

Building the Diversity Bridge Abroad: The Journey to Implement Cultural Competent Health Care in Lausanne, Switzerland

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Abstract

Introduction

Although the United States has been central in bringing cultural competency into the discussion of high-quality care, health systems all over the world are faced with the effects of global immigration and the widening disparities gap between socioeconomic classes. Lausanne University Hospital is one of five Swiss academic medical centers chosen to develop programs addressing cultural competency. Here we focus on our medical training as a model for other international settings looking to build curricula based on best practices, but tailored to their local context.

Setting and Participants

At Lausanne University Hospital, diversity is part of clinical practice. Just over a third of the patient population is non-Swiss, and include undocumented and recently arrived refugees. The center serves other high-risk and vulnerable populations. The strategies presented here focus on medical learners at the Lausanne center.

Program results and historical overview

Primary cultural competency topics are social determinants of health, cultural groups in the local community, stereotypes, and unintended biases. Early sessions begin with medical anthropology material which raise consciousness of the learner's own potential biases. Medical education evolves to a more case-based medical training- focusing on the social determinants of health through clinical vignettes linked to disparities (mental health, HIV). Our narrative describes the inception of such teaching topics and its evolution over time given national health mandates and Switzerland's environmental context.

Discussion

We describe one of the few official cultural competency medical curricula in Europe. We present the theoretical framework and pedagogical models that have been most applicable to our endeavor since its inception in 2005, educational content, developmental approach, and assessments. In summary, we provide a "roadmap" for international health-education systems developing cultural competency medical training, at various learner levels, in the context of their local setting.

Keywords: cultural competency; health disparities; medical education; immigrant health; vulnerable populations

1. Introduction

Culture is defined as "a shared system of beliefs, values, and learned patterns of behaviors," and is intimately tied to the practice of medicine. The field of cultural competency has emerged as one strategy to address disparities in health care, particularly among patients who are at higher risk for health disparities- given the discordance between personal culture and the local health care system (Nelson, 2002), (Betancourt, Green, Carrillo, Ananeh-Firemong, 2003). In the health care setting, the combination of socio-economic vulnerability and medical vulnerability may lead to "clinical vulnerability", thus resulting in healthcare access barriers and inequitable/sub-optimal treatment for patients within the clinical context (Nelson, 2002), (Betancourt et al., 2003). Although the United States has been central in the policy and

research discussion addressing cultural competence in health care, medical systems all over the world are facing the effects of global immigration and the widening health disparities gap between socioeconomic classes. This is crucial at a moment in history when Europe, in particular, faces the greatest mass migration of asylum seekers of recent times, due to civil wars and human rights violations in places like Syria and Iraq (Abbasi, 2015).

The challenges and stresses encountered by healthcare professionals when caring for a diverse patient population highlight a need to adequately address socio-cultural factors when treating patients. Health care leaders should be aware that socio-cultural tension and misunderstanding between patients, providers and healthcare systems can lead to patient mistrust, dissatisfaction, decreased confidence in the medical system, and ultimately, poor health outcomes (Betancourt et al., 2003), (Statistique Lausanne, 2013), (Betancourt 2003), (Beach et al., 2006), (Beach et al., 2005). Thus, cultural competence should be of utmost interest to every health professional.

The "Swiss Hospitals for Equity" project is the national plan addressing this endeavor since the early 2000's (originally titled "Migrant Friendly Hospitals"), aiming to establish diversity care centers of excellence that are in keeping with the needs of vulnerable populations at risk for healthcare disparities (MFH- Migrant Friendly Hospitals, 2013). Lausanne University Hospital (together with its Department of Ambulatory Care and Community Medicine) is part of five academic medical centers across the country chosen to pilot and develop opportunities related to diverse and vulnerable populations and high-quality health services. In its current long-term health-policy agenda "Health 2020", the Swiss Federal Office of Public Health outlines priority areas and measures, including cultural competence training, that promote health equity and a better quality of life for all populations.

At this academic medical center, socio-cultural patient diversity is part of clinical practice. About a third of the patient population is not of Swiss-nationality, and include undocumented and recently arrived immigrants seeking medical treatment in precarious states of health. The center also serves other types of vulnerable populations: low-income Swiss residents, prisoners/detainees, homeless/traveler patients, drug and alcohol addicts and people with disabilities, high-frequency emergency department users, uninsured individuals and patients with mental health issues (Karl-Trummer, Novak-Zezula, Metzler, 2010), (Statistique Lausanne, 2013). In 2013, the ambulatory clinic in Lausanne (the largest in Switzerland) had 39,516 consultations with patients considered to be "vulnerable" (Statistique Lausanne, 2013), (Rapport Annuel PMU, 2013), (Données internes au CHUV, 2013).

We describe the ten-year evolution of the cultural competence strategy and the current educational programs in Lausanne. We focus on 1) how a patient-based cultural competence skills model, developed primarily in the United States, became applicable in Switzerland while adapted to the local context, and 2) how educational approaches across different levels of training have been tailored. Our aim is that this case report serves as a guide for other international settings looking to build evidence-based cultural competency training programs, tailored to local context and teaching style.

2. The Program's Beginning

2.1 A Federal Immigrant Health Mandate Develops- Opportunity for Synergy in Cultural Competence Development

Following the changing waves of immigrants in the early 1990's, a focus on immigrant health in Europe emerged (MFH, The Amsterdam Declaration, 2014); the Swiss Federal Office of Public Health (OFSP) launched "Migration and Health" in 1991 with a call on university health centers to focus on HIV/AIDS prevention and treatment among immigrant populations. From 2002-2007 the program evolved to focus on the elimination of health care barriers/disparities among the Swiss migrant population, giving rise (among other projects) to the specific "Migrant Friendly hospitals" project. In 2008 and 2013, the agencies' funding priorities have been changed to "mainstream" the focus points, applying these objectives to all aspects of diversity in the healthcare process (MFH- Migrant Friendly Hospitals, 2013), (MFH, The Amsterdam Declaration, 2014).

Over the years, our projects have synergized with the OFSP action items, which include:

- a. Promotion of health and prevention: specifically, the adaptation of existing services to the needs of migrants and other vulnerable populations.
- b. Access to interpreters.
- c. Research that increases fund of knowledge regarding vulnerable populations (health status of particular groups).
- d. Cultural competence training for healthcare providers using documented best practices, followed by assessment and evidence-based evaluation methods.

2.2 Genesis of Cultural Competence Education in Medicine in Lausanne

Our approach to cultural competence began in 2002- using PowerPoint lectures about specific cultural groups living in Lausanne in congruence with current migration trends (Bigby, 2003). At the time, this mainly included specific lectures

for primary care residents on asylum-seekers/refugee patients (Yugoslavia, Central Africa, and Congo) and undocumented migrants (Ecuador)- with a presentation about each ethnic group. By 2005, these presentations broadened to include aspects about the asylum-seeking process and local resources for undocumented migrants. The change in 2005 marked the formal inclusion of cross-cultural training into the academic curriculum for resident physicians in the Department of Ambulatory Care and Community Medicine. Given the positive reception at the post-graduate level, courses for medical students soon followed that year.

The first institutional survey about cultural competence took place in 2010 and used a validated questionnaire to ask about perceived cultural competence knowledge, attitudes, skills, and resources/training among resident physicians and nurses in various specialties (Casillas et al., 2014). These physicians and nurses reported that they felt less prepared for patients “with health beliefs/practices at odds with Western medicine,” “whose religious beliefs affect treatment,” and who had “distrust of the health care system.” The results particularly supported the need for increased cultural competence training among nurses and increased diversity efforts in the work force among physicians (Casillas et al., 2014).

2.3 The Educational Approach

In developing the survey, Lausanne cultural competence educators had already established a relationship with cultural competence experts at Massachusetts General Hospital and Harvard Medical School. With these results in hand, members from our teaching team took part in a one-year Harvard training program under diversity management experts at the Disparities Solution Center, exploring culturally competent care tutorial material under their supervision and guidance. The objectives were to: 1) align cultural competence in practice with the priority of high quality patient care delivery 2) outline the social and cultural issues that are most relevant in the care of diverse patient populations 3) communicate effectively across cultures, and 4) develop appropriate management strategies to take into account patient’s cultural perspective and preferences.

No consensus yet exists on how to teach cultural competence in medicine, especially when these trainings are inevitably delivered to different learning audiences (healthcare workers with different roles and learning levels, various specialties). We have grappled with the following factors- relevance of content to target audience, timing and volume of material. Various educational approaches and tools have been used: lectures, case-discussion, live patient interview by experienced moderator, and clinical vignette (including role play between learners and/or simulated patients).

One key step in our experience includes a formal partnership with the Medical Education Unit of Lausanne University, adding simulated patients for our cross-cultural training activities. Scholars from the School of Education now train patient-actors according to scenarios related to specific cross-cultural issues to create an effective role-play between physicians and simulated patients- “patients” who are capable of giving feedback to a physician about an encounter.

Importantly, our 2010 institutional survey also showed that departments outside of primary care and psychiatry were the least exposed to cultural competence resources and teaching (Casillas et al., 2014). Pilot work has begun in training modules to form a more connected training across specialties.

The advantages of “outsourcing” the trainings across specialties are as follows:

- a. Content is adaptable and tailored to the ground covered in the specialized practice.
- b. Addresses the reluctance of certain physicians to incorporate cross-cultural training in their teaching by making it instantly applicable in their real life patient cases (the training is rooted within a specific issue that is commonly encountered, and the learner must solve the problem by applying concrete lessons); this “problem-based learning” has been well-received by students at Harvard Medical School (Shields et al, 2009).
- c. “Train the trainer”- allows cultural competence to be introduced in teaching forums that already exist within each specialty. Since there is no need to pull learners “out” of their other duties for cross-cultural courses in another department, it addresses the “no time for cultural competence” excuse.
- d. Allows these specialists to be exposed to cross-cultural care experts and those sensitized in cultural competence training.

In 2013 we piloted cultural competence teaching sessions with specialist attending physicians, where each physician role-played patient encounters they had found challenging (based on prior qualitative interviews). Cross-cultural care experts in the primary care department and an international expert from Harvard Medical School moderated this seminar. It was well received by participants; the current aim is to teach useful tools to attending specialists (who teach residents and students), so that they may readily adapt their own teaching style and content to clinical situations that are specifically connected to the socio-cultural diversity of their patient panel. Cultural competence experts from primary care will serve as consultants in the process. This approach echoes the aforementioned “migration mainstreaming,”

proposed by the OFSP- and similar approaches nationwide, as an electronic learning tool on cross-cultural care made available to (E-learning in Switzerland, 2015) to develop universal tools for cultural competence training across all types of health care settings in Switzerland.

3. Current Cross-cultural Education in Lausanne

3.1 Post-Graduate (Primary Care Resident) Program

In contrast to the student curriculum, cultural competence modules at the resident level focus specifically on developing skillfulness that affects clinical practice- based on the Harvard model mentioned above. This includes teaching about attitudes and skills that affect clinical encounters and a physician's decision-making. This training helps physicians evaluate patient health literacy (language, illiteracy, health knowledge) and work with an interpreter, determine a patient's socioeconomic context, and explore a patient's disease and treatment models. The modules probe the learner to reflect about their own beliefs, stereotypes, and unconscious bias that influences clinical practice. Different teaching modalities are used (video, live patient, lectures, case discussion) and now include simulated patients (trained actors from the education school, used for role play). Seminars are taught four times a year, 60-120 minutes per session.

In 2012, Bardet and colleagues published a qualitative (three focus groups) and pre/post quantitative evaluation (Multicultural Assessment Questionnaire, MAQ) of 17 primary care residents' experiences in our modules (Bardet et al., 2012). Using the MAQ, they observed a higher global performance score (versus baseline) three days post training, an effect that was still present three months after training. Focus groups showed that the skills model not only brought awareness of multicultural issues to these physicians, but also helped participants understand their own cultures (many physicians in Switzerland are immigrants themselves), perception of others, and preconceived ideas. One assessment point particularly demonstrated the need for cultural competence education, especially from our Swiss perspective: "Some physicians reminded us that the Swiss population is unique, with its four languages and plethora of cultural differences, having either a German, French, or Italian influence. Even people from urban areas, or those who live in more rural mountainous regions, or come from neighboring countries such as Germany, England, or France, have notably different beliefs, disease portrayals and use of the healthcare system" (Bardet et al., 2012).

3.2 Pre-Graduate (Medical Student) Program

Education on cultural competence in medicine begins with a sensitization approach, rather than divulging a skills training that is not applicable at this point in training. First year sessions focus on medical anthropology material included in a human and social science curriculum with the intent to raise consciousness of the learner's future practice and own potential biases. A two-hour lecture is delivered to students four times in the year. By the third year, education evolves to case-based medical training which focuses on the social determinants of health through clinical vignettes linked to disparities (mental health, HIV/ID, public health). The three sessions are: health and migration, communication with an interpreter, and LGBT health disparities. In the third and fourth years, students may enroll in a 12-week health disparities elective and community immersion experience, respectively. Finally, in the sixth year, students elect to rotate in the ambulatory clinic for a month and develop a health disparities project (thus exposing them to our primary care residency for potential recruitment).

3.3 Continuing Medical Education Program

Since 1995, the University of Lausanne (UNIL), the Lausanne University Hospital (CHUV) and the Department of Ambulatory Care and Community Medicine (Policlinique Medicale Universitaire) have provided a community forum for cultural competent healthcare. The normal audience is comprised of 80-100 individuals (clinical and non-clinical) who work with immigrant populations who face health access barriers. It consists of four afternoons per year where a socio-cultural theme is discussed as it relates to pediatrics, gynecology, internal medicine, and the social sciences (for example, in 2013 it was "discrimination in the healthcare system.") In addition to physicians and nurses, academics from the social sciences as well as artists, have been invited as guest lecturers and facilitators for various workshops.

The discussion series "Pause projections" organized by the Medical Education Unit and the Audio-visual communications department (CEMCAV) at the university's medical center is open to all of its employees. Here, we screen movies and documentaries to highlight issues having to do with the impact of social, economic and cultural contexts on health. The goal is to sensitize community members to the needs of vulnerable populations and the value of cultural competent medical training from the start, even before patients walk through the clinic's door.

4. The Vision Ahead

While many differences exist between the United States and Switzerland, cultural competence medical education (developed and tested in the US) has proven to be relatively "exportable," and well received as a patient-centered skills model here in Lausanne (Carrillo, Green, Betancourt, 1999). After ten years of development in Lausanne, we document this experience as a call to action to our European colleagues who are faced with providing care to waves of vulnerable

populations at this crucial junction in time. We remind them that providing culturally competent healthcare to all patients is our moral medical imperative (Abbasi, 2015). This is also a call to action to the many American programs that have yet to develop a robust cross-cultural care education curriculum, despite mandates by the American College of Graduate Medical Education, the ACGME (Ambrose, Lin, Chun, 2013). In our case, the Swiss content and approach to cultural competence training will continue to evolve as our students, residents, attending physicians, community advocates and citizens become more aware of the importance of high-quality culturally competent health care- and more vocal about what is needed from this training in order to better help their patients and fellow neighbors.

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