Cultural competencies of selected health care workers in the West Pomeranian Voivodeship

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A. Study design/planning • B. Data collection/entry • C. Data analysis/statistics • D. Data interpretation • E. Preparation of manuscript • F. Literature analysis/search • G. Funds collection

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ABSTRACT

Introduction: The cultural competence of health care workers has a major impact on the quality of medical care provided. They are gained by developing awareness of one's own beliefs, feelings, and thoughts in such a way as to eliminate their inappropriate nature and impact on people from other backgrounds, accept and respect cultural differences, and provide care according to the cultural expectations of the patient. The main goal was to assess the cultural competence of health care workers from the West Pomeranian Voivodeship.

Material and methods: In the presented study, responses from 206 healthcare workers were analysed, including nurses, midwives, doctors, psychotherapists, receptionists, medical secretaries, physiotherapists, and psychologists. It was performed using the standardised Cross-Cultural Competence Inventory (CCCI) and the author's questionnaire.

Results: The surveyed medical workers had a medium level of cultural competence. Analysis of the data showed that older respondents had statistically significantly higher levels of competence in the domains of Determination and Willingness to Engage, while younger respondents, in the Tolerance domain ($p > 0.05$). Respondents from the largest cities had significantly higher cultural competence in the domains of Cultural Adaptability and Mission than residents of smaller towns and rural areas ($p > 0.05$). Those who spoke more than 2 foreign languages had significantly higher general cultural competence than the rest of the respondents ($p > 0.05$). People going abroad scored significantly higher ($p < 0.05$) on the domains of Cultural Adaptability and Determination than those not traveling outside Poland ($p > 0.05$).

Conclusions: The surveyed healthcare workers had cultural competence at a moderate level. Older people were more confident and able to cope with stress in cross-cultural interactions, while younger ones were more tolerant. Higher levels of cultural competence were associated with living in a large city, knowing foreign languages, and traveling.

Key words: multiculturalism, transcultural nursing, cultural competence.

INTRODUCTION

Cultural competence is a set of behaviours, attitudes, and ways of acting that enable the entire system as well as individual employees to take effective action when meeting someone from another cultural area. This is one of the first definitions of cultural competence in the context of medical care [1]. This concept was first used by psychologist Paul Pederson in 1988. The introduction of this term changed the way medical practices are perceived. The need for medical professionals to adopt the right attitude and acquire knowledge and skills in caring for patients from different cultural areas was recognised, as was their later willingness to engage in the process of becoming culturally aware. There are many definitions of cultural competence available in the literature [2]. Cultural competence can also be defined as the ability to cooperate with people who are culturally different. The main goal of acquiring cultural competence by health care workers is to create culturally competent care [1, 3] that explores, understands, and explains the interrelationships between care and culture [4]. The effectiveness of a culturally competent approach, according to Taylor, involves language services, staff training in cultural competence, and organisational support [5].

Cultural competence is gained by developing awareness of one's own beliefs, feelings, and thoughts, in such a way as to eliminate their inappropriate nature and impact on people from other backgrounds, accept and respect cultural differences, and provide care according to the cultural expectations of the patient [6]. Cultural competence determines the

level of professionalism of health care providers. It is an important value that translates into the quality of their services [7].

Poland is currently seeing an increasing number of foreigners who are becoming patients of Polish health care. Therefore, there is a growing need for culturally competent medical care that will meet the needs of a modern, multicultural society [1, 3].

Providing holistic care to patients by a nurse involves meeting their biological and physical, but also social and spiritual needs. As early as the 1950s, this was highlighted by the pioneer of multicultural nursing, Madeline M. Leininger. She noticed the need for sensitivity and knowledge of patients' cultural differences. Leininger created a model of transcultural patient care based on her own theory, in which she emphasised that the patient has the right to be understood in his or her socio-cultural background in the same way that his or her physical and psychological needs are expected to be understood and recognised [8].

Competence in the field of culturally specific health care means respecting the patient's cultural distinctiveness, being open to his or her different value system, religion, language, tradition, and history, and basing relationships not only on similarities, but also on differences [9].

Cultural competence among health care workers may influence the quality of medical care provided. Medical staff with a high level of cultural competence can notice and understand various patient behaviours and events that may result from cultural background. For this reason, the level of competence of health care workers should be improved [2, 10]. It is also important to work toward reducing the disparities that exist in the health status of culturally diverse communities [11]. According to Shepherd *et al.* [12], patients who were cared for by a nurse who took into account their cultural needs were more likely to report greater satisfaction with nursing care. It is presumed that there is a positive relationship between nurses' cultural competence and patient satisfaction. Moreover, according to Cruz *et al.* [13], cultural competence contributes to reducing health disparities in healthcare facilities and improving health equity.

However, nurses and other health care workers may lack intercultural competence, understood as the conglomerate of knowledge, skills, attitudes, and cultural awareness necessary to provide safe and equitable care to all patients, both undifferentiated and culturally diverse [14]. Many studies point to significant obstacles in caring for foreigners [1, 6, 9, 10]. These are mainly the language barrier and lack of cultural competence. According to Antón-Solanas *et al.*, they may also include nurses' workload, a lack of specific resources, and a certain degree of prejudice against a particular group of people, for example, Muslims in Belgium and Gypsy Roma in Spain [15]. Many researchers suggest that introducing classes to develop intercultural competence into the health professions curriculum could effectively reduce these barriers by raising the level of intercultural competence among medical professionals [1, 9, 16-18].

The main goal was to assess the cultural competence of health care workers from the West Pomeranian Voivodeship.

MATERIAL AND METHODS

The study included 206 health care workers from the area of the West Pomeranian Voivodeship in Poland. The inclusion criterion for the study was practicing as a nurse in a public health care facility for at least one year. The study participants were not selected in terms of their experience in caring for patients from other cultural backgrounds or their preparation for it. The purpose of the study was to analyse the level of cultural competence of nursing representatives, without applying additional entry criteria. The only exclusion criterion was a lack of consent to participate in the study. Information on recruitment for the study was made public on social networks and through posters distributed in health care facilities. The respondents applied by phone. The study was cross-sectional. Each respondent was briefed on the subject and purpose of the research, and informed that completion of the questionnaire was voluntary and anonymous, and that the data obtained would be used in accordance with the purpose. All those who agreed to participate in the study were given a set of questionnaires, which they filled out independently. The selection of the sample was based on convenience sampling, which involves recruiting people who are available and willing to participate in the study. A total of 231 health care workers volunteered, 206 of whom were included in the project. The exclusion of 25 people was because they returned incomplete questionnaires. The following were used as independent variables: age, place of residence, foreign language skills, active travelling, and visiting parts of the world.

The first part of this survey-based study was performed using the author's questionnaire. It included 9 questions concerning sociodemographic data (age, sex, place of residence, profession, education, workplace), as well as foreign language skills, travelling, and visited regions of the world.

In the second part, the standardised Cross-Cultural Competence Inventory (CCCI) [19] was used. It included 63 questions divided into 6 domains: Cultural Adaptability, Determination, Tolerance, Self-Presentation, Mission, and Willingness to Engage. Answers were rated on a 6-point Likert scale, where 6 denoted

Table 1. Characteristics of the study sample

Variable	*n*	%
Sex		
Woman	156	75.73
Man	43	20.87
No answer	7	3.4
Age		
20-30	52	25.24
31-40	38	18.45
41-50	56	27.18
51-60	48	23.30
61-70	10	4.85
71-80	1	0.49
No answer	1	0.49
Place of residence		
A city of up to 10,000 people	13	6.31
A city of 10,000–100,000 people	22	10.8
A city of over 100,000 people	141	68.45
Rural areas	29	14.08
No answer	1	0.49
Education		
Secondary	59	28.64
Third-level	146	70.87
No answer	1	0.49
Profession		
Nurse/midwife	87	42.23
Physician	53	25.73
Other*	66	32.04
Workplace		
Private health facility	52	25.24
Public health facility	121	58.74
Private and public health facilities	28	13.59
No answer	5	2.43
Knowledge of foreign languages		
I don't know any	35	16.99
One	103	50
Two	56	27.18
More than two	9	4.37
No answer	3	1.46
Trips abroad		
Yes	181	87.86
No	25	12.14
Visiting areas of the world		
Europe	193	93.69
America	32	15.53
Asia	35	16.99
Africa	37	17.96

** Other professions were: psychologists, physiotherapists, and receptionists*

'I fully agree', and 1 meant 'I fully disagree'. The CCCI measures the general intercultural competence of respondents.

Permission to use the CCCI was obtained from the authors of the Polish version of the tool [20]. They confirmed the accuracy and reliability of the CCCI (from 0.83 to 0.86), and the internal consistency of the adapted inventory (Cronbach's α) was 0.83.

A positive opinion from the Bioethics Committee (WNoZ-302-03/S/16/2022) was obtained prior to the study. The research was based on the principles of the Declaration of Helsinki, so that it did not violate the dignity of the study participants and ensured that they were respected.

Statistical analysis was performed using R software v. 3.6.3. Comparison of quantitative variables in 2 groups was performed using the Mann-Whitney *U* test, and in 3 or more groups using the Kruskal-Wallis test. When statistically significant differences were detected, post-hoc analysis was performed with Dunn's test to identify statistically significantly different groups. Correlations between quantitative variables were analysed using Spearman's correlation coefficient. A significance level of 0.05 was assumed.

RESULTS

The study involved 206 health care workers, most of whom were women (75.73%) aged 41-50 years (27.18%). Most of the respondents (68.45%) lived in cities with a population of more than 100,000, and 70.84% had third-level education. Nurses and midwives constituted the largest group of respondents (42.23%). The second group, comprising 32.04% of the respondents, consisted of receptionists, medical secretaries, dental assistants, physiotherapists, and psychologists. The least numerous group was doctors, constituting 25.73% of the participants. The workplace of most respondents was a public institution (58.74%). Half of the respondents (50%) knew one foreign language. Most of the respondents travelled abroad (87.86%), and the most frequently visited region of the world was Europe (93.69%) (Table 1).

Analysis of the data showed that age correlates significantly and positively with determination ($p < 0.05$) and willingness to commit ($p < 0.05$), and significantly and negatively with tolerance ($p < 0.05$) (Table 2).

Another variable on the basis of which the cultural competence of health care workers was analysed was their place of residence. Statistically significant differences ($p < 0.05$) were found in the domains of Cultural Adaptability and Mission. Respondents from the largest cities had significantly higher cultural competence in these domains than residents of smaller towns and rural areas. Differences were also

observed in the domain of Determination – people from medium-sized cities had significantly lower competence than the other groups. In the domain of Self-Presentation, significantly higher competence was demonstrated by residents of the smallest towns compared to the other groups (Table 3).

Data analysis showed statistically significant differences in the level of cultural competence of the health care workers depending on their knowledge of foreign languages ($p < 0.05$).

Those who spoke more than 2 foreign languages had significantly higher general intercultural competence than the rest of the respondents.

Moreover, the group of respondents with knowledge of more than 2 foreign languages achieved higher average scores in the domains of Cultural Adaptability, Tolerance, Mission, and Willingness to Engage than the other groups, but the differences were not statistically significant (Table 4).

Statistically significant differences ($p < 0.05$) were found both in the level of general intercultural competence and in the Cultural Adaptability and Determination domains between people going abroad and those not traveling outside Poland (Table 5).

DISCUSSION

Mass modern migrations mean that cultural competence is becoming increasingly important in Poland. Foreigners are treated in medical facilities, and the medical staff are becoming more and more culturally diverse. A lack of knowledge regarding cultural differences can cause unnecessary conflicts. A culturally competent nurse can adapt the process of care to

Table 2. Correlations between the age of the respondents and their intercultural competence according to the 3CI

3CI	Age
	Spearman's rank correlation coefficient
General intercultural competence	$r = 0.117$, $p = 0.096$
Cultural adaptability	$r = 0.108$, $p = 0.124$
Determination	$r = 0.141$, $p = 0.044$*
Tolerance	$r = –0.213$, $p = 0.002$*
Self-presentation	$r = -0.099$, $p = 0.159$
Mission	$r = 0.093$, $p = 0.186$
Willingness to engage	$r = 0.173$, $p = 0.013$*

** Statistical significance ($p < 0.05$)*

Table 3. Differences in intercultural competence according to the 3CI depending on the place of residence of the respondents

3CI		Place of residence				*p*
		A city of up to 10,000 people – A ($n = 13$)	A city of 10,000-100,000 people – B ($n = 22$)	A city of over 100,000 people – C ($n = 141$)	Rural areas – D ($n = 29$)	
General intercultural competence	M ±SD	3.7 ±0.31	3.6 ±0.39	3.79 ±0.39	3.61 ±0.42	0.053
	Me	3.64	3.59	3.78	3.6	
	Q1-Q3	3.46-3.9	3.4-3.86	3.56-4.02	3.25-3.87	
Cultural adaptability	M ±SD	4.04 ±0.59	4.18 ±0.62	4.44 ±0.61	4.13 ±0.63	0.005*
	Me	3.95	4.16	4.47	4	
	Q1-Q3	3.53-4.16	3.66-4.63	4.05-4.79	3.79-4.42	C > D, A
Determination	M ±SD	3.71 ±0.59	3.16 ±0.86	3.68 ±0.79	3.81 ±0.69	0.025*
	Me	3.62	3	3.75	3.88	
	Q1-Q3	3.5-4.12	2.53-3.75	3.12-4.25	3.38-4.12	D, A, C > B
Tolerance	M ±SD	2.78 ±0.51	2.67 ±0.82	2.42 ±0.69	2.39 ±0.73	0.149
	Me	2.58	2.75	2.33	2.33	
	Q1-Q3	2.42-3.17	1.98-3.25	1.92-2.92	1.83-2.83	
Self-presentation	M ±SD	3.3 ±0.71	2.59 ±0.54	2.81 ±1	2.52 ±0.83	0.037*
	Me	3.4	2.7	2.8	2.4	
	Q1-Q3	2.6-3.8	2.25-2.95	2-3.4	2-2.8	A > C, B, D
Mission	M ±SD	4.31 ±0.67	4.64 ±0.68	4.76 ±0.72	4.48 ±0.79	0.028 *
	Me	4.43	4.79	4.71	4.29	
	Q1-Q3	3.71-4.71	4.57-5.00	4.29-5.29	4-4.86	C > D, A
Willingness to engage	M ±SD	3.88 ±0.48	3.75 ±0.66	4.02 ±0.66	3.82 ±0.76	0.126
	Me	4.00	3.62	4.00	3.75	
	Q1-Q3	3.58-4.17	3.38-4.33	3.67-4.42	3.33-4.17	

*M – mean, SD – standard deviation, Me – median, Q1 – lower quartile, Q3 – upper quartile, p – Kruskal-Wallis test + post-hoc analysis (Dunn's test), *statistical significance ($p < 0.05$)*

Table 4. Analysis of the impact of the respondents' foreign language skills on the level of their competence

3CI		Knowledge of foreign languages				*p*
		I don't know any – A (*n* = 35)	One – B (*n* = 103)	Two – C (*n* = 56)	More than two – D (*n* = 9)	
General intercultural competence	M ±SD	3.63 ±0.4	3.73 ±0.42	3.75 ±0.33	4.02 ±0.35	0.049*
	Me	3.59	3.71	3.78	4.02	
	Q1-Q3	3.43-3.85	3.49-3.95	3.57-3.9	3.89-4.33	D > C, B, A
Cultural adaptability	M ±SD	4.16 ±0.61	4.33 ±0.65	4.39 ±0.55	4.81 ±0.59	0.059
	Me	4.16	4.32	4.42	4.84	
	Q1-Q3	3.84-4.58	3.87-4.68	4.13-4.79	4.53-5.37	
Determination	M ±SD	3.48 ±0.69	3.62 ±0.76	3.75 ±0.87	3.86 ±0.7	0.328
	Me	3.5	3.62	3.81	3.75	
	Q1-Q3	3.12-4.00	3.12-4.12	3.12-4.28	3.62-4.38	
Tolerance	M ±SD	2.56 ±0.75	2.48 ±0.75	2.36 ±0.58	2.74 ±0.56	0.349
	Me	2.58	2.5	2.33	2.75	
	Q1-Q3	2.00-3.25	1.87-3.17	1.98-2.75	2.08-3.25	
Self-presentation	M ±SD	2.69 ±1.02	2.83 ±0.95	2.72 ±0.86	2.76 ±0.77	0.708
	Me	2.6	2.8	2.6	2.6	
	Q1-Q3	2-3.3	2.1-3.4	2-3.2	2.4-3.0	
Mission	M ±SD	4.45 ±0.72	4.65 ±0.76	4.79 ±0.66	5.02 ±0.57	0.057
	Me	4.43	4.57	4.79	5.14	
	Q1-Q3	4.00-5.00	4.14-5.14	4.43-5.18	4.71-5.43	
Willingness to engage	M ±SD	3.87 ±0.67	3.96 ±0.7	3.96 ±0.6	4.12 ±0.78	0.691
	Me	3.75	3.92	3.92	4.33	
	Q1-Q3	3.42-4.25	3.42-4.38	3.48-4.35	3.75-4.75	

*M – mean, SD – standard deviation, Me – median, Q1 – lower quartile, Q3 – upper quartile, p – Kruskal-Wallis test + post-hoc analysis (Dunn's test), *statistical significance (p < 0.05)*

each patient, taking into account their psychophysical, social, cultural, and spiritual needs [7].

Our study showed that all the groups had an average level of general intercultural competence, which appears to be insufficient to provide the highest quality services to patients from other cultures. Lubowiecki-Vikuk and Gnusowski emphasise the great importance of having cultural competence by health care professionals, which translates into reducing the potential negative effects of cultural differences regarding artifacts, values, norms, and behaviours [2].

Our findings and those of other researchers [7, 10] indicate that the level of intercultural competence is affected by sociodemographic factors. Younger people are more tolerant and so are more likely to adapt to new conditions and related difficulties. Szkup-Jabłońska *et al.* also underline the influence of age on openness to new experiences and adaptability to new challenges – the youngest respondents are more open and adaptable [7]. This is supported by Zimny *et al.*, who found that the youngest respondents (aged 21 to 25 years) were the most open and those aged 36 to 45 years were the least open to new experiences [21]. In the study by Laskowski *et al.*, on the other hand, the youngest surveyed students of the Medical University of Białystok did not notice the problem of multiculturalism [22]. Perhaps this is because younger people have potentially more opportunities to gain experience with culturally diverse people, thanks to their greater openness to new challenges, higher motivation and willingness to expand their knowledge, and better foreign language skills, which mean that the language barrier is not a problem for them.

In our study, respondents who spoke more than 2 foreign languages had significantly higher intercultural competence. The lack of knowledge of a foreign language is the greatest barrier to communicating with a patient of a different culture. The language barrier prevents proper diagnosis, describing the disease, and communicating information related to further testing and diagnosis. Even if an immigrant speaks the language of the country of residence in everyday situations, they may have difficulty understanding specialised medical vocabulary [23, 24]. Based on the literature analysis by Majda and Zalewska-Puchała, they reached a similar conclusion, emphasising the immense importance of developing language skills, social skills, openness, and sensitivity among healthcare workers. Developing these features and skills allows medical workers to avoid many mis-

understandings related to incorrect diagnosis, treatment, care, and education [9]. Strzelczyk *et al.*'s study showed that the biggest difficulties in the context of cultural competence are the language barrier, as well as the attitude of the patient and his or her family toward blood transfusions and unfamiliarity with other cultures [3]. A study by Kiszka *et al.* also discusses the problem of the language barrier in the context of cultural competence. In their work, these authors propose a solution to the communication problem by employing professional translators in health care facilities [24]. However, a study by Mei-Hsiang *et al.* shows that such a solution is unlikely to be used due to the inconvenience of the night-shift interpreter service, but also due to the unavailability of interpreters in most hospitals [25]. Moreover, medical facilities are not legally obliged to provide access to an interpreter for a specific language. Language differences are also not taken into account in the management of emergency patients [23]. It can be assumed that legal regulations should be more precise and supplemented with a law that guarantees that foreign-language patients are fully informed about their health state and further treatment. However, currently, and under applicable legal conditions, it also seems to be a good solution to create a publicly available list of clinics/specialists who are fluent in a foreign language [26].

Jeznach and Piekarska reached similar conclusions based on their research on intercultural competence of nursing students [27]. They confirmed a higher level of intercultural competence among second-cycle students of nursing, mainly due to better foreign language skills. Problems in communication with foreign patients caused by the language barrier were also confirmed by Kaspar [28] and Paternotte *et al.* [29], who emphasise that proper communication is a challenge for both the doctor and the patient. Zgliczyński and Cianciara, on the other hand, suggests encouraging health care workers to obtain language certificates, but also making every effort to ensure that they learn the linguistic nuances of name pronunciation. They point out that information materials and documents containing descriptions of medical procedures for patients from different countries should be adapted to linguistic and cultural requirements [30].

Our research also confirmed the relationship between intercultural competence and place of residence. Studies by other authors addressing issues related to factors affecting the level of cultural competence do not take into account place of residence. However, our own study showed that the level of intercultural competence was significantly higher in people from the largest cities, compared to residents of smaller cities and rural areas. Based on our results, it can be concluded that respondents living in large cities potentially have more experience interacting with people from other cultures and religions than residents of smaller towns and villages.

Table 5. Analysis of the impact of active travelling outside Poland on the level of the respondents' intercultural competence according to the 3CI

3CI		Do you travel abroad?		*p*
		yes (*n* = 181)	no (*n* = 25)	
General intercultural competence	M ±SD	3.77 ±0.39	3.53 ±0.4	0.002*
	Me	3.78	3.51	
	Q1-Q3	3.56-3.97	3.3-3.67	
Cultural adaptability	M ±SD	4.38 ±0.61	4.07 ±0.66	0.018*
	Me	4.42	4.11	
	Q1-Q3	3.95-4.79	3.58-4.47	
Determination	M ±SD	3.7 ±0.77	3.32 ±0.82	0.038*
	Me	3.75	3.25	
	Q1-Q3	3.12-4.25	2.75-3.88	
Tolerance	M ±SD	2.49 ±0.7	2.29 ±0.7	0.192
	Me	2.5	2.25	
	Q1-Q3	1.92-3.08	1.75-2.92	
Self-presentation	M ±SD	2.79 ±0.93	2.69 ±0.95	0.77
	Me	2.6	2.8	
	Q1-Q3	2-3.4	2.2-3	
Mission	M ±SD	4.7 ±0.72	4.53 ±0.84	0.308
	Me	4.71	4.57	
	Q1-Q3	4.14-5.14	4-5.14	
Willingness to engage	M ±SD	3.98 ±0.66	3.8 ±0.74	0.298
	Me	3.92	3.83	
	Q1-Q3	3.5-4.33	3.25-4.42	

*M – mean, SD – standard deviation, Me – median, Q1 – lower quartile, Q3 – upper quartile, p – Mann-Whitney U test, *statistical significance ($p < 0.05$)*

Travelling is another factor influencing the level of intercultural competence. Each journey to culturally different places provides an opportunity to develop intercultural competence by learning new values, norms, and behaviours, as well as the language of a given culture. Our study showed that people traveling outside the country had significantly higher general intercultural competence and intercultural competence in the domains of Cultural Adaptability and Determination. The influence of this factor has not been investigated by other researchers. It can be assumed that people with a high level of cultural competence gain experience and knowledge about other cultures by travelling, thanks to which they show greater empathy and openness to cultural differences in their professional work. This may also be related to a lower language barrier among people who communicate using foreign languages when travelling. It is likely that travelling abroad is a necessary element to maintain a continuous process of intercultural competence developmenMarkey *et al.* suggest the

need to introduce cultural simulations into the undergraduate nursing curriculum to foster cultural competence by providing opportunities for cross-cultural encounters in simulated settings [31].

Low levels of cultural competence cause problems in interactions between medical personnel and patients from other cultural backgrounds – the lower the level of cultural competence, the greater the problems. It is therefore important to make changes already at the level of preparation for the profession (in the nursing curriculum), and then to continuously educate health care workers to raise the level of their intercultural competence. Properly trained medical staff will be able to adapt their behaviour to the expectations and needs of culturally different patients, and to respect their preferences and values. Having culturally competent staff will ensure that patients communicate effectively, understand their health state, and have a sense of respect for their cultures [1, 9, 31].

LIMITATIONS

The study presented here has some limitations. The respondents were self-reporting individuals who met the inclusion criteria, but not randomly selected. Continuing the research in a larger group of respondents would allow the formulation of generalised conclusions that go beyond the study group. A strength of the research is the use of a standardised tool: the CCCI, which is a reliable tool for assessing cultural competence.

CONCLUSIONS

The surveyed health care workers had a medium level of cultural competence.

Older people were more confident and able to cope with stress in cross-cultural interactions, while younger ones were more tolerant.

Higher levels of intercultural competence were associated with living in a large city, knowing foreign languages, and traveling.

Disclosures

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