TABLE 11.3. COMPLETED LITERATURE ANALYSIS HYBRID CHART.

Citation	Shapiro, J., Hollingshead, J., & Morrison, H. (2002). Primary care resident, faculty, and patient views of barriers to cultural competence, and the skills needed to overcome them. *Medical Education, 36, 749–759.*	Kripalani, S., Bussey-Jones, J., Katz, M. G., & Genao, I. (2006). A prescription for cultural competence in medical education. *Journal of General Internal Medicine, 21,* 1116–1120.	Rosen, J., Spatz, E., Gaaserud, A., Abramovitch, H., Weinreb, B., Wenger, N., et al. (2004). A new approach to developing cross-cultural communication skills. *Medical Teacher, 26*(2), 126–132.	Derosa, N., & Kochurka, K. (2006). Implement culturally competent healthcare in your workplace. *Nursing Management, 37*(10), 18–26.
Purpose	Literature has very little info on perception of barriers to achieve culturally competent communication for residents, faculty, and patients. Study aims to address this issue	Not all cultural competence education is effective in improving attitudes and skills of health professions; authors propose elements to improve education	Most cross-cultural training for medical students consists of lectures on topic during preclinical years rather than training in clinical years; purpose: to give students awareness, attitude, and knowledge plus communication skills	To outline a six-step approach to delivering culturally competent care to an increasingly diverse patient population
Subjects	Faculty and residents who come from socioeconomic and diverse backgrounds; patients who fall below federal poverty line		32 third-year medical students from Ben Gurion University	
Methodology	Focus groups: 5 faculty groups, 3 resident groups, 2 patient groups Questions revolved around perceptions of effective cross-cultural communication and the barriers to it		1.5-day workshop included: intro to cross-cultural medicine issues, video on using interpreters, intro of CHAT (Cultural and Health Belief Assessment tool), actors used—students do mock interviews with patients—4 each, students devise treatment and prevention plans for each patient	Design/analysis
Design/ analysis	Initial debriefing session with facilitators to look for emerging themes; verbatim transcripts made, content analysis initially descriptive and then interpretive		Students did self-evaluations at end of workshop; students surveyed before workshop and 6 weeks following workshop to assess attitudes in cross-cultural communication in 7 content areas, computed means for each pre/post-survey	

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Theoretical framework		Gives general overview of 3 approaches to teaching cultural competency: knowledge based, attitude based, skills based Mentions Berlin and Fowkes LEARN guidelines, Kleinman's questions, RISK framework, and diffusion of innovations theory	The author's evaluation survey was based on work of Kleinman and the revised developmental model of ethnosensitivity by Borkan and Neher	Includes Fowkes's LEARN guidelines; mentions Kleinman's questions; includes Narayan's elements of a cultural assessment; refers to preserve-accommodate-restructure framework—not clear which author this is
Conclusions/ results	Residents more language focused than faculty, patients defined competence in more generic terms than culture specific; residents and patients more likely to use person-blame models when talking of barriers; all 3 groups focused on providers for solutions	Authors conclude by calling for a more active approach to cultural competence that is integrated across all levels of medical education	Students showed a significant improvement in 5 of 8 areas measured. Authors deem workshops can be an effective, feasible, interesting, and entertaining way to hone cross-cultural skills, though note mastering cross-cultural skills cannot be achieved in a single workshop	Respect for patients must include respect for their cultural beliefs, values, and practices
Implications	Need to realize many residents are skeptical of cross-cultural training, suggests courses taught by physicians who are respected by residents and focus on generic skills of patient-centered communication	An integrated approach to cultural competence training is more likely to yield long-term outcomes rather than isolated workshops	With increasing diversity of the population, medical schools must equip students with skills needed to practice in multiethnic environment—the current depth of cross-cultural courses is insufficient and timing of courses (preclinical) suboptimal-acquisition of cross-cultural skills is continuous process	If you acknowledge the patient and family are the experts about their cultural norms and see yourself as becoming, rather than being, culturally competent, you'll achieve the most effective outcomes possible in working with patients

(Continued)

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TABLE 11.3. (CONTINUED)

Weaknesses	Excluded patients who couldn't speak English because no interpreters (authors do list this as limitation); only had 2 patient groups out of 10 total groups; had patient focus groups in clinic—wonder about their comfort in this setting	Article describes current state of cultural competence education and its problems (lack of consensus on how to teach, limited outcome measures), but doesn't give information about their teaching experiences in the area; article would have been better if they included more examples of successful practices/ programs	No background given on students (including ethnicity); did not discuss how many students attended until Results section; got poor survey response rate at end of workshop, should have been able to get >75% in my opinion	Authors could use more examples of best practices to illustrate suggestions—very few are given; authors state, "Six steps have been named that meet the cultural needs and expectations of patients." It's not clear if they are the authors of these steps. Very few people are cited in the article.
Strengths	Gave good background details of participants; tried to get high percentage of residents/faculties from each site; questions used included; key points illustrated well; good details and analysis of focus group sessions given	Encourages use of educational methods that correspond to principles of adult learning; 69 references listed so obviously did a fairly good search of the literature; article easy to read—gives clear ideas of how to improve culturally competent training	Points out that students attending workshops were doing rotations at hospital at same time—could have affected survey results not related to workshop; authors speculate about areas that did not improve	Easy to read for layperson; key ideas/ examples pulled out into boxes for quick referral; good examples given of differences in nonverbal communication and questions to ask in a cultural assessment
Other	Adversarial undercurrents in groups noted—suggest importance of compassion and humility in field	Authors emphasize need for outcomes-based research to determine value of their strategies and others used in cc training	Authors note there is currently no standardized rating scale for defining essential components of an effective medical interview	

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