Exploring provider-related factors in the patient-provider relationship that affect the provision of adequate care to ethnic minorities and provider-level strategies to reduce this health care disparity, with a focus on Indigenous peoples in Canada

By

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BSc in General Science, University of British Columbia, 2014

Capstone Project Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Public Health

in the

Faculty of Health Sciences

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Abstract

Health status has been shown to vary by ethnicity. While experiences of ethnic minority patients in the health care system have been well researched, less is understood about how healthcare providers contribute to disparities in the delivery of care. A literature review was undertaken to examine the patient-prover interface from both the patient perspective, and the healthcare professional perspective when treating people from ethnic minority groups. A number of factors were revealed as influential, including historical elements, socio-cultural differences and preconceived ideas about ethnic minority groups. Strategies were identified to reduce these ethnic health care disparities in order to improve the provision of care for different populations.

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Introduction

Ethnic minority populations have been growing from the start of the migration of settlers and as a more recent result of globalization and the internationalization of the market (Scheppers et al, 2006). This has caused Indigenous peoples, the original inhabitants of the country, and new immigrants to a new country to become ethnic minorities. The term "ethnic minority" is defined in this capstone as a group of people that share a minority status because they are set apart from the "dominant" population in numerical or socioeconomic factors and based on ethnicity, language, place of birth, religion or culture (Scheppers et al, 2006). This capstone uses Scheppers et el (2006)'s definition of ethnic minorities that includes both immigrants and Indigenous peoples because parallels can be drawn from the experiences of these populations in the health care system, from which we can learn[1]. Ethnic minorities face barriers when accessing health care, not only because they are minorities but because they tend to be concentrated in lower status areas of cities (Scheppers et al, 2006). It is important to note, however, that not all ethnic minorities are of low socioeconomic status and within minorities, socioeconomic status varies a great deal.

The objective of this literature review is to explore the provider-level factors that affect the patient-provider interface between health care providers and ethnic minorities, from both the provider and the patient perspective. Understanding these modifiable provider-level factors or barriers could potentially aid in the provision of adequate care for different population groups and may reduce ethnic health disparities caused by health care disparities. Furthermore, the goal

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[1] This definition including the term "ethnic" might not align with Indigenous peoples' self-identification and historical continuity with pre-colonial societies.

is to understand the reasons these barriers exist and from where they stem in order to develop strategies to address them appropriately. Exploring the patient-provider interface, specifically with indigenous peoples in Canada, allows an understanding of how socio-historical mediated assumptions or factors can affect and shape this relationship (Browne, 2007).

Ethnic minority populations' health issues are significantly different than their majority counterparts. For example, infant death and diabetes are almost two times higher and the prevalence of diseases is significantly larger in Indigenous populations compared to non-indigenous populations (Broome & Broome, 2007). There is comprehensive evidence of ethnic health disparities, however there is limited literature on the role of the provider and what barriers contribute to disparities in the delivery of care. It is unknown how much of these disparities in health status are attributed to the provision of care or the provider (Cooper et al, 2002), however ethnic minorities face barriers when accessing health services, of which providers are often unaware, even though they might be contributors (Scheppers et al, 2006). It is unclear whether provider biases and the quality of care are directly linked, however diagnosis and treatment have been shown to be affected by the patient's race or ethnicity (Smedley et al, 2003). Social differences create a vertical relationship between the patient and the provider, creating a potential barrier between the two that may limit the provision of adequate care (Scheppers et al, 2006).

Ethnic minorities are sometimes referred more quickly to specialists, receive less pain medications and other therapies, and undergo more complex pathways to care compared to their ethnic majority counterparts (Scheppers et al, 2006). Van Ryn (2002) proposes a hypothesized causal pathway for the provider's behaviour and the delivery of care shaped by the social

cognition theory which explains the human nature, regardless of class, culture, or position, of categorizing and generalizing groups of people, a reason for which the provider's perceptions and beliefs on a patient can affect their behavior towards them. Stereotyping or ethnic profiling is a barrier to care and can be especially coercive when providers impose Western-oriented concepts of patient autonomy (Cornelison, 2001).

Methodology

The aim of this literature review is to examine provider-level factors that negatively affect the ethnic minority patient-provider interface, from the perspective of both the patient and the provider. Medline was searched to find articles pertaining to this public health issue. A combination of the following terms was used to search the database: barriers, quality of care, indigenous peoples, ethnic minorities, patient-provider relationship, intercultural challenges, provider perceptions, provider challenges, culture. Only articles after the year 2000 were considered. A total of 15 articles were found for the results, some of which overlapped in different sections; 5 articles were used for the provider's perspective, 5 for the patient's perspective, and 8 found specifically regarding Indigenous peoples. To be included in the review, the articles required the inclusion of barriers specific to the provider with patients of ethnic minorities from the perspective of the provider or the patient. Articles containing observational research, patient experiences or barriers at the health care system-level or patient-level were excluded. Data collection of the articles used included focus groups, semi-structured interviews, surveys, and literature reviews, of which the majority was analyzed by thematic analysis.

In this capstone, the provider is considered as any health care provider in the health care system, including physicians, nurses, midwives, etc. For the term "ethnic minorities", articles including ethnic minorities, immigrants, racial minorities, cultural minority, minority and Indigenous peoples were reviewed. Although these terms are not interchangeable, they are related and for the purpose of this capstones used to describe a minority group. In this case, culture refers to a set of values and beliefs, race refers to biological variation, while ethnicity refers to common ancestry which can include language, history, religion, etc. (Cornelison, 2001).

Results

The results of this review are organized by the perspective of health care providers, the perspective of patients of ethnic minorities in general, and the relationship between health care providers and Indigenous patients characterized by both perspectives.

Providers' perspective on barriers

It is important to understand providers' perspectives on the barriers they believe impact the patient-provider relationship and thereby care. A study by Taylor et al (2013) exploring providers' perceptions for caring for patients from ethnic minorities found that language barriers were the main difficulty. However, providers also considered patient attitudes, beliefs and other cultural factors as barriers to providing care because of a lack of understanding of health and cultural beliefs which affected how the patient perceived the problem and sometimes lead to misdiagnoses. Some providers perceive failure to comply with medical treatment a cultural issue,

when patients may just prefer alternative or traditional methods of treatment (Komaric et al, 2012).

Providers sometimes fear offending patients' religious or cultural practices, specifically regarding gender attitudes (Taylor et al, 2013), which may affect care and limit providers' clinical decision-making. A lack of understanding on behalf of the patient of the role of the provider, interpreter, and different procedures and protocols were stated by providers as barriers. The perceived barriers were thought to affect provider's workflow and require more time than other patients. In a similar study, focus groups with providers found that although interactions with ethnic minority patients were positive, cultural and language differences were the most significant barriers (Komaric et al, 2012). Furthermore, the providers in the study noted that they were aware of discrimination taking place in health care practice. Cornelison (2001) provides examples of discrimination faced by ethnic minorities, such as being less likely to receiving drugs to alleviate pain or adequate treatment.

In a study on immigrant women, physicians considered the cultural attitudes of their patients as a problem or obstacle in providing appropriate care (Degni et al, 2012). Some even believed that patients should adapt to local norms and not impose their cultural traditions on providers. Even some nurses who had more frequent contact with the patients assumed the same patients were not educated or that refusal of treatments was associated with religious or cultural factors, which some believed would change as they adapt to the social and cultural local context. Neglecting the importance of religion, spirituality or the role of the patient's family in care can act as a barrier

(Scheppers et al, 2006). Nonetheless, nurses reported trusting relationships with immigrant women and a new sense of understanding towards them (Degni et al, 2012).

Patient perspective on barriers in the patient-provider relationship

Ethnic minority patients perceive cultural differences with their health care provider to disrupt the provision of care (Komaric et al, 2012). Although language or communication are most often stated as the most significant barrier, cultural incompatibility, which can take the form of racism or a lack of awareness, is perceived as the main problem contributing to the misunderstanding or miscommunication between a patient and a provider (Komaric et al, 2012). Patients of ethnic minorities reported the quality of care slightly lower than the ethnic majority, explained by differences in the provider's cultural sensitivity (Saha et al, 2003). Patients of some ethnic minority groups value a warm and personal relationship with providers, for example; when providers are too formal, this can be a barrier to their interaction (Scheppers, 2006). Although this can be a reflection of cultural preferences, expectation for the patient-provider relationship may alter attitudes and behaviour towards the other.

The quality of patient-physician interaction was found to be lower in Hispanics and Asians in the United States, one of the reasons reported being providers' cultural insensitivity (Saha et al, 2003). However, Saha et al (2003) suggest that some of their findings do not align with previous studies due to a possible increase in provider awareness of health disparities and physician bias towards ethnic minorities, which has improved their behaviour. Nonetheless, the literature suggests that discrimination towards ethnic minorities in health care settings in Latin America is still a major barrier to accessing quality care (Castro et al, 2015). Poor intercultural care and

cultural sensitivity is a significant contributor to this issue, while other barriers include rejection of traditional cultural health practices and beliefs, humiliation and neglect (Castro et al, 2015). Castro et al (2015) argue that it is a broader problem than merely provider behaviour, and strategies to address this problem need to target the socioeconomic inequalities faced in the health care system.

A focus on the Indigenous patient-provider relationship

The literature suggests that the engagement between indigenous patients and non-indigenous health care providers is undermined (Roe et al, 2012). Indigenous patients in Canada report many negative encounters with their health care providers, including not being listened to and believed, or judged and ignored (Hole et al, 2015). This has affected their reception of care, as diagnosis and treatment were unclear or not explained properly to the patient. The interactions between the two are influenced and shaped by different factors, including cultural orientation and paradigms (Roe et al, 2012). For this reason, cultural respect and understanding are essential to attend to the patient-provider engagement. The perception of care providers on obstacles to delivering care to First Nations in a study done in Canada was divided between those who placed the responsibility on the patient and those who were aware of the hierarchal relationship between the patient and the provider (Bhattacharyya et al, 2011a). Providers in the latter category believed a greater partnership would improve care. Placing greater responsibility on patients can be described as patient empowerment because it gives control to patients making their own decisions about their health and their care, however Bhattacharyya (2011a) suggests this is can be a way for providers to take responsibility off of their hands, which may be harmful for patients who do not have the resources to do so. Cultural factors were not suggested by providers as barriers, possibly

meaning a lack of awareness of cultural issues on their end. In a similar study, findings from a national survey showed that providers also perceived patient factors to be the most significant factor contributing to the quality of care, as opposed to structural or systematic factors (Bhattacharyya, 2011b).

Hole et al (2015) highlight the importance of recognizing that historical realities and colonial legacies shape the relationship between the health care system and Indigenous peoples in Canada. Therefore, it is important to examine the patient-provider interface in a wider social and historical context, which continue to impact the lives of Aboriginal peoples (Browne, 2007). In Browne's study (2007), observations of encounters between providers and indigenous patients, along with interviews with those providers were done to investigate the factors that influence the patient-provider encounters. Providers interpreted varying patient communication styles as merely cultural differences, instead of acknowledging possible power differences felt by patients reflecting historical relations of power and paternalism, sometimes leading to frustration for the provider due to miscommunication. Most providers changed their communication style when caring for Indigenous patients and assumptions made by the provider sometimes led to misinterpreting patient needs. If patients do not interact the way is expected by providers, their needs may be neglected (Browne, 2007). Categorizing patients off the bat into "types of patients", such as "angry" or "quiet", prevented building a connection or relationship between the patient and provider. Nurses admitted to unintentional discrimination towards Indigenous patients because of the preconceived views based on past colonial discourses- for example, having a view of uncleanliness towards Indigenous peoples and subconsciously "protecting" oneself against them. Browne (2007) suggests that Indigenous peoples can be marginalized in

clinical practices by Othering them, reflecting the wider socio-cultural context and the colonizing discourse. The authoritative communication style in which some health care providers interact with ethnic minority patients can cause feelings of shame and discomfort (Scheppers et al, 2006).

Perceptions of health care providers towards Indigenous patients can affect the way they provide care. A second study by Browne (2009) explored how providers are influenced by the knowledge and assumptions they hold towards Indigenous patients and how these perceptions are a reflection of the broader discourse of Indigenous peoples' depictions in the public. Browne (2009) gives examples of the Canadian government having used pictures to manipulate the public in the past to popularize the viewpoint that Indigenous peoples are irresponsible and neglectful. Nurses seemed to view social problems as cultural characteristics to justify these problems, and overlooked the wider socio-economic and historical contexts in which these problems were rooted. In addition, some nurses believe Indigenous peoples don't like "them", not only contributing to the divide of "us and them", but believing this dislike had been instilled in them from childhood (Browne, 2007). For this reason, Browne (2007) discusses the importance of looking through a historical lens when analyzing interactions between patient and providers who view each other as the "other", that has been shaped by their life experiences and social discourse.

A study done in Peru aimed to examine whether the behaviour of health care providers contributes to ethnic disparities in the receipt of care by evaluating provider's differences in following national guidelines during patient-provider interactions by using simulated patients (Planas et al, 2015). No significant differences were found across ethnicities, counter to findings

from observational studies in the region. However, overall treatment quality was poor and was identified as a potential barrier to access for Indigenous patients as their needs were still not met.

Discussion

Four areas of discussion emerged from the results: the factors that influence the barriers found at the provider-level, the implications this issue has in public health, the application of decolonizing methodologies to health care, and strategies to mitigate this public health issue.

Factors that influence providers' interactions with ethnic minority patients

Although this capstone focuses on provider-level barriers, both patient and provider perceptions are valuable in order to compare perceived challenges and to help in shaping interventions or programs to improve their relationship and the care provided. Providers deal with barriers they face with patients of ethnic minorities as best they could (Taylor et al, 2013); however, it is unclear whether patients' needs are fully met. It is important to understand the factors that affect the barriers identified and the patient-provider interaction.

Most barriers to the patient-provider relationship are found to stem from cultural and socio-historical differences or lack of awareness and acknowledgement of these factors. It is evident from the literature that health care providers bring their own beliefs, perceptions and values in their interaction with patients which shape the way they act or care for them. These can be imbedded in their beliefs from their childhood, religion or educational training (Degni et al, 2012), and learned from and shared by their family and members of the same culture

(Cornelison, 2001). Like the rest of society, health care providers may not realize they hold certain beliefs or prejudices that they may manifest in their behaviour or the way of providing care (Smedley et al, 2003). Chapman et al (2013) describes this as "implicit bias". Based on evidence, Van Ryn (2002) hypothesizes that beliefs held about patient's social and behavioural characteristics shape whether the provider believes the patient is deserving of or appropriate for specific types of care. In other words, the influence on clinical decision-making is based on the provider's perceptions of their patient's social context. For example, providers may be generalizing patients too often based on population statistics and health trends for specific populations, instead of individualizing care (Van Ryn, 2002). Additionally, having experience with individuals of the same ethnic background who hold similar beliefs or behaviours might lead to the assumption that these beliefs and assumptions apply to all who are identified in the same ethnic group (Degni et al, 2012).

Cultural miscommunication between the patient and the provider occurs when providers interpret patient's cultures based on their own, which lead to a misunderstanding of the other's motives (Cornelison, 2001). Of most concern is when the provider constructs patient needs based on these interpretations and assumptions (Browne, 2007), which can be detrimental to the patient. Although the act of "othering" is not intentional by health care providers, there is a gap in the views of egalitarianism and its operationalization in practice (Browne, 2007). Therefore, social distancing can affect the delivery of care and the patient-provider engagement (Browne, 2007).

Communication and cultural sensitivity are central to providing adequate care to ethnic minorities; cultural appropriateness takes place when the provider is aware and acknowledges

that culture is a significant component of medical care (Degni et al, 2012). This is important because treating equity the same as equality means different patients' needs cannot be met with care that does not look at cultural, historical or social factors (Hole et al, 2015). Despite laws against racism or discrimination, the remnants of history that cause provider biases which might not involve conscious intentions to discriminate, plague the context of health care delivery (Smedley et al, 2003).

Implications for public health

The increase in ethnic diversity is extremely significant in public health; planning for new health, community, and other services to meet different needs is part of the field's scope (Taylor et al, 2013). Although there is evidence of ethnic disparities in health, but less of disparities in the provision of care, there is limited evidence on the reason behind the difference in care received (Van Ryn, 2002). The implications for public health are significant, as tackling peoples' perceptions, conscious beliefs and unconscious stereotypes are far more complex and rooted than educational training can offer.

In Taylor et al (2013)'s study, providers and researchers believe that promoting patients of ethnic minorities to learn English is the best solution to barriers between the two and will contribute to the process of their empowerment[2]. Providers put the responsibility of improving care on patients, without considering any interventions or strategies to change how they react or interact

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[2] The solution stated is only the perspective of the providers in Taylor et al (2013)'s study and does not reflect the solutions suggested in this Capstone because it is at odds with cultural/linguistic continuity.

with them. Other providers acknowledged the importance of educating health care professionals to better understand and care for patients of ethnic minorities.

Despite the many barriers identified, both patients and providers in a study felt that interactions are mutually beneficial and positive, however in need of improvement (Komaric et al, 2012). One strategy suggested was to increase cultural competence by conducting cultural awareness training which they believed would improve the provision of care as they both noticed the lack of cultural diversity in the health care workforce. Furthermore, a "multicultural agenda" was encouraged to be taken by the government and by the health care system to reflect the population consisting of different ethnic groups living in the country and therefore improving health outcomes through empowerment, and more efficient and acceptable services.

There is a need for health care providers to be critically aware of what cultural, social, and other assumptions they hold towards all patients, especially Indigenous patients, to ensure clinical practices are not contributing to marginalizing processes (Browne, 2009). Cultural awareness is crucial to garner a positive patient-provider relationship; providers may better understand the importance of cultural competence if evidence-based practice shows the benefit and the improved outcomes (Bhattacharyya, 2011a). Health care providers claim that they are not trained well enough in cross-cultural encounters and are not aware of cultural boundaries that challenge communication, which may lead to misunderstandings (Henderson et al, 2016). Research shows that the view of the importance of communication varies across different types of health care providers; in a study, doctors viewed it as less significant than community health representatives (Battacharryya et al, 2011b). In Henderson et al (2016)'s study, providers also admitted to

stereotyping cultural behaviours because of the lack of knowledge and understanding across cultures which can have negative effects on the encounter. Comprehensive approaches in cultural competence training may allow health care providers to better understand and attend to the needs of their Indigenous patients and other ethnic minorities. The role of public health is to encourage and push for cross-cultural training and reinforce these values in health care.

Applying decolonizing methodologies to health care

An intervention that can aid the patient-provider relationship is taking the same approach as decolonizing methodologies used in research. This approach should be included in health care training to benefit providers caring for different population groups, as described later. Decolonizing methodologies were developed specifically in response to the ongoing negative impacts of colonization on Indigenous peoples (Zavala, 2013). Indigenous peoples still suffer from the colonizing discourse; although not always obvious, clinical encounters can represent this argument (Browne, 2007). Decolonization can be defined as the rise of an "anti-colonial struggle" faced by Indigenous peoples that takes an approach that privileges Indigenous ways of knowledge and doing (Zavala, 2013). In traditional social science research, academia has been valued more than local knowledge which has resulted in colonial approaches setting the agenda for research; however, decolonizing methodology challenges this approach (Zavala, 2013). Decolonizing methodologies involve the inclusion of the community in the process of research, including prioritization and agenda setting to allow their voice to be heard, valuing Indigenous knowledge and protocols, which challenges the paradigm that Western methodologies, concepts and knowledge are the standard (Sidmonds & Christopher, 2013). It can be viewed as a process in which partnerships between researchers and the community are maintained to ensure

community engagement throughout the research in the case that modifications in theories or methods are needed to reflect the indigenous community's needs (Sidmonds & Christopher, 2013). Paralleling this to the patient-provider relationship, providers should understand and acknowledge cultural practices, value them as equally as western practices and include them in clinical practice to best meet the needs of their patients.

Zavala (2013) discusses the importance of collaboration in transforming Western/modern dominated methodologies that can supress the voices of some populations and further stigmatize them, similarly if applied to patients in a health care setting. Decolonizing research approaches challenges the positivist paradigm which hold a Euro-American perspective of only having one truth and not valuing experiential knowledge (Braun et al, 2014). Sidmonds & Christopher (2013) claim that decolonizing methodologies do not aim to discard Western research as they can be beneficial, but provides an opportunity to equally distribute power between researchers and Indigenous communities in each step of research. Believing in or acknowledging traditional practices does not disregard the belief of the benefits of western health care practices, but allows both to operate in parallel with each other (Scheppers et al, 2006). Indigenous patients value and appreciate medical technologies, however applying it on its' own disregards cultural healing methods (Hole et al, 2015). This allows Indigenous communities to be involved in decision-making and setting their own agenda based on their needs (Sidmonds & Christopher, 2013). This involvement in decision-making should be applied to health care, as it also needs to be participatory where the interaction between a patient and a provider is considered as an exchange of information. It is important for the provider to be flexible, accept differences and be willing to learn from their patients (Degni et al, 2012). Decolonizing methodologies is a context-specific

concept; different Indigenous communities have varying views, knowledge, and epistemologies that shape their methodologies and will determine acceptable practices to acknowledge self-determination (Sidmonds & Christopher, 2013; Braun et al, 2014), as do patients of different ethnic backgrounds.

As colonial legacies have led to power imbalances between subpopulations in society, decolonizing methodologies instead allows the perspectives of marginalized groups to hold value[3]. This shift from traditional research not only contributes to the process of self-determination, but also responds to colonialism which allows communities to recover and heal from its' historical legacy (Zavala, 2013). However historically, health-related research involving Indigenous communities have not used an anti-colonial framework; local perspectives or knowledge have been dismissed reflecting the past relationship between the state and Indigenous communities, further disempowering Indigenous communities and reinforcing institutionalized racism (Sidmonds & Christopher, 2013). Survival and resistance strategies used in Indigenous health for centuries are left unnoticed by the body of research that has been until recently trying to validate the dysfunctionality and challenges of Indigenous patients (Roe et al, 2012).

Although decolonizing methodologies have been developed specifically in response to the struggles of Indigenous peoples, much can be learned from this approach and applied to other ethnic minorities during the provision of care. Health care providers have acknowledged that culturally-tailored health services and information would benefit the population as services

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[3] This holds true for different marginalized groups (due to ethnicity) if decolonizing methodologies are applied to other ethnic groups.

directed at the dominant majority is not sufficient (Komaric et al, 2012). Patients believe that

comprehension of disease and management will improve with a more culturally competent

approach (Komaric et al, 2012). Although this capstone focuses on the provider-level and the

direct interaction with ethnic minorities, system, institutional, professional, and individual

(provider) change is needed to develop more culturally appropriate care comprehensively

(Komaric et al, 2012).

Steps Forward

The increasingly changing ethnic make-up of the population means that it is essential for health

care workers to be culturally competent, which in turn will allow them to achieve other personal

and professional competencies (Cornelison, 2001). Recognizing and responding to the needs of

cultural diversity will simplify health care delivery and provide an opportunity to garner trust and

respect between a health care provider and a patient and result in mutual understanding

(Cornelison, 2001). Given the resources in the health care system, ignoring the ethnic disparities

in the provision of care may reduce the returns on health care investments (Cooper et al, 2002),

which can be reason for the government to alter their agenda. A comprehensive approach and

prioritization of cultural competence training will not only benefit patients, but also providers,

communities and the health care system (Battacharyya et al, 2011a). For these reasons, there is a

need for funding (Battacharyya et al, 2011a); the success of programs or interventions to reduce

disparities have been dependant on government funding (Castro et al, 2015). Although disparities

in health status are also a result of wider socioeconomic factors (Cooper et al, 2002), the purpose

of this capstone is to address health care professionals who have control not on patients'

contextual contributors to health status disparities, but of their behaviours, attitudes and

perception that may contribute to these disparities. Intercultural intervention and humanization-of-care programs have been able to provide useful information on strategies to reduce disparities in health care delivery among Indigenous, Afro-descendant and other patients of ethnic minorities (Castro et al, 2015).

Designing interventions to eliminate ethnic health disparities can identify their target group as a specific group or community, or target health care providers' attitudes, behaviours, etc. (Cooper et al, 2002). In order to reach a level of cultural competence and safety adequate enough to meet the needs of patients of different ethnic minorities, interventions should be designed for the provider since they care for all types of patients. Furthermore, race discordance was not found to be a factor in the disparity of care provided (Saha et al, 2003), demonstrating the need to work on provider behaviours regardless of race or culture. Although providers are the target group, it is important to involve different stakeholders including individuals of communities or ethnic groups to provide input on their needs with a health care provider in order to shape interventions. The role of a health care provider is to make use of their skills and knowledge to the best of their ability in order to benefit the patient (Degni et al, 2012), including culturally competent skills to care for ethnic minority patients. Cultural competency focuses on the skills, knowledge, and attitudes of practitioners that are needed to effectively communicate and provide quality care (McNaughton-Dunn, 2002), whereas cultural safety goes beyond cultural competence to addresses and understand the power differentials between the provider and the patient (Spence, 2001). There are concerns with training to make providers more knowledgeable about customs, practices and values of different groups which may further drive negative stereotypes, but cultural competence is less about knowing facts and more about taking a patient-centered

approach (Saha et al, 2002). Bhattacharyya et al (2011a) also believe patient-focused

interventions will improve the partnership between the patient and the provider, and the health

outcomes. A strategy known as "individuating" emphasizes the focus on the specific patient and

the information they provide for more effective decision-making (Chapman et al, 2013).

The "challenges" that come with patients whose historical and social contexts need to be

acknowledged during care should not limit the delivery of adequate care, even in the busy

clinical context (Browne, 2007). These should first and foremost not be viewed as challenges,

but rather factors in patient care. Providers' preparedness needs to be assessed in order to shift

the model of care to include collaboration because cultural awareness and understanding and the

patient-provider relationship go hand-in-hand (Bhattacharyya et al, 2011a), with an end goal of a

horizontal partnership between the two (Castro et al, 2015). Cultural knowledge begins with

providers attentively assessing patients in their environment; however, understanding cultural

concepts to improve the provision of care requires time (Degni et al, 2012). For this reason,

health care providers should be educated from the beginning of their training. Medical training

covers group-level information which may include population risk factors and statistics of illness

and disease- although important, this may reinforce stereotyping later on in their career

(Chapman et al, 2013). The University of Southern California piloted a course for their physician

assistant program that made graduates more culturally aware, knowledgeable about marginalized

groups and aware of their personal prejudice towards others (Cornelison, 2001). There is a need

for educational tools and frameworks that encourage and push for critical consciousness and

reflection of the social context in which providers are delivering care and how this context or

dominant discourses shape clinical practices and interactions with patients and may contribute to

marginalization (Browne, 2007). Engaging in critical reflection about this inequity and learning about the implications of it on health outcomes is crucial in improving care (Browne, 2007; Castro et al, 2015). Most health care professionals describe their cultural awareness knowledge as being acquired through work experience and not formal education (Henderson et al, 2016). The medical curriculum in Canada would benefit from such a course. Aboriginal health education programs, in Diabetes for example, have been able to improve the patient-provider relationship (Bhattacharyya et al, 2011a); however, these are not always part of general programs. Currently, Canadian medical schools require a form of cultural diversity education in their curricula and have also developed a Social Accountability Initiative to meet the needs of communities they work with (Dogra et el, 2010). However, all schools have a different understanding and approach to the topic and are included in the curriculum in different ways and to a different degree (Dogra et al, 2010). Therefore, it is unclear to what extent the students learn and apply cultural concepts. Medical schools and other health care-related programs should be required to include extensive training in cultural competency and safety to be able to effectively care for patients of different ethnic minorities. Furthermore, the analogy between decolonizing methodologies and approaches to the patient-provider interface should be included for health care providers to understand its importance and benefits to all in the provision of care.

Simply adopting a legal framework that includes both biomedical and traditional practices does not eliminate disparities or discrimination because the latter may be disregarded; providers need to have cultural humility and respect towards patients of ethnic minorities for these types of frameworks to be effective (Castro et al, 2015). To make sure Indigenous perspectives are heard, health authorities play an important role to accommodate the collaboration between Indigenous

partners, researchers and the health authority (Hole et al, 2015), which should be used as a tool to reshape training and therefore practices. Providers' understanding of the connection between spiritual, emotional, cultural and socio-economic factors and illness, care, and healing is important for Indigenous peoples (Bhattacharyya et al, 2011a). It is also important for providers to remember and consider that their interaction with Indigenous patients is linked to sociopolitical and historical contexts (Browne, 2007). Indigenous patients described culturally safe care by the provider when they were acknowledged, meaning they were treated with respect and providers were responsive to their needs (Hole et al, 2015).

Ways to promote culturally safe practices may include increasing Indigenous health care workers, making interpreter services available and ensuring patients are involved at every step in their health care discourse (Roe et al, 2012). Although language has been a significant barrier, overcoming this barrier is not sufficient to addressing providers' cultural incompetence (Komaric et al, 2012). Effective care involves the cultural awareness and competence of health care providers (Cooper et al, 2002). In the United States, the Department of Health and Human Services Office of Minority Health issued culturally and linguistically appropriate health care services national standards, a set of guidelines for providers to follow (Cooper et al, 2002). This has driven a new research agenda to investigate the facilitation of clinical practices with culturally diverse patients. Although Canada has adopted a more cultural safe lens in its' health services, there is room for improvement to meet the needs of Indigenous patients (Hole et al, 2015). Cultural safety only takes place when power differences are recognized and when providers can care for patients in their specific context and reality (Hole et al, 2015). For this

reason, decolonizing methodologies should be included in primary education training for all health care professionals to improve the patient-provider interface.

Smedley et al (2003) argue that cross-cultural training needs to focus on three different conceptual approaches: Attitudes, knowledge, and skills. To tackle providers' attitudes, the cultural sensitivity/awareness approach is taken to allow providers to explore and reflect on impacts of sociocultural factors, culture, racism and how these might influence clinical decision-making. The multicultural/categorical approach to increase provider's knowledge should focus on teaching methods to assess communities/patients and evidence-based factors that impact delivery. Otherwise, learning facts or cultural norms will only add to more stereotyping and generalizing. Finally, the cross-cultural approach to acquire skills is patient-oriented and builds foundation for the provider to be able to care for different patients by improving communication skills and involving participatory decision making to reflect appropriate care based on the patient's context. Although changing provider behaviour is challenging, building effective communication skills may positively influence the relationship between health care providers and Indigenous patients (Bhattacharyya et al, 2011b). Research shows the effectiveness of cultural competence interventions and programs, their increase in provider knowledge, attitudes, and skills, and how it has lead to an in increase in patient satisfaction- however not much is known on which types of interventions are beneficial for different outcomes (Breach et al, 2005).

Conclusion

The purpose of this capstone was to identify provider-level factors that affect the provision of adequate care to ethnic minorities. Factors that were identified by providers included patient attitudes, beliefs, and culture, while patients found that a lack of cultural competence and sensitivity were provider-level barriers to their care. In terms of the relationship between Indigenous patients and providers, these barriers were found to be rooted in the wider socio-historical context where the legacy of colonialism continued to shape this relationship. Furthermore, the objective was to find strategies to mitigate this public health issue due to the need for not only the providers' awareness of the connection between cultural, historical, and social factors and health, but to understand the importance of a patient-centered approach and reflecting on personal prejudices and assumptions. Due to the lack of adequate training in this area of health, applying decolonizing methodologies from the field of research to the field of health care in cultural competency training in primary education is suggested as an intervention to reduce the provider-level barriers that negatively affect the patient-provider interface, and thereby the provision of care. This can improve the care provided to different populations due to the parallels between indigeneity and ethnic minorities and what has been learned from these two populations in the patient-provider interface.

Critical Reflection

The limitations of this capstone may be that it does not capture all views and perspectives of patients and providers because the research referred to is limited to the articles published in the searched databases. The typical relationships found between the patient and the provider are not to put blame on the provider or paint a negative picture of their role in healthcare disparities, but

to raise awareness of this issue and improve the provision of health care to those who are already marginalized. Not all ethnicities were represented in all the studies and differences within ethnic groups were not covered, however most findings may be applied across ethnicities or cultures to improve care. It is important to acknowledge that the patient-provider relationship is context-specific and different barriers are involved; different ethnicities are treated differently by different providers and in different countries. Another limitation is the type of data collection used in some studies. Although very few in this capstone, some of the studies used had self-reported data from patients and providers which may include response bias.

Writing this capstone has allowed me to reflect on myself, the Master of Public Health program at Simon Fraser University and how it has molded me. As an Iranian-Canadian public health student, I bring my personal biases and worldviews to this issue that may shape the ideas and analysis of this capstone. Although using a culturally safe lens, personal experiences and beliefs influence research. The capstone may sound pessimistic towards the issue and point fingers at the providers contributing to problem, but the goal is to get the point across that there needs to be a drastic change in provider behaviour and the way they care for patients of ethnic minorities. Needless to say, there are providers committed to this cause, in hopes of promoting culturally safe practice and who are enthusiastic about receiving the training required to fulfill their job and change marginalizing practices. Some providers discuss their growing understanding of socio-historical factors that impact the patient-provider relationship when working in Indigenous communities (Browne, 2007). However, it is still important to acknowledge one's personal views and understanding of their position and worldviews, to help drive the first steps of moving forward with culturally competent and safe practices, and awareness.

The role of future public health practitioners is not only to understand the role of culture in health, but to also be aware of the ongoing impact of history and colonialism that affects Indigenous peoples in Canada and for it to be taken into consideration in any area in the health care field. It is important to explore the impact of Canada's wider social context to understand how it may marginalize already vulnerable populations. Increasing the Indigenous health workforce is extremely important, however, cultural safety/competency training is crucial as providers engage with a diverse group of patients and there might not always be Indigenous workers to meet patient needs. More research is required to shape training and understand the needs of patients and providers to improve their behaviour and any assumptions they hold. It is crucial for providers to critically think of their positioning in society and how their views are framed. Critical self-reflection is the first step towards equitable health care delivery, especially to those who have been historically marginalized. For example, research, program planning, and policy development would benefit from understanding the barriers that limit the best possible care for different populations. There is a lot of research on patient experiences at the provider level- although this is important, it is also crucial to understand the roots of provider behaviour and how they have come to be in order to tackle the underlying factors that cause it. This way, along with patient experiences, health care providers can be better trained in order to address the assumptions they hold over patients that affect their interaction and the provision of care.

There is also extensive research on barriers limiting ethnic minorities' access to adequate care, such as health beliefs, financial restrictions, health insurance, time, and stress. However, there is limited research of the contribution to ethnic disparities at the provider-level due to the

challenges faced methodologically; provider bias is a sensitive issue, to which providers have a difficult time admitting and makes for an uncomfortable research topic for researchers (Van Ryn, 2002). If viewed as an unconscious nature of the social cognition process (Van Ryn, 2002) and/or a reflection of the wider social context, evidence-based interventions could be created to address these public health issues. Further research is required to explore the patient-provider interface, disparities is the delivery of care and whether it creates ethnic disparities in health status and more specifically, strategies to improve quality of care for Indigenous peoples and other ethnic minorities. There are opportunities for improvement as there has been more funding towards cross-cultural education and research (Smedley et al, 2003). Health care delivery disparities can be reduced if health care providers are aware of their susceptibility to implicit bias and stereotyping (Chapman et al, 2013). Health care providers are usually the only direct contact patients have with the health care system and we need to ensure the patient-provider relationship does not contribute to health care or health status disparities among ethnic minorities in order for all patients to receive equitable and adequate care.

References

Bhattacharyya, O. K., Estey, E. A., Rasooly, I. R., Harris, S., Zwarenstein, M., & Barnsley, J. (2011a). Providers' perceptions of barriers to the management of type 2 diabetes in remote Aboriginal settings. *International Journal of Circumpolar Health,70*(5), 552-563. doi:10.3402/ijch.v70i5.17848

Bhattacharyya, O. K., Rasooly, I. R., Naqshbandi, M., Estey, E. A., Esler, J., Toth, E., . . . Harris, S. B. (2011b). Challenges to the provision of diabetes care in first nations communities: results from a national survey of healthcare providers in Canada. *BMC Health Services Research,11*(1). doi:10.1186/1472-6963-11-283

Braun, K., Browne, C., Ka'opua, L., Kim, B., & Mokuau, N. (2013). Research on Indigenous Edlers: From Positivistic to Decolonizing Methodologies. *The Gerontologist, 54*(1):117-126.

Beach, M. C., Price, E. G., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A., . . . Cooper, L. A. (2005). Cultural Competence. *Medical Care,43*(4), 356-373. doi:10.1097/01.mlr.0000156861.58905.96

Broome, B., & Broome, R. (2007). Native Americans: Traditional Healing. *Urol Nurs, 27*(2), 161-3.

Browne, A. J. (2007). Clinical encounters between nurses and First Nations women in a Western Canadian hospital. *Social Science & Medicine,64*(10), 2165-2176. doi:10.1016/j.socscimed.2007.02.006

Browne, A. J. (2009). Discourses Influencing Nurses' Perceptions of First Nations Patients. *Canadian Journal of Nursing Research, 41*(1), 166-191.

Castro, A., Savage, V., & Kaufman, H. (2015). Assessing Equitable Care for Indigenous and Afrodescendant Women in Latin America. *Rev Panam Salud Publica, 38*(2).

Chapman, E. N., Kaatz, A., & Carnes, M. (2013). Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities. *Journal of General Internal Medicine, 28*(11), 1504-1510. Doi: 10.1007/s11606-013-2441-1

Cooper, L. A., Hill, M. N., & Powe, N. R. (2002). Designing and Evaluating Interventions to Eliminate Racial and Ethnic Disparities in Health Care. *J Gen Intern Med, 17*(6), 477-486.

Cornelison, A. H. (2001). Cultural Barriers to Compassionate Care- Patients's and Health Professional's Perspectives. *Bioethics Forum, 17*(1), 7-14.

Degni, F., Suominen, S., Essén, B., Ansari, W. E., & Vehviläinen-Julkunen, K. (2012). Erratum to: Communication and Cultural Issues in Providing Reproductive Health Care to

Immigrant Women: Health Care Providers' Experiences in Meeting the Needs of Somali Women Living in Finland. *Journal of Immigrant and Minority Health,14*(2), 344-344. doi:10.1007/s10903-011-9486-1

Dogra, N. Reitmanova, S., & Carter-Pokras, O. (2010). Teaching Cultural Diversity: Current Status in U.K., U.S., and Canadian Medican Schools. *J Gen Intern Med, 25*(2), 164-168. Doi:10.1007/s11606-009-1202-7

Henderson, S., Barker, M., & Mak, A. (2016). Strategies used by nurses, academics and students to overcome intercultural communication challenges. *Nurse Education in Practice,16*(1), 71-78. doi:10.1016/j.nepr.2015.08.010

Hole, R. D., Evans, M., Berg, L. D., Bottorff, J. L., Dingwall, C., Alexis, C., . . . Smith, M. L. (2015). Visibility and Voice. *Qualitative Health Research,25*(12), 1662-1674. doi:10.1177/1049732314566325

Komaric, N., Bedford, S., & Driel, M. L. (2012). Two sides of the coin: patient and provider perceptions of health care delivery to patients from culturally and linguistically diverse backgrounds. *BMC Health Services Research,12*(1). doi:10.1186/1472-6963-12-322

McNaughton-Dunn, A. (2002). Cultural competence and the primary care provider. *Journal of Pediatric Health Care 16*(3), 151-155.

Planas, M., García, P. J., Bustelo, M., Carcamo, C. P., Martinez, S., Nopo, H., . . . Morrison, A. (2015). Effects of Ethnic Attributes on the Quality of Family Planning Services in Lima, Peru: A Randomized Crossover Trial. *Plos One,10*(2). doi:10.1371/journal.pone.0115274

Roe, Y. L., Zeitz, C. J., & Fredericks, B. (2012). Study Protocol: establishing good relationships between patients and health care providers while providing cardiac care. Exploring how patient-clinician engagement contributes to health disparities between indigenous and non-indigenous Australians in South Australia. *BMC Health Services Research,12*(1). doi:10.1186/1472-6963-12-397

Ryn, M. V. (2002). Research on the Provider Contribution to Race/Ethnicity Disparities in Medical Care. *Medical Care,40*(Supplement). doi:10.1097/00005650-200201001-00015

Saha, S., Arbelaez, J. J., & Cooper, L. A. (2003). Patient–Physician Relationships and Racial Disparities in the Quality of Health Care. *American Journal of Public Health,93*(10), 1713- 1719. doi:10.2105/ajph.93.10.1713

Scheppers, E. (2006). Potential barriers to the use of health services among ethnic minorities: a review. *Family Practice,23*(3), 325-348. doi:10.1093/fampra/cmi113

Sidmonds, V. & Christopher, S. (2013). Adapting Western Research Methods to Indigenous Ways of Knowing. *American Journal of Public Health, 103*(12):2185-2192.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). *Unequal treatment: confronting racial and ethnic disparities in health care*. Washington, D.C.: National Academy Press.

Spence, D. (2001). Hermeneutic notions illuminate cross cultural nursing experiences. *Journal of Advanced Nursing, 35*(4), 624-630.

Taylor, S. P., Nicolle, C., & Maguire, M. (2013). Cross-cultural communication barriers in health care. *Nursing Standard,27*(31), 35-43. doi:10.7748/ns2013.04.27.31.35.e7040

Zavala, M. (2013). What Do We Mean by Decolonizing Research Strategies? Lessons from Decolonizing, Indigenous Research Projects in New Zealand and Latin America. *Decolonization: Indigeneity, Education & Society, 2(*1):55-71.