



Measuring Physician Cultural Competence: Results from a National Survey

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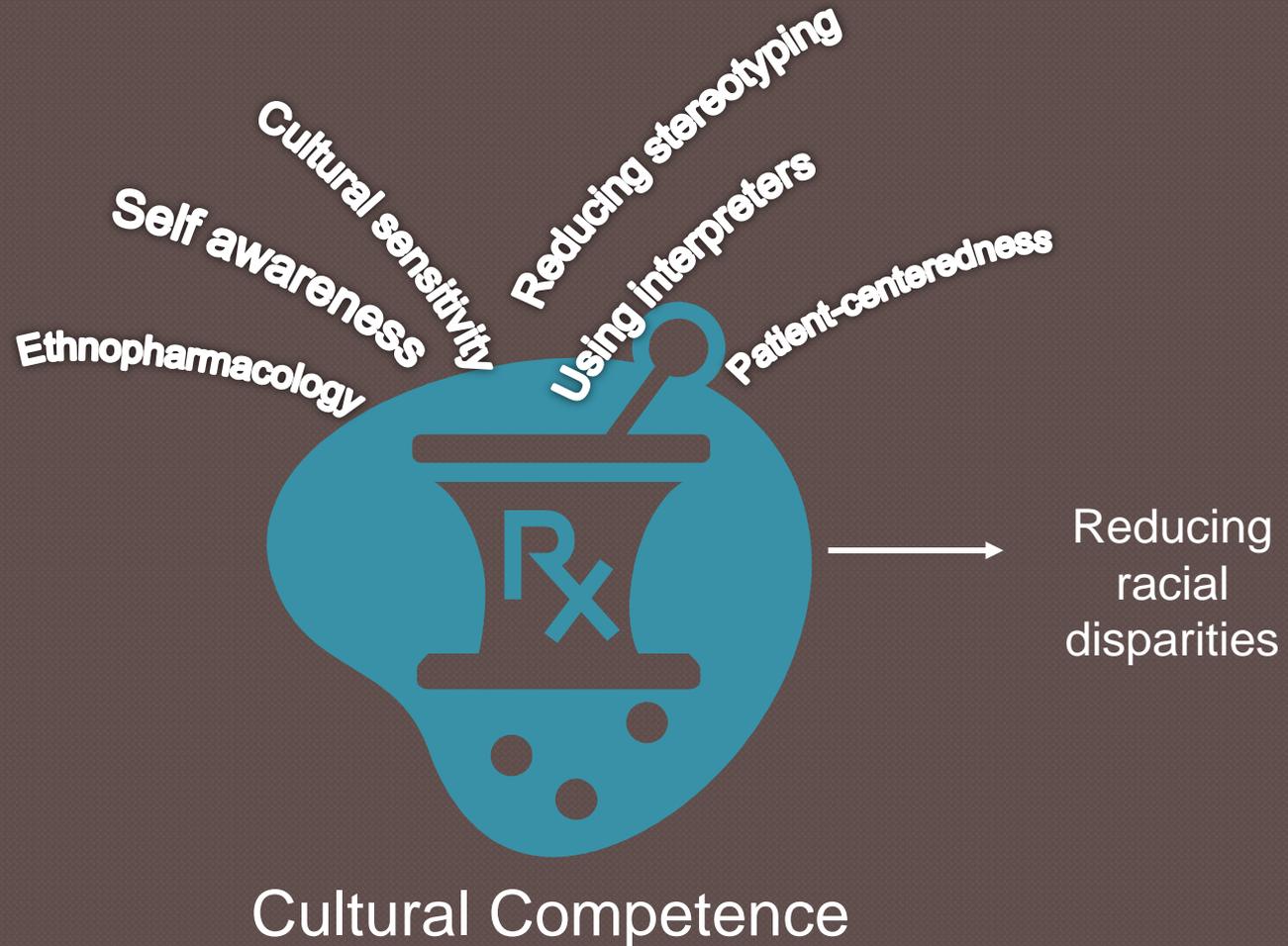
Background

- Quantity and quality of health care are lower for racial/ethnic minority Americans than for whites
 - Not explained by differences in access or ability to pay
- May be due to cross-cultural and other racial barriers between patients and providers
- “Cultural competence” training for physicians proposed to improve care, reduce disparities
- Little empirical evidence whether being “culturally competent” has any impact on patient care

Research Agenda

- Does cultural competence among healthcare providers improve quality/equity of care?
- But first...
 - What is it?
 - Can we measure it?

What is Cultural Competence?



Can We Measure It?

- Literature review of existing instruments
 - Several different instruments
 - Mostly in nursing and social work literature
 - None were comprehensive
 - None were rigorously developed
 - None had face validity for physicians

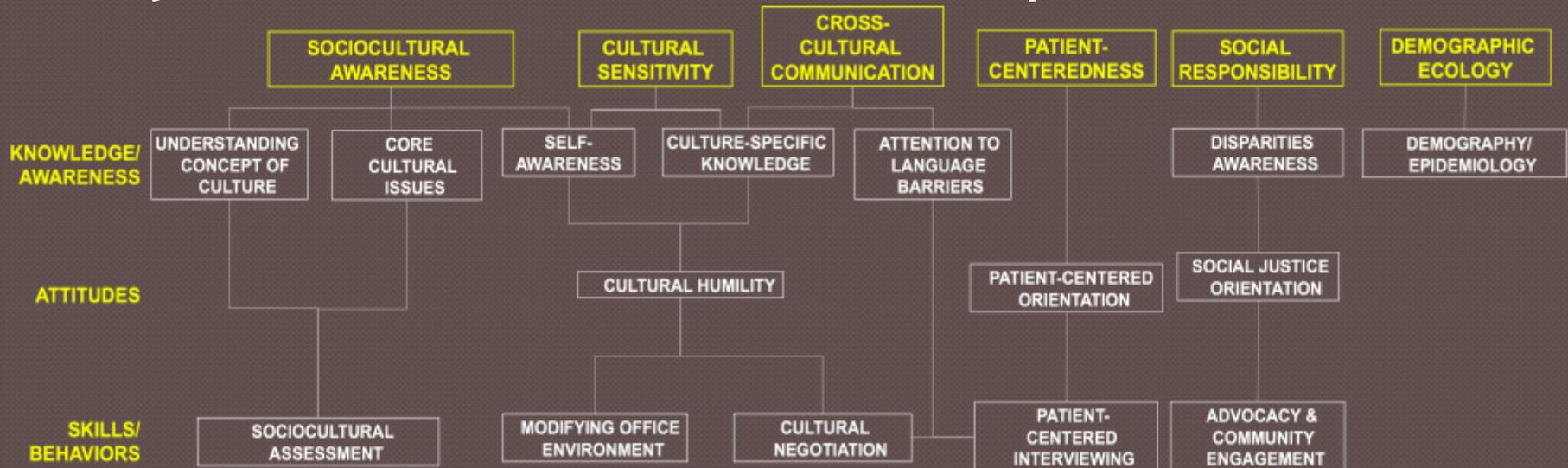
Measuring Cultural Competence (MC²)

- Goal: measure self-assessed CC among physicians
 - Define dimensions
 - Develop item pool
 - Conduct survey
 - Develop scale(s)

Defining Dimensions

- Goal: comprehensive conceptual framework

- Systematic review of conceptual models



Item Pool

- Used dimensions in our composite model to develop items that covered the breadth of meaning in each dimension
 - 5 items for most, 10 items for broader dimensions
 - 91 items total
- Sent items to group of 8 national experts
 - Rated items on 0-2 scale for content validity
 - Not/somewhat/very relevant to CC

Item Pool

- Based on expert review:
 - 91 → 59 items
 - Substantial overlap in content of dimensions
 - Some dimensions dropped entirely:
 - Respect for persons, social responsibility

Item Pool

- Cognitive interviews
 - 29 physicians from diverse backgrounds/specialties
 - Rephrasing, describing what items mean
- Based on cognitive interviews:
 - Reworded some items, replaced others
 - Decided to focus on generalist physicians (FP, IM)

Survey

- National survey of internists and FPs
 - Obtained list from vendor
 - Oversampled minority physicians
 - Restricted to physicians practicing in ZIP code areas with at least 25% nonwhite population
 - Conducted by Survey Research Lab in Portland

Survey

- Five-touch process

- 1800 physicians (IM and FP)

1. Initial letter, option of doing survey online

2. Hard copy survey with \$20 bill in priority mail

3. Postcard reminder

4. Hard copy survey in regular envelope

5. Phone calls to all non-responders

Analysis

- Factor analysis

- Iterative analysis with data reduction decisions based on factor loadings, scree plots, and response distributions
- Group process for naming scales

- Internal consistency reliability testing

Analysis

- Validity testing

- Higher CC scores among:
 - Nonwhite physicians
 - Physicians with prior CC training, and to a lesser degree with prior communication training only
- Linear regression adjusting for physician age and gender

Results

- 1516 eligible physicians, 795 responded
 - RR = 52%

| Physician Characteristics | N = 795 |
|-------------------------------|-------------|
| Age, mean (SD) | 49.7 (11.3) |
| Female | 35% |
| Race/ethnicity | |
| African American | 12% |
| Latino | 9% |
| Asian | 21% |
| White | 55% |
| Prior CC training | 62% |
| Prior communications training | 78% |

Results

- Analysis favored a 7-factor solution

| Factor | Items | Alpha | Mean (range 1-6) |
|-----------------------------------|-------|-------|---------------------|
| Cultural Awareness | 8 | .87 | 4.5 |
| Perceived Cultural Self-Efficacy | 5 | .79 | 4.8 |
| Awareness of Racial Disparities | 5 | .81 | 4.0 |
| Valuing Diverse Perspectives | 6 | .77 | 5.3 |
| Support for CLAS Standards | 6 | .80 | 4.6 |
| Strict Biomedical Orientation (R) | 2 | .67 | 4.3 |
| Relationship-Centered Practice | 13 | .88 | 4.6 |

Results

| Scale | Age | Female | Non-white | Prior CC | Prior Comm |
|----------------------------------|-------------|------------|------------|------------|------------|
| Cultural Awareness | .002 | .02 | .23 | .40 | .05 |
| Perceived Cultural Self-Efficacy | .003 | .10 | .27 | .22 | .05 |
| Awareness of Racial Disparities | .009 | .36 | .29 | .29 | -.16 |
| Valuing Diverse Perspectives | .001 | .24 | .14 | .11 | .11 |
| Support for CLAS Standards | .001 | .37 | .41 | .47 | .07 |
| Strict Biomedical Orientation | .005 | -.19 | .17 | -.16 | -.03 |
| Relationship-Centered Practice | .008 | .30 | .14 | .19 | .18 |

Summary

- Developed new instrument intended to measure CC explicitly among primary care physicians
- Most of the 7 scales had good reliability (for group measurement purposes)
- Content and construct validity

Limitations

- Non-responders likely to differ in attitudes from responders
- Factor solution not yet cross-validate
- Reliability may be low for the purpose of scoring individuals

Conclusions

- CC is a broad concept with several underlying dimensions
- Validated measure of CC can start us on the road to testing its impact on patient care
- Need cross-validation and further scale refinement before instrument is ready for use in medical education setting