.1.2 Sampling

The participants were selected based on their ability to contribute to the development of the theory, known as theoretical sampling, a type of purposive sampling (77). With purposive sampling, also known as nonprobability sampling, the researcher focuses on

selecting cases or participants, narrowing down the sample size in a non-random manner as to select those which will best provide information on the research question (22).

Eligible participants were men and women aged eighteen or above, who had immigrated to Canada within the previous ten-year period. To exclude participants who may have had a single positive or negative health care encounter, only those who had visited their primary health care provider a minimum of three times were included. For reasons of feasibility, only English or Spanish-speaking participants were eligible to participate. Participants who were severely ill or cognitively impaired were excluded. All participants had to be willing to share their experiences of their health care encounters in Canada.

4.1.3 Sample Size

As opposed to quantitative research studies, it is not feasible to predetermine sample size for qualitative studies. Sample size in this field is therefore determined by data saturation, defined as the point at which no new information or themes are emerging from the data. Factors affecting data saturation include the scope of the research question, the variability of the sample, and the type of qualitative approach being used. Generally, it is common to have a small sample size in qualitative research. For example, Creswell suggests a sample size between twenty and thirty when using a grounded theory approach, whereas other authors have reported reaching saturation even sooner (24,78)

Based on existing literature, a sample size of no more than thirty participants was expected during the initial stages of this study. As data collection and analysis occurred

simultaneously and in an iterative manner to allow for the assessment of emergent themes, data saturation was reached at twenty interviews.

4.1.4 Recruitment Procedures

Participants were initially informed of the study through recruitment posters distributed in two community health centers: the Somerset-West Community Health Centre and the South East Ottawa Community Health Centre (see Appendix D for Recruitment Poster). Other recruitment strategies included contacting key community leaders presently engaged in research partnerships with other University of Ottawa researchers. Recruitment was in large part respondent driven, where participants would contact other potential participants among their acquaintances.

Interested potential participants were instructed to contact the principal investigator by e-mail or telephone. After receiving additional information and having their questions answered, and upon ensuring they meet the inclusion criteria, an appointment was scheduled with the participant to conduct the interview.

4.1.5 Development of Interview Guide

A preliminary literature review was conducted prior to the start of the study, at the thesis proposal development stage. This review allowed for the identification of gaps in the literature around patients' conceptualization of culturally competent care at the primary health care level. Based on this literature review, an initial interview schedule was created. Additional feedback was sought from experts in the field of immigrant health and primary

health care, as well as from researchers with experience in qualitative interview techniques.

Interview prompts focused on inquiring about the participants' migration story, their experiences during health care encounters in Canada, differences and similarities between health care encounters in Canada as opposed to their experiences back home, aspects around the communication relationship during the medical encounter, and the presence of language or cultural barriers. In addition to the interview questions, a questionnaire was developed to capture demographic information, and was given to the participants at the end of the interview for them to complete (See Appendix E for guide).

The interview questions were pilot tested among personal acquaintances with backgrounds similar to those of the population of interest. The purpose of this testing was mainly to assess clarity of the questions, length of time it took to conduct the interview, and finally, to identify where additional prompts were needed to elicit the necessary information. This initial testing led to slight modifications and clarifications of questions.

As themes began to emerge during the actual interview phase of the study, the interview schedule was once again modified to allow for the inclusion of important relevant topics not previously considered, and to rephrase certain questions which were unclear to some participants¹⁰.

¹⁰ Data analysis began after the first five interviews were completed. Early emerging themes from these interviews were used to slightly modify the way certain questions were asked, as well as to create new questions for the interview schedule to further explore arising themes not previously considered. As such, data collection and data analysis were conducted in a simultaneous manner throughout the remainder of the interviews.

4.1.6 Interview Procedures

With the exception of three cases, all interviews were conducted at the Institute of Population Health. Of the three participants who could not be interviewed at this location, two were interviewed at their home, and one was interviewed at their work location. The encounter began with a thorough explanation of the research study, after which they were given the consent form to read (See appendix F for Consent Form). Emphasis was placed on the standard guidelines of confidentiality and anonymity and voluntary participation. Participants were informed of the option of skipping any questions they did not feel comfortable answering, or stop the interview altogether. After all questions had been answered, the consent form was signed and participants were given a copy.

All interviews lasted between 25 and 60 minutes, and were conducted in English and Spanish depending on participant preference. Once all the questions on the interview guide were explored, participants were asked if they had any final thoughts or comments on the topics covered. On some occasions, this led to further discussion. Upon completion of the interview, patients were asked to fill out the demographic questionnaire. All participants were given a \$20.00 honorarium and were thanked for their participation.

4.1.7 Data Collection

Participant interviews began in April 2011 and were completed in August 2011. Each interview was audio-recorded both with a digital recording device and an audio recording software (Audacity) on a laptop for backup. Notes were also taken to capture non-verbal cues such as body language and hand-gestures.

Interviews were transcribed verbatim using word processing software within two to five days of the original interview date, with the exception of two transcriptions, which were transcribed within a week of the interview. At a later stage, transcripts were rechecked against the recordings corrections were made as necessary. For the purposes of maintaining confidentiality, at this stage all participants were assigned a pseudonym, and electronic source documents were password protected.

Once the interview had concluded, participants were given the demographics questionnaire, and once again were reminded of their right to skip any question they did not feel comfortable answering. They were given a moment alone for this portion of the data collection as to avoid any additional pressure, time during which a photocopy of the signed consent form was made and provided to them.

4.1.8 Data Analysis

Initially, both manual coding and analysis software were considered as alternatives for analysing the data. However, because of the manageable sample size and the use of only one source of data (i.e. audio only, as opposed to audio-visual), manual coding was used.

The analysis procedure for grounded theory, as described by Strauss and Corbin, consists of structured stages (26). The process begins with open coding, where the researcher breaks down the information from the interviews into main categories. A category in itself can be made up of “events, happenings, and instances” (24)(p.64). Each of the main categories can also contain subcategories to further explain them.

Once this step is complete, the data is rearranged into new categories in what is known as axial coding. In this stage, one main category is identified as the “core phenomenon”,

with all other categories organised around it. These surrounding categories take the shape of “causal conditions” (factors responsible for causing the phenomenon), “strategies” (actions that address the core phenomenon), “intervening conditions” (factors that influence the strategies) and “consequences” (result of using the strategies).

The last stage of analysis consists of selective coding, where the researcher tells a story or explains the phenomenon through the interrelation of the categories. Depending on the research question, this stage may also include presuppositions or hypotheses. Important to note is the dynamic, iterative characteristic of this approach, where the researcher simultaneously conducts data collection and analysis, comparing the emerging categories to the data collected, known as the constant comparative method.

Data analysis for this thesis research followed the procedures described above. Transcripts were analyzed using an open coding technique, identifying the main themes. These themes were then categorized and broken down further into subcategories. Common themes within each category were identified and analyzed using the constant comparison method to help saturate each category.

During the analysis of the transcripts, sentences or paragraphs related to a specific theme were extracted and placed on a separate Excel template. The passages on the original source transcript were numbered to maintain an audit trail once the sentence or paragraph was inserted into the Excel template (i.e. the code 18.105 refers to interview number 18, line 105).

Measures for verifying accounts were also taken, such as examination of rival information, alternative themes and divergent patterns, which has been described by Patton as a way to enhance credibility (79) (p.553). An audit trail was accomplished by

saving multiple versions of the re-categorization, in order to trace back decisions that were made.

4.1.9 Research Ethics Board Approval

Ethical approval was obtained through the Ottawa Hospital Research Ethics Board (OHREB) in two steps. Because both English and Spanish-speaking participants were eligible to enrol in the study, it was necessary to submit a certified translation of the recruitment poster and the consent form to the OHREB for approval. Temporary approval was granted on January 13th, 2011 until March 13th, 2011 to conduct interviews in English only while the Spanish versions were being reviewed. On February 11th, 2011, approval was extended until January 12th, 2012, to recruit Spanish-speaking participants as well (See appendix G for OHREB letters of approval)

CHAPTER 5 INFORMANT INTERVIEW RESEARCH: FINDINGS

Participant Characteristics

The proportion of male and female participants in this study was roughly equal, with nine male participants and eleven female participants (See table 1 below). Of the twenty participants, four chose not to disclose their year of birth. The remaining participants were mostly between the ages of 25-40 (n=10), and the rest were older than 40 (n=6).

When asked about their race/ethnicity, the majority of participants identified as Hispanic (n= 9), followed closely by those identified as Asian (n=7). One participant identified himself as black, two participants identified themselves as “other”, and one participant chose not to respond.

In terms of language capabilities, all participants stated they were proficient in English or French. It is important to note, however, that proficiency was not officially assessed or verified in any of the participants as this information was collected through self-report. For interviews conducted entirely in Spanish, it was impossible to ascertain participants' working level of English or French. In addition, this questionnaire item referred to current language proficiency as opposed to language proficiency on arrival. As discovered through the interviews, many participants had health care encounters early upon their arrival in Canada and experienced language barriers due to limited proficiency in English or French. With the exception of one French-speaking participant, all others identified a language other than English or French as their native language. The majority spoke Spanish (n=8), followed by Nepali (n=5) and Portuguese (n=2). Other languages included Shona (n=1), German (n=1), Vietnamese (n=1), and Urdu (n=1).

Participants originated from a variety of countries, which included Nepal (n=5), Brazil (n=2), Colombia (n=2), Venezuela (n=2), Peru (n=1), El Salvador (n=1), Chile (n=1), Algeria (n=1), Zimbabwe (n=1), Germany (n=1), Pakistan (n=1), Turkey (n=1), and Vietnam (n=1). The length of time in Canada also varied. The majority of participants reported residing in Canada between 1-5 years (n=9), followed by those residing between 6-10 years in Canada (n=7), and finally those reporting less than four years (n=4).

When assessing level of education, almost two-thirds of participants reported having either a bachelor or graduate university degree (n=12). The remainder of the sample reported grade 10-12 education (n=2), some college or university courses (n=2), and holding a trade or certificate diploma (n=2). One participant indicated “other” without specifying the type of education, and one preferred not to respond. Although the questionnaire did not ask participants to specify where the education was obtained, it was found through the interviews that the majority had studied in their countries of origin.

The relatively high education level of participants contrasted with their reported annual household income. For example, almost half of the participants reported an income under \$30,000 (n=9) despite many having a university degree. This is well below the \$60,000 median household income in Canada (80) and in this sample was mainly due to difficulties transferring skills into the Canadian workforce setting or being a recent newcomer. A third of participants reported an annual income over \$60,000 (n=6), and the remainder reported an income between \$30,000-\$59,000 (n=3). Two participants chose not to respond.

Through the demographic questionnaire it became evident that socio-economic status was not dependent on education as much as it was on length of residence in Canada.

Furthermore, the fact that all patients with the exception of one identified a language other than English or French as their native language is in keeping with statistics Canada findings which demonstrate that 80% of the 1.1 million immigrants who settled in Canada between 2001 and 2006 were allophones (81).

Table 1a. Participant Characteristics

	Total Number	%
Gender		
Male	9	45%
Female	11	55%
Age		
18-24	0	0%
25-40	10	50%
>40	6	30%
No answer	4	20%
Race/Ethnicity		
Black	1	5%
Asian	7	35%
Hispanic	9	45%
Other	2	10%
No answer	1	5%
Native language		
Nepali	5	25%
Shona	1	5%
Spanish	8	40%
Portuguese	2	10%
French	1	5%
German	1	5%
Vietnamese	1	5%
Urdu	1	5%
Proficiency in French or English		
Yes	20	100%
No	0	0%
Length of time residing in Canada		
Less than 1 year	4	20%
Between 1-5 years	9	45%
Between 6-10 years	7	35%

Table 1b. Participant Characteristics

	Total Number	%
Country of Origin		
Algeria	1	5%
Brazil	2	10%
Chile	1	5%
Colombia	2	10%
El Salvador	1	5%
Germany	1	5%
Nepal	5	25%
Pakistan	1	5%
Peru	1	5%
Turkey	1	5%
Venezuela	2	10%
Vietnam	1	5%
Zimbabwe	1	5%
Education		
Grade 10-12 non-graduate	2	10%
Some college/univ. courses	2	10%
Trade certificate/diploma	2	10%
University degree (Bachelor)	3	15%
University degree (Graduate)	9	45%
No answer	1	5%
Other	1	5%
Annual HH income		
Under 10,000	6	30%
10,000-29,999	3	15%
30,000-59,999	3	15%
Over 60,000	6	30%
No answer	2	10%

Culturally Competent Care: The Patient’s Perspective

This section presents the main themes that emerged during the participant interviews, addressing the overarching research question: How do patients conceptualize culturally competent care? Three main themes were identified through the participant interviews: Pre-existing Expectations for Health Care Encounter, Experiences of Health Care Encounters in Canada, and Easing the Dissonance. Selected quotations are presented to reflect patients’ perspectives in relation to each of these themes.

All participants gave clear descriptions of the type of health care encounters they were accustomed to in their countries of origin. Consequently, this significantly influenced their expectations for health care encounters in Canada. Stories shared reflected differences in the type of physician-patient relationship, access and timeliness of care. All this gave rise to the theme of Expectations for Health Care Encounter, which went on to influence the other two main themes (see Figure 10 below).

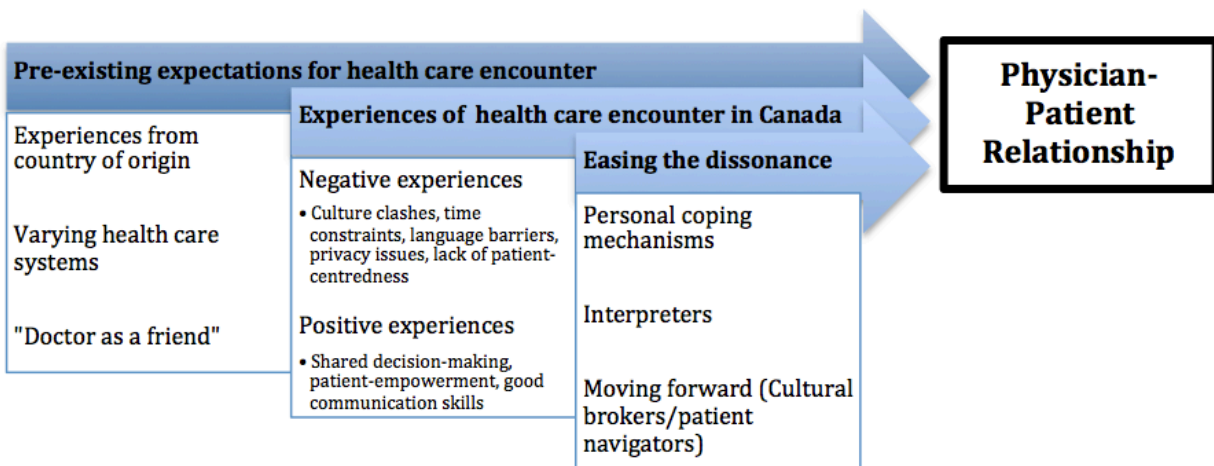


Figure 10. Cultural Competence from the Patient’s Perspective

The second main theme identified was Health Care Encounter Experiences in Canada, which consisted of positive and negative health care encounters as described by participants. While this theme was influenced by pre-existing expectations for health care, there were several components which were independent of previous experiences and relied solely on cultural or religious preferences. Negative experiences generally involved language barriers, perceived lack of privacy or confidentiality, time constraints, and lack of patient-centredness. Conversely, positive health experiences were identified around shared decision-making practices, patient-empowerment and good communication skills.

The final theme, which once again was influenced by the prior two discussed, was Easing the Dissonance. This theme consisted of personal coping mechanisms identified by participants, along with suggestions for improving the relationship between physicians and the immigrant population. Interpreters and cultural brokers were two resources deemed beneficial by participants.

These three themes along with their sub-themes, were the main factors affecting cross-cultural communication, the component of cultural competence being studied in this project. In addition to these main themes, several participants made reference to other aspects which they regarded as important in relation to health care. These issues were repeated consistently, resulting in the emergence of other categories unrelated to the research objectives of this thesis, such as access to health care, finding a family physician, and other difficulties related to the migration process. While these issues were considered important, they were not the focus of this research and as such were excluded from the analysis and discussion that follows.

5.1.1 Pre-existing Expectations for Health Care Encounter

“If we have anything, we can go to directly to the doctor”

Health care systems and organizations vary greatly from country to country, and in some cases such as Canada, even vary within countries as well. Considering this study included participants from thirteen different countries, discussions around health care systems and organizations inevitably arose. The majority of participants had been previously exposed to two-tiered health care systems, and had accessed private health care in their home countries on multiple occasions. The effect this had on patients' expectations during the health care encounter was evident and greatly influenced their opinion of how their physician in Canada communicated with them. For example, participants strongly associated the amount of time the physician spent with them, with the communication style of the physician. They felt that communication was enhanced when physicians took time to properly listen to their concerns, which usually resulted in longer consultations.

All participants who were interviewed had, at one time or another, accessed health care in their own countries. While the reasons for these medical visits and the degree of involvement with the medical system varied greatly among participants, they all had clear opinions about their experiences with health care professionals in their country of origin. Inevitably, comparisons were repeatedly made when describing their encounter with physicians in Canada, leading to the theme of ‘Expectations for the Health Care Encounter’.

Although the interview questions were geared towards understanding the factors affecting the physician-patient relationship, several participants had difficulty discerning health system-related issues from the actual communication issues with their physicians. The lack of immediate access to a physician was interpreted as a negative health care

experience in Canada, despite the fact this had little to do with the actual family physician caring for them. The inability to be seen by a physician was interpreted as inaccessibility on behalf of the physician as opposed to a health system limitation, leading participants to transfer their concerns and dissatisfaction with the system to their opinion of their relationship with their physician.

Himal, a thirty year old refugee participant from Nepal, explained:

I find it a little bit different because sometimes we're sick...unbearable pain sometimes, and we cannot consult directly with the doctor. We make the appointment and we have to wait one month, two months and then we see the doctor...[in Nepal] if we have anything, we can go to the doctor directly, we do not have to make any type of appointment. And the doctor, we meet the doctor at the time, and the doctor will check everything and will prescribe the medication, and we will get the medication...that's the problem, a little bit of the problem.

This feeling was shared among other participants, coupled with the length of time it took the physician to investigate a certain medical problem. Pedro, a man from Venezuela, was frustrated with the way his family physician in Canada was managing his medical complaint. He commented:

What I have been used to all my life before coming to Canada was, if you go to a clinic and you or your insurance pays for the visit, and you tell the doctor: "I feel like there is a worm in the middle of my sternum", just to give an outrageous example, the [doctor] will order a CT scan, see what is going on there, draw some blood, do a lumbar puncture, and by the end of three to four days, you will have the result of what it is you have, and all the results are there for you. "Look, the worm is not there", he will show you the CT scan and explain the whole thing. That is what happens in Venezuela and it happens in a week.

In this case, Pedro had access to private health care in his country. Despite being knowledgeable about the Canadian health care system, for Pedro, the fact that his physician was not ordering multiple exams in a hasty manner was interpreted as inefficiency and affected the trust relationship, ultimately leading him to look for a new family physician.

Other participants shared similar stories and while the effect was more significant in those who had private insurance in their countries of origin, it was also present in those using the public health care system. Himal, for example, who had received care through the public health system in Nepal also commented on the length of time needed to access care in Canada but was more satisfied with the outcome. He commented on doctors in Canada saying:

...they will do nicely... they will do slowly but nicely.

The difference in accessibility and timeliness of care was also mentioned by another Nepali participant, Suraj, who relied on his country's public system for his medical needs:

...Surely it is completely different because normally in Nepal, in my country, we for example if somebody is sick, now we can go directly to see the doctor. One possibility, or we can take our appointment by telephone also. We don't wait many days. Just for example if I telephone in the morning, I can see the doctor in the evening.

Similar issues were mentioned around the differences accessing specialists, where participants were accustomed seeking specialist care without the need of a referral. For the most part, participants did not understand why they needed to see their family physician prior to seeing a specialist. Veronica, a forty year-old woman also from Venezuela explained how the referral process works in her home country:

When you already know what you have, or when you already know your symptoms, we simply don't have family physicians [back home], but there is a clinic...and you go straight to the specialist.

Despite the fact that participants were aware of the differences in health care systems between their countries of origin and Canada, these issues were mentioned by nearly all participants as factors that impacted their health care experience. For participants with access to private health care in their own countries, these differences were more significant, yet to a lesser degree they were also mentioned by participants relying on public health care.

“The doctor takes his time and he is like part of your family”

Aside from the health system factors which participants believed influenced the physician-patient relationship, other factors revealing participants' expectations were discussed. Several participants described the type of relationship they had with their physicians back home, and based their expectations for health care encounters on these experiences. Factors such as the degree of physician involvement in patients' private life, levels of familiarity and continuity of care, were repeatedly identified as important components of the physician-patient relationship. For example, Alejandra, a forty year-old woman from Colombia described her relationship with physicians in her home country:

Doctors in Colombia pretty much sit down and have a coffee with you. They take their time. The Colombian doctor takes his time and he is like part of your family, so you have a relationship. Only now that I am here do I realize how important this relationship is. Can this be found here? Simply put: no, you won't find it.

The experience of having a close physician-patient relationship was expressed by other participants as well, especially in relation to continuity of care and establishing long-lasting relationships with their physicians. Having the same physician throughout the span of one's lifetime was a common expectation among most participants. Isabel, a thirty year-old woman from El Salvador described her relationship with her son's paediatrician:

First of all, the same doctor that receives your baby when they are born cares for your child until they are older, it's the same paediatrician. I even had his cell phone number and the relationship was so, so, so good that, well, it was easy to speak to him on the phone and he would say, for example: "right now I am busy but call me later, or I can call you" and sure enough later [he would say], "so what is wrong with the boy, etc.", and "no, better bring him to me"...I don't know if it's because of the culture, because of the language, because of the time, I really don't know where the secret lies but it is something I don't fully understand about here.

Having immediate access and personalised service were highly valued by other participants as well. Veronica, a forty year-old woman from Venezuela described a similar relationship with her physician back home:

In Venezuela, I had the same doctor for many years. In fact, he was well known by my parents. My gynaecologist was the same doctor that delivered me as a baby, and he was also my mother's gynaecologist...that is how I chose my gynaecologist. Unfortunately he died [but] the gynaecologist I had afterward was a person very close to my family. So for me, the person who cares for me must be very close to me...it is important for them to be very close to me emotionally...I am not going to get a pap test in a walk-in clinic!

At the time of the interview, Veronica still had not found a family physician and refused discussing issues around sexual health and contraception, or undergoing a full physical examination with physicians from walk-in clinics.

Although having a close relationship with their physician was a common expectation among most of the participants from Latin American backgrounds, other participants described similar expectations in terms of verbal communication. Shadia, a thirty-five year-old woman from Pakistan described her first medical encounter soon after her arrival in Canada, and compared it to her expectations for health care from back home:

...in my back home we all are used to having more talkative doctors. Like, we are more comfortable if a doctor talks more with us. So that's why I, at that time I was new and I was thinking: "why I wasted my time here?" It would be possible to have a nurse and nurse was dealing me better. So, but it was a quick appointment... patient needs basically emotional support.

In the case of Shadia, she had waited for her appointment and was disappointed to find that the physician spent very little time with her, compared to what she was accustomed to. She was aware of the time constraints doctors worked under but felt this was no excuse to give what she considered to be poor quality care. She added:

...it's okay if you have no time, you just have five minutes...even in my back home doctors are not so free to give around fifteen minutes, half an hour. But they are not rude by this. They talk like friendly. If you are busy...okay, you are busy. But if you are rude with your facial expression...I don't think so.

Shadia argued that friendliness and good communication should not be compromised as a result of time constraints and considered this detrimental to the physician-patient relationship, particularly among the elders in her community.

For participants with Latin American backgrounds, time was not only important but also the degree of involvement and richness of the physician-patient relationship. Past experiences with both the health care system the physician in their countries of origin, influenced what they now considered to be positive or negative health counters in Canada.

5.1.2 Negative Experiences of Health Care in Canada

Although none of the participants had an acute medical condition, due to the immigrant recruitment criteria¹¹ all had had at least three medical encounters in Canada. Based on their previous experiences visiting their physicians back home, several of the encounters they described were considered negative and in some cases influenced the way they sought care thereafter.

“They don’t give you time to think about what you want to say”

Considering participants’ expectations for length of appointments and relationship with the physician discussed above, it is not surprising many of the negative health care experiences in Canada dealt around these issues. Veronica, for whom establishing a connection with the physician was highly important, noted:

It seems to me that they give you maximum five minutes. They speak to you quickly, give you something quickly, and then bye! They don’t listen. They don’t give you time to think about what you want to say because they are in a hurry to receive the next person.

¹¹ Recruitment criteria for the study required participants to have been living in Canada for less than ten years, be 18 years or older, and have visited a physician in Canada a minimum of three times.

This feeling was shared among other Latin American participants. Roberto and Alejandra, a couple from Colombia described one of their early experiences with health care professionals in Canada. During her first annual medical visit, Alejandra was informed by her physician she was severely anaemic, a condition she was not at all familiar with:

She said to me: "Your exams show you are anaemic so you need to take this [medication]. You take it like this, like this and like this. Goodbye." It didn't take more than three minutes I believe. I left. My husband was outside and he said: "How did it go?" and I said: "I don't know!" I mean, it was really a shock to me. In Colombia, the doctor shows you the exam results, he sits down with you and he tells you: "Look, these are the reference values"...he explains to you.

Because they were accustomed to having an in depth discussion about a medical problem with their physician in Colombia, they felt not enough time was spent with them and as a result did not obtain the health information they were seeking. When it was time for Alejandra's follow-up appointment, they decided to go to a different family physician. Although they felt their new doctor was quite knowledgeable, they once again encountered communication difficulties, especially in terms of having their questions answered:

(My wife) was explaining that she was tired of taking the iron because it had to be taken at certain hours, restricting certain foods, etc. "Take this drug and keep taking this drug"...that was the response. He didn't say: "Look, you have to have to keep taking the drug for this amount of time, for such and such reasons". I mean, I was expecting an explanation. He listens to her and his response is: "Continue with the treatment". Period. No explanation. In Colombia, they explain to you. I mean, if you ask a doctor in Colombia: "Can I stop taking my iron?" [He will say]: "If you stop taking the iron these things will happen later on" or he will say: "No, keep taking the iron for three or four months, we need to increase your level of iron because of such and such reasons". He explains to you... This is a big communication difference.

Both Roberto and Alejandra have decided that this is perhaps the way medicine works in Canada, and have chosen to keep their family physician. Roberto explained:

The issue with this doctor is that he barely speaks! So you tell him things and you don't know if he has understood you or not. He takes notes but he doesn't let you know what he is writing. And at the end he says: "Take this [medication] and come back in this amount of time" and he gives you the requisition for exams. However, he has worked [for us], but he doesn't explain things...so I guess maybe the Canadian system is like that.

In this case, Roberto and Alejandra decided that because the treatment given by the physician was appropriate, they were willing to accept the fact that the physician did not communicate effectively. They were aware this situation was not ideal, but had come to accept it.

Other participants felt similarly around this issue as well. Indra, a forty-nine year-old man from Nepal noted:

...they are more mechanical over here. More mechanical because of so many unnecessary policies and something. And even sometimes they want, but they cannot talk to the person.

Indra noticed the distance physicians kept from their patients in Canada, compared to the physicians in his own country. However, he believed that physicians in Canada had to maintain this distance due to existing protocols around legal matter. He did not take this personally and had what he considered to be a good relationship with his physician.

Deema, a woman from Algeria who preferred not to disclose her age, agreed that time was an issue, particularly when visiting a walk-in clinic. Her son being asthmatic, Deema

had multiple encounters with family physicians and disagreed with the approach taken by most of them:

The approach is different. Some physicians are different than others. Like when the physician stands at the door saying: "Hey, what brings you here?" and he takes two seconds, he refills your puffers and then leaves the room. Yeah, I don't think that's very appropriate. But my family doctor doesn't do that, even if I just go for a refill of birth control pills. The other doctors I have seen at the walk-in for my son, who is four, to refill his prescription, his puffers, is like:

- *"hey what brings you in?"*
- *"I want to refill my son's puffers"*
- *"Ok, here you go"*

... then he leaves the room. He just asked me if he was, um, if he was coughing, if he had a fever, if his asthma...like he probably asked three questions, overall it took him ten seconds maybe. The door wasn't even closed.

This example provided by Deema describes a situation where not only time management was an issue, but also medical professionalism. While she was content with the care she was receiving from her family physician, she explained that on certain occasions when her regular physician was unavailable, she had to take her son to walk-in clinics for renewal of his asthma medication. Deema had difficulty trusting doctors in walk-in clinics because she believed that even for prescription refills, it was the doctor's duty to spend a reasonable amount of time questioning the patient to ensure good medical practice. She added:

Why was he trusting me? He never even knew I had um, if um, like if I know. What if my son was having some other problems that I did not [know]? See what I mean? Okay, I told him he's not fever, he's not wheezing or anything but how would you trust me, right? You are refilling his prescription, you might as well examine at least his lungs and see how he's doing. But when I spoke to my friends, they were okay with that.

Deema was surprised to find that the majority of her friends did not have an issue with physicians being quick to prescribe and instead indicated they preferred that type of approach. Deema's friends were not Algerian, although she did not specify where they were from. Differences in patient preferences and expectations in this case were once again linked to satisfaction of the medical encounter.

Deema was not the only participant concerned about the care her son was receiving. Isabel, the participant for whom having a close relationship with her son's paediatrician was highly important, shared a similar experience. Shortly upon arriving to Canada, her son developed sudden swelling of his hands and feet. While he was promptly seen at the hospital, Isabel states the hospital staff never explained to her what had been the cause of her son's condition. In addition, she was asked to continue with follow-up care with her family physician, which involves a weekly urine analysis for the next two years. She shared her confusion and frustration:

I am very disappointed you could say. Very disappointed because to this day nobody has given me a diagnosis that convinces me or at least calms me down or lets me know that this has passed. Asking my son to give a weekly urine test for the next two years makes me believe that there is still something going on that can reoccur any day! Because it's something that started so suddenly which the itching...out of the blue!

For Isabel, her concern lies primarily in the lack of communication and information given, as opposed to the quality of care provided to her son. She does not understand what diagnosis her son was given, and consequently is confused about the need for weekly testing.

“I Felt my Privacy was Compromised”

Nearly all participants considered time constraints and communication styles significant contributors to negative health care encounters. Closely tied to these factors was the issue of privacy and confidentiality. For many participants, routine medical proceedings and questioning styles were interpreted as invasive, irrelevant and inappropriate, severely damaging the physician-patient relationship.

For Bheka, an HIV positive man from Zimbabwe, privacy was a particularly important issue. He described his first experience visiting a family physician in Canada:

It was horrible. I was in the reception, they were asking me: “Do you have TB? Do you have HIV?” ... I’m treated like you want to know my real private stuff. What about you? I don’t even know who you are!

Although Bheka was aware of his HIV status prior to arriving in Canada, he was shocked at the approach taken by his physician and the public health authorities regarding his diagnosis. He recalled the moment his physician explained to him the need to inform public health:

- *“By the way, um, HIV...it’s um, a communicable disease so we have to report it”*
- *I said: “well you didn’t tell me about that! I didn’t know!”*

So the doctor didn’t tell me that... Public Health and God knows how many people knew about my situation that I didn’t even know! And I felt my privacy was compromised because the whole process wasn’t explained to me... I do understand after having been here for six years, for the record... however, when I was new, someone asked me direct questions like that: “who are you having sex with? Are you using condoms?”... That was very shocking.

As Bheka describes, he eventually understood the purpose of existing policies in the Canadian health care system. However, he believed his experience would have been less traumatic had the process been carefully explained to him. He also argued that a more sensitive approach to questioning around private issues would have been more appropriate.

Other participants, particularly women, also felt uncomfortable when asked personal questions mainly around issues of sexual health. Eliza, a forty-six year-old Muslim woman from Germany described her experience visiting a doctor in Canada to have a Pap test done:

There was a huge questionnaire and it was so embarrassing. I mean, even in Germany I never had this. "How many contacts you have?"- I'm divorced! I'm not married! "How many different..." I mean, it was disgusting! I was so shocked! And then they hurt me a lot and they said; "Oh...don't be so sensitive" or something. It was very rude and I never went again. I'm not married. In Germany I did this every year and my doctor never asked any stupid questions as I came the first time to her. I mean, that's not their business!

Eliza felt that the questions she was being asked were inappropriate given her cultural and religious background. Upon arrival in Canada, Eliza had been unable to find a female family physician and felt uncomfortable discussing women's health issues with her physician who was male. The experience described above took place when her physician referred her to a female health care practitioner to have her Pap test done. Based on this negative health care encounter, Eliza now refuses to have another Pap test done. In addition, she feels unable to discuss issues around menopause and considers this is

negatively affecting her health. She continues to actively search for a female family physician to address these concerns.

Veronica, who valued the close relationship with her gynaecologist, described a similar situation when visiting her family physician to request birth control pills:

I was asking him for the birth control pill, and he was asking me very personal questions and I felt very bad, it was invasive you know? I did not feel comfortable. First of all I am not in my own country; second of all I do not know the doctor; and third, I did not think it was an appropriate conversation subject. I had to talk about the way I do my things in order to avoid getting pregnant if I am not on the birth control pill...he wasn't the doctor to be discussing those things with.

As with the case of Eliza, Veronica did not return to this particular family physician, as she considered the doctor's questions to be intrusive.

"I am North African, He is Chinese Canadian"

Regardless of the length of time in Canada, degree of acculturation and country of origin, the majority of participants described situations in which cultural differences influenced the physician-patient relationship. Issues around physician gender preferences, alternative medicine and family dynamics were repeatedly identified among participants.

For Eliza, her perceived invasion of privacy during the medical interview was compounded by significant cultural factors affecting the physician-patient relationship. As previously mentioned, one of her greatest difficulties was finding a female physician:

One of the clinics asked me if I wanted to have a family doctor. I said, "I wish, but I want to have a female doctor"- so they couldn't help me with that.

After balancing the importance of having a primary health care provider with the difficulty of actually finding one, Eliza agreed to have a male physician. She stated:

If you have no choice then, then I go for... you know, as Muslims, we take care of things. As a female you go to a female doctor, as a male you go to a male doctor. If there's no other choice, before you die, of course you take the doctor which is available.

For Deema, also of the Muslim faith, it was particularly challenging to establish a good relationship with her physician. She shared her early experiences with her family physician in Canada:

I am North African. He is, I believe, Chinese Canadian. So there is no way we can understand, he can understand what I am talking about, or I can understand what he is talking about at that time. Like asking me for a Pap smear. Like, I wasn't even married and in theory if we're not married we are not supposed to be having sex. So, having the Pap test, I had to explain why I didn't want to have a Pap test. I had to explain why I didn't want to have STDs checked. I had to explain why I wasn't taking any birth control pills. It might be like small details for him but for us it was a shock at the first time.

As a Muslim woman, Deema found it frustrating that her family physician was not aware of her religious and cultural preferences. This initially influenced the physician-patient relationship in a negative way, yet after multiple appointments where Deema shared many of her beliefs and preferences, the relationship with her physician improved.

Although other participants did not reveal any particular preferences for physician gender, they did mention other cultural preferences. Alejandra, the Colombian woman introduced earlier, shared her confusion and disappointment when informed that she and her husband could not be seen together in the same room by the physician:

I think that family issues are just that, FAMILY issues. We are just the two of us; we don't have any children or anything. Therefore, I am his support and he is mine. This means that if something happens to him, I need to answer for it. So for me it is important to know...They didn't let him in. They told him, "You wait here while she goes in okay?"

This was particularly worrisome for Alejandra, given that neither of them were entirely comfortable communicating in English or French when they first arrived in Canada. As such, they felt going to medical appointments together helped them better understand what was being said. When asked if they informed the physician of their preferences, Alejandra responded:

No, because the lady (referring to the doctor) is fierce!

At a later point, Alejandra was referred to a gynaecologist within the same clinic and once again, her husband was asked to wait outside. However, she admits that neither she nor her husband asked for him to be allowed in. It is difficult to speculate what would have happened had Alejandra and her husband expressed their preferences.

The remainder of cultural preferences identified by participants involved the use of complementary and alternative medicine. It was evident that participants held several viewpoints at once, often integrating western medicine with traditional beliefs and practices. Roberto, who had struggled for many years with a genetic condition causing high cholesterol levels, commented on his experience negotiating alternative treatment with his family physician shortly after arriving in Canada:

...I was on treatment with Lipitor¹², and I went to see the doctor to tell him about the issue. He ordered some tests, took a look at the tests, and said to me, "Continue with the Lipitor". He gave me another appointment and ordered other tests, and realized it (the cholesterol levels) hadn't decreased at all. At that point I was having a lot of joint pain, it was more of a discomfort than pain, and I said to him, "Look, I am going to stop taking the medication because my cholesterol levels are not decreasing, and I am having an adverse effect that is not at all pleasant. Give me another alternative, or tell me where I can find alternative medicine that will help me manage my cholesterol issue, acupuncture, or I don't know, something else." He gave me no solution other than increase the dose of this (the medication), and I told him I would not do it.

For Roberto, increasing his medication was not an acceptable solution, and he was disappointed that his physician could not link him to further resources to access alternative treatments. Despite being aware of the cardiovascular risks of having high cholesterol levels, Roberto stopped taking his medication and was unsuccessful in finding alternative treatments. He eventually found a different family physician and at the time of the interview, was trying a new medication.

Eliza experienced a similar situation when her son developed a skin rash. She went to see a family physician at a walk-in clinic and disagreed with the approach taken by the physician:

...There was a rash on the body and I wanted her to give something to us, and she said, "Cortisone". What? My son was just five, four or five years old, and cortisone? I said, "Sorry, my son doesn't take cortisone and he has never antibiotics. I'm pretty much concerned about this", and she said, "No, we have to do something for the rash". I

¹² Lipitor is the brand name for the generic medication, Atorvastatin, used for the treatment of high cholesterol and prevention of cardiovascular disease. In some patients, it is known to have adverse effects such as joint pain, muscle pain and arthritis, among others.

said, "No, we have to check for the root. It's coming from something". So by my own research, I try now to just avoid sugar, white sugar, white flour. Now it's a bit better but I never took cortisone into consideration...I never went there again.

When Eliza was asked how her physician responded to her decision of not wanting her son to use cortisone creams, she responded:

She said, "There is nothing else". But I'm sorry...I can't accept this. I have the feeling that the doctors have just these much choices for medication and they just give it, they don't look further.

In this case, Eliza felt her physician had not thoroughly explored her son's medical problem and had been too quick to prescribe medication as opposed to trying other alternatives first, an approach she was not accustomed to. While Eliza openly discussed her concerns with her physician, other participants were more hesitant to do so.

Isabel from El Salvador timidly acknowledged alternative medicine was not always accepted by everyone including some of her family members, and therefore felt embarrassed discussing some of her common practices. Nevertheless, she shared her views during the interview:

Isabel: We believe a lot in natural medicine, even though my brother is a doctor...meaning, he doesn't believe at all in "el mal de ojo"¹³ and all of that, for him it doesn't exist, but I don't care, I just want for my son to be cured and I want to see him return to his usual self...

Interviewer: So how did you finally end up treating him?

¹³ "Mal de ojo" (Evil eye), is a term used by many cultures to describe a situation where someone causes another person harm by simply looking at them. In some Latin American cultures, mainly young infants are susceptible and are given a bracelet for protection.

Isabel: With the egg¹⁴, rue and alcohol

Interviewer: Would you feel comfortable discussing this with your doctor?

Isabel: I don't know if I would have his approval of it or not...It is difficult to establish a relationship with the family doctor.

As in the case of Alejandra and her husband, Isabel had not attempted to communicate her beliefs or preferences to her physician. Having a brother who was a physician and who openly disapproved of her healing methods, she was reluctant to share her beliefs with her physician in Canada.

“We cannot say, we cannot express”

Nearly all participants described language limitations when communicating with their physicians. These limitations ranged from a complete lack of fluency in English or French, to a working knowledge of the official languages. Regardless of proficiency level, participants agreed that communicating health-related issues was particularly challenging. Length of time in Canada was directly related to language proficiency. At the time of the interview, many participants felt confident communicating with their physicians yet they shared their early experiences struggling with language barriers.

Himal, a twenty-nine year-old man from Nepal who entered Canada as a refugee, felt his limited language proficiency coupled with his strong accent was a significant barrier when communicating with his physician:

¹⁴ Rubbing a raw egg over the body is also a traditional healing method shared by various cultures. It is believed to cure “evil eye” among others. The raw egg is rubbed over the body and then cracked into a glass of water. Evidence of cooked portion of the egg indicates the treatment was successful.

...they speak quite fast and I could not get all the thing...

For Bheka, language was also one of the several barriers he faced upon arrival to Canada:

...and my accent was very heavy when I came here, so the doctor would say, "excuse me, what did you say?", and I felt annoyed because I thought I was expressing myself, but whether he wasn't hearing me or I don't know, whatever it is, it was a language issue.

For Amita, a forty-six year-old woman from Nepal, pronunciation was a barrier as well, particularly when dealing with medical terminology. She commented:

...we don't know the terminology about the medical term. For us, the normal people, it hard to communicate with them. To express our feelings and sometimes, I also found that the accent, the pronunciations we speak to express, it's really hard. It's the gap between the language, the communications, that's why [it is] really hard to express what we are feeling. That's the main, I found, that's the main cause.

Suraj, a fifty year-old participant from Nepal had a similar view regarding this issue:

Some of the medical terms, we cannot say, we cannot express. Even for educated people also, same thing. Yeah, not only for uneducated people, it's the same thing for educated people.

Suraj argued that medical jargon was problematic regardless of education level, making communication even more difficult when there is a language barrier present. Similarly, for Pedro, it was surprising to discover that although he had studied English for three years prior to coming to Canada, he was unable to communicate at the level he would have liked.

He commented:

I had studied English in Venezuela, and as I was saying, the English you study at the academy is not the same as the English you encounter in “real life”. It is something completely different...you know which is your stomach, which is your ear, which is your nose, but how do you explain you have an inflammation of your pancreas? That’s when things begin to get complicated.

Overall, participants identified a disconnect between level of education and their success in communicating with their physicians in a different language. Veronica, for example, considered herself highly educated and as such, was frustrated with her inability to properly communicate:

It’s very sad, you know... that at 40 years of age and with a university degree, which of course doesn’t guarantee your intelligence, that you feel like an imbecile! Yes! And then you get depressed. You get depressed because you think, “not even for my own health can I communicate and make him understand I am in pain.”

The same held true for Roberto, also from Colombia, who felt relatively comfortable speaking in English or French, except for when he had to discuss matters related to health:

It is problematic in either of the two official languages in Canada. It is problematic because at times I feel I am left without the precise word that I would normally use in my native language... I feel it is a serious limitation. Very, very serious. To have some symptom, a symptom that many times is difficult to describe even in your own language, and then have to explain it in a different language. It’s very complicated.

These two participants discussed above had a relatively good working knowledge of English and were therefore able to communicate to a certain degree with their physicians. This was not the case a few other participants, who arrived in Canada with no fluency in either English or French. For these participants, barriers were present not only when

communicating with their physicians, but at all levels of accessing care. Sofia, a forty-nine year-old woman from Chile, described her experience navigating through the health care system shortly after arriving in Canada. Although she was grateful for all the settlement services and guidance that were offered to her, her significant language limitation made it difficult for her to take advantage of available resources, especially in regards to accessing health care:

When you arrive here, you don't know anything. People mention OCISO¹⁵ or Catholic Immigration¹⁶, but you don't even know where they are located! You don't know which buses to take, you don't have money, and the first person who will greet you there is someone who speaks English... So you can't even ask that person, "Where can I find Juanita Perez who works on the 3rd floor?" It is super hard! For example, it happened to me several times when they would say: "so if you need more information, you can find it on the internet". Sometimes the person assisting me would tell me this, my social worker for example, and I would say, "but I can't search the Internet because it's all in English!" I mean, I needed her for everything. Absolutely everything!

Shadia, the participant from Pakistan, also considered language barriers to be a significant problem during the medical encounter. Although she herself was able to communicate effectively, she had close ties with her community and knew of several instances where patients suffered negative health consequences due to language barriers. She shared one of her stories which took place during a party where she saw one of her "aunties":

I knew one of my aunties, she was having a diabetic foot. She was unable to speak in English so she went to the emergency department and somebody gave him (sic) some

¹⁵ OCISO is the Ottawa Community Immigrant Services Organization

¹⁶ Referring to the Catholic Immigration Centre which provides various settlement services for newcomers

like, lotions and cover and clean her foot. Auntie did not understand that she has to remove the gauze and she has to go back again to see the nurse practitioner. So when I sat aside with her, I talked to her: "Auntie, what is this?, because the gauze was stained and it was leaking something. So I talked to her: "Have you seen your nurse practitioner?" She told me: "No, the doctor said the gauze is going to work and there is no need, and other things I cannot understand." So, because in my back home it is common that you have to have a gauze and after that the wound is healed, it's going to go away. You can remove it. But it's not simple in diabetic foot. And you cannot imagine, after three months she went there and she got her foot amputated, her fingers. Can you imagine? ... then she realized and now she is using a language interpreter.

In the case of Shadia's "auntie" the combination of a significant language barrier and cultural differences led to a negative health outcome. Shadia mentioned her "auntie" had not only misunderstood her physician, but was also under the impression that going to her appointment with the nurse practitioner was unnecessary, as she was not familiar with the scope of practice of nurse practitioners in Canada compared to nurses back home, and believed only the doctor could properly care for her. This led the patient to skip her follow-up appointment with the nurse practitioner and wait for her doctor's appointment three months later, resulting in what might have been an avoidable amputation.

"Each Person is Different, Each Situation is Different"

The final component of the 'Negative Health Care Experiences' theme emerged as a result of participant experiences reflecting lack of patient-centredness during the medical encounter. As argued in the previous section, lack of patient-centredness is detrimental to all health encounters, not only those involving the immigrant population. However, when

combined with other barriers described above, immigrant patients may encounter greater difficulties in establishing good relationships with their physicians.

Bheka, the HIV-positive man from Zimbabwe, shared his experience when discussing treatment options with his physician:

It was horrible. I was meant to, you know, understand that you are in a better place by the doctor and decides whatever he says was best for me. Given the situations where I was coming from, I think that was unfair for me to be forced to say whatever he says, goes. I think I had the right to say: "You know, this is what I want for me"...we didn't really agree most of the time...I felt that how I felt and other issues that were affecting me were not taking into consideration by the doctor. He wanted to prescribe what he thought I needed to do about myself, without taking into consideration how I was feeling and certain things that were affecting me.

Bheka described how he had been HIV positive for many years and have never taken any medication for his condition while he was living in his own country. He felt treatment was being imposed on him by his physician in Canada, who he believed failed to understand his reasons for not wanting to take medication.

This feeling was shared by Chilean participant Sofia who had the same impression when it came to her physician respecting her point of view:

Sometimes the doctor, you are explaining something but the doctor only wants to see things from his point of view. So he gives you a prescription for some medication, while you try to tell him "that's not what I have!" But for them it's shorted and faster: "No, it's nothing, maybe just a temporary pain, look just take this and it will pass, alright?" But what one really wants to explain is that the pain is there, it is present every certain amount of time, especially around certain dates, or when you eat certain foods, so therefore it requires further investigation. But sometimes doctors just want to end the issue and they say, "No, it's nothing, if anything just call me. But here, take this

(pill). Take it when it occurs, it will calm you down and it will pass.” It’s as if they don’t want to complicate their lives...it’s faster and shorter.

Sofia felt her pain concerns were being quickly dismissed and greatly minimized. She believed her doctor failed to explore how the pain was impacting her life. This was particularly worrisome for Sofia, who many years back had noticed a small lump on her breast and was diagnosed with breast cancer. Since then, she felt she always “knew her own body” and could tell when there was something wrong. She attributes her successful recovery to her attentiveness to her symptoms:

I had no (other) symptoms. I didn’t have any arm pain; I didn’t have any arm swelling like some people say, or anything. I mean, if I had not known my body, I would not have gone to the doctor, and my cancer was already very advanced you know?

Regardless of the actual cause of Sofia’s pain, the physician was unaware of how seriously Sofia perceived her symptom, along with its psychological implications. It is possible that the treatment given by the physician was adequate, yet failing to validate Sofia’s concerns resulted in what she now considered to be a negative health care encounter.

Other participants voiced their desire to be treated as an individual, with medical care tailored to their specific needs; another principle of the patient-centred approach. This was particularly evident around the use of antibiotics. In general, participants agreed with the conservative approach taken by most physicians in Canada, yet they felt it did not always apply to their situation. Veronica from Venezuela shared her perspective on this issue:

What I think happens is that they try to be the least invasive possible. This is the way in which they manage things. But that does not apply in all situations. Every person is different, every situation is different. It’s good they don’t want to be invasive.

I applaud that because for example if they give antibiotics as soon as you have an earache, they will end up damaging other organs, so then your next visit will be to look after the organ that they damaged after giving you the strong antibiotic. I understand that and I applaud that here, but it is not applicable to everyone, it can't be, it just can't be that way.

Isabel, from El Salvador, also strongly felt that care should be individualized, especially when it came to taking her son to the doctor:

I wish they would pay just a little bit more attention. For him to not be treated like a number, but like a person. Not just because he is my son, but because he is a human being.

Isabel felt that the doctors caring for her son were always too rushed to take time to properly assess him, asking very superficial questions about his symptoms and quickly prescribing medication.

Only one participant mentioned a negative attitude towards participating in her care, another component of patient-centred care. Erika, a thirty-eight year-old woman from Brazil who was undergoing imaging studies for a breast lump, was told by her physician that everything indicated her lesion was benign. When Erika asked if a biopsy of the lesion was necessary, she was surprised at the response she received:

I found it strange that when she gave to me the option. When I said that maybe the biopsy she said, "If you think you would be more safe doing the biopsy, you can ask [for it]".

Erika was not accustomed to this approach and felt that being given the option of whether or not she wanted to have a biopsy done was inappropriate.

5.1.3 Positive Health Care Experiences in Canada

For most participants, the negative experiences described above led them to find a different family physician or develop ways to improve the relationship with their present one. As a result, the comments in this section represent what participants considered to be positive health care encounters.

“He Recommends, but the Decision is Mine”

A recurrent theme among participants was the option of deciding for themselves the best way to manage their medical condition. This approach was new for many participants, and was received positively. This was particularly true for Bheka, who experienced multiple disappointments when it came to discussing HIV management options with his family physician. He felt the physician had been insensitive, rude, and had betrayed his trust, in addition to feeling pressured to take HIV medication. This dramatically changed when he began seeing a different family physician:

She made it very comfortable for me. She sort of wanted to hear from me, where I was coming from and you know, what it is that I would expect from a doctor. [She] has been able to work with me to say that: “You know, I am amazed that you are so well for the last ten years...so you’ve just been eating food? Tell me, how did you do that?” And I felt so good to explain that I didn’t eat meat, I ate a lot of vegetables... that gave me an opportunity to explain. She didn’t say “BUT”, she said “AND”...”and what you can also do is with the drugs AND the food.” You see? There wasn’t “BUT” you see? So there is no doing down what it is that I’ve been doing...I decided to go with the advice, now I am on medication...I totally agree with her, because I didn’t felt judged, I felt validated.

The positive relationship that Bheka developed with his physician resulted in him accepting to start treatment for HIV. Although he admitted his physician was not knowledgeable about his home country or his background, he was surprised at how eager the physician was to learn more about him and his treatment preferences. He still recalled the initial medical encounter and how effectively his physician made him feel at ease:

She said, "If [you] were in Zimbabwe talking to a doctor, what would you have liked the doctor to say to you?"

Bheka believed this opening remark set the mood for the rest of the medical interview, and allowed him to openly discuss his treatment preferences and beliefs. Her non-judgemental attitude and willingness to negotiate cross-culturally led to a strong physician-patient relationship, ultimately influencing Bheka's decision to take medication for HIV:

She was able to explain it in such a way, that I saw a lot of benefits of being on treatment.

Other participants also described moments during which they were actively involved in their own care. This was a new approach for most participants, yet they felt this positively influenced the physician-patient relationship. Erika from Brazil, shared her thoughts on this approach:

I like when they explain everything that they have. I like when they show the possibilities of the treatment... I like when he said to me, "I recommend you stop with the medication". He explained why. Because sometimes they, not just the doctors but the health professionals, they think that they have the knowledge, they have the power, and that the patient should just listen and obey. I don't believe that, and I like it when he said to me, "I recommend you stop with the medication because of (this, this, and this)". He could just say, "You have to stop this eye drop" but he said, "I recommend". I

really appreciate when he said, "I recommend" instead of "You have to stop". It's like, he recommend but the decision is mine.

Coming from a country where patients seldom question doctors' orders, Erika was pleased to find she could participate in her own care, and the final decision on whether or not to follow a recommendation was hers. The situation described above took place when Erika found out she was pregnant and was unsure if she should continue using eye drops for her glaucoma. After meeting with her physician, she was provided with all the necessary information, including the physician's suggestion, but was left to make the decision on her own.

Alejandra from Colombia, also felt this approach greatly differed to what she had been previously accustomed to:

The doctor always gives the patient the option and [the patient] accepts the consequences. This is one of the things I like more about the Canadian system as opposed to back home. We are paternalistic therefore the doctor wants to solve all your life's problems... What I like about the health-related experiences we have had in Canada is that they tell you, "We will give you all the information...whether you want to do this or not, it is your responsibility and you should accept the [consequences]". I love that. I love that about Canada.

Alejandra noticed this approach was present not only during medical encounters, but also when accessing other services such as nutrition and healthy life-style programs. Like Erika, she appreciated being given all the pertinent information, including the consequences of each action or inaction, knowing the final outcome depended on her own decisions.

Although the majority of the participants commented on having good communication with their physicians in their countries of origin, they seldom were given the opportunity to participate in their management. Eliza commented specifically on this difference:

[In Germany] the doctor will not ask and will not get any consent. He's not supposed to take any consent about what you are taking. Are you ready to take this medication? Are you ready to have this test or not? No. There, he or she is used to have like investigations list and prescription on his own choice or her own choice. But here, the doctor is concerned about my choice, and I am the person who can select which medication I should have, and which should I have not. I like this approach.

Patient empowerment, as a component of patient-centred care, was considered by participants to positively influence the physician-patient relationship. Overall, it was a new approach to patient care and was closely associated with stories of positive health care encounters.

"You Feel Understood, You Feel Heard"

Despite the many examples of poor communication leading to negative health care encounters described earlier, participants also shared examples of good communication with physicians. The majority of these positive experiences did not take place during the first medical encounter but rather, occurred as a result of participants searching for a new family physician due to a previous negative interaction.

Veronica, from Venezuela, had spent her first years in Canada going from one family doctor to another, unable to establish a strong relationship with a physician she trusted. Most of the negative experiences she shared corresponded to this period of time. After

multiple attempts, she encountered a physician with whom she was able to establish the connection she was seeking:

When I feel heard, despite my language limitations, my stress begins to decrease, and my pain begins to decrease, because you feel understood, you feel heard; not just by your family and your husband, but by someone who can actually solve your problem. In my opinion, she (the doctor) is particularly special, and she is Canadian, she is not Latin!

Veronica was surprised she had been able to find a physician she could communicate effectively with, even with her limited English language skills. Knowing there was a relationship between her stress and her symptoms, she found that the simple act of being heard was therapeutic.

For other participants, knowing that their physicians were making a true effort to communicate with them, positively contributed to the physician-patient relationship, regardless of the success of these efforts. Sofia, who arrived from Chile not knowing any English, commented:

...Everything was in English but in a way I saw they were also doing their best to try to understand me.

Other participants felt the same way, especially when physicians provided them with resources to better communicate information about their medical condition. Eliza noted:

He was always very nice and helpful and he explained even when I didn't understand because in this moment my English was not that strong. I didn't understand the different medical names...so he gave me a printout from the website so I could research, do my own research. He really explain, explains me and show me with

pictures what's not really working, or what cartilage is lost or thin and...he suggested me something to treat.

Emir, the participant from Turkey, also mentioned the benefit of using visual aids or handing out material as a component of communication:

When I had the problem and numbness in my finger she even called me back the following week and told me, "I have some materials printed out from internet for you", and has called me in and gave me this material about what not to do, what [to] do, you know, to keep the situation in stabilization...I, from the discussion I had with her and from those handouts she gave me from the internet, I started to continuously and rigorously to do massage on my hand and the problem eliminated without seeing a surgeon.

Clearly explaining what a certain medical condition entails, along with an easily understandable management plan, contributed to patient satisfaction, as Himel from Nepal simply expressed:

Doctor explains us clearly what to do, what not to do. They will explain us very clearly and then so according to the doctor's instruction, we follow it.

Clarity, even in the context of a short medical visit, was also mentioned by Colombian participant Alejandra as an important component of good communication:

[She] treated us in a kind manner, and asked us where we came from. She didn't begin with all that of, "Why are you here? We can't help you with that, good bye", but on the contrary, "Who are you? Where are you coming from? What are your routine dietary habits...you require these certain tests, and these are the steps we will be taking. See you later." So it's quite short but it is good. You think to yourself, "I am being taken care off in a way that has been clearly explained to me".

Alejandra not only appreciated the clarity of the whole process, but was also pleased that the physician had taken interest in understanding her background and lifestyle.

Other participants also believed certain physician attitudes and behaviours contributed positively to the physician-patient relationship. Emir, for example, was surprised at the degree of involvement on behalf of his physician:

... I'm always coming on bike. She saw me on bike on the street and the next time she told me, "Hey, use helmet, I saw you in the street with your bike"!

Other positive experiences shared by participants involved physicians who were familiar with and knowledgeable about challenges faced by the immigrant population. This was primarily due to frequent exposure to this population, or because their own cultural background.

For Suraj from Nepal, finding a family physician was rather simple, as he was well connected to the Nepali community and was quickly referred to doctor who cared for a large part of this community. As such, Suraj was pleased with the care he received from this physician:

His service is very good, even when he knows we are from other countries, and what will be the problems for immigrants. So sometimes he counsels, how we stay here, how we should take care of our health in Canada. So he's okay. From one side he is our doctor and on the other side he is also our counsellor...He has already taken contact [with] many immigrants because he knows what is the problem of immigrants.

Suraj mentioned that this physician was not Nepali, but rather came from a Middle Eastern background and had been living and practicing in Canada for many years now. A similar situation was described by Claudia, a thirty-four year old participant from Peru. Shortly

upon arrival, Claudia and her husband began having difficulty adjusting to their new life in Canada, resulting in a significant impact on her health and well-being. Like Suraj, by asking friends in her community, Claudia managed to find a Canadian physician with a Peruvian background. She commented on her experience:

The first time I went to her, I felt a tremendous relief, tremendous...in every aspect because I had finally found someone who could listen to me, who could understand me, who could speak to me in my language, who helped me in every way, every way. She was not only my doctor, she was also my friend, my counsellor, and I felt she became very involved in my case and took my situation very seriously...She would ask me about everything, not just my health but also my personal life, how things were going with my husband, and she would even ask my husband to come to appointments as well.

For these two participants, having a physician who understood the immigrant experience was perceived as an advantage and was beneficial to the physician-patient relationship.

5.1.4 Easing the Dissonance

Depending on the length of stay in Canada, many participants described skills they had developed to help them cope and adapt to the Canadian health care system. Overall, these coping mechanisms consisted of adjusting expectations, changing attitudes, and identifying resources to assist them, such as interpreters and cultural brokers. For other participants, visiting their countries of origin and accessing health care there remained the primary way of getting health care needs met.

“I won’t leave the room without clarifying”

The majority of participants took an active role in taking care of their health. Being aware of their language limitations and unfamiliarity with a new culture, participants described ways in which they gained the necessary knowledge to ensure they were properly informed. The Internet was identified by some participants as one of the primary sources of information, while others relied on interpreters. Overall, participants were adamant about fully understanding what was being said during the medical encounter. Veronica, who arrived with very limited English language skills, commented:

I always re-check what has been said. I say something and when the person responds, I say: “So what you mean is this and this?” I always do that and I always write it down. That’s why I am always carrying around agendas and papers... I never assume I have understood what people have said to me. I always re-check, revise. I always use Internet tools to revise what they have said to me, to avoid making a fool of myself.

Emir also agreed the Internet improved the communication between him and his doctor:

I also do some search in the Internet. Because today with the invent of the Internet, you can get lots of descriptions, even the right terminology when you go see a doctor... which helps the doctor to better understand and perceive your situation.

Other participants mentioned the Internet in the context of interpretation services. This was particularly true for participants who were hesitant to use an interpreter due to confidentiality reasons. Veronica, for example, shared her thoughts on using an interpreter:

They were asking me very personal questions, and I was gesturing with my eyes to indicate there were things I didn’t want to say, things I didn’t want to explain, which were things about my uterus, I mean, you have to explain things that are very

personal...I would prefer if [the interpretation] were through the internet or over the phone, again, because they are personal questions. I don't want to have someone sitting beside me telling them everything about my life and then have to bump into them later... You might bump into the same interpreter that knows your entire life, in the Latin party or Latin festival. I don't want that!

Pedro, also from Venezuela, agreed with the challenges encountered when using a live interpreter:

Definitely, having an interpreter to assist you here and there during a consult, or even better, having a doctor that speaks your own language, is undoubtedly good. The problem is you arrive, you go to the doctor and tell him about all your hardships and you go to a refugee hearing and talk about all your things, and suddenly, you go to a Colombian party and find them there partying: "Hey! How are you?"

Sofia found the internet useful in a situation where communication would have otherwise been impossible given her very limited English proficiency:

...We had to use the computer translator, and it was ideal! They were not understanding me and I was not understanding them, and it occurred to one of them to use the computer translator, and we were able to exchange [words] and communicate.

In some cases, participants shared stories showing an overlap between cultural brokers and interpreters. This was due mostly to the fact that the majority of interpreters were ad-hoc interpreters, such as friends or family members. Emir occasionally interpreted for newly arrived immigrants from his native Turkey. He shared his experience:

Emir: I accompanied another new immigrant to a doctor. I saw the family doctor who were just following, blindly following the guideline, sending to this specialist and sending to this and that, without trying to understand by himself what's going on.

Interviewer: and did you, as an interpreter, do anything about that?

Emir: I tried to question back and I couldn't intervene too much but later, when I came out of the office of doctor, I told him, "Hey, what the doctor says, from my experience, doesn't look ok. He doesn't pay attention. He just gave you a pill for your pain, a tranquilizer without asking you any questions, without understanding what is going on, because the pain will go away with the tranquilizer but it is temporary."

While using a live interpreter may indeed breach certain aspects of privacy and confidentiality, or may lead to unethical interventions of behalf of interpreters, patients, or both, Alejandra from Colombia believed the benefits outweighed the risks:

There are people that don't like anyone, like, being close to their information. But basically I think that regardless of the means, the person must understand in their own language the problem that they have. No matter how small it is, if the person understands it incorrectly and follows the wrong medical advice, the problem can easily become more complicated.

Other participants felt more confident about their language skills, yet still took the necessary measures to ensure they had understood everything that had been discussed during the medical encounter. Gabriel, a thirty-four year-old man from Brazil who arrived with a working knowledge of English, commented:

If I don't understand some parts and I ask, she can explain different words. Yeah, so I won't leave the room without clarifying, until I know for sure what she is talking about.

Overall, participants were cognisant of the importance of insuring optimal communication with their physicians, whether it was through the use of interpreters or by using their own resources.

Other methods of coping described by participants, involved keeping close ties to their countries of origin or their communities as a way of having their health care needs met.

Veronica from Venezuela, for example, described how she accessed health care in Colombia:

What I did was...I found a Colombian doctor who can treat me from Colombia over the phone. It's like medical tourism. What he did, what this doctor did was, with all the explanation I provide him and the tests results that I scan and send, he provides me with a natural way of solving my problems without using medicine.

A similar situation was described by Alejandra from Colombia, who maintained close ties with her home country:

We were able to go to Colombia, so in Colombia we went to the dentist, we did our rounds. But still you say to yourself: "I am living [in Canada] now, so I need something from here".

Alejandra's husband Roberto, also commented how they consulted with Colombian friends living in Canada who were physicians but not able to practice in Canada. He considered them a resource when it came to getting their health care needs met:

We are lucky enough to have a couple of doctor friends here... so sometimes when things happen, we call them and we ask them, but they can't prescribe. But sometimes they tell us: "Look, tell the doctor you are feeling this way and this way." They know what to say so that the doctor orders an exam. But without them it wouldn't be easy, I mean, we are lucky, really lucky.

Other participants relied on their own medical understanding and medications they were familiar with, to treat certain medical conditions and avoid having to depend on doctors in Canada. Isabel from El Salvador, who used a mixed of traditional healing methods with Western medicine, explained:

We had brought medication from our country, because we know how to use antibiotics...so we managed things there, in our apartment.

In certain countries it is common practice for patients to self-medicate, as many antibiotics are available over-the-counter. Isabel had brought a large supply of medication from El Salvador and felt confident enough to use it for her various medical needs. She combined these medications with her traditional healing methods, and felt this was an adequate alternative to visiting her family doctor in Canada. For other participants who could not meet their health care needs by traveling back home or managing their own medical condition, finding a physician from a similar cultural background was another alternative.

Shadia from Pakistan, explained:

Many doctors are now working in the community. So whenever they have some knowledge about doctor from Pakistan or from India: "Oh I have to go there", and they try their best to get the opportunity, even after six months, to get an appointment...They are more familiar with our problems, community problems, because communities are the same, Indian and Pakistani, so that's why peoples in my community get comfortable...we have Indian doctor and Pakistani doctors. It's good, because it's loving, caring.

As Shadia expressed, many people in her community felt more comfortable accessing a physician from a similar cultural background, even if this meant having to wait longer for an appointment.

“Attitude is the Key”

Nearly all participants described moments where they attempted to find physicians from a similar cultural background, who spoke their same language, or who at least were familiar with the challenges they faced as immigrants. Those who were not successful in finding physicians meeting these requirements were left to find other ways to have a good relationship with their physician. Adjusting their expectations and adapting to new cultural norms were some of the coping techniques employed by participants. Roberto, who was content with his migration from Colombia to Canada, shared his opinion on this subject:

Look, migrating and being successful in the migration process, in my opinion, is 100% linked to your attitude. So you can come here and say: “Why does there have to be daylight savings time?” Because there is! You have to adapt to it! You are not going to change it!

Roberto used the example of people who generally complain about certain aspects of the Canadian lifestyle to show how this can have an impact on the settlement process. Other participants shared this opinion and resolved to become more flexible with their cultural and religious beliefs. Deema, from Algeria and of the Muslim faith, shared her experience negotiating cross-culturally with her male family physician:

During my pregnancy, more I wanted to have a female physician, so he referred me to one of his colleagues. She was following me during my pregnancy and then after I delivered I went back to him. He referred me and he understood very well. And then

after that when I went to see him for my post-partum, he had to do a pap smear and I asked him: "I'd like to have a female". There was a resident at that time that they were training so he said: "Are you okay with a resident doing your pap smear?" "Sure". She did my pap but the year after that there was no one, so he had to do it. It was alright.

Deema appreciated how accommodating and understanding her physician had been regarding her cultural and religious beliefs. Therefore, when the time came when he could not find an adequate arrangement, Deema decided to adjust to the circumstance. This did not affect in any way the physician-patient relationship, as she was keen to note:

He's really good though. I love him now. I wouldn't change my family doctor for nothing. Even now, if they offer me like a doctor of my own culture, whatever, I wouldn't change.

While adjusting expectations and adapting cultural beliefs may not be an option for everyone, these participants found it positively contributed to their settlement process in Canada.

Moving Forward

Nearly all participants had suggestions for improving the physician-patient relationship for the immigrant population. The majority of these suggestions involved a mediator, such as an interpreter or cultural broker, and participants explained how having access to them would have been beneficial. Bheka from Zimbabwe, who on arrival had a particularly difficult time understanding the Canadian health care system, commented:

It would have made a difference if the interpreter would say: "That's how they do it here. They will ask you personal questions, however, it is for your advantage." It would

have made a world of difference because then I would know they don't mean any harm, but they mean good. So if the interpreter was there to explain this to me it would have made a difference... I understand it now, but by then I did not understand it. Trust me, if it would have been explained initially, I would not have had any problems. But the whole process wasn't explained to me...

Although what Bheka described corresponds more to the activities of cultural broker than those of an interpreter, it is clear he would have benefitted from someone explaining the difference in communication styles during the medical encounter. Deema from Algeria, shared his opinion:

If someone explains to people what to expect, I believe it would help a lot of people.

Indra from Nepal agreed and thought the guidance should involve navigating the health system as well:

Sometimes it is confusing, so in the beginning, let's take care all newcomers properly and guide them properly...so that they will get familiar with the Canadian public health system or policy.

In addition to mediators, participants also highlighted certain skills that physicians could work on to enhance the medical encounter. Bheka was firm in his belief that physicians should work on their communication skills, particularly when caring for patients from countries other than Canada:

...They have to be able to know how to communicate with patients from another cultural specific background. It may be Indian, it may be African, it doesn't matter but just put yourself in the situation where the client is a friend of you, she is Indian and then you say: "Excuse me ma'am, I really don't know how you normally talk to doctors.

So imagine if you are in India, and there is a doctor in front of you, what would they say?" and by so doing, that gives the patient an opportunity to express themselves clearly without being feel judged or stigmatized, and that empowers the patient to talk clearly...They don't have to learn the culture of all thousand countries, but it's just the approach.

While Bheka believed it was not necessary for physicians to be familiar with patients' backgrounds, he acknowledged it was beneficial to have physicians who were familiar with the immigration process and its associated challenges. He indicated:

Canada is really an immigrant country and as such, doctors, half of the time or part of their learning have to know how to relate to people from other countries, or if at all, they can take in doctors like yourself, from outside, and train you to talk to individuals who are new, because then you know. You've lived the experience of being an immigrant, and as such, I think that would really help.

A similar belief was shared by Emir from Turkey:

I noticed that there are people from different backgrounds working at the community centre and there is a clinic over there. So probably that will help a lot to make it better.

Emir was convinced more could be done to facilitate the immigrant settlement experience.

Similarly, Suraj from Nepal commented:

In my opinion, if the doctor understands the whole situation of immigrants, then it would be very nice.

Despite the lack of participant homogeneity, there was sufficient repetition in each of the categories to constitute the individual themes presented above. This held true

regardless of cultural or ethnic origin, language proficiency, socioeconomic status, age and educational level.

CHAPTER 6 DISCUSSION AND CONCLUSION

The main purpose of this thesis research was to understand what immigrant patients perceive to be culturally competent care. Two objectives, the first being to perform an evidence review of the literature around the subject of cultural competency in primary care, and the second being to conduct interviews with immigrant patients, addressed this. The information obtained through the literature review demonstrated the trajectory of the development of various frameworks and definitions of cultural competency in health care throughout the years. While these were helpful in providing a theoretical understanding of cultural competency, the evidence review also identified significant gaps, particularly in the areas of what a culturally competent medical encounter looks like in practice, how patients conceptualize culturally competent care and its effect on health outcomes.

The second objective of this study, which involved conducting interviews with immigrant patients, contributed to filling these gaps by identifying key aspects that affect the physician-patient relationship and patient satisfaction with the medical encounter.

This chapter provides a discussion of both the literature review and interview research findings, and is presented according to the main categories identified through the participant interviews: Pre-existing Health Care Expectations, Negative and Positive Health Care Experiences, and Easing the Dissonance. Whenever possible, findings are compared to the data obtained from the literature review. The chapter concludes with a summary of recommendations and suggestions for future research directions.

Interpretation of findings

6.1.1 Evidence Review in the Context of Participant Interviews

Although cultural competency was not consistently defined in the literature, the authors from the main studies presented in this thesis described cultural competency as a continuum or goal to be reached. Many of the stages presented on the continuum described physicians' attitudes and behaviours, which were also identified through the participant interviews. Although practitioners were not included in the study, it was possible to hypothetically place them on the continuum based on the experiences shared by participants, demonstrating how these frameworks can be used to a certain extent to understand at what stage a practitioner finds themselves. For example, the model developed by Cross et al. (1), which ranged from cultural destructiveness to cultural proficiency, described a stage of 'cultural incapacity' located towards the lower end of the continuum, where the system or individual may not necessarily intend to be destructive but fails to respond to the particular needs of culturally and/or linguistically diverse groups. For the most part, the negative experiences described by participants appear to correspond to this stage, such as failing to take into account family dynamics, treatment preferences or linguistic limitations. When compared to the model proposed by Borkan et al., ranging from 'ethnocentricity' to 'ethnosensitivity', these behaviours most closely correspond to the stage of 'relativism' found midway through the continuum, where awareness and acceptance of diverse cultural groups exists yet an understanding of its clinical implications is lacking (34). The authors suggest techniques to address this limitation such as becoming familiar with culture-specific needs, but are keen to highlight this might not always be feasible and suggest relying on Kleinman's Explanatory Model

Approach (6) and the LEARN guidelines (38) (discussed in Chapter 3) to assist with communication in any cross-cultural interaction.

Although to a certain degree it was possible to relate participants' experiences to the place on the continuum where their physicians appeared to be, the usefulness of being able to situate the physician in the continuum is questionable. As Borkan et al. note, a physician may tend to be ethnosensitive when caring for one cultural group, yet tend to be ethnocentric when caring for another. Therefore, this location appears to be theoretical and may not necessarily guarantee a consistent culturally competent approach when caring for diverse populations.

Interestingly, participants reporting positive health encounter experiences involved physicians who knowingly or unknowingly were using components of Kleinman's Explanatory Model, emphasizing a patient-centred approach. Examples of this included physicians asking participants how their physician would have addressed the health issue in their country of origin, acknowledging differences in health beliefs and negotiating treatment preferences. Although Borkan et al. also suggest learning about culture-specific needs by attending cultural events or participating in experiential learning, interview participants did not identify these, or any similar activities, as interventions that would improve the relationship between them and their physician.

While early conceptualizations of cultural competency incorporated certain aspects of patient-centred care into its definition, the distinction of which components belonged to which approach was not clearly made. Recent literature, however, has focused on differentiating components corresponding to culturally competent care, patient-centred care, and their area of overlap. Saha et al., for example, clearly defined each of these

components (5). Not only does this distinction allow researchers to identify specific behaviours or actions that can strengthen the physician-patient relationship but it also promotes clearer training objectives and assessment. For example, the majority of experiences shared by interview participants reflected components belonging to the overlapping region of cultural competency and patient-centredness, as defined by Saha et al., such as allowing involvement of family or friends during the medical encounter, providing information tailored to the patient's level of understanding and building rapport and trust. This finding suggests that educational and implementation efforts could likely be most effective when targeting both patient-centredness and cultural competency components. Carrillo et al. (3) and Betancourt and Green (2) have worked extensively on developing a patient-based approach to providing cross-cultural primary care. Again, this approach relies heavily on the patient-centred approach and Kleinman's Explanatory Model to ensure adequate communication with patients from any cultural background.

The evidence review provided a theoretical conceptualization of cultural competency in primary health care, yet certain gaps were also identified, specifically in three main areas: what cultural competency looks like in practice, patients' understanding of cultural competency, and the relationship between cultural competency and health outcomes.

Although there were a few articles exploring the patient perspective of cultural competency or the aspects affecting the physician-patient relationship, these studies focused mostly on race and ethnicity as opposed to migration status. In addition, these studies were predominantly U.S.-based making it difficult to generalize findings to the Canadian immigrant population. As a result, there remains a gap in understanding how

Canadian immigrants conceptualize culturally competent care. This is one of the main areas where the participant interviews conducted as part of this thesis research contributed to filling this gap in the literature, discussed in detail in section 6.1.3, *Experiences of Health Care in Canada* below. The experiences shared by participants not only provide an insight into what patients believe to be culturally competent care, but also provide examples of what this looks like in actual practice. By sharing positive and negative experiences of the health care encounter, it was possible to identify aspects that significantly affect the physician-patient relationship, mainly in the areas of cultural differences, language barriers, privacy and trust issues, shared decision-making and communication skills.

Despite a theoretical association between culturally competent care leading to improved patient satisfaction, increased adherence and uptake of preventative screening resulting in optimal health outcomes, there was insufficient evidence in the literature review to support this. The participant interviews conducted for the qualitative component of this thesis research did not provide any evidence of this association either, given it was not designed to confirm this hypothesis. Nevertheless, some participants admitted to starting medication or following medical instruction they were previously hesitant to doing, following a thorough conversation with their physicians where the reasons behind the medical advice were clearly explained. Further studies directly linking this behaviour to improved health outcomes, ideally using a quantitative approach, are still needed.

In addition to addressing the gaps in the literature discussed above, the participant interviews uncovered additional factors affecting the physician-patient relationship, which were not present in the literature review. The most significant of these were pre-existing expectations for the health care encounter. The idea that patients' perceptions of the health

encounter in Canada is influenced by previous experiences in their countries of origin, was a recurrent theme in nearly all the interviews. This finding was even more pronounced in those who had had access to private medical care in their countries of origin and played an important role in patients' perception of quality of care received. This finding is further discussed in section 6.1.2 below.

Other patient-related factors influencing the physician-patient relationship were the multiple coping mechanisms used by patients to facilitate communication between them and their providers, such as actively participating in their care by requesting clarification from their providers, relying on the Internet for further education and strengthening their language skills, among many others. The concept of acknowledging the influence of patient-related factors on the physician-patient relationship was not identified in the literature, yet was a prevalent theme in the participant interviews. This, along with other participant-suggested methods of easing the dissonance is discussed in section 6.1.4 below.

What follows is a comparative discussion between the literature review and participant interviews, focused on the three main categories identified in this thesis research: pre-existing expectations for the health care encounter, experiences of the health encounters in Canada and easing the dissonance.

6.1.2 Pre-Existing Expectations for Health Care Encounter

The main focus of this study was to understand how patients conceptualize culturally competent care. Naturally, participants drew comparisons between their medical encounters in Canada and those in their countries of origin. From their responses, it was

clear that nearly all participants held certain expectations of what the medical consultation should entail, as well as the type of physician-patient relationship they were accustomed to. Despite the clear connection between expectations and satisfaction with health care arising from the interviews, the literature review failed to identify any studies dealing with this particular aspect of recent immigrants accessing care. While most studies were able to determine the main reasons why immigrants reported low satisfaction with the medical encounter, their pre-existing expectations were never explored. As seen in this study, immigrant patients generally have had multiple health encounters in their countries of origin, within health care systems and standards of practice quite different from those in Canada.

The most striking example of this was the expectation that the physician should spend more time with the patients during the consultation. Feeling rushed and unheard severely impaired the physician-patient relationship, as several participants were accustomed to longer appointments with their physicians in their countries of origin. In some cases, this was linked to physician behaviour as well, where participants desired a “deeper” connection with their physician.

Specifically in the Latin American population, this physician characteristic has sometimes been described as “personalismo”, which can be translated as “formal friendliness” (41). “Personalismo”, as defined by Perez-Stable, “is a character trait sought in individuals perceived to hold power or authority over an individual or a group. In the case of the physician, this authority is a reflection of knowledge about health and disease gained by education.” Similar to what has been identified in the literature, Latin American participants in this study seemed to place more emphasis on finding a physician with

“personalismo” rather than medical competence. Having the opportunity to discuss with their physicians in a friendly manner, including non-medical topics was a significant expectation for the health care encounter in this population. As Perez-Stable describes, “Legitimate use of humor in communications, some sharing of personal experiences, and other interactions that lead a patient to feel like the doctor could be a neighbor capture the spirit of this cultural script.” (41) Reflecting this description, it is interesting to note that participants describing positive health care experiences from their home countries rarely spoke of physicians’ medical competence, qualifications or clinical outcomes.

Physician characteristics vary greatly in any context, but it is not rare for physicians in Canada to be reluctant to share their personal information with patients. In fact, there is a tendency to set boundaries with patients and avoid becoming emotionally involved (82). Depending on patients’ cultural background and expectations, this may be incorrectly interpreted as being uncaring or rude. While it was mostly the Latin American participants with strong feelings around this issue, to a smaller degree it was also present in participants from other cultural backgrounds. This would suggest an overall preference for a “friendlier” and “deeper” connection with the physician, likely due to pre-existing expectations.

Lengthier and “friendlier” appointments are likely desired by the majority of Canadians, not just the immigrant population. However, for patients unaccustomed to the system and Canadian cultural norms, the negative impact on the physician-patient relationship may be more significant.

It is important to highlight, however, that several participants came from countries where they had access to private health care, despite their socio-economic status. Private

health care may have an effect on several aspects of the medical encounter, from length of an appointment, to services offered, or any other factor related to customer satisfaction. It appeared that participants accustomed to this form of care were less satisfied during their health care encounters in Canada, failing to realize that waiting times and certain medical protocols were system-regulated as opposed to physician-dependent.

Two examples of system-based issues, which reflected poorly on the physician-patient relationship, were the lack of immediate access to the physician (as in same-day appointments) and the inability to consult a specialist directly without the need for a referral. For many participants, it was the first time they encountered barriers such as these. Coming from countries where in some instances it was not even necessary to make medical appointments, or where patients can request sophisticated investigations regardless of whether or not it is medically warranted, significantly influenced participants' expectations for health care. The fact that many immigrant patients had access to varying degrees of private health care in their countries of origin may significantly affect their views of the quality of care received in Canada. Given that a considerable amount of literature around cultural competent care is U.S. based, where patients also may have access to private care, it is possible that previous studies have failed to identify this as a contributing factor. Being aware of these expectations and clearly providing guidance and education around the Canadian health care system is one way of avoiding misunderstandings and managing expectations, setting the stage for a trustworthy, transparent physician-patient relationship.

6.1.3 Experiences of Health Care Encounters in Canada

All reports of health care encounters in Canada were divided into positive and negative experiences. Some of the negative health experiences were clearly linked to participants' expectations described above, while others were due to cultural and religious differences. Findings from the participant interviews in this section most closely matched those from the study conducted by Ngo-Metzger et al., who identified patient preferences, physician-patient communication and experiences leading to trust and distrust, among others, as important components of perceived culturally competent care (4). While the authors agreed there were few studies exploring the underlying causes of distrust and dissatisfaction, they did identify racial discrimination as a contributing factor in their literature review. Interestingly, racial discrimination was not mentioned by any of the participants in this thesis research, highlighting once again that caution should be taken when interpreting results on this subject based on a different patient population.

Negative Health Care Experiences

A common concern for all participants, regardless of their background, was the short amount of time allotted for medical consultations as they felt it affected the quality of care received. This was due to the fact that there was limited time to ask questions or clarify doubts they had about their health, as well as insufficient time for physicians to clearly explain diagnoses and instructions. In several instances, participants believed proper communication was lacking due to time constraints, and this in turn affected their decision

to adhere to treatment or follow medical advice. Participants were generally unsatisfied with the medical encounter when the physician failed to clearly explain the reasoning behind their treatment recommendations. For example, when the anaemic participant approached her physician regarding discontinuing her iron supplementation, she was not given a clear explanation as to why it was necessary for her to continue, making it difficult for her to justify continuing the medication. The relationship between time spent during the medical appointment and patient satisfaction with the encounter has been previously identified in the literature, spanning across various cultural groups, as was also the case with many participants in this study (4,51,52,83).

Similarly, participants reported insufficient information in terms of being told about their diagnosis. The most striking example was that of the mother asked to provide samples of his son's urine on a weekly basis for two years. She was never given a diagnosis or explanation as to why this was necessary. While it is possible that the doctors were uncertain of the diagnosis to begin with, the participant was left with the impression that no one wanted to take the time to explain her son's situation. In this case, taking additional time and care to convey the uncertainty of her son's case could have turned this into a positive health encounter, despite the lack of a clear diagnosis. Other participants shared similar stories, where they left their physician's office without knowing what their diagnosis was. This clearly impacted participants' perception of quality of care received, and negatively affected the physician-patient relationship.

Another aspect that resulted in negative health care encounters was the perception of lack of privacy. The experiences shared around this issue demonstrated lack of sensitivity on behalf of the physician as well as opposing views regarding what is considered

“confidential”. Clear examples are the stories involving health questionnaires during the medical visit. The questionnaire approach is employed in several medical offices as a quick and effective way of gathering basic information regarding a patient’s health, particularly during the first medical encounter. This questionnaire, however, may include questions deemed inappropriate by some patients. Being asked to provide personal information to a stranger without a clear explanation of the reasons behind the questioning, led to a perceived invasion of privacy even before the medical interview was started. Furthermore, being asked these questions out loud was even more damaging to the physician-patient relationship, as the majority of the participants were not accustomed to openly discussing personal issues. The most difficult discussion areas dealt with sexual health (e.g. sexual practices, sexually transmitted infections) and women’s health (e.g. contraception, Pap tests, menopause). This is similar to what has been described in other qualitative studies, where patients from diverse cultural and ethnic backgrounds are reluctant to openly discuss sensitive topics (52,84). The negative consequences of these experiences ranged from refusing further preventative screening tests, to avoiding going to the doctor altogether. However, many of these experiences took place in the setting of a male physician caring for a female patient, an important point considering some participants had religious reasons for preferring a female physician. Matching patients to same sex physicians is not always feasible, and participants were well aware of this. Nevertheless, physicians who acknowledged patients’ preferences and made a sincere effort to adjust to their cultural and religious beliefs were able to establish a stronger relationship with their patients. For example, referring a patient to a female colleague for a Pap test only, led to a stronger relationship between a Muslim patient and her male physician. The next year,

when there were no available female physicians to do her Pap test, she agreed to let her male physician do it. This example demonstrates that negotiating cross-culturally depends not only on physicians but on patients as well.

There were other cultural differences that led to negative health encounters, such as failing to take into account varying family dynamics. In many cultures, it is common for the family, and sometimes even the extended family, to be present and involved in the care of the patient (3,85). Participants who were asked to wait for their spouse outside during the medical consultation were puzzled, especially when no explanation for this practice was provided. Asking a spouse to wait outside during a medical appointment may be appropriate in certain circumstances, such as screening for intimate partner violence when suspected, or addressing other partner-related issues. However, patients' preferences around this topic are seldom acknowledged and may in fact negatively affect the physician-patient relationship. Despite this preference, it is unclear how many patients request having their family members present during the medical interview. As one participant mentioned, she and her husband were afraid to inform the physician of their preference. Questioning or going against an established protocol may be challenging, especially for recent immigrants unfamiliar with the health care system in Canada. As such, the onus may be on the physician to explore patient preferences regarding this issue.

Participants also voiced concerns about treatment preferences, especially with regards to antibiotic prescription. Despite being from different backgrounds, it was interesting that several participants indicated a preference for conservative or minimally disruptive interventions. Overall, participants felt their physicians were quick to prescribe medications as opposed to taking a more "natural" approach to treatment. In contrast to

other patient preferences described above, this is one area where participants openly refused certain treatments they disagreed with, or specifically requested complementary and alternative medicine (CAM) for their medical needs (e.g. acupuncture). Participants described situations which demonstrated little, if any, willingness to negotiate on behalf of the physician. As a result, these participants seldom took medication as prescribed and instead, turned to home remedies, friends' advice and the Internet, among others, to address their health care needs. This may pose a challenge for the treating physician, who may be working under the assumption that their patient is compliant, and may not be aware of natural remedies they are taking instead. The benefits and challenges of addressing preferences for CAM in this population have been well documented and reflect what was also evident from the participant interviews in this study (4,36,46,57,85). Although the use of CAM is often an important component of cultural competency teaching, almost none of the participants felt this preference was properly addressed or felt comfortable discussing it with their physicians.

The patient-centred process, as outlined by Stewart et al., specifically addresses this aspect of the physician-patient relationship under the "finding common ground" component where "two potentially divergent viewpoints (are) brought together in a reasonable plan" (7). This generally involves recognizing the patient's problems and priorities, determining the goals of treatment and defining the roles of the physician and the patient. As identified in this study, participants seldom felt their preferences were incorporated into the treatment plan, and related concerns were quickly dismissed. It is understandable that CAM alternatives may be beyond the scope of practice of most family physicians, but being aware of this important component and knowing how to connect the

patient to resources or specialists in this area may result in improved patient satisfaction (2,3,41,52,86,87).

Participants expressed other experiences leading to negative health care encounters, once again, reflecting a lack of patient-centredness on behalf of the physician. These experiences correlate with two components of the patient-centred process: “exploring both the disease and the illness experience” and “understanding the whole person”(7). The difference between disease and illness lies in that the former is defined by a pathophysiologic process whereas the latter relies on the physical, psychological, social and cultural dimension of a person (88). Findings from the interviews in this study suggest that failing to elicit patients’ illness experience negatively affected the physician-patient relationship and the health care encounter. Participants described moments where they disagreed with the physician’s explanation of what was causing their illness, and were not given an opportunity to express their point of view. This was exacerbated by the fact that participants felt the care they received was not individualized, and many times did not account for context-related factors. One example was the symptom of unspecific pain in a participant with a past medical history of breast cancer. Failing to associate her underlying fear of cancer recurrence and being quick to dismiss her complaint of pain, resulted in low patient satisfaction with the medical encounter. As demonstrated in this study, when patients disagree with the cause of illness, they also tend to disagree with the treatment plan. This correlates with what has been demonstrated in the literature, and is an important cause of non-adherence in this population (41,86,89).

Patient disclosure of sensitive information is also closely tied to patient satisfaction with the medical encounter (52). Female participants in this study, regardless of their cultural or

religious background, were reluctant to share personal information or discuss matters of sexual health with their providers if a strong physician-patient relationship had not been previously established.

The final contributing factor to negative health encounters was the presence of language barriers, which further accentuated the communication problems described above. This limitation was identified by nearly all participants in the context of negative health care experiences, and was more pronounced in the early stages of the settlement process. Considering all participants had a native language other than English or French, it was surprising that only one individual had a medical encounter with the assistance of a professional interpreter. While the remaining participants had a basic knowledge of English or French upon arrival in Canada, they still described language-related communication difficulties which may have been avoided with the use of an interpreter. In addition, several participants made reference to the fact that it is quite different to transmit medical information in a foreign language than it is to transmit regular everyday information. This could become particularly problematic in cases where both the patient and physician are under the impression that language proficiency is sufficient to discuss medical issues. This may lead to patients failing to request an interpreter or translated material, and physicians failing to transmit information in a more comprehensible manner.

All participants agreed on the importance of optimal communication during the medical encounter, and the majority indicated they would have appreciated having an interpreter present for their medical appointments. Participants described negative health outcomes which could have been avoided had an interpreter been present. An example of this is the participant who relayed the story of her “auntie” having a foot amputation due to a

language misunderstanding. This is a particularly complex barrier, given the physician may incorrectly overestimate a patient's language proficiency, and in turn, the patient may be reluctant to inform the physician of his or her limitation. The responsibility to assure proper communication should be shared, and ideally be done during the first encounter. Guidelines such as the U.S. CLAS Standards described in Chapter 3, symbolize an important step in ensuring the language component of culturally competent care is addressed. This is particularly valuable given that language barrier is one of the few factors that has so far been linked to poor health outcomes (62,63,90). Unfortunately, these guidelines are broad and fail to provide suggestions as to how these recommendations can be carried out.

This study did not thoroughly explore preferred interpretation or translation options, yet it was clear that privacy was concern for many participants when considering an "in-person" translator. This was due in part to the fact that many times interpreters belong to the same cultural group or community as the patient, leading to a perceived increased risk in breach of privacy. This concern was greater in participants who had arrived in Canada as refugees, or who needed to discuss matters of sexual health.

Positive Health Care Experiences

Several of the positive health care experiences described by participants arose from physician behaviours and reactions opposite to those presented in the section above. For example, participants identified several occasions where physicians made sincere efforts to communicate effectively. Using resources such as printed out medical material and images, using basic vocabulary and avoiding medical jargon, were all identified by participants as

ways of improving communication during the medical interview. This held true despite the length of appointments remaining short. As one participant remarked, she was pleased that although her appointment time was limited, her physician was able to convey a true interest in understanding where the patient came from, what her life was like, and clearly explain what the next steps were in terms of addressing her medical concerns.

Another physician trait associated to a positive health care encounter was their familiarity with the immigration experience. While some participants indicated they preferred physicians who were immigrants themselves, others were simply satisfied with physicians who had experience caring for the immigrant population. Most participants felt it was an advantage to have a physician who was aware of the challenges immigrants face, as these physicians often knew of helpful resources and provided context-specific guidance. There is evidence suggesting benefits to having race or ethnicity matching of physician and patients, showing an increase in patient satisfaction and an overall improvement of health outcomes (19,47). However, the majority of these studies are based in the United States, where immigrant population demographics vary greatly from those of Canada, along with the reasons for migration. The migrant population in the United States is largely Hispanic which facilitates the tailoring of services or arrangement for ethnic-concordant appointments. This may not be feasible in Canada considering the diverse backgrounds of the immigrant population, and results from this study suggest it may not even be necessary. Participants were initially sceptical when meeting with physicians whose backgrounds varied drastically from their own. However, participants were able to establish strong relationships with physicians who acknowledged these differences and actively found ways to bridge the cultural gap. At the time of the interviews, several

participants had stopped searching for a physician who spoke their native language or who came from a similar background, as they had found a physician they “would not change for anything”. These physicians generally used several techniques considered part of the patient-centred process, such as understanding the patient as a whole and eliciting the patient’s explanatory model. They were also sensitive and receptive to various cultural preferences, demonstrating interest in learning more about the patient’s background.

Another factor, which positively contributed to the medical encounter, was that of patient empowerment. Patient empowerment, sometimes referred to as patient activation, is being increasingly emphasized in health care given its positive impact on perceived quality of care and physician-patient relationship (91-93). Because many participants came from countries with a paternalistic approach to medicine, it was surprising to find they appreciated being given the option of participating in their own health decisions. This was recognized as one of the most significant differences between health care in Canada and participants’ countries of origin. While there is little evidence of the effectiveness of this approach in the immigrant population, findings from this study suggest the approach may also be beneficial in this population. Not only does it allow patients to be responsible for their own health, but it also encourages them to communicate with their physician when concerns with the management plan arise. As previously argued, optimal cross-cultural communication depends on both patient and physician factors; patient empowerment may be one way of assisting immigrant patients in achieving this ideal form of communication.

6.1.4 *Easing the Dissonance*

Regardless of the positive or negative health care encounters described above, all participants mentioned skills, tools and techniques employed to cope with the different health care system in Canada. Although coping mechanisms were mentioned in nearly all the participant interviews, none of the studies included in the literature review identified patient-dependent factors as an important component of the cross-cultural medical encounter or the physician-patient relationship. As seen through the interviews, many patients who reported being satisfied with their physicians described at least one situation where they had to acknowledge that they were in a new and different setting which required some adjustment, and were willing to do so as long as help and guidance were provided along the way. What follows are a few examples of some of the main strategies participants reported using to improve their health care experience.

Because language barrier was a significant limitation for many participants, the Internet was consistently identified as a tool to gain further information or clarification, prior to and after a medical appointment. With the abundant resources available on the Internet, it is not surprising that participants turned to this option for support. The Internet was used for gaining information regarding a particular medical condition, translating medical terminology and researching alternative treatment options. Only one participant indicated that it was impossible for her to search for information on the Internet, given her significant language limitations. For the other participants, however, this was a viable option. As highlighted by one of the participants, not all immigrants may have access to the Internet especially in the early stages of settlement process. Nevertheless, most

participants agreed this was a valuable source of information as they are familiar with its use and relied on it for other information as well (e.g. browsing job offers, searching for schools for their children, etc.) Because of the extensive amount of information available through the Internet, patients could benefit from guidance as to which sources are reliable and trustworthy. It is an easily accessible, relatively inexpensive, underused tool with the potential of increasing patient's health literacy and promoting patient empowerment.

Also addressing the issue of language barriers, some participants relied on friends and family for interpretation during the medical encounter. Many times this was far from ideal, considering the sensitive nature of some medical issues. Participants agreed that asking a friend or a community acquaintance to interpret for them was uncomfortable, and could lead to breaches in privacy or confidentiality. The only exception to this was the presence of a professional medical interpreter, which as mentioned before, was only offered to one participant in this study. Alternatives such as phone interpretation or machine translation (e.g. Google Translate) were occasionally mentioned as more "secure" ways of communicating with the physician, yet only in hypothetical situations.

Some countries, such as the United States, require all health organisations recipient of federal funds to provide patients with interpretation or translation services, at no cost to the patient and at all hours of operation (32). In addition, these organisations must provide patients with written material in their language of preference. In Canada, some hospitals offer interpretation services as well, yet they are rarely available in the primary care setting. As a result, patients are left to struggle with their limited English or French proficiency, secure their own interpreter for the medical appointment, or rely on ad-hoc interpreters occasionally available in the medical office. While some may question the cost-

effectiveness of interpreters in these settings, there is evidence to suggest that interpreter-assisted communication leads to less unnecessary testing and fewer medical errors, although the impact on length of appointment time remains unclear (90,94). As such, implementation of interpretation services at the primary care level could potentially be a cost-effective intervention.

Not all coping mechanisms involved adapting to the Canadian health care context. For some participants, maintaining close ties to their countries of origin was an alternative to meeting their health care needs. Despite having OHIP coverage in Canada, participants reported visiting their regular physicians back home and even having procedures done in their own countries. This is also known as medical tourism, where patients travel abroad to access health services not readily available in their place of residence. For those who traveling home was not an option, telemedicine was occasionally practiced as well as informal consults with foreign trained physicians not licensed to practice in Canada. It appears participants mainly relied on this option during the initial stages of settlement, indicating a gradual transition in health care seeking.

Finally, participants suggested ways in which the experience of the health care encounter could be improved for the immigrant population. The majority of these recommendations described activities often practiced by cultural brokers or community health workers. Participants agreed that many negative experiences could have been avoided if special care would have been taken to explain the process or the way health care is delivered by family physicians in Canada. This could best be explained by a person from their own community or familiar with their cultural values or religious beliefs. Although participants indicated they eventually discovered these nuances on their own, they agreed

it would have made the transition easier and could have avoided several uncomfortable situations and misunderstandings with their physicians.

Cultural brokers, also sometimes referred to as patient navigators or patient assistants, have been identified in the literature as a potential solution to reducing health inequities in the immigrant population (30,95-97). As defined by Black, “a cultural broker is someone either from the non-dominant culture, or who has an intimate knowledge of that culture, who can speak the language and understands the beliefs and values of that culture” (30). As opposed to a simple interpreter, cultural brokers may also be familiar with the challenges faced by the particular cultural group as they may have lived through many of the same experiences themselves. This option could be particularly beneficial for immigrant patients with lower health literacy or significant language barriers, as they serve as interpreters, navigators and problem solvers (97).

In consideration of all the findings described above, it appears that participants in this study experienced a transition which began with pre-existing expectations for the health care encounter upon their arrival in Canada, and gradually began to change depending on the type of experiences they were exposed to. Eventually, after developing certain coping mechanisms or adjusting expectations, most participants were able to find a physician they felt comfortable with and in some cases even established a relatively strong physician-patient relationship. The speed at which each person transitions, if at all, appears to depend on multiple factors which were not the focus of this thesis research. Nevertheless, it would be interesting to continue exploring this component as it may yield further insight regarding ways to improve the relationship between immigrant patients and their physicians.

Strengths and Limitations

While this is not the first study to explore immigrants' perspectives of cultural competency in primary health care, it is one of the few focusing on a particular component of the medical encounter as opposed to general access barriers. This allowed for a careful examination of physician-patient communication dynamic. The emphasis placed on the patient-centred approach to cultural competency as defined in recent literature, led to a better understanding of this growing trend in clinical practice.

The fact that the majority of the sample had completed a certificate or diploma after high school represented a different population group than those of other studies, which tend to have a somewhat lower educational background. Participants in this study mostly fell within the "Skilled Class" category of immigrants, a group highly important to the economic development and progress of Canada. This population is generally not considered "vulnerable" given their higher level of education, socioeconomic status and language proficiency, yet findings in this study suggest this population also encounters difficulties when communicating cross-culturally, at least in the initial stages of migration.

Conversely, there were also some limitations to this study. Because of the qualitative research design, findings from this study cannot be generalized to the immigrant population group as a whole, or to any individual cultural or ethnic group. The small sample size and the results from semi-structured interviews did not allow for any statistical analysis. Likewise, the qualitative nature of the literature review did not allow for pooling or aggregation of findings, making it impossible to precisely quantify any findings.

In terms of recruitment, only participants who were fluent in English or Spanish were included in the study. Considering the influence of language barriers on cultural competency, this might have led to underrepresentation of certain cultural or ethnic groups not fluent in either of these languages. Along similar lines, recruitment was done mainly through written material, which likely excluded participants with lower levels of literacy.

Areas for Policy Consideration

Many of the findings in this study mirror what is described in some of the literature around cultural competency, especially regarding the importance of interpretation services and the use of a patient navigator. However, there were some discrepancies in other areas, such as the usefulness of ethnic matching during the medical encounter or the effectiveness of learning about specific cultural groups. Although the participants selected varied in terms of cultural and ethnic background, there were sufficient similarities among their responses to support existing literature on what improves the physician-patient relationship. What follows are a series of recommendations arising from this study. While evidence strongly suggests that following these recommendations may improve patient satisfaction and strengthen the physician-patient relationship, it is clear that further research is needed to determine whether or not this will translate into improved patient outcomes.

Patient Navigators

Patient navigators, sometimes referred to as community health workers or health brokers, have been shown to improve both access to health care as well as assist during the medical encounter. Generally, the patient navigator not only speaks the same language as the patient, but also belongs to the same cultural group. This allows for the patient navigator to act as a broker, assisting with communication between the patient and the physician, making clarifications when necessary and explaining to the patient what to expect from the health care encounter.

This option has the potential of compromising a patient's confidentiality, as patient navigators tend to belong to the same community, yet it appears that the benefits outweigh the risks in most occasions. Nearly all patients in this study agreed they would have benefitted from someone guiding them through the system upon arrival, and explaining what to expect during the medical encounter. There is an associated cost to this intervention which requires further analysis, yet it has the potential of decreasing the amount of appointments necessary to address a certain health issue, as well as improve the uptake of preventive screening tests.

It may become challenging to determine who should receive this service, therefore a screening tool could be used following a similar approach employed in a U.S. study where immigrants were asked: "Do you think you will be able to make the appointment?" immediately after their first appointment. If the answer was no, the patient was enrolled in a Physician Assistance Group program where they were assigned a patient navigator for their following visits (97). A similar approach could be used as soon as the person arrives in Canada and meets with the immigration officer. Although far from ideal, a quick

screening tool such as this could help identify those in greatest need to better allocate resources.

Interpretation

Where patient navigators are not an option, professional medical interpreters should be considered. Both the literature and the findings from this study indicate that patients may benefit from the use of a trained interpreter, even if they have a basic level of English or French. Medical vocabulary is complex even when lay terms are employed and important information such relaying a diagnosis or explaining how to take medication should not leave room for error. The argument has been made that using interpreters during the medical encounter may lead to prolonged appointments, in a setting where time constraints is already an issue, yet recent literature suggests that the use of interpreters may in fact decrease the amount of time it takes to communicate when compared to the physician or patient struggling to get a message across. As with patient navigators, interpreters also pose a threat to patient confidentiality and as such it is important that patients are aware of this potential risk and agree to proceed despite this limitation. The use of ad-hoc interpreters should be discouraged, and relying on family members in particular should be avoided. While this is sometimes unavoidable and frequently becomes the only way to communicate, it should not be considered the equivalent of a trained interpreter or halt efforts to obtain one.

Emphasise a Patient-Centred Approach to Cultural Competency Care

There is a significant overlap between components of patient-centredness and cultural competency, which has been identified both in the literature and in the results of this study. A patient-centred approach to teaching and incorporating cultural competency into practice involves moving beyond a patient's ethnic and cultural background, and understanding additional individual factors that shape the person's understanding of illness and disease. Medical education objectives and clinical practice is gradually shifting from focusing on learning about individual cultural groups to developing an approach which may be used in with patients from any cultural or ethnic background. Findings from this study demonstrated that participants were able to establish significant relationships with their physicians even when physicians' ethnic, cultural and religious backgrounds differed from their own, indicating the benefits of ethnic matching may be overestimated. Approaches relying in Kleinman's explanatory model, such as the "patient-based approach to cross cultural care" developed by Carrillo, Green and Betancourt, could enhance the physician-patient relationship, regardless of patients' background. Considering Canada's increasing migration trends, it is likely all physicians could benefit from learning approaches such as these.

Recommended Research Directions

While it is clear that using a patient-centred, culturally competent approach during the medical encounter results in increased patient satisfaction, there is very little evidence demonstrating how this translates into improved patient outcomes. Focusing on medical conditions where adherence to medication is essential for optimal management, such as

diabetes or hypertension, may be one alternative to explore this phenomenon. Randomized controlled trials where a cultural intervention is examined, may lead to more evidence regarding this association. Studies using a mixed methods design also play an important role, considering the complexity of cultural competency and how it is conceptualized by different populations. Obtaining the “patient perspective” is not always possible through surveys or questionnaires, often making interviews or focus groups a necessary component. Further research regarding the role and effectiveness of patient navigators or community health workers is also warranted, as preliminary findings indicate this could be an effective intervention for reducing health inequities in the immigrant population.

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Appendices

Appendix A- Search Strategy

- 1 "Emigrants and Immigrants"/
- 2 Cultural Competency/
- 3 cultur\$ competen\$.ab,ti.
- 4 immigra\$.ab,ti.
- 5 emigra\$.ab,ti.
- 6 migrant\$.ab,ti.
- 7 1 or 2 or 3 or 4 or 5 or 6
- 8 Patient-Centered Care/
- 9 Communication/
- 10 Communication Barriers/
- 11 (patient\$ adj4 center\$).ab,ti.
- 12 (patient\$ adj4 centre\$).ab,ti.
- 13 8 or 9 or 10 or 11 or 12
- 14 7 and 13
- 15 limit 14 to (english or french or spanish)
- 16 limit 15 to yr="2000 -Current"

Appendix B- Study Relevance Appraisal Guideline

Question	Yes	No
1. Is the <i>main</i> focus of the article on cultural competency OR patient-centredness OR cross-cultural communication?		
2. Does the article focus on immigrant population OR culturally diverse populations?		
3. Is the article written in English, Spanish or French?		
4. Does the article mention cultural competency in the context of primary care*?		
5. Are all four criteria for inclusion met?		

* The 'primary health care' inclusion criteria is broad and includes publications based on primary health care providers/users, processes of care, certain health care systems, or services that may be delivered at the primary care level in the Canadian context.

Appendix C- List of Included Studies

1. Aballouche S. 2002. Intercultural mediation. *Anuario De Psicologia* 33(4):593-6.
2. Ailinger RL, Martyn D, Lasus H, Lima Garcia N. 2010. The effect of a cultural intervention on adherence to latent tuberculosis infection therapy in Latino immigrants. *Public Health Nursing* 27(2):115-20.
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Appendix D- Recruitment Poster



Université d'Ottawa | University of Ottawa

Faculté de médecine | Faculty of Medicine

Épidémiologie et médecine sociale | Epidemiology and Community Medicine

Let's talk about Health!



If you immigrated to Canada 10 years ago or less, and have visited a doctor at least 3 times, the researchers at the University of Ottawa are interested in talking to you about your experience

This study involves:

- A personal and confidential interview (between 30-60 minutes in length)
- An opportunity to discuss your health care experiences in Canada
- A \$20.00 honorarium

Requirements to participate

- Age 18 or above
- Have been living in Canada for 10 years or less
- Have visited a doctor at least 3 times

If you would like more information or are interested in participating,
please contact _____ at _____ or at _____

Appendix E: Interview Guide

Interview Guide: Cultural Competency in the Primary Health Care Relationship

Interviewee pseudonym:	Date:
Place:	Time:

Note: Project must be described, and consent form must be explained and signed prior to beginning the interview.

Questions:

1. Could you please share with me your migration story?

Prompts:

- *Where did you migrate from?*
- *How long ago?*
- *What were your reasons for migration?*

2. Can you tell me about the first time you visited a doctor in Canada?

Prompts:

- *How did you find a doctor?*
- *What was the reason for the visit? When?*
- *Difficulties experienced during the encounter?*
- *Language barriers?*
- *Was the health issue properly addressed?*
- *If positive health care encounter, why?*
- *If negative health care encounter, why?*

3. What differences or similarities have you noticed between visiting your doctor here and back home?

4. Can you describe other experiences you have had with doctors in Canada since then?

Prompts:

- *Was it the same doctor?*
- *If different doctor, reason for change? (i.e. lack of Family Doctor, unsatisfied with prior care, etc)*
- *If same doctor, what were the reasons for continuing with this doctor?*
- *How did these other experiences compare with your first visit to a doctor?*

5. How would you describe the communication between you and the doctor(s) in your medical encounters?

Prompts:

- *How well did you feel the doctor understood your main concerns?*
- *Was your opinion of your condition/disease/situation listened to?*
- *Did you understand the medical advice/instruction that was given to you?*

- *Would you say that your preferences for the medical visit taken into consideration? (E.g. having family members/friends present, physician gender, use of interpreters, etc.)*
- *If an interpreter was used → how did you feel the doctor and interpreter understood what you said?*
- *If an interpreter was not used → how do you feel you might have benefitted from having one?*
- *If disagreements about treatment plan, how were they resolved?*
- *How were your cultural beliefs/religious practices part of what the doctor recommended for treating your health problem?*

6. What qualities do you value most in a doctor?

7. What factors influence you to follow doctors' advice?

Prompts:

- *Incorporates your own treatment preferences?*
- *Takes time to explain difficult concepts?*

8. To what degree do you feel your relationship with your doctor affects your health?

Prompts:

- *How secure do you feel with the care your doctor provides you?*

9. Is there anything related to this interview that we have not discussed which you would like to talk about?

Note: At this point the patient will be thanked for answering interview questions above, and a transition statement such as: *"I would like to conclude this interview by asking you some last personal questions, would that be alright?"* Upon patient acceptance, demographic questions on the following page will be asked (if not already responded during interview):

Demographic Questions

1. Sex: Male
 Female

2. What year were you born in? _____

3. What race/ethnicity do you identify yourself with?

African Canadian/Black	<input type="checkbox"/>
North American Indian/Métis/Inuit	<input type="checkbox"/>
Asian	<input type="checkbox"/>
Latino/Hispanic	<input type="checkbox"/>
Caucasian	<input type="checkbox"/>
Other	<input type="checkbox"/>

4. What is your native language? _____

4. (a) If native language is not English or French, ask: Do you speak either English or French?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

5. How long have you been living in Canada?

Less than 1 year	<input type="checkbox"/>
Between 1-5 years	<input type="checkbox"/>
More than 5 years	<input type="checkbox"/>

6. What country did you immigrate from? _____

7. What is your highest level of education? _____

Grade 9 or lower	<input type="checkbox"/>
Grade 10-12 non-graduate	<input type="checkbox"/>
High school diploma	<input type="checkbox"/>
Some college or university courses	<input type="checkbox"/>
Trade certificate or diploma	<input type="checkbox"/>
University degree (Bachelor)	<input type="checkbox"/>
University degree (Professional)	<input type="checkbox"/>
University degree (Graduate)	<input type="checkbox"/>
Other (Specify) _____	<input type="checkbox"/>

8. What is your annual household income level (before taxes)?

Under \$10,000	<input type="checkbox"/>
\$10,000 to \$19,999	<input type="checkbox"/>
\$20,000 to \$29,999	<input type="checkbox"/>
\$30,000 to \$39,999	<input type="checkbox"/>
\$40,000 to \$49,999	<input type="checkbox"/>
\$50,000 to \$59,999	<input type="checkbox"/>
\$60,000 to \$69,999	<input type="checkbox"/>
\$70,000 to \$79,999	<input type="checkbox"/>
Over \$80,000	<input type="checkbox"/>

Appendix F- Consent Form

“Cultural Competency in the Primary Health Care Relationship”

Principal Investigator:
Epidemiology and Community Medicine- University of Ottawa

Introduction

You are being asked to participate in this research study as part of a University of Ottawa thesis research project. Please read this Consent Form carefully and make sure all your questions are answered before deciding whether to participate in this study.

Description of the study

The purpose of this research study is to have a better understanding of how the communication between immigrant patients and their doctors can affect the quality of care the patients receive. Participants in this study include immigrants living in Canada, such as yourself, who have had encounters with the Canadian Health Care system. We would like to know what patients consider to be culturally sensitive health care, as well as what factors lead to a positive or negative health care experience. The information collected through this study may help policy makers and programme planners make decisions to improve the quality of care that immigrant patients receive in Canada.

Study Procedures

If you agree to participate in this study, you will be interviewed about your experiences with the health care system in Canada. You will be asked questions about your reasons for coming to Canada, the health care experiences you have had in your country of origin, your health care experiences here in Canada and your cultural and ethnic background and beliefs. You are free to decide which questions you want to answer, or stop the interview at any time. The interview will last between 30 minutes to an hour, and will be audio-recorded to provide a record of our conversation.

Possible Risks

Although there are no known risks to participating in this study, there is a chance that you may experience some emotional distress during the interview, particularly if you have had a difficult experience related to some of the interview questions.

Benefits of the Study

You may not receive any direct benefit from your participating in this study. However, your participation in this research may allow the researchers to gather important information regarding ways to improve health care delivery, especially for the immigrant population living in Canada.

Withdrawal from the Study

You have the right to withdraw from this study at any time without any impact to your current and future care from your health care provider.

Compensation

In return for your time and participation, you will receive a \$20.00 honorarium. This amount will be provided upon completion of the interview.

Confidentiality

All personal information gathered about you will be kept confidential, unless release is required by law. The researchers directly involved in this study will have access to the information gathered about you, as well as the Ottawa Hospital Research Ethics Board and the Ottawa Hospital Research Institute for auditing purposes.

You will not be identifiable in any publications or presentations resulting from this study. You will be assigned a pseudonym at the beginning of the study, and only the Principal Investigator will have access to the link between your real name and your pseudonym. All information related to this study will be kept for a period of 15 years. During this time, all paper records will be stored in a locked file cabinet, and all electronic records will be stored on a computer protected by a password. At the end of the retention period, all paper records will be shredded and electronic records will be permanently deleted.

Voluntary Participation

Your participation in this study is voluntary. You do not need to participate in this study in order to receive medical care, nor will it affect the care you receive at this time or in the future.

Questions about the Study

If you have any questions or concerns related to this study, please contact the Principal Investigator,

The Ottawa Hospital Research Ethics Board (OHREB) has reviewed this protocol. The OHREB considers the ethical aspects of all research studies involving human subjects at The Ottawa Hospital. If you have any questions about your rights as a research subject, you may contact the Chairperson of the Ottawa Hospital Research Ethics Board at _____, extension _____.

Appendix F- Consent Form

Cultural Competency in the Primary Health Care Relationship

Consent to Participate in Research

I understand that I am being asked to participate in a research study about cultural competency in primary health care. This study has been explained to me by the researcher,

I have read and understood this 3 page consent form and all my questions have been answered to my satisfaction. If I decide at a later stage in the study that I would like to withdraw my consent, I may do so at any time.

I voluntarily agree to participate in this study.

A copy of the signed Consent Form will be provided to me.

Signatures

Participant's Name (Please Print)

Participant's Signature

Date

Investigator Statement

I have carefully explained to the research participant the nature of the above research study. To the best of my knowledge, the research participant signing this consent form understands the nature, demands, risks and benefits involved in participating in this study. I acknowledge my responsibility for the care and well-being of the above research participant, to respect the rights and wishes of the research participant, and to conduct the study according to applicable Good Clinical Practice guidelines and regulations.

Name of Investigator

Signature of Investigator

Date

