Author's response to reviews

Title: Cultural competency of health-care providers in a Swiss University Hospital: Self-assessed cross-cultural skillfulness in a cross-sectional study

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Dear Editor:

Thank you very much for your helpful comments on our article titled “Cultural competency of health-care providers in a Swiss University Hospital: Self-assessed cross-cultural skillfulness in a cross-sectional study” submitted to BMC Medical Education.

We appreciate this opportunity to respond to the reviewers’ comments and improve our paper. Below we address each suggestion point-by-point. We look forward to working with you and thank you for this opportunity.

Reviewer #1

Major Compulsory Revisions:

1) Method, measures- independent variable and covariates, and Tables: Why did you not include age of the providers as a demographic factor? This could have influenced your outcomes.

Response: Thank you very much for this comment. As this was a secondary data analysis, we were limited to the variables that had already been collected. Age had not been asked about in the primary survey tool. Given that age was not available, we used “time at institution” (a variable which had been collected) to incorporate the effect of experience/age. Although we admit this is hardly a perfect substitute, it was what we had available. We will note though that most physicians taking this survey were of about the same age, given that the physicians were all at the resident/chief resident level (and most physicians at this institution follow the same training path in terms of time)- so at the physician level, we probably would have not seen an age effect on outcomes. Nevertheless, we thank you for this comment and have incorporated this question about age into our limitations: “Our study has several limitations. Because this was a secondary data analysis, we were limited by the information, which had already been collected. Notably, we were not able to adjust the models for the effects of respondents’ age. In this case, we used “time at institution” as an alternative, acknowledging nevertheless that this is not a perfect substitute.”

Minor Essential Revisions:

1) Introduction, end second paragraph and third paragraph. You state that you conducted a baseline survey and used the CCCS tool. This should not be part of the introduction, but belongs in the method section.

Response: This sentence has been re-written in more general terms in the introduction, without any specific mention of the CCCS until the methods: “We used portions of an innovative, internally consistent, and valid self-assessment tool that better captures competencies related to all aspects of culture- with specific regard to perceived skillfulness.”

2) Introduction: last sentence, first paragraph. I don’t know exactly what you mean by the sentence: “By educating providers to develop patient-centered approaches, which may compensate for barriers that hinder patients from fully accessing the benefits of health care”. Please explain or rewrite.

Response: This statement addresses the fact that patients inherently possess socio-cultural factors that affect their ability to successfully interact with a traditional healthcare system. For example, if a patient
speaks a different language, or has a mistrust of the medical system, it will be more difficult for them to engage with the medical system. Thus, it is also the responsibility of individual providers to develop patient-centered approaches, so that they may engage these harder-to-reach patients, despite these initial, potential socio-cultural barriers. We have re-written the sentence as follows: “Indeed, the field of cultural competence has emerged as one strategy to address these health disparities [2] [3] [4]: by educating providers to develop patient-centered approaches which focus on the socio-cultural factors that can affect a patient’s ability to beneficially engage the health system [5].”

3) Method, general survey instrument. You could explain more about which items you took from the validated survey tool and which one you changed/added (referring to the Tables). Also more information about pre-testing and finalizing is useful.

**Response:** When we refer to specific measures in the methods section, we do indicate which questions were taken directly from the CCCS, in regards to this specific secondary data analysis. Please see the following statements:

-“Our primary outcome is perceived skillfulness: nine Likert-response items about providers’ self-assessed skills to provide cross-cultural care that cover common and concrete items like language, which many other tools do not [13, 14]. All of the skillfulness questions in this survey come directly from the CCCS.”

-“Providers’ reported training experiences were included, as these are associated with provider skillfulness [25]. These four items were from the CCCS (specifically using training experiences that may be encountered in this institution) where respondents answered “yes” or “no.””

-“Five questions from the CCCS on cross-cultural care awareness evaluated attitudes regarding the impact of cross-cultural care on patient care [25]. Response options were “1=no problem,” “2=small problem,” “3=moderate problem,” and “4=big problem.” We dichotomized each of the five items with “moderate” and “big” grouped together.”

We have added the following information about pre-testing and finalizing of the overall survey: “The survey was extensively reviewed and revised for use among this population of clinicians, achieving face-validation with nurses, a nurse leader and physicians during pre-testing (10 people in pilot tests- half nurses, half physicians). Questions were finalized with cultural competence experts in Switzerland and in the United States. Pilot testing was done to test the general structure/flow of the questions and the time needed to complete the survey. Questions that had been formulated for the CCCS were not changed as these had been previously validated. Testing was done to ensure that translation had not altered the original question.”

4) Results: You state that the effect of provider role with higher skillfulness associated with physicians remained significant even after adjusting for possible explanatory factors. Which explanatory factors do you mean?

**Response:** Explanatory factors refer to all the variables in the multivariate models (variables used in adjustment to assess the relationship between provider role and skillfulness). This is stated in the methods section: “We examined the effect of provider role on skillfulness after adjusting for demographic and workplace factors, and training and attitudes/awareness items related to cross-cultural care.”

5) Discussion, limitations. You state that: In further analyses, we found no significant differences between the final sample and the recruitment pool in gender and provider role, representative of the general provider population. I don’t understand the meaning of this sentence.

**Response:** This means that the final sample population was representative of the initial recruitment
population in terms of gender and percentages of nurses/physicians. We have re-written the sentence to be more clear in this regard: “In further analyses, we found no significant differences between the final sample and the initial recruitment pool in terms of gender and percentage of physicians versus nurses.”

6) Conclusion, point 3: Could you be more specific about which discovered gaps the health institutions should address?

Response: Thank you so much for pointing this out. We are referring to the specific training gap found between nurses and physicians (we have added that clarification in sentence you refer to). Also in the discussion, we state: “…in these analyses, we observed that nurses reported less access to training resources, compared to physicians. The impact of provider role on cross-cultural skillfulness clearly signals the need for inter-professional health-education in Swiss cultural competency efforts, a collaborative movement that is already seeing momentum in the United States across different training areas in health care [27, 28]”

Discretionary Revisions:

1) Acknowledgement: shouldn’t you acknowledge the participants, pre-testers and the cultural competence experts in Switzerland and the US for finalizing the questionnaire?

Response: Thank you for this suggestion. We have added it in: “We would like to acknowledge the cultural competence experts in Switzerland and the United States who lent their expertise to the team in Lausanne. We would also like to thank the participants and pre-testers who took part in the survey.”

Reviewer #2

Minor Essential Revisions:

1) CCCS
a. Because the survey assesses the perceptions of the respondents, this needs to be emphasized/clarified throughout the manuscript and on the tables (e.g., Table 2 -- "Perceived Cross-Cultural Skillfulness. . .")

Response: Thank you- we have changed the title of all tables to reflect this. We state the fact that skillfulness was a perceived measured least once in the beginning of all of the primary areas of the paper as seen here below:

Abstract- “We compared physicians’ and nurses’ mean composite scores and proportion of “3-good/4-very good” responses, for nine perceived skillfulness items (4-point Likert-scale) from a previously validated tool.”

Introduction- “We used portions of an innovative, internally consistent, and valid self-assessment tool that better captures competencies related to all aspects of culture- with specific regard to perceived skillfulness.”

Methods- “Our primary outcome is self-perceived skillfulness: nine Likert-response items about providers’ self-assessed skills to provide cross-cultural care that cover common and concrete items like language, which many other tools do not [13, 14].”

Results- “Table 2 shows that physicians had better mean composite scores for perceived skillfulness than nurses (2.67 vs. 2.50).…”

Discussion- “Notably, provider role made a difference regarding skillfulness even after adjustment-lower perceived skillfulness scores among Swiss nurses was a surprising finding…”
b. As the authors pointed out, assessment of effectiveness of cross-cultural/cultural training is lacking. Therefore, it would be helpful to include a more detailed description of the survey that was used. Parts of the manuscript give the impression that the CCCS was used (reference in the abstract to a "previously validated tool"), when actually only some of the questions/items from the CCCS were included.

Response: Thank you for helping us to clarify this point. Indeed, the survey included questions that were beyond the CCCS. For this analysis, we have stated what questions were used from the survey that were also CCCS items (given that these questions had been previously and vigorously validated in other studies):

-“Our primary outcome is perceived skillfulness: nine Likert-response items about providers’ self-assessed skills to provide cross-cultural care that cover common and concrete items like language, which many other tools do not [13, 14]. All of the skillfulness questions in this survey come directly from the CCCS.”

-“Providers’ reported training experiences were included, as these are associated with provider skillfulness [25]. These four items were from the CCCS (specifically using training experiences that may be encountered in this institution) where respondents answered “yes” or “no.””

-“Five questions from the CCCS on cross-cultural care awareness evaluated attitudes regarding the impact of cross-cultural care on patient care [25]. Response options were “1=no problem,” “2=small problem,” “3=moderate problem,” and “4=big problem.” We dichotomized each of the five items with “moderate” and “big” grouped together.”

We have also clarified this point in the abstract: “A survey on cross-cultural care was mailed in November 2010 to front-line providers in Lausanne, Switzerland. This questionnaire included some questions from the previously validated Cross-Cultural Care Survey. We compared physicians’ and nurses’ mean composite scores and proportion of “3-good/4-very good” responses, for nine perceived skillfulness items (4-point Likert-scale) using the validated tool.”

c. More details on the pre-testing of the survey specifically developed for this study would also be helpful (number of participants involved in the pilot tests, how decisions were made to include/exclude items, etc.).

Response: We have added the following information about pre-testing and finalizing of the overall survey: “The survey was extensively reviewed and revised for use among this population of clinicians, achieving face-validation with nurses, a nurse leader and physicians during pre-testing (10 people in pilot tests- half nurses, half physicians). Questions were finalized with cultural competence experts in Switzerland and in the United States. Pilot testing was done to test the general structure/flow of the questions and the time needed to complete the survey. Questions that had been formulated for the CCCS were not changed as these had been previously validated. Testing was done to ensure that translation had not altered the original question.”

d. Finally, in the discussion section, include any plans to conduct follow up studies utilizing the tool and whether further validation will be pursued.

Response: Thank you so much for this important point. Currently as part of the “Swiss Migrant Friendly Hospitals” (MFH) project, we have launched a re-vamped institution-wide cross-cultural care curriculum for medical students, primary care residents, physician-attendings, and nurses. Our plans will be to repeat the survey in 2014 to assess “the state of affairs” at our institution. The study will be cross-sectional in nature, so we will not have longitudinal follow-up the same individuals. Nevertheless the results will be
used to have a progressive “snapshot” of providers’ perceived competencies in cross-cultural care and to look for trends given the changes we have made. We now mention this in the discussion, as suggested: “Health centers should continue to evaluate these competencies in all providers and settings- institutions should also 1) address the efficacy of current training programs in regards to measured skillfulness, 2) develop further explanatory factors for skillfulness, and 3) amend the current strategies in training to address discovered gaps between nurses and physicians. At Lausanne University Hospital, we plan to repeat a survey in 2015 to document progress in provider perceived competencies following the curricular changes we have made as part of the aforementioned Swiss MFH project.”

2) Differences between providers
It was very surprising to learn that nurses apparently did not have much exposure to cross-cultural/cultural training as physicians. The manuscript hinted at this, but could there be a possibility that the nurses have a higher standard with regard to what constitutes cross-cultural/cultural training? Since this study took place in Switzerland, it could be that its nursing programs do not emphasize cultural competency training to the same extent in the U.S. where, historically, nursing tends to have far greater/more in-depth training opportunities than medicine.

Response: This is a great point- thank you for this. There definitely could be some cultural reasons for why nurses do not have as much perceived exposure to training. We have re-written the following in the discussion: “Notably, provider role made a difference regarding skillfulness even after adjustment-lower perceived skillfulness scores among Swiss nurses was a surprising finding. The nursing profession in Switzerland is known for emphasizing the topic of cultural competency, with many nurse voices advocating for better cross-cultural care. However, nurses have commonly expressed difficulty in having their concerns/questions addressed in the treatment of vulnerable patients, on account of historical inequalities between nursing staff and physicians in Swiss health-centers [23]. Also in these analyses, we observed that nurses reported less access to training resources, compared to physicians- possibly also because of the historical inequalities between the two professions.”

3) Other comments
a. For more specificity, you may want to clarify that the study (reference 11) noted in the discussion section involved general surgery and family medicine residents.

Response: This has been changed- thank you: “Although more research is needed to explain this discrepancy, this phenomenon has been observed before. In a study of Hawaiian general surgery and family practice residents, the surgical trainees tended to score higher on self-rated skillfulness compared to those in primary care, despite having less formal training on the topics [11].”

b. Table 1 -- section “a” is a little confusing. Instead of using “Ref.” I would recommend listing the other option (e.g., report both “Male” and “Female”).

Response: This has been done- thank you. We simply took out the “reference” to make it clearer and simple.

Discretionary Revisions:

1) The authors should consider including a copy of the survey as an Appendix or make it readily available to anyone interested.

Response: We will make the survey available to anyone interested and have included this statement in the manuscript.
Again, to our knowledge, this is the first study to directly compare skillfulness in cross-cultural care between physicians and nurses, and one of the few studies to examine cultural competence of health providers in Europe. Therefore, this manuscript should be of high interest to the international reader audience of BMC Medical Education. All authors listed have contributed sufficiently to the project to be included as authors, and all those who are qualified to be authors are listed in the author byline. Permission has been obtained from each person or organization listed in the acknowledgements. To the best of our knowledge, no conflict of interest, financial or other, exists.

We thank you for this opportunity to revise our paper and look forward to the next step.

Sincerely,
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