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Commentary

Cultural Diversity and the Importance of Communication, Cultural Competence, and Uncertainty in Radiography

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ABSTRACT

Cultural diversity has been well-recognized as a challenge for health care providers in many countries, thereby stressing the importance of effective and sufficient communications between patients and health care staff. Culturally competent care is a key to day-to-day practice, and we must strive to provide optimum care despite personal differences. If the health care service is to provide culturally competent care, our radiographers are vulnerable and prone to errors because effective communication requires both cultural competence and knowledge of the language. An understanding in effective communication, cultural competence, and uncertainty is important in the profession of radiographers.

RÉSUMÉ

Le défi de la diversité culturelle est bien connu des professionnels de la santé dans de nombreux pays, soulignant l'importance des communications efficaces et suffisantes entre les patients et le personnel soignant. Les soins culturellement compétents sont l'une des clés de la pratique quotidienne, et nous devons nous efforcer d'offrir des soins de qualité optimale malgré les différends personnels. Si un service de santé dit être en mesure d'offrir des soins culturellement compétents, nos radiographes n'en sont pas moins vulnérables et enclins aux erreurs, parce qu'une communication efficace exige à la fois des compétences culturelles et la connaissance de la langue. La compréhension de la communication efficace, de la compétence culturelle et de l'incertitude est importante pour les radiographes.

Keywords: Cultural diversity; medical radiation; medical imaging; radiography; cultural competence

Introduction

Every year, millions of people resettle in different parts of the world as a result of globalization, creating a cross-cultural and cross-linguistic phenomenon. This therefore creates cultural, linguistic, and communication differences among the health care providers and the patients. Regardless of their cultural background, a mutual understanding is vital in clinical encounters, especially in cases with a language barrier [1,2]. As a result, cultural diversity has been well-recognized as a challenge for health care providers in many countries, thereby stressing the importance of effective and sufficient communications between patients and health care staff [1,2]. Although cultural diversity generally applies to all fields of health care, it is particularly complex in the context of radiography practice. This complexity is governed by the need for adequate communication in short encounters followed by technical requirements in stressful and unfamiliar environments for patients. Radiographers are exposed to the risk of making a variety of both minimal and potentially critical errors. If the health care service is to provide culturally competent care, our practitioners are vulnerable and prone to errors because effective communication requires both cultural competence and knowledge of the language [3]. Although cultural diversity and cultural competence have been previously discussed in the context of radiography practice and education, there is still a significant gap in the literature regarding the importance of uncertainty in

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radiography [4–7]. Little to no research has also been conducted to link cultural diversity and the importance of communication, cultural competence, and uncertainty. In the following article, the influences of the cultural diversity on the radiographer's communication, cultural competence, and uncertainty will be discussed. Examples and strategies of culturally competent care will also be incorporated.

Communication and the Role of the Radiographer

Communication is not simply about passing information from one to another; rather, it is a sophisticated interchange of knowledge between the practitioner and the patient. Successful and positive exchange of information heavily relies on compassion and recognition, acknowledgement, and non-judgemental acceptance of diversity. Diversity should not be defined as referring to an ethic or minority group in a social system [8,9]. Diversity should, in fact, incorporate emotional states, beliefs, and individual characteristics [10]. To maintain the provision of adequate care, the health care providers are now required to be competent and knowledgeable about cultural diversity [11,12]. In a short period of time, often less than five minutes, a radiographer must convey critical information to the patient. This interaction is often inhibited by the patient's fear of a serious diagnosis, the technical and physical difficulty of the examination, and the language and cultural barriers [13].

The roles of radiographers encompass a variety of components—from caring for the patient to handling and operating technical equipment and not limited to conveying instructions and information [14]. Fulfilling all these roles with optimal imaging quality is therefore often difficult. Communication between radiographers and patients with a foreign language could be quite challenging without the interpreters' assistance [15]. When no professional interpretive assistance is offered, help from other people such as the patient's relatives or hospital staff can provisionally suffice. For instance, bilingual children are commonly used as their immigrant parents' interpreter [16]. However, it is worth noting that using a family member as the translator could potentially have a negative impact on the patient's treatment because of incorrect translation of medical terminology and/or lack of impartiality, including misinformation [17]. For instance, when being used as interpreters, the children might be affected by what is happening to their family members and find it difficult to hear and translate [18]. The use of a child can also pose potential legal liabilities where there might be miscommunication between the patients and the radiographers [18–20]. From a simplistic point of view, many radiography procedures seemingly require minimal communication, other than "hold still" or "hold your breath". However, clinical experience and research have shown that the issue is more complex than anticipated [21,22]. For instance, computed tomography examinations with the use of contrast require high-quality communication between the radiographer and the patient to facilitate written informed consent. The fundamental principle of informed consent states that the patients should be provided sufficient information so that they can make an informed decision about their care [23]. Informed consent must include the benefits and possible risks of the examination and the alternatives [24]. An example of this includes when contrast medium is administered, the patient should be informed of the certain 'normal' side effects (eg, taste of metal in the mouth and warm sensation inside the body) and the risks. Active participation by the patient is required to ensure the quality of the examination and the patient safety. In other words, the patient must understand and communicate appropriately so that preventative measures can be established for any early signs of a hypersensitivity reaction with the contrast medium, such as nausea, pain, and breathing difficulties. Therefore, the radiographers, the referring clinicians, and/or the radiologists should carefully balance and determine whether the need for an interpreter is required. If part of the examination must be completed without an interpreter, this may lead to unsatisfactory and suboptimal examination and stress for both the staff and patients [2]. Often, interpreters are considered an economic burden on the health care system [1]. Avoidance of the cost involving an interpreter might save some money in the short term. However, studies have demonstrated that providing adequate interpretative services could in fact create lower health care costs in the long term [15,25]. For example, complications of the patient's disease and other conditions are reduced as a result of improved patients' utilization of primary care and preventative care services as well as follow-up visits and medication [15].

To overcome the problems that arise from ineffective communications, broadening the meaning of the term "adapted technique" is suggested. In radiography education and training, the adapted technique is often associated with modifications of radiographic techniques and production of the image [26]. This includes an emphasis on communication skills and techniques in perception and expressions of nonverbal cues. For instance, the practitioners would need to adapt their communication technique to best communicate with patients from diverse cultural backgrounds [10]. Research has found that where the health services and patient care were perceived as suboptimal, this was predominantly related to the workplace or because of cultural factors not because of the flaws in individual practitioners [27]. Moreover, because of excessive pressure in workload within the departments, optimal and compassionate patient-centred care is often compromised [27]. Research by Williams, Moeller, and Willis [28] also highlighted the importance of assessing the health literature in a radiotherapy department and proposed ways to promote effective communication of information in patients with low literacy skills. Consequently, practitioners need to adapt their communication styles to match each individual to improve health outcomes for patients with low literacy [29]. To promote patient understanding and implement communication techniques to relay information in different ways, a thorough health literacy toolkit was developed by

Health Education England. These communication strategies comprise speaking in plain English, using explanation skills, asking direct questions, and assessing understanding [30].

Use of Plain English in Oral Communication

In health care, particularly in radiography, jargon is used extensively without the practitioners' realization. Studies have found that the use of jargon reduces the patient's understanding of conveyed information [31,32]. When followed by immediate explanation in plain English, utilization of jargon can increase patients' health literacy [28]. Oral communication plays an essential role in health literacy, and patients often favour face-to-face interactions to obtain information regarding their health [33]. Practitioners could start using analogies to explain concepts and moderate length sentences with conjunctions to make a verbal message highly listenable and easier to understand [33]. For example, the practitioners could provide immediate explanation of a "*mammogram*" being *"an x-ray of the breast"* as soon as the jargon is used [31].

Asking Direct Questions

Promoting patient engagement in conversations is essential to facilitate their understanding [28]. Asking direct questions has been proven effective in improving information recall, increasing patient compliance, and reducing their anxiety. Using the computed tomography examinations as an example, the practitioners could directly ask whether the patient has had it before, how they felt after the examination, and if they have any specific questions or concerns regarding today's examination. With direct questions, patients can feel a sense of control and empowerment [34,35].

Assessing Your Patients' Understanding

Effective strategies such as the "teach-back" method and the use of open-ended questions can be applied in assessing patient understanding in clinical settings. The "teach-back" method has been shown to be the most comprehensive and valuable approach to assess if the patient understands the information conveyed. This is simply conducted by asking the patients to recall information given to clarify any misunderstanding and evaluate their grasp of information [28,36]. Open-ended questions such as "what questions do you have?" can prompt patients to think and seek clarification, whereas closed questions such as "do you have any questions" should not be overused [37]. Closed-ended questions presume prior knowledge of the patient's health status (collected from patient notes, eg), encourage a yes or no response, and place the patients as passive authorities [38]. It has also been reported that compared with open-ended questions, patients produce significantly less discrete symptoms and less problem presentations (11.3s vs. 27.1s) [39].

Effective patient-practitioner communication is important in delivering high-quality health care. Good patient-practitioner communication is linked to better patient satisfaction and improved health outcomes [40,41]. The practitioners, however, often encountered different cultural backgrounds, beliefs, practices, and languages that require culturally competent communication to maximize the quality of care they provide [40,41]. The concept of cultural competence is therefore vital in health care delivery.

Cultural Competence

Culturally competent care is defined as "sensitivity to issues of culture, race, gender, sexual orientation, social class, and economics" (p.131) [42] and is the key to international and cultural considerations in radiography practice [43]. On an individual level, practitioners should not only identify their own cultural values and beliefs but also recognize that others may view the world through different cultural lenses [44].

In Canada and the United States, education highlights the importance of addressing racial/ethnic disparities in health care, and the needs of First Nations, Inuit, and Metis communities have become increasingly popular [45]. As a result, practitioners must be culturally sensitive, that is, they need to possess certain knowledge about the different cultures and languages of their patients to communicate and provide effective care [46]. A main challenge for the provision of culturally competent care to our patients is to achieve a situation where culturally diverse groups of patients are able to connect with each other in meaningful ways [47]. Therefore, although it is not possible for our practitioners to learn all predominant languages in their areas, learning some new languages even at a vocational level can prove effective in providing health services to the multicultural public [48]. Research by Shah (2004) also noted the usefulness of identifying communication obstacles in the workplace [49]. The lack of cultural understanding can cause serious misdiagnoses and/or categorizing different patient groups as uncooperative, noncompliant, or resistant, leading to negative health outcomes [50]. For instance, it has been found that different ethnic groups, especially refugees in Australia [50], indigenous people from New Zealand [51], and non-Caucasian people in Canada [52] underused available health care services. This pattern has been related to the health care providers' cultural insensitivity, patients' perception of racial discrimination, and inappropriate formalization of services for culturally diverse groups. Moreover, African Americans were found to be less likely to undertake diagnostic imaging examinations and orthopaedic interventions as they viewed that they would receive better care if they were not of African origins [53].

The Health Foundation, in 2011 published a report—'Can patients be teachers?'—involving the patients in educating health care professionals [54]. The report found that there is a lack of patient involvement in health care education. Patients should be invited into teaching sessions to share their stories to the students. By involving the patients in the teaching curriculum, radiography students are able to develop an understanding of working with patients from a range of diverse social and cultural backgrounds [36,37]. Patients who have undergone a diagnostic imaging scan could speak of their experiences in the radiology department. Patients could also be encouraged

to speak to the students about what it was like for them and provide students with some communication tips [21]. In clinical assessment, patients could be asked to share their opinion, comment, and give feedback about students while they are being examined undertaking an x-ray examination. This can in turn allow the students to discover how the patient feels about their examination [21].

Uncertainty

Despite an increasing growth in cultural competence development programs and associated guidelines and procedures, there is limited research about how health care practitioners themselves experience and perceive their work with patients from culturally diverse backgrounds [55]. There is convincing evidence that some health care practitioners are still worried about appearing culturally inappropriate and unsure how to deal with patients from culturally diverse backgrounds, thereby leading to uncertainty [55]. Uncertainty is well-recognized in clinical decision-making and is a central theme of complexity in care provision. The practitioners' uncertainty is thought to disempower, creating a disabling hesitancy and inertia in their practice [56,57]. For these practitioners, disempowerment is depicted by anxiety and stress in cross-cultural interactions with the patients. Some practitioners worried that their lack of specific cultural awareness and knowledge may appear discriminatory, causing further uncertainty about how to act. Some others worried about asking or were uncertain about how to ask patients about their beliefs, values, perspectives, or practices. An example of this includes getting patient changed for their examination. Yet, those who had experience of cultural competency and cultural diversity training continued to feel incompetent to respond to patient's needs. This is particularly characterized by the fear of "getting it wrong" and being perceived as racist and ignorant by the patients [55]. In addition, there is also a concerning issue that investing greater time and effort to address some patients' needs may be viewed as preferential treatment by other patients and/or other colleagues [55]. A disabling hesitancy and inertia in practice were also a common consequence of uncertainty, resulting in a compromise in satisfactory interactions with the patients. For instance, the practitioners expressed their concerns about the lack of rapport they felt while dealing with patients from diverse cultural backgrounds, that is they often wondered when it was acceptable to touch someone or whether they might do the wrong thing and jeopardize their relationship with the patients [55].

As the first and only qualitative study to report on professional uncertainty and disempowerment, this article also informs multiple interventions to enhance culturally competent and high quality of care and the practitioners' experience of working with cultural diversity [55]. Firstly, practitioners in our profession should start with acknowledging and legitimizing uncertainty as inherent. They should be supported and encouraged to reflect on their responses to uncertainty and its possibility to create inertia in their clinical practice [58]. Secondly, the greater emphasis on patient-centred care, where the patient is seen as an individual, should be considered rather than knowledge-based cultural expertise approach. Essentially, defining "cultural competence" in most knowledge-based training has proven somewhat ineffective [55]. Cultural competence is in fact more than a question of knowledge; rather, it is a more human and emotional investment to successfully engage and connect with those whose beliefs may differ [59]. This ethnographic article provides a way forward for our practitioners because it places the patient's point of view, values, practices, and beliefs as a central importance [60]. These research findings bridge the possibility to actively embrace, rather than being fearful or uncomfortable with the uncertainty as a result of sociocultural diversity [55]. Thirdly, we should recognize and acknowledge that content-based information about cultural and ethnic differences is still crucial in the education and training of radiography students. Discussion of cultural issues and examples does in fact provide a practical context for learning and engage our practitioners to be naturally interested in learning the "difference". Nevertheless, care should be taken to balance this engagement with avoidance of stereotype and cultural assumptions [61–63].

In principle, radiographers need to be supported to reflect on their own cultural influences as a health care worker and have the confidence and encouragement to explore patient perspectives where there may be uncertainty. They need to be able to respond to patients as individuals whose cultural diversity incorporates not only ethnicity, but also the patients' gender, sociocultural backgrounds, and education statuses [60]. Following this ethnographic method, rather than assuming their patient's cultural knowledge and needs, the practitioners are required to inquire individual patients about their beliefs and views and what matters most to them. This will help empower our practitioners to use individualized information to enable their understanding of patient expectations and perspectives [59]. The governing bodies and managers do not expect or desire our practitioners to be familiar with all facets of different cultures [55]. Empowering this cognitive function in the context of cultural diversity might even increase their engagement and participation with the more social, emotional, and humanist aspects of health care [64]. These strategies can help the practitioners to work effectively with cultural diversity and uncertainty. Failure to empower the practitioners to accept and work constructively with uncertainty may have significant consequences and potential to prolong inequality in the experience of receiving health care from our ethically and culturally diverse patients [55].

Conclusion

Culturally competent care is a key to day-to-day practice, and we must strive to achieve a situation where culturally diverse populations are able to connect with one another in

meaningful ways. As a society, efforts must be made to ensure that patients have equitable access to good-quality health services and treatment. The issue of uncertainty is highly relevant across the health professions. The uncertainty our radiographers experience had a disempowering effect which is characterized by anxiety and stress in cross-cultural interactions and inertia in their clinical approach. Uncertainty is inherent in cultural diversity; if cultural competence is to be patient-centred, uncertainty must be acknowledged and developed as part of the cultural diversity. Further research is required to establish greater uniformity on core components of cultural competence and uncertainty education, especially how they are evaluated in the field of radiography. The patient outcomes, treatment outcomes, health behaviours, and the student and/or radiographer's behaviours toward uncertainty should also be measured.

References

[1] Fatahi, N., Mattsson, B., Hasanpoor, J., & Skott, C. (2005). Interpreters' experiences of general practitioner-patient encounters. *Scand J Prim Health Care* 23(3), 159–163.

[2] Fatahi, N., Mattsson, B., Lundgren, S. M., & Hellstrom, M. (2010). Nurse radiographers' experiences of communication with patients who do not speak the native language. *J Adv Nurs* 66(4), 774–783.

[3] Jirwe, M., Gerrish, K., & Emami, A. (2010). Student nurses' experiences of communication in cross-cultural care encounters. *Scand J Caring Sci* 24(3), 436–444.

[4] Antwi, W. K., Kyei, K. A., & Quarcoopome, L. N. (2014). Effectiveness of multicultural communication between radiographers and patients and its impact on outcome of examinations. *World J Med Res* 3(4), 29–37.

[5] Davidhizar, R., Dowd, S. B., & Newman-Giger, J. (1997). Model for cultural diversity in the radiology department. *Radiol Technol* 68(3), 233–238.

[6] Maldonado, L. E., & Huda, K. (2018). Increasing the cultural competence of student radiographers. *Radiol Technol* 89(6), 616–620.

[7] Cowling, C., & Lawson, C. (2020). Assessing the impact of country culture on the socio-cultural practice of radiography. *Radiography*.

[8] Cox, T. (1994). A comment on the language of diversity. *Organization* 1(1), 51–58.

[9] Jackson, S., Brett, J., Sessa, V., Cooper, D., Julin, J., & Peyronnin, K. (1991). Some differences make a difference: individual dissimilarity and group heterogeneity as correlates of recruitment, promotions, and turnover. *J Appl Psychol* 76, 675–689.

[10] Bleiker, J., Knapp, K. M., Morgan-Trimmer, S., & Hopkins, S. J. (2018). "It's what's behind the mask": psychological diversity in compassionate patient care. *Radiography* 24, S28–S32.

[11] Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Med Care Res Rev* 57(Suppl 1), 181–217.

[12] Whitman, M. V., & Davis, J. A. (2008). Cultural and linguistic competence in healthcare: the case of Alabama general hospitals. *J Healthc Manag* 53(1), 26–39, discussion -40.

[13] Levin, K. S., Patricia Braeuning, M., O'Malley, M. S., Pisano, E. D., Barrett, E. D., & Earp, J. A. L. (2000). Communicating results of diagnostic mammography: what do patients think? *Acad Radiol* 7(12), 1069–1076.

[14] Edenbrook, B. T., Fridlund, B., Elgan, C., & Axelsson, A. B. (2008). Radiographers' areas of professional competence related to good nursing care. *Scand J Caring Sci* 22(3), 401–409.

[15] Jacobs, E. (2008). A better measure of patients' need for interpreter services. *J Gen Intern Med* 23(10), 1724–1725.

[16] Jacobs, B., Kroll, L., Green, J., & David, T. J. (1995). The hazards of using a child as an interpreter. *J R Soc Med* 88(8), 474P–475P.

[17] Moreno, M. R., Otero-Sabogal, R., & Newman, J. (2007). Assessing dual-role staff-interpreter linguistic competency in an integrated healthcare system. *J Gen Intern Med* 22(Suppl 2), 331–335.

[18] Haffner, L. (1992). Translation is not enough. Interpreting in a medical setting. *West J Med* 157(3), 255–259.

[19] Muller, J. H., & Desmond, B. (1992). Ethical dilemmas in a cross-cultural context. A Chinese example. *West J Med* 157(3), 323–327.

[20] Poon, A. W., Gray, K. V., Franco, G. C., Cerruti, D. M., Schreck, M. A., & Delgado, E. D. (2003). Cultural competence: serving Latino patients. *J Pediatr Orthop* 23(4), 546–549.

[21] Harvey-Lloyd, J. M., & Strudwick, R. M. (2018). Embracing diversity in radiography: the role of service users. *Radiography* 24, S16–S19.

[22] Abrishami, D. (2018). The need for cultural competency in health care. *Radiol Technol* 89(5), 441–448.

[23] O'Dwyer, H., Lyon, S., Fotheringham, T., & Lee, M. (2003). Informed consent for interventional radiology procedures: a survey detailing current European practice. *Cardiovasc Interv Radiol* 26(5), 428–433.

[24] Obergfell, A. M. (1995). Law & ethics in diagnostic imaging and therapeutic radiology with risk management and safety applications. University of Michigan: W.B. Saunders.

[25] Jacobs, E., Shepard, D., Suaya, J., & Stone, E. (2004). Overcoming language barriers in health care: costs and benefits of interpreter services. *Am J Public Health* 94(5), 866–869.

[26] Carroll, Q. (2014). In: D. Bowman (Ed.), *Adaptive radiography with trauma, image critique and critical thinking*, (1st ed.) Australia: Delmar, Cengage Learning.

[27] Walshe, K., & Higgins, J. (2002). The use and impact of inquiries in the NHS. *BMJ* 325(7369), 895.

[28] Williams, R., Moeller, L., & Willis, S. (2018). Barriers and enablers to improved access to health information for patients with low health literacy in the radiotherapy department. *Radiography (Lond)* 24(Suppl 1), S11–S15.

[29] Nutbeam, D. (2008). The evolving concept of health literacy. *Soc Sci Med* 67(12), 2072–2078.

[30] England, P. H. (2015). Local action on health inequalities: improving health literacy to reduce health inequalities. London: Equity UIoH.

[31] Deuster, L., Christopher, S., Donovan, J., & Farrell, M. (2008). A method to quantify residents' jargon use during counseling of standardized patients about cancer screening. *J Gen Intern Med* 23(12), 1947–1952.

[32] Schnitzler, L., Smith, S. K., & Shepherd, H. L., et al. (2017). Communication during radiation therapy education sessions: the role of medical jargon and emotional support in clarifying patient confusion. *Patient Educ Couns* 100(1), 112–120.

[33] Rubin, D. (2012). Listenability as a tool for advancing health literacy. *J Health Commun* 17(sup3), 176–190.

[34] Dimoska, A., Tattersall, M. H., Butow, P. N., Shepherd, H., & Kinnersley, P. (2008). Can a "prompt list" empower cancer patients to ask relevant questions? *Cancer* 113(2), 225–237.

[35] Eggly, S., Harper, F. W. K., Penner, L. A., Gleason, M. J., Foster, T., & Albrecht, T. L. (2011). Variation in question asking during cancer clinical interactions: a potential source of disparities in access to information. *Patient Educ Couns* 82(1), 63–68.

[36] Slater, B. A., Huang, Y., & Dalawari, P. (2017). The impact of teach-back method on retention of key domains of emergency department discharge instructions. *J Emerg Med* 53(5), e59–e65.

[37] Farrell, M. H., Kuruvilla, P., Eskra, K. L., Christopher, S. A., & Brienza, R. S. (2009). A method to quantify and compare clinicians' assessments of patient understanding during counseling of standardized patients. *Patient Educ Couns* 77(1), 128–135.

[38] Robinson, J., & Heritage, J. (2006). Physicians' opening questions and patients' satisfaction. *Patient Educ Couns* 60(3), 279–285.

[39] Heritage, J., & Robinson, J. D. (2006). The structure of patients' presenting concerns: physicians' opening questions. *Health Commun* 19(2), 89–102.

[40] Stewart, M., Brown, J. B., Boon, H., Galajda, J., Meredith, L., & Sangster, M. (1999). Evidence on patient-doctor communication. *Cancer Prev Control* 3(1), 25–30.
[41] Weech-Maldonado, R., Morales, L. S., Spritzer, K., Elliott, M., & Hays, R. D. (2001). Racial and ethnic differences in parents' assessments of pediatric care in Medicaid managed care. *Health Serv Res* 36(3), 575–594.
[42] Williams, R. (1999). Cultural safety–what does it mean for our work practice? *Aust N Z J Public Health* 23(2), 213–214.
[43] Flaskerud, J. (2007). Cultural competence: what is it? *Issues Ment Health Nurs* 28(1), 121–123.
[44] Fitzgerald, M. (2000). Establishing cultural competency for health professionals (pp. 184–200). London: Jessica Kingsley.
[45] Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong 2nd, O. (2003). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Rep* 118(4), 293–302.
[46] Kardong-Edgren, S., & Campinha-Bacote, J. (2008). Cultural competency of graduating US Bachelor of Science nursing students. *Contemp Nurse* 28(1-2), 37–44.
[47] Arnold, E., & Boggs, K. (2015). Interpersonal relationships: professional communication skills for nurses. Saint Louis: Elsevier.
[48] O'Neill, S., & Hatoss, A. (2003). Harnessing a Nation's linguistic competence: identifying and addressing needs for lote in the tourism and hospitality industry. *Aust Rev Appl Linguist* 26, 31–45.
[49] Shah, S. (2004). The researcher/interviewer in intercultural context: a social intruder!. *Br Educ Res J* 30(4), 549–575.
[50] Renzaho, A. M., Swinburn, B., & Burns, C. (2008). Maintenance of traditional cultural orientation is associated with lower rates of obesity and sedentary behaviours among African migrant children to Australia. *Int J Obes (Lond)* 32(4), 594–600.
[51] Ellison-Loschmann, L., & Pearce, N. (2006). Improving access to health care among New Zealand's Maori population. *Am J Public Health* 96(4), 612–617.
[52] Kafele, K. (2004). Racial discrimination in mental health: racialized and aboriginal communities. Toronto, Canada: Ontario Human Rights Commission.
[53] LaVeist, T. A., Nickerson, K. J., & Bowie, J. V. (2000). Attitudes about racism, medical mistrust, and satisfaction with care among African American and white cardiac patients. *Med Care Res Rev* 57(Suppl 1), 146–161.
[54] *Can patients be teachers? Involving patients and service users in healthcare professionals' education [press release]*. 2011. London: The Health Foundation.
[55] Kai, J., Beavan, J., Faull, C., Dodson, L., Gill, P., & Beighton, A. (2007). Professional uncertainty and disempowerment responding to ethnic diversity in health care: a qualitative study. *PLoS Med* 4(11), e323.
[56] Djulbegovic, B. (2004). Lifting the fog of uncertainty from the practice of medicine. *BMJ* 329(7480), 1419.
[57] McNeil, B. J. (2001). Hidden barriers to improvement in the quality of care. *N Engl J Med* 345(22), 1612–1620.
[58] Kai, J. (2005). Professionals responding to cancer and ethnic diversity. London: Cancer Research UK.
[59] Gopalkrishnan, N. (2019). Cultural competence and beyond: working across cultures in culturally dynamic partnerships. *Int J Commun Soc Dev* 1(1), 28–41.
[60] Wall, S. (2015). Focused ethnography: a methodological adaptation for social research in emerging contexts. *Forum Qual Sozialforschung* 16, 1–15.
[61] Kai, J., Bridgewater, R., & Spencer, J. (2001). " 'Just think of TB and Asians', that's all I ever hear": medical learners' views about training to work in an ethnically diverse society. *Med Educ* 35(3), 250–256.
[62] Kai, J., Spencer, J., & Woodward, N. (2001). Wrestling with ethnic diversity: toward empowering health educators. *Med Educ* 35(3), 262–271.
[63] Kashima, Y. (2000). Maintaining cultural stereotypes in the serial reproduction of narratives. *Personal Soc Psychol Bull* 26(5), 594–604.
[64] Christakis, N. A. (1995). The similarity and frequency of proposals to reform US medical education. Constant concerns. *JAMA* 274(9), 706–711.