Systematic review on embracing cultural diversity for developing and sustaining a healthy work environment in healthcare


CRD summary
This review evaluated evidence on structures and processes that support development of cultural competence in the health-care setting. The key findings were that linguistic services and inter-cultural staff training and education contributed to the development of a culturally competent workforce. The review combined the findings from limited research evidence and expert opinion.

Authors' objectives
The overall objective was to evaluate the evidence for structures and processes that support the development of effective culturally competent practices and a healthy work environment in the health-care setting. This included an evaluation of the effects of culturally competent practices on outcomes for nurses, patients, organisations and systems.

Searching
MEDLINE (1966 to 2005), PubMed, EMBASE (1980 to 2005), CINAHL (1982 to 2005), PsycINFO (1966 to 2005), Current Contents (to September 2005), ERIC, Sociological Abstracts, EconLit, ABI/INFORM, the Cochrane Library, DARE and Dissertation Abstracts International were searched; the search terms were reported. Reference lists were checked for additional studies. Unpublished and published studies in the English language were eligible for inclusion.

Study selection
Study designs of evaluations included in the review
Quantitative and qualitative research studies were eligible for inclusion, as well as textual discussion or opinion papers (although the latter were not study designs, they were included here because that evidence was an integral part of the review). A cohort study, a descriptive study of survey data and studies with qualitative research designs were included (together with discursive evidence).

Specific interventions included in the review
Strategies to promote cultural competence in the health-care work environment were eligible for inclusion. The included studies examined the impact of patient-centred communication and self-reported patient-physician racial concordance, or explored experiences around racial discrimination, care of ethnic minorities and culturally diverse groups, perceptions of culturally sensitive care and the phenomenon of inter-cultural communication.

Participants included in the review
Participants including staff and patients involved in, or affected by, culturally competent concepts in the nursing workforce were eligible for inclusion. The included studies variously included: physicians and patients; non-institutionalised adults; multi-professionals working in health service organisations; older Asian patients and relatives; female nurses; and immigrant women nurses with grievances about racism.

Outcomes assessed in the review
Nursing staff outcomes, patient outcomes, organisational outcomes and system outcomes were eligible for inclusion. The outcomes reported included patient and physician satisfaction, and patients' and health professionals' views and perceptions.

How were decisions on the relevance of primary studies made?
The authors did not state how the papers were selected for the review, or how many reviewers performed the selection.
Assessment of study quality
Two reviewers assessed study quality independently using standardised checklists within the System for the Unified Management, Assessment and Review of Information package (SUMARI). Any disagreements were resolved by discussion or recourse to a third reviewer.

Data extraction
Quantitative data were extracted using a standardised form available in the report. Qualitative data were extracted using a standardised tool within the SUMARI package. The number of reviewers involved was not reported.

Methods of synthesis
How were the studies combined?
The findings from the quantitative and qualitative studies were summarised in a narrative. Qualitative data were synthesised using the Qualitative Assessment and Review Instrument. Textual data were synthesised using the Narrative, Opinion and Text Assessment and Review Instrument. Meta-synthesis was used to categorise the findings from the qualitative and textual data (i.e. analyse and identify common themes) and further categorise them to reach the final synthesised findings.

How were differences between studies investigated?
Quantitative and qualitative studies were summarised separately. Any differences between the studies were described in the text and illustrated in tables.

Results of the review
Two quantitative and four qualitative research studies were included (together with 13 textual papers). The quantitative studies included 31 physicians and 252 patients, and 3,120 survey respondents, respectively. There were a total of 68 participants in the qualitative studies.

Quantitative evidence.
A cohort study found that patients were more satisfied and rated physicians as more participatory when patient and physician were of the same race, white or African-American (31 physicians, 252 patients). The results were supported by a descriptive study of data from a minority health survey of non-institutionalised African-American and Hispanic adults in the USA (3,120 respondents).

Qualitative evidence.
Results from a Canadian study of nine immigrant nurses with grievances about discrimination suggested that organisations should implement process to support equity and fair practices. A study of 22 professionals working in health service organisations in England showed a lack of attention to cultural competency in initial training and identified training needs to meet the health care needs of ethnic minorities. In another UK study, older south Asian patients (n=4) and relatives (n=3) viewed culturally sensitive care as practice that respects individuality, dignity and spiritual needs. A study of 30 community health nurses in the USA, to identify perceptions of the level of knowledge required to be culturally competent, found that practitioners needed an understanding of the spiritual and customary beliefs of culturally diverse groups.

Synthesis.
Twenty key findings were extracted from the four qualitative research studies and 101 key findings from the 13 textual papers.

The final key findings of the review were that appropriate and competent linguistic services and inter-cultural staff training and education would contribute to the development of a culturally competent workforce.
Authors’ conclusions
It was recommended that health provider agencies established links with organisations that could address the needs of culturally diverse patient groups, and included cultural competence in staff education and decision support systems. In-service training should consider skills needed to foster a culturally competent workforce. Patient information should be culturally relevant.

CRD commentary
The review addressed a broad question and had wide inclusion criteria. It was well reported. The sources searched were wide-ranging. Methods to minimise reviewer bias and errors in the study selection process were not reported, and the restriction to papers in English could have introduced language bias. The validity assessment (study quality) and data extraction were done systematically using appropriate tools and, for the validity assessment at least, methods were used to minimise reviewer bias and errors.

The narrative description of the quantitative and qualitative study findings was appropriate, but did not clearly incorporate the assessment of study quality. Established software was used to synthesise the qualitative and textual data and the method of analysis was appropriate for the type of data. Although the validity of all the data sources was assessed, it was not entirely clear how it was taken into account in the synthesis of the findings. The conclusions were consistent with the evidence reviewed but the evidence was primarily textual and opinion papers or, as the authors stated, situated within the interpretive and critical paradigms. The research studies included in the review were conducted in the UK, USA and Canada, which could limit the generalisability of the findings.

Implications of the review for practice and research
Practice: The authors stated that cultural competence should be included in practice and policy manuals. Cultural competence should be a component of education and training for all specialties. Patient information should meet the needs of culturally diverse groups. Staff recruitment and development plans should include skills needed to deliver culturally competent care. The recommendations were graded on the feasibility, appropriateness, meaningfulness and effectiveness (FAME) scale as having moderate support.

Research: The authors stated that further research on the impact of culturally competent practices on the creation of a healthy work environment, with a specific focus on patient, nurse and organisational outcomes, is required. Both quantitative and qualitative research is needed. There is also a need to clarify the concept of a ‘healthy work environment’.

Bibliographic details

Indexing Status
Subject indexing assigned by CRD

MeSH
Attitude of Health Personnel; Communication; Cooperative Behavior; Cultural Characteristics; Cultural Diversity; Decision Making, Organizational; Ethnic Groups /psychology; Health Facility Environment /organization & administration; Interprofessional Relations; Leadership; Occupational Health; Organizational Culture; Personnel, Hospital /psychology; Professional Competence; Social Environment; Social Identification; Workplace /organization & administration /psychology

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Record Status
This is a critical abstract of a systematic review that meets the criteria for inclusion on DARE. Each critical abstract contains a brief summary of the review methods, results and conclusions followed by a detailed critical assessment on the reliability of the review and the conclusions drawn.