

Does Having a Culturally Competent Health Care Provider Affect the Patients' Experience or Satisfaction? A Critically Appraised Topic

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Clinical Scenario: The level of cultural competence of health care providers has been studied. However, limited scholarship has examined whether the cultural competence of the health care provider affects patient satisfaction. **Focused Clinical Question:** Does cultural competence of health care providers influence patient satisfaction with their experience with their provider? **Summary of Key Findings:** Having a culturally competent health care provider, or one who a patient perceives as culturally competent, does increase patient satisfaction. **Clinical Bottom Line:** Cultural competence in health care plays an important role in patients being satisfied with their providers, as well as patients willingly and actively participating in their treatment. **Strength of Recommendation:** Questions 1 to 5 and 9 of the critical appraisal skills program were answered “yes” for all studies in the critically appraised topic. Thus, the authors strongly support the findings.

Keywords: cultural competence, patient satisfaction, health care provider, cross-cultural communication, multiculturalism

Clinical Scenario

People from different cultures, races, ethnicities, genders, sexualities, and other social locations have different beliefs about illness and different needs and preferences when it comes to receiving health care. Cultural competence in health care can generally be defined as the ability of health care providers to have awareness about these differences, as well as to respect them and shift their treatments to the specific needs of their patient. Studies have examined health care provider's level of cultural competence. Some health care providers have received training to become culturally competent or are perceived by their patients as being culturally competent. However, does a health care provider's level of cultural competence influence the provider-patient relationship? Do patients care? Limited studies have examined the effect provider cultural competence has on patient satisfaction. The studies that have examined this show that cultural competence has benefits for the patient.

Focused Clinical Question

Does having a culturally competent health care provider/staff member (or provider who is perceived to be culturally competent) affect the patients' experience/satisfaction with their provider?

Summary of Search, “Best Evidence” Appraised, and Key Findings

- We searched for studies that discussed patients' satisfaction with their health care experiences as related to whether they believed their provider (or other staff) to be culturally

competent. To be included, the answers to section A questions 1 to 5 (ie, Are the results of the study valid?) of the critical appraisal skills program (CASP) must be “yes.” The answers to section B question 9 (ie, Do you believe the results?) must be “yes,” as well. The remaining questions could be “cannot tell” or “no.”

- The primary author read 41 articles' abstracts to determine if the article was relevant to our research question. From those 41 abstracts, 18 full articles were read. Five of these articles met our predetermined inclusion criteria and were analyzed in this critically appraised topic (CAT).
- All articles analyzed in this CAT found benefits to health care staff displaying cultural competence, and 1 article reported how a lack of cultural respect worsened the experience of the patients.

Clinical Bottom Line

Strength of Recommendation

Questions 1 to 5 and 9 of the CASP were answered “yes” for all studies. Thus, there is strong evidence to suggest that the perceived or actual cultural competence of health care providers/staff has a positive effect on the patients' satisfaction with their experience.

Search Strategy

We used the following terms to conduct our search:

- Patient/Client group: patient perspective views
- Intervention/Assessment: cultural competency of health care providers, physicians, or staff
- Comparison: no control
- Outcome: patient satisfaction

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Other search term combinations included: “importance to patients of providers being culturally competent”; “importance of cultural competence in health care”; “patients perception of cultural competence”; “discrimination in health care”; “cultural competence × patient satisfaction”; “physician cultural competence and patient satisfaction”; and “‘cultural competence’ AND ‘patient satisfaction.’”

Sources of Evidence Searched

- Google Scholar
- Sage Journals
- Smart Search Central Michigan University
- PubMed

Inclusion and Exclusion Criteria

Inclusion

- Studies that examine patients’ perspectives of their providers/health care staff
- Studies had to mention whether patients’ perceptions of cultural competence in their health care provider/staff impacted how satisfied the patients were with their experience
- Limited to English language studies between 2005 and 2016

Exclusion

- Studies that did not focus on the patients’ perspective (ie, physicians’ or providers’ perspective)
- Studies that did not discuss whether cultural competence affected patient satisfaction
- Studies from before 2005

Results of Search

We found 5 studies¹⁻⁵ that met our predetermined inclusion and exclusion criteria. Each study was independently analyzed using the CASP⁶ for cohort studies. The CASP for cohort studies is a questionnaire with 12 questions divided into 3 sections (A, B, and C) used for health research. Aside from questions asking what the results and implications of the studies are, as well as how precise the results are, the questions were answered with “yes,” “cannot tell,” or “no.” Section A (questions 1–6) of the questionnaire is used to determine if study results were valid; all of the studies we used appeared valid. Section B (questions 7–9) asked about the results of the study, and section C (questions 10–12) asked whether the results will help locally (see Table 1 for CASP questions and our responses). Although there is limited research done on patient satisfaction and provider cultural competence, the studies examined were either the first of their kind or their results fit with evidence done from other studies. Not all of the results from the studies included in this paper can be generalized to all populations, but the studies used here collectively examined numerous different populations (ie, Latinas,¹ Southeastern Americans,² individuals with hypertension³).

Best Evidence

The studies¹⁻⁵ in Table 2 were selected for inclusion in this CAT. These studies all discussed how patients’ experiences with health care were affected by the cultural competence (including perceived cultural competence) of the people giving care. Questions 1 to 5 (section A) and 9 (section B) were all answered “yes.” Thus, we believe the studies are valid and the results are believable.

Implications for Practice, Education, and Future Research

Health care providers, such as nurses,^{9,10} physicians,¹⁰ and athletic trainers,¹¹ have demonstrated various levels of cultural competence. But does the level of cultural competence or perceived cultural competence of the health care provider affect patients’ experiences and satisfaction? The most prominent conclusion from this CAT is that cultural competence of health professionals does affect patients’ experiences and satisfaction. Not surprising, the more cultural competence a health professional displayed, the more beneficial it was to patients’ experiences. Of the 5 articles analyzed, 4 mentioned a variety of benefits patients experienced interacting with culturally competent providers.^{1,3-5} First, more cultural competence resulted in higher patient satisfaction.^{1,3-5} Second, patients tended to be more open with³⁻⁵ and trusting of^{4,5} the health care staff if the professionals showed cultural competence. Patients who perceived their provider as being culturally competent also were more likely to follow the medical advice of the provider.^{2,4} Additionally, having a provider who could speak the same language as the patient was shown to correlate with higher patient satisfaction.¹ Conversely, 1 article² reported negative effects of having staff whom were not culturally competent. The participants of this study who identified as European American or African American both perceived age and racial discrimination, felt discriminated against if uninsured, or felt they were treated unfairly by the verbal and nonverbal communication of the nonphysician health care staff.² Helping such staff develop adequate patient-centered care practices could be beneficial in increasing patient satisfaction.²

The current study has some limitations that offer opportunities for future research. The studies in this CAT show that increased cultural competence is associated with increased patient satisfaction. This CAT did not discuss, however, how other factors unrelated to provider cultural competence may impact the satisfaction of a patient. Future research could examine the relationships between compounding factors and cultural competence on patient satisfaction. Additionally, the findings of the studies¹⁻⁵ in this CAT cannot be generalized to all populations of people; they focused on narrow populations. Future studies could continue to examine the impacts of cultural competence on other populations of people.

In conclusion, the results of this CAT indicate that cultural competence of health care staff and providers has an influence on patient satisfaction. The more culturally competent a patient considers their provider, the more satisfied the patient.^{1,3-5} Additionally, patients seem to be more willing to comply with their treatment and engage with the provider if the provider is culturally competent.³ Becoming culturally competent as an employee in health care, therefore, is beneficial and should be encouraged. This CAT should be repeated after more studies are published on the relationship between cultural competence and patient satisfaction.

Table 1 Critical Appraisal Skills Program Questionnaire

	Castro and Ruiz ¹	Ohana and Mash ⁴	Paez et al ³	Tajeu et al ²	Thom and Tirado ⁵
Q1. Did the study address a clearly focused issue?	Yes	Yes; addresses multiple issues	Yes	Yes; addresses multiple hypotheses	Yes
Q2. Was the cohort recruited in an acceptable way?	Yes	Yes	Yes	Yes	Yes
Q3. Was the exposure accurately measured to minimize bias?	Yes	Yes	Yes	Yes	Yes
Q4. Was the outcome accurately measured to minimize bias?	Yes, although not blinded because of type of study	Yes; not blinded but patients kept anonymous	Yes, although not blinded because of type of study	Yes, although not blinded because of type of study	Yes, although not blinded because of type of study
Q5a. Have the authors identified all important confounding factors?	Yes; mentioned lack of education/ language as a barrier; participants often asked a partner to read them questions	Yes; one hypothesis considered cultural background, gender, and ethnicity of participants	Yes; considered recall and social desirability biases	Yes; mentioned education level and low rates of insurance and small sample size	Yes; mentioned low socioeconomic status, low literacy, and limited English of nonrespondents as limitations
Q5b. Have they taken account of the confounding factors in the design and/or analysis?					
Q6a. Was the follow-up of subjects complete enough?	Not an ongoing study	Not an ongoing study	Not an ongoing study	Not an ongoing study	Yes
Q6b. Was the follow-up of subjects long enough?					
Q7. What are the results of this study?	See Table 2	See Table 2	See Table 2	See Table 2	See Table 2
Q8. How precise are the results?	Reliability alpha coefficients of .88, .85, .91, and .94 found from various questionnaires used (see Table 2). Correlation scores significant at .05 level	Satisfaction of medical care and CC $r = .87$ Gap between physicians' and patients' perception of physicians' CC $r = -.02$ Differences in perceptions and adherence to treatment $r = -.5$	OR = 3.1; 95% CI, 1.4–6.9	No CI given	PRPCC found to have construct and predictive validity —patient satisfaction: $r = .32, P < .001$; patient trust: $r = .53, P < .001$; decrease in blood pressure in hypertensive patients: $r = -.18, P < .05$ PSACC less reliable than PRPCC
Q9. Do you believe the results?	Yes	Yes	Yes	Yes	Yes
Q10. Can the results be applied to the local population?	Cannot tell; generalizable to Latina population	Cannot tell; generalizable to Israelis, Ethiopians, or former Soviet Union populations	Cannot tell; applicable for people in middle to lower class with hypertension and/or diabetes	Cannot tell; results are most applicable to people of Southeastern United States	Cannot tell; states that results may not be generalizable
Q11. Do the results of this study fit with other available evidence?	Yes, but evidence is limited	Yes	Not an ongoing study; first study of its kind	Not an ongoing study; first study to look at satisfaction with nonphysician health staff	Yes
Q12. What are the implications of this study for practice?	Health care should employ NPs with CC, higher education and ability to speak same language as primary population	Important to have providers be CC, communicate with patient, and share the treatment plan with patient	Important to patients to have physicians' attitudes and actions be culturally competent	Important for nonphysician staff to be polite to patients and aware of existence of implicit biases	Appropriate interpersonal behaviors are important in provider cultural competence

Abbreviations: CC, cultural competency; CI, confidence interval; NP, nurse practitioner; OR, odds ratio; PRPCC, Patient-Reported Provider Cultural Competency; PSACC, Provider Self-Assessment of Cultural Competency.

Table 2 Characteristics of Included Studies

	Castro and Ruiz ¹	Ohana and Mash ⁴	Paez et al ³	Tajeu et al ²	Thom and Tirado ⁵
Patients, n	218 Latina patients, most from Mexico and spoke little/no English 15 female NPs, about half spoke Spanish, and 93.3% had some CC training	417 patients who speak Hebrew (56.4% women, 38.1% men, and 5.5% unknown) and 90 physicians (27.8% women, 71.1% men, and 1.1% unknown) in outpatient clinic in Israel	26 PCPs (mean age = 43.6 y, 42% white, 27% African American 31% other, and 65% female) from Baltimore and 123 patients with hypertension (mean age = 61.9 y, 31% white, 69% African American, and 64% <\$35,000 income)	African American (n = 55, 52.7% female, mean age = 49.7 y, and 5.6% uninsured [22.2% Medicare or Medicaid]) and European American (n = 37, 49.6% female, mean age = 46.7 y, and 32% uninsured) who spoke English and had visited a health care provider within the past year	– 53 family physicians (62% practicing and 38% residents, 45% female, mean age = 39.2 y, and 72% white) – Patients, n = 429 (age = 58.1 (12.0), 54.9% female, and 26.4% white non-Hispanic) – Visited physician within past year for diabetes and/or hypertension
Experimental design and methods	– Descriptive correlational design – NPs filled out demographics questionnaire and IAPCC survey – Patients filled out demographics questionnaire, PSQ-III measuring satisfaction, and ARSMA-II measuring acculturation	– Patient questionnaire of perception of physician’s CC (modeled after study used by Michalopoulou et al ⁷). Had 3 parts: demographics, perception of provider CC/satisfaction with care, and adherence to recommendations – Physician questionnaire modeled after questionnaire by Doorenbos et al. ⁸ Had 3 parts: demographics, perception of their own CC, and their belief of how much patient was following recommendations	Clinical trial: – PCPs filled out surveys measuring usage of components of CC, motivation to learn about other cultures, and measuring “power and assimilation” beliefs – Patients completed surveys about satisfaction, respect from, and trust in physician – Measured patient participation using Perception of Involvement in Care Scale and a questionnaire	– 12 focus groups examining perception of discrimination during primary care visit – Participants were in separate groups based on race and gender • Debriefing and transcribing after data collection – Demographic questionnaire of focus group participants	– Surveys including PRPCC given to patients – Questionnaire (PSACC) given to physicians’ measuring their ratings of their own CC – Results compared with find reliability/ validity of PRPCC
Results	– Significant correlation ($r = .193$) between CC of NP and patient satisfaction – Correlation between NP CC and patient satisfaction with general care ($r = .16$) and interpersonal aspects of care – Latina patients prefer NPs who are Latina – Highest indicator of satisfaction was shorter wait time	– Relationship exists between physician and patient cultural backgrounds and chance of conflict – Positive correlations between patients satisfaction of care and patients’ perception of: • cultural knowledge and competence of provider ($r = .97$ and $r = .87$, respectively) • patient involvement in treatment ($r = .81$) • perceived communication ($r = .80$) – Patients view providers as more CC than providers view themselves – Ethnicity impacts level of CC they view provider as having and affects satisfaction – Smaller the gap between physician and patient perception of CC, the more patients adhere to treatment	– Found the more CC the provider/ willingness to learn about other cultures, the more patient satisfaction and openness with provider – No relationship found between physician CC and patient trust	– Both races reported discrimination based on their racial and socioeconomic status, and through verbal and nonverbal communication of nonphysician staff – European American reported age discrimination	– PRPCC had construct validity • Moderately coordinated with patient satisfaction and trust – Patients reporting providers giving behavioral change suggestions also reported higher provider CC – No correlation found between patient and provider reports of provider CC – Physician reported CC not correlated with patient trust or satisfaction

(continued)

Table 2 (continued)

	Castro and Ruiz ¹	Ohana and Mash ⁴	Paez et al ³	Tajeu et al ²	Thom and Tirado ⁵
Conclusion	<ul style="list-style-type: none"> – Latina patients prefer Latina NPs with training in CC, have higher education, and speak Spanish – Shorter wait time is number one factor for Latina patient satisfaction 	<ul style="list-style-type: none"> – Patient view of provider CC significantly correlates with patient satisfaction (higher the perceived CC, higher the satisfaction) – Lower probability of conflict when fewer differences exist between culture of provider and patient – Greater the difference between perceived CC of provider and patient, less likely patient will follow medical advice – Poor provider/patient communication could negatively impact satisfaction – Patient involvement in care may impact satisfaction and perception of provider CC 	<ul style="list-style-type: none"> – Facilitation of physician CC including changing their actions and beliefs (as related to different cultures) could be important for physician–patient relationships 	<ul style="list-style-type: none"> – Interaction with health care staff can affect patient satisfaction and perceived discrimination – Patients could benefit from more courtesy and patient-centered care from health staff 	<ul style="list-style-type: none"> – Patient reports of provider CC may be more ideal because more correlated with processes and results of care than provider reports – Similarities between measuring physician CC and interpersonal ability – A measure of CC could be beneficial with CC training and implementation in health field

Abbreviations: ARSMA-II, Acculturation Rating Scale for Mexican Americans; CC, cultural competence; IAPCC, Inventory to Assess the Process of Cultural Competence Healthcare Professionals; NP, nurse practitioner; PCP, primary care physician; PRPCC, patient-reported provider cultural competency; PSACC, provider self-assessment of cultural competency; PSQ-III, Patient Satisfaction Questionnaire.

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