# Physicians' Experiences with Cultural Competency in Clinical Practice at a Mid-Atlantic Teaching Hospital and Practice Sites

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## Dedication

To Daniel, you’re the best. You make my life complete in every way.

## Acknowledgments

I thank the many people who assisted and supported me through this challenging and exciting experience.

First, to my participants, I would like to express my gratitude for your time and candor, particularly during the COVID-19 pandemic, which has posed ongoing challenges for the provision of healthcare delivery globally. My research study was made possible by the discussions and experiences you shared. I appreciate your viewpoints and ideas. I gained insight into your world of clinical practice in healthcare delivery through your experiences.

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Dr. Howard, thank you for your class on qualitative research. From our first research project, I knew qualitative research was best suited to my study interests. The class research project enabled me to understand the value of narrative inquiry-based data collection and analysis. Your advice and critique allowed me to move through data

analysis. Qualitative research was pivotal to my study. The collection of rich, thick data served as the basis for my dissertation. I appreciate your support. Thank you.

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I also wish my father, a former teacher, was still with us to see that I always understood his unspoken wish for me to complete my dissertation and comprehend the power of education.

Daniel, my spouse, best friend, and fellow globetrotter—through three degrees, not two or one—you took care to make life easier for me. You were there for me every time I said “this is never going to end,” offering me encouragement and support. You’ll always be my forever. I will always love you.

## Abstract of the Dissertation


Physicians' Experience with Cultural Competence in Clinical Practice
at a Mid-Atlantic Teaching Hospital and Practice Sites

Culturally competent healthcare providers improve healthcare delivery and outcomes for ethnically and racially diverse patients (Nair & Adetayo, 2019). Cultural competency also improves collaboration between individuals from different cultures and healthcare experiences for diverse patients (Nair & Adetayo, 2019). This study explored how physicians learn and practice cultural competence when serving ethnically and racially diverse patients and how their experiences inform their clinical practice. This study aimed to answer two research questions:

RQ1: How do physicians describe their experiences of learning and practicing cultural competence when serving ethnically and racially diverse patients?

RQ2: How do physicians make meaning of these experiences to inform their clinical practice?

One model and one theory constructed the conceptual framework for this study. Campinha-Bacote's (1998) model is about "the process of cultural competence in the delivery of healthcare," and Kolb's (2021) four-phase experiential learning theory is about learning informally through encounters with others. The two worked together synergistically and were considered to be the best fit for the study. Campinha-Bacote's model was chosen because of its use in healthcare delivery. Kolb's experiential learning theory was selected to inform how physicians learn cultural competence informally and experientially from mentors, peers, and patients.

This basic qualitative study utilized narrative inquiry. This study had eight participants who were purposively selected. Data were collected through 90-minute interviews guided by Seidman (2013). This study used first- and second-cycle coding with a priori, descriptive, and in vivo codes.

This dissertation detailed the lived experience of physicians through their narratives of practicing medicine in clinical encounters with marginalized patient populations. These physicians are at the forefront of healthcare, and in practice cultural competence plays an integral part in better healthcare outcomes.

Findings revealed physicians' opinions on cultural competence terminology, healthcare diversity, and the need for more minority physicians in healthcare. Additionally, the study surfaced the need for preparedness for global pandemics and natural disasters. Finally, the physicians discussed their self-awareness of cultural competence and their career choice to deliver healthcare to ethnically and racially diverse patients.

*Keywords:* Physicians, Cultural Competence, Meaning Making, Ethnic/Racial Patients

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# CHAPTER 1:

# INTRODUCTION

## Overview

Cultural competence in healthcare combines the tenets of patient/family-centered care with an understanding of the social and cultural influences that affect the quality of medical services delivery to diverse patients (American Association of Medical Colleges [AAMC], 2005). The importance of cultural competence in healthcare has been recognized for decades in the United States and Canada. In addition to medical and technical education, cultural competence is now a required standard in medical education learning. As such, it is taught to all physicians in the United States who graduated from medical education programs that lead to a doctorate of medicine degree in the United States and Canada and is monitored by the Liaison Committee on Medical Education (LCME) (n.d.).

The concept of culturally competent care started in the field of nursing in the 1950s. In the 1970s, "transcultural nursing," also known as "cultural care theory," defined as healthcare delivery taking the patients' cultural norms and beliefs into consideration, was developed by scholar-theorist Leininger (1978) as a formal area of study and practice. Cultural competence training, as noted by Leininger (2002), was predominantly for nurses, as they were at the forefront of serving multicultural patients (Leininger, 2002; McFarland & Wehbe-Alamah, 2019). Furthermore, Leininger explained that nurses and healthcare practitioners were mainly interested in biomedical concepts and practices and Western medicine ideological modes of thinking instead of non-Western diverse patients. Building on the groundbreaking work of Leininger,

scholar-theorist Campinha-Bacote (1991) conceptualized and developed the first version of a model called the culturally competent model of care (Campinha-Bacote, 1998, p. 182). Although various definitions and models of cultural competence have been utilized as frameworks for training and curriculum development, this study relies on the definition of cultural competence from Campinha-Bacote (1998): "An ongoing process in which the healthcare provider continuously strives to work within the cultural context of the client effectively (individual, family, community)" (p. 182). Thirty years later, there is still a need for nurses and physicians who have learned cultural competence skills and can use them as part of their clinical practice.

Literature is abundant on cultural competence training and utilization for nurses. For example, Lin and Hsu (2020) investigated the effects of a cultural competence educational course on nurses' self-assessment of their cultural competence. Their study provided evidence that an education program effectively improved clinical nurses' cultural competence (Lin & Hsu, 2020). Similarly, Debiasi and Selleck (2017) found that cultural competence training positively affects the nurse practitioner's ability to provide culturally appropriate care. Debiasi and Selleck's (2017) study provides insights for how resident physicians may utilize cultural competence training learned in medical school to inform their practice with patients, thus moving from theory to real-world experience. However, there is a lack of literature on how physicians—recent medical school graduates who are fulfilling residency requirements (years 1-4) under the supervision of attending physician supervisors/mentors—transfer cultural competence skills to inform their clinical practice.

The transfer from learning to practice is at issue. As Van De Ven and Johnson (2006) noted, "Understanding the relationship between theory and practice is a persistent and difficult problem for scholars who work in professional schools, such as business, engineering, education, social work, medicine, agriculture, journalism, and law" (p. 802). Physicians' formal cultural competence training in medical school may be primarily based on theory through lectures and texts. Referencing Vygotsky's (1978) zone of proximal development, Podolsk (2012) noted that what learners have already mastered, such as the cultural knowledge bring from their backgrounds, can help bridge the gap when they are provided with new cultural knowledge. While scholars consider cultural competence an ongoing process (Campinha-Bacote, 1998; Kolb, 2015), there was a lack of firsthand knowledge on how resident physicians close the gap and learn new cultural skills from their peers, mentors, and diverse patients. In addition, little was known about the subjective knowledge residents bring from their backgrounds or how they learn and practice cultural skills during residency as they serve ethnically and racially diverse patients, particularly marginalized patients. Additionally, there is limited information on how more experienced attending physicians learn and utilize cultural competence skills post medical school in clinical practice with diverse patients. Also, there were questions on how attending physicians who in some instances are preceptors and mentors training residents instill cultural competence skills in residents or learn skills from peers.

Additionally, the effects of the COVID-19 pandemic have been felt globally. In the United States, particularly in metropolitan areas such as Washington, DC, the COVID-19 pandemic has disproportionately affected ethnically and racially diverse and socioeconomically disadvantaged communities. Marginalized minority populations have

been subject to health disparities and health equity issues due to socioeconomic factors, limited access to healthcare services, and underlying health conditions prominent in minority populations, such as hypertension, diabetes, and nicotine use. Further, in directly caring for patients, physicians and other healthcare professionals have experienced a new way of working under required changes due to the pandemic. Therefore, the study is relevant to how residents and attending physicians learn and practice cultural competence under new working conditions.

## Statement of the Problem

Studies have shown that healthcare providers' cultural competence can improve healthcare delivery and result in better healthcare outcomes for racial and ethnic minority patients. According to Nair and Adetayo (2019), cultural competence leads to effective collaboration with individuals from different cultures, improving healthcare experiences for diverse patients. However, there was limited research on how pre-residency medical students' and post residency attending physicians learn the cultural skills needed to provide culturally appropriate and patient-centered care instead of disease-based care for diverse patients.

Additionally, Reede (2003) stressed that minority patients respond to and comply with health interventions when treated by minority physicians. However, there is a low number of minority physicians to serve minority patients. The minority patient population in the United States is projected to increase through the year 2050 (Shaya & Gbarayor, 2006). Consequently, Reede noted, the racial/ethnic composition of the U.S. physician workforce does not reflect that of the general population. With the lack of sufficient

minority healthcare providers, cultural competence learning and practice are important for all physicians.

Accreditation agencies such as the Accreditation Council for Graduate Medical Education (2021) have also recognized the importance of cultural competence skill sets for resident physicians to improve the healthcare delivery provided to all individuals. Better healthcare delivery by physicians may aid in mitigating healthcare disparities and improving healthcare equity for marginalized groups. Cultural competence standards have been established to ensure that resident physicians understand the concepts and requirements of culturally competent care. However, literature was limited on how physicians, pre- and post-residency, learn, reflect on, and make meaning of cultural competency and how they described their experiences. Additionally, literature was limited on how medical students fulfilling clerkships and physicians new to practice experience their new role utilizing cultural competence skills with patients. Finally, understanding how post-residency attending physicians make meaning of their experiences serving diverse patients over time showed the progression of cultural competence skill sets. Such knowledge offers insight into advancing educational initiatives on cultural competence to inform practice.

## Purpose of Study and Research Question

Initially, this basic qualitative study aimed to explore resident physicians' learning and practice of cultural competence in serving ethnically and racially diverse patients. Due to the COVID-19 pandemic and unavailability of resident physicians due to constraints on scheduling, the researcher modified and expanded recruitment efforts to include attending physicians with a positive response to participation.

Two research questions guide this study: the study questions were altered from solely resident physicians to include attending physicians.

RQ1: How do physicians describe their experiences learning and practicing cultural competence when serving ethnically and racially diverse patients?

RQ2: How do physicians make meaning of these experiences to inform their clinical practice?

## Statement of Potential Significance

Sutton (2000) posited that "racial, ethnic, and cultural disparities exist in all aspects of society, but nowhere are they more clearly documented than in healthcare" (p. 1). Thus, Sutton noted, culturally competent physicians will be vital in serving diverse populations as they encounter illness and ailments suffered disproportionately by diverse patients. Due to the importance of culturally competent physicians, the LCME introduced the U.S. medical school requirement for cultural competence and set a standard for curriculums in 2000. The LCME noted that faculty and medical students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and treatments (AAMC, 2005). Accordingly, physicians should learn to recognize and appropriately address diverse patients and cultural beliefs in healthcare delivery while considering first the health of the patient (AAMC, 2005). Additionally, in response to the COVID-19 pandemic, the National Standards for Culturally and Linguistically Appropriate Services (CLAS) developed and introduced a framework to guide policies supporting health equity patient care (Golden et al., 2021).

Although cultural competence, a mandated standard, exists as a part of medical school education, there was a lack of information on how resident physicians relate the

importance of cultural competence to their clinical practice. The significance of how they learned cultural competence and the use of cultural competence skills to inform clinical practice added to the literature in healthcare. The firsthand experiences described by resident and attending physicians serving diverse patients helps fill the gap in the understanding of how physicians pre and post residency learn cultural competence skills. Additionally, the experiences shared by attending physicians who learned cultural competency skills experientially in clinical practice adds to the knowledge on how physicians expand cultural competence knowledge in a manner without formal classes. According to McCalman et al. (2017), hospitals, healthcare systems, and healthcare administrators can envision how incorporating cultural competence as an initiative may foster better health promotion initiatives and workforce development. This was primarily important due to the underrepresented ratio of minority physicians compared to the underserved population of minority patients.

Prescott-Clements et al. (2012) suggested that healthcare professionals' cultural competence affects patient satisfaction and positive patient care outcomes. Metrics on these factors are a major focus of healthcare administrators. Understanding how resident physicians learn cultural competence skills allows healthcare organizations to be more effective in promoting these skills across their workforce and thus provide better equitable healthcare. In agreement, Dreachslin et al. (2017) noted that cultural competence might reduce healthcare disparities and improve health equity. Physicians' knowledge of cultural competence based on their cultural backgrounds provided a benchmark of learning brought to medical school. However, later in practice, cultural competence experiences shared by physicians provided evidence of residents' cultural

awareness self-assessment and that of attending physicians to serve marginalized minority patients.

After an extensive review of the evolution of cultural competence models and studies (e.g., Betancourt, 2003; Campinha-Bacote, 1998; Leininger, 1990), the researcher chose the Campinha-Bacote model to align with the study's conceptual and theoretical frameworks and support the study questions. A review of models to include Pernell etc. of cultural competence provided a view of how cultural competence programs and initiatives were developed and introduced to assist healthcare practitioners, medical schools, and organizations in initiating programs to advance better care delivery. The researcher chose Campinha-Bacote's cultural competence model due to its focus on healthcare and its expansion of Leininger's notable work in the field. The process of cultural competence in the delivery of healthcare services model of care aligned with the study framework and study questions. Compared to the Betancourt (2003) and Leininger (1991) models, this model comprises tenets directly related to healthcare practitioners. In addition, the Campinha-Bacote model includes the tenet of "cultural desire," the ability to work with others, which was absent from other cultural models. Additionally, Campinha-Bacote developed and introduced a test, the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals Revised (IAPCC-R©), to assess cultural competence. The validated test is used to assess cultural competence levels, including cultural competence self-awareness. In line with Campinha-Bacote's cultural competence model, the IAPCC-R© and its student version (IAPCC-SV©) were shown to be reliable and valid across various healthcare settings in the United States and globally (Campinha-Bacote, 1999; Capell et al., 2008; Chen et al., 2020; Kardong-Edgren et al.,

2008). The AAMC developed the Tool for Assessing Cultural Competence Training to assist schools in developing and evaluating cultural competence curricula to meet standard requirements (Jernigan et al., 2016). However, the IAPCC-R© may be considered a preferred test, as it has global reach and physicians practicing in the United States can come from different countries. The use of Campinha-Bacote's validated model of care and associated test of how resident physicians self-assess their cultural knowledge and awareness of cultural concepts bridge the gap between cultural learning and clinical practice. New insights from resident physicians detailing their experience of learning cultural competence as part of their medical school requirements and later experientially in practice may help foster cultural competence training initiatives beyond this group of resident trainees and attending physicians in healthcare.

## Theoretical Framework

The study's theoretical foundation was underpinned by Campinha-Bacote's (1998) *The Process of Cultural Competence in the Delivery of Healthcare Services*. Campinha-Bacote defined five elements of cultural competence: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Her theory posits that the constructs of cultural competence relate to care that considers the cultural norms and healthcare beliefs of culturally diverse patients.

Additionally, experiential learning theory (ELT), developed by Kolb (2014), was incorporated. It strengthened the framework by showing how residents and attending physicians learn experientially and later employ their learning as they care for diverse patients. Kolb's ELT theory discusses four phases of knowledge: experiencing, reflecting, thinking, and acting.

Based on these two theories, resident physicians and attending physicians adhering to the tenets of the cultural competence model learn cultural competence skills formally through education and experientially in clinical practice in an ongoing, continuous process. Physicians emerged from their experiences, reflections, and meaning-making of encounters to serve diverse patients while being mindful of patients' cultural beliefs and healthcare norms. ELT and the model of culturally competent care work synergistically and are considered a cyclical spiral that continues throughout life. One never stops learning through experience and continues to hone cultural skills for future encounters.

While numerous models relate to cultural competence, Campinha-Bacote's (1998) cultural care model, *The Process of Cultural Competence in the Delivery of Healthcare Services,* was chosen as the best fit for the study due to its alignment with healthcare and its tested evidence-based validity. Kolb's (2015) ELT was chosen as it reflected how residents and attending physicians learn experientially in clinical practice. Both theories are integrated, and the research questions and interview questions are aligned with them.

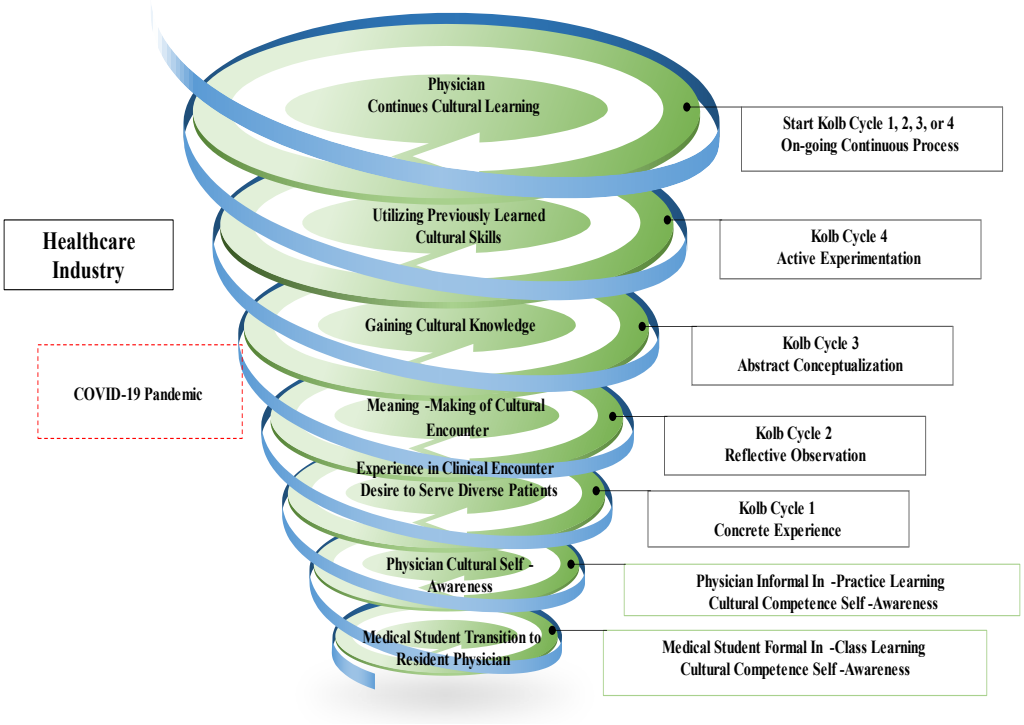
## Conceptual Framework

Miles and Huberman (1994) described a conceptual framework as a graphic or narrative representation of "the key factors, constructs or variables—and the presumed relationship among them" (p. 18). The conceptual framework for this study is illustrated in Figure 1.1. The spiral represents Campinha-Bacote's (1998) five-dimensional model of cultural competence. Kolb's (1984) four-phase ELT cycle is represented as an ongoing process necessary for physicians to learn experientially, reflect, and make meaning of their experience. Kolb and Kolb (2019) noted that the learning cycle is a recursive circle

or spiral instead of the linear, traditional information transmission model of learning used in most education, where information is transferred from the teacher to the learner. Kolb's learning cycle can be entered at any phase instead of following a step-by-step progression. Thus, learning occurs continuously in an ongoing process. This research also addressed the global effects of the COVID-19 pandemic as it affected physicians' working regulations as they applied to the study.

**Figure 1.1**

*Conceptual Framework*




*Note*: Adapted from Kolb (2021) and Campinha-Bacote (1998).

## Summary of Methodology

A basic qualitative approach was chosen as the best way to answer the study's research questions, which sought to understand individual perspectives in depth, which "can best be done through interviews" (Seidman, 2013, p. 54). This approach inquiries about individuals' experiences and meaning-making. Exploring and understanding the experience of resident and attending physician participants when serving ethnically and racially diverse patients in clinical encounters could only be accomplished through qualitative research. Although many forms of a qualitative study are available, for this study, a basic interpretive study design was chosen to collect, interpret, describe, and write the stories provided by each participant through semi-structured interviews (Merriam & Tisdell, 2016, p. 111). As stated by Crotty (1998), "Meaning is not discovered but constructed" (p. 42). Thus, how residents reflected on their experiences of utilizing cultural competence skills learned through formal medical education and later had the opportunity to build upon skills experientially in practice aligns with the study framework to provide evidence supporting the theory of ongoing cultural competence learning through clinical practice.

### Data Collection

Seidman's three-series phenomenological approach "build" with participants was modified to one interview. As a result of difficulty recruiting solely resident physicians, the researcher expanded the sample pool to include resident and attending physician recruitment. Additionally, the interview of 60 to 90 minutes was modified to 90 minutes to allow participants sufficient time to respond to questions, follow-ups, and probes. Finally, the originally modified two protocols were crafted for one interview with

overlapping questions. Interview questions were crafted to focus on residency training (prospective) to post-residency implementation in clinical practice. The researcher started the interviews by focusing on the physician's background information to establish a comfortable rapport before discussing cultural competence learning and usage. Additionally, interview questions were posed to inquire about the physicians' medical school cultural competence training and experience of learning and practicing cultural competence skills in simulations with peers and later in clinical practice with diverse patients. Finally, the protocol allows more profound follow-up and probing questions to clarify residents' formal learning experiences in medical school.

Additionally, attending physicians were asked the same interview questions, follow-up questions and probing questions to achieve rich data. Attending physicians also shared their experiences working and in some cases mentoring resident physicians and providing care to ethnically and racially diverse patients.

**Data Analysis**

The analytic process defined by Creswell (2013) was used to analyze the captured study data. The study's conceptual and theoretical frameworks guided the analytical process; a priori codes were established through deductive logic, reasoning from the general to the specific (Burrell & Morgan, 1979). The analytic process began by specifying Kolb's ELT, determining how experiential learning occurs while doing, reflecting, conceptualizing, and meaning-making in clinical encounters with patients. The interviews showed evidence that resident physicians and attendings could navigate a spiral of learning experientially from peers and ethnically and racially diverse patients. According to the shared experiences as told by physicians, learning occurs through the

cycles of concrete experience, reflective observation, and abstract conceptualization throughout the learning process, as posed by Kolb.

Additionally, based on Campinha-Bacote's model of cultural competence, interview responses related to cultural awareness, knowledge, skill, encounters, and desire were coded if they emerged in the interviews. Again, guided by the study theories and frameworks, a priori codes were established through deductive logic, as detailed by Burrell and Morgan (1979). This study underwent several cycle coding processes (Saldana, 2016) that involved highlighting and labeling any meaningful words or passages that emerged while reading the transcripts. In addition, this study used in vivo and descriptive coding for the interviews. In vivo, codes are the exact words participants used, while descriptive codes summarized passages into a word or a short phrase.

Finally, inductive coding was used, applying descriptive and in vivo codes. Themes were developed and presented to explain resident development of cultural competence and attending physicians acquired cultural skills and usage with ethnically and racially diverse patients.

## Delimitations and Limitations

The study has delimitations. Initially, participation was delimited to resident physicians, however, the researcher modified the study to include fellow and attending physicians as participants. Due to the addition of aforementioned physicians, those that supervised or were preceptors/mentors of residents were interviewed. Second, the researcher originally planned for interviews to be conducted in resident and attending physicians' physical settings at Mid-Atlantic teaching hospitals and healthcare practice settings. Interview settings were unavailable and the research site was eliminated

replaced with conducted interviews using a WebEx digital platform. Based on these delimitations, the study findings may not transfer to other clinical settings. Wiersma (2000) explained that "qualitative studies occur in the natural setting and are therefore extremely difficult to replicate in other settings" (p. 211).

In addition, the study has limitations, residents work at the behest of their attending physician supervisors and have time constraints related to their clinical rotations and practice settings. Thus, the researcher worked to tailor scheduled or rescheduled time according to the resident's and attending physicians' availability. Additionally, attending physicians were extremely busy and their schedules were modified to adjust to meeting the demands of patient care as a result of the COVID-19 pandemic. As previously mentioned, Seidman's typical three-part interview was modified to one interview with the goal of retaining more participants in the full study. Second, not all residents, and attending physicians have experienced the same medical school training, as the COVID-19 pandemic was not present for third- and fourth-year residents. This issue became unimportant as only one resident participated in the study. Third, residents and attending physicians who met the criteria for participation in the study may not represent diverse backgrounds since the number of minority residents as well as attendings in practice is limited. Although they may not reflect the diversity of the population, they may reflect the physician population in many teaching hospitals and healthcare settings (i.e., outpatient clinics, emergency departments etc.). Finally, although physicians in fellow status were invited to participate in the study they did not respond to the researcher's invitation to participate. The absence of fellows did not pose a problem

for the study as all attending physicians were in fellow status prior to completing residency rotations and gaining the status of attending physician.

## Definition of Key Terms

*Attending physician:* A physician or surgeon serving on the staff of a hospital or similar healthcare facility who has primary responsibility for the treatment of a patient and often supervises treatment given by interns, residents, and fellows ("Attending," 2024).

*Competemility:* A synergistic relationship between cultural humility and cultural competence (Campinha-Bacote, 2003).

*Cultural competence:* The ongoing process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community) (Campinha-Bacote, 2002).

*Culture:* The beliefs, values, and attitudes that structure the behavior patterns of a specific group of people (Merriam & Tisdell, 2016, p. 29).

*Resident*: In medicine, a physician who has finished medical school and is receiving training in a specialized area, such as surgery, internal medicine, pathology, or radiology. Board certification in all medical and surgical specialties requires the satisfactory completion of a residency program and successful completion of a specialty board examination (Conrad Stoppler, 2021).

*Teaching hospital:* A hospital affiliated with a medical school that provides a means for medical education (American Hospital Association, 2015; "Teaching hospitals," n.d.).

*Temporality:* The state of existing within or having some relationship with time (Oxford Languages Dictionary, 2023).

*Underrepresented minority:* Racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population (Reede, 2003).

## Summary

Campinha-Bacote et al. (1996) stated that "cultural competence is a critical factor in providing relevant services to our growing culturally/ethnically diverse patient population" (p. 59). Cultural competence must be learned, and Kolb and Kolb (2018) posited that learning is an endlessly recurring cycle, involving experience. This qualitative study was conducted to understand how resident and attending physicians describe the experience of learning cultural competence and making meaning of cultural skills to inform practice can add to the literature on cultural competence in healthcare.

# CHAPTER 2:

# LITERATURE REVIEW

This chapter reviews the literature relevant to this study and its two research questions:

RQ1: How do physicians describe their experiences of learning and practicing cultural competence when serving ethnically and racially diverse patients?

RQ2: How do physicians make meaning of these experiences to inform their clinical practice?

As guided by the study research questions and frameworks, this chapter reviews the literature in four main parts. The first part, on cultural competence, reviews perspectives and definitions, the need for cultural competence, theories and models, the assessment of cultural competence, views of practitioners, and studies of cultural competence outside of medicine. The second part, on cultural competency in medical education, examines requirements for the subject to be taught in medical school and residency, as well as ongoing educational interventions in healthcare. The third section presents experiential learning theory (ELT) with the view that residents and attendings, who are practicing physicians, learn through experience. A brief final section on the COVID-19 pandemic presents several contextual factors related to the time period of the study. Additionally, information on the effects of health equity and disparities and how they affect ethnically and racially diverse patients is presented, along with academic medical center programs developed to improve healthcare initiatives for marginalized groups. Literature on these topics was searched for the last 20 years, except for key literature from earlier years.

## Methods of the Literature Review

The literature search was narrowed to scholarly peer-reviewed journals available in the Gelman Library databases and websites to ensure the literature's accuracy and integrity. Online databases included ERIC, EBSCO*host*, Gelman Library & Consortium Database, Google Scholar, Ovid, PubMed, ResearchGate, and Sage. Keywords were searched individually and in combination to obtain robust yet bounded search results. The terms included "cultural competence," "physician AND cultural learning," "resident physician AND cultural competence," "cultural competence AND models," "experiential learning AND learning theorist," "resident physician AND medical school training," "experiential learning," "medical school AND standards," "cultural competence AND testing," "resident physicians AND minority patients," " minority patients AND healthcare delivery," and, as relevant to the study, "COVID-19 AND [name of research site ]," and "COVID-19 AND medical students." Preliminary searches were not limited by date and enabled identification of seminal studies (e.g., Betancourt, 2003; Campinha-Bacote, 1998; Leininger, 1990) key to the foundation and evolution of cultural competence models and training programs for healthcare professionals. All articles reviewed were identified for use or eliminated for the study. After review, all articles were mined for secondary references.

Data sources on cultural competence in other fields were reviewed for evidence of its benefits or weaknesses in organizations outside of healthcare. Reviewed cultural competence models were shown to be applicable for use in psychology, business, and government. This literature was used primarily for reference; it expanded the researcher's knowledge of the topic and helped develop theoretical and conceptual frameworks and

interview questions. Ultimately, the selected peer-reviewed empirical articles, books, and models on cultural competence were narrowed down to those used by healthcare organizations, medical schools, and healthcare professionals.

Searches with the terms *cultural competence* and *healthcare* provided a voluminous list of studies, reports, and articles on the importance of cultural competence in healthcare. The articles were narrowed to focus on cultural competence models, resident physician learning, and ELT. The researcher also sought literature on cultural competence learning and practice to serve diverse minority patients, as interview questions focused on this target population. Although aspects of formal medical school cultural competence training appeared within the cultural competence literature, there was little literature on how residents or fellows and attending physicians described learning cultural competence or how learning informed their clinical practice. At the time of the study there was also limited literature on the effects of the COVID-19 pandemic for physicians as a whole in practice.

Finally, the researcher reviewed new initiatives to address cultural competence aligned with the U.S. Department of Health and Human Services Office of Minority Health (2019) Federal National Standards for Culturally and Linguistically Appropriate Services. The review also included new program initiatives introduced into the medical school curriculum as part of the U.S. emergency preparedness plan for the COVID-19 pandemic.

## Cultural Competence

Cultural competence is considered a factor in patient care. Physician cultural competence involves effective communication, which allows a clearer understanding of

patients' beliefs about their health. Hashim (2017) noted that it is essential to have the ability to provide patient care that is respectful and responsive to a patient's needs and takes into consideration the patient's values. Cultural competence moves healthcare delivery beyond disease-centered care, involving clinical procedures and interventions, to patient-centered care (Park et al., 2006). Additionally, consequences of cultural competence are satisfaction with care, the perception of quality healthcare, better adherence to treatments, effective patient-physician interaction, and improved outcomes (Henderson et al., 2018). There are various definitions of cultural competence and its relevance in different work settings.

**Perspectives and Definitions**

Cultural competence has been defined in different ways depending on the environmental context, including in the work settings of human resources, education, and psychology. Tehee et al. (2020) noted 34 definitions of cultural competence in healthcare and other business fields. For instance, Flaskerud (2007) offered a definition commonly used in business practice: "A set of congruent behaviors, attitudes, policies, and structures that enable an individual to work in cross-cultural situations effectively" (p. 121). Similarly, in 1989, Cross et al. provided a definition that is widely accepted in clinical practice: "A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable the system, agency, or professionals to work effectively in cross-cultural situations" (p. 13).

The definitions of Flaskerud (2007) and Cross et al. (1989) are applicable to business settings. One example is an American working overseas, where utilizing cultural competence appropriate to the business setting may be applicable. It is essential for

Americans to understand that customs in the United States differ in many respects (culturally, religiously, etc.) from those of other countries. However, these definitions lack alignment with a healthcare setting, where physician/patient communication is more personal and directed specifically to the individual. Based on that, the researcher examined cultural competence models directed to healthcare providers that include aspects of training and assessment, as well as a specific set of tenets related to cultural competence, and that also aligned with a dynamic process of learning based on the theory of experiential learning in practice.

In healthcare, cultural competence from a Western point of view is viewed from two perspectives. First, in the *essentialist* perspective, cultural competence is considered a static, never-changing process focused on the acquisition of specific factors of cultural competence, patient values, beliefs, and traditions (Garneau & Pepin, 2015).

The essentialist perspective may present bias toward patients as a static overgeneralized group with "one-size-fits-all" beliefs about any specific culture and may impede healthcare professionals from treating a particular patient holistically (Garneau & Pepin, 2015). In contrast, the *process* perspective views cultural competence as continually changing. This perspective acknowledges healthcare providers' ability to learn, gain knowledge, and reflect on their role in treating patients. Garneau and Pepin (2015) noted that differences in cultures in the United States that were once well defined are difficult to define today, mainly due to globalization, and they attributed much of this change to redefining the definition and role of cultural competence education, specifically in the field of nursing. Theorists Leininger, Campinha-Bacote, and Kolb have agreed with the concept that cultural competence is an ongoing lifelong process of learning, as

opposed to a static Socratic form of being educated, where one may be considered thoroughly trained upon completion of teaching.

Some scholars postulated that a revision of cultural competence using a constructivist view enhances the concept by emphasizing that it is an ever-changing process and not static. Viewed from the constructivist lens, healthcare professionals can transition from a rigid approach to cultural competence and foster enhanced relationships with their patients, improving patient communication and trust. A process-based perspective of cultural competence in healthcare is essential because patient trust is vital for effective patient-physician relationships. Intercultural, cultural, and linguistic differences are key to building trust, especially when treating minority patients (Alpers, 2016).

Since then, others have interpreted the definition of cultural competence in the healthcare field or attempted to refine, expand, or elaborate on previous conceptions of cultural competence (Center for Substance Abuse Treatment, 2014). Bazron and Scallet (1998) defined culturally responsive services as those that are tailored to the unique cultural needs of bicultural/bilingual and culturally distinct populations.

The Office of Minority Health (2000) merged various existing definitions to conclude that cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among healthcare professionals that enables effective work in cross-cultural situations. In addition, cultural competence implies having the capacity to function within the needs presented by individuals. This refined definition was presented to guide the development of treatment improvement protocols by the Substance Abuse and Mental Health Services Administration within the

U.S. Department of Health and Human Services (Center for Substance Abuse Treatment, 2014).

The Center for Substance Abuse Treatment (2014) defined cultural competence as "the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. Cultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time" (p. 12). The American Association of Medical Colleges (AAMC) (2005), the governing body of medical education, acknowledged the most widely accepted definition as the following:

> Cultural and linguistic competence is a set of congruent behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups. "Competence" implies having the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices, and needs presented by patients and their communities. (p. 1)

**The Need for Cultural Competence**

Cultural competence skills have become a vital factor in healthcare. One reason is the underrepresentation of minority physicians and the increasing numbers of minority patients being served. In the United States, Black/African American and Hispanic/Latino physicians' makeup only 4% of the healthcare physician workforce (Aibana et al., 2019), while minority groups in the U.S. continue to grow (Shaya & Gbarayor, 2006). Minorities will account for more than 90% of the U.S. population growth from 1995 to 2050 (Shaya & Gbarayor, 2006). According to Grewal et al. (2021), the AAMC estimated that over the next 15 years, the demand for physicians treating ethnic and racial

minority patients (specifically Black, Hispanic, and other mixed-race individuals) would increase along with the growth in marginalized populations.

Dall et al. (2020) explained that culturally competent healthcare delivery could reduce healthcare disparities in the United States. However, the status quo of the current healthcare system will not meet the healthcare workforce demand of the future. In addition, they stressed that patients' cultural factors may affect healthcare utilization due to patient healthcare cultural needs. Furthermore, Dall et al. (2020) noted that demand for physician services is projected to grow proportionately faster for minority populations based on national demographic trends. A new study from the George Washington University (2021) Milken Institute School of Public Health has found a severe lack of diversity in the healthcare workforce, a problem that, according to researchers, could worsen health disparities for minorities. Thus, the need for culturally competent physicians persists.

Using data from the AAMC coupled with federal and state-level U.S. Census data, Lett et al. (2019) assessed whether the medical student population (and thereby future physician workforce) represents the U.S. population it serves. The study noted that although the Liaison Committee of Medical Education (LCME) imposed medical school diversity accreditation guidelines in 2009, the underrepresentation of minority students has not changed. The authors' cross-sectional study of self-reported race/ethnicity of U.S. medical schools found that the number of medical school matriculants from 2002 to 2017 who were Black, Hispanic, American Indian, or Alaska Native increased. Nonetheless, the rate of increase in minority matriculants was slower than that of their age-matched minority counterparts in the U.S. population. Specifically, the number of minority

physicians increased 53.6% from 33,625 to 51,658, and the number of matriculants increased 29.3%, from 16,488 to 21,326. In the same time interval, the proportion of Black, Hispanic, Asian, and Native Hawaiian or Other Pacific Islander individuals aged 20 to 34 years in the United States increased. Thus, the physician workforce still does not represent the demographic characteristics of the U.S. population. Sobowale (2020) noted that Black patients have better outcomes when they see Black physicians. These findings underscore the need for culturally competent physicians in the workforce. Further, Lett et al. (2019) cautioned that due to the duration of physician training, any changes to strategies or initiatives by the LCME to improve recruitment or retention of minority physicians in the workforce would take a decade to be seen (Lett et al., 2019). Purnell et al. (2018) conducted a cultural competence needs assessment with 1,220 practicing physicians and showed that less than half the participants reported utilizing culturally competent skills.

The need for cultural competence is also driven by the prevalence of specific conditions and diseases among minority groups, such as obesity and age-related illness, and cultural and health-related behaviors such as nicotine use (Dall et al., 2020). Kumar et al. (2019) explained that culturally competent healthcare delivery can reduce healthcare disparities in the United States. The Centers for Disease Control and Prevention (CDC) has tracked health disparities for decades; recently, it documented disparities in rates of COVID-19 exposure, illness, hospitalization, and death (CDC, 2020).

The American Board of Family Medicine (2020) noted that two epidemics transfix America. The first is the COVID pandemic, with 155,000+ deaths in the United

States. The second is the more silent epidemic of health disparities, as demonstrated by the pandemic (Newton et al., 2020). The significant 2003 report *Unequal Treatment* from the Institute of Medicine found evidence that healthcare disparities resulted from social policy and intrinsic bias in the health system and among physicians (Smedley et al., 2003). In response, the American Board of Family Medicine created a certifying board to address disparities. The board supports organizations and physicians by developing innovative curricula in professionalism, the social contract, advocacy, health equity, and social drivers of health at all levels of education. In addition, the certification program is designed to help eliminate health disparities by supporting physicians to make improvements to their practices addressing health equity.

Additionally, programs such as the Doris and Howard Hiatt Residency in Global Health Equity and Internal Medicine at Brigham and Women's Hospital have begun to offer residents the opportunity to focus part of their training on a specific type of practice within their specialties—such as community/social medicine or management/leadership to address healthcare access and outcome inequalities (Palazuelos et al., 2018). Little is known if resident physicians are participating in these specialty practice trainings.

Nelson (2002) submitted a report for the Institute of Medicine committee detailing that the quality of care received by racial and ethnic minorities in the United States was generally lower than that provided to the majority population. Based on Nelson's report, the Institute of Medicine suggested integrating cross-cultural education into training, highlighting the need for cultural competency learning among physicians to help mitigate healthcare disparities for racial and ethnic minorities.

Research conducted by Flynn et al. (2019) with a culturally diverse population in the United States indicated that negative healthcare experiences have psychological and behavioral consequences that significantly impact subsequent care, particularly for minority populations. The study also found that provider cultural competence reduces some consequences of negative health encounters relevant to health behavior—showing an important link from cultural competence to health outcomes.

According to McGregor et al. (2019), health disparities, including behavioral health disparities, in different racial and ethnic groups have persisted in the United States despite the development of healthcare strategies to address these disparities. They presented the results of a survey of more than 200,000 reported racial/ethnic minorities, noting that they are overrepresented among low socioeconomic populations, experience racism and bias, and have a *cultural mistrust* of the healthcare system—all of which place an additional burden on accessing care and obtaining good healthcare outcomes. Further, McGregor et al. (2019) cautioned that there is limited research exploring how cultural considerations may impact physician and behavioral health outcomes among African Americans and other diverse minorities in care settings. Accordingly, the authors noted, cultural competence in healthcare has been recognized as an essential feature of high-quality healthcare delivery, contributing to improved knowledge and attitudes among healthcare professionals and increased patient satisfaction.

Through cultural competency training, providers learn to meet the needs of racial/ethnic minority patients who experience barriers such as delayed treatment and diagnosis and continued engagement in treatment (McGregor et al., 2019). McGregor et al. (2019) suggested that training provides guidance on communication in a culturally

competent way to reduce stigmas in healthcare. In the end, cultural competence acknowledges the social determinants of health that may be powerful in shaping the healthcare outcomes of underserved populations (McGregor et al., 2019). Thus, cultural competence may help mitigate disparities and improve health equity.

To meet the goals of better healthcare outcomes and to foster healthcare equity among diverse patients, there is a need to understand what cultural competence is as a concept and theory and the models that have been developed as guidelines for training and practice. To reduce healthcare barriers and improve healthcare equity, McGregor et al. (2019) suggested linking racial/ethnic minority patients to other care services, such as behavioral health specialists, social workers who can provide housing assistance, and faith-based communities near their home, to improve health quality. This objective aligns with the Campinha-Bacote model of cultural competence as it is foundationally biblically based.. Exploring cultural competence expanded the researcher's view of the various models developed for cultural competence training and how theorists conceptualize cultural competence concepts.

**Theories and Models on Cultural Competence**

The evolution of the concept of cultural competence began with seminal theorist Madeleine Leininger, who introduced the cultural care theory and was nominated for the Nobel Peace Prize for this work (American Sentinel College of Nursing and Health Sciences, 2020). Leininger (1991) described cultural care as holistic and culturally based, incorporating a spectrum of broad humanistic dimensions about patients in their cultural life context. The concept includes social structure factors, such as religion, politics, economics, cultural history, life span values, kinship, and philosophy of living, as well as

geo-environmental factors, as potential influencers of culture care (Leininger, 1991, 1994; Leininger & McFarland, 2006).

Leininger noted that patient care was generally enhanced and improved when nurses were aware of and utilized cultural competence skills in their care delivery. She specifically mentioned an advantage in using cultural competence skills when caregivers treat patients who have different racial and ethnic backgrounds than their own. Leininger (1978) noted that an accurate notion of patients' cultural beliefs and values is essential to understanding their needs (pp. 85-86).

Since Leininger's work, several models have been developed as tools of training cultural competence. The most cited models in the literature are those of Betancourt (2003), Purnell (2002; National Association of School Nurses, 2013), and Campinha-Bacote (1998).

***Betancourt Model***

Betancourt (2003) viewed cultural competence in a cross-cultural paradigm through the lens of concepts to be utilized jointly to facilitate better patient outcomes. Betancourt (2003) identified three conceptual approaches to cross-cultural education necessary for effective patient care (p. 561) (Table 2.1).

According to Betancourt (2003),

> Culture is neither 'exotic' nor does it belong only to 'others'; thus, it should not be a marginalized factor in education and care. Students must locate both themselves and their patients within a cultural context and utilize a framework to explore and subsequently negotiate critical issues. (p. 968)

**Table 2.1**

*Betancourt Model of Cultural Competency*

| Approach | Description | Primarily taught |
|---|---|---|
| A: Awareness/ sensitivity approach | ● Focus: Provider attitudes<br>● Goal: To increase provider awareness of how sociocultural factors affect patients' beliefs, values, behaviors, and quality of care<br>● Students consider issues such as culture, racism, classism, and sexism, with a focus on curiosity, empathy, and respect | Medical school years 1 and 2 |
| B: Multicultural categorical approach | ● Focus: Increase provider knowledge of cross-cultural issues<br>● Highlights limits of making generalizations about cultural characteristics<br>● Reviews methods of community assessment and evidence-based factors (e.g., disease incidence, historical factors shaping health behaviors) | Throughout medical school |
| C: Cross-cultural approach | ● Focus: Developing tools and skills<br>● Instruction is process-oriented, highlighting practical skills in medical interviewing and communication, as well as sociocultural and ethnographic tools | Clinical years |

*Note:* Adapted from Betancourt (2003, p. 561).

Betancourt (2003) argued that physicians who ignore a patient's health beliefs can adversely affect communication in the clinical encounter. Betancourt also speculated on globalization and its effect on diversity, which revealed the need to incorporate cultural competence education to address how physicians provide healthcare services. Further, Betancourt highlighted the need for cultural training in medical education. Various landmark reports and studies by Betancourt (2005) highlight the importance of cultural competence in improving healthcare quality and eliminating racial/ethnic healthcare disparities.

Although Betancourt's model is a directed approach to healthcare, no validated tests were found to support the assessment of physician cultural competence learning through the use of the model. Therefore, without validated testing, the Betancourt model

was not selected to support the study framework. However, the model is recognized in the literature as empirical scholarly research on the study of cultural competence.

### *Purnell Model*

Purnell's model has 12 interacting cultural domains for healthcare providers to consider:

- Overview/heritage (e.g., country of origin, economics, educational status, occupation)
- Communication (e.g., dominant language, nonverbal communication)
- Family roles and organization (e.g., gender roles, child-rearing)
- Workforce issues (e.g., autonomy, individualism, communication styles)
- Bicultural ecology (e.g., differences in body stature, genetic diseases)
- High-risk behaviors (e.g., tobacco, use of safety measures)
- Nutrition (e.g., food choices; use of food for wellness)
- Pregnancy and childbearing (e.g., birth control, taboo practices)
- Death rituals (e.g., views of death, burial practices)
- Spirituality (e.g., use of prayer)
- Healthcare practices (e.g., magic religious beliefs, views of personal responsibility for health)
- Healthcare practitioner (e.g., status, gender) (Purnell, 2002; National Association of School Nurses, 2013)

Beyond these 12 domains, the model indicates that healthcare providers can be unconsciously incompetent, consciously incompetent, consciously competent, or

unconsciously competent in providing culturally competent care (Purnell, 2002; National Association of School Nurses, 2013).

The Purnell model was not selected for the study, mainly due to its focus on provider attributes (e.g., unconsciously incompetent, consciously incompetent, workforce issues, etc.). The model does not align with the tenets and framework of this study. With its 12 domains, the model differs from traditional tenets of cultural competence and focuses on issues among providers and less on direct personal physician/patient encounters, which is the focus of the current study.

**Model Used in This Study: Campinha-Bacote**

Dr. Josephina Campinha-Bacote (2002) explained that the changing demographics of a growing multicultural world and the healthcare disparities in the health status of people from diverse cultural backgrounds have challenged healthcare providers to consider cultural competence as a priority in healthcare. Therefore, she developed her model of cultural competence in healthcare delivery as a framework for delivering culturally competent healthcare to diverse patients. Building on the work of Leininger, Campinha-Bacote (2002) developed a four-stage cultural competence model, *The Process of Cultural Competence in the Delivery of Healthcare Services*. In 1998, she expanded the model to five stages, with the addition of cultural desire. Campinha-Bacote (2002) defined the five elements in the model as follows:

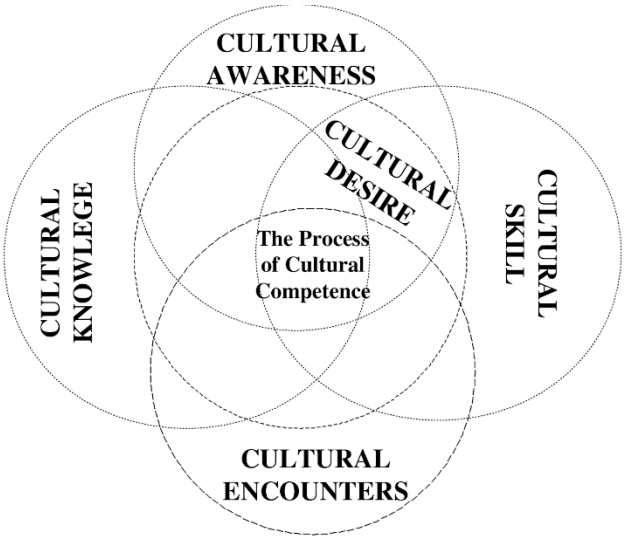
- **Cultural awareness:** "The process of conducting a self-examination of one's own biases towards other cultures and the in-depth exploration of one's cultural and professional background. Cultural awareness also involves being aware of the existence of documented racism and other 'isms' in healthcare delivery."

- **Cultural knowledge:** "The process in which the healthcare professional seeks and obtains a sound educational base about culturally diverse groups. In acquiring this knowledge, healthcare professionals must focus on integrating three specific issues: health-related beliefs, practices and cultural values, disease incidence and prevalence."
- **Cultural skill:** "The ability to collect culturally relevant data regarding the patient's presenting problem, as well as accurately performing culturally-based physical, spiritual, psychological, and medication assessments in a culturally sensitive manner."
- **Cultural encounters:** "The process which encourages the healthcare professional to directly engage in face-to-face cultural interactions and other types of encounters with clients from culturally diverse backgrounds to modify existing beliefs about a cultural group and to prevent possible stereotyping."
- **Cultural desire:** "Do I really want to engage in the process of competemility?" She described the term *competemility* as a synergistic relationship between cultural humility and cultural competence.

Campinha-Bacote saw the five constructs as interrelated, as shown in a Venn diagram (Figure 2.1). Regardless of when a healthcare provider enters into the process, he or she must address and/or experience all five constructs. The intersection of these constructs depicts the process of cultural competence.

**Figure 2.1**

*The Process of Cultural Competence in the Delivery of Healthcare Services*




*Note:* Reprinted with permission from Campinha-Bacote (1998).

Physicians may be from different cultural backgrounds and have healthcare opinions based on their subjective views and awareness of cultural norms and beliefs. As a tenet of the cultural competence model developed by Campinha-Bacote (2002), cultural awareness is the deliberate self-examination and in-depth exploration of one's cultural background. Resident physicians, fellows and attending physicians may have predetermined notions about the culture of a particular patient, peer, or mentor, affecting their ongoing learning and work relationships due to cultural differences. Understanding how resident physicians described their self-assessment of cultural knowledge based on their cultural backgrounds helped establish how their cultural competence knowledge was acquired before formal medical education and offer insight into baseline cultural competence awareness levels.

### *Assumptions of the Model Constructs*

Campinha-Bacote's (2002) model has five main assumptions:

1. Cultural competence is a process, not an event.
2. Cultural competence consists of five constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.
3. There is more variation within ethnic groups than across ethnic groups (inter-ethnic variation).
4. There is a direct relationship between the level of competence of healthcare providers and their ability to provide culturally responsive healthcare services.
5. Cultural competence is an essential component in rendering effective and culturally responsive services to culturally and ethnically diverse clients (Campinha-Bacote, 2002).

### *A Model with a Biblical Base*

The model is biblically and spiritually based to provide a holistic approach to cultural competence (Campinha-Bacote, 2005). According to Dillard et al. (2021), religion and spirituality play an essential role in many people's lives, including healthcare providers and patients. In their survey study examining the relationship between religion, spirituality, and the cultural competence of healthcare providers—viewed through four composite variables of patient care knowledge, patient care skills/abilities, professional interactions, and systems-level interactions—they found no evidence of a significant impact of healthcare providers' religious/spiritual beliefs on delivering culturally competent care. In contrast Oman (2018) suggests, religion and spirituality is an underappreciated but essential dimension of health behavior and health outcomes.

### *Critique of the Cultural Competence Model*

Cultural competence is characterized as a process or continuum by Cross et al. (1989) and Campinha-Bacote (1999). Additionally, (Rukadikar et al., 2022) note Leininger (1993), and other theorists offer a more "methodical perspective on cultural competence that focuses on the strategies that a professional may employ to become culturally competent and deliver culturally competent care" (p.4322).While Campinha-Bacote's model of cultural competence has been used extensively, some have expressed various critiques. As suggested by (Rukadikar et al., 2022) suggest, some research focused on the term competence, defining cultural competence as a spectrum or a process, while others focused on the work culture, referring to cultural competence development approaches. The issue appears to be the different domains of the models' various theorists attributed to cultural competence. An example, the Pernell model for cultural competence was based on ideas stemming from anthropology, biology, geography, sociology, economics, political science, pharmacology, and nutrition (p. 4323). Although the Pernel model presents a methodological approach for learning and comprehending culture it is broad based and inclusive of healthcare managers and administrators, possibly a less targeted approach directed to physicians. In contrast, Campinha-Bacote (2002) described cultural competence as a process inclusive of five tenets cultural knowledge, cultural awareness, cultural encounters, cultural skill, and cultural desire. Leininger's model in contrast was developed as a care component based on nursing theory and the culture component based on anthropological theory and her life experiences as a nurse. Leininger's cultural model components included health beliefs, vales, philosophy, and religion (Rukadikar et al., 2022, p.4321,4323). Leininger's (2002)

approach to cultural competence is from a viewpoint directed toward patients care (Kagawa Singer, 2012).

Others have also commented on the idea of cultural humility. Henderson et al. (2018) argued that recognizing the pitfalls of cultural competence is essential. They posited that the concept of cultural competence is an achievable mastery of a finite body of knowledge. In agreement, Engebretson et al. (2008) suggested that learning cultural competence concepts (cultural awareness, cultural desire) implies an endpoint. Both groups of authors suggested cultural humility as a preferred way to conceptualize and educate. They considered cultural humility an ongoing process of introspection and reflection. However, Betancourt (2003) challenged the separation of the terms *cultural competence* and *cultural humility*. They suggested that cultural competency and humility are promising approaches to illuminating the underlying challenges affecting members of racial and ethnic minority groups and working toward the ultimate goal of alleviating racial and ethnic healthcare disparities and improving culturally competent healthcare. In agreement with Campinha-Bacote Nguyen et al. (2021) posited that combining cultural competence and cultural humility presents a more effective clinical practice than focusing solely on the tenets of Campinha-Bacote's model of cultural competence Further, Nguyen et al. (2021) stated that practitioners need to have the humility to be a learner rather than an expert and start with a focus on being open and receptive to patients from diverse populations. According to Nguyen et al., cultural competence and cultural humility are not mutually exclusive. They do not compete with each other. The authors asserted that diversity should be addressed using cultural competence and humility for effective services, focusing on patient cultural sensitivity. Although there are various theories on

how the model of cultural competence tenets, components, and frameworks should be defined they agreed that working with diverse patient populations can be complex and challenging. However, combining cultural competence can enable practitioners to work with patients effectively.

Additionally, Smith (2020) noted that although there has been much discussion about social determinants to health, many medical schools have not caught up with this defining feature of American life. He posited that to achieve health equity in the United States, "structural competency" must find its way into the medical school curriculum. Thus, cultural competency may not be enough to solve the issues of health disparities and health equity. Smith pointed to the comment of Dr. Hansen, recorded at an American Medical Association meeting, which suggests that structure highlights the need to shift the focus from the individual to the institution and to retool patient presentations from a cultural interpretation to a structural variation. Therefore, clinical education requires changes to address health disparities. In response, aligned with National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards in Health and Human Care, programs have been introduced to health medical centers as a guide to help structure training and initiatives to improve health equity and reduce health disparities

In response to some of these critiques, it was important to point out that Campinha-Bacote's (1998) model views cultural competence as an ongoing process with no endpoint. Thus, healthcare providers are considered *becoming* culturally competent. Within the process, healthcare providers strive to learn cultural competence continuously to achieve the ability to serve individuals, family, and communities considering their

cultural healthcare norms and beliefs. This characteristic of the model addresses some of the points of cultural humility.

### *Rationale for the Choice of This Model*

The Campinha-Bacote culturally competent model of care was selected for use in this study due to its five stages of care, which directly focus on the study framework. Additionally, the model elements allowed the crafting of interview questions that support the research questions. The model is structured and works in an integrated manner to support Kolb's theory of experiential learning. Utilizing Campinha-Bacote's model and Kolb's theory allowed the researcher to provide evidence of learning and gaining cultural knowledge to inform clinical practice, the basis of the study.

Along with the model of cultural competence, Campinha-Bacote developed and introduced a test, the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals Revised (IAPCC-R©), to assess cultural competence. The validated test measures are used to assess cultural competence levels. In line with Campinha-Bacote's cultural competence model, the IAPCC-R© and its student version (IAPCC-SV©) were shown to be reliable and valid across various healthcare settings in the United States and globally (Campinha-Bacote, 1999; Capell et al., 2008; Chen et al., 2020; Kardong-Edgren et al., 2008). Although other tools have been developed to measure cultural competence, including the Tool for Assessing Cultural Competence Testing (TACCT) used by the American Association of Medical Colleges (ACCM, n.d.), the availability of a validated cultural competence assessment test that is aligned with a model of cultural competence added to the rationale for choosing this model for the study.

Campinha-Bacote (1999)'s IAPCC-R is a paper-and-pencil self-assessment tool that consists of 25 items measuring the five cultural concepts of cultural desire, awareness, knowledge, skill, and encounters with a Likert-type scale (Campinha-Bacote, 1999). Campinha-Bacote's cultural competence assessment has been used in several studies by organizations, graduate students, and healthcare administrators to educate and verify the process of learning cultural competence. The face validity of the IAPCC-R was established by reviews from national experts in the field of transcultural healthcare (Campinha-Bacote, 2020).

**Views of Practitioners on Cultural Competence**

Few studies have addressed healthcare providers' direct experiences with cultural competence. One of the few studies was a qualitative study in Australia conducted by Mollah et al. (2018), which involved in-depth interviews with 20 mental health practitioners working with immigrant patients. Although the participants had a common understanding of cultural competence, operationalization differed by health setting, locality, and years of experience. Of note, urban psychiatrists were more functional in their approach to cultural competence and authoritarian in their communication with patients. In comparison, non-specialist mental health settings in rural areas with less experienced psychiatrists were less functional in their approach to cultural competence. According to Mollah et al., there is limited evidence about what frontline practitioners consider culturally competent care. Further, the researchers noted that there is limited literature on what helps or hinders healthcare practitioners from delivering culturally competent care in clinical practice. Mollah et al. (2018) stressed the need to change how

cultural competence is taught to improve outcomes for patients and providers of healthcare.

### Cultural Competence Studies Outside of Medicine

Cultural competence has a benefit in fields outside the field of healthcare. In a 1-year study conducted from 2015 to 2016, the Levine Museum of the New South in Charlotte, North Carolina, featured an interactive exhibit that explored the bidirectional ways Latinx and the U.S. South influence one another. To strengthen the exhibit's impact, the museum launched a dialogue program to enhance attendees' cultural competence, as measured through relevant gains in knowledge, acceptance, appreciation, and skills. Sixty-six group dialogues took place with 863 individuals. The museum's dialogue program utilized "intact" groups of 5 to 16 individuals from the same institution who participated in a 2-hour experience, including a visit followed by a facilitated dialogue. To recruit groups, the museum leveraged relationships with over 100 current and past partners across the business, nonprofit, media, education, faith, and healthcare sectors in the Charlotte metropolitan area (Schuch et al., 2020). Results demonstrated increased knowledge of Latinx in the U.S. South and appreciation of different cultures, but fewer proficiencies along the cultural competence spectrum. Study results show a need for additional cultural competence skill-building. According to the Levine Museum of the New South, study findings show great potential for cultural institutions to offer carefully constructed programming that pairs exhibits and community dialogue as a tool to enhance cultural competence.

A study comprising athletic training students studying abroad revealed that the U.S. students were not reflective of the ethnic demographics within athletic training and

may challenge the diverse healthcare athletes are given (Sears et al., 2021). The study findings showed that students felt the most helpful method to improve cultural competence would be engaging in discussions or incorporating cultural training in courses. After initial cultural training, athletic students found valuable training in their cultural skills for other countries or different cultures (Wright & Frank, 2020).

## Cultural Competency in Medical Education

The American Medical Association (AMA) (2021) considers cultural competence to be central to patient communication and care. Further, the AMA listed cultural competence as one of the 15 professional skills necessary for student preparedness for medical school and, later, residency (Murphy, 2020). Medical school is a 4-year program following a bachelor's degree, consisting of classroom instruction and clinical rotations; it is followed by a 3-year to a 5-year residency program, in which those with medical degrees and medical licenses provide patient care and learn a specific specialty in an accredited program to qualify for board certification.

The AAMC has included cultural competence training and testing as part of the curriculum in all U.S. medical schools. Therefore, medical students must take cultural competence training and pass cultural competence tests to obtain their medical degree. In addition, the LCME has adopted testing, including the TACCT and others, to assess the attainment of cultural competence skills (AAMC & AMA, 2019). After medical school, in residency training, cultural competence has been identified as a critical factor in enhancing resident physicians' clinical knowledge, improving physician-patient communication, and enhancing patient-centered care for patients from diverse cultural backgrounds (Park et al., 2006).

## Medical School

As outlined by the Association of American Medical Colleges (AAMC) (2005), the content has five domains: rationale, context, and definition of cultural competence; critical aspects of cultural competence; the impact of stereotyping on medical decision-making; health disparities and factors influencing health; and cross-cultural clinical skills (p. 9). The medical school cultural competency component further prepares physicians to effectively treat people holistically in addressing their clinical care needs (Paul et al., 2018; Visram et al., 2016).

Students learn about cultural competency in medical school through formal cultural training, lectures by minority faculty, and team-based learning (Worden & Ait-Daoud Tiouririne, 2018). Nonetheless, Worden and Ait-Daoud Tiouririne (2018) posit that medical students, like students in other disciplines, learn from their own experiences outside of the classroom, rather than solely from carefully designed lesson plans. Furthermore, medical students have varying perspectives on cultural competence education. Many students at the University of Virginia School of Medicine, for example, considered cultural competence to be "soft" in comparison to bioscience topics after attending cultural competence lectures (Worden & Ait-Daoud Tiouririne, 2018).

Upon completing the required medical curriculum on cultural competence, medical students may have the opportunity to practice clinical encounter simulations with peers (Liu & Li, 2022). According to Coakley et al. (2019), the transition to clinical practice is challenging and complex. They suggested that a deeper understanding of how new resident physicians experience this phase may inform interventions to ease the transition from student to doctor. Coakley et al. used a phenomenological analysis with

semi-structured interviews to explore the individual experiences of making the transition. Students were questioned on how they anticipated the transition. Results described the students as bracing for the shift to clinical practice. The researchers used the metaphor of stage actors waiting in the wings to describe the experience of medical students on the brink of entering clinical practice. Themes of abrupt transformation, mixed feelings, and strategic planning emerged as students made sense of this phase. The strategic planning for clinical practice involved making meaning from experiences such as clinical encounter simulations with peers. Residents may use the prior experiences of working with peers to inform future clinical practice.

The study findings highlighted the positive effect of experience-based learning on cultural competence. Worden and Ait-Daoud Tiouririne (2018) cautioned that medical educators must thoughtfully consider the content and delivery methods used to introduce the topic of cultural competence. Their concern was how students learned about culture and race and how the subject could provoke unexpected negative responses from a sensitive topic, hindering learning. However, the overarching goal was to ensure that all patients receive the highest quality medical care. To that end, Worden and Ait-Daoud Tiouririne (2018) noted that educators must continue to prompt medical trainees to understand how cultural issues can affect healthcare and appreciate the value of cultural competence.

Lee and Ervin (2018) analyzed 15 cultural competence programs based on the six domains of cultural competence. Their findings revealed that most prelicensure cultural competence training programs heavily focus on non–patient-centered self-assessments to evaluate program effectiveness. They indicated that with some assessments, it is difficult

to quantify the medical impact of cultural competency on healthcare. They suggested a unified approach to measure the efficacy of cultural competence comparing characteristic healthcare outcomes.

According to Weissman et al. (2005), fewer than half of Harvard Medical School students felt sufficiently prepared to provide cross-cultural care in their final year in areas such as caring for patients with health beliefs at odds with Western medicine or patients with religious beliefs that might affect medical treatment. Similarly, Green et al. (2017) reported that while medical students reported that preparedness and skill in caring for culturally diverse patients increased with training, fourth-year students still felt inadequately prepared and skilled in many essential aspects of cross-cultural care.

Although over two decades have passed since the LCME mandated cultural competence standards training in U.S. medical schools (Vasquez Guzman et al., 2021) However, there are still challenges to implementing training, including non-standardized training, curricular constraints, and various interpretations of cultural competence. One such challenge is a potential loss of skills. In an educational setting of pharmacy school rather than medical school, Chen et al. (2020) studied the longitudinal impact of integrating health literacy—obtaining and using health information for decision-making (Neilson-Bohlman et al., 2004)—and cultural competence education in an introductory pharmacy practice experience taught over the 4-year program. The researchers recruited a cohort of pharmacy students and assessed their baseline health literacy and cultural competence levels after the first professional year. Assessments were repeated utilizing a health literacy survey tool for 3 years. This design allowed Chen et al. to assess any changes over time due to continuous training. Student assessment scores improved

progressively from year 1 to year 4. However, scores dropped if the curriculum skipped the concepts or if there were no activities (patient encounters). These factors strengthen the tenets of Kolb and Campinha-Bacote theories and the importance of ongoing cultural training and learning in practice.

According to Lopez et al. (2008), during residency, new physicians have the opportunity to build on their cultural competence education from medical school as they work with patients. Specifically, when treating patients from various cultural backgrounds, they are exposed to the nuances of applying cultural competence after being exposed to it as part of their medical curriculum. A better understanding of how and if cultural competence training was transferred to clinical practice was needed to advance knowledge on the experience of cultural competence usage with ethnically and racially diverse patients. Additionally, knowledge on how physicians learn cultural competence from peers is necessary to add to the body of research on the subject.

Cultural competence learning to integrate into clinical practice has become a pivotal part of resident physicians' education due to formalized standards set forth by the LCME in 2000 (Vasquez Guzman et al., 2021). Stubbe (2020) noted that Accreditation Council for Graduate Medical Education (ACGME) has recognized cultural competency as part of three out of six core competencies—patient care, interpersonal and communication skills, and professionalism—that residency training programs address.

Cultural competency education in medical school touches on topics such as personal biases and diverse belief systems with the ultimate goal of translating this understanding into residency training as a way for physicians to become more autonomous, informed, and competent in clinical practice (Crockett et al., 2019, p. 7).

Through their medical school training, resident physicians deemed culturally competent are expected to provide care for ethnically and racially diverse patient populations utilizing cultural competence skills. Resident physicians may attain cultural competence through their clinical encounters with patients, the attending physicians who are preceptors/mentors and supervise their work. And physicians also actively experiment with new knowledge to serve patients with similar backgrounds, reinforcing Kolb's tenet of active experimentation supporting the study framework.

According to Archibald et al. (2021), postgraduate training is when resident physicians develop both their medical, technical competency and their professional identity. The researchers suggested that it may be helpful for residents to identify their preconceived beliefs and address ways to develop new programs to target and mitigate hindrances that may stymie cultural competence learning. In support of the study theory, an interview question addressed the cultural knowledge residents bring from their backgrounds. In interactions with more experienced attending physicians' residents have the opportunity to watch and learn from peers and mentors how cultural competence plays a role in effectively delivering care to diverse patients.

Gard et al. (2019) noted that medical training has traditionally focused on the proximate determinants of disease with a narrow focus on how social conditions influence health. They conducted a review of a wide variation of curriculum development, implementation, and evaluation. The curriculums were designed to teach primary care residents about the social determinants of health defined by the World Health Organization (2020) as the conditions in which people are born, grow, and work. According to Gard et al., these forces contribute to root causes of health outcomes, and

providers who know how to ask about social challenges are more likely to help patients address these issues. The authors stressed the need for resident physicians to learn more about the social aspects of patients' health and not simply focus on their medical needs. As part of the study, a new curriculum was developed that emphasized experiential learning as posited by Kolb (2014). The goal was for residents to attain knowledge, attitudes, and skills needed to care for vulnerable and underserved urban patients; however, the curriculum was not evaluated regarding the status of patient outcomes.

International experiences may be another way to foster cultural competence among residents. According to Campbell et al. (2010), there has been a surge in demand by resident physicians for training and experience in global health. A national survey conducted by surgical medical residents who were members of the American College of Surgeons found that 92% of the 724 respondents were interested in participating in an international elective, and 82% would prioritize the experience over other electives (Powell et al., 2009). In a study conducted by Campbell et al. (2010), in which 21 resident physicians in plastic and reconstructive surgery participated in the inaugural Operation Smile Regan Fellowship, a volunteer program to provide surgical services to underserved multicultural populations overseas, all residents agreed that participation in the international mission was a quality educational experience. Participation in the mission offered valuable training in cultural competence and fulfilled the ACGME and Residency Review Committee mandate of educational growth through six core competencies (Campbell et al., 2010).

According to Grewal et al., while continually learning and unlearning is at the very core of modern medicine, it may be nearly impossible to train or retrain

independently practicing physicians and sensitize them to expand their awareness of implicit knowledge biases toward cultural incompetence. Thus, incorporating cultural competency into the professional training of resident physicians appears to offer great promise in addressing this seemingly insurmountable challenge (Betancourt & Green, 2010). Yet, Mainous et al. (2020) asserted that less than half the physicians reported receiving cultural and linguistic competency training in medical school or residency.

Mollah et al. (2018) emphasized standards and policies related to cultural competence training, as medical schools and clinical residency programs require adherence to standards and policies. In actual practice, how healthcare providers (i.e., residents, nurses, pharmacists, etc.) practice cultural competence may be difficult to standardize across all healthcare settings.

**Standards After Residency**

Cultural competence training and learning can be elusive for physicians unaware of standards or cultural competence's role in healthcare. There are mandates to address culturally and linguistically appropriate services (CLAS) for ethnically and racially diverse patients. The U.S. Department for Health and Human Services Office of Minority Health released 15 national CLAS standards that provide individuals and organizations a blueprint for the implementation and maintenance of CLAS services (Federal Register, 2013; Office of Minority Health, 2019; U.S. Department of Health and Human Services, 2019). The CLAS standards recognize the importance of culturally competent health services for the quality of healthcare.

To determine familiarity with CLAS, Mainous et al. (2020) utilized survey data from a 2016 National Ambulatory Medical Care Survey supplement for office-based

physicians. They found that out of a sample of 363 physicians, only 35% had ever heard of the CLAS standards. Further, only 18.7% reported that cultural competence training was required for newly hired physicians who joined their practice. Of note, the research found no statistically significant differences between those who had versus had not received training in terms of self-reported consideration of race/ethnicity or culture in assessing patient needs, diagnosis, treatment, and patient education (Mainous et al., 2020).

### Ongoing Educational Interventions

Ongoing cultural competence learning may be advantageous for new physicians, as cultural competence is a never-ending process, as Campinha-Bacote (2020) detailed. Anderson and Vanderbilt (2018) noted a gap between cultural competence training and clinical behaviors and attributed part of this gap to a lack of physician education on cultural competence beyond medical school. They posited that cultural competence should be taught in the classroom, modeled, and taught in clinical settings. Anderson and Vanderbilt cautioned that cultural competence learning may be hampered without closing the gap between attending physician training and medical student education.

A review conducted by Brottman et al. (2020) was guided by two research questions: (1) Are healthcare professionals and medical students learning about implicit bias, health disparities, advocacy, and the needs of diverse patient populations? (2) What educational strategies are being used to increase student and educator cultural competency? The researchers identified 89 articles from 2005 to 2016 related to cultural competency or diversity and inclusion education and healthcare training. The educational intervention studies ranged from single-day workshops to a 10-year curriculum. Brottman

et al. (2020) evaluated 11 educational strategies used to teach cultural competency and health disparities. Many studies recommended using multiple educational strategies to develop cultural knowledge, awareness, attitudes, and skills. However, less than half of the studies reported favorable outcomes. Further, various studies highlighted the difficulty of implementing curricula without experienced and knowledgeable faculty. Brottman et al. (2020) concluded by suggesting that cultural competence supporting a culturally diverse patient population requires comprehensive training of trainers in conjunction with longitudinal studies evaluating educational interventions. Brottman et al. (2020) stressed that best practices must be initiated for cultural competence training progress.

Another systematic review of the literature showed that health workforce cultural competency interventions are elusive. Jongen et al. (2018) noted that major initiatives exist to train and develop a strategy toward improved cultural competence in health services and systems. However, although diverse approaches have been used, the effects of interventions beyond practitioner knowledge and attitudes remain unclear. Thus, Jongen et al. (2018) suggested that the impact on health outcomes needs to be assessed to build a more substantial evidence base. Further, they acknowledged that positive results have been reported from cultural competency interventions targeted toward the healthcare workforce, particularly practitioners.

Jongen et al. (2018) stressed that health professionals play a crucial role in determining the nature of clinical encounters and patient experiences. Arguing that cultural competence training has focused chiefly on developing cultural knowledge and awareness of cultural competence, they noted a need to focus on teaching the skills

required to translate knowledge and awareness into tangible practitioner behaviors. Evidence from their review demonstrated great diversity in approaches to address the cultural competence of the healthcare workforce. Accordingly, Jongen et al. (2018) suggested that more research is needed to compare the different approaches and establish the benefits of development opportunities such as mentoring and supervision.

In a more recent systematic review, Chae et al. (2020) aimed to identify, appraise, and synthesize the evidence for the effectiveness of cultural competence educational interventions. Although their findings provided evidence that cultural competence educational interventions positively affect health professional outcomes, they pointed out the lack of research assessing whether interventions can change patient outcomes.

One major weakness of cultural competence training programs has been the teaching approach. Lee and Ervin (2018) suggested applying an andragogical adult learning approach. Knowles et al. (2015) promoted a self-teaching approach from theory to practice, turning experience into understanding. This teaching approach is in alignment with Kolb's cyclical phase of experientially learning from concrete experiences. The next section discusses that theory in detail, as it serves as part of the study's theoretical framework.

## Experiential Learning Theory

The experiential learning theory was developed by David Kolb (1939-present), building upon the foundational work of adult learning scholar John Dewey (1859-1962) (Dewey, 1916, 1938). Kolb (2014) attributed the emergence of experiential learning to the contributions of what he called the foundational scholars of experiential learning: William James, Kurt Lewin, and Jean Piaget, among others. Kolb noted that he

developed ELT to integrate the common themes of their work into a framework that can address 21st century problems of learning and education, which could be applied to all situations in life.

Kolb's influential work defines experiential learning as a "process whereby knowledge is created through the transformation of experience" (Kolb, 1984, p. 41). Kolb noted that through active engagement and learners' interaction with their surroundings, they gain applied rather than abstract knowledge (Yardley et al., 2012). For Kolb, learning without direct contact leaves a gap in the importance of firsthand knowledge. In agreement with Dewey, Kolb maintained that something was lost from the learner's understanding without direct personal experience. As Kolb (n.d.) explained, "There are two goals in the experiential learning process. One is to learn the specifics of a particular subject, and the other is to learn about one's own learning process" (Institute for Experiential Learning, n.d.).

The experiential learning cycle is the most widely recognized and used concept in ELT (Kolb, 2015; Kolb & Kolb, 2017). The authors attribute the usefulness of the four-stage cycle of experiencing, reflecting, thinking, and acting as the main reasons for its popularity. Further, the authors outline the deeper foundations of ELT in eight important insights:

1. Learning is an endlessly recurring cycle, not a linear process.
2. Experiencing is necessary for learning.
3. The brain is built for experiential learning.
4. The dialectic poles of the cycle are what motivate learning.
5. Learning styles are different ways of going around the learning cycle.

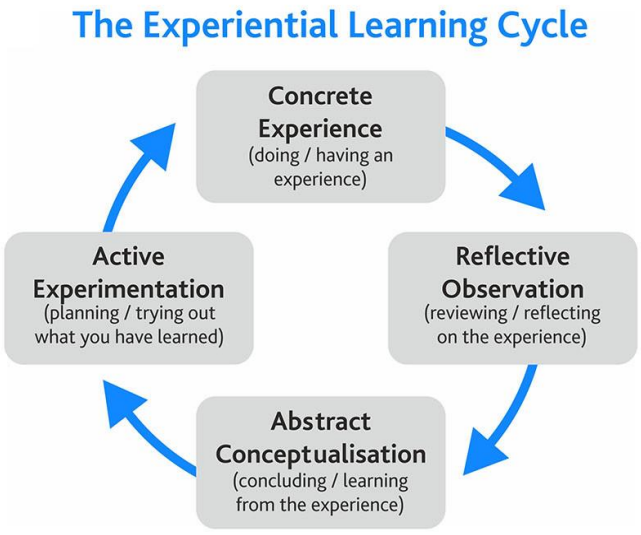
6. Full-cycle learning increases learning flexibility and development.
7. Teaching can be organized around the learning cycle.
8. The learning cycle can be a rubric for holistic, authentic assessment.

According to Kolb and Kolb (2018), this process of learning is recursive or spiral. The cycle has four parts—all of which are ongoing, as the cycle continuously begins anew (Figure 2.2):

- Concrete experience: The learner has an experience.
- Reflective observation: The learner reflects on that experience.
- Abstract conceptualization: In thinking about the experience, the learner gains new insights from it, including abstract generalizations.
- Active experimentation: The learner acts on the knowledge that was gained and tests new hypotheses, which in turn constitutes a new concrete experience.

**Figure 2.2**

*The Experiential Learning Cycle*




*Note*: Reprinted with permission from Experience-Based Learning Systems, LLC (EBLS), D. Kolb, 2021, https://learningfromexperience.com/index.html. Copyright [1984] by David Kolb.

Guided by the study framework and research questions, the researcher is interested in interpreting how resident physicians describe learning through ELT instead of through a linear, static Socratic form of learning through texts or lectures. In this "banking concept of education," ideas are seen as being deposited in the minds of passive learners (Freire et al., 2000, p. 72). Kolb (2015) expressed that in the ELT cycle of learning, learners receive information through concrete experiences (i.e., clinical encounters) and transform it through reflection and meaning-making and then transform it again through their actions with others. Therefore, all modes of the ELT learning cycle are experiences, and it is the here-and-now experiencing initiating learning. Residents' first-hand experiences serving diverse patients and learning in practice allowed them to express what they have learned and how it informs their clinical practice. Their descriptions highlighted how they gained new knowledge on cultural competence and provide information on their learning style, formal and informal.

Resident physicians often work in hospital teams and are supervised by attending physicians who guide their professional standards, including communication, clinical ethics, and work behaviors. Residents communicate with and learn from peers and attending physicians during group/team sessions. Through the collective process of sharing information with others through active participation and interactions within their surroundings, learners gain applied rather than abstract knowledge. The synergic effect of working in teams may allow experiential learning of cultural competence to give residents different perspectives in constructing knowledge.

## COVID-19 Pandemic

The current study was conducted during the ongoing COVID-19 pandemic. The pandemic has affected several contextual factors related to the study.

### Disparities and Health Equity

Ethnically and racially diverse and socioeconomically disadvantaged communities have historically been disproportionately affected by disasters and public health emergencies in the United States (Golden et al., 2021). In addition to CLAS standards, which detail how to provide reasonable, equitable, understandable, and respectful quality care that is responsive to diverse cultural health beliefs and practices, the U.S. Department of Health and Human Services Office of Minority Health established the National Consensus Panel on Emergency Preparedness with the primary goal of guiding organizations to develop health equity–focused strategies to advance preparedness and eliminate disparities among ethnically and racially diverse communities. The panel worked with community partnerships to address health equity during the COVID-19 pandemic. As part of the efforts to address health equity, academic-community partnerships used existing resources and expertise to develop an operational framework that supports clinical operations infrastructure and health equity initiatives during a pandemic for academic medical centers. Golden et al. (2021) explained that the framework also supports CLAS. The standards apply to curriculum requirements for all U.S. accredited medical schools. An example is Johns Hopkins Medicine's endorsed framework recommended for addressing institutional policy-making, unconscious bias training, and resources for staff training to improve health equity for ethnically and racially diverse groups.

The COVID-19 pandemic has disproportionately affected racial and ethnic minority groups, with high death rates in African American, Native American, and Latinx communities (Tai et al., 2021). However, Tai et al. (2021) cautioned that for clinicians who are already overwhelmed by tending to the medical needs of COVID-19 patients and the challenges of resuming routine clinical care, it can be overwhelming to consider the root causes of disparities and health equity that fall outside the realm of their expertise. The authors stressed that clinicians should provide high-quality standard care for all patients, regardless of race or cultural background, at the most basic level. There are several reasons why minorities are affected by health disparities and a lack of health equity, including social determinants of health such as low income and poor living conditions. Their predisposition to worse health outcomes through chronic medical conditions including hypertension, diabetes, and obesity, combined with lower access to healthcare, may portend worse COVID-19 outcomes. Tai et al. (2021) posited that a disproportionate burden of preexisting chronic medical problems and living and working conditions likely contribute to the disparity in COVID-19 outcomes. In agreement, Hardeman et al. (2021) noted that minority populations have approximately a five times greater risk of adverse COVID-19 consequences related to social determinants of health that may exacerbate patient comorbidities. Further, Richardson et al. (2020) found preliminary data showing that diabetes, hypertension, and obesity increase patients' risk of severe COVID-19 disease and mortality. African American patients are more likely to die prematurely than Whites due to all causes (Cunningham et al., 2017).

Thus, having physicians tend to the needs of ethnically and racially diverse patients and consider patients' cultural health beliefs and medical conditions may be an

essential part of healthcare delivery to foster better health outcomes, particularly during the COVID-19 pandemic. Residents transitioning from medical students to practicing physicians may provide information on new experiences resulting from changes in healthcare delivery due to the COVID-19 pandemic.

In addition to affecting minority communities, the COVID-19 pandemic also affects the minority healthcare workforce that often serves them (Sobowale, 2020). According to the Centers for Disease Control and Prevention (CDC), "at least 107 Black healthcare workers have died, and thousands more may be suffering the complications of infection" (Sobowale, 2020, para.2). Sobowale (2020) stressed that the small number of Black physicians in the U.S., approximately 45,500 or 5% of U.S. doctors, are not replaceable. Additionally, as suggested by (Filut & Carnes, 2020) Black physicians' exposure to COVID-19 and risk of contracting is greater than other physicians because they are more likely to practice in areas with a higher population of Black patients and in smaller institutions and outpatient clinics that have been particularly under-resourced with PPE born out of data from the CDC, which found that Backs accounted for 21% of the 9,282 healthcare workers who have contracted Covid-19.

**Changes in Clinical Practice**

Clinical practice for resident physicians, changed from 2020 to 2021 due in part to the COVID-19 pandemic and the related safety requirements. CDC protocols, for example, involve wearing personal protective equipment to prevent spreading of the virus and employing social distancing. In addition, the AAMC recommended that medical schools suspend student clerkships where students are in direct contact with patients during clinical rotations (Miller et al., 2020) so that the students did not become vectors

for viral transmission. At the same time, the ACGME required health facilities to uphold residents' work hour limitations, supervision, and COVID-19 training to maintain their accreditation. Further, ACGME urged institutions to ensure resident physicians' and fellows' educational continuity, viewing furloughs of residents and fellows as unacceptable (White, 2020c). Therefore, all ACGME policies, procedures, and requirements are applicable (White, 2020a, 2020b, 2020c). Additionally, there is little information on how the U.S. emergency preparedness mandates, standards, and newly formed initiatives are affecting resident physicians. Not all residents are new to clinical practice, and as such some may not have been exposed to current COVID-19 programs as part of their former medical school curricula.

### Communication with Patients

Minority patient populations are experiencing a disproportionate increase in COVID-19 cases. Therefore, culturally competent physicians must communicate with ethnically and racially diverse patients and share information on COVID-19, particularly with patients who may distrust medical interventions or treatment regimens. The distrust has a variety of causes, including historical events such as the Tuskegee Syphilis Study (CDC, 2019), where study participants suffered as a result of unfair treatment practice. Therefore, resident physicians have the opportunity to foster communication focused on imparting health information to a marginalized patient population.

## Conclusion

The thrust for cultural competence learning and training is the ongoing increase of minority patients and the focus on patient-centered care, with sensitivity to patients'

cultural beliefs and norms. In contrast to disease-centered care, patient-centered care fosters better patient/physician relationships where patients have the opportunity to be active participants in care delivery and decision-making based on their health beliefs. Therefore, physicians who learn and apply cultural competence skills may focus on patients' beliefs, gain and achieve shared clinical decision-making with patients, and enhance patients' compliance with healthcare interventions and maintenance. If culture is not considered when caring for ethnically and racially diverse patients, the patients may have a negative experience and their health outcomes may be hampered. Thus, it is vital to address cultural competence learning—learning that is applied with patients.

Young and Guo (2020) explained that being culturally competent means that healthcare professionals have the knowledge, skills, and tools to practice and are committed to the ongoing process. Some researchers have suggested that cultural competence is a process rather than an outcome (Bednarz et al., 2010). They have stressed that while workshops and in-service practice are valuable, becoming culturally competent is an ongoing process and based on self-reflection of one's various experiences. Understanding how resident physicians describe their cultural awareness through learning formally and informally in practice can bridge the gap on what is known about formal cultural competence training and add to the literature. Post-residency residents' complete rotations in various clinical departments under attending physicians' supervision. Attending physicians provide leadership and mentor residents throughout their residency. Although cultural competence training is required in medical school, there is a lack of formal residency training. Instead, didactic medical training is the main focus. Therefore, the opportunity to learn cultural competence skills from peers and

patients may occur informally through experiential learning. Due to Covid-19 and an increase in patients, the constraints of time have a direct effect on learning. According to Förster et al. (2023), "the meaning of time, especially in a crisis, where situations are likely to become more complex, uncertain, and disruptive, is crucial.". The authors caution, intensified by the Covid-19 pandemic, the leader's ability to effectively deal with a critical situation becomes even more important in healthcare organizations. They argue that time is not only important but it is also highly significant. Thus, the temporality of time affected the learning of cultural competence skills from peers and mentors and the utilization of cultural skills.

This study focused on residents, who are in the early years of clinical practice and have opportunities to apply the cultural competency learning mandated in medical school. Additionally, it considered attending physicians, who may have had formal cultural competence training in medical school. As clinicians, they are engaged in experiential learning. There is a gap in the literature on how resident physicians transfer skills and practice cultural competence serving ethnically and racially diverse patients in clinical encounters. There is little literature on how attending physicians experientially learn and practice cultural competence skills in practice. Additionally, the study included attending physicians in clinical practice with ethnically and racially diverse patients. Sometimes, the supervisors are preceptors/mentors of residents completing rotations in Mid-Atlantic hospitals and clinical practice sites. Due to the effects of Covid-19, time became a factor in the availability of residents and attending physicians to learn or utilize cultural competence skills with diverse patients. The study explored how the time constraints adversely affected their clinical practice and availability to address diverse patients'

cultural norms and beliefs. The theories of Campinha-Bacote and Kolb undergird the study. Campinha-Bacote's model of cultural competency focuses on cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire, with the idea that cultural competence considers the cultural norms and healthcare beliefs of culturally diverse patients. Additionally, ELT developed by Kolb (2014)—the process wherein knowledge is created through the transformation of experience—is part of the study's theoretical framework to show how residents and attending physicians learn cultural competency through a cycle of concrete experience, reflective observation, abstract conceptualization, and active experimentation as defined in Kolb's ELT. An integration of the theories was used to focus the research questions and formulate interview questions. The next chapter details the methods that were used in this study.

# CHAPTER 3:

# RESEARCH METHODS

This chapter explains the methodology that was used for this study, the research design employed, and the methods used for data collection and analysis. The study explores how physicians experientially learn and practice cultural competency in clinical practice. There are two guiding research questions:

RQ1: How do physicians describe their experiences of learning and practicing cultural competence when serving ethnically and racially diverse patients?

RQ2: How do physicians make meaning of these experiences to inform their clinical practice?

This chapter begins by presenting the epistemology and ontology that informed this study.

## Ontology and Epistemology

Following the suggestion of Crotty (1998), the study frameworks are inclusive of ontology and epistemology, which inform the theoretical perspective of the study. Ontology, as defined by Crotty (1998), is the study of being and "what is," with the nature of existence and the structure of reality as such (p. 10). The researcher aims to understand the ontological aspects of how residents and attending physicians learn in their work world, inclusive of interactions with peers, attending physician supervisors/mentors, and patients in various clinical settings. Additionally, the new global effects of the COVID-19 pandemic has shifted a focus on residents' work world as they work with ethnically and racially diverse patients who may be adversely affected by

the pandemic due to issues of health equity and disparities experienced by marginalized minority populations. Thus, as the COVID-19 pandemic is included in the theoretical and conceptual frameworks, attention was given to this new way of working as residents experience the effects. An ontological focus undergirded the study by embracing the multiple realities of the resident physician participants and presenting forms of evidence in themes using participants' actual words and different perspectives, as posited by Creswell (2013, p. 20).

The epistemology-orientation for the study is constructionism as defined by Crotty (1998), who states, "there is no objective truth waiting for us to discover it, truth, or meaning comes into existence in and out of our engagement with realities of the world" (p.8). Merriam and Tisdell (2016) further note the theory of constructivism by stating, "researchers do not find knowledge; they construct it" (p.9). Guided by the study frameworks, the researcher was interested in how resident, fellows and attending physicians experience patient encounters, reflect, and construct new knowledge of cultural competence. Primarily working with those from different backgrounds than their own. The participants shared stories that allowed the researcher to understand through dialogue and interpret their constructed meaning-making of the experiences during encounters with patients.

The researcher's epistemological approach relied on the assumption that "conducting a qualitative study means that the researcher tries to get as close as possible to the participants being studied" (Creswell, 2013, p. 20). The epistemology of the study is aligned with the research questions and the researcher's quest for knowledge. Following guidance from Seidman (2013), the researcher was primarily interested in

surfacing how residents and attending physicians perceive their formal cultural competence learning in medical school training and how they have utilized the skills through their descriptions of active experimentation, concrete experiences, and other tenets of the five stages of Campinha-Bacote's (1998) cultural competence model.

Further, the researcher explored how and if experiential learning occurs in clinical practice aligned with Kolb's theory based on responses to semi-structured interview questions. In the context of discovering knowledge in concert with the participants, the researcher's epistemology aligned with constructionism, and of importance resident physicians constructed knowledge in different ways, as suggested by Crotty (p.9). The belief was that people construct knowledge in an ongoing fashion as they engage and make meaning of an activity, experience, or phenomenon (Merriam & Tisdell, 2016, p. 23). Crotty (1998) described constructionism as "the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being developed and transmitted within an essentially social context" (p. 42). Further, new first and second-year residents can provide emerging learning experiences in medical schools in contrast to their third and fourth-year residents' curriculum, which may have been modified with new standards due to the COVID-19 pandemic.

According to Creswell (2013), knowledge is known through people's subjective experiences (p. 20). In contrast, quantitative research is based on the view that knowledge is preexisting and waiting to be discovered (Merriam & Tisdell, 2016).

## Research Methodology

A basic qualitative approach was chosen as the best way to answer the study's research questions, which inquire about individuals' experiences and meaning-making.

Exploring and understanding the experience of resident physician participants when serving racial and ethnic patients in clinical encounters could only be accomplished through qualitative research. With qualitative research, according to Crotty (1998), "Meaning is not discovered but constructed" (p. 42).

Although many forms of a qualitative study are available, for this study, a basic interpretive study design was chosen to collect, interpret, describe, and write the stories provided by each participant through semi-structured interviews (Merriam & Tisdell, 2016, p. 111). According to Merriam and Tisdell (2016), all qualitative research is interpretive, and giving qualitative research a label has been a struggle. They noted that generic, basic, and interpretive labels had been used for qualitative research. A basic interpretive study differs from other specific qualitative methodologies, such as phenomenology, discourse analysis, or grounded theory research, which were not considered ideal for this study (Starks & Brown Trinidad, 2007). Qualitative research "is based on the belief that people in an ongoing fashion construct knowledge as they engage in and make meaning of an activity, experience, or phenomenon" (Merriam & Tisdell, 2016, p. 23).

The research methodology for the study was based on the study's conceptual and theoretical frameworks. The tenets of cultural competence were addressed to answer the research questions of how resident physicians and attending physicians learned cultural competence formally and learn experientially and how learning informs their practice with diverse patients. Semi-structured interview questions were crafted to allow residents and attending physicians to detail their experiences of learning cultural competence. Participant responses gave evidence of different perspectives on cultural competence.

The qualitative study will surface rich data, allowing codes and themes to emerge. The researcher aimed to understand the participants' experiences and make interpretations as they related their narrative stories of serving diverse patients. Thus, the basic qualitative study provided the preferred way to report participants' experiences.

## Research Site and Context

The study was initially planned for the residency program centered at a mid-Atlantic teaching hospital where the patient population is diverse (Fisher, 2019), and the residents in the program worked at core affiliated clinical sites. Thus, resident physician participants would likely have many opportunities to practice cultural competence.

The residents in this program come from around the country and the world. For example, the entering class for fall 2020 came from various ethnic backgrounds, with 55% non-Caucasians representing 30 states, the District of Columbia, China, Saudi Arabia, and Canada. The Committee on Admissions seeks to build a diverse class to meet local, national, and international community needs.

The selected research site would have allowed the researcher to interview a cross-section of resident physicians with varied clinical work experiences (e.g., routine physical exams to emergency surgeries) via rotations, grand rounds, and participation in targeted programs (i.e., community health programs). Resident physicians work in clerkships under the supervision of more experienced attending physicians, educators, and mentors who guide residents through 4 years of learning medical skills and effective clinical encounters for patient-physician decision-making on healthcare. Attending physicians/mentors foster resident learning and practice by reducing supervision over

time, promoting residents to work more autonomously as fourth-year residents with limited supervision.

As a result of the COVID-19 pandemic, the researcher recruited one resident participant. Due to the limited availability of resident participants, attending physicians were recruited and accepted as participants. In addition, the researcher expanded efforts of recruiting attending physicians to capture data on resident/attending physician mentorship relationships as related to experiential learning of cultural competence skills. Thus, supporting the study's conceptual framework and study questions. The addition of interviewing attending physicians positively expanded the data capture resulting in rich, thick data to support the study theory and aid in answering the research questions.

## Participant Sampling

A sample of 5 to 8 physicians who met the study criteria was formally invited and selected for study participation. Since the study is qualitative, the participant sample was designed to be small and nonrandom, as posited by Merriam and Tisdell (2016), in contrast to the larger participant samples found in many quantitative studies.

Purposeful sampling was utilized, which involved selecting participants, the research settings, or activities relevant to the research questions and the study's goals (Maxwell, 2013, p. 97).

The researcher recruited and selected participants within the Mid-Atlantic metropolitan areas where physicians practice in hospitals and clinical settings. Physician activities included providing delivering healthcare services to ethnically and racially diverse patients.

The researcher followed the guiding principles of saturation provided by Morse (1995) by selecting a cohesive sample of resident and attending physicians, ensuring data were rich, full, and complete, and interviewing participants until no new information emerged. Importantly, as Morse (1995) posited, the principles of theoretical sampling were followed to ensure the resulting theory made sense, and interview data had been fully explored for the study's validity.

Maxwell (2013) defined five key goals in purposeful sampling selection:

1. Achieving adequate representation of the settings, individuals, or activities of the population
2. Obtaining representation of the complete scope of a variety of the population
3. Intentionally selecting individuals who are key for testing theories
4. Establishing comparisons to shed light on why differences evolved between individuals
5. Deliberately selecting individuals who will be most suited to help solve the research question

This study focuses on Goals 1, 2, and 5, as they were best suited to the research questions. No theories or comparisons are being tested in this study, so Goals 3 and 4 did not apply.

In terms of Maxwell's (2013) Goal 1, adequate representation, the researcher selected a purposeful sample of 5 to 8 resident physicians in clinical residency positions at the study site. In support of Goal 2, the scope of the population, participants were recruited from different Mid-Atlantic hospitals and clinical practices. The resident and attending physicians were from various medical departments; examples are neurology,

general medicine, pediatrics, and pain management. In addition, efforts were made to have both male and female participants.

To participate in the study, individuals must meet four criteria:

1. Be a physician in clinical practice at the research site.
2. Be a resident supervised by an attending physician/mentor or an attending physician.
3. Have had clinical practice encounters with patients.
4. Be able to interview in English.

Resident physician coordinators were recruited to serve as gatekeepers to provide a list of names of potential study participants. Attending physician administrative assistants were contacted as recruitment gatekeepers to pass on and inform attending physicians about the study. In addition, the coordinators were informed of the study purpose and the sample selection criteria. Invitations to participate in the study were emailed with detailed information about the study (Appendix B). In addition, information about the study was included in the consent form (Appendix C).

## Data Collection

The researcher captured data verbatim through interviews with a resident and attending physicians about their experiences, opinions, and knowledge obtained through serving ethnically and racially diverse patients. In addition, the researcher sought to capture the stories shared by participants in their own words as they reflected and made meaning of their experiences. Interview data was the only form of information that was collected for the study. Due to requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 (U.S. Department of Health

and Human Services, 2017), the researcher did not capture any private patient information from participants. Therefore, participants were asked to select pseudonyms to protect their identity throughout the study.

**Interview Protocol Process**

Due to physicians' time constraints and work requirements, with the COVID-19 pandemic potentially affecting their availability, the study was designed to be emergent, flexible, and responsive to the changing conditions of the study, as suggested by Merriam and Tisdell (2016, p. 18). Initially, participant interviews were to be held in two sessions, reflecting a modification of Seidman's series of three phenomenological interviews. However, due to the COVID-19 pandemic and the time constraints of participants' the interview protocol was modified to one session. Additionally, interview time was increased from 60 to 90 minutes to a minimum of 90 minutes or more, providing participants adequate time to respond to study questions, follow-ups, and probing questions to capture rich, thick data. The interviews were designed to incorporate the tenets of the conceptual framework, both the experiential learning theory by Kolb (2014) and the model of cultural competence developed by Campinha-Bacote (1998). The full interview protocol appears in Appendix A.

Following precautions for COVID-19, interviews were conducted and audio recorded through a Webex digital platform or phone call. The researcher was cognizant of the participants' time and the relationship between the researcher and the study participants. The interviewer's goal was to transform her relationship with the participant into an "I-Thou" relationship that verges on a "We" relationship (Seidman, 2013, p. 98). Seidman (2013) cautioned that the study discourse is not a conversation between the

researcher and participant but an interview (p. 98). The primary focus was on answers to the interview questions as a resident and attending physicians told their stories of experience in clinical practice. The researcher and participant's distance allowed the physicians to respond to questions as independently as possible. Seidman (2013) noted that participants and researchers might be from different racial and ethnic backgrounds and face difficulties in establishing interviewing relationships. Seidman (2013) suggested maintaining good manners, respect, and interest in participants' stories (pp. 101-102).

After each interview, the researcher created memos/journal entries noting initial interpretations and thoughts that might inform the analysis. Memos were used to manage and note subjectivity. Memos were written during and after the participants' interviews as accurately as possible to mitigate the loss of data after conversations had ended. Tufford and Newman (2010) cautioned that researchers bring their values, assumptions, emotions, and theories to the interview with collectively considered preconceptions. Tufford and Newman (2010) stated that "these preconceptions influence how data are gathered, interpreted and presented" (p. 81).

**Interview Protocol**

Initially, The 60- to 90-minute interviews were to be held in two sessions. However, as previously mentioned, the protocol was modified to one session, and although changed, the researcher followed Seidman's protocol. The interview protocol consisted of questions to capture a profile of individual participants, including their background, medical education, and cultural self-awareness before formal cultural competence medical school training (i.e., texts, lectures). In addition, the interviews were designed to establish rapport with the participants. The researcher's study interest was

understanding how residents perceive and describe their cultural competence self-assessment, which aligned with cultural awareness and cultural knowledge tenets of Campinha-Bacote's model of cultural competence. Additionally, the questions supported the study theory; resident physicians come to medical school and later residency with former cultural competency knowledge based on their backgrounds. More experienced attending physician's post-residency were posed the same questions on their backgrounds and probed further on their mentoring and learning cultural competence from residents and peers.

The interviews focused on the tenets of the cultural competence model and precisely captured data on participants' cultural awareness and cultural knowledge. Additionally, it addressed their concrete experiences in simulations with peers and later with actual patients, supporting Kolb's (2015) experiential learning theory's focus on "concrete experience." Participants were asked questions about their beliefs about cultural competence. Therefore, the interview involved tenets of the study's theoretical framework. Follow-up probing questions were asked so that participants could clarify and expand their responses, leading to the capture of rich, thick data. Inquiries established evidence of experiential learning, how residents build upon cultural skills acquired from their backgrounds and clinical simulations with peers, and how it informs clinical practice. Questions were asked about their cultural experiences outside of work.

The questions were based on the study's underlying theory of cultural competence being an ongoing experiential learning process throughout life. Although initially slated for the second interview, the researcher continued to ask the participants the remaining study questions. All participants were probed to reconstruct and reflect upon their

experiences as suggested by Seidman. Thus, allowing the researcher and the participants to "reconstruct and reflect upon their experiences" (Seidman, 2013, p. 25). Consequently, the researcher and participants could make meaning of the shared experiences as told by the participants. Van Manen (1990) noted that interviews are "not conducted to predict or to control that experience" (p. 22). Therefore, modifying Seidman's protocol and time elements did not pose any issues capturing study data. Likewise, Seidman (2013) indicated that there is nothing magical or absolute about this time frame as long as it is established before the interview (pp. 23-24).

The interviews continued focusing on the concrete details of the resident physicians' present lived experiences as residents. Special attention was focused on their work during the residency with probing questions related to their learning and practice of cultural competence skills. An example is asking if their training has been affected due to the COVID-19 pandemic. Participants were asked to share their experiences and subjective opinions, beliefs, and delivery of cultural competence skills. Also, how cultural skills impact their work with ethnically and racially diverse patients. Participants were also questioned on the diversity of their working environments. In particular, attending physicians were probed on recruitment efforts to attract and retain minority physicians into residency positions to increase diversity in their workplace settings.

Additionally, attending physicians were asked about their relationships with mentoring or being preceptors to residents and how they experience training and learning cultural skills experientially in practice. Finally, attending physicians were asked to share their experiences of cultural competence skills usage while delivering healthcare to diverse patient populations. The protocol was designed to elicit details aligned with the

tenets of the study. The modification of Seidman's three-series phenomenological interview protocol to one interview will focus on questions that ask the participants to share and reflect on the meaning of their experiences. The process of putting experience into language is a meaning-making process (Vygotsky, 1978).

Overall, questions from the interview were crafted to support the study research questions: The initial questions on residents were modified to reflect resident and attending physicians.

RQ1: How do physicians describe their experiences learning and practicing cultural competence when serving ethnically and racially diverse patients?

RQ2: How do physicians make meaning of these experiences to inform their clinical practice?

## Data Analysis

The researcher followed the steps outlined by Seidman (2013) in analyzing data (p. 132):

- Reduce interview data to what is essential for the study.
- Label important excerpts into categories to develop a profile of individual participants or explore themes embedded in the excerpts.
- Sort labeled excerpts into files that are easy to identify and retrieve for the study.

Additionally, the data analysis relied on the analytic process defined by Creswell (2013) and the method of thematic analysis which included an inductive and deductive process, as described by Ryan and Bernard (2003).

Data analysis began during the interview. During each interview the researcher listened to understand the stories shared by participants and jotted notes. Upon the

conclusion of each interview, the interview was transcribed and read in its entirety during which a code was assigned to chunks of the interview data. As defined by Saldaña (2013), a code is "a word or short phrase that symbolically assigns a summative, salient, essence-capturing attribute for a portion of language-based data" (p. 2). Coding for the study was accomplished in two cycles: first cycle and second cycle (Saldaña, 2013). During both cycles of coding the researcher used a deductive and inductive coding approach to assign codes to the interview data. Each interview transcript was listened to and read multiple times to enable the researcher to gain a clear understanding of answers to questions in the interview protocol. The study data consisted of interview transcripts and the researcher's written notes. Notes were jotted during the interview and also after re-reading the transcripts and reflecting on the shared experiences as told by participants. The notes allowed the researcher to make-meaning of the data and analyze each transcript for a priori and emerging codes.

Deductive Coding: Use of a Priori Codes

Guided by the study theories and frameworks, a priori codes were created. Table 3.1 lists the priori codes that were established through deductive logic (reasoning from the general to the specific) (Burrell & Morgan, 1979). Burrell and Morgan detailed the deductive logic approach. The direction of this reasoning is "top-down" from theory to data. This coding process provided insight into the study's theories and frameworks and guided the inductive coding analytic process. The development of these codes began by identifying the key constructs that comprise Kolb's experiential learning theory (ELT) and Campinha-Bacote's (1998) model of cultural competence. A-priori codes derived from Kolb's experiential learning theory (ELT) include experiential learning, reflective

observation, and active experimentation (see Table 3.2). A-priori codes were also derived from Campinha-Bacote's (1998) model of cultural competence: cultural awareness, knowledge, skill, and desire. Collectively, these five theoretical codes were applied to the narrative data as appropriate (See Tables 3.1 and 3.2).

**Table 3.1**

*A Priori Codes Derived from Campinha-Bacote Model*

| Cultural Awareness | Cultural Knowledge | Cultural Encounter | Cultural Skill | Cultural Desire |
|---|---|---|---|---|
| • Perceived Self-Awareness<br>• Cultural Background<br>• Beliefs<br>• Race-based Medicine-Emerging<br>• Gender<br>• Perceived Self-Awareness | • Cultural Bias<br>• Limited<br>• Knowledge<br>• Cultural Race Assumptions<br>• Experiential Learning<br>• Over Confident | • Limited Time Constraints<br>• Inability to Address the patient's Culture<br>• Difficulty Attending to Cultural Needs<br>• Unexpected Cultural Norm(s)<br>• Diverse Patient Encounters | • Impact of Training<br>• Utilization in Practice<br>• Beliefs About Importance<br>• Utilization of Skills Differs From<br>• Classmates and Patients<br>• Changes Improved Over Time<br>• Learn from patients | • Inspired to Work<br>• Importance<br>• Consideration<br>• Personal Cultural Experiences<br>• Learned in Practice<br>• Relevance<br>• Relationships<br>• Need to learn |

**Table 3.2**

*A Priori Code Derived from Kolb's Experiential Learning Theory*

| Concrete Experience | Reflective Observation | Abstract Conceptualization | Cultural Competence | Active Experimentation |
|---|---|---|---|---|
| • Peers' vs Patients<br>• Simulations vs real<br>• Simulations & preparedness<br>• Patient Needs<br>• Relationship | • Cultural skills are helpful<br>• Skill mapping (grand rounds)<br>• Learning<br>• Authoritative<br>• Subservient | • Communities of practice<br>• Theory | • Ongoing process<br>• Meaning-making<br>• Experiential Learning | • Working from memory<br>• Trying cultural skills on new patient<br>• Thinking "out of the box" to apply cultural skills |

| | |
|---|---|
| • Master | • Trying cultural skills on new patient |

## Codes

### Inductive Coding: Descriptive and In Vivo Codes

In addition to deductively analyzing the data, the researcher used inductive logic (reasoning from the specific to the general) to examine and analyze data. As suggested by Saldaña (2013), inductive codes emerged through participants' shared stories of learning and practicing cultural competence through concrete encounters with ethnically and racially diverse patients which aligned with Kolb's experiential learning theory.

Due to the ontological stance of the study questions being asked to address the nature of the lived experience of participants, the researcher selected the elemental method process of descriptive coding . Descriptive coding summarizes the primary topic of the excerpt Saldana (2013, p.4). Further, descriptive coding summarizes in a word or short phrase-most often as a noun-the basic topic of a passage of qualitative data Saldana (2013, p.88). Descriptive coding was used to assign basic labels to data inclusive of A priori codes and emergent codes which surfaced from the interviews. Saldana (2013,p.83) suggested that this was the first step employed in the data analysis. Finally, in Vivo coding, as defined by Saldaña (2013, p. 59), was utilized as this method was considered the best choice to capture the participants' voices verbatim. In vivo, codes described the participants' stories through their direct language rather than using researcher-generated words and phrases. Furthermore, the researcher chose this method to capture the participants' points of view. The researcher was unaware of and open to the participant's point of view rather than assuming what codes may emerge during the interview.

According to (Saldaña, 2013), manual coding is recommended for small scale studies. The researcher used the following steps to start the coding. First, immediately after interviewing participants via Webex digital platform, audio files were uploaded into OTTER software to transcribe the audio file into a text file in Microsoft Word. Second, the Word file was printed, and the researcher read through the printed hard-copy text using paper and pencil to jot notes and highlight a priory and emerging codes. Data in the form of quotes were included to support the study's findings, as they contribute to the descriptive nature of qualitative research (Merriam & Tisdell, 2016). Data included participants' verbatim quotes from the transcripts of the interviews and not just notes on what the researcher felt was significant to the study (Maxwell, 2013).

Notes that were taken by the researcher during the interview were also jotted in the printout. This process of analytic memo writing aided the researcher in capturing nuances of participants' shared stories and the researcher's reactions and reflections on the discussions. Manual coding continued as new codes emerged from the responses to interview questions. Third, the researcher uploaded Microsoft Word files to the computer-assisted qualitative data analysis software (CAQDAS), NVivo software. This CAQDAS program aided in managing the data and was a significant help in working across multiple interview transcripts to establish using pattern coding to come up with themes. The deductive coding was accomplished manually using paper and pencil. Therefore, the researcher utilized manual and software programs to facilitate coding.

**Within-Case and Cross-Case Analysis**

For this study, the researcher referred to Creswell (2013), focusing first on each transcript considered within-case analysis to capture a detailed description of the

participant's narrative and themes within the transcript. In agreement with Yin (2009), the researcher identified issues within each transcript and looked for common themes that transcended the interviews. Thus, the analysis was rich in the context of each interview in which the participants shared their experiences.

Thus, data analysis was conducted for each participant interview. The process was followed by a thematic analysis defined as a cross-case analysis to determine codes and themes across all interviews that were both common and uncommon among the participants, along with a priori and emerging meanings. Additionally, as part of the cross-case analysis, the researcher considered the participants' assertions and made meaning of the data captured in the interviews as suggested (Creswell, 2013, p. 101).

**First-Cycle Coding**

The researcher had previously established inductive codes to begin the first cycle coding process. The a priori inductive codes were derived from the study's theoretical framework. The first-Cycle coding process was conducted to read each participant's transcript multiple times. Then, the researcher manually highlighted the printed text with a pencil to keep track of specific word choices or phrases. In Vivo, descriptive codes that emerged as the participant shared their experiences of cultural competence training, learning, and utilization of skills were highlighted and placed in quote marks. The method of In Vivo coding provided the researcher with an avenue to capture data in paragraphs rather than single lines. The researcher found this method a way to make meaning of the participants' voices, perspectives, and worldviews about cultural competence learning, practice, and encounters with patients as suggested (Seidman, 2013, p. 4).

### Second-Cycle Coding

Second-cycle coding processes were conducted, wherein codes were combined, renamed, or eliminated (Saldaña, 2013). The focus was "coding for patterns," as posed by Saldaña (2013, p. 5). This stage used the NVivo computer-assisted qualitative data analysis software to organize data collection and coding.

Themes were developed from the codes. Saldaña (2013) argued that there is no "theme coding"; a theme is an outcome of coding, categorization, or analytic reflection (p. 14). Conclusions were drawn from the categories and themes to answer the research questions.

## Trustworthiness

Lincoln and Guba (1985) stated that considering the trustworthiness of a research study is essential when evaluating its worth. They indicated that trustworthiness involves establishing the following four factors to empower the credibility of the study:

- Credibility: Confidence in the "truth" of the findings
- Transferability: Showing that the findings have applicability in other contexts
- Dependability: Showing that the findings are consistent and could be repeated
- Confirmability: A degree of neutrality or the extent to which the study's findings are shaped by the respondents and not researcher bias, motivation, or interest (Lincoln & Guba, 1985)

## Credibility

The responses to study questions were reviewed and analyzed for categories and themes relevant to the study. In the process, findings emerged. The researcher relied on the participants' responses to understand whether they were truthful about the study. Additionally, Merriam and Tisdell (2016) noted that objectivity and truthfulness are critical to qualitative research traditions (p. 206). Lincoln and Guba (1985) said that first and foremost, the researcher seeks believability (p. 206). This approach, "writ large in most qualitative studies, involves taking data, analyses, interpretations, and conclusions back to the participants so that they can judge the accuracy and credibility of the account" (Merriam & Tisdell, 2016, p. 252).

To this end, the researcher strived to ensure data collection and analysis findings represented the participants' interpretations by employing *member checking* for accuracy. For example, each study participant received a copy of their transcribed interview by email for review to ensure the accuracy of the data (Merriam & Tisdell, 2016, p. 246). In addition, as Seidman (2013) explained, "Once the interviewer writes a report on the interviews, he or she may share the report with participants" (p. 100).

As a form of *inter-coder reliability*, the researcher employed an independent coder to review and analyze data capture and codes and quotes for reliability and agreement with the researcher's decisions.

## Transferability

Transferability was addressed in this study by offering a *rich, thick description*. That will allow readers to make decisions on the transferability of the findings (Merriam & Tisdell, 2016, p. 252).

Findings may ultimately be helpful to a variety of groups. This study may benefit residents, attending physicians, hospitals, healthcare systems, and administrators. Attending physicians working with residents may gain insight into the importance of experiential learning of cultural competence and using skills in practice. This study may influence attending physicians who are mentors/preceptors in assessing residents' work with patients and draw attention to their efforts as role models. In addition, hospital faculty and healthcare administrators can envision how incorporating cultural competence as an initiative may foster better health promotion initiatives and workforce development (McCalman et al., 2017). Findings showed that residents work, learn, and utilize cultural skills during a pandemic. This learning provided a benchmark and guidelines to use in terms of preparedness for future uncertain events.

Based on the study findings documenting physician experiences, healthcare administrators may want to consider new guidelines and standards to enhance cultural competence. Prescott-Clements et al. (2012) argued that health professionals' cultural competence affects the satisfaction with and positive outcomes of patient care—major metrics that healthcare administrators focus on. According to Sutton (2000), "racial, ethnic, and cultural disparities exist in all aspects of society, but nowhere are they more clearly documented than in healthcare" (p. 1).

The study findings showed how resident physicians may or may not learn cultural competence experientially in clinical practice. This understanding gained through their individual stories highlights the need to add, modify, or change cultural competence curricula to foster new knowledge transfer for residents to learn cultural competence continuously. In addition, literature has revealed that culturally competent physicians will

be vital in treating diverse populations as they encounter illnesses and ailments suffered disproportionately by racial and ethnic minority patients (Sutton, 2000).

In other situations, business and government organizations and workplaces outside of healthcare may also find aspects of the study's finding applicable. For example, in a study conducted by Sears et al. (2021) appraising the cultural competence of athletic training students studying abroad, results revealed that students found the training helpful in their cultural skills for use in other countries with different cultures. In essence, the rich, thick description will allow readers to make decisions on the transferability of the findings (Merriam & Tisdell, 2016, p. 252).

**Dependability**

The study findings depended on the researcher conducting the study based on a *validated interview protocol* and *empirically peer-reviewed theory concepts.*

**Confirmability and Subjectivity Statement**

The researcher addressed neutrality by using journaling throughout the research process to mitigate bias and by providing a *subjectivity statement* so that readers have the background information to assess potential bias. The subjectivity statement appears below.

The researcher may have had certain biases in interpreting findings based on her former employment at a clinical site. For example, the researcher spent 16 years as a healthcare applications trainer, working with former physicians and other healthcare faculty, staff, and management. As a result, she is keenly aware of current medical policies, procedures, computer technology, and medical terminology. The researcher has

also received healthcare services as a patient. Journaling captured personal assumptions and feelings regarding the interviews to help note the researcher's subjective thoughts on the participants' responses.

As this research study involved investigating how physicians describe their experiences of learning and practicing cultural competence when serving ethnically and racially diverse patients, it was important that the researcher acknowledge and address her subjectivity related to being an African American woman. In addition, since she worked for healthcare facilities located in Wards 7 and 8 in Washington, DC, comprising ethnically and racially diverse patients, the researcher has limited knowledge of the training and practice (or not) of cultural competence skills by resident and attending physicians in these urban areas with diverse patient populations.

The researcher has been an attendee and a trainer for resident physicians and has not experienced cultural competence during training. Although the researcher believes cultural competence training and skill sets are essential to healthcare outcomes based on empirical research and personal experience, she stepped back and held this preconceived belief from the research interviews; participants were not made aware of her beliefs or cultural competence experiences when participating in the study to avoid the skewing of their responses. The researcher was interested in the individual stories of the participants from their point of view only.

## Ethical Considerations and Protection of Participants

The research was submitted to the George Washington University Institutional Review Board for approval before data collection begins. Requirements of the Office of Human Research Requirements were followed before, during, and after the interview

process. It was stressed that participation in the study was voluntary; physicians could choose whether or not to participate and could stop participation at any time. The researcher provided participants with an informed consent form that clearly described the research's purpose, the expectations of participants, and privacy rights. Participants could refuse to answer any questions during the interview. Once the audio recording started, the researcher asked for the participant's verbal consent to proceed with the interview. There was no need for a signature on a consent document as a way to keep participants' identities further concealed. However, if the participant preferred to sign instead of verbally acknowledge consent, the form was available, and the participant would keep a signed copy. Participants' willingness to participate in the research study was implied if they proceeded with the interview.

Upon the initial contact with the participants, they were allowed to use their personal email for correspondence. Participants were asked to choose a preferred pseudonym for anonymity used for the study duration. All efforts were made to protect participants' confidentiality.

For participant security, a numbered computer file was created to allow the researcher to match and trace data to individual participants. Audiotapes were labeled to allow a match of the audio recording to the participant. All data, audio recordings, and transcripts in Microsoft Word files were stored separately to ensure security. Data and audiotapes were password protected and securely stored in a locked location. The researcher deleted any identifiable participant information to protect the participant's personal information.

The researcher followed all HIPAA privacy rules, which protect individuals' medical records and other personal health information. The rules require appropriate safeguards to protect personal health information privacy and set limits and conditions on the uses and disclosures of such information without patient authorization. The researcher reminded resident physicians and attending physicians of HIPAA regulations before the interview (U.S. Department of Health and Human Services, 2017). Upon completion of the study, all data collected will be securely destroyed to protect participants' anonymity.

## Summary of Methodology

This chapter detailed the research design components and how the research questions were answered. The researcher's epistemological and ontological orientation supported the methodological approach of this study, which is a basic qualitative research design. From the diverse urban research site of the residency program centered at a mid-Atlantic hospital, 5 to 8 physicians who met the study criteria were purposively selected and invited to participate. Data were collected through semi-structured interviews following an interview protocol to answer the two research questions. Interview data were transcribed and coded using a priori, descriptive, and in vivo codes. Themes were developed from the codes. Various measures were to ensure the study's trustworthiness, including member checking, thick, rich descriptions, the use of a validated interview protocol, journaling, and a subjectivity statement and review by an Inter-Coder for reliability. Informed consent was obtained from study participants, and their confidentiality was protected.

# CHAPTER 4:

# FINDINGS

This qualitative study explored physicians' experiences learning cultural competence skills through training. It further explored how their learning and utilization of cultural competence impacted their clinical practices with diverse patients. Two research questions guided this study: (1) *How do physicians describe their experiences of learning and practicing cultural competence when serving ethnically and racially diverse patients? (2) How do physicians make meaning of these experiences to inform their clinical practice*?

This chapter begins with a description of the study's participants, including their demographic and organizational characteristics and profiles situated in the context of this study. The second section provides a detailed discussion of the five themes that emerged: Family Background and Cultural Experiences; Cultural Competence Training and Experiential Learning; Lack of Diversity in Healthcare; the Destruction of COVID-19 and Its Effects on Physicians' Work; and Clinical Practice Time Pressure. The chapter closes with a summary.

## Study Participants

### Participant Demographics

The study involved interviews with eight physicians who work in urban settings and encounter ethnically and racially diverse patients in Mid-Atlantic hospitals and outpatient clinical practices. Seven physicians were attending physicians, and one was a

second-year resident physician. Table 4.1 shows each participant's demographic characteristics.

**Table 4.1**

*Participant Demographic Characteristics*

| Participant | Pseudonym | Gender | Ethnicity | Years in practice | Attending or resident | Specialty |
|---|---|---|---|---|---|---|
| 1 | Ernest | Male | White | 7 | Attending | Pediatrics |
| 2 | Lotus | Female | Persian | 10 | Attending | Pediatrics |
| 3 | Mary | Female | White | 27 | Attending | General practitioner |
| 4 | Ann | Female | White | 18 | Attending | Obstetrics |
| 5 | Henry | Male | White | 2 | Resident | Rotating |
| 6 | Leslie | Female | African American | 20 | Attending | General practitioner/ practice owner |
| 7 | Gail | Female | African American | 12 | Attending | Emergency medicine |
| 8 | Marvin | Male | White | 8 | Attending | Pain management |

Participants were recruited in 2020, during the highest level of COVID-19 (World Health Organization, 2020). This presented challenges, since physicians were delivering clinical services under extreme clinical practice conditions and were overworked.

## Participant Profiles

**Ann** identifies as a White woman. She is from a metropolitan city and has been in clinical practice for 18 years as an obstetrician. She shared that she knew at age 8 that she would be a physician. Ann attended medical school in a large metropolitan city where many patients were from the Dominican Republic. Her experience living in the city influenced her choice of medical school. Ann stated that she deliberately chose to provide services to a diverse population; she felt it would allow exposure to many different groups and people of different ethnicities. Ann also shared that she received no formal

cultural competence training in medical school. Additionally, she mentioned that all of her cultural competence learning was from peers and mentors in clinical practice; thus, learning occurred experientially.

**Ernest** identifies as a White man. He is from a large Mid-Atlantic metropolitan city. Ernest has been in clinical practice for 7 years as an attending physician in pediatrics. He discussed being raised in a diverse city by an upper-middle-class family. He taught in public schools for a while, searching for his calling. After a life-crisis trip to Morocco, he applied to pre-med classes and chose a medical school in a large metropolitan city. He remarked that during his 7 years as a clinician, he strategically worked to devote his practice of medicine to ethnically and racially diverse patients. Ernest worked in a Mid-Atlantic hospital in an outpatient clinical setting dedicated to caring for children and adolescents. Since becoming a physician, he has worked with Doctors Without Borders in Malaysia and the Congo/Central Africa. Additionally, Ernest conveyed that he had participated in formal cultural competence training and had learned from his peers. He discussed teaching cultural competence to residents when time permits. Ernest is a member of the Diversity and Inclusion Committee at work. During his interview, he repeatedly referred to the U.S. medical system as a hierarchical apartheid system.

**Gail** identifies as an African American woman. She is a general practitioner physician. She was raised in a predominantly Black neighborhood in a Mid-Atlantic metropolitan area. Early in her career, she worked for a government agency and later at a physician's office, where she became interested in medicine. Gail shared that she was previously a member of an offshoot of the Black Panther organization and received the

advice that Black people didn't need social workers; they required more doctors and lawyers. As a result, Gail decided to attend medical school at age 30. She practiced for a Mid-Atlantic hospital emergency department. Gail has attained a high position in the medical field, in charge of other physicians and a medical department. In this position, she serves as a mentor and educator. Gail shared that she did not have formal cultural competence training and discussed her aversion to the term *cultural competence*. During her interview, Gail conveyed that she did not believe it is a relevant term and frankly stated, "We are not competent in our cultures." She preferred the term *human competence*.

**Henry** identifies as a White man from a rural town upstate in the Mid-Atlantic region. Henry attended college in a rural town where the population was very homogenous and not diverse. Consequently, Henry enrolled in a Mid-Atlantic medical school, hoping he would have ethnically and racially diverse peers. However, he said it was rather homogeneous, mostly White and Asian medical students. Henry is a second-year resident physician who works in a Mid-Atlantic hospital, currently completing required rotations in various departments, such as orthopedics, internal medicine, and hematology. He will attain the status of fellow and then attending physician upon completion. In addition, Henry shared that he has completed formal cultural competence training and exams required for the degree of a medical physician. He admitted that he sometimes feels uncomfortable trying to gracefully deliver care to diverse patients who are different from him. However, he is working to build rapport with patients.

**Leslie** identifies as an African American woman from a Mid-Atlantic city. She shared that at an early age, her parents encouraged her to help people. She recalled

assisting her mother, a teacher, and transferring the skills she learned to her clinical practice. She decided to become a physician at age 8. Leslie has now been in clinical practice for 20 years. She is a general practitioner and owns a Mid-Atlantic private pediatric medical practice in an urban setting. Leslie attended medical school in a metropolitan city and has had cultural competence training. During her interview, she expressed how formal cultural competence simulations helped inform her practice with diverse patients.

**Lotus** identifies as a Hispanic woman from a large Southern state in the United States. Lotus attended medical school in Texas. She is a pediatrician and practices at a Mid-Atlantic hospital. She serves a diverse population of Latino patients and others migrating to the United States. Lotus shared that she spent a year in Sub-Saharan Africa as a resident physician. During her interview, she conveyed that she attended formal cultural competence training in medical school. Lotus is interested in learning cultural competence from diverse patients and peers. She expressed that being culturally competent helps her tailor healthcare delivery to patients individually to foster physician/patient relationships and compliance with treatment.

**Marvin** identifies as a White man and is from a Mid-Atlantic city. Marvin shared that one of his parents is a doctor and he initially pushed back against a career in medicine. He mentioned that he did not declare a major during his freshman year at a Mid-Atlantic university. He also shared that most of his college friends wanted to be doctors, so he followed them, subsequently attending medical school on his classmates' advice. Marvin is an attending physician general practitioner with 8 years of experience in the specialized field of medical pain management. Marvin is the lead doctor in his

practice; additionally, Marvin trains board-certified attending physicians to bring them to the next level of expertise in pain management. During his interview, Marvin shared that he has had formal cultural competence training and is aware of cultural training online and the requirements of passing the competency exam.

**Mary** identifies as a White woman and is from a metropolitan city. Mary shared that her family members are nuclear engineers and teachers and that combining science and education inspired her to become a physician. Mary is a seasoned practitioner with 27 years of experience in pediatrics. Her patients are from diverse backgrounds. She works in a large Mid-Atlantic facility dedicated to children and adolescents. Mary shared that she doesn't remember completing specific cultural competence training. However, she did discuss how her medical school took a holistic approach to delivering healthcare to patients. Mary has attended seminars on cultural competence and trains residents and fellows. She remarked, "It is essential to have formal cultural competence embedded in training new physicians."

## Themes

A priori coding of the interview data was undergirded by two theories that served as the study's theoretical framework: Campinha-Bacote's (1998) model of cultural competence and Kolb's (2014) experiential learning theory. The first theoretical base was Campinha-Bacote's (1998) model of cultural competence, which views cultural competence as an ongoing process where healthcare providers strive to gain the ability to effectively work within the cultural context of the client (individual, family, community). This model has five stages: cultural awareness, cultural knowledge, cultural skill, cultural

encounters, and cultural desire. According to Campinha-Bacote (1998), cultural competence is an ongoing process of integrating the five stages.

The second theory was Kolb's (2014) experiential learning theory, which posits a dynamic cyclical view of learning driven by the resolution of the dual dialectics of action/reflection and experience/abstraction. According to Kolb (1984), learning is "the process whereby knowledge is created through the transformation of experience. Knowledge results from the combination of grasping and transforming experience" (p. 41). From this perspective, grasping experience refers to the process of taking in information, and transforming experience is how individuals interpret and act on that information. This process is portrayed as an idealized learning cycle or spiral where the learner "touches all the bases"—experiencing, reflecting, thinking, and acting—in a recursive process that is sensitive to the learning situation and what is being learned. This theoretical base also emphasizes that immediate or concrete experiences are the basis for observations and reflections. These reflections are assimilated and distilled into abstract concepts from which the learner can draw new implications for action. These implications can be actively tested and serve as guides in creating new experiences.

Based on the coding, five themes were developed, as shown in Table 4.2. The first theme had two subthemes; the second theme had six subthemes; the third theme had one subtheme; the fourth theme had two subthemes; and the fifth theme had two subthemes.

**Table 4.2**

*Themes*

| | Theme | Subthemes |
|---|---|---|
| 1 | Family Background and Cultural Experiences | 1.a. Family Background and Cultural Self-Awareness<br>1.b. Non-Western Cultural Experiences |
| 2 | Cultural Competence Training and Experiential Learning | 2.a. Formal Cultural Competence Training in Medical School<br>2.b. Cultural Competence Training with Simulation Versus Actual Patients<br>2.c. Cultural Competence Experiential Learning On the Job<br>2.d. Becoming Culturally Competent Lifelong Learning Process<br>2.e. Terminology of Cultural Competence<br>2.f. Meaning Making of Cultural Competence to Inform Clinical Practice |
| 3 | Lack of Diversity in Healthcare | 3.a. Underrepresentation of Minority Physicians |
| 4 | The Destruction of the COVID-19 Pandemic and Its Effects on Physicians' Work | 4.a. COVID-19 Vaccine Hesitancy and Unavailability<br>4.b. COVID-19 Physician Community Outreach |
| 5 | Clinical Practice Time Pressure | 5.a. Cultural Competence as a Luxury<br>5.b. Competing Clinical Priorities |

## Theme 1: Family Background and Cultural Experiences

The first theme, family background and cultural experiences, illuminates what influenced the physicians' self-awareness of diverse cultures and choice to practice medicine in Mid-Atlantic urban settings, delivering healthcare services to primarily ethnically and racially diverse patients. Additionally, it considers physicians' opportunities to gain cultural competence knowledge working with patients in non-Western countries. "Within the context of Campinha-Bacote's (2002) model of cultural competence, such experiences can be framed as cultural encounters." Campina-Bacote defines cultural encounters as "the process which encourages the healthcare professional

to directly engage in face-to-face cultural interactions and other types of encounters with clients from culturally diverse backgrounds to modify existing beliefs about a cultural group and to prevent possible stereotyping" (p. 182). Being immersed in non-Western cultures exemplifies how learning in a different country strengthens and reinforces cultural competence.

In some cases, physicians discussed their choice of medical school locations as predicated on having access to ethnically and racially diverse patients. Additionally, working outside the United States delivering care to marginalized diverse patients can help physicians gain knowledge on non-Western cultures and can be an impetus to working in the United States with patients from diverse cultures. Subsequently, the learning can be applied and transferred to patients of similar backgrounds in the United States. According to Kolb (2015), this learning transfer is a result of the experiential learning phases of concrete experience, reflective observation, abstract conceptualization, and active experimentation, where mapping of new knowledge can occur with similar patients.

### *1.a. Family Background and Cultural Self-Awareness*

Physicians shared how they became aware of diverse cultures different from their own. In some cases, cultural awareness stemmed from physicians' families and communities. Other physicians expressed learning cultural competence in medical school and later in clinical practice. Physicians were candid in discussing their knowledge of cultural competence and self-awareness.

Leslie shared her early experiences with family and exposure to different cultures and religions, leading to enhanced cultural competence self-awareness:

> My mom and dad, and being a minority myself, there was definitely an emphasis on understanding different people and different cultures, We didn't just do things with African American people. You know, Rabbi, so actually ceremonies, Caucasian people we went to temples, different churches, different religions … appreciation for different cultures, accepting and treating people as they are.

In contrast, Gail expressed her limited knowledge of cultural self-awareness due to her upbringing in a homogenous setting and attending a predominantly Black medical school:

> I grew up in the Southeast when I went to the Mid-Atlantic. I said: Where did all these White people come from? I don't know where I am right now. I went to medical school; at Mid-Atlantic was my first encounter with White people. Doing my internship at Mid-Atlantic I was the only Black intern in the whole hospital.

Ann described her self-awareness of cultural competence as coming from a marginalized population not inclusive of ethnically and racially diverse people: "I think my cultural competence was probably very low. I didn't go to school with English language learners or rural students. I think it [diversity] was pretty low on all fronts."

In summary, physicians with diverse family backgrounds and encounters with diverse communities were found to be more self-aware of diverse cultures than those from homogonous settings.

### *1.b. Non-Western Cultural Experiences*

Two physicians, Ernest and Lotus, discussed how they gained opportunities to acquire specific cultural skills by working abroad, where cultural skill sets were tailored to a specific culture's expectations and needs, for example, African, Latin, and Native traditional norms.

Ernest and Lotus shared how their patient encounters and how non-Western cultures played a role in their decisions on the delivery of healthcare to ethnically and

racially diverse patients. Ernest discussed delivering care to patients from non-Western cultures and tailoring care to adhere to their cultural traditions. Ernest explained how what he learned from providing care outside the United States manifested in his clinical encounters. For example, Ernest described

> working for a health center with a Native American patient who found it impolite for a physician to look him in the eye due to cultural traditions. I made eye contact occasionally. Also, I learned when working in Malawi that you give people things with your right hand. And so now whenever I work with African families I use the same gesture.

Similarly, Lotus shared her experience working with patients who hold non-Western cultural traditions. Her work serving patients in Africa gave her a perspective of specific patients' expectations from a provider.

> During my residency, I did get the opportunity to spend a year abroad. I did work in Sub-Saharan Africa and a country there for a year. It was the way I saw was 100% a different culture, how I talked was different, my approach was even different—you have to give things with your right hand. That experience was life changing. It made me recognize what does the patient want, what does the patient want to like, what do they want help with.

Lotus also commented on paternalism within this context:

> That experience [working abroad] was, is really life changing for me because it made me recognize the whole idea that we [physicians] can't be paternalistic in medicine, but we have to be: Ok, what does that patient want? What do they want help? It's a powerful lesson I have learned.

Lotus also had an experience near the Mexican border and discussed the learning opportunities that often arose:

> When I went into my clinical years I actually was in a different part of Texas close to the border [Mexico] where you're almost working in a different culture. It was really interesting for me seeing patients in that setting…. How a patient … interfaces with their culture is so different that there's always going to be some new thing you're going to learn every time…. It's as every opportunity is a

> learning opportunity. I had a patient the other day. And it was so interesting, because they were from an African country.

Lotus discussed how the mother's tickling of the boy was initiated with the belief it would bring the boy money, a belief held in some African cultures.

Ann chose a medical school that allowed her to interact with patients from diverse backgrounds. She shared that having experience providing care to diverse communities benefited her career, as she knew working in a Mid-Atlantic location would mean interacting with a diverse patient population. Ann stated:

> The medical school that I attended has a large population of patients from the Dominican Republic. And so, I was drawn to, you know, being at a school that serves a diverse community. And so that was a large reason why I chose it and just being in Mid-Atlantic [city] knowing that you'd have exposure to a number of different groups and populations was really attractive to me.

Like Ann, Gail chose to attend a medical school and work in an urban Mid-Atlantic hospital that provides healthcare to ethnically and racially diverse patients. As shared in her interview, Gail's previous position and experience as a member of an offshoot of the Black Panther organization informed her desire to deliver care to diverse populations. Gail stated, "They've [Black Panther offshoot] kept saying: We don't need social workers; we need doctors and lawyers." For Gail, this organizational messaging profoundly impacted her medical career.

Unlike Ernest, Locust, Gail, and Ann, Henry did not have similar opportunities or immersive experiences to engage with ethnically and racially diverse patients. In many regards, Henry's medical school experience was quite the opposite of Lotus's and Ann's. During Henry's interview, he discussed his limited understanding of the diverse patient

cultures and his opinion on physicians' attempts to deliver care to patients from various backgrounds. Henry expressed,

> In medical school I don't have a whole lot of experience with backgrounds different from mine. So, it's actually been quite uncomfortable in terms of being able to relate in a graceful way when placed in them [situations with racially and ethnically diverse patients]. I think the patients are aware of this. Many of us are trying to deliver care who are also not likely at that background and trying to build rapport and relationships with those patients.

In summary, this theme exemplified how study physicians were influenced to attend medical schools with access to diverse patients. This theme detailed how, in some cases, physicians' experiences working in immersive settings with ethnically and racially diverse patients influenced the choice to deliver care in clinical settings where diverse patients receive healthcare services.

**Theme 2: Cultural Competence Training and Experiential Learning**

The second theme, cultural competence training and experiential learning experiences, was an *a priori* code derived partly from Kolb's experiential learning theory. Kolb's theory posits that individuals learn informally through concrete experiences (encounters) with others and use gained knowledge with new encounters. This theme revealed that although some physicians were trained on cultural competence formally in medical school, others learned it after medical school experientially in clinical practice from ethnically and racially diverse patients and peers. Additionally, Campinha-Bacote's cultural competence model details that healthcare professionals need process (cultural humility) and product (cultural competence) for meaningful encounters with culturally diverse patients. Within this theme, five subthemes emerged.

It became apparent from physicians that, in some instances, formal cultural competence learning occurs through courses and curriculums mandated in medical schools as a requirement to attain the medical degree, and once completed it is not always reinforced in clinical practice. More experienced attending physicians who work as mentors, supervisors, and preceptors for residents and fellow physicians may not have had cultural competence as part of their medical school training curriculum. These older physicians obtained their degree before cultural competence was mandated for U.S. medical schools in the 1980s. As a result, more senior, more experienced attending physician preceptors who supervise residents and fellows may not have the cultural competence training or direct attention to the attributes of patients' culture as part of their training efforts. Study physicians Mary, Ernest, and Lotus discussed the issue of older attending physicians who supervise resident physicians and the need to incorporate cultural competence education. Mary shared,

> It's [cultural competence] absolutely essential. I think it's important to have sort of formal dedicated cultural competence training. That is, we do structure clinical observation; it is how we approach it here at the hospital. It's essential to have some formal training.

Ernest discussed how older physicians should be aware they are supervising new residents who have attended formal cultural competence training while being cognizant of their own medical education, stating, "You need to be careful about your audience, a med student. I encounter today, tomorrow, yesterday probably smarter than I am, equally smart."

Lotus discussed physicians who have not had formal cultural competence training, commenting on the way they approach the supervision of cultural competence when in supervisory roles for residents and medical students. Lotus stated,

> As you're going around, some of it's going to happen as you see it modeled [cultural competence]. As so it's seeing how your president [medical] does it when you are a medical student, or how your attending physician [supervisor] does it. And I think that makes a difference.

### *2.a. Formal Cultural Competence Training in Medical School*

The second subtheme related to formal cultural competence training in medical school. This theme revealed inconsistencies in the formalization of cultural competency educational requirements. Most physicians participating in this study expressed that they did not have formal cultural competence training in medical school. In many cases, the physicians could not recall the concept of cultural competence being taught formally in medical school. However, three physicians in this study Lotus, Henry, and Leslie shared that they participated in formal cultural competence training, and one physician Marvin was unsure whether or not they had participated. It is important to note that all of the study physicians attended medical school in the United States, but the medical school dates of attendance and names are unknown by the researcher.

Within the United States, medical education programs leading to the MD degree are accredited by the Liaison Committee on Medical Education (LCME). The LCME's scope is limited to complete and independent medical education programs whose students are geographically located in the United States for their education and that are operated by universities or medical schools chartered in the United States. LCME's (2023) accreditation requires medical programs to demonstrate that their "graduates exhibit general professional competencies appropriate for entry to the next stage of their training and that serve as the foundation for lifelong learning and proficient medical care" (p. 1). In 2000, the LCME added educational standards for cultural competency (LCME, 2023). According to LCME (2023), the standard for cultural competence requires demonstrating

> an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. Medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery while considering first the health of the patient. (p. 11)

The purpose of this standard was to give added impetus and emphasis to medical schools to introduce education in cultural competence into the undergraduate medical curriculum (or, in some cases, specifically identify it). As noted by Goyal et al. (2020), cultural competence is a difficult skill to teach, as it has several operational definitions as well as limited and unstandardized training procedures. "Currently, there is no formal cultural competency training at the undergraduate level for students who seek to become a medical doctor" (p.1). According to Programmatic vs. Institutional Accreditation (2024), the LCME is recognized by the U.S. Department of Education as an accrediting agency for medical education programs leading to the MD degree. The LCME references "schools" instead of "medical education programs leading to the MD degree." Though references by the LCME to "schools" are synonymous with "medical education programs," the distinction between programmatic accreditation vs. institutional accreditation is an important one. Institutional accreditation is granted by regional accrediting agencies and is required to qualify for federal financial assistance programs authorized under Title IV of the Higher Education Act. Programmatic accreditation for medical education programs leading to the MD degree is granted by the LCME. Because the LCME is not recognized as an institutional accrediting agency, it lacks standing to accredit stand-alone medical schools as institutions of higher education. Thus, medical education programs leading to the MD degree must first hold institutional accreditation to be eligible for initial full accreditation and for continuing accreditation by the LCME.

The difference between formal or informal training in medical school appears to be vastly different than learning experimentally in clinical practice. Kolb (2015) detailed observation and concrete experimentation concepts to substantiate how working in real-life situations reinforces what one knows when transferring skills into new encounters. The importance of experiential learning as a focus of how physicians acquire cultural skills from peers became apparent when asked about formal education in clinical practice. All physicians informed the researcher that there is no standard curriculum for cultural competence training when serving patients in clinical practice. Physicians discussed their opinions on extended cultural competence learning opportunities after medical school on the job in clinical practice.

In this study, only three of the eight physicians—Henry, Leslie, and Lotus—participated in formal cultural competence training. The two had different opinions on their formal cultural competence training. Henry, a resident physician, believed the training was not sufficient:

> I have [formal cultural competence training]. I've done so as part of my curriculum in medical school. I think it's [formal cultural competence training] a nascent sort of endeavor and one that could probably stand to be improved. I think my experience [formal cultural competence] was rather weak.

Leslie went into great detail discussing her formalized medical school cultural competence training. She spoke of how training was provided to enhance her ability to work with diverse patients and to address them individually according to their religious and ethnic backgrounds:

> We [medical school students] had cultural competence training; they even had patient scenarios. We had actors and actresses who would pose as patients and you had to figure out what was going on. They had people with different

> religions. You wouldn't be told that they were different ethnicities. You were taught to even differentiate sexualities.

Lotus had difficulty remembering formal cultural competence training. Lotus detailed her experience learning about other cultures, participating in groups, and discussing various patient clinical cases:

> I think we had it [formal cultural competence training]; I can't remember. So, in medical school we did [cultural competence training] in small groups, really talking through cases, and that's kind of how I was taught cultural competence.

Mary, Marvin, Ann, Gail, Ernest and shared that they did not receive formal cultural competence training in medical school. In a few cases, these physicians shared they had never been exposed to the term *cultural competence* while in medical school. Three participating physicians shared that they couldn't recall participating in formal cultural competence training. Instead, they shared that they experienced a variety of learning experiences that may have touched on the concept of cultural competence. Study physicians who had cultural competence training as part of their training had various opinions on how cultural competence was presented and expressed their experience learning cultural competence.

The variety of learning experiences included seminars on patient care and small group interactions. For example, Mary noted the various formats she participated in during her medical school education. Although no formal cultural competence training was dedicated to cultural competence, Mary explained how the topic was covered in medical school:

> From medical school, I don't think we had anything formal [cultural competence training]. We definitely had some sort of seminars engaging with patients, regarding the patient/physician relationship, and my recollection was that there were some cultural competence things mixed in with that.

From Marvin's perspective, formal cultural competence training was not a part of his medical school education. Marvin had a hard time recalling if sessions were explicitly offered on cultural competence. He stated,

> If it [cultural competence training] was, I can't recall, or perhaps I didn't attend those sessions; I just don't remember. This [cultural competence training] wasn't a significant part of the education.

Ann shared, "We certainly had classes on, you know, talking with patients in mock encounters, but I don't recall anything that addressed it [cultural competence]."

Gail responded to her medical school training, "Not in my training. It [cultural competence] wasn't trendy or popular."

Ernest talked about his education in medical school and the lack of formal cultural competence training, stating,

> No, nothing like that [formal cultural competence training]. I just think it was the late Bush administration. I think it was just a function of the time [cultural competence training].

Additionally, some physicians expressed that they learned cultural competence informally outside the medical school environment from family backgrounds and exposure to other cultures in various countries outside the United States with homogenous patient populations. Consequently, physicians who did not have formal cultural competence training in medical school indicated that they learned from family, ethnically and racially diverse patients, and peers experientially.

### *2.b. Cultural Competence Training with Simulation Versus Actual Patients*

Physicians shared the experience of practicing patient encounters in medical school with peers instead of actual patients. Although training had a concentration and focus on the patient clinical encounter interview process, newer classes have begun to

address the trending aspects of bias and racism and cultural competence (Brottman et al., 2019).

According to Neff et al. (2020), research on disparities in health and healthcare has demonstrated that social, economic, and political factors are key drivers of poor health outcomes. However, Neff et al. (2020) posited that "the role of such structural forces on health and healthcare has been incorporated unevenly into medical training" (p. 1). The implementation of a brief structural competency curriculum was designed to fill this gap and address key structural factors of healthcare disparities. In agreement, Castillo et al. (2020) noted, "Health inequities stem from systematic, pervasive social and structural forces" (p. 1817). Consequently, these forces marginalize populations and create the circumstances that disadvantage patients, as reflected in differences in outcomes like life expectancy and infant mortality and in inequitable access to and delivery of healthcare resources (Castillo-Page et al., n.d.).

In consultation with medical and interprofessional education experts, Neff et al. (2020) developed open-ended, written-response surveys to qualitatively evaluate this curriculum's impact on participants. This curriculum, adapted by Neff et al. (2016) after a pilot phase, represents a novel attempt to develop and disseminate a curriculum using a structural competency framework for medical students, residents, and other health professional trainees. This curriculum offers several modules consistent with the recommendations from the ACGME Clinical Learning Environment Review (CLER) Health Care Quality Pathway 5. Weiss et al. (2014) noted that "residents, fellow and faculty member education is important on reducing health care disparities" (p. 6).

As posited by Capers et al. (2020), "As a subset of a society that struggles with racism and other explicit biases, it is inescapable that some physicians and health-care employees will have the same explicit biases as the general population." The authors noted that patients who receive care at academic medical centers (hospitals connected with medical schools) interact with multiple individuals, some of whom may have explicit and implicit biases that influence patient care. Further, reports have documented that some physicians, healthcare workers, and health professional students have negative biases based on race, ethnicity, obesity, religion, and sexual identity, among others. These biases can influence decision-making and aggravate healthcare disparities and patient-physician mistrust. In a study conducted by Capers et al. (2020), four actual cases from academic medical centers illustrated how well-intended physicians and healthcare workers can be influenced by bias and how this can put patients at risk; the authors suggested strategies to mitigate bias and recommended a teaching tool: periodic "bias and racism rounds" in teaching hospitals, in which real patient interactions are reviewed critically to identify opportunities to reduce bias and racism and to attenuate the impact of bias and racism on patient outcomes. Additionally, Kanter et al. (2020) related that racial bias in medical care is a significant public health issue. Their study revealed that interventions to decrease microaggressions, stereotyping, and bias are being empirically evaluated. Kanter et al. (2020) suggested that to improve the quality of patient-provider interactions, innovations in physician training interventions are needed to decrease microaggressions and improve communication and rapport with patients of color during medical encounters. The emergence of bias and racism training and efforts to mitigate

these factors remains a subject for further research, as they may hamper attention to cultural competence due to stereotyping diverse marginalized patients.

During the participant interviews physicians discussed the differences between simulations with peers and actual patients. The importance of small training groups became apparent to the researcher as the "takeaway" of the process yielded how training impacts their clinical work and how it influences different learning stages dependent on how more culturally aware peers can share with less knowledgeable peers. According to Coakley et al. (2019), the transition to clinical practice is challenging and complex. Simulations before actual practice may be a foundational way to alleviate cultural issues and allow better communication between patient and physician, especially for resident physicians new to clinical practice and at the beginning stages of working with patients.

Ernest discussed the difference he experienced working with actual patients and the importance of bridging the gaps between encounters with peers versus patients. He explained that there was not necessarily a way to practice encounters in simulations, which is in tandem with actual diverse patients. Ernest described it as advancing resident physicians' cultural competence skills. Ernest believed mentoring and exposing cultural skills to residents early in their clinical rotations can add to their skill sets. Early cultural competence skill utilization may be effective as residents recently completed cultural courses in medical school and are now in clinical practice with actual patients from diverse backgrounds. Ernest stated,

> There's a real difference between being in the room with a family who may not be like you, whatever, melanin content, I.Q. points, age, language, affluence, and then like faking it, where I pretend to be a surly patient who doesn't speak English to the med student, or they bring in an actor who may not really look like the residents. So, I mean, what I, the things I try to model certainly with the med students, if I get to them early in their rotation.

Lotus discussed the role of practicing skills and stated:

> I think simulation was such a new field at that time. And so, I don't know that we got to really read a couple of textbooks but not really no more focus on clinical skills. And some, of course, like, you know, how you talk to the patient, rather than the cultural aspect of things. I think really practicing most skills is going to be really helpful. I think, any skill set we always need help and work with. And so, I think, practicing how to work with people from diverse backgrounds is really an important piece. I think having a practice session for encounters and things like that is really helpful.

A more experienced physician, Mary, stated that her clinical practice has ongoing cultural training.

> Simulations so, not necessarily when I was in training, I mean, maybe there probably was some training around learning how to do a patient interview. Definitely I think now at the Mid-Atlantic Hospital that's much more embedded. We do structured clinical observation with both real patients and simulated patients. They're also actually just this year implemented bias and racism training at the hospital, which also includes a lot of videos of sort of observing staged interactions between people that have varying levels of cultural competence and discussing them. And the training is actually conducted in small groups of about 10 to 12 people.

Mary noted the impact of understanding healthcare delivery from the patient's point of view and the importance of cultural competence training to take a holistic approach to care. Mary stated,

> I think it's important to have sort of formal, dedicated training. I think the residents go through a training that is designed to teach them about the impacts of poverty on health and they do some simulations through that as well, sort of putting themselves in the patient's shoes.

In contrast to Mary's experience, Leslie described simulations held in medical school and commented on the difference in learning when you encounter a concrete experience in clinical practice as found in a stage of experiential learning.

> We had actors and actresses who would pose as patients and you had to go in there and kind of figure out what was going on. They had people with different

> religions; you wouldn't be told that they were different ethnicities. You were taught to even differentiate sexualities. You know, just in terms of how you were going to deal with those cultural norms and being appropriate and being mindful of it…. That was a part of the training before you started your rotations…. You had to pass those things or else you would not be able to be able to interact with patients. In actual practice you learn more concretely.

Unlike other physicians, Gail questioned the effect of simulations in actual practice, stating,

> We do simulations with patients who refuse medications based on spiritual beliefs, and the students have to work through that and try to understand that. So, I think those things are in place. Yes. The question is, how effective are they?

In summary, physicians who had the experience of learning through simulations discussed the effects of gaining knowledge through practicing encounters with peers and actors prior to working with actual patients. Some physicians found the experiences of simulations helpful. Other study physicians shared that in some cases simulations centered on patients who refuse non-Western medicine and questioned if simulations were an effective way to prepare physicians for actual clinical practice.

### *2.c. Cultural Competence Experiential Learning on the Job*

Although, according to physicians, there is no formal cultural competence training in clinical practice, there are avenues for learning opportunities if one chooses to take classes, read literature, or gain more knowledge through various formats such as lectures or videos. Leslie described the ongoing educational programs:

> I realize if I am not competent with that population, I need to learn something. The beautiful thing about medicine is there's always seminars. We have to do a certain amount of CMEs [continuing medical education sessions, which are] always a way to learn about something.

Physicians detailed experiential cultural competence learning differences when working among physicians from diverse cultures. The concept of experiential learning aligns with the study framework and Kolb's (2015) experiential learning theory. For example, a physician noted the benefits of working with peers from different cultural backgrounds. The physician cautioned that practicing cultural competence should be addressed with patients similarly. Mary shared,

> I do think working with your peers on it [cultural competence] could be helpful because, in my instance, I'm super fortunate that I work with a diverse group of physicians. Also, sometimes within your group all the patients feel like everyone has been trained the same way, and they are not getting widely different experiences with one person versus another.

Ann shared that she did not have formal cultural competence training. She discussed her cultural learning opportunities, stating,

> As you went along, certainly all the learning was from peers and other attending physicians, who may have been practicing in the area [Mid-Atlantic] for a while. But nothing formal. I never heard the terms cultural competence, cultural humility, nothing.

Although Ann never participated in formal cultural competence educational requirements, she stressed the significance of teaching physicians how to have encounters. She revealed that during her medical school training, physicians "were not permitted to interact with actual real patients until they had completed the required class on clinical encounters." Ann added,

> I think it would be good [cultural competence work] for again, we still have no formal curriculum for attending physicians around cultural competence, so that doesn't exist at my institution. There's still no ongoing mechanism for training [on cultural competence]. If you want to do it and learn more, … you have to make that happen for yourself as an attending physician.

Like Ann, Gail shared that cultural competence was not addressed during medical school. Instead, Gail recalled that cultural competence was more specific to patients' cultural norms concerning their healthcare traditions. For example, Gale commented,

> Nothing [cultural competence training], nothing at all. I mean, it wasn't trendy, or popular…. Their [medical school] talks about in the early days, we use to think cultural competence was to teach people that if you see a Korean patient, and they have a bruise on their, a circular bruise on their bodies, because they believe in coining [non-Western health therapy].

In the same manner, Ernest shared his belief that cultural competence training was not part of his medical school training. However, he described learning opportunities during extensive travel to other countries, where he was exposed to diverse cultures. Ernest stated,

> No nothing like that [formal cultural competence training]. I just think it was the late Bush administration…. I lived in various places and saw some stuff, and so some of my cultural competence came from just seeing how the rest of the world is.

Ernest shared his view of healthcare delivery outside the United States:

> Full disclosure. So, I lived and worked in the Congo and Malawi for 2 years in pediatric HIV, and I did Doctors Without Borders in the Congo for 9 months. So, I've had a lot of those kinds of reactions [clinical encounters] admittedly, with skewed power relationships that develop, … and the skinny White guy coming as if he has all the answers.

Ernest was also a member of the diversity and inclusion group at his Mid-Atlantic hospital and worked to impart cultural training to faculty and staff physicians. He shared how practicing and training cultural competence skills impact clinical practice:

> That's very important, very important. And I would hope that it'd be done in a serious, sincere, and sustainable way. I'm on, you know, I'm still some diversity and inclusion groups at the hospital here. Their staff members are smart thinking people who experience our society in various pleasant and unpleasant ways and they want to repair that.

In summary, Henry and Leslie, who experienced formal cultural competence training in medical school, detailed the various ways the topic was taught, with two examples being seminars and scenarios with actors posing as patients. Henry, a resident, expressed his belief that his formal medical school cultural competence training was weak and could be improved. The cultural competence training in medical school was a precursor to working with actual patients later in clinical practice. Study physicians also shared their opinions on the role experiential learning plays in attaining cultural competence skills from patients and peers. Of particular interest, physicians who delivered care outside the United States expressed learning cultural competence in settings where treating marginalized patient populations reinforced cultural competence skills, which were transferable to patients from similar backgrounds in the United States.

### *2.d. Becoming Culturally Competent Lifelong Learning Process*

The third subtheme related to cultural competence experiential learning and concrete experiences is competence as a lifelong learning process, in line with the views of Campinha-Bacote (2015). Campinha-Bacote suggested that one must consider oneself *becoming* culturally competent instead of *being* culturally competent, as there is no end point to learning. Similarly, theorists Leininger and Kolb (Kolb, 2015; Kolb & Kolb, 2017) suggested that cultural competence is an ongoing process of learning, as opposed to the static Socratic form of being educated, where one may be considered thoroughly trained upon the completion of teaching.

During interviews, physicians expressed their interest in learning more about cultural competence. They shared that cultural skills enhanced and informed their clinical practices as they delivered healthcare services in urban settings with ethnically and

racially diverse patients. All but one of the study physicians agreed that learning cultural competence is a lifelong process and promoted the idea that conferences and continuing classes help them acquire cultural skills. The one participant holdout on lifelong learning cautioned that it may be challenging to learn about others when we still need to understand and address our own American Western cultures.

Study physicians agreed that cultural competence is not a concept one completely learns in medical school or becomes versed in after formal classes. They expressed the idea that cultural competence is never fully achieved and is a process that requires lifelong learning; therefore, residents and more experienced attending physician supervisors/mentors share learning and foster skills in diverse settings. A physician's cultural desire in becoming culturally competent may play a significant role in learning. Ann noted the need to hone cultural skills continuously. Physicians made meaning of how cultural skills evolve. Therefore, increased interaction with patients and peers is considered to foster cultural skills to improve physician/patient relationships and potentially improve healthcare outcomes. Physicians agreed it was more fruitful to learn in actual clinical practice with diverse patients than solely in medical school classes. Physicians also agreed it might be essential to learn and think "out of the box," especially when trained in "Western medicine" and according to American cultural standards and norms concerning healthcare. Ann candidly spoke of her position of willingness to learn:

> I just can't presume to understand another culture that I wasn't raised in or didn't grow up in. And, yeah, I just feel like that's super presumptuous, and it has to be lifelong learning.

Henry discussed the difference between the knowledge of cultural competence among new resident physicians, more experienced fellows, and attending physicians. It

became apparent that residents' training did not always transfer to actual practice. Henry stressed the need for clinical experience and context in cultural competence training:

> When approached with this topic, they have an innate understanding that they're not as culturally competent in all settings as they are in others, and that most people feel that viscerally and would like to do something about it. The biggest concern I have is, I just don't think it's done very well. And I think it's not done very well because it tends to be done in the setting of trainees who are not actually practicing. And that when you're a trainee who's not practicing, you don't actually know what you're doing.

Mary discussed how cultural skills are transferred from medical school to practice:

> You'll find this through your study that cultural competence skills evolved with time. People approached medical education a little differently. And I went to a place where actually, they approached it more holistically than most. So, Mid-Atlantic Hospital definitely had a reputation for a more holistic approach than most.

Leslie summed up her beliefs on lifelong learning of cultural competence skills, stating:

> You're constantly evolving and growing; of course, you're going to be presented with situations that you've got no training for. And you're supposed to, you know, see one, do one, teach one, right? So, in the sense that, you know, you have this experience, and then maybe, you know, and then I would go tell my colleagues.… We're like, I had this interesting case. I had this patient. Really? Okay, did you have anything like this? Or, hey, have you encountered this? Or, hey, I found out this when you— We all share because … it's a team effort, and it's and it's a learning community.… You do not go through all this training if you're not excited about learning, and that doesn't just stop after you become a doctor, right? And it, it's a lifelong learning. We have to take tests every 10 years; we have to do a test to continue us to be, you know, our CMEs, our continuing medical education.

In this study, five physicians, Ann, Gail, Mary, Lotus, and Ernest, expressed their opinions on attaining cultural competence skills. Additionally, Gail discussed the trending topic of diversity and inclusion in healthcare delivery. Although Ann admitted

that cultural competence is ongoing, she described her self-perceived belief that it may be challenging to understand the cultures of others. In contrast, Ernest discussed his opinion on the relevance of cultural competence in lifelong learning compared to advancing the learning of medical therapies. Examples of physicians' experiences with lifelong cultural competence learning include Ann, a physician who expressed being unsure of an effective process to learn about a culture other than one's own. Ann shared:

> And I think it is lifelong learning. I feel it would be very presumptuous to say that I could take one class or series of classes. I don't see how one class or lecture or series of lectures could ever accomplish that [cultural competence]. And I think it's a lifelong journey and lifelong process. I mean I wish there was a solution.… I don't know how to be culturally competent in a culture I didn't grow up in.

Similarly, Gail expressed that cultural competence is not only a lifelong process but also an evolving topic that may be learned and discussed in conjunction with other issues, such as diversity and inclusion in healthcare as a factor of delivering care to ethnically and racially diverse patients. Gail's assertion of cultural competence being rephrased as diversity and inclusion inferred that cultural competence is being meshed or interconnected with that subject. Gail, a more experienced physician based on time in clinical practice, discussed how the process of cultural competence is ever evolving:

> Today they mostly call it diversity and inclusion.… In the early days we used to think that cultural competence was teaching people if you see a Korean patient with a circular bruise, they believe in coining [medicinal therapy]. It's because of their culture—ridiculous stereotyping, not teaching people to be culturally competent. To me cultural competence, we are more trying to look at how the patient interprets their illness and health. Cultural competence is always evolving.

Lotus and Mary expressed views that were divergent from those of Ann and Gail. They agreed that cultural competence is a lifelong learning process and shared how cultural competence humanizes patient care and ongoing cultural learning. Although

physicians tend to agree on the process, divergence appears to exist in becoming culturally aware of various cultures. For instance, Lotus stated,

> Culture humanizes us.… It moves away from someone being a patient and puts that identities and experiences in front of us.… In the end, that person is always evolving. I am always evolving. [Cultural competence] is not a one-stop thing; you're constantly going to be describing culture.

Mary discussed how her practice has set up clinics to address specific patients' needs based in part on their race.

> You're always sort of learning about yourself and about each other, basic [cultural competence] education. [It is] important developing understanding of different people. We have predominantly Latino clinics and others that are mixed. You never really learn cultural competence; basic education is really important but it's the first paragraph in the book basically. It [cultural competence] is an ongoing process.

Ernest cautioned that length of time is a factor for learning about the nuances of life experiences, and thus is an ongoing process for learning. Ernest stated, "So you know, teaching humility and curiosity and difference to people's life experiences is not something that can be done in a week or a month or a year."

In discussing the relevance of lifelong learning and cultural competence learning, Marvin provided an example of how time influences how he prioritizes his learning time:

> There's only 24 hours in a day. You have to allocate your resources. A number of resources is keeping up with education. You have to pick and choose where you're going to focus, and so if someone says you have a choice of two things in the choice of a cultural competency course or a course that will prove to relieve the suffering of your patient, diagnose the problem, and they can go on with their life that they've been unable to do, there's no question [how] I've spent my time.

In summary, physicians described learning about cultural competence as a lifelong process. The participants shared their opinions on the importance of cultural competency when delivering healthcare to ethnically and racially diverse patients. Mary

and Lotus discussed how cultural competence humanizes patient care. Also discussed was how cultural competence may be interconnected with diversity and inclusion. Ann stressed how becoming versed in cultural competence may be a struggle when one is from a different background. Additionally, Marvin expressed that he prioritized learning new medical information to benefit his patients over information on cultural competence.

### *2.e. Terminology of Cultural Competence*

In addressing culturally appropriate healthcare, one factor relates to the debate on the definition of cultural competence. There are differing ideas on which term is best. Although participants were familiar with the term *cultural competence*, some thought another term may be a better way to define how to deliver care. In addition, the researcher probed how physicians ascertained their self-awareness of cultural competence from their backgrounds.

**Terminology.** While some study participants became familiar with the term *cultural competence* in medical school training, they expressed differing opinions on the term and its ability to capture the true nature of ethnically and racially diverse cultures. Ann and Gail preferred the terms *cultural humility* and *human competency* over cultural competency. *Cultural humility*, as posited by Tervalon and Murray-Garcia (1998), is a lifelong learning process (p. 100). Gail, Mary, and Ann voiced that using other terms to encapsulate the meaning of cultural competence is better. Additionally, Ann and Gail shared their dislike for the term *cultural competence*, although they believed the idea is important to healthcare delivery. Ann commented:

> A large amount of training may be the different types of practices or beliefs, particularly regarding health and spirituality, and all the things that impact families, all the things that affect your health. To me, that's all part of cultural competence. I don't even really like the term. I don't know if it's the right term.

> But I know there's lots of debate around cultural competence, cultural humility. But I think it involves, like, just a real openness to learning and, and recognizing how big a part that is of someone's health. I think I like the term cultural humility a little more because it is more evolving.

Mary preferred the term *cultural humility;* she defined it as continuous cultural competence learning:

> One of our colleagues who's a community leader likes to refer to it [cultural competence] as cultural humility. I really like it. It's understanding that you're always learning about yourself and others.

Gail also gave her opinion on *cultural competence* and referenced how she disapproved of the term; she discussed cultural humility.

Lotus also discussed how she worked with different cultures and the term *cultural competence* may not be an accurate fit to describe delivering appropriate healthcare to others. She explained:

> I don't like the term cultural competence because I don't think we can be competent in other cultures. We're barely competent in our own cultures usually, so I don't like to use the term. If we are going to talk about being competent I would call it human competence or how to learn how to relate to other people no matter who they are. I think that's the intent of the term [cultural competence] but I understand it.

Consequently, Betancourt (2003) challenged the separation of *cultural competence* and *cultural humility*. Betancourt (2003) suggested that cultural competency and humility are promising approaches to illuminating the underlying challenges affecting members of racial and ethnic minority groups and working toward alleviating racial and ethnic healthcare disparities and improving culturally competent healthcare. In agreement with Campinha-Bacote, Nguyen et al. (2021) indicated that combining cultural competence and cultural humility presents a more effective clinical practice than focusing solely on the tenets of Campinha-Bacote's model of cultural competence.

Nguyen et al. (2021) stated that "practitioners need to have the humility to be a learner rather than an expert and start with a focus on being open and receptive to patients from diverse populations" (p. 1). According to the research (Davidson & O'Neal, 2022), the definition of cultural humility is the "ability to maintain an interpersonal stance that is other-oriented and includes self-questioning, cultural immersion and active listening skills" (para. 1).

As suggested by Foronda et al. (2016), cultural humility involves a change in the way we focus on others in various cultures rather than simply focusing on cultural skills and information on a particular culture. Additionally, Foronda et al. (2016) suggested that cultural humility is a way of being (p. 4). Consequently, they stressed that cultural humility provides awareness of the power distance between physician and patient and focuses on humility with all individuals. Foronda et al. (2016) emphasized that this process is not immediate and takes time, reflection, and effort to attain progress. Although beyond the scope of this research, the term "cultural humility" is trending in new literature. This term is a suggested way for healthcare practitioners to recognize the need and added benefit of learning cultural skills. Such skills can be utilizing with patients to improve healthcare delivery and outcomes.

In summary, the debate continues about the most appropriate term or terms to use to describe cultural competence. The model used in this study, as defined by Campinha-Bacote (2002), describes the cultural competence tenet of cultural desire: "Do I really want to engage in the process of competemility?" Campinha-Bacote described competemility as a synergistic relationship between cultural humility and cultural competence. Some participants expressed that cultural humility may be a more

appropriate term for cultural competence. Physicians' responses exemplified the differences in their opinions on the terms used to describe cultural competence and how they made-meaning of cultural competence.

### *2.f. Meaning Making of Cultural Competence to Inform Clinical Practice*

Campinha-Bacote (2011) posited, "At the core of both patient centeredness and cultural competence is the importance of seeing the patient as a unique person" (p. 1). Further, cultural competence skill is the ability to collect relevant cultural data regarding the patient's presenting problem (Campinha-Bacote, 2007).

The patient-provider relationship has long centered around communication, with effective communication enhancing health outcomes and ineffective communication stymieing efforts. Communication within patient encounters encompasses written language, spoken language, body language, literacy, and technology. It can be impacted by the views that physicians and patients hold, both explicitly and implicitly (Ogbogu et al., 2022). According to Betancourt et al. (2000), the clinical encounter relationship between patient and physician may become complicated if the social and cultural differences between physician and patient are not factored into the clinical encounter.

How physicians understand, reflect, and make meaning of patient clinical encounters may be essential to foster better healthcare outcomes, especially for racial and ethnic minority patients navigating and making decisions on their healthcare options with their physicians. The encounters are critical in decision-making. When interpreting cultural competence to guide their clinical practices and appropriately modify and adapt healthcare delivery for patients who are ethnically and racially diverse, doctors should consider several factors. Particularly in patient clinical encounters, data showed that

observation and reflection, as posited by Kolb, influenced meaning making of the experience. Rich data allowed meaning-making of participants' experiences for both the researcher's and physicians' possible ethnocentric values of healthcare. As physicians discussed the challenges they encountered, a number of factors emerged. These included communication, language interpretation, biracial patients, and non-Western healthcare practices. Physicians shared how they learned from these experiences and adapted and modified cultural skills to improve the delivery of healthcare services tailored to ethnically and racially diverse patients.

**Communication.** Mary expressed her opinions of patient encounters by detailing how she reflected and considered specific patients and their family's healthcare concerns:

> I don't know that I think, consciously reflect on it in that way. But if it's been an encounter where you're like, you could tell, oh, the family was really upset or nervous or worried, and you were able to come to a resolution that felt good for everybody, you reflect on that. And when you, once the family is like not happy, or you just leave feeling like I just, like I missed something there and I don't know what it is. But there's something that we do not back reflect about.

Lotus noted the knowledge gained through encounters with diverse patients:

> But there's still kind of been interesting to see some of the similar needs and some of the different differences in the population. And I found really, I think that, creating a trusting environment has been— actually one of my passions is, how do we make families feel comfortable and, of course, it might mean that they're not going to do what I think is the ideal goal at the first visit. But if I talk in, you know, if we talk and we get to a stage where we get to a mutually acceptable goal, then that's a success. So, I've really enjoyed getting to work with this [diverse] population and really learning about the needs and meeting people where they're at.

Additionally, physicians discussed language aspects of communication. Lotus reported using interpreters in Guatemala, where patients use 300 distinct languages. Interpreters were crucial to ensuring communication between physicians and patients.

Communication, in some ways, facilitates physician/patient healthcare decision-making and adherence to health maintenance. Also, the lasting effect of communication helps establish a positive physician/patient relationship to achieve better healthcare outcomes.

In response to Kolb's (2015) phase of "concrete experience" and reflective observation, Lotus used an opportunity to note an instance of cultural competence that bridged a gap between her and the patient that would serve new patients of similar cultural backgrounds.

> The dad and I were talking and I didn't have an Arabic translator…. I could sense that I hadn't made that connection with the person, even despite using the translator. And at the very end of the visit, I said "Shukran," which means thank you in Arabic, and it was just really instantaneous, where the dad's like, whole, his whole face hit you like lit up at that moment…. It put me in the perspective of being like, for this man, he's in a new country, doesn't understand anything. And having a moment of where, you know, somebody just said something that's familiar made them just feel so much more comfortable. And so, so yes, I did write that down. So, I sometimes do poetry. But I do have a little notebook that I'll write down kind of some of these things that you can't really put in their person's chart. But I do play it for my own personal note.

Leslie shared her experience of working with patients who expressed beliefs culturally relevant to their health, stating,

> I have some patients who do different religions and don't want to do certain testing or don't want to do certain things like that. But I think probably the biggest thing has been vaccines. Okay, however, that that is, I have some parents who have religious purposes, they don't want to do the vaccines because they believe that there's fetal cells in the vaccines.

**Making Meaning of Subcultures.** Gail alluded to the issue of subcultures being a part of understating patients culturally. Examples are biracial patients who grow up in two cultures and American patients born to non-American parents. Additionally, she mentioned her belief that it might be better to ask physicians to be curious about their patients. Gail proposed,

> To me, cultural competence means being inquisitive about who somebody is and understanding how they interpret illness and health. We're more trying to look at cultural competence from that lens, rather than trying to describe every culture in the world and teaching people to know a teeny little piece of every culture, which really doesn't make any sense since especially since there's so many subcultures within any culture. I mean, there's multiple cultures. So, which are we going to be competent in? I think it's counterproductive to even tell, to try to teach people that they can be competent, because if you're competent, then you're not curious anymore. So, to me, it's how do we teach people to maintain curiosity?

Leslie also remarked on generational culture differences:

> You also have the fact that you have a lot of people who are born in other countries, but they have their kids and their first generation here. And so being raised here in America is different than how you grew up there. So, you have these two cultural traditions from here, but they're also being influenced by a lot of stuff around here. And it's not going to be the same and so but trying to try and make sure you hear the parents' point of view, as well as the kids' point of view.

**Non-Western Health Practices.** Physicians discussed delivering care to ethnically and racially diverse patients who relied on homeopathic remedies that are traditional to their cultures. In some cases, the non-Western health practices are generational and currently used today. Examples presented below are accepted cultural norms, and some are considered health hazards by Western medically trained physicians. Further, physicians discussed the need to become familiar with alternative non-Western health practices to address their patients' cultural needs and ensure appropriate medical treatment. It was essential to understand how physicians distinguished and made meaning of diverse patients' cultural differences based on non-Western healthcare beliefs, mainly when Western-trained physicians provide healthcare services to ethnically and racially diverse patients.

One of the traditional standards of Western medicine is the healthcare decision-making process, where the patient or the patient's parent is the clinical decision-maker. In

contrast, physicians detailed a non-Western culture where family elders or other family members are in charge of clinical decision-making. During her clinical encounters with ethnically and racially diverse patients and their family members, Mary shared her experiences of patient and family clinical encounters where healthcare decision-making takes place, stating, "Child infant sleeping practices … backwards, stomach, cultural influences on the decisions families make and generational influences. Often the decision maker can be, yes, grandma or auntie."

Ann also described the consequences of not being aware of non-Western cultural norms and beliefs and their effect on the physician/patient relationship:

> I think if providers have zero kind of understanding or knowledge or background of what might be the beliefs, practices, or approaches of the patients, it's hard to work in partnership with patient and family because there's such a divide where the patient and family might be and where the provider might be. The problem centers around Caucasian White, Northern European norms. That's not reflective of the populations we teach and that we treat. A huge impact on outcomes, trust in the system, feeling respected, heard, listened to, and family experiences.

Ann and Gail related the need to become aware of the differences between traditional Western medical practices and non-Western practices based on the norms and beliefs of other cultures. Gail mentioned the importance of recognizing patients' cultures to individualize and tailor care specifically to the individual and family. Similarly, Lotus remarked,

> Recognizing those identities that a person comes with and brings into the room is really, really key. And so, and it also really helps you to think through things like compliance and really tailor that treatment plan to what works for the patient. I tell my medical students and residents who work with me, I don't really believe in entity as noncompliance. I think it's just a way to shame families. But really this idea of how can we work with families to really optimize their compliance and really get them successful? And so sometimes it really involves thinking compliance in the sense of them agreeing with treatment or following your directions, that kind of thing?

Leslie shared that learning about the traditions of diverse patients is beneficial in delivering their healthcare:

> I worked for an Indian lady. There's a lot more homeopathic medicine in India, a lot of alternative therapies. It was … "Oh, Doc, you know, we stopped the asthma medicine. We went over to India.… We were given certain types of homeopathic treatments. And she's doing a lot better now with that." So, I had to sit here and say, when you're in medicine, you're trained. We do this for this problem.… I'm not saying that we don't come to appreciate certain alternative therapies. A lot of homeopathic medicine has kind of increased a little bit. But, I feel like other cultures and some people would bring stuff from their countries. I would have to kind of look and say, "Oh, this is the same as this particular medicine in this country," or I would have to look it up because they want to know, "Is this safe? Can I take this with the medicines that you're giving me now?" I had to learn about alternative treatments.

Physicians also discussed the challenges of delivering healthcare to patients who hold cultural norms and beliefs that may be different than those customarily aligned with Western medicine practices. An example is the religious belief held by patients who are Jehovah's Witnesses. Leslie described this scenario:

> You're going to encounter people who have different customs than you who have different than you.… Even religion—like Jehovah's Witness, they don't take blood products, understanding that if you're offering somebody [patient] a transfusion to them, that they are going to say no; it's a part of their religion.

Ann shared her clinical encounters with the cultures of diverse patients.

> There's a lot of practices around newborn care, for example, bandaging the belly button area … is not something that traditionally hospitals in the United States do. I had to learn a lot about family's beliefs.… There's also necklaces and bracelets they put on their newborns as a ward off evil spirits.… They come in conflict with Western medicine, if Western medicine's the term but just United States medicine.

Ernest described working with ethnically and racially diverse patients with cultural norms specific to their cultures. Further, Ernest reflected and mapped

experiential learning to new patients from the same culture, which supports three stages of Kolb's (1974) experiential theory. Ernest stated,

> I worked at a federally qualified health center out in a U.S. state. I don't know if you're familiar … but it is impolite to look people in the eye amongst this Native American tribe. And so, it would be irritating to me if a patient didn't look me in the eye, but I was sort of warned about it by a colleague who'd been there longer. He told me: Yeah, Ernest, is just how it's done. And so, then I'd, I would still sensitively make eye contact occasionally. I learned working in Malawi that you give people things with your right hand. And if you really want to be polite, instead of touch your elbow and give it to them. And even now, with African families that I see, I make a point of that gesture.

In summary, making meaning of the patient/physician relationship and addressing patients' cultural beliefs and norms can be a significant factor in delivering care. Meeting people where they're at may be a distinct way to tailor healthcare delivery following their cultural norms and beliefs. Although this may be a lofty goal, it depends on the time a physician has to allow the development of the clinical encounter and the physician/patient relationship. Physicians were aware of the differences in the health beliefs of patients from diverse backgrounds. They talked about the important role that cultural competence plays in the decision-making process, providing healthcare, and meeting the expectations of ethnically and racially diverse patients. Physicians shared the adverse effects of not taking into consideration non-Western cultural norms and beliefs in the delivery of healthcare.

### Theme 3: Lack of Diversity in Healthcare

The third theme that emerged from the data analysis process was lack of diversity in healthcare. This theme revealed the disproportionate ratio of ethnically and racially diverse physicians in the workforce. Sutton (2000) posited that "racial, ethnic, and

cultural disparities exist in all aspects of society, but nowhere are they more clearly documented than in healthcare" (p. 1).

### *3.a. Underrepresentation of Minority Physicians*

The LCME imposed medical school diversity accreditation guidelines in 2009. Although decades have passed, the underrepresentation of minority medical students has not changed; thus, there is no strength in numbers representing the minority residents entering the workforce. Additionally, Reede (2003) stressed that minority patients respond to and comply with health interventions when treated by minority physicians. However, there is a low number of minority physicians to serve minority patients. The minority patient population in the United States is projected to increase through the year 2050 (Shaya & Gbarayor, 2006).

Consequently, Reede noted that the racial/ethnic composition of the U.S. physician workforce does not reflect that of the general population. With the lack of sufficient minority healthcare providers, cultural competence learning and practice are important for all physicians. According to Daley et al. (2021), "The absence of Blacks in medicine means a dearth of practitioners who understand their patient's needs and who inspire trust in communities subject to historic deficiencies in healthcare services and quality of care" (p. 1).

Although there is a lack of diversity in the healthcare workforce, physicians agreed their experiences of experientially learning cultural competence skills and passing the knowledge to new physicians would enhance clinical practice encounters with diverse patients. As previously mentioned, Lett et al. (2019) conducted a cross-sectional study of self-reported race/ethnicity in U.S. medical schools and found that the number of medical

school matriculants from 2002 to 2017 who identified as Black, Hispanic, American Indian, or Alaska Native increased. Nonetheless, the increase in minority matriculants was slower than their age-matched counterparts in the U.S. population.

Mary noted the differences in her workforce when speaking about diversity recognition and the organization:

> It depends a little bit to [sic] in which aspect of the workforce that you look at. Uh, we [Mid-Atlantic Hospital] actually have an increasingly diverse faculty workforce. It really is, I think, it's better than many medical organizations. But given the lack of diversity in physician healthcare to begin with, there's that. The residents actually have a very diverse class—I think this year, 50% to 60%; it was good. So, so very diverse, and that was very deliberate. That was a very deliberate, very thoughtful and deliberate effort over the course of about 10 to 15 years to really, really focus on that…. We are deliberate in terms of recruitment, in terms of really trying to help make sure that we were recruiting really diverse applicants.

Gail defined her patient demographics and expressed that her Mid-Atlantic department serves a diverse patient population because it is an emergency department in an urban area.

> I think probably about 70% African American, maybe 10%, 20% Spanish speaking? Well, that's too much. Okay. Maybe it's 50% African American, 30%. Why? … We are, you know, downtown. There's a big international population that comes to our hospitals. So, you see, people don't speak English, but they may speak Mandarin, or they may be Ethiopian. We have lots of people from international cities.

In summary, the lack of diversity in healthcare professions, especially minority physicians, was acknowledged by the physicians, who expressed that efforts to attract and retain minority physicians appear to be ongoing. As the numbers of ethnically and racially diverse patients increase in the United States for the foreseeable future, how physicians experience delivering care to various patients presents a view of the current patient demographics in urban Mid-Atlantic healthcare settings.

**Theme 4: The Destruction of COVID-19 and Its Effect on Physicians' Work**

Although the unprecedented global COVID-19 pandemic impacted organizations at large, it was especially significant in healthcare delivery. The criticality of time only intensified within healthcare organizations during the pandemic (Förster et al., 2023). During the pandemic, the large numbers of confirmed cases of COVID-19 in the United States changed the schedules of clinical practices to meet the demand of treating pandemic patients. Cultural competence training became negligible due to the pandemic and emergency clinical needs for pandemic patients. Physicians shared cultural competence learning and utilization experiences and the impact directly encountered due to the COVID-19 pandemic.

Time in clinical encounters is a foundational element of cultural competence learning. Consequently, physicians spoke of the value of learning cultural competence from peers and mentors (attending physician supervisors). The physicians expressed the experience of having limited time to attend to patients' individual cultural healthcare norms and beliefs due to time constraints. Additionally, learning and using cultural competence skills in their clinical practices became difficult under constraints due to COVID-19.

The COVID-19 pandemic is an environmental jolt that has changed primary care delivery in the United States and internationally. Beginning in March 2020 and continuing throughout 2020 and 2021, primary care physicians and their practices were forced to adapt (Hoff & Neff, 2023), often suddenly and with little guidance, to changing conditions that were unpredictable and significant for their businesses and patient care. Additionally, COVID-19 changed the financial well-being of primary care offices. Patient care was also

delayed and decreased, and demand became unpredictable. According to Rubin (2020), many patients grew apprehensive about seeing a doctor in person, and primary care providers were asked overnight to rethink how they delivered care.

Healthcare leaders were already concerned about a potential stress cycle that could weaken their capacity for resilience, but the COVID-19 pandemic made things worse. Healthcare workers were stressed during the pandemic because they had a lot of work, had to make many changes quickly, and dealt with uncertainty. Resilience became essential to combat the pandemic in a way that was both productive and healthy (Förster et al., 2023).

The COVID-19 pandemic has disproportionately affected racial and ethnic minority groups, with high death rates in African American, Native American, and Latinx communities. A study by Boserup et al. (2020) indicated that the COVID-19 pandemic has disproportionately impacted all major racial and ethnic minority groups. Additionally, physicians have become ill from COVID-19. Resulting deaths have left an already challenged lack of diversity in the healthcare workforce in worse shape for clinicians who are already overwhelmed by tending to the medical needs of COVID-19 patients. The Black physicians' exposure to SARS-CoV-2 and risk of contracting COVID-19 are proportionately greater than those of other physicians because they are more likely to practice in areas with a higher population of Black patients (Filut & Carnes, 2020). The loss of physicians due to illness or death from COVID combined with the retirement of older physicians has placed a strain on the healthcare workforce, as fewer physicians are available to address the needs of patient routine care.

Regular clinical care may be paramount to patients' ongoing health. Routine physical exams and diseases diagnosed and treated early may improve healthcare

outcomes. Physicians voiced their opinions on the effects of COVID-19 and how normal clinical conditions were turned upside down. The inability to treat patients for routine care, vaccine hesitation or refusal, and patient mental health concerns were prevalent in discussions.

In summary, the COVID-19 pandemic was unprecedented and changed healthcare delivery in unexpected ways. Physicians are still feeling the effects of the pandemic in clinical practice.

### *4.a. COVID-19 Vaccine Hesitancy and Unavailability*

Lotus described her experiences with patients who were hesitant to receive the COVID-19 vaccination, especially parents of children: "In some instances, regular maintenance (annual physicals, elective surgeries, etc.) was delayed as the number of COVID-19 patients increased."

Leslie remarked on the difficulty of staffing the Mid-Atlantic practice: "I mean, I will, I will say that with the pandemic, we lost a lot of our primary care, I'd say a good 30%. So, at this point, I'm recruiting anybody."

Gail referenced the initial fear for herself and the medical staff she supervised:

> Mostly been scary, made people feel more unsafe in the work environment than ever before. It's just worried, constant worry. Before yourself, before your family, you know, we all have families, especially people that elderly parents are looking for little children, even after the vaccine was available, and little kids couldn't get vaccinated. I think it's a burden that it's very difficult even to describe how it affected people who were truly on the frontline taking care of patients walking in the door, and you didn't know. You know, who knew? Who had what? It's not like we have never experienced it before, but not to this level. I mean, there was, you know, the Ebola crisis, which turned out not to be as widespread as was initially feared because that would have been really terrifying.… Most people dealt with it. We did what we had to do, put on protective gear, and marched on, but it made it very difficult and more difficult for families who couldn't even be with their loved ones. And just the whole hospital system was turned upside down.

Ann spoke of the marginalized patient populations and the effects of COVID-19:

> So much focus on school, both and access to education, then managing the anxiety over going back to school and school safety. I feel like those are two things that have just … dominated my practice, particularly on the school front. So much of that is impacted by patients' cultural backgrounds and experiences.

In contrast to other physicians, Ernest was pragmatic about the COVID-19 pandemic and sounded angry at the state of U.S. healthcare's response. Ernest shared,

> Some of what I'm going to say is probably going to surprise you by now. The COVID pandemic has just revealed the deep fault lines in our society, access to medicine, access to healthcare, access to knowledge and esteem of the person's understanding of these experiences. I think 15% of Africa has seen zero vaccines. How on earth can we give a third and a fourth dose? It is shocking. And it's really not shocking, as … we live in an apartheid capitalist society. And this is how this works.… They're less fortunate than we are. It's B.S. to put a blunt point term on it. So, it all has trickled down to a distrust or distrust of a health system that represents all the sort of uncomfortable but pretty intentional structural violence done to a lot of our citizenry.

Physicians who practice as pediatricians were candid regarding the effects of the COVID-19 pandemic on their practice. The unavailability of vaccines for children in the early days of the pandemic was difficult for children who were out of school and unavailable for routine clinical care. Leslie expressed,

> I think if you had told me so many years ago that I would have such a high incidence of children, did not prepare people, didn't do well with the pandemic, on the pediatric side of it. You have kids are not in school. And some of them that mental health went into the toilet. Depression, anxiety, … suicidal patients every week. And for the mental health providers, therapists, social workers, they were being burnt… We didn't have enough of them.

Mary shared that some parents were particularly hesitant to have children vaccinated for COVID-19:

> When we talk with families about the COVID vaccine, particularly now that the, it's been approved for the 6-month-old to 5-year-old, that's sort of a new conversation, and I think lots of families are like, I'm not quite ready yet, but

> they're not combative about it. They're just like, I want to think about it a little bit, or I'd like a little bit more information. So, which that's good. That's not, there's other areas of it. There's other places where patients are yelling at the doctor, like how could you want to give my child this death shot or things like that.

In summary, physicians faced challenges advising parents and patients on the value of COVID-19 vaccines.

### *4.b. COVID-19 Physician Community Outreach*

Mary talked about her understanding of the COVID-19 vaccine hesitation and her nonclinical work in community outreach.

> I, over the course of the pandemic, have mostly been in a nonclinical role. I've mostly been doing, like, sort of larger public health response. So, I kind of see, we have it better here. It's easier here than it is in other places of the country, actually. I mean some of my colleagues in areas of the country where there's particularly high vaccine hesitancy, their patients that are verbally and sometimes physically abusive. It has not been great for in some places. I think there's a good amount of vaccine hesitancy here locally, but it's, but not like other places. And so, there's been one of the nice things … our clinics, there's actually been a really strong grassroots community engagement around building confidence in the COVID vaccines. I think that's been really helpful, because it means we're all kind of having the same conversation together.

In summary, the COVID-19 pandemic played a crucial role in contributing to the lack of diversity in healthcare. Physicians spoke of the difficulties and opportunities with acquiring and utilizing cultural competence skills. Time constraints left less time for cultural competence learning or utilizing skill sets, as the priority was delivering clinical care. Particularly during the COVID-19 pandemic, when physicians were extremely busy with COVID-19 patients, telemedicine appointments due to cancelled in-person appointments and community outreach initiatives to disseminate information about the COVID-19 vaccine were common. Additionally, although confirmed COVID-19 cases and death rates have decreased, COVID-19 still affects clinical practices. The lack of

diversity in the U.S. healthcare workforce has increased due to the effects of COVID and the loss of minority physicians and healthcare workers (nurses) to illness, which has impacted service delivery to patients, particularly those who are ethnically and racially diverse. Physicians discussed treating the large numbers of patients due to the pandemic as a defining moment. Additionally, physicians shared the issues of hiring staff and working under stressful conditions. In some communities, vaccine hesitancy became an issue that physicians and patients were concerned about, and community outreach was found to be important to address and provide information on the COVID-19 vaccine. The consequences of COVID to the lack of diversity in U.S. healthcare are still being felt, as it may be anticipated more minority physicians may be subject to illness from COVID.

**Theme 5: Clinical Practice Time Pressure**

The fifth theme that emerged from the data analysis process was the clinical practice time pressure. This theme illuminates physicians' experience of time as a barrier to both their willingness to address the cultural beliefs and norms of ethnic and racially diverse patients as well as their ability to tailor healthcare delivery to individual patient and family cultural norms and beliefs. Time constraints in clinical practice have been an issue for physicians. A study conducted by Porter et al. (2022) found that for an average 2500-patient case load, a primary care provider would require 26.7 hours per day to provide preventive, chronic, and acute care with documentation and inbox management. Additionally, the 2020 COVID-19 pandemic at least temporarily increased the workload for primary care physicians (Huston et al., 2020; Morreel et al., 2020), leading to large increases in electronic documentation work, which was not accounted for in the analysis (Porter et al., 2022).

Many physicians expressed concerns about the length of time available for clinical practice, and the perception that time is inadequate is now pervasive (Braddock & Snyder, 2005). A study conducted by Shapiro et al. (2002) found that resident physicians complained about having insufficient time to spend with patients, which resulted in barriers to culturally competent communication.

Ernest spoke of the ramifications of treating patients and addressing cultural competence issues. Additionally, Ernest shared his experience of working against time and adverse outcomes:

> I think there's literature that supports this, that the busier the clinical setting is, the more incidence of bias and, and lack of confidence, clinical cultural competence, there is, so that certainly impacts it.

***5.a. Cultural Competence as a Luxury***

All study physicians discussed the limitations of their time to see patients. Physicians spoke of busy schedules, the reality of COVID-19, the resulting rush of patients for clinical care, and healthcare systems' expectations to meet patients' needs. Ernest candidly spoke of his willingness to use cultural competence skills and how the lack of time thwarted his efforts to some degree:

> I'm still [involved in] some diversity and inclusion groups at the hospital here, but don't get any time in the week to think about it, and the hospital wants me to donate that time, right…. I know [those at Mid-Atlantic Hospital] think it's [cultural competence is] important. Their staff members are smart-thinking people who experience our society in various pleasant and unpleasant ways, and they want to repair that. But if you don't give me time, and you just like, shut up and see patients again, Ernest, I actually don't believe you're that sincere.

Mary, with limited time constraints, also mentioned the effect time has had on patients and described how a long waiting time affects patient care:

> We had a pretty busy clinic afternoon, and I was sort of supervising the residents and so wasn't seeing patients myself, but was kind of teaching them and doing, and anyway, it was really busy. And people were waiting a really long time, and the patients in the waiting room for I mean, for lack of a better word, this was in a clinic we were serving predominantly African American families. I mean, they, for lack of a better word, they sort of like staged a revolt. They [parents of patients] made a petition, passed it around in the [clinical practice] waiting room. And there was one mom in particular leading the charge, families had to sign, she was taking it [petition] to the ombudsman. It was really like great advocacy. We [physicians and staff] were fast to speak good. Families were stressed and worried, and they had sick kids.

### *5.b. Competing Clinical Priorities*

In discussing the relevance of time constraints and cultural competence learning, Marvin, clearly an outlier from traditional attending physicians, reported that his patients had to be seen on a regular basis through COVID-19. Marvin, a pain management physician in charge of his practice, provided an example of how time pressure influenced how he prioritized his learning time:

> There's only 24 hours in a day. You have to allocate your resources. A number of resources is keeping up with education. You have to pick and choose where you're going to focus, and so if someone says you have a choice of two things in the choice of a cultural competency course or a course that will prove to relieve the suffering of your patient, diagnose the problem, and they can go on with their life that they've been unable to do, there's no question [how] I've spent my time.

In summary, although the researcher did not ask a direct question on time, it became apparent that physicians tasked to deliver care to patients are subject to the constraints of time. Particularly due to the pandemic, physicians discussed the limited time available for further learning and practicing cultural competence skills to their full capability. Thus, in some cases, the lack of available time became a barrier to ongoing cultural competence learning.

## Summary

Five themes emerged as physicians shared their experiences of how cultural competence learning and utilization of cultural competence skills informed their clinical practices in delivering healthcare services to ethnically and racially diverse patients in mid-Atlantic hospitals and clinical practice settings. The first theme, family background and cultural experiences, surfaced how physicians' backgrounds and life experiences fostered their interest in medical school choice and later their career paths to deliver healthcare to ethnically and racially diverse patients. The second theme, cultural competence training and experiential learning, delved into how physicians formally learned cultural competence skills in medical school and informally through simulations and later from peers and patients in clinical practice. This theme explored the opportunities and challenges facing physicians in their quest to develop relationships with their patients and balance time for lifelong cultural competence learning.

The third theme, lack of diversity in healthcare, emphasized the ongoing process of healthcare organizations developing programs to attract and retain minority physicians—particularly in urban settings where minority physicians are underrepresented and needed to care for marginalized, diverse patient populations. The fourth theme, the destruction of the COVID-19 pandemic and its effect on physicians' work, emerged as the virus affected healthcare and posed challenges to patients and to physicians' clinical practices. Physicians shared the constraints in delivering care during the pandemic and how they worked to inform patients about vaccines and promote vaccine acceptance. Additionally, physicians discussed the adverse effects COVID-19 posed on learning and utilizing cultural competence skills due to time constraints. Also

presented was the effect COVID-19 posed to minority physicians, specifically the loss of Black physicians due to illness or death related to the COVID-19 pandemic. The fifth theme, clinical practice time constraints, provided information from the participants' point of view on how the availability of time influences the ability to address diverse patients' cultural norms and beliefs. These themes are further explored within the context of the extant research literature and conceptual framework in Chapter 5.

# CHAPTER 5:

# DISCUSSION

This basic qualitative study aimed to explore physicians' learning and practice of cultural competence in serving ethnically and racially diverse patients. Two research questions guided the study: (1) How do physicians describe their experiences learning and practicing cultural competence when serving ethnically and racially diverse patients? and (2) How do physicians make meaning of these experiences to inform their clinical practice?

The first section of this chapter expounds upon the interpretations of findings related to the first research question, discussing the experiences of physicians formally learning cultural competence skills both in medical school and later experientially in practice from diverse patients and peers. Findings for the second research question follow, addressing how physicians make meaning of their experiences both learning and utilizing cultural competence. Both questions align with the study framework theories, the model of cultural competence espoused by Campinha-Bacote (1998) and the experiential learning theory (ELT) defined by Kolb (2014). Additionally, the benefits or challenges of cultural competence learning and practice are explored under the conditions brought on by the COVID-19 pandemic. The chapter concludes with recommendations for further research and healthcare organizational practices.

## Findings

This section interprets the findings as they relate to the two research questions and the literature review data from Chapter 2. The findings are presented in connection with the question they inform.

### Research Question 1: Learning and Practicing Cultural Competence

*How do physicians describe their experiences learning and practicing cultural competence when serving ethnically and racially diverse patients?*

#### *Finding 1: Cultural Self-Awareness as a Precursor to Learning Cultural Competence*

According to Campinha-Bacote (2018), self-awareness refers to statements such as "I readily admit when I am wrong" and "I recognize missed opportunities to discuss my client's cultural background" (Gonzalez et al., 2020). In this study, the researcher found that physicians' self-awareness of cultural competence was essential to further learning cultural competence in clinical practice. Seven of the study's eight physicians discussed how their exposure to different cultures, families, and communities before medical school education was foundational to their knowledge and self-awareness of others as well as themselves.

The study revealed a stark difference between physicians with early socialization experiences with people from different cultures and physicians exposed to ethnically and racially diverse people later in their lives. Exposure to medical school classes and clinical encounters enhances and reinforces cultural competence learning and utilization. Thus, self-awareness of cultural competence helps physicians better interpret the cultural norms and beliefs of patients and families from various cultural backgrounds. Additionally, this study presented the effect of gaining knowledge of cultural competence and awareness of

the cultural norms and beliefs of ethnically and racially diverse patients through immersive clinical encounters in marginalized clinical settings.

In contrast to my findings, Grewal et al. (2021) had a different opinion on the positive aspects of physician self-awareness of cultural competence. Further, Grewal et al. posited that although ongoing learning and unlearning are at the core of modern medicine, it may be almost impossible to train or retrain practicing physicians and sensitize them to expand their awareness of implicit knowledge biases toward cultural competence. Thus, although the benefit of physician self-awareness as a precursor to different cultures may be a benefit to delivering healthcare, it may also pose the negative effect of physician implicit bias toward diverse patients.

### *Finding 2: Non-Western Immersive Cultural Experiences*

According to Matthews et al. (2021), the opportunity to travel abroad and work in clinical practice "offers a service-learning experience, and one of the goals of these cultural immersion international learning experiences may be the development of clinical skills and enhance cultural competence" (p. 875).

One participant recounted working for Doctors Without Borders, providing care in Africa; this experience was an immersive experiential learning process due to the expectations of patients with non-Western cultural norms and beliefs. Another physician, who worked in the United States near the Mexican border, spoke of cultural competence being essential; certain norms and beliefs may require attention when tailoring care to ethnically and racially diverse patients from various Latino backgrounds. Learning and practicing cultural competence can be enhanced and reinforced by delivering healthcare services to marginalized patients in non-Western countries in the United States and

abroad. Two physicians working in the immersive experience of encounters with patients outside the United States expressed the need to consider non-Western cultural beliefs as a prerequisite to tailor and modify healthcare appropriately to facilitate healthcare delivery.

Physicians discussed the cultural norms and beliefs traditionally focused on religious aspects of their patients' cultures and the alternative treatments patients take as part of their regular healthcare routines. They spoke of the importance of learning about homeopathic and non-Western medicine treatments that patients inform them about during clinical encounters. In some instances, physicians shared that the non-Western healthcare practices of diverse patients had been passed down through generations and are considered traditional in their cultures. Of importance, physicians introduced their belief that knowledge of patients' non-Western practices helps with clinical decision-making.

Patients wanted to know if what they had been prescribed could work with their traditional homeopathic practices for improved health. Physicians needed to understand alternative therapies as patients brought alternative medicines from their home countries. Additionally, physicians discussed trying to keep up-to-date and knowledgeable about drugs not found in U.S. healthcare formularies, as some diverse patients take non-Western medicine.

Literature has revealed that immersive clinical encounters abroad enhance students' cultural competence skills. In support of the finding, a study comprising athletic training students studying abroad revealed that the U.S. students did not reflect the ethnic demographics within athletic training and may challenge the diverse healthcare athletes are given (Sears et al., 2021).

Abe-Hiraishi et al. (2018) posited that through study abroad, students will integrate cultural competence within another culture through immersive experiences while delivering healthcare. Further, combining didactic and clinical experiences allows students to incorporate learned cultural competence skills in a practice setting and improve cultural competence. Abe-Hiraishi et al. (2018) also suggested implementing study-abroad opportunities in athletic training programs (p.24).

A research study designed by Arizona State University and conducted in Malawi and Nicaragua by de Diego-Lázaro et al. (2020) provided findings that graduate students in audiology and speech-language pathology developed cultural awareness and cultural competence skills. Furthermore, even though the service-learning program was short, de Diego-Lázaro et al. found that cultural awareness, cultural competence skills, and self-efficacy were increased. Consequently, the exposure that physicians receive through immersive encounters in settings with ethnically and racially diverse patients, such as urban areas, may foster the development of cultural competence. All of the study physicians delivered healthcare in Mid-Atlantic urban environments, which can be considered immersive settings as they are working with diverse patients.

***Finding 3: Formal Medical School Training and Experiential Learning***

Cultural competency was adopted by the Accreditation Council for Graduate Medical Education (ACGME) as a part of medical education reform as a means to improve the quality of healthcare delivery from physicians to minority patients (Ambrose et al., 2013). Additionally, since 2001, the Liaison Committee on Medical Education (LCME) has required medical schools to have cultural competence training as part of their accreditation requirements (Vasquez Guzman et al., 2021). Further, the LCME

Standards and Elements require that "the medical school faculty ensures that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address biases in themselves, others, and the health care delivery process" (UC Davis School of Medicine, 2024). Despite the adoption of medical school curricula, the teaching of the topic of cultural competence has not been standardized. Study findings revealed that physicians who attended formal cultural competence training in medical school were exposed to different frameworks for cultural competence curriculums; examples provided were lectures, texts, and simulations. It was apparent that the training was different for the physicians formally trained.

The researcher found that physicians' simulations were not standardized across their medical training. As referenced by McCalman et al. (2017), due to the ratio of minority medical students compared to their peers, simulations may be conducted using nonminority students playing the role of patients. This scenario does not represent the actual ethnically and racially diverse patient populations physicians will encounter in clinical encounters. Additionally, two physicians spoke of their medical schools using actors from diverse backgrounds to represent ethnically and racially diverse patients, which they felt were more aligned with real, diverse patient encounters.

In this study, the researcher found inconsistencies in the formal cultural competence training required of physicians in medical school. Some study participants attended medical school before the topic was mandated in 2001. Even among those receiving formal training, one resident physician believed they were unprepared to utilize cultural skills with actual patients.

In contrast to the impetus to train physicians on cultural competence knowledge and promote cultural competence skills, some scholars have posited that cultural competence training may present negative consequences in the delivery of appropriate care to ethnically and racially diverse patients. Lekas et al. (2020) stated, "Although this intention is commendable, training providers in becoming competent in various cultures presents the risk of stereotyping, stigmatizing, and othering patients and can foster implicit racist attitudes and behaviors" (p. 1).

### *Finding 4: Learning Cultural Competence on the Job Experientially*

The second theoretical base for the study is derived from Kolb's (1985) ELT, which posits experiential learning as essential to gaining knowledge through a four-stage process (or cycle) inclusive of concrete experience, reflective observation, abstract conceptualization, and active experimentation which transform into effective learning—clinical practice.

The researcher found that with formal cultural competence training ending after medical school, physicians could learn and utilize cultural competence skills in clinical practice. Additionally, for more experienced physicians, cultural competence may not have been taught in their medical school curricula. Study physicians without formal training expressed learning cultural competence in clinical practice as they delivered healthcare to ethnically and racially diverse patients and worked with peers from different backgrounds. Consequently, one physician spoke of being fortunate to work in a Mid-Atlantic healthcare practice with diverse faculty and staff, which reinforced and enhanced her cultural competence, knowledge, and skills.

A physician shared the importance of learning cultural competence on the job because medical students cannot encounter actual patients before residency. Thus, the opportunities to encounter actual patients provide a cultural experience not found in medical schools due to the disproportionate ratio of minority students to their nonminority counterparts.

### *Finding 5: Lifelong Learning of Cultural Competence*

Campinha-Bacote posited that one must consider oneself *becoming* culturally competent instead of being culturally competent, as there is no end point to learning. Similarly, theorists Leininger and Kolb (Kolb, 2015; Kolb & Kolb, 2017) suggested that cultural competence is an ongoing learning process, as opposed to the static Socratic form of being educated, where one may be considered thoroughly trained upon the completion of teaching. In agreement, Thibault (2020) stated the need for "more emphasis on the continuum of healthcare professionals' education for the life-long learning and long-term well-being of health professionals" (p. 685).

All physicians except for one believed that cultural competence is a lifelong process and that, in some cases, learning beyond formal medical school training would reinforce and enhance cultural competence skills that could be utilized in clinical practice. The physicians discussed working in Mid-Atlantic practices with ethnically and racially diverse patients. In one case, a physician set up two treatment programs, one for African American patients and the second for Latino patients. She believed tailoring services to specific cultures helps to promote better healthcare outcomes for diverse patients.

In contrast, two study physicians controversially discussed lifelong learning. One physician believed there is no way to become culturally competent, and she suggested we are not culturally competent in our own cultures. A second physician shared that although he believed cultural competence is essential and requires ongoing learning, education in his specialty of pain management took priority over cultural competence learning. The physician stressed that he advanced his knowledge of cultural competence when time permitted through online classes and exams. He also shared his knowledge of cultural competence skills with physicians he trained as part of pain management classes.

### *Finding 6: Debate on the Term Cultural Competence*

As Harrison and Turner (2010) stated:

> The idea of cultural competence has been afforded significant importance in the caring professions while also being the subject of considerable debate. It is a prominent discourse in the health and social work literature and is enshrined in organizational policy and human resources training. However, it is a somewhat murky concept in that culture can evoke a multitude of meanings while understandings of competence are context-dependent. Moreover, it is unclear what sense practitioners actually make of such an abstract concept in practice. (p. 333)

According to Campinha-Bacote (2018), for decades, "a medley of definitions and conceptualizations has created intense debate, questioning its true ability to address cross-cultural problems in healthcare delivery" (p. 1).

Consequently, Betancourt (2003) challenged the separation of *cultural competence* and *cultural humility*. Betancourt (2003) suggested that cultural competency and humility are promising approaches to illuminating the underlying challenges affecting members of racial and ethnic minority groups and working toward alleviating racial and ethnic healthcare disparities and improving culturally competent healthcare. In

partial agreement with Betancourt, Campinha-Bacote (2018) stated, "A new paradigm of thought regarding the relationship between cultural competence and cultural humility will be proposed, one necessitating that cultural humility and cultural competence enter into a synergistic relationship" (p. 1). However, Campinha-Bacote (2018) cautioned that the proposed change of a new paradigm connecting cultural humility and competence may not mitigate the ongoing debate over the correct term. Additionally, Kirmayer (2012) suggested that although it is essential that "health professionals be technically competent, in the case of physicians, this competence includes interpersonal skills, ethical commitments, and the ability to effectively refine and use one's empathic capacity" (p. 157). For this reason, some have advocated alternative concepts through metaphors such as "cultural responsiveness" (Sue et al., 1991) or "cultural humility" (Tervalon & Murray-Garcia, 1998).

The researcher found that this study elucidated physicians' knowledge of the term cultural competence. All but one of the physicians acknowledged that they were familiar with the term cultural competence introduced in medical school training. Two physicians suggested that cultural humility may be a better term for tailoring care to diverse patients, considering their cultural norms and beliefs. The two physicians also thought cultural humility was more appropriate as it emphasized empathy and creating a comfortable relationship with patients, particularly parents of sick children. Further, the two physicians preferred the term cultural humility as they believed it captures better ways to consider the patient in a less paternalistic relationship between patient and physician, allowing patients to have more control over their care decisions.

Four physicians voiced their opinions on whether cultural competence captures the true intent of delivering care acceptably to ethnically and racially diverse patients. Additionally, three physicians were ambivalent about the debate on the term cultural competence.

During discussions with study physicians over what they believed was the correct term to use, there were varying opinions on how cultural competence is defined and which term was best to capture the meaning of cultural competence. Physicians offered the terms cultural competence, cultural humility, and cultural diversity as possible choices to encapsulate the meaning of cultural competence.

One physician did not like the term and suggested that physicians should be curious about their patients without a specific term. Some physicians discussed the term *diversity* as a movement beyond cultural competence. One physician had never heard the term *cultural competence* in medical school training. As of this writing, cultural competence is the ongoing term used in medical school training and is a course required by the LCME (2000) and the Association of American Medical Colleges (2005).

Findings also described a positive result of the term cultural competence, as it imparts a way for physicians to deliver healthcare to ethnically and racially diverse patients tailored to their healthcare cultural norms and beliefs. However, Lekas et al (2020) proposed that the term may lead to negative relationships with patients due to stereotyping and bias based on physicians' beliefs about the non-Western beliefs and norms of diverse patients.

In conclusion, the researcher found that although study physicians had various opinions on the terminology used to describe and define cultural competence, the term

*cultural competence* was a significant factor in the construct, as ascribed by Campinha-Bacote (1998). For all of the participants, the various terms used to describe cultural competence were not as crucial as their meaning-making of cultural competence and how their learning and utilization of cultural competence skills informed and played a role in their healthcare delivery to ethnically and racially diverse patients. Consequently, the term *cultural competence* was familiar to several physicians and is part of medical school curricula. Therefore, although there is debate on the term, its relevance and importance to mandating organizations continues.

**Research Question 2: The Meaning of Cultural Competence in Clinical Practice**

*How do physicians make meaning of these experiences to inform their clinical practice?*

As posited by Campinha-Bacote (2007), cultural competence is considered to be the ability to collect relevant cultural data regarding the patient's presenting problem. Further, Campinha-Bacote (2011) posited, "At the core of both patient-centeredness and cultural competence is the importance of seeing the patient as a unique person" (p. 1). In support of Kolb's (2015) ELT, meaning-making may occur through four phases: concrete experience, reflective observation, abstract conceptualization, and active experimentation. Making meaning of cultural competence can result from physicians' constant exposure to ethnically and racially diverse patients through clinical encounters, as well as through interactions with their peers from diverse backgrounds different than their own. The consensus of the study physicians was that cultural competence is relevant and plays an important role in their delivery of healthcare to ethnically and racially diverse patients. Study physicians stressed that they utilize cultural competence to inform

their practice when time permits and have an understanding of the value cultural skill sets hold, particularly when working with patients, peers, and mentors.

### *Finding 1: Engagement in Cultural Competence Awareness*

Six of the eight physicians described how their exposure to various cultures in their families and the communities they grew up in prior to attending medical school influenced their self-awareness of their cultural competency. Compared to study physicians from homogenous backgrounds, those who had early engagement with diverse friends and family were starkly different in cultural competence awareness, allowing physicians to make meaning of different cultures from past and future encounters.

Each of the study physicians voiced their opinions on cultural competence as a concept and how it plays a role in their clinical practices. All physicians described cultural competence as necessary to their practice and patient relationships. The physician-patient relationship experiences are fundamental in making meaning of clinical encounters with ethnically and racially diverse patients, mainly when delivering care based on the underpinnings of Western medicine taught and practiced in U.S. medical schools.

In the study, physicians made meaning of the patient-physician relationship and the importance of addressing ethnically and racially diverse patients' cultural norms and beliefs. Physicians discussed how utilizing cultural competence skills can be a significant factor in delivering healthcare to diverse patients.

### *Finding 2: Communication in the Physician-Patient Relationship*

Study findings detailed that cultural norms and beliefs are not the only traits that inform clinical practice. Communication plays a positive role in the physician-patient

relationship. The familiarity of coded language between physicians and their patients can enhance dialogue by understanding language in specific cultures. As an example, a physician who identified as African American detailed how her clinical staff knew that when she was talking to an African American patient, her speech and communication differed when she spoke with White patients. She believed speaking in this coded language improved the physician-patient relationship and benefited her African American patients.

Physicians also used interpreters to break down language barriers, which can impede the physician-patient relationship due to the slowing of the clinical decision-making process on the part of patients with non-English language skills. A physician who worked close to the U.S. border with Mexico reflected on time spent working with Latino patients and experienced navigating 300 Latin language dialects. The meaning of this experience propelled the physician to devote her career to developing clinical programs for Latino patients. The clinical programs were meaningful to the physician's practice, and due to their benefit to Latino patients, an additional program was added targeted to African American patients. Thus, the physician's experience working in a marginalized setting of Latino patients informed her clinical practice.

### *Finding 3: Immersive Clinical Encounters*

This study adds first-hand knowledge of the experiences of acquiring cultural competence in direct relationship to the norms and beliefs of marginalized populations. Making meaning of the immersive experience of delivering culturally appropriate care to ethnically and racially diverse patients added the benefits of transferring competence skill sets to inform their clinical practices.

Two physicians explained how their cultural competence learning outside the United States enhanced their ability to deliver culturally competent healthcare in marginalized communities, such as urban healthcare settings consisting of mainly minority populations such as immigrants from the Dominican Republic and Africa. They were able to transfer the cultural skills learned abroad in their U.S. clinical practice. Thus, working with a specific culture offers opportunities for physicians to hone skills through concrete experience and abstract conceptualization, posited by Kolb (2015) as stages of the experiential learning process. These stages allow physicians to experience the clinical encounter interaction and make meaning of the experience, which may be mapped to patients of similar cultural backgrounds, informing their clinical practice.

Study physicians shared how they made meaning of their diverse patients' cultural norms and beliefs. One physician, a pediatrician, questioned a parent about tickling a young child, and the parent explained that this behavior is thought to bring about prosperity (money) in her culture. Another physician detailed learning not to offer items with the left hand in Africa, as in that culture the right hand is the proper hand to use. The physician mapped this cultural norm to African patients to inform his clinical practice in the United States. He received a positive response from patients from similar backgrounds who recognized his effort to adhere to their cultural norms. Kolb (2015) referred to this transfer of skills as "active experimentation," a cycle of the ELT.

According to study physicians, culturally competent healthcare should not be undervalued by physicians. In agreement, Campinha-Bacote (1998) posited that every encounter is a cultural encounter.

Physicians shared their experiences of the advantages of meeting people where they're at and how it may be a distinct way to tailor healthcare delivery considering patients' cultural norms and beliefs. Nevertheless, this may be a lofty goal, as it depends on the time a physician has in the clinical encounter to learn more about the patient's cultural norms and beliefs.

### *Finding 4: The Underrepresentation of Minority Physicians in Healthcare*

A continuing issue facing healthcare organizations in the United States is the underrepresentation of minority physicians in treating minority patients (Reede, 2003). As stated by Sylk Sotto-Santiago et al. (2023), the changing demographics of the United States and the vast health inequities and disparities among racial groups continue to be highly visible. The number of historically underrepresented providers across medicine remains dismal. The issue of underrepresentation of minority physicians was echoed by Goode and Landefeld (2018); they suggested that "the future healthcare of the nation will become much more dependent upon a diverse healthcare workforce" (p. 1). The current numbers in health professional programs and practice must be considered inadequate despite efforts over many years to address this underrepresentation.

In this study, two physicians were not only aware of the need for more minority physicians but also discussed how their clinical practices were working to meet the need. Physicians addressed the importance of adding minorities to their clinical practice and related how the front office staff (nurses and medical administrators) were diverse; the diversity of the back office clinical settings, which consisted of residents and attending physicians, was sparse and not reflective of the minorities they served. According to physicians, healthcare organizations were trying to attract and retain minority physicians

to increase diversity in the healthcare workforce. Two physicians shared how their clinical practices were introducing programs and initiatives to hire more minority residents into their practices and retain them in their clinical settings after their residency rotations were completed and they attained the status of attending physicians. Two physicians shared that after understanding the need for minority physicians in their practices, they had made meaning of the issue and were increasing their efforts to add diverse physicians to their practices.

### *Finding 5: Vaccine Hesitancy and Community Outreach*

In a clinical setting with mostly minority patients, physicians were tasked with communicating information on the COVID-19 vaccines. Communication through community outreach programs was provided, which took time from clinical practice, adding to the time constraints of serving patients. Community outreach programs were considered to be important due to vaccine hesitancy, particularly among minority populations who have mistrust toward medical providers, which stems from past medical practices deemed racist. An example is the Tuskegee, Alabama, syphilis study, among others (Wiley & Weber, 2023). Physicians agreed that culturally competent communication is essential to address patient concerns and mitigate barriers to healthcare treatment. In agreement, Wiley and Weber (2023) advised communicating in a culturally competent way and understanding historical and existing barriers to vaccine acceptance, while acknowledging the importance of social determinants of health that may limit vaccine access.

### *Finding 6: Clinical Time Constraints Due to the COVID-19 Pandemic*

A common thread among physicians was the time constraints in delivering healthcare services during the COVID-19 pandemic. In many cases, the large numbers of confirmed cases of COVID-19 changed the schedules of clinical practices to meet the demand of treating pandemic patients. One example was canceling routine healthcare maintenance (routine physical exams and elective surgeries). One physician discussed how the pandemic turned their clinical practice upside down and how finding time to treat patients was complex. Findings highlighted how physicians' preparedness for the COVID-19 pandemic varied depending on their patients.

Consequently, due to time constraints imposed by COVID-19, physicians expressed that although they were interested in learning and utilizing cultural skills, the lack of time prevented them from addressing cultural issues beyond enlisting language interpreters when needed as part of patient clinical encounters.

The effect of lack of time on clinical practices was challenging, especially for ethnically and racially diverse patients. Cultural competence skill sets that could have been an advantage were often overlooked due to time constraints. Some physicians mentioned staffing problems when physicians contracted COVID during the height of the pandemic (World Health Organization, 2020). A physician mentioned the difficulty of hiring additional physicians for her practice due to the pandemic, as few pediatricians were available. Due to COVID-19, physicians working in larger clinical practices used telemedicine out of concern for the safety of both physicians and patients. In support, as stated by Omboni et al. (2022),

> During the COVID-19 pandemic, telemedicine has emerged worldwide as an indispensable resource to improve the surveillance of patients, curb the spread of

> disease, facilitate timely identification and management of ill people, but, most importantly, guarantee the continuity of care of frail patients with multiple chronic diseases. (p. 2)

Physicians shared that during the COVID-19 pandemic, nonemergency clinical encounters were held via telemedicine, which did not allow them to observe the nuances of patients' body language. The shortened sessions were not necessarily tailored to the application of cultural competence skills. The physicians said patient encounters were different when virtual, with a lower level of communication than in-person visits. As Kolb (2015) suggested, observation is a factor in learning. Observation is impaired in patient encounters that occur through the lens of a WebEx or Zoom platform with a partial view. A gap can exist in the perception of the patient's actual physical state, which is necessary for clinical decision-making. The pain management physician and the physician working in emergency department settings detailed how seeing patients in person was paramount to their healthcare delivery, and they were extremely busy due to the COVID-19 pandemic. Of note, the emergency department physician explained how she tried to develop a trusting relationship with patients she served for the first time and believed factoring in cultural competence skills was essential and a significant factor in their care. Although the COVID-19 pandemic affected the healthcare delivery of physicians in a manner not experienced in decades, the lessons learned from the pandemic can be utilized when another pandemic occurs.

## Recommendations for Practice

After completion of the study, several suggestions for practice surfaced, including offering ongoing cultural competence training, considering the effects of hierarchy in medical practice, offering opportunities for immersive clinical encounters, making efforts

to ensure effective physician-patient communication, and offering education on alternative remedies and behaviors. In addition, lessons were learned from the COVID pandemic that can be used for preparedness.

### Cultural Competence Training in Residency

The researcher recommends focusing on lifelong learning as part of cultural competence training and incorporating cultural competence training modules throughout resident training each year. This change in training would enforce continuous learning and make training accessible to residents by allowing time for additional study. Also, more familiarity with the importance of cultural competence would help mitigate negative opinions held by some physicians. As an example, one physician discussed how one could not become entirely culturally competent in the norms and beliefs of every ethnically and racially diverse patient. The physician believed cultural competence may be an unattainable goal, as she expressed that we are not culturally competent in our own cultures. This assessment aligns with Campinha-Bacote's (1998) model of espousing cultural competence, as it is a lifelong learning process.

Two physicians shared that they vaguely remembered learning cultural skills in medical school, and three physicians were not formally taught in medical school. A physician working with patients in pain management was concerned primarily with new concepts in managing diseases and ailments. However, he believed cultural competence skills were beneficial in informing clinical practice. Carving out time in clinical practice for ongoing cultural competency learning through various formats, such as classes, online lectures, and texts, is recommended to enhance and reinforce cultural competency in clinical practice. Thus, clinical practices would benefit from programs for learning.

**The Effects of Hierarchy in Medical Practice**

Study findings highlighted physicians' concerns about paternalistic patient-physician relationships, which may negatively affect patient care. Western medicine as a system is often hierarchical. In healthcare organizations, medical students and residents follow the organizations' leadership, generally headed by the chief medical officer and experienced attending physicians who play a role in how clinical practices are run following rules, regulations, and state and federal guidelines when overseeing medical faculty and staff.

Practicing physicians are subject to the rules and regulations of their organizations, which make decisions on clinical training and the supervision of residents during their respective work rotations. Some study physicians believed that attending physicians who did not have formal cultural competence training in medical school may not consider the cultural competence factors of providing healthcare delivery when supervising residents during clinical and technical training. The physicians expressed the notion that Western medicine is hierarchical. Attending physician preceptors/supervisors oversee resident training. Additionally, Western medicine hierarchy can affect communication with medical students, and resident physicians can take a subservient stance to attending physicians, which can interfere with the relationship between residents and higher-status attending physicians under their supervision. To close the power distance between residents and supervising attending physicians, new training efforts should be developed to provide opportunities for more experienced attending physicians who may not have had cultural competence training to participate in

continuous training and programs to modify and enhance teaching skills beyond technical medical training with the addition of cultural competence training.

The researcher recommends that attending physicians who are supervisors/ preceptors and mentors to resident physicians participate in cultural competence training. Additionally, as part of their supervision, attending physicians who are supervising should ensure that their resident physicians are learning and utilizing cultural competence skills as part of their graded work.

**Immersive Clinical Encounters**

The researcher recommends that medical school students and residents have the opportunity to engage in internships outside the United States, where they would be introduced to the non-Western healthcare norms and beliefs of marginalized patient populations. Further, after medical school, residents would benefit from assisting physicians working abroad in non-Western countries. Two study physicians discussed how working with marginalized patients allowed them to tailor healthcare delivery appropriately to U.S. patients with similar backgrounds. Thus, working abroad positively influenced their cultural competence, learning skills, and clinical practice skills.

The benefits of immersive clinical experiences are documented in the literature. According to the research (Slifko et al., 2021), those who completed an elective in global health in medical school were more likely than their peers who did not participate in global health to pursue careers with underserved populations. Slifko et al. (2021) suggested, based on an observational study of a public U.S. institution, that the inclusion of global health experiences can enhance the interests and skills that would "better prepare them to work with underserved populations in the U.S. and abroad" (p. 1).

Additional research on current and proposed curriculums concerning the inclusion of global health electives in medical school and residency would provide more evidence of the value of electives to benefit healthcare delivery to ethnically and racially diverse patients.

**Effective Physician-Patient Communication**

A study physician voiced concern that they are not versed in the proper language (pronouns) to use with patients who identify their preferred gender and sexuality, which may be other than their biological gender. The study physician shared how they want to learn more about communication and the language used to be culturally appropriate when speaking with LGBTQ+ trans and nonbinary patients. According to Squires and Thompson (2021), "Learning a culturally mindful language is a critical step toward achieving health equity. These will include individuals belonging to immigrant populations, LGBTQIA+ individuals, from racial and ethnic minority groups" (p. 871). Further, Pratt-Chapman et al. (2022) recommended developing standards for cultural competency training for healthcare providers of LGBTQ+ patients which "teach communication skills to optimize respectful shared decision making" (p. 343).

The literature in the United States is trending on LGBTQ+ as it relates to appropriate healthcare delivery and as a factor of adherence to diversity, equity, and inclusion (DEI) initiatives for physicians and their patients. As posited by Fadus et al. (2019), medical students gain foundational knowledge during preclinical years; however, they can encounter challenging conversations that they may not feel prepared for during years of training. The researcher recommends that clinical practices inform and train physicians on the effective use of language for patients who self-identify as LGBTQ+

and include the topic within cultural competence training to enhance and improve physician-patient communication, clinical decision-making, and the physician-patient relationship for better healthcare outcomes.

### Education on Non-Western Healthcare Alternative Remedies and Behaviors

Study physicians discussed their encounters with ethnically and racially diverse patients who take non-Western remedies and therapies for their healthcare. Study physicians stressed that they need more knowledge regarding these alternative healthcare methods. The researcher found that literature is sparse on the topic of non-Western remedies and leans toward the traditional medicines and remedies of Western medicine. This may be due to efficacy and regulations on the accepted use of traditional Western medicine. Consequently, although Western-trained physicians are aware of patients' exposure to non-Western healthcare behaviors and remedies, healthcare providers and patients may underestimate the therapeutic potential of these medicines (Jansen et al., 2021). The researcher recommends more training on alternative remedies and therapies to add to physicians' knowledge base, particularly when addressing the issue of patients taking alternative remedies as part of their cultural healthcare norms and beliefs. Physicians' understanding of non-Western alternative remedies and healthcare behaviors may then be addressed to foster better healthcare outcomes.

### COVID Pandemic Lessons Learned—Next Time Preparedness

Although the unprecedented global COVID-19 pandemic impacted organizations, it was especially significant in healthcare delivery. The criticality of time only intensified within healthcare organizations during the pandemic (Förster et al., 2023). According to

Knox and Haupt (2020), “The lack of culturally respectful responses to diverse populations underscores the critical need for cultural competency training in higher education and practice” (p. 1).

The study participants spoke candidly about how they faced challenges due to the COVID-19 pandemic in clinical practice. Examples included efforts to help parents caring for children showing mental health symptoms due to COVID-19 and efforts to offer telehealth meetings versus in-person patient visits. Three physicians expounded on the adverse effects on children due to school closures during the height of the pandemic. For two pediatric physicians, COVID-19 brought on the challenges of working with parents who were dealing with the health issues of their children, the surfacing of mental health problems related to being home from school, and the inability to receive needed childhood vaccinations due to busy schedules. Clinical settings became overly busy with COVID-19 patients. Physicians also discussed how they would try to be prepared for a future catastrophic health-related event.

For health professionals and first responders, there is a plethora of literature on disaster recovery and case studies showing how understanding cultural competence is advantageous for effective teaching in emergency preparedness for disasters and global pandemics (Knox & Haupt, 2020; Wehde, 2023). All study physicians discussed the global pandemic in terms of how it changed their work in healthcare practices. As previously mentioned, practices shifted into gear to reschedule routine appointments, provide community outreach to educate people on COVID-19, and deliver care to pandemic patients. Some study physicians voiced that more was needed to address issues faced with the pandemic (safety equipment, telehealth, etc.). This researcher suggests that

additional plans be developed and introduced to better prepare health professionals for a crisis due to a global pandemic or the chance of a disaster such as Hurricane Katrina, among others. By developing plans for future global pandemics and natural disasters affecting adults and children's health, healthcare providers may be better prepared to deliver healthcare. The enhancement of current plans and development of future preparedness for a pandemic or natural disaster may assist physicians, faculty, and staff to deliver healthcare more efficiently during challenging events.

## Recommendations for Future Research

To date, there is a lack of literature measuring graduating U.S. medical school students' perception of curricular time spent on immigrant and refugee health or students' confidence in caring for these populations once they attain the status of resident physician (Stryker et al., 2023). This study highlighted the need for studies and first-hand accounts of physicians delivering healthcare tailored to immigrants and refugee patients. Such studies may benefit physicians, healthcare organizations, and healthcare systems due to the influx and increasing numbers of ethnically and racially diverse populations entering the United States and receiving healthcare services from Western medicine-trained physicians. The researcher recommends further studies on the time medical students spend on formal learning of cultural competence to attain cultural skills in preparing to deliver appropriate healthcare to diverse patients. Additionally, the researcher recommends the use of cultural competence testing as developed by Campinha-Bacote to assess residents' levels of cultural competence. Other recommendations relate to cultural competence education for front staff, efforts to attract and retain ethnically and racially diverse physicians, nuanced use of code-switching particularly for physician-patient

communication, understanding how to avoid patient stereotyping and bias in efforts to be culturally competent, incorporating cultural competence with DEI efforts even in a culture of backlash against DEI, addressing the debate on the term cultural competence, understanding the utility of the cultural competence model, and considering aspects such as humility and secular approaches in the evolution of the cultural competence model.

**Standardization of Cultural Competence Training**

The study captured the experiences of physicians' formal and informal experiential learning in cultural competence. It became apparent through discussions with study physicians that formal cultural competence training in medical school was not yet standardized. Literature has revealed that, although mandated for medical schools, the topic is not standardized (Goyal et al., 2020). The topic of cultural competence training raises the question: Can efforts be made to standardize formal cultural competence training in medical school curriculums and introduce ongoing training in clinical practice? The effectiveness of cultural competence training in medical schools needs to be established from the perspective of both students and faculty. Once programs are evaluated through research, standardization may be possible. Training standardization may lead to ways to effectively operationalize how cultural competence is taught across medical schools and clinical practices. The researcher suggests that new studies should be conducted to assess the effectiveness of standardizing cultural competence training curriculums. Results from formalized cultural competence training and testing could bridge the gap in knowledge on the issue and assist in developing and introducing new programs to address ongoing training needs. Standardized formal cultural competence

training can benefit healthcare organizations and policymakers charged with developing programs and mandating changes to clinical practice.

**Integration of Cultural Competence in the Medical School Curriculum**

Regarding an appropriate approach to the pedagogy of medical school training and promoting students' desire to learn cultural competence, the researcher suggests the strategy provided by the CoachDiversity Institute, which posits that students must have cultural humility and self-awareness. This assertion is in agreement with Campinha-Bacote's tenet of cultural self-awareness. Thus, as a precursor, instructors may need to tailor the curriculum to assess students' cultural self-awareness and provide a self-awareness class as a part of formal cultural competence training.

To accomplish the aim of facilitate students' willingness to learn cultural competence skills, the researcher suggests adding a survey to the curriculum to assess their preferred approach to understanding cultural competence (e.g., online, texts, lectures) and to evaluate their preferred cultural competence topics to ascertain what they perceive to be their weaknesses and strengths when delivering care to ethnically and racially diverse patients tailored to patients' cultural norms and beliefs. This approach built into the curriculum may expose gaps in the medical curriculum, as posited by Seeleman et al. (2014).

Early training would help foster students' open-mindedness and willingness to gain knowledge about changing cultural attitudes and their sensitivity to the cultural differences of ethnically and racially diverse patients in clinical encounters. Self-awareness training would enhance the curriculum and offer effective results in further cultural competence training. In support of current cultural competence training methods,

a study by Lakra et al. (2023) indicated that fourth-year medical students and internal medicine physicians rated their understanding of cultural competence as excellent after training. Finally, this approach may present healthcare organizations with an intervention to provide a healthcare intervention for continuous cultural competence learning after medical school for interns, resident physicians, and attending physicians.

### The Importance of Cultural Competence for Front Staff

Reede (2003) noted that the racial/ethnic composition of the U.S. physician workforce does not reflect that of the general population. With insufficient minority healthcare providers, cultural competence learning and practice are essential for the healthcare workforce. There is a need for front staff (e.g., medical assistants and intake coordinators) to understand, learn, and practice cultural competence skills when engaging with ethnically and racially diverse patients.

The front staff is the first contact that a patient and their family have with the healthcare practice. First impressions can set the stage and create a positive impression. Immediate contact between the patient and front desk staff may help obtain information on the patient's cultural norms and beliefs. Examples include gathering or updating information on the patient's religious affiliation, alternative remedies, and non-Western healthcare practices. Current medical data allows physicians to understand patients' cultural norms and behaviors. Thus, healthcare delivery is tailored appropriately to the patient's cultural needs.

Although there is a lack of diversity in the healthcare workforce, physicians agreed that their experiences of experientially learning cultural competence skills and passing the knowledge to other physicians, faculty, and front staff would enhance clinical

practice encounters with diverse patients and introduce, reinforce, and strengthen cultural competence skills. Additionally, healthcare staff provide community outreach programs and serve ethnically and racially diverse patients in marginalized areas. Further research is needed to aid in developing and introducing programs and initiatives to train and reinforce cultural competence skills for front staff and community outreach practitioners, preparing all levels of healthcare staff to engage with patients in a culturally competent manner.

### Programs to Attract and Retain Residents

Although efforts are being made to increase the ratio of minority physicians, it may take years to reach an adequate number of ethnically and racially diverse physicians to deliver healthcare to minority patients. It takes almost 10 years of medical school and residency before an individual is fully equipped to work in clinical practice without supervision. Two study physicians discussed plans to attract and retain minority physicians, as they believe their clinical practices will benefit from having providers and staff representative of their ethnically and racially diverse patients. They specifically mentioned programs and incentives to attract minority physicians and retain them after the completion of their residency rotations. Researchers have proposed that the number of minority medical students is not representative of the minority patients they serve (Aibana et al., 2019).

Another recommendation is to conduct a longitudinal study to understand better why physicians remain at the same Mid-Atlantic hospital after residency for at least 4 years of clinical practice. The results could reveal the effectiveness of programs to attract and retain physicians, as efforts are needed to replicate programs and incentives found to

attract and retain more minority physicians to serve diverse patients in urban healthcare organizations.

**Nuanced Use of Code-Switching to Establish Credibility**

An African American study physician spoke of her peers and colleagues hearing and knowing the difference in her language when talking to an African American patient. "Code-switching"—the mixing of languages, dialects, tones, or lexicons within a single conversation—is a prevalent linguistic phenomenon described thoroughly in the social science literature (Wood, 2018). However, Wood (2018) argued that it is relatively unknown to the medical community despite its clear implications for clinicians as they navigate their role as communicators in the physician-patient relationship. "Multidisciplinary literature, case studies, and thought experiments on the subject provide an actionable framework by which health professionals can work toward achieving this goal of cultural competence" (p. 464).

Physicians traditionally speak in Standard American English (SAE), the formal language of college-educated Americans (Lippi-Green, 2000). The study physician probably talked to her patient in African American English (AAE) or Ebonics. According to Wood (2018), Black people are often bidialectal. They may speak both fluent SAE and AAE, and this alternating of dialects is called "code-switching."

Further, Wood (2018) noted the differences in code-switching during clinical encounters. If speaking informally about the patient's family, AAE is used; if speaking formally/professionally about a medical treatment option, SAE is used. Residents and attending physicians may positively affect physician-patient relationships and strengthen the relationship through code-switching. In contrast, Wood (2018) cautioned that code-

switching could influence a patient's adherence to a treatment plan through manipulation. Therefore, physicians might cross an ethical line if they use code-switching to charm patients into changing their healthcare decision-making. Beginning or continuing to code-switch should be done with concern for patients.

In another framework, Black physicians may use code-switching to promote Black people's engagement in a variety of behaviors to avoid stereotyping and promote a professional image in the workplace. Racial code-switching is one impression management strategy where Black people adjust their self-presentation to desirable outcomes (e.g., perceived professionalism) by mirroring the norms, behaviors, and attributes of the dominant group (i.e., White people) in specific contexts. A study conducted by McCluney et al. (2021) examined whether racial code-switching enhances perceived professionalism for Black employees. The study results indicated that employees who engage in racial code-switching are consistently perceived as more professional by both Black and White participants compared to employees who do not code-switch. Perhaps the code-switching depends on the circumstance in which it is utilized (e.g., Black patient/Black physician, Black physician/White workplace). More research is suggested to investigate how code-switching can positively or negatively affect physicians and their patients' healthcare.

**The Risks of Patient Stereotyping and Bias**

Further research is recommended to explore and provide information on the benefits of cultural competence learning versus the risk of stereotyping and bias when utilizing cultural competence skill sets. The risk of stereotyping may raise questions about how physicians perceive the term. To address these risks, Lekas et al. (2020)

suggested training physicians in cultural humility, which aligns with the opinions of some study physicians.

Further, as suggested by Tervalon and Murray-García (1998), "cultural humility is a lifelong commitment to self-evaluation and critique, to redressing power imbalances" (p. 123). Sylk Sotto-Santiago et al. (2023) agreed, stating, "In the 1990s, … cultural humility also offered a way to encourage self-reflection, lifelong learning, and a check of power imbalances to develop meaningful communication and mutually respectful relationships with patients" (p. 1). Additional research would be of value to ascertain if Campinha-Bacot's (2018) proposed paradigm of combining cultural competence and cultural humility would be synergistic, enhancing the concept of cultural competence in the delivery of healthcare services and possibly addressing the issues of stereotyping and bias. As a result of the study findings, the researcher recommends further research on the issues of stereotyping and bias based on physicians' ideas and assumptions of their diverse patients' races and cultures. As previously mentioned, this effort may provide a demarcation between what is considered a health issue based on race and possible stereotyping or bias on the part of the physician.

### Addition of Cultural Competence to the Diversity, Equity, and Inclusion Framework

A study physician voiced their challenges with hiring and retaining minority physicians for their Mid-Atlantic clinical practice. Literature has revealed that DEI efforts in healthcare organizations are needed. One reason is the underrepresentation of minority physicians and the increasing number of minority patients receiving healthcare services.

In the United States, Black/African American and Hispanic/Latino physicians make up only 4% of the physician workforce (Aibana et al., 2019).

The need for more minority physicians is based primarily on better healthcare outcomes for minority patients. In a longitudinal study conducted by Snyder et al. (2023) of the primary care physician workforce in U.S. counties where there were black primary care physicians, higher levels of Black representation within the physician workforce were directly associated with longer life expectancy and lower all-cause mortality rate disparities for Black patients.

This researcher suggests conducting additional research on DEI to develop a framework that includes cultural competence. It became apparent from the study that there may be a more advantageous way of connecting cultural competence with DEI to improve and enhance cultural competence learning. First, *diversity* is consistent with the ongoing effort to attract and retain minority physicians in the workforce. Second, *equity* contributes to the positive impact of culturally competent healthcare, which may help lower the unequal treatment of minority patients. Additionally, when looking at the issues of health disparities that impact the care of ethnically and racially diverse patients, DEI can foster equitable access to healthcare services. Third, inclusion would help all entities (healthcare organizations, systems, medical schools) incorporate best practices in cultural competence training. However, the task of equitable inclusion may be subject to the current status of DEI and the issues of a trending focus on its survival.

**The Backlash on Diversity, Equity, and Inclusion**

As detailed by Blackstock et al. (2024), health care is the new battlefront for anti-DEI attacks. It reflects a broadening of the wave of state-level anti-DEI in higher

education legislation that has surged through the country, with 65 anti-DEI bills introduced since 2023, eight of which have become law. According to Blackstock et al. (2024), the impact of attacks on DEI initiatives within healthcare has potentially devastating consequences for existing efforts to diversify the healthcare workforce in service of an increasingly diverse nation, as well as for existing racialized health inequities in the United States. The issue of the backlash of DEI underscores the need for culturally competent physicians who may be tasked with mitigating the effects of anti-DEI, potentially resulting in a less diverse physician workforce to deliver healthcare to racially and ethnically diverse patients.

Regarding value in a nonfriendly contemporary social context where there is a backlash against DEI, the CoachDiversity Institute posited that organizations need culturally competent employees capable of working with people from different cultures. CoachDiversity Institute (2024) has suggested that in the age of globalization, healthcare services, public service administrations, social care systems serving transgender people, and LGBT communities' educational institutions are some sectors of employment that need to enforce cultural competence training.

Additionally, CoachDiversity Institute (2024) suggested incorporating cultural competence training in healthcare organizations to help mitigate the possible backlash against DEI in the workplace. As their report indicated, the value of cultural competence training programs is expected to reach $1.46 billion by 2025. Training programs assure us of better productivity and relationships in workplaces (CoachDiversity Institute, 2024).

**The Utility of the Cultural Competence Model and Debate on the Term Cultural Competence**

The model of cultural competence has been found to be important in the healthcare field. Cultural competence training is required during medical school in the United States and Canada. The term *cultural competence* may still be used in medical school curricula since that term is used by the LCME and is frequently used in the literature (e.g., Betancourt, 2003; Campinha-Bacote, 1998; Leininger, 1990). However, there is an ongoing debate among healthcare professionals on which term best captures the meaning of cultural competence. Understanding the debate over the term may assist in finding a suitable way to foster cultural competence training and utilize it in clinical practice.

Study physicians shared their opinions about the best term to capture the meaning of cultural competence. Two terms emerged: cultural competence and cultural humility.

Additionally, Ann and Gail shared their dislike for the term *cultural competence*, although they believed the idea is essential to healthcare delivery. Ann commented:

> A large amount of training may be the different types of practices or beliefs, particularly regarding health and spirituality, and all the things that impact families, all the things that affect your health. To me, that's all part of cultural competence. I don't even really like the term. I don't know if it's the right term. But I know there's lots of debate around cultural competence, cultural humility. But I think it involves, like, just a real openness to learning and, and recognizing how big a part that is of someone's health. I think I like the term *cultural humility* a little more because it is more evolving.

Gail also gave her opinion on *cultural competence* and referenced how she disapproved of the term; she preferred the term *cultural humility*. Gail believes cultural humility better describes cultural competence in healthcare delivery. Similarly, Mary

preferred the term *cultural humility,* which she defined as continuous cultural competence learning. Mary shared:

> One of our colleagues, a community leader, likes to refer to it [cultural competence] as cultural humility. I really like it. It's understanding that you're always learning about yourself and others.

Lotus also discussed how she worked with different cultures, and the term *cultural competence* may not accurately describe delivering appropriate healthcare to others. She explained:

> I don't like the term cultural competence because I don't think we can be competent in other cultures. We're barely competent in our own cultures usually, so I don't like to use the term. If we are going to talk about being competent I would call it human competence or how to learn how to relate to other people no matter who they are. I think that's the intent of the term [cultural competence].

As previously mentioned, a cultural competence model that uses both terms, cultural competence and cultural humility, may help mitigate the debate. Consequently, Betancourt (2003) challenged the separation of *cultural competence* and *cultural humility*. Betancourt (2003) suggested that both are promising approaches to illuminating the underlying challenges affecting members of racial and ethnic minority groups and working toward alleviating racial and ethnic healthcare disparities and improving culturally competent healthcare. In agreement with Campinha-Bacote, Nguyen et al. (2021) indicated that combining cultural competence and cultural humility presents a more effective clinical practice than focusing solely on the tenets of Campinha-Bacote's model of cultural competence.

Further research on terminology may be necessary due to the ongoing debate on terminology. Such research is recommended to capture how health professionals understand and define cultural competence and to establish a foundation on which new

terminology may be introduced, with the goal of consensus on the term best suited for acceptance by health professionals (physicians, healthcare organizations, policymakers).

**The Evolving Model of Cultural Competence**

As mentioned in Campinha-Bacote's model, *The Process of Cultural Competence in the Delivery of Healthcare Services,* the term "comptemility" was used to describe the synergistic relationship between cultural competence and cultural humility. Campinha-Bacote argued that it is not enough to be aware of all the tenets of the cultural competence model; it is necessary to have the desire to continue becoming culturally competent, as there is no endpoint in learning cultural competence (Campinha-Bacote 2002b).

Sara Taylor of the CoachDiversity Institute noted that attaining inclusivity to the point that companies can draw upon it as a strength is elusive to so many. Taylor posited that it is not enough to direct your workers "to go out and be inclusive." Instead, she said, "We need to develop inclusivity as a competence" (CoachDiversity Institute, 2024). Further, Taylor suggested teaching employees (physicians) about how we perceive our differences and how to make inclusion a reality not by minimizing what makes us different but by recognizing and celebrating it. By understanding how our own experiences of the world have filtered our understanding of others, we can begin to rise above easy stereotypes and the prejudices they spawn. Taylor explained:

> We are uncomfortable talking about our differences, so we downplay them. But we can shift our understanding and be more effective working together by having a conscious awareness of our filters—and a nonjudgemental awareness of other people's filters.

The researcher believes that a cultural competence tenet of "inclusivity" may strengthen the model of cultural competence in a positive manner for ethnically and racially diverse patients.

Although Campinha-Bacote's model is biblically based, the researcher believes cultural humility may hold value from a secular position. Campinha-Bacote's model details that healthcare professionals, religious or secular, need a process (cultural humility) and a product (cultural competence) for meaningful encounters with racially and ethnically diverse patients. An evolving model of cultural competence might include the tenet of cultural humility as a separate tenet.

The power of humility may hold value in a secular position. Humility means " the state of being humble" ("Humility," n.d.). Humility from a secular position may encompass the moral virtues of humility, compassion, and social justice, as well as not placing oneself higher than other human beings. Several aspects of the power of humility are not defined in a biblical context. Nguyen et al. (2021) stated that "practitioners need to have the humility to be a learner rather than an expert and start with a focus on being open and receptive to patients from diverse populations" (p. 1). According to the research (Davidson & O'Neal, 2022), the definition of cultural humility is the "ability to maintain an interpersonal stance that is other-oriented and includes self-questioning, cultural immersion and active listening skills" (para. 1).

Further, as suggested by Tervalon and Murray-Garcia (1998), cultural humility is "a lifelong commitment to self-evaluation and critique and redressing power imbalances" (p. 123). Additionally, Foronda et al. (2016) suggested that cultural humility is a way of being (p. 4). Consequently, they stressed that cultural humility provides awareness of the

power distance between the physician and patient and focuses on humility with all individuals.

The researcher suggests that more research is needed to evaluate ways to redress power imbalances between physicians and patients, which would benefit patients and foster better healthcare outcomes. The researcher suggests that an evolving cultural competence model might include the tenet of "self-reflection" to improve the power distance relationship; study physicians suggested that the relationship can be hierarchical and paternalistic, and an improved stance would foster a physician-patient relationship on an even level, with patients having more control of their healthcare decisions. Finally, self-reflection would positively reinforce the power of humility by directing physicians to reflect on their attitudes and be humble toward patients.

## Summary

This basic qualitative study aimed to explore physicians' learning and practicing of cultural competence in delivering healthcare to ethnically and racially diverse patients. The study was guided by two questions: (1) How do physicians describe their experiences learning and practicing cultural competence when serving ethnically and racially diverse patients? (2) How do physicians make meaning of these experiences to inform their clinical practice? This study led to several conclusions.

First, physicians experience, learn and make meaning of cultural competence in various ways. Formal cultural competence is a required part of the curricula for medical school students. Physicians also have the opportunity to learn cultural competence experientially in clinical practice from peers and mentors. Additionally, physicians learn cultural competence experientially from ethnically and racially diverse patients in clinical

encounters. Additionally, physicians engage, learn, utilize skill sets, and make meaning of cultural competence through communications with peers, mentors, and diverse communities. Physicians concur that cultural competence learning is an ongoing, lifelong process that would benefit from education after medical school, especially when physicians were not formally trained.

Second, physicians rely heavily on competence and experience in delivering healthcare and adjusting to the norms and beliefs of non-Western patients. Two study physicians discussed their experiences in immersive settings in Texas, near the Mexican border, and Africa. The transfer of learning supports ELT. Thus, ELT continues to be relevant to continuous cultural competence learning.

Debate continues over the most appropriate term to define and encapsulate cultural competence. This study presented various opinions held by physicians. Campinha-Bacote (2018) suggested combining two terms, cultural competence and cultural humility, to mitigate the debate. Campinha-Bacote (2018) stressed that this option may not end the discussion on the most appropriate term.

The lack of diversity in healthcare continues to be an issue. Healthcare organizations may be experiencing ongoing issues involving a backlash against DEI as U.S. states are being challenged on efforts to include DEI as a part of employment strategies to hire minorities in the workplace. Small efforts are being made to attract and retain minorities in Mid-Atlantic clinical practices. However, there is still a gap in the number of minority physicians entering healthcare practices due to the underrepresentation of minorities in healthcare in comparison to the general U.S. population. Some study physicians in charge of their practices are developing and

introducing programs to attract and retain minority physicians to deliver healthcare to ethnically and racially diverse patients. The experiences of study physicians provided information for future research endeavors.

Minorities will account for over 90% of the U.S. population growth from 1995 to 2050 (Shaya & Gbarayor, 2006). According to Grewal et al. (2021), the American Association of Medical Colleges estimated that over the next 15 years, the demand for physicians treating ethnic and racial minority patients (specifically Black, Hispanic, and other mixed-race individuals) would increase along with the growth in marginalized populations. Thus, the cultural competence model for learning and practicing cultural competence skills in healthcare delivery to ethnically and racially diverse patients is essential to foster better healthcare outcomes. Additionally, efforts to train and reinforce cultural competence skills after medical school may be tasked with developing new methods to encourage medical students, physicians, and healthcare staff's desire to learn and practice cultural skill sets.

The study explored the utility of Campinha-Bacote's (1998) cultural competence model, *The Process of Cultural Competence in the Delivery of Healthcare Services.* The tenets of the model were described, as were suggestions on how the model can evolve by adding cultural humility in contrast to the synergetic relationship of cultural desire, as posited by Campinha-Bacote. The separation of cultural competence and cultural humility may strengthen and give power to cultural humility. The researcher suggests that physicians and patients view cultural humility from a secular position.

Code-switching, although an outlier voiced by one physician in the interview responses, was reviewed. The researcher suggests the communication practice requires

careful consideration, particularly when communicating with various audiences (e.g., health professionals, patients, and peers) to mitigate bias and stereotyping. Also, physicians should be conscious of the nuances of code-switching and the effects of utilizing code-switching to establish credibility, which may negatively affect communication.

Ultimately, the study showed the importance of ongoing learning and utilization of cultural competence skills in healthcare delivery. It continues to be essential to provide healthcare that considers the cultural norms and beliefs of patients from ethnically and racially diverse patients backgrounds, with the aim of better healthcare outcomes.

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# APPENDIX A:

# INTERVIEW PROTOCOL

## Research Questions

RQ1: How do resident physicians describe their experiences of learning and practicing cultural competence when serving ethnically and racially diverse patients?

RQ2: How do resident physicians make meaning of these experiences to inform their clinical practice?

## Process

A modified version of Seidman's (2013) in-depth phenomenological interview approach and Merriam and Tisdell's (2016) semi-structured interview approach will be used to gather data on the participants' life history and the details of their experience of cultural competence in practice. Specifically, the interviews will focus on resident physicians' backgrounds and professional work, how they experientially learn cultural competence skills in practice, how they experience serving ethnically and racially diverse patients, how their cultural competence experience differs from medical school learning, and how these experiences inform their clinical practice.

## Purpose

To collect data related to participants' life histories, experience learning and practicing cultural competence, and serve ethnically and racially diverse patients based on the theoretical frameworks and how learning informs their clinical practice.

## Coding

The interview questions refer to codes from elements of the conceptual framework:

| Experiential learning theory (Kolb, 2015) | Culturally competent model of care (Campinha-Bacote, 1998) |
|---|---|
| Concrete experience (CON) | Cultural awareness (CA) |
| Reflective observation (RO) | Cultural knowledge (CK) |
| Abstract conceptualization (AC) | Cultural encounter (CE) |
| Active experimentation (AE) | Cultural skill and desire (CSD) |

**Questions: Interview 1**

1. Tell me about your medical school background. Why did you choose to become a physician? (Background Information)

2. What does cultural competence training mean to you? (CA, CK, CSD)

3. Tell me about your experience of cultural competence training in medical school.
    a. Follow-up: Did you practice cultural skills in simulations with peers?
        i. Probe: If yes, please describe the training/simulation experience.
        ii. Follow-up: Describe the impact, if any, these training/simulations have had on your practice with culturally diverse patients.
        iii. Probe: To what extent, if at all, do you believe these trainings/simulations have enhanced your clinical practice?
        iv. Follow-up: In what ways? Why not? If no, why do you think such practice was not made available to you? (CE, CON)

4. Please help me understand your beliefs about cultural competence. Do you believe you need to learn more about cultural competence? (CA, RO, CSD)

5. How would you describe your cultural awareness before cultural competence training in medical school?
    Probe: Have you practiced cultural competence outside of work? If yes, can you provide an example?

6. Let's talk about the differences between cultural competence training in medical school and during encounters with patients.
    Follow-up: Is cultural competence a part of clinical training in practice? If yes, how? Testing, observations from preceptors/attendings?

7. What kind of population do you serve?
    Follow-up: On average, what percentage of your patients have a different background than your own (specifically, racially, ethnically, culturally)? Did you practice cultural skills in simulations with peers?

8. How have you learned cultural competence over a long period of time?

9. Can you share a specific example of how you learned new knowledge about a patient's knowledge?

10. Do you believe cultural competence skills impact your work with diverse patients from different backgrounds?
    Probe: If yes, in what way do cultural competence skills inform your practice?
    Probe: Are cultural competence skills helpful, or do they make work more of a challenge?

11. Do you engage in reflection after having an encounter with a patient?

12. Has the practice of cultural competence in simulations with peers been helpful? If not, would cultural competence be beneficial if practiced with peers and texts and lectures?

13. Can you describe a specific difficult or challenging situation in which you utilized cultural competence in a patient encounter?

14. How has the COVID-19 pandemic affected your work with patients?

**Linking to the Research Questions**

A matrix was created to map interview questions to the research questions, based on questions asked in each interview.

**Interview Questions**

| Interview question | What I want to know with this question |
|---|---|
| 1. Tell me about your medical school background. Why did you choose to become a physician? | Background on the resident's profile. Establish rapport at the start of the interview. |
| 2. What does cultural competence training mean to you? | The participant's initial stance on cultural competence's relevance to patients.<br>*Tenets*:<br>Cultural learning<br>Cultural self-awareness |
| 3. Tell me about your experience of cultural competence training in medical school. | If the training was a positive or negative experience; the form of training.<br>*Tenets*:<br>Cultural learning<br>Cultural knowledge |
| Follow-up: Did you practice cultural skills in simulations with peers? If yes, please describe the training/simulation experience. | The medical school peer demographics supporting the literature review of minority medical students.<br>*Tenets*:<br>Cultural skills<br>Cultural learning/practice |
| Follow-up: Describe the impact, if any, these training/simulation experiences have had on your practice with culturally diverse patients. | Whether residents have transferred skills sets or learned experimentally in informal training; whether or not they found find it helpful for practice; whether it added to/enhanced cultural awareness or desire.<br>*Tenet*:<br>Ongoing cultural competence |

| Interview question | What I want to know with this question |
|---|---|
| Probe: To what extent, if at all, do you believe these trainings/simulations have enhanced your clinical practice? In what ways? Why not? If no, why do you think such practice was not made available to you? | Residents' initial beliefs and views of training at a surface level to allow them to reflect on their training in medical school, which may have occurred early in their curriculums. The ongoing process of cultural competence learning and how it informs their practice in alignment with RQ2.<br>*Tenet*:<br>Cultural learning |
| 4. Please help me understand your beliefs about cultural competence. Do you believe you need to learn more about cultural competence? | Support for theoretical/conceptual framework.<br>*Tenets*:<br>Cultural desire<br>Ongoing process of learning |
| 5. How would you describe your cultural awareness before cultural competence training in medical school?<br>Probe: Have you practiced cultural competence outside of work? If yes, can you provide an example? | Whether, after reflection, there has been a change in thoughts of self-assessment of cultural knowledge.<br>*Tenets*:<br>Cultural awareness<br>Cultural knowledge<br>Cultural self-awareness |

| Interview question | What I want to know with this question |
|---|---|
| 6. Let's talk about the differences between cultural competence training in medical school and during encounters with patients.<br>Follow-up: Is cultural competence a part of clinical training in practice? If yes, how? Testing, observations from preceptors/attendings? | To explore and examine support for any or all of the ongoing cycles of cultural competence frameworks to answer RQ2.<br>*Tenets*:<br>Abstract conceptualization<br>Active experimentation<br>Cultural encounter<br>Concrete experience |
| 7. What kind of population do you serve?<br>Follow-up: On average, what percentage of your patients have a different background than your own (specifically, racially, ethnically, culturally)? Did you practice cultural skills in simulations with peers? | Background of work environment/population; difference between patient and resident background.<br>Support for RQ2.<br>*Tenet:*<br>Working with ethnically and racially diverse patients |
| 8.How have you learned cultural competence over a long period of time? | Resident background outside of healthcare, experience with cultural competence |
| 9. Can you share a specific example of how you learned new knowledge about a patient's culture? After reflecting on our past interview is there a factor of cultural competence learning that has changed? | Discrete examples of cultural competence experiential learning.<br>*Tenets:*<br>Cultural awareness<br>Cultural desire |

| Interview question | What I want to know with this question |
|---|---|
| 10. Do you believe cultural competence skills impact your work with diverse patients from different backgrounds? Probe: If yes, in what way do cultural competence skills inform your practice? Probe: Are cultural competence skills helpful, or do they make work more of a challenge? | Tenets of cultural competence and the possible challenges presented in practice to hinder clinical practice encounters.<br>*Tenets*:<br>Cultural skill/desire<br>Cultural awareness<br>Reflective observation |
| 11. Do you engage in reflection after having an encounter with a patient? | Kolb's phase of active reflection.<br>*Tenet:*<br>Experiential learning |
| 12. Has the practice of cultural competence in simulations with peers been helpful? If not, would cultural competence be beneficial if practiced with peers and texts and lectures? | If simulations encourage the use of cultural competence skills and informed practice.<br>*Tenets*:<br>Active experimentation<br>Reflective observation<br>Cultural encounter(s) |
| 13. Can you describe a specific difficult or challenging situation in which you utilized cultural competence in a patient encounter? | Discrete examples of cultural competence experiential learning.<br>*Tenets*:<br>Cultural awareness<br>Cultural knowledge |
| 14. How has the COVID-19 pandemic affected your work with patients? Is there a consideration other than medical that you have discussed with a patient for example cultural conditions that may affect their health care outcomes examples (compliance with treatment)? | If there is a change in the way communication is conducted with patients. Whether COVID changed the time they spend with patients to address cultural norms of the patient.<br>*Tenets*:<br>Cultural skill<br>Cultural desire<br>Reflective observation |

## APPENDIX B:

## INVITATION TO PARTICIPATE

Stephanie Holder sdholder@gwu.edu

Hello XXX-

Thank you for the opportunity to gain your perspective on how resident physicians experience serving ethnically and racially diverse patients in a metropolitan hospital and outpatient practice.

To begin this study, please answer the following prescreening questions that will start our process.

Full Name:
Age:
Phone Number:
Email:
Race/Ethnicity:
Gender:
Year of Residency/Practice:

If you decide to participate in my study, there will be one 90-minute interviews via telephone/Zoom or Webex digital platform conversation. The interview will be audiotaped to enable me to accurately reflect on our discussions and capture all relevant data for the study. The tapes will be transcribed and, afterwards, no longer used. Your participation in the study is confidential and your identity will be anonymous when the results are published.

Taking part in this study is your decision. You may decide to decline to answer any question you are not comfortable answering.

If this study is something you are interested in, please respond back to me by [date].

You may reach me via my email account or via my mobile phone (202-236-0189).

Thank you for your consideration.

Stephanie H.

## APPENDIX C:

## PARTICIPANT CONSENT FORM

**Physicians' Experience with Cultural Competency**
**at a Mid-Atlantic Teaching Hospital, Clinical Practice**
IRB #NCR213390

Principal Investigator: Shaista E. Khilji, Ph.D., 202-994-1146
Doctoral Candidate: Stephanie Holder, 202-236-0189

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INTRODUCTION

You are invited to participate in a research study conducted by Stephanie Holder under the direction of Dr. Shaista E. Khilji of the Department of Human and Organizational Learning in the Graduate School of Education and Human Development at George Washington University.

First, we want you to know that *taking part in this research is entirely voluntary.* You may choose not to take part, or you may withdraw from this study at any time. You will receive no benefit from taking part in this study. This research may give us knowledge about how resident physicians experience, construct, and make meaning of cultural competence learning in practice when serving ethnically and racially diverse patients in Mid-Atlantic hospitals and health care settings in Washington, D.C., Maryland, Virginia, and other areas. Before you decide to participate, please take as much time as you need to ask any questions and discuss this study with colleagues, family, or friends.

ABOUT THE RESEARCH

You are being asked to participate in this study because you are viewed as a resident physician within the [study site] or affiliated hospitals and clinical care settings.

The purpose of this study is to contribute to the research on cultural competence and the literature on adult experiential learning in clinical practice with diverse patients. Two main research questions guide this study:

> RQ1: *How do physicians describe their experiences of learning and practicing cultural competence when serving ethnically and racially diverse patients?*
> RQ2: *How do physicians make meaning of these experiences to inform their clinical practice?*

The interviews will focus on experiences in practice as resident physicians (how the decision was made to become a physician, the experience of cultural competence when serving patients from a different cultural background, the difference in learning cultural competence in medical school versus actual practice, and how resident learning of cultural competence informs clinical practice). The research will be conducted through two 60- to 90-minute interviews via telephone, WebEx, or Zoom at an agreed upon date and time. An estimate of 15 to 20 participants will be interviewed for this study.

WHAT IS INVOLVED IN THIS STUDY?

The total amount of time you will spend in this study is 90 minutes, with an additional follow-up by phone or e-mail to discuss findings and questions with you. The follow-up contact would be within 5 days of your interview.

If you choose to take part in this study, this is what will happen.

*The Interviews:*

You will participate in one 90-minute interview about your experiences as a physician in practice at [the study site] or affiliated hospitals and clinical care settings.

- The interviews will be audio-recorded, voice only, with your permission. You will be asked again at the interview time to give your verbal permission to participate in the study and be recorded. Your consent will be recorded in response to the statement, "Please state 'yes' if you are comfortable with this interview being audio-recorded." If you do not feel comfortable with the interview being recorded, the interviewer will take notes during the interview.
- Please do not identify yourself by name during the interview. You will be asked to provide a pseudonym of your choice to remove your voice's identification with your name at the interview time.
- Following HIPAA privacy and protection rules, please do not provide any patient, peer, or attending physician names.
- The audio files will be kept in a secure place and destroyed after the end of the study.

*The Follow-Up:*

- Not everyone will be contacted for a follow-up conversation.
- If you do not wish to have any follow-up contact, let the researcher know and you will not be contacted.
- It is estimated that follow-up conversations will take no more than 15 minutes.
- You may choose whether you would like to be contacted by telephone, Webex, Zoom, or e-mail for follow-up.
- The purpose of the follow-up contact is to discuss aspects of your interview with you or the general findings after conducting several other interviews.

WHAT ARE THE RISKS OF THE STUDY?

The study has the following risks.

Given the interview questions' nature, you will not likely feel any stress or discomfort during the interview. You are free to skip any questions or stop the interview at any point. There is a small chance that someone not on our research team could find out that you took part in the study or somehow connect your name with the information we collect about you; however, the following steps are being taken to reduce that risk.

- As described above, a pseudonym will be used in the interview and transcription of the interview. A hardcopy only (no computer file) key linking your name and

the pseudonym as well as the audio files will be locked in a secure location separate from the research materials (transcriptions, data encoding, and analysis).

- All computers used for the project will be password protected, as will the software.
- When the results of this research study are reported in journals or at scientific meetings, the people who participate are not named or identified. Direct quotes may be published from the research, and if so, the quotes will be cited with the participant's chosen pseudonym.
- George Washington University will not release any information about your research involvement without your written permission unless required by law.
- At the end of the project, all material with identifiable data will be destroyed.

ARE THERE BENEFITS TO TAKING PART IN THE STUDY?

The benefits to society focus on expanding knowledge on how physicians experience and construct knowledge on cultural competence to inform clinical practice—explicitly serving ethnically and racially diverse patients in [the study site] or affiliated hospitals and clinical care settings.

Cultural competence and experiential learning theories are being used as a guide to show how physicians reflect, construct, and make meaning of cultural competence knowledge beyond formal medical school learning in practice.

WHAT ARE MY OTHER OPTIONS?

You do not have to participate in this study if you do not want to.

WHAT IF I CHANGE MY MIND?

You may stop taking part in the study at any time.

WILL I RECEIVE PAYMENT FOR BEING IN THIS STUDY?

You will not receive payment for taking part in this study.

WHAT ARE THE COSTS FOR TAKING PART IN THIS STUDY?

Besides the use of your time, taking part in this study will not lead to added costs for you.

PROBLEMS OR QUESTIONS

Research-specific questions should be addressed to the principal investigator, Dr. Shaista E. Khilji, at telephone number (202) 994-1146 or e-mail address sekhilji@gwu.edu. In addition, the Office of Human Research of George Washington University can provide further information about your rights as a research subject: (202) 994-2715.

## APPENDIX D:

## PERMISSIONS

Alice Kolb <aliceykolb@gmail.com> Thu, Jan 21, 2021 at 1:54 PM
To: sdholder@gwmail.gwu.edu

Greetings, Stephanie:
Thank you very much for your interest in experiential learning theory. You are welcome to cite the ELT model in your dissertation.
I also encourage you to check out our research library available at www.learningfromexperience.com for more research resources on experiential learning.
Let me know if you have any questions.

Best,
Alice Kolb Ph.D.
President and CEO
Experience Based Learning Systems, Inc.
www.learningfromexperience.com
phone: 808-798-6639
Experiential Learning Cycle Video
https://learningfromexperience.com/themes/experiential-learning-theory-videos/
The Kolb Learning Style Inventory products are available at:
https://store.kornferry.com/stores/kornferry/en/search?search=klsi
Alice & David Kolb The Experiential Educator: Principles and Practices of Experiential Learning Kaunakakai, HI: EBLS Press 2017
Are you an Experiential Educator? Take the FREE Kolb Educator Role Profile at
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TRANSCULTURAL C.A.R.E.
Clinical, Administrative, Research & Educational Consultation in Transcultural Health Care

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Cincinnati, Ohio 45241

April 5, 2021 2021

To: Ms. Stephanie Holder
From: Dr. Josepha Campinha-Bacote
President, Transcultural C.A.R.E. Associates

RE: **Contractual Agreement for Limited Use of Campinha-Bacote's Model of Cultural Competence**

This letter grants one-time permission to Ms. Stephanie Holder to copy my 1998 model of cultural competence as it appears on my website at in http://transculturalcare.net/the-process-of-cultural-competence-in-the-delivery-of-healthcare-services/, in her academic paper to be submitted in her doctoral proposal and final paper in 2021.

**TIME FRAME**: Permission to use my model is a one-time use as stated above when she submits it to her professor in an academic paper by April 30, 2021.

**RESTRICTIONS OF COPYING**: This permission only allows the copying/ of my model in this paper and Ms. Stephanie Holder agrees that my model cannot be copied for any other reason outside of this paper. This includes, but not limited to, not being copied in another formal or informal publication or academic paper, handouts, Power Point presentations, presentations to her faculty, students or colleagues, Poster presentations or in any hard copy or electronic formats for presentations or for any other purpose.

Ms. Ms. Stephanie Holder will use the following citation when citing my model in her paper:

**The Process of Cultural Competence in Mentoring**
**Copyrighted 1998 by Campinha-Bacote**

**GOVERNING LAW:** All parties acknowledge that this Contractual Agreement for Limited Use of Campinha-Bacote's Models of Cultural Competence is a valid contract. This contract shall be governed and construed under the laws of the State of Ohio, except as governed by Federal law. Jurisdiction and venue of any dispute or court action arising from or related to this contract shall lie exclusively in or be transferred to Hamilton County Municipal Court, Hamilton County Court of Common Pleas, or the Federal Court situated in the County of Hamilton, Ohio.

**ATTORNEY'S FEES AND COSTS:** In any action to enforce any provision of this Agreement, the prevailing party will be awarded reasonable attorney's fees and costs.

Dr. Josepha Campinha-Bacote — Date 4/5/21

Ms. Stephanie Holder — Date