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Research paper

Improving ethnocultural competence of hospital staff by training: experiences from the European 'Migrant-friendly Hospitals' project

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ABSTRACT

Cultural competence training for staff in healthcare seems one of the most widespread measures to deal with ethnocultural diversity, especially in North America. Most of the studies and experiences of this training originate from the United States; European contributions, especially from continental Europe, are rare. This paper contributes to the cultural competence discourse by presenting experiences from hospitals in eight states in the European Union. These experiences were collected as part of the 'Migrant-friendly Hospitals' project, which aimed to improve the impact of hospitals on the health and health literacy of migrants and ethnic minorities in 12 member states. In the part of the project reported here, cultural competence training was provided for all types of hospital staff, primarily with the intention of providing support for staff. The evaluation criteria were feasibility/acceptability, quality, effectiveness, cost-effectiveness and sustainability. Data were collected through a staff questionnaire in a 'before and after' design, documentation sheets, telephone interviews with project co-ordinators and group discussions at project meetings. Key findings showed that seven of the eight pilot hospitals managed to implement cultural competence training. Acceptance of the training among staff, measured in terms of participation, varied considerably. Variations were also identified in the quality of the training as measured by concordance with an agreed implementation pathway. The training had a positive impact on staff perceptions of their knowledge, skills and comfort levels in transcultural situations. The training was also considered to be cost-effective with regard to external costs, and sustainable in that it was accepted as part of continuous professional development in hospitals. The most critical factors for implementing cultural competence training were: (1) support by management is crucial; (2) time and energy are needed to convince staff of the relevance of the training; (3) training oriented at solving the real specific problems of everyday practice is more likely to be accepted; (4) a skills-oriented design including experiential learning is useful but difficult to integrate with long working hours and changing shifts; (5) recruiting competent trainers is crucial but the profile required for an integrated, skills-oriented training is difficult to match; (6) thus, splitting the integrated training model into a short generic introduction combined with the inclusion of cultural diversity issues into the normal quality improvement routines of departments should be tested.

Keywords: cultural competence training, hospital staff, management support, multi-hospital implementation and evaluation, training design, trainers' profiles

Introduction

Europe is becoming more and more ethnically and culturally diverse as a result of increasing mobility within the European Union, tourism and migration (Koehn, 2004). In this context the cultural competence of health professionals and healthcare organisations has become one of the key issues in discussions about health policy and the quality of service provision in relation to health disparities/inequalities fields (Brach and Fraser, 2000). These discussions have been particularly prominent in the United States and with increasing intensity during the last ten years (McBride, 2005). According to Cross *et al* (1989) 'cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations'. This definition has been widely adapted and modified in the past years and has served, especially in the USA, as a basis for further conceptual and practical work, e.g. Health Resources and Services Administration (2001), Betancourt *et al* (2002) and Goode and Dunne (2003). It has also informed the development of the standards for culturally and linguistically appropriate services (CLAS) (United States Department of Health and Human Services (HHS) Office of Minority Health and Resources for Cross Cultural Health Care, 1999). Cultural competence is considered important because, it is argued, culture influences people's perceptions of the causes of health and disease, their experiences of illness and how they express their symptoms. In addition, culture impacts on their help-seeking behaviours, decisions about treatment and compliance with recommendations (Cohen and Goode, 2003). It seems only plausible that a clash of diverse expectations or perhaps even a failure to recognise differences in comprehension and expectations is likely to generate conflicts and quality problems.

The traditional approach used in many programmes, projects and initiatives that address cultural competence has been to focus on the intercultural (transcultural/transnational) behaviour of key healthcare providers like nurses or physicians alongside the dimensions of cultural awareness, knowledge and related skills (see for example Campinha-Bacote, 1994). In this approach, competence is understood as something that varies between individuals and which can be supported by training in the same way as other professional skills. The authors are aware of the ongoing and very important discussion about this approach including new concepts such as cultural humility as an alternative to cultural competence (Tervalon and Murray-Garcia, 1998), transnational competence (Koehn, 2004) and transcultural nursing (e.g. Papadopoulos *et al*, 2004). However, these are not explored here because the project reported in this paper used the traditionally accepted approach to cultural competence training.

Cultural competence training has been widely promoted as part of continuous professional education and adopted as a measure for quality assurance and improvement in the United States as a likely short-term impact (Health Resources and Services Administration, 2001; Betancourt *et al*, 2002). Evidence of the effectiveness of cultural competence training is, so far, not very strong mainly due to a lack of controlled studies, with special weaknesses concerning the measurement of the effects on patients and their health (see a series of newly published reviews: Anderson *et al*, 2003; Fortier and Bishop, 2004; Beach *et al*, 2005; Price *et al*, 2005). However, current literature was sufficiently convincing for eight European hospitals to implement and evaluate cultural competence training for staff as part of the European 'Migrant-friendly Hospitals' project (see Box 1). The experiences and outcomes of this implementation are presented in this paper. These outcomes are of direct relevance to hospitals and other healthcare organisations interested in staff support and quality improvement and also have implications for the further research agenda on cultural competence training.

Handling cultural diversity as a common problem area in European hospitals

A needs assessment conducted at the beginning of the project identified staff difficulties in dealing with (ethno) cultural diversity as one of the most important problems in 10 out of 12 hospitals (Schulze *et al*, 2003). Staff experienced problems in understanding migrant patients' symptoms, communicating treatment options and decisions and generally developing relationships with patients. Different and unknown assumptions, expectations and conceptions about the client–provider relationship were reported as leading to conflicts between migrants and staff, especially when coupled with a lack of awareness about culture, misunderstandings and prejudices. Eight participating hospitals agreed to conduct a cultural competence training initiative for six months, from January until June 2004. The primary goal was to make staff feel more comfortable in cross-cultural situations by providing them with relevant knowledge and skills. An actual improvement in the quality of care was expected to follow from this, but partners agreed that systematic monitoring of this change would be methodologically difficult and out of the narrow time frame of the project.

Box 1 The European 'Migrant-friendly Hospitals' project

The project (2002–2005) was sponsored by the European Commission, General Directorate Health and Consumer Protection and co-financed by the Austrian Federal Ministry for Education, Science and Culture. The project aimed to improve the impact of hospitals on health and health literacy of migrants and ethnic minorities. Pilot hospitals from 12 member states of the European Union, a wide range of experts and several international organisations and networks collaborated under the auspices of the Ludwig Boltzmann Institute for the Sociology of Health and Medicine (LBISHM) at the University of Vienna which acted as co-ordinator. The project aimed to focus attention on the issue of migrant-friendly, culturally competent healthcare and health promotion, putting it higher on the agenda of hospitals and health policy in Europe. At the same time, the project compiled knowledge and instruments relevant to everyday practice to support hospitals in their quality development. The main strategy was to select three common problem areas on the basis of a systematic needs assessment in the 12 pilot hospitals, to implement and evaluate specific evidence-based interventions identified from a systematic literature review (Bischoff, 2003) and to monitor the overall organisational development process towards migrant friendliness initiated by the project, using the Migrant-friendly Quality Questionnaire, an instrument developed in the project. The three subprojects were: 'Improving interpreting in clinical communication', 'Migrant-friendly information and training in mother and child care' and 'Staff training towards cultural competence: enabling hospital staff to better handle cross-cultural encounters'. For detailed information about research instruments and outcomes, see the final project report by Krajic *et al* (2005) at www.mfh-eu.net/public/home.htm.

Research objectives

The first objective of the initiative was to test the feasibility of cultural competence training in various types of hospitals in diverse national and local situations through the collection of data about factors that enhanced or hindered implementation. A systematic feasibility study was appropriate as only a few European countries, such as the UK, had so far introduced policies, programmes and projects about cultural competence and there was little evidence that ethnocultural diversity played any major role in quality discussions in European healthcare. Given this marginal position, an investigation into the cost-effectiveness and sustainability of cultural competence training seemed useful.

A semi-standardised intervention

A common approach to cultural competence training, known as the 'Pathway', and modular content (see Krajic *et al*, 2005) were developed. The common approach was based especially on the work of Like *et al* (1996), Carrillo *et al* (1999), Gilbert (2003a), Anand (1999) and Welch (2003). Using the same approach provided common ground for planning and delivering the training, monitoring quality and discussing the outcomes of the evaluation. Although a higher degree of standardisation, including agreement on a shared model, would have been most useful from a research perspective, it was not possible to find a consensus due to time and resource constraints. Nevertheless, the 'Pathway' provided guidance and orientation for planning, organising and implementing as well as evaluating cultural competence training.

The core recommendations for implementing the 'Pathway' and the modules in each hospital were to:

- obtain strong support from management to ensure that staff would accept and participate in the training and to secure the necessary financial and material resources such as providing a venue, materials and trainer fees
- emphasise that cultural competence training was voluntary but endorsed by management, that it would carry credits for continuing professional education and that it would take place during regular working time
- focus on two or three pilot departments that volunteered to be the first to undergo training although, in the long run, training would be offered to all staff
- conduct needs assessments at department level to identify specific training needs and to facilitate tailoring of the course material to the everyday work encounters and problems experienced by staff
- select competent trainers, either individuals or groups, and work with them to develop specific content around issues of awareness, knowledge, skills and follow-up sessions based on experiential learning
- plan 10 hours training over a period of about 10 weeks to allow for experiential learning
- use interactive teaching designs
- decide on the mix of participants
- evaluate the training in a before-and-after design.

Methodology

The evaluation of the training was based on five criteria: feasibility and acceptability; quality of implementation; effectiveness; cost-effectiveness and sustainability of the training. A range of measures was developed. These included documentation sheets, progress reports, telephone interviews and group discussion with key people in each hospital. To assess the quality of implementation, the 'Pathway' and modules served as standards against which to compare qualitative and quantitative information provided by each hospital.

The effectiveness of cultural competence training for staff was measured in questionnaires that were administered before, the CCCTQ-PRE (65 items), and after, the CCCTEQ-POST (59 items), the training. These instruments were developed on the basis of the Clinical Cultural Competency Questionnaire (CCCQ) developed initially for work with physicians by Like (2004) at the UMDNJ–Robert Wood Johnson Medical School, NJ. Like kindly gave permission for the use of the CCCQ, and the tool was further developed for use with a variety of health professionals in seven European languages (see Krajic *et al*, 2005; www.mfh-eu.net/public/experiences_results_tools/cct_eval_instruments.htm).

The study measured changes in participants' awareness, knowledge, skills and comfort levels related to caring for members of culturally diverse populations before and after training. In addition, interest in cultural issues, satisfaction with the training and self-rated impact on everyday practice were checked retrospectively. Data were pooled, but variations between the specific hospitals are also presented below. Changes were analysed and are presented here on the basis of a group comparison. Within the areas of awareness, self-awareness, knowledge, skills and comfort level, the average score of all items has been calculated. For testing significance, a *t* test was used.

The reliability and internal consistency of aggregated dimensions were tested with confirmative factor analysis for both surveys using SPSS. In the 'knowledge' domain, all items were accepted (Cronbach's alpha score > 0.9 in both pre- and post-survey). In the 'skills' domain, two items were excluded, leaving 13 items remaining (Cronbach's alpha score > 0.87 in pre- and post-survey). In the 'comfort level' domain, nine of the 16 items were included (Cronbach's alpha score > 0.8). In the 'awareness' domain, two constructs were identified: 'awareness' (Cronbach's alpha score > 0.84) and 'self-awareness' (Cronbach's alpha score > 0.82). One item had to be removed. See Box 2 for the 'skills' domain as an example of the items in the questionnaire.

Characteristics of the population and response rate

Out of 143 participating staff, 122 filled in the pre-questionnaire, 98 the post-questionnaire. As not all participants provided information for both surveys or provided the relevant information to link the first with the second questionnaire (date of birth), only 81 persons could be included in the analysis. Useable responses were received from 11 physicians (14%), 50 nurses (62%) and 19 others (24%). The response rate for nurses was 74%, considerably higher than for physicians (48%) and others (50%).

Box 2 Skills items of CCCTQ/ CCCTEQ

How skilled are you in dealing with social–cultural issues in the following areas of patient care:

1 greeting patients in a culturally sensitive manner?
2 eliciting the patient's perspective about health and illness (e.g. its aetiology, name, treatment, course, prognosis)?
3 eliciting information about the use of folk remedies and/or other alternative healing modalities?
4 eliciting information about use of folk healers and/or other alternative practitioners?
5 performing a culturally sensitive physical examination?
6 prescribing/negotiating a culturally sensitive treatment plan?
7 providing culturally sensitive patient education and counselling?
8 providing culturally sensitive clinical preventive services?
9 providing culturally sensitive care for dying patients?
10 assessing health literacy?
11 dealing with cross-cultural conflicts relating to diagnosis or treatment?
12 dealing with cross-cultural adherence/compliance problems?
13 dealing with cross-cultural ethical conflicts?

Categories: not at all (1), a little (2), somewhat (3), quite a bit (4), very (5), does not apply (missing)

Outcomes of the cultural competence training

Outcomes are presented here with regard to each of the five criteria for the evaluation: the feasibility and acceptability of cultural competence training; the quality of the training; the effectiveness; the cost-effectiveness and the sustainability of the training.

Feasibility and acceptability

Seven out of eight hospitals (from Austria, France, Germany, Ireland, Italy, Spain and Sweden) managed to implement cultural competence training within the time scale of the project. A total of 143 staff participated in parts of the training. Participation varied between hospitals and between professional groups, with more nurses in all hospitals taking part. In two hospitals not a single physician participated (see Table 1).

Quality

The quality of the cultural competence training courses varied a lot. In all seven hospitals, training addressed awareness and knowledge. Skills were covered in five hospitals. Interactive teaching methods were applied in all hospitals. A departmentally focused approach was realised in six hospitals. Specific needs assessments to ensure the practical relevance of training were undertaken in five hospitals. The performance of the trainer was judged unsatisfactory by project co-ordinators in two hospitals. Follow-up sessions using experiential learning were realised only in two hospitals.

Effectiveness: retrospective assessment

Staff satisfaction with the cultural competence training can be summed up (see Table 2) as rather high in most hospitals, even if in a couple of cases training seemed not to have fully met their expectations; 81% reported an increase in the second indicator, the 'desire to learn more about culturally competent healthcare'. Nearly all (92%) of the participants reported at least some impact on their everyday practice, but variations between hospitals was considerable, especially in the extreme category:

- satisfaction: 'very satisfied' varied between 10% and 86%
- increase of interest: 'increased a lot' varied between 20% and 86%
- impact on everyday practice: 'very significant' varied between 10% and 60%.

Effectiveness: measured change

The use of the questionnaire before and after cultural competence training confirmed improvements in staff

Table 1 Overview on the cultural competence training in 'Migrant-friendly Hospitals' participating hospitals

Measures	H1	H2	H3	H4	H5	H6	H7
Number of courses	2	2	1	1	2	1	2
Course duration (weeks)	3	10	10	2	10	2	6 and 2
Hours	10	10	13	6	10	15	12 and 9
Number of participants	39	19	16	6	22	17	24
Participating professional groups	12 doctors, 13 nurses, 4 other staff NA=10	3 doctors, 13 nurses, 3 other staff	0 doctors, 6 nurses, 7 other staff NA=3	1 doctor, 4 nurses, 1 other staff	0 doctors, 7 nurses, 15 other staff	5 doctors, 6 nurses, 6 other staff	2 doctors, 19 nurses, 2 other staff NA=1
Main targeted departments	Psychiatric, admission, emergency, internal medicine	Internal med., surgical ward	Obstetric, haematology, emergency, clinical laboratory	No specific department targeted	X-ray, radiography, health promotion, nursing	Emergency, paediatric, gynaecology, obstetrics	Cardiothoracic surgery, oncology

NA, no answer

Table 2 Self-rated effect of training: overview

Were staff satisfied with the training?					
Not at all (%)	A little (%)	Somewhat (%)	Quite a bit (%)	Very (%)	Total (*n*)
0	9	11	40	40	86
The desire to learn more about the subject of culturally competent healthcare					
Decreased a lot (%)	Decreased somewhat (%)	Remained the same (%)	Increased somewhat (%)	Increased a lot (%)	Total (*n*)
0	1	17	36	45	86
Impact on everyday practice					
None (%)	A little (%)	Some (%)	Quite a lot (%)	Very significant (%)	Total (*n*)
2	6	25	36	31	84

Table 3 Changes of average score CCCTQ: data on basic training outcome dimensions

	Before training	After training	Increase	Significance	Number of valid cases
Knowledge	2.48	2.98	0.5	**	81
Skills	2.38	2.79	0.41	**	77
Comfort level	2.84	3.16	0.32	**	79
Awareness	3.91	4.17	0.26	**	78
Self-awareness	3.46	3.39	–0.07		78

The scale ranges from 1 to 5. 1 = not at all, 2 = a little, 3 = somewhat, 4 = quite a bit, 5 = very. Scores vary between 1 and 5, with 4 being the highest self-rating of competence. ** $P < 0.01$.

Table 4 Variations of increase of average score on basic training outcome dimensions between hospitals

	Lowest increase	Highest increase	Difference in increase
Knowledge	0.05	1.12	1.07
Skills	0.06	0.92	0.86
Comfort level	0.05	0.8	0.75
Awareness	0	0.49	0.49
Self awareness	–0.3	0	–0.3

self-rated awareness, knowledge, skills and comfort level in cross-cultural situations. Results on those dimensions pointed to the expected direction and were highly significant ($P < 0.01$). Only scores concerning self-awareness could not be raised (see Table 3).

Effectiveness results varied considerably between hospitals (see Table 4). The highest differences in increase were measured in the knowledge dimension (1.07 points on a scale of 5) and lowest on the dimension self-awareness (0.3 points). Differences between doctors, nurses and a pooled group of other staff were also measured, with doctors showing the lowest increases and nurses the highest.

Cost-effectiveness

As international comparison of costs is difficult due to different local and national funding and accounting rules and traditions, the project has chosen an approach to ask for a qualitative internal comparison in each of the hospitals. Focal persons were asked to judge the costs of the training as 'low', 'medium' or 'high', comparing them to other hospital training programmes. The additional and external costs of the training (fee for trainer, costs of participants' working hours, rent for facilities, training materials, etc.) were rated 'medium' or even 'low' compared to other hospital training programmes, but all hospitals stated that the organisational costs (time needed for planning, recruitment of trainers and participants, negotiating a programme, finding time slots for the training, etc.) were relatively 'high'.

Sustainability

Cultural competency training will be continued in six out of seven hospitals. Decisions concerning the exact form of continuation of the training were still outstanding at the end of the project. In two hospitals, cultural competence training will be integrated as a standard part of continuing professional education.

Discussion

Cultural competence training was implemented in seven European hospitals using a common 'Pathway' adapted to local circumstances, local organisational culture and available resources because the measures were organised and financed out of local hospital funds. Thus, this study involves an implicit comparison of rather diverse training approaches and circumstances. Diversity has been documented, but is complex and multidimensional. The authors were not able to develop a typology simple enough to use for quantitative analysis. Nevertheless, the project provided a wealth of information on the successes and difficulties hospitals experienced before and during the implementation of training, as well as a consensus on specific measures among the group of project co-ordinators. Two of the project co-ordinators provided short sketches of central aspects of their experiences (see Boxes 3 and 4).

Feasibility attained in seven hospitals

The resources needed for cultural competence training were obtained in seven hospitals although the nature, extent and quality of these resources varied considerably. In most cases, key persons reported that much effort was needed to secure staff participation and it proved difficult to find trainers meeting the required profile. Only one hospital could not demonstrate the feasibility of a training course, but implemented ethnic diversity as a criterion in a mirror meeting; that is, a standard quality procedure where patients are interviewed about their experiences and the staff concerned watch from behind a mirror.

Box 3 Cultural competence training in the University Hospital of Uppsala

We had two courses in cultural competence: one for staff from the oncology department and one for cardiothoracic surgery. Both took place in the spring of 2004 and were conducted according to the overall project. Participants were primarily nurses (19), and two physicians specialising in oncology also took part. It appeared that doctors did not experience the same need for cultural competence as nurses. Their relationship to their patients was often very different.

Motivating doctors to take part in cultural competence training was difficult. They may have considered the time frame of 12 hours as too long. A possible motivating factor for doctors could be a shorter time frame, e.g. 4 to 6 hours. That should allow enough time to raise their interest and it could be followed up if doctors volunteered for further training.

Those who took part showed a very high interest in the training, so I think that we had not only the training but also an exchange of experiences because we were discussing cases all the time. Participants have been asking not only for training in cultural issues. They told us that they had experiences of several cases of refugees with experience of trauma and therefore they wanted education about post-traumatic stress disorder. Our courses have been special in that we included discussion about traumatised patients. We learned a lot and profited very much from the exchange of ideas presented during case discussions. My recommendations for training organisers are: extensive and early preparation, considering the practical realities in advance, and concentrating strongly on each department to find out a lot of staff needs.

(Manuel Fernandez, MD Senior Consultant Psychiatry, MFH Project Co-ordinator)

Box 4 Organisations and individuals: the experience at Punta de Europa Hospital, Algeciras, Spain

When we got involved in cultural competence training for staff, among the goals to be achieved was that of establishing the initial response to an educational request that our staff stated during our 'Migrant-friendly Hospitals' needs assessment in March 2003. This proved a starting point for a journey full of challenges, aimed at improving the knowledge of our staff on migration-related issues. It enabled us to put cultural competence training high on the continuing professional education department's agenda and to eventually integrate this training within normal routines, thus bridging the gap between the academic phenomenon of migration and personal, sometimes intimate, migration experiences.

It was not an easy road. Two outstanding absences marked the beginning of the training sessions. One was the absence of a budget, so we had to set up the course on the basis of the voluntary work of trainers, organisers, and staff who attended outside of hospital working hours. The other remarkable absence was that of medical staff. Only one physician attended the sessions. What were the reasons? Maybe it was because cultural competence is an issue without distinct limits. It lies in the interdisciplinary terrain of medicine, nursing, social work, in a no man's land, without a typical medical case approach. In this instance cultural competence training lay within the framework of a project co-ordinated by a nurse, in the organisational structures of nursing and was to be attended on a voluntary basis.

In the time frame given, we were unable to obtain support for follow-up activities from the nursing directorate of the hospital in which our continuing professional education department was located. This had a negative effect on the project. However, in the evaluations the response from both the participants and the trainers was very positive and both groups asked for more and more even on a voluntary basis. Our impact at the organisational level was weak. Cultural competence training has not yet been included in regular continuing professional education programmes, but this also may well be due to the generally decreasing activity of the education department. During 2004 and the current 2005, very few courses have been scheduled in that period, regardless of the topic addressed.

The attendance response achieved, participants' commitment and interest have been our main sources of encouragement. Blackouts, severe storms or lack of promotion, money or time investment from some nursing managers did not represent insuperable obstacles. Not even the coincidence of the promotion of the sessions with the 11 March Madrid train terrorist bombings and the events that followed was a handicap to developing the cultural competence training sessions. A wide range of professionals attended the four sessions of the course, which was conducted by highly experienced cultural mediators from Algeciras Acoge, our partner non-governmental organisation in the 'Migrant-friendly Hospitals' project.

From our experience, the main obstacle to cultural competence training for staff has been the poor innovative potential of some organisational structures and their lethal tendency to undermine new ideas. The best investment was thus in the innovative potential of individuals, as champions for change that will make cultural competence real – and contagious! ... but only as initial steps towards a more steady scenario.

The sustainability of cultural competence training is guaranteed only if organisational support is achieved as well, and the directorate levels are brought on board. For long-term success, the cultural competence organisers need to carefully tailor measures to their local environments, which requires a clear, deep, and updated knowledge of the local situation in terms of resources available, the needs to be met, the balance of power, the political and social climates as well as a great amount of critical reflection based on the feedback obtained. Only by doing this will the initial investment in cultural competence training for staff pay off in a better quality of service, which is the long-term success.

(Antonio Salceda de Alba, Head Nurse, MFH Project Co-ordinator)

What have we done wrong that we need to receive training?

Most training organisers reported that acceptance of a need for cultural competence training required strong 'communication work'. Staff acceptance required priority setting in relevant structures at departmental level. Staff asking 'what have we done wrong that we need to receive training?' is one example for the understanding of training rather as burden than as a support.

Organisational difficulties in releasing staff

Organisational difficulties were apparent in releasing staff from the departments concerned. Key persons

reported that timelines for inviting participants were often considered too short to arrange shifts. In addition, staff shortages and unexpectedly busy workloads limited participation. Short-term cancellation of a training module due to the illness of a trainer turned out to be rather disruptive for the whole course and was interpreted by the key person in the hospital concerned as one source of a rather critical evaluation result.

Doctors' absence

Different acceptance of the cultural competence training was evident among the professional groups, physicians, nurses and other staff. The fact that in several cases it was nurses who organised and were responsible for the training might explain some of the difficulties involved in getting physicians on board. Difficulties might also be related to the different work and learning cultures of professional groups, including different concepts of priorities and time management. It would seem worthwhile to direct further research at this difference, investigating whether it is general and what are the causes – especially those that can be addressed.

An integrated 10 hours' training: beyond time budgets?

The overall time frame of approximately 10 hours, distributed over 3–5 modules, was considered too long for busy hospital schedules. The logistics of fitting these modules into the 24-hour services including night shifts was reported as being extremely complicated, and to shift cultural competence training into leisure time is not a good alternative although some of most successful cases operated on this basis.

Practical relevance is worthwhile

The 'Pathway' was designed to ensure practical relevance by conducting a specific needs assessment in the targeted departments, including skills training and using experiential learning such as case work. Hospitals that had been especially successful concerning effectiveness attributed their success to efforts in relating to practical problems and needs. On the other hand, key persons in two of the hospitals that did not target improvements in practical skills felt that this had been a limitation to the training. Finally, the importance of follow-up sessions, that enabled exploration of experiential learning, was highly valued by key persons, although it was rarely realised.

Competent trainers

The requirements for conducting cultural competence training in hospital settings were considered to be extremely high already at the outset of the project. The subject of cultural competence relates to the specific work realities of staff. These are very diverse within hospitals and, to be accepted, a trainer needs specific expertise, not just basic knowledge. As Gilbert (2003b) points out, 'Nothing renders a workshop for physicians and nurses, for example, more ''dead in the water'' than for a trainer to be unfamiliar with the exigencies of day-to-day patient care'. At the same time, issues in cultural competence have the potential to arouse strong feelings, inducing conflict or suppression, and thus trainers need expert psychosocial and group moderation skills. Finally cultural diversity and its implications is an area of expertise by itself. Training organisers had to realise that finding trainers or teams that combine all the necessary competences would be almost impossible. For the authors, this difficulty indicated a major problem in following the integrated approach suggested in the literature and proposed in the 'Pathway', and led to radical conclusions, recommending a split between cultural competence training and cultural competence in normal quality work.

Effectiveness: limitations

Data quality and possibilities for analysis were limited by the lower response rates on the second survey, especially from doctors and the group of 'others'. This may indicate limited acceptance of cultural competence training by doctors. The group of 'others', which included many non-clinical workers, rightly felt that the questionnaire, focusing on clinical work, was not sufficiently tailored to their diverse work reality. Further limitations lie in limited standardisation of the training intervention between hospitals and in the lack of a control group. Also, the impact of other developments, such as the terrorist attack in Spain referred to in the case report from the hospital in Algeciras, cannot be completely excluded, but given the rather short interval between the first and second surveys in most hospitals, we suggest that most of the observed changes can be attributed to the training.

Cultural competence training is appreciated by participants

As staff had participated on a voluntary basis in all hospitals, the good results can be partly understood as the result of a selection process and partly as the

outcome of convincing communication about relevance by project co-ordinators and, finally, of good training. The positive results are consistent with qualitative reports by key persons and trainers with a lot of interest and enthusiasm. Especially promising seems the self-perceived impact on practical work. Even though actual effects on everyday practice could not be measured within the project timelines, this impression is supported by reports from key persons.

Training makes a difference

In general, the outcomes regarding effectiveness seem encouraging. Staff awareness, knowledge, skills and comfort level with cross-cultural situations improved significantly, although self-awareness did not increase. Findings varied between hospitals, probably in part because of differences in training approaches, types of trainers, participants and contexts. Consensus among training organisers, supported by the evaluation results, showed that:

- it is possible, as a result of cultural competence training, to demonstrate increases in knowledge, skills and comfort levels among staff
- participants' perceptions of the quality of the trainer are very important
- approaches that are highly practical and respond to staff problems and the reality of their daily work have better impact.

One warning concerning the simplified presentation of the cultural competence approach used in this project: an increase in awareness of cultural differences and their consequences might lead to a decrease in self-estimated knowledge, skills and comfort level, in which case the result of training could then be understood as an increase in cultural humility (Tervalon and Murray-Garcia, 1998). This again underlines the need for further conceptual clarification and more sophisticated measurement strategies, neither of which can be provided in this paper.

Differences between professional groups

Effectiveness results varied between doctors, nurses and the group of 'others', with doctors showing the least impact and nurses the highest. This is in line with other outcomes such as more participation by nurses in training and evaluation, but control analysis showed that, in this study, these differences cannot be separated from the contexts of the hospitals. The numbers of doctors and those in the 'others' group were too small for more detailed analysis. Further research is needed to take a closer look at variations of effectiveness between professional groups.

High developmental cost

High organisational training costs can be considered as part of the development and they will decline once training has become routine within the hospital's organisation. However, the high effort needed to convince staff of the relevance of the issue is more worrying. Cost-effective ways to work on resistance should be searched for. On the other hand, it is rather promising that the investment was considered worthwhile by all hospitals.

Planned modifications of the training

Cultural competence training will continue in six out of the seven participating hospitals. However, the intentions of the training organisers to modify training have been voiced clearly. The training time frame will be reduced and the training planned well in advance. To increase the specificity of training measures and thus raise acceptability, single departments or small units will be targeted. An increased practical training approach is on the agenda for future interventions.

Conclusions and recommendations

As a result of this investigation the authors propose to reshape the training into a two-step process:

1 generic basic training, combining knowledge about cultural diversity in clinical practice, awareness-raising techniques and communication skills, organised in 1–2 modules with a total of 4–6 hours' duration
2 integration of practical cultural competence skills development as part of quality management routines at departmental or ward level, adapted to the different professional needs and cultures using a range of strategies such as case discussions supported by experts for cultural diversity and mirror meetings with migrant patients. Many US authors have considered what integrating cultural competence into a broader quality framework might mean (for a new example, see National Initiative for Children's Healthcare Quality, 2005) especially as healthcare disparities seem to be more and more accepted in US health professions and organisations. Quality improvement and patient safety strategies are well received among healthcare professionals (personal communication. Robert C. Like, 31 October 2005). On the European level, we would like to refer also to the concepts, experiences and results of implementing 'migrant-friendliness' in the quality structure and culture of hospitals.

A final lesson is that it has proven helpful to tackle a diverse and also difficult issue in a multi-hospital benchmarking approach which had, in addition, the prestige of a European project. Cultural competence

training within the 'Migrant-friendly Hospitals' project had the big advantage of the commitment in principle of top management to put the issue of ethnocultural diversity and migration-related problems higher on the hospital agenda. The prestige of the European project has been an asset in convincing reluctant staff, and local organisers had the support of a group of others in similar position.

Resistance to the complex and controversial issues inherent in cultural competence training should not be underestimated, and support by hospital management and the wider healthcare and health policy environment will be urgently needed to make cultural competence development part of standard training, and everyday quality work in more than a handful of hospitals in Europe. To keep the issue on the agenda and to provide practical support for European hospitals, a Task Force for Migrant-friendly and Culturally Competent Hospitals has been set up within the World Health Organization Network of Health Promoting Hospitals, co-ordinated by the Italian Health Promoting Hospitals – Network of the Emilia Romagna (a member of the WHO Network of Health Promoting Hospitals). Information on the task force will be made available via www.hph-hc.cc.

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CONFLICTS OF INTEREST

None.

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