Cross-cultural Competence in Health Education in Norway: Perceptions and Implementation of the RETHOS protocol in The University of Bergen

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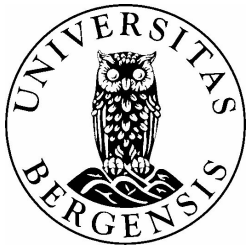

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This thesis is submitted in partial fulfilment of the requirements for the degree of Master of Philosophy in Global Health at the University of Bergen.

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Cover Story

Acronyms

C2ME - Culturally Competent in Medical Education

FGD – Focus Group Discussion

IDI – In-depth Interviews

RETHOS - National Curriculum Regulation for Norwegian Health and Welfare Education

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Acknowledgement

To God, who levels all exalted places, I am Immensely grateful.

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Dedication

To you, who defies the limitations of your world in pursuit of knowledge, and do not shy away from having difficult conversations with unfamiliar people in strange places.

1. Introduction

It is widely recognized that health services must consider culture to be ethically sound and clinically effective (1). Cross, Bazron, Dennis, and Isaac in a 1989 study, defined cultural competence as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" (2). This approach relates directly to a set of behaviours and competencies that should be possessed by a health system and individuals therein, with respect to cross-cultural situations. A more health-service-oriented definition was provided by Betancourt et al in 2003. They defined cultural competence as "the ability of a system to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural and linguistic needs" (3).

Regardless of the behavior and service oriented variants to its definition, a major point of convergence is the need to "improve the skills of clinicians, health care services and systems to address ethnocultural diversity" (3). Literature across Europe document different approaches that have been employed in a bid to achieve this. One of such ways, is by consciously embedding teachings in cross-cultural competence in health education (4). Diaz and Kumar (5) provided a justification for this, noting that there is a gap in knowledge among health professionals and students in Norway, on appropriately managing encounters with patients of foreign origin.

Previously, the only study in Norway, which assessed the teaching in cross-cultural competence in Health education was by Berre et al, in 2010. While it suggests that students' knowledge of migration and health increases throughout their studies, it also indicates that many graduating students do not believe that they have sufficient knowledge of many important areas (6). This suggests that there are inadequacies in the teachings. Generally, the assessed teachings in migration and health consisted of two double lectures that were not compulsory for the students. Results from the survey specifically indicated that the students did not have sufficient knowledge on the mental health of migrants and the use of interpreters in clinical consultations.

In recognizing the cultural history or tradition from which people understand health and illness, it is important to deliver health services in contextualized ways. To acknowledge the cultural fundamentals of human understanding of health and illness, it is important to deliver health services through professionals that are cross-culturally competent. This is considered especially important in the Norwegian context because of its growing numbers of immigrants.

Data from Statistics Norway show that immigrants and people born in Norway to immigrant parents make up 18% (819,356) of the total population as of March 2022. This is a 194% leap from 2012, when the number was 278,256 (5.5%), with an 8.9% increase in the total population between 2012 and 2022.

To respond to this increasing diversity, the Norwegian state thought it necessary to put measures in place that would guarantee a holistic healthcare system to cater to its population. More specifically, to ensuring that the health system provides services that can be accessed and appreciated by a culturally diverse population. One of such efforts is the Inter-ministerial National Curriculum Regulation for Norwegian Health and Welfare Education (RETHOS). This was developed in the acknowledgement of, among other things, the changing demographics of the Norwegian society; and to "increase the influence of the health and welfare service providers on the academic contents of these educations" (7).

Aspects of the RETHOS reform prescribe that knowledge on cross-cultural competence be embedded in medical curriculum to ensuring that students are trained on issues related to culture, language, discrimination, and equity, in relation to health outcomes.

1.1. Study Rationale

In the literature, the barriers to health care for immigrants have been documented in three major categories, including: cultural, organizational, and structural barriers. Cultural barriers relate to the cultural characteristics of different people such as their language, and beliefs which form their understanding of health and thus influences their health seeking behaviours (8, 9, 10). Organizational barriers have to do with the health system's preparedness to respond to the peculiar needs of different cultural groups in the population (10, 11, 12), while the structural barriers include factors such as discrimination in access to and use of health services as well as in the representation of minority groups among health service providers (10, 13, 14).

The aforementioned studies also suggest various interventions to remove the identified barriers. These generally include the provision of health information in different languages represented in the population, the use of interpreters during patient-provider encounters and increasing representation of immigrant health professionals in the health workforce. It has also been suggested that cultural competence training be embedded in medical education curricular (4, 5), which is the aim of the RETHOS reform. However, there is yet to be a guideline to facilitate teachings that will ascertain the achievement or evaluation of its outcomes. Therefore, the current study aims to assess the perception and implementation of the guideline among

teachers and students in medicine in the University of Bergen, Norway. Considering that RETHOS is the first step to embed cross-cultural competence in Norwegian Health Education, this study is a contribution to understanding how such interventions concretely work in removing barriers to health for immigrants. Additionally, this study is justified by the need to assess the new intervention (RETHOS reform) and the understanding and perceived importance of the need for cross-cultural competence training among teachers and students, based on the assumption that their perceived importance of it influences the implementation of RETHOS.

1.2. Cross-cultural Competence

According to Shepherd et.al. (15), participants in a study on healthcare provider perspectives on the challenges of cross-cultural competence in the workplace "largely expressed confidence in their ability to meet the needs of a culturally diverse patient group, despite not having undergone formal training in cross-cultural competence". This is because most of them viewed cross-cultural education from a cultural awareness perspective. The differences between these two concepts are expressed in terms of the adequacy of knowledge possessed by professionals in dealing effectively with cross-cultural encounters. For example, the respondents believed that possessing wide knowledge of norms and customs and ability to facilitate communication (such as recognizing the need for interpreters) are pointers to cultural competence. This are in fact some of the prerequisites for cultural competence. However, to be holistic, it would benefit from the inclusion of issues of systemic cultural competence such as the recognition of racism; power imbalances and patients' sense of vulnerability in encounters with professionals; majority culture biases and; the need for reflection on one's own prejudices as highlighted by Paul, Ewen and Jones, emphasizing the importance of establishing "a congruent formal, informal and hidden curriculum" (29). The current study, using a cross-cultural competence perspective, hopes to identify and discuss the above issues with respect to RETHOS implementation in Norway's medical education.

As earlier noted, cross-cultural competence has to do with the coming together of various elements to ensure that a system works effectively in cross-cultural situations (2). Embedding cultural competence in healthcare systems enables the systems to provide appropriate care to patients with diverse values, beliefs, and behaviours, including meeting patients' social, cultural and linguistic needs (4). Interventions to improve cultural competency need to consider the individual and organizational contexts and the interplay between them. Training programs may need to be tailored to particular groups, for example physicians would need particular knowledge and skills specific to their clinical tasks that would not be applicable

for reception staff. Cultural competence education for health professionals has emerged as a strategy in high-income English-speaking countries, such as the United States and Canada, in response to evidence of health disparities, structural inequalities, and poorer quality health care and outcomes among people from minority culturally and linguistically diverse backgrounds (4).

Furthermore, in recognition of such factors as "variations in patients' health belief; values; preferences; behaviours; and, the ability to communicate symptoms and understand the prescribed management strategy, the field of cultural competence in healthcare emerged" (16). It is now widely recognized as an approach to eradicating inequalities and incongruencies in health and healthcare.

Studies on cross-cultural competence are common in societies with a long multicultural tradition, but less so in societies like Norway, where diversity is relatively a new phenomenon. However, literature abounds on this topic specific to the United States, and a wider European context.

1.3. Previous Efforts to improve cross-cultural competence

The "Culturally Competent in Medical Education" (C2ME) project is the most notable attempt in Europe to foster exchange among medical schools about cultural competence training. The program involves medical schools from eleven European countries including Denmark, Germany, Hungary, and Belgium. C2ME organized a symposium in 2014, where stakeholders highlighted the teaching approaches and methods that are used to teach cultural competence as well as the institutional challenges that make it difficult to integrate cultural competence into the medical curricula. Despite a wide spectrum of opinions presented on approaches to cultural competence by different institutions, some issues appear to be common. These, according to Hudelson, et al (2016), are as follows:

> *Cultural competence teaching is frequently initiated and sustained by a small number of interested 'experts', usually those working closely with vulnerable migrant populations (of asylum seekers and undocumented migrants); Specific faculty development activities aimed at expanding the cultural competence teaching pool are rare; Formal faculty recognition of cultural competence teaching is often lacking; Curriculum time devoted to cultural competence topics is often limited and precarious. Seemingly well-established courses may be cancelled to make room in the curriculum for other, more highly prioritized subjects; Cultural competence teaching may occur in isolated blocks, rather than be integrated across the curriculum; Cultural competence topics are often addressed*

separately from other learning objectives, and identified as a specialized field of relevance mainly to health care professionals working with vulnerable migrant populations; Formal assessment of students with regards to cultural competence learning objectives are rare (17).

Several studies, in the last few decades have documented the higher susceptibility of particular cultural groups to negative healthcare experiences and health outcomes (15). In response to such findings, health systems in the United States, Canada, Australia, and New Zealand have made efforts to adapt their health service delivery practices and policies to improve the quality and accessibility of health services to culturally diverse populations. Specifically, these efforts are designed to better facilitate communication, through the use of interpreters, between patients and care providers from different cultural backgrounds; foster the development of care approaches that are responsive to needs of diverse patients and; "reduce provider discrimination and care disparities" (15).

Across Europe, several calls have been made for the development and implementation of interventions aimed at equipping the healthcare system to be able to cater for a culturally diverse population (18). This is due to the increasing proportion of immigrants in European countries (19). However, much of these efforts are inclined towards health literacy; operationalized as encompassing "knowledge motivation and competency to access, understand, appraise and apply health information to make decisions in terms of healthcare, disease prevention and health promotion to promote and maintain quality of life throughout the life course" (20). By this logic, health literacy interventions will feature empowerment strategies to increase individuals' control over their health, as well as providing avenues to gain the required knowledge on how to seek healthcare, prevent diseases and exhibit positive health behaviours. This approach excludes interventions at clinical and health educational levels to equip healthcare professionals with skills to handle encounters with patients from foreign origins. Asides this, the interventions are further hindered by the differences in the composition of the immigrant communities and their rights to health from country to country. Thereby, posing a barrier to its further development and implementation (21). We are inclined, in this research to explore the complementarity of both approaches; suggesting that the training of health professionals on cultural competence doesn't only improve their skills but may also increase the confidence of immigrant patients in the care process.

The Nordic countries have not been left out of these efforts. In Finland, a qualitative study following a training intervention for nurses on cross-cultural care suggested that they perceived such trainings to be useful at three levels: general, personal, and patient care levels.

Nurses in this study believed that the training provided knowledge on: the possibilities of initiating open discussions on cross-cultural care and practices; reflecting on one's own culture and stereotypes therein with respect to the influences they have on interactions with others and; awareness and recognition of the varying cultural characteristic of patients (22). However, while awareness is an important part of achieving cultural competence, it is not enough. it is important to move beyond simply being aware cultural differences to actual skill acquisition to harness the knowledge for equitable health outcomes.

Additionally, as part of the C2ME project, Sorensen, and colleagues in a 2019 survey highlighted the need for ensuring cultural competence in medical programs of European Union member countries including Denmark and Norway,[1] all together representing 4% of all EU medical education programs. Ultimately, findings from the study suggest cultural competence exists in various levels across the included education systems. It is however deemed inadequate. "Students are not evaluated based on cultural competence and most programmes do not offer cultural competence training for teachers" (23). Furthermore, it is widely acknowledged among the programs that available trainings on cross-cultural competence is "not adequate for future healthcare jobs in their respective countries (23)". This, therefore, necessitates the assessment of the RETHOS reform (as an example of such efforts) in Norway, to ascertain its adequacy in initiating or improving the training of medical personnel in cultural competence.

1.4. Norwegian government intervention in health education

Within the Norwegian context, policies are generally formulated through a multistakeholder process to ensure the maintenance of the nation's democratic ideals; which are considered to have long historical roots (24). This method was adopted in the formulation of the RETHOS, which in Norway is the project that is aimed towards fostering cross-cultural competence in the education of health and welfare professionals. Many actors cooperated to develop the new curricula and define the learning outcomes (Higher Education Learning Outcomes, HELOs) which specify the knowledge and skills expected from students after graduation. The plan was initiated by the Ministry of Education, which led and provided guidance to other stakeholders involved. These other actors include representatives of higher institutions of learning, organizations responsible for providing health and social services; many advisory bodies; councils and interest groups.

[1] While Norway is not part of the European Union, it is fully integrated into the European Economic Area. Therefore, participating in most EU initiatives, particularly those related to education.

The interactions between the state, local education authorities and the schools are integral to understanding the interpretation of education reforms within the Norwegian context (25). The government relies on its capacity to garner solidarity in favour of, and to implement new policies, through various state apparatus, while the local authorities' influence depend on how the policy is perceived and interpreted locally.

Another feature of the Norwegian education system worth noting is the effort invested in ensuring equity. As Møller and Skedsmo (25) suggested, the system is set up to be sensitive to individual and group needs of students. That is, appreciating peculiarities and providing specialized services that facilitate better learning process for diverse student groups. In addition to this, it is also important to ensure fairness in the distribution of financial resources to all stakeholders within the sector. These practices have been directly linked with the sustenance of the democratic political ideals that feature in power distribution and leadership in Norway (26); with schools being the medium through which patriotic and civil citizens are developed. However, while these influences have been studied and appreciated, there appears to be a knowledge gap regarding the extent to which education inspires cross-cultural competence; especially in health and welfare services in Norway (5).

To a limited extent, previous academic findings have indicated a positive relationship between "cultural competence training interventions and increased cultural competence levels of healthcare providers" (27). However, while emphasizing the importance of mutual trust among healthcare providers and patients, Alpers (28), in a Norwegian study noted that cultural and linguistic differences still hinder the establishment of an effective relationship between these two groups. Therefore, rather than implement periodic, short-term interventions, "practical experience and guidance when caring for migrant patients must be addressed in the long term" (5); hence the need to harmonize the contents of written reforms (curricula) and the informally projected knowledge to the learners by educators (29).

Because immigrant patients often prefer to be treated by immigrant health workers (30), it is easy to conclude that the majority of the linguistic and multicultural challenges faced by health and welfare professionals can be addressed by simply employing a diverse personnel group. While this seems like a right approach to the problem, it has been noted that it "should concur along with the enhancement of cultural awareness and competence among health professionals and not replace it" (31). So, rather than burden immigrant professionals with the extra responsibilities from being preferred by immigrants, a more sustainable strategy would be to provide education that can increase cultural awareness, and improve the cross-cultural

competence for all health and welfare professionals (5). This is the notion behind the development of the RETHOS framework.

While confirming the description of the situation in other countries, and from their own encounters with undergraduate students and healthcare professionals in Norway, Diaz and Kumar (5) noted that there is a gap in the knowledge of these groups in dealing with patients of foreign origins. Language and communication are a major source of difficulty (32), but also issues around "dealing with family members, intimate care, death, and managing different expectations for patient care" (5). In an attempt to close this gap, the Regulations on National Guidelines for Medical Education proposes that on completion of their studies, graduates of medicine should:

1. Understand the significance of cultural background for the understanding of health and illness, prevention and follow-up;
2. Be able to mitigate the barriers brought about by language differences between patients and healthcare providers;
3. Understand the effects of discrimination on the health of minorities and;
4. Be able to provide equitable health service to all groups in the society.

1.5. Barriers to health equity

As previously stated, barriers to healthcare use among immigrant populations fall within the three major categories: Cultural, organizational, and structural barriers. Cultural barriers relate to the cultural characteristics of different people such as their language, and beliefs which form their understanding of health and thus influence their health seeking behaviours. Organizational barriers have to do with the health system's preparedness to respond to the peculiar needs of different cultural groups in the population and, the structural barriers include factors such as discrimination in access to and use of health services as well as in the representation of minority groups among health service providers respectively.

The conceptualization of health equity in this study relates to the notion that health services should be provided to individual peoples according to their (special) needs rather than merely ensuring that everyone has equal access to healthcare. The barriers to health equity among majority and minority groups in most populations are multifactorial. Such factors include: socioeconomic disadvantages like lower levels of education, poor living and work conditions (16).

1.5.1. Influence of culture on health

More recent studies have identified factors that serve as barriers to healthcare for immigrant populations in Norway. A study from 2017, looked at barriers and facilitators to cervical cancer screening among Pakistani and Somali immigrant women in Oslo (33). Participants in this study echoed a lack of understanding of the benefits of the screening, suggesting inadequacies in the modes and language of communication between health professionals and the immigrant population. Other factors identified include the stigma attached to the disease and cultural and religious beliefs preventing unmarried women to be sexually active (33).

Additionally, the women suggested that the availability of female doctors would increase their willingness to undergo the screening which they consider intrusive especially considering their cultural beliefs around women's modesty. Also, they believed that their concerns about the use of complicated language by healthcare professionals could be reduced if they had access to doctors with whom they shared similar cultural and language backgrounds.

1.5.2. Language barriers

Specific issues to this category of barriers bother on language differences between patients and their healthcare providers. Polish migrants in Norway, who participated in a study on the barriers and facilitators in access to and utilization of healthcare services pointed at insufficient command of the Norwegian language and lack of knowledge about navigating the health system as barriers to healthcare (9). These findings are corroborated by those from another qualitative study among newly-arrived polish migrants in Scotland who reported that health information were only available in the local language and that they had difficulties understanding prescriptions (12). In both studies, it was concluded that "practitioners need specialist training in order to address immigrants' gap in knowledge and the cultural differences around expectations and health practices".

Similarly, Norwegian community pharmacists identified cultural barriers encountered in providing service to non-western immigrant patients. They suggested that the presence of language and other cultural barriers limited the "kind and how much (i.e. quality and quantity) information they were able to provide to this category of immigrants" (8). They further associated cultural barriers to such elements as "all-covering clothing, differences in body language, non-western gender roles and the use of non-professional interpreters, especially children, and the way these can hamper provider-patient communication". The respondents suggested the provision of multilingual brochures, and state funded professional interpreter services at the pharmacies.

1.5.3. Discrimination

Studies abound that address issues of discrimination in healthcare delivery, especially as it affects immigrants and other ethnic minorities. Discrimination is also talked about with respect to differential treatments experienced by people belonging to minority groups such as the LGBTQ and the physically challenged. Additionally, with regards to immigrant populations, discrimination also comes to play when addressing issues of representation in the healthcare workforce (13, 14). Studies more specific to the Scandinavia and other similar countries mostly associate issues of discrimination to cultural differences and language barriers. For example, the inability to provide professional interpreter services when needed as noted by community pharmacists in a study in Oslo (8) and a strict adherence to rigid healthcare protocols regardless of patients' unique cultural characteristic and needs. For example, Pakistani and Somali immigrant women in a study on facilitators and barriers to cervical cancer screening noted that little or no attention was given to their needs, based on cultural and religious beliefs, to be screened by female doctors due to the intrusive nature of the screening These narrow associations ignore the implicit biases that may unconsciously influence the healthcare professionals' attitudes, diagnoses, and treatment decisions (33).

A 2017 systematic review on implicit bias in healthcare professionals identified forty-two articles out of which twenty-seven examined racial/ethnic biases. Thirty-five studies discovered evidence of implicit bias in healthcare professionals, with all studies that investigated correlations finding a direct relationship between higher levels of implicit bias and lower quality of care (34). These findings emphasize the need for healthcare professionals to tackle the influences of implicit biases in healthcare disparities. When considering bias as a potential precursor for discrimination, actions to eliminate discrimination must go beyond the provision of specialized services such as interpreting to knowledge provision capable of stimulating self-awareness for professionals to check their implicit biases.

1.5.4. Equity

The issue of equity bothers on health system´s preparedness to provide health services to individual patients according to their needs rather than providing the same quality and quantity of services to all peoples (equality). As such, achieving equity would mean the absolute elimination of disparate health outcomes in the population based on any such characteristics as race, gender, religion, sexual preferences, migrant status etc. However, like the studies on

discrimination, most studies focus merely on language and cultural issues when examining issues of equity. For example, in a 2019 review of ethnicity and Type 2 diabetes in the UK, L.M. Goff identified "cultural barriers to accessing healthcare as an important contributor to ethnic inequalities to diabetes (35)". They noted that linguistic and cultural differences as well as migrant statuses predispose individuals from non-white European ethnic backgrounds to having poorer diabetes knowledge and even worse treatment experiences. In addition to these, and perhaps closer in context, is the systematic review on ethnic inequalities in child and adolescent health in the Scandinavian welfare states of Sweden, Norway, and Denmark. Overall, it was found that "non-Western immigrant children experience worse health outcomes than their ethnic majority peers" (36).

Interestingly, the review concluded that asides language and cultural factors, the identified differences were not only attributable to lower socioeconomic statuses but also amplified by factors such as lack of holistic healthcare policy and societal discrimination among other things. These findings shed light to equity issues at both policy and healthcare provider levels; again, pointing at provider-preconceptions towards patients and a laidback predisposition (by institutions, in terms of policy formulation) towards ensuring equitable access to healthcare for all groups.

Conclusively, the assumption that merely bridging the language gap and providing diverse cultural knowledge to healthcare professionals will help to ensure health equity ignores the potential influences of their innate preconceptions about patients based on the latter´s specific characteristics. As suggested by Akhavan and Karlsen, "the negative perceptions of migrant clients held by some Swedish physicians place the onus for addressing their poor health with the clients themselves and risks perpetuating their health disadvantages" (37). Therefore, beyond bridging language gaps, health professionals will benefit positively from interventions that will encourage reflections on these preconceptions, ensure awareness and facilitate the acquisition of knowledge that can ease the handling of these assumptions during healthcare encounters.

1.6. Education for a more Equitable Clinical Experience

From the forgoing, literature abound pointing at the various factors that stand as barriers to equitable access to healthcare for immigrant populations. Also, various interventions have been proposed including the provision of facilities to bridge language barriers during clinical encounters, provision of health promoting information (as well as information about successfully navigating the healthcare system) in languages reflecting the diversity of the

general population, and increased flexibility on time usage during doctor-patient consultations. These are all in response to challenges of faced by immigrant populations in seeking healthcare, at the clinical level. Additionally, and perhaps most relevant to this study is the evidence in literature, pointing to the need to ensure cross-cultural competence is embedded in the training of medical students (5) in order to equip them for encounters with immigrant patients. This is backed by findings from existing research such as the C2ME (15) outcomes, documenting the potentialities of a more healthcare-education-focused intervention to ensure that students take ownership of acquiring the required skills to provide equitable services to immigrant patients.

Interestingly, there is very scarce research assessing the perception of cross-cultural competence among the teachers and students in the medical professions. The only existing study in Norway was prior to the development and implementation of RETHOS protocol. Thus, it is important, now that a new curriculum has been developed, to investigate the understanding of cross-cultural competence among teachers and students of medicine in Norway, with respect to the RETHOS reforms. Particularly, to investigate how much knowledge is being imparted on the importance of culture as a health determinant; the effects of language differences between patients and providers; the effects of discrimination on the health of minorities and the provision of equitable health services to all groups in the society.

2. Objectives of the Study

This research takes a qualitative exploratory approach to examine the reflections on cross cultural competence among teachers and students in Medicine, at the University of Bergen, based on teachings following the RETHOS reform. To achieve this, the following are the specific objectives we would focus on:

1. Assess the understanding of cross-cultural competence among students and educators in the field of medicine;
2. Assess the adequacy of the teaching and learning process to achieve cultural competence.

In line with the four themes- culture, language, discrimination and equity, some key elements of the questions will attempt an understanding of how much knowledge, skills and competence the professionals are being trained to possess on (1) the significance of cultural background for the understanding of health and illness, prevention and follow-up; (2) their ability to communicate effectively with patients and relatives in a professional and empathetic way, and facilitate the use of digital aids and interpreters; (3) We shall assess their reflections on how factors such as discrimination and racism particularly affect the public health of

minority groups and indigenous peoples; and (4) attempt to also facilitate discussions on the potential applicability of knowledge gained in the studies to ensure that healthcare services are made available to all categories of people according to their needs regardless of their sociocultural background, gender, age, ethnicity, religion and outlook on life, functional ability, sexual orientation, gender identity and expression.

3. Method and Methodological considerations

This study utilized qualitative research methods to assess the understanding and interpretation of the Higher Education Learning Outcome among educators and students of medicine. This is because the topic in question had not been previously studied in-depth, and it was a perception study.

Through a purposive sampling technique, this study identified and recruited educators, early career doctors, and students of medicine at the University of Bergen, Norway. Although RETHOS is designed for all healthcare professions, we chose to limit this study to students and teachers in medicine because of time constraints and easier access to them. More specifically, teachers were identified and recruited through snowball sampling, starting off, based on the recommendation of the project supervisors. This helped to facilitate easier access to the population. We had set out to recruit and interview 10 teachers. However, only 9 were included due to time constraints. They include 6 Norwegians and 3 participants with immigrant origins: 5 females and 4 males.

The student sample included both genders, and different levels of study to ensure broad representation. In all, particular attention was given to ensuring the selection of a culturally diverse participant group, to include students with and without immigrant background. This was important to see that we gained insights into the differences that may influence individual perceptions of cultural awareness and their knowledge of cross-cultural competence. In all, 16 student participants were included, 10 of which were females and 6, males. 10 students were Norwegian, while the remaining 6 were immigrants.

An additional sample of early career doctors was included in the study. Specifically, those in the first or second year of practice, who would have had some education under the RETHOS guidelines. This was aimed at eliciting information about their experiences with cross-cultural encounters during practise, and how they adequate or inadequate they perceive their education to have been in preparing them for such encounters. A sample consisting of two female participants were purposively selected.

Qualitative data was collected from the sample of teachers through in-depth interviews (IDI), using pre-determined, semi-structured guides. This was to adapt to the respondents' busy schedules as it would have been more challenging to organise Focus Group Discussion (FGD) sessions with them.

Qualitative data was collected from the student groups through focus group discussions and in-dept Interviews. We reckoned that it would be easier to gather students in groups than staff members who are fewer in number and have more tight schedules. Also, we anticipated that putting students in groups would help to create a more stimulating ambiance to facilitate and inspire open, honest, and rich discussions. In all, we conducted 3 FGDs with students in the 10^{th}, $11^{th,}$ and 12^{th} semesters. It is important to note that all study levels were contacted and only in the included four were interests shown to participate. An additional 2 in depth interviews were conducted with a female student from the 12^{th} semester and a male student in the 7^{th} semester of study. This were participants who showed interest in our study but could not be included in FGD sessions due to their busy schedules and unfavourable timing.

Having asked what language? participants were comfortable with; all interviews and FGDs were conducted in English because all participants could comfortably understand and speak.

The interview and Focus group discussion guides were pre-tested to ensure validity. The pre-test was conducted with 2 teachers and 1 student in the University of Bergen, selected through the researcher's personal network and were subsequently not interviewed or asked to participate in focus group discussions during data collection.

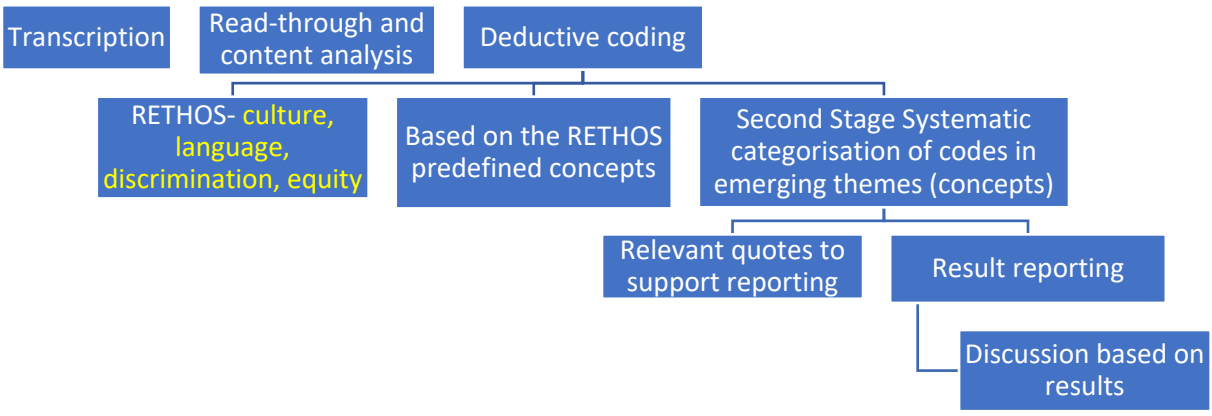
The interviews and Focus Group Discussions were recorded, with the participants' permission, and fully transcribed in English to allow for detailed analysis. Table below provides clearer details about participants, their recruitment, and data collection methods.

Table 1: An overview of participants' characteristics and methods of data collection

Categories		**Method of data collection**		**Gender**		**Immigrant status**	
		IDI	**FGD**	**Male**	**Female**	Norwegian Born	Immigrant
Teachers		9	0	4	5	6	3
Students	7th Semester	1	0	1	0	0	1
	10th Semester	0	1	2	4	3	3
	11th Semester	0	1	1	2	1	2
	12th Semester	1	1	2	4	5	1
Early Carrier Doctors		2	0	0	2	1	1
Total		13	3	10	17	16	11

We deductively coded the transcripts by assigning codes to the predefined concepts: culture, language, discrimination, and equity, drawn from the RETHOS learning outcomes. This was followed by a second-stage systematic categorization of codes into emerging themes for structured reporting. Supporting quotes were then drawn and utilized to buttress some points during the presentation of results. Where quotations were used, attributes were given such that the anonymity and confidentiality of participants are maintained. The figure below describes the analysis process in greater details:

Figure 1: Data analysis plan



Ethical issues were duly considered, and we found that no ethical approvals were required to conduct this research since we did not obtain any sensitive information from

participants. However, all participants were clearly informed of the purpose of the study and their rights. We however, secured approval to process the personal data of respondents from Norwegian Center for Research Data (NSD), now Data Protection Service under the Norwegian Agency for Shared Services in Education and Research (Sikt). This was to ensure that the processing of personal data is lawful and complies with data protection legislations. Through this process, we developed the approved informed consent forms and data collection guides. With these tools, all participants indicated their unforced willingness to participate in the research, having understood its purpose. The data was also duly anonymised while transcribing.

3.1. Limitations of the Study

The main language of communication in Norway is the Norwegian language. However, virtually all educated persons (among whom our samples were drawn) have a command of the English language that would be considered adequate for effective participation in our research. Albeit we proceeded in our fieldwork, prepared to provide interpreter service to any respondent who would prefer to be interviewed in Norwegian. Participants were asked about their language preferences beforehand and they all either opted for English over Norwegian or expressed indifference to the use of either. In hindsight, these tendencies may have been deliberate attempts by our respondents to accommodate the researcher's inability to communicate in Norwegian, rather than affirm their true preferences. During IDI and FGDs, there were thoughts and ideas that the respondents encountered difficulty in expressing in English. They would proceed to say such in Norwegian and then provide a less fitting explanation in English. We believe some contexts may have been lost in these translations. Recruitment of respondents in the second and third samples was challenging. This resulted in the inclusion of a smaller sample than we had purposed. We may have been blindsided to more varying responses that could have been possible with a larger sample. Triangulation in data collection by using multiple data collection methods is a common way of ensuring data comparability and minimising ambiguities and contradictions. In this research, we utilised both in-depth interview and Focus Group Discussions specifically as an adaptive measure to the challenges envisaged before, and faced during respondents' recruitment i.e. their busy schedules. Our research could have benefitted from a more triangulated data collection process across the respondent categories. That is, using more than one data collection method per respondent category. Despite these limitations, and the paucity of literature on cultural competence interventions focusing on medical education in Norway, our findings are corroborated by existing literature from other contexts, in several instances. This gives confidence in the results and the arguments therein.

4. Presentation of findings and discussion

Having deductively coded and analyzed the data in this study based on the four themes (language, culture, discrimination, and equity), extracted from the RETHOS learning outcomes. We went further to present our findings in terms of the overarching issues that cut across all categories of the initial analysis. These issues include challenges with communication, teaching uptake curriculum design, the ability of the current teaching to reach the expected RETHOS outcomes and the RETHOS design and implementation process. The discussions of our findings and recommendations reflected that the communication skills of students themselves should be assessed as part of the teaching process; medical anthropologists should be engaged to develop curriculum and teach courses aimed at achieving cultural competence; and cultural competence should be treated as a required skill for medical practice. It should be taught through structured efforts rather than assumed to be attainable by ad hoc behavior modifications such as curiosity and open-mindedness.

We have presented the results and discussion from this study in article format, to be submitted to "International Journal of Medical Education (IJME)". The article can be found below, following the reference list and annexes to this cover letter.

Reference List

1. Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE, Normand J, Services TFoCP. Culturally competent healthcare systems: A systematic review. American journal of preventive medicine. 2003;24(3):68-79.
2. Cross T, Bazron B, Dennis K, Isaacs M. Towards a culturally competent system of care, Volume 1. Washington, DC: CASSP Technical Assistance Center. Center for Child Health and Mental Health Policy, Georgetown University Child Development Center. 1989.
3. Qureshi A, Collazos F, Ramos M, Casas M. Cultural competency training in psychiatry. European psychiatry. 2008;23:49-58.
4. Horvat L, Horey D, Romios P, Kis-Rigo J. Cultural competence education for health professionals. The Cochrane database of systematic reviews. 2014;5:CD009405.
5. Diaz E, Kumar BN. Health care curricula in multicultural societies. Int J Med Educ. 2018;9:42-4.
6. Berre I, Dæhli TW, Nordløkken A. Hva Lærer Fremtidige Leger om Migrasjon og Helse?: En Kartlegging av medisinstudiet i Oslo. 2010.
7. Nordberg TH, Andreassen TA. Challenging professional control? Reforming higher education through stakeholder involvement. Journal of Education and Work. 2020;33(2):169-83.
8. Håkonsen H, Lees K, Toverud E-L. Cultural barriers encountered by Norwegian community pharmacists in providing service to non-Western immigrant patients. International journal of clinical pharmacy. 2014;36(6):1144-51.
9. Czapka EA, Sagbakken M. "Where to find those doctors?" A qualitative study on barriers and facilitators in access to and utilization of health care services by Polish migrants in Norway. BMC health services research. 2016;16(1):1-14.
10. Kvamme E, Ytrehus S. Barriers to health care access among undocumented migrant women in Norway. Society, Health & Vulnerability. 2015;6(1):28668.
11. Scheppers E, Van Dongen E, Dekker J, Geertzen J, Dekker J. Potential barriers to the use of health services among ethnic minorities: a review. Family practice. 2006;23(3):325-48.
12. Sime D. 'I think that Polish doctors are better': newly arrived migrant children and their parents′ experiences and views of health services in Scotland. Health & place. 2014;30:86-93.
13. Linton S. Black and Asian doctors still face discrimination when applying for jobs in the NHS. bmj. 2021;375.
14. Linton S. White doctors in London are six times more likely to be offered jobs than black doctors. British Medical Journal Publishing Group; 2021.
15. Shepherd SM, Willis-Esqueda C, Newton D, Sivasubramaniam D, Paradies Y. The challenge of cultural competence in the workplace: perspectives of healthcare providers. BMC Health Services Research. 2019;19(1):1-11.
16. Betancourt JR, Green AR, Carrillo JE, Owusu Ananeh-Firempong I. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public health reports. 2016.
17. Hudelson P, Dogra N, Hendrickx K, Verdonk P, Essink-Bot M-L, Suurmond J. The challenges of integrating cultural competence into undergraduate medical curricula across Europe: experience from the C2ME'Culturally competent in medical education'project. MedEdPublish. 2016:1-7.
18. Kalengayi FKN, Hurtig A-K, Ahlm C, Ahlberg BM. "It is a challenge to do it the right way": an interpretive description of caregivers' experiences in caring for migrant patients in Northern Sweden. BMC health services research. 2012;12(1):1-18.
19. Rechel B, Mladovsky P, Ingleby D, Mackenbach JP, McKee M. Migration and health in an increasingly diverse Europe. The Lancet. 2013;381(9873):1235-45.

20. Sørensen K, Van den Broucke S, Fullam J, Doyle G, Pelikan J, Slonska Z, et al. Health literacy and public health: a systematic review and integration of definitions and models. BMC public health. 2012;12(1):1-13.
21. Ward M, Kristiansen M, Sørensen K. Migrant health literacy in the European Union: A systematic literature review. Health Education Journal. 2019;78(1):81-95.
22. Kaihlanen A-M, Hietapakka L, Heponiemi T. Increasing cultural awareness: qualitative study of nurses' perceptions about cultural competence training. BMC nursing. 2019;18(1):1-9.
23. Sorensen J, Norredam M, Suurmond J, Carter-Pokras O, Garcia-Ramirez M, Krasnik A. Need for ensuring cultural competence in medical programmes of European universities. BMC Medical Education. 2019;19(1):1-8.
24. Østerud Ø. Introduction: the peculiarities of Norway. Western European Politics. 2005;28(4):705-20.
25. Møller J, Skedsmo G. Modernising education: New Public Management reform in the Norwegian education system. Journal of Educational Administration and History. 2013;45(4):336-53.
26. M∅ ller J. Democratic schooling in Norway: Implications for leadership in practice. Leadership and Policy in Schools. 2006;5(1):53-69.
27. Govere L, Govere EM. How Effective is Cultural Competence Training of Healthcare Providers on Improving Patient Satisfaction of Minority Groups? A Systematic Review of Literature. Worldviews Evid Based Nurs. 2016;13(6):402-10.
28. Alpers LM. Distrust and patients in intercultural healthcare: A qualitative interview study. Nurs Ethics. 2018;25(3):313-23.
29. Paul D, Ewen SC, Jones R. Cultural competence in medical education: aligning the formal, informal and hidden curricula. Advances in Health Sciences Education. 2014;19(5):751-8.
30. Díaz E, Hjörleifsson S. Immigrant general practitioners in Norway: a special resource? A qualitative study. Scandinavian journal of public health. 2011;39(3):239-44.
31. Kumar BN, Diaz E. Migrant Health : A Primary Care Perspective. Milton, UNITED KINGDOM: Taylor & Francis Group; 2019.
32. Mladovsky P, Ingleby D, Rechel B. Good practices in migrant health: the European experience. Clinical medicine. 2012;12(3):248.
33. Gele AA, Qureshi SA, Kour P, Kumar B, Diaz E. Barriers and facilitators to cervical cancer screening among Pakistani and Somali immigrant women in Oslo: a qualitative study. Int J Womens Health. 2017;9:487-96.
34. FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. BMC medical ethics. 2017;18(1):1-18.
35. Goff LM. Ethnicity and type 2 diabetes in the UK. Diabetic Medicine. 2019;36(8):927-38.
36. Mock-Muñoz de Luna CJ, Vitus K, Torslev MK, Krasnik A, Jervelund SS. Ethnic inequalities in child and adolescent health in the Scandinavian welfare states: The role of parental socioeconomic status–a systematic review. Scandinavian journal of public health. 2019;47(7):679-89.
37. Akhavan S, Karlsen S. Practitioner and client explanations for disparities in health care use between migrant and non-migrant groups in Sweden: a qualitative study. Journal of Immigrant and Minority Health. 2013;15(1):188-97.

Annexes

Interviews guide (Teachers)

Preamble: Permission to record
Data protection rights and rights to voluntary withdrawal
Date
Personal Information: name, gender, age, nationality

Introduction:

- Describe your academic backgrounds and the course(s) you teach in the department

Definitions and relevance to medicine

- What do you know about the RETHOS Protocol?
- What do you understand by cross-cultural competence?
- How would you describe the relevance of cross-cultural competence to the topics you teach?

Issues with health equity

- What in your opinion are the specific health needs of migrant populations in Norway? (And also, barriers to care)
    - How would you describe the relationship between culture and health?
    - How important do you consider language to be in doctor-patient interaction?
    - How do you think discrimination affects the health of minority populations?
    - What are the ways to ensure equitable access to healthcare for all population groups?

RETHOS Assessment

- Based on your teachings, how would you describe the preparedness of medical students to meet these needs in their practice?
- What are the teaching and assessment methods you employ knowledge on cross-cultural competence?

Cultural competence: practical description

- How would you describe a physician who is culturally competent?

Finally, is there anything you would like to add?

FGD Guide (students)

Preamble: Permission to record
Data protection rights and rights to voluntary withdrawal
Date:

Personal Information: name, gender, age, study specialty, year of study, nationality

Transition Question: When do you think is meant by cross-cultural competence?

Key Question: How would you describe the relevance of cross-cultural competence to medical practice?

Follow up: What have you learnt so far in your studies about cross-cultural competence?

Probing question: would you say the teachings have helped you to understand the relationship between culture and Health better?

Key Question: what do you think are the specific health needs of migrant populations in Norway?

Follow up: how would you describe the roles of medical practitioners in meeting these needs?

Probing Question: In what ways do you think your current studies prepare you to play those roles effectively?

Key Question: how do you think your own cultural norms and customs would influence your interactions with patients from other cultural backgrounds?

Follow up: How do you think marginalization, stigmatization, discrimination and racism affect health and health behaviours?

Pr**obing Question:** How would you describe the significance of language in physician-patient interaction? (If language has not come up in previous discussions)

Ending Question: what improvements do you think can be made to your curriculum to better prepare you for cross-cultural encounters?

How would you describe a physician who is culturally competent?

Information letter

Are you interested in taking part in the research project

”Cross-cultural competence in health education in Norway: Perceptions and Implementation of the RETHOS guidelines”?

This is an inquiry about participation in a research project where the main purpose is to assess the understanding of cross-cultural competence among student and teachers in the Medicine department at University of Bergen. In this letter we will give you information about the purpose of the project and what your participation will involve.

Purpose of the project

We wish to assess the understanding and perceived relevance of cross-cultural competence to medical education in Norway. This will be done by examining the interpretation of the Learning outcomes prescribed in the RETHOS guidelines, by teachers and students of medicine, in the University of Bergen.

The project's objectives are to:

1. Assess the understanding of cross-cultural competence among students and educators in the field of medicine;
2. Examine students' understanding and interpretation of teachings on cross-cultural awareness/competence;
3. Assess the awareness of students and teachers about the RETHOS protocol.

This project is being done in partial fulfilment of the requirements for master's degree in Global health at the Centre for International Health, University of Bergen.

Who is responsible for the research project?

Centre for International Health, Faculty of Medicine, University of Bergen is the institution responsible for the project.

Why are you being asked to participate?

You have been purposively selected to participate in this study firstly because of your position as a teacher or student in the medicine department.

For participants who are students, we have selected a representative sample of students across all 6 academic levels. We also ensured that our sample is representative of the gender and migrant backgrounds among students within the department. We intend to have Focus Group Discussions and you will be assigned to one of the sessions as a participant.

For participants who are teachers, through a snowball sampling, starting with the recommendations of the Project supervisors, we were able to gain access to you. We intend to interview between 4 and 7 teachers like you.

What does participation involve for you?

Teachers:

If you chose to take part in this project, this will involve that you participate in an in-depth interview. The interview will take between 30 and 45 minutes. Questions will be asked about your understanding and experiences of cross-cultural competence. We will also ask about your awareness and interpretation of the RETHOS protocol and the Higher Education Learning Outcomes in your teachings. Your responses will be recorded electronically.

Students:
If you chose to take part in this project, this will involve that you participate in a Focus Group Discussion. The discussion will take between 60 and 90 minutes. Questions will be asked about your understanding and experiences of cross-cultural competence. We will also ask about your awareness and interpretation of the RETHOS protocol and the Higher Education Learning Outcomes in your Learnings and; your assessment of the teaching methods on cross-cultural competence. Your responses will be recorded electronically.

Participation is voluntary
Participation in the project is voluntary. If you chose to participate, you can withdraw your consent at any time without giving a reason. All information about you will then be made anonymous. There will be no negative consequences for you if you chose not to participate or later decide to withdraw.

Your personal privacy – how we will store and use your personal data
We will only use your personal data for the purpose(s) specified in this information letter. We will process your personal data confidentially and in accordance with data protection legislation (the General Data Protection Regulation and Personal Data Act).
Only the primary researcher, who is a Master's degree candidate, and the project supervisor, all affiliated with the above stated institution will have access to the data.

Your names and contact details will be replaced with pseudo names and codes respectively. The list of names, contact details and respective pseudos and codes will be stored separately from the rest of the collected data. All data will be stored in a research server for safe keeping during and after the research. (I am not sure which)

In publications, participants will only be identifiable by their gender, occupation and age. Real names and other personal information will not be published.

What will happen to your personal data at the end of the research project?
The project is scheduled to end by 30th June, 2023.
The data will be anonymised at the end of the project. However, it will be kept indefinitely in the research server for the purposes of verification and future research. Only the researcher and project supervisors will have access to the data.

Your rights
So long as you can be identified in the collected data, you have the right to:

- access the personal data that is being processed about you
- request that your personal data is deleted
- request that incorrect personal data about you is corrected/rectified
- receive a copy of your personal data (data portability), and
- send a complaint to the Data Protection Officer or The Norwegian Data Protection Authority regarding the processing of your personal data

What gives us the right to process your personal data?
We will process your personal data based on your consent.

Based on an agreement with Centre for International Health, Faculty of Medicine, University of Bergen, NSD – The Norwegian Centre for Research Data AS has assessed that the processing of personal data in this project is in accordance with data protection legislation.

Where can I find out more?
If you have questions about the project, or want to exercise your rights, contact:

- Centre for International Health, Faculty of Medicine, University of Bergen via Ifeaanu Joseph Ajekiigbe. (ifeaanu.ajekiigbe@student.uib.no)

  Project supervisors:
  Carmeliza Rosario
  +4740336458 (carmeliza.rosario@uib.no)

  Esperanza Diaz
  +4747414104 (esperanza.diaz@uib.no)

- Our Data Protection Officer: *[insert name of the data protection officer at the institution responsible for the project]*
- NSD – The Norwegian Centre for Research Data AS, by email: (personverntjenester@nsd.no) or by telephone: +47 55 58 21 17.

Yours sincerely,

Project Leader

(Researcher/supervisor)

Student (if applicable)

Consent form

I…… voluntarily agree to participate in this research study.

1. I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer any question without any consequences of any kind.
2. I understand that I can withdraw permission to use data from my interview within two weeks after the interview, in which case the material will be deleted.
3. I have had the purpose and nature of the study explained to me in writing and I have had the opportunity to ask questions about the study.
4. I understand that participation involves having an interview with the researchers.
5. I understand that I will not benefit directly from participating in this research.
6. I agree to my interview being audio-recorded.
7. I understand that all information I provide for this study will be treated confidentially.
8. I understand that in any report on the results of this research my identity will remain anonymous. This will be done by changing my name and disguising any details of my interview which may reveal my identity or the identity of people I speak about.
9. I understand that disguised extracts from my interview may be quoted the research report and presentations.
10. I understand that if I inform the researcher that myself or someone else is at risk of harm, they may have to report this to the relevant authorities - they will discuss this with me first but may be required to report with or without my permission.
11. I understand that signed consent forms and original audio recordings will be retained in a digital storage device and only the researchers will have access to data for two years until the exam board confirms the results of our dissertation. After that, the data will be anonymised and kept indefinitely for the purpose of verification and future research.
12. I understand that a transcript of my interview in which all identifying information has been removed will be retained for two years until the exam board confirms the results of our dissertation.
13. I understand that under freedom of information legalisation I am entitled to access the information I have provided at any time while it is in storage as specified above.
14. I understand that I am free to contact any of the people involved in the research to seek further clarification and information.

Statement of Consent and Signatures

I have read this form or had it read to me. I have discussed the information with the researcher. My questions have been answered. I understand that my decision to take part in the study is voluntary. I understand that if I decide to join the study I may withdraw at any time. By signing this form, I do not give up any rights that I have as a research participant.

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Signature of participant Date

I believe the participant is giving informed consent to participate in this study

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Signature of researcher Date

Scientific Paper

Teachers´ and Students´ Perceptions about the Implementation of Teaching Cross-cultural Competences in Medical Education in Norway

Authors:

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Abstract

From January 2021, a revised medical curriculum came to use in the University of Bergen, Norway. Its development was guided by the National Curriculum Regulation for Norwegian Health and Welfare Education (RETHOS), which prescribes among other learning outcomes, that medical education should ascertain the training of culturally competent professionals. This study aims to assess the understanding and interpretation of cross-cultural competence among teachers and students in medicine as well as assess the adequacy of the teaching and learning process to achieve cultural competence. This study was conducted between September and December of 2022 in Bergen, Norway. It took a qualitative explorative approach. We recruited 16 students, 9 teacher and 2 early career doctors, conducting 13 In-depth Interviews and 3 Focus Group Discussions in all. This study found that the teaching associated with cultural competence neither followed specifically laid down guidelines nor pursued clear learning outcomes. Rather, they proposed that students should be "curious and openminded" in their encounters with immigrant patients; emphasizing person centered care over the acquisition of cultural competence as a required skill in medical practice. We concluded that the teaching of cultural competence should take a more holistic form that will include the engagement of stakeholders like members of immigrant communities and professional interpreters; and emphasize the acquisition of cultural competence as a skill rather than the focusing on curiosity and open-mindedness as strategies, during encounters with immigrant patients.

Keywords: Cultural competence, Medical Education, Migrant health, Norway

1. Introduction

Cultural competence emerged as a strategy in high-income English-speaking countries such as the United States and Canada, in response to evidence of "health disparities, structural inequalities, and poorer quality health care and outcomes among cultural minorities and people with linguistically diverse backgrounds" (1). Cultural competence is defined as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" (2). In a more health-service-oriented way, it is "the ability of a system to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural and linguistic needs" (3). A major point of convergence of these definitions, is the need to "improve the skills of clinicians, health care services and systems to address ethnocultural diversity" (3). One way to achieve this is by consciously embedding teachings in cross-cultural competence in health education (1, 4). Berre et al's 2010 work pioneered assessing this phenomenon in Oslo, the capital of Norway, with the highest proportion of immigrants in the country. Though this study noted a continuous increase in the knowledge of students on migration and health throughout their studies, it also exposed the inadequacies in the teachings as reported by students (5).

In countries such as Norway with a growing immigrant population amounting to 18%[2] of the total population as of March 2022, it is important to have cross-culturally competent healthcare professionals disregarding on where in the country professionals are educated. To have a homogeneous curriculum among health care providers, the Norwegian education authorities created the Inter-ministerial National Curriculum Regulation for Norwegian Health and Welfare Education (RETHOS). RETHOS, in turn, prescribed, among other things, that knowledge on cross-cultural competence be embedded in medical curriculum to ensure that students are trained to: i) understanding the influences of culture on health; ii) mitigating the barriers brought about by language differences between patients and healthcare providers; iii) understanding the effects of discrimination on the health of minorities and; iv) providing equitable health service to all groups in the society.

The barriers to health care for immigrants have been documented under three major categories: cultural (6, 7, 8), organizational (8, 9, 10), and structural barriers (8, 11, 12). Solutions generally include the provision of health information in different languages

[2] Immigrants in Norway also include individuals who are both foreign-born and Norwegian-born with two foreign-born parents, and four foreign-born grandparents.

represented in the population, the use of interpreters during patient-provider encounters and increasing representation of immigrant health professionals in the health workforce. In 2019, of the 28,542 active physicians in Norway, at least 5,016 (17.5%) had foreign origins, with most of them from other European countries like Germany, Sweden, Denmark, Poland, Hungary, Serbia and Russia (13). Because immigrant patients often prefer to be treated by immigrant health workers (14), it is easy to conclude that the majority of the linguistic and multicultural challenges faced by health and welfare professionals can be addressed by simply employing a diverse personnel group. While this seems like a right approach to the problem, it has been noted that it "should concur along with the enhancement of cultural awareness and competence among health professionals and not replace it" (15). So, rather than burden immigrant professionals with the extra responsibilities from being preferred by immigrants, a more sustainable strategy would be to provide education that can increase cultural awareness and improve the cross-cultural competence for all health and welfare professionals (4).

Although the RETHOS reform partially intended to address this last point, it did not include any guideline to facilitate implementation of the four targeted outcomes or ways to ascertain the achievement or evaluation of its outcomes. Thus, it remains unclear if, how or to which degree the intentions of the reform are taking place. Therefore, this study assesses the perceptions among teachers and students in medicine in the University of Bergen, Norway regarding the implementation of the RETHOS explicit outcomes related to cross-cultural competence. we will specifically focus on assessing the understanding and interpretation of cross-cultural competence among teachers and students in medicine as well as assess the adequacy of the teaching and learning process to achieve cultural competence.

2. Materials and Methods

This research takes a qualitative exploratory approach to examine the reflections on cross cultural competence among teachers and students in Medicine, at the University of Bergen, based on teachings following the RETHOS reform. To achieve this, the following are the specific objectives we would focus on:

1. Assess the understanding of cross-cultural competence among students and educators in the field of medicine
2. Assess the adequacy of the teaching and learning process to achieve cultural competence.

In line with the four themes presented in RETHOS- culture, language, discrimination and equity, some key elements of the questions will attempt an understanding of how much

knowledge, skills and competence the professionals are being trained to possess on: 1) the significance of cultural background for the understanding of health and illness; 2) their ability to communicate effectively with patients and relatives in a professional and empathetic way, and; 3) facilitating the use of digital aids and interpreters.

The data was collected between September and December of 2022 at the Faculty of Medicine at University of Bergen, one out of the four medical schools in Norway.

2.1. Participants and Recruitment

Stemming from the network of faculty members of two of the authors, the first sample of participants; nine faculty members, were recruited for in-depth interviews (IDI) through a snowballing approach. The second sample of respondents, consisting of sixteen students across four study levels, was reached through the help of some of the professors, who invited the researcher to their classes to recruit interested students. It is important to note that all study levels were contacted and only in the included four were interests shown to participate. Although, it had been the intention of the researchers to include students with immigrant backgrounds for the research, no deliberate efforts were made to reach this specific category of students. All respondents were approached in large groups and only volunteers were recruited. Additionally, two early career doctors were recruited as the third sample of study participants to identify the possible divide that may exist between the cultural competencies acquired during their study and the applicability of these in practice. They were reached through the network of students in the second sample, and at the final stages of their studies, who thus had more practical engagements at the hospital. The table below provides a detailed description of participants' characteristics and the methods of data collection employed.

Table 1: An overview of participants' characteristics and methods of data collection

Categories		**Method of data collection**		**Gender**		**Immigrant status**	
		IDI	**FGD**	**Male**	**Female**	Norwegian Born	Immigrant
Teachers		9	0	4	5	6	3
Students	7th Semester	1	0	1	0	0	1
	10th Semester	0	1	2	4	3	3
	11th Semester	0	1	1	2	1	2
	12th Semester	1	1	2	4	5	1
Early Carrier Doctors		2	0	0	2	1	1
Total		13	3	10	17	16	11

2.2. Research and Ethical Approvals

This study was approved by the Norwegian Centre for Research Data in August 2022 (NSD; Ref: 662080). Written informed consent was sought from all participants. No form of material or monetary compensation was paid in exchange for participation in the research.

2.3. Data Collection

All the In-depth Interviews and Focus Group Discussions were carried out by the first author in English, having been assured by each participant of their ability and willingness to communicate thus. All sessions were audio recorded. Two In-depth Interviews, one with a teacher and another with a student were conducted remotely using zoom and phone call respectively. Transcription of audio recordings were done by the first author after each session.

2.4. Analysis

The analysis of materials took place continuously with data collection by the first author under the close supervision of the second and third authors, implying that we were sensitive and adaptive to new and emerging findings. This for example necessitated the inclusion of the third sample of respondents, which were initially not planned for. Additionally, our data collection tools were equally adaptive to the realities of emerging thoughts and as such constantly sought to elucidate them. At the end of the data collection process, the authors did a thorough read-through of the transcribed data for further familiarization with the contents. The textual data were then transferred into an excel spreadsheet assigning codes to the predefined concepts: culture, language, discrimination, and equity, drawn from the RETHOS learning

outcomes. This was followed by a second-stage systematic categorization of codes into emerging themes for structured reporting. Supporting quotes were then drawn and utilized to buttress points during the presentation of results. Where quotations were used, attributes were given such that the anonymity and confidentiality of participants are maintained.

3. RESULTS

From our second stage systematic categorization, in this section, we present our findings based on the emerging themes. We begin with participant's reflections on the mismatch between teaching cultural competence and using the skill in practice, with communication being a central issue. We also present some inconsistencies found in the teachers' ideas of what is being taught and the students' understanding of the relationship between culture and health. Furthermore, we present findings on the adequacy of teachings; and the development of RETHOS.

3.1. Communication: mismatch between teaching and practice

Here, we present our findings on the teaching efforts currently being made to ensure that students in medicine are equipped with the skills needed to communicate effectively with their patients, based on need.

The majority of participants in the student and teacher sample categories agreed on the importance of utilizing professional interpreters in encounters with patients from immigrant origins, sometimes through painful experiences, as in the case of one teacher *"Well, basically not having a common language makes it impossible. I have one of my first encounters with a patient that I didn't share a language with, a female patient. She had recently given birth and obviously had a bad pain. She came to see me but we couldn't communicate at all and at one point, she kind of laid down on my floor, yelling, screaming out of pain and I had no idea what this was and I couldn't ask her anything. I ended up having to send her to the hospital. She had an infection of the uterus after this birth. These made a great impression on me, feeling so helpless as a junior doctor where there's a patient in pain that I had no means to communicate with."* (*Teacher, Female, Norwegian*).

Additionally, they reported that specific teachings are provided to students in their second year for "two days" on communication using interpreters: "*the topic was "Communication through an interpreter". In these two days, we were cooperating with the interpreting services from Bergen municipalities to talk about: When do we need an interpreter? Who is the interpreter? How do we go about when we communicate through an*

interpreter? And what does the law say when it comes to rights and duties in interpreting." (*Teacher, Female, Norwegian*)

Across all participant categories, there was a clear understanding of the need for, and the practicalities of interpreter use in medical practise. Participants reflected on some challenges surrounding the use of interpreters associated with clinical and structural barriers that impede interpreter use. They include the constraints brought about by the limited time allotted to clinical consultations: "*...It's 100% fundamental… I think for most disciplines within the health system, particularly from a medical point of view, the time budget we are operating under is so strained, there are massive kind of demands of being efficient and anything that is postponing things or delaying things unnecessarily, you try one way or another to cut that..."* (*Teacher, Female, Norwegian*).

The same IDI participant went ahead to add that the frequent use of interpreters increases the length of clinical encounters, resulting in the higher likelihood of healthcare providers to maintain a "superficial" approach to their investigation, and not "know as much" as they should. Other concerns include inability of doctors to determine in advance, the need for an interpreter before the patient presents, thereby resulting in the use of improvised alternatives such phone interpretation and relatives who accompany the patient: *"...Do you have to speak English? Is your English good enough, I think mine is, and yours is too. But very often not at all and then you need an interpreter and then you are often, it's too late to sort of order an official interpreter so you have to make do with the husband or the child, whoever..."* (*Teacher, Male, Norwegian*) Another respondent added that: "*I think having an interpreter and ensuring that, understanding between patient and doctor is very important and I feel like it's not used enough, people try to do like charades and explain as well as they can, but I think we should have better system in place to have interpreters available, because it's makes a big difference, having an interpreter, and usually we do like phone interpretations and it's like you have the interpreter on the phone, so they are not there and it's a rather difficult situation."* (*Student, Female, MED 10*)

3.2. Teaching Uptake and Curriculum Design Insufficiencies

There are inconsistencies between the contents of teachings on cultural competence, as reported by teachers and the reflections of the students on the influences of culture on health. Therefore, in this section, we will juxtapose our findings on the contents and contexts of teachings provided on culture and its influence on health with the understanding demonstrated by students on the topic. Majority of teachers had aligning ideas on the kinds of knowledge that

students should possess on the influences of culture on patient health. There was consensus believe in the importance of teaching a "patient centred" care approach, "…*so when I teach communication, I teach what we call patient-centred method. It means that as a doctor and certainly as family doctor GP, you shouldn't just try to elicit the patient's symptoms but also how the patient understands the symptoms, what it means to the patient and the context of the patient and culture obviously has everything to do with that, the words you use, your, could you say the lay interpretation of your health, your symptoms or whatever and so, culture obviously enters into this teaching* (*Teacher, Male, Immigrant*).

Additionally, teachings were described by teachers as specifically designed to help students to avoid stereotypes in encounters with patients from immigrant origins but to induce openness and critical reflections on how such origins may determine the patients disposition towards their symptoms, especially since it is not only foreign cultures that influence health; : *"...we use cases in teaching and it turns out the patient has a cultural background and everyone says "oh yes! He comes from Africa or from the, from the, the outside of Europe so he obviously or she thinks differently about this which is relevant because they might, due to different culture, cultural background and then secondly, to take that a step further on and say yeah but there are also culture assumptions among people from Norway and we cannot take that for granted..."* (*Teacher, Male, Immigrant*)

On the other hand, students reported that the teachings they have had on culture dealt specifically with disease that were considered uncommon in Norway. They reported these teachings to have omitted "the cultural aspects" of the disease but dwelt on their rareness, as a justification for their importance to be studied: "*we were talking more about... we had HIV and tuberculosis and we are gonna talk about malnourishment and diarrhea. It's more of a what disease we do not see as not here in the rest of the world more than the cultural aspect of it, I think."* (*Student, Female, MED 10*). Others more clearly associated health conditions to geographical positioning of patients per time, birthplace and immigrant status: *"I also thought how the risk of one type of disease increases or decreases as you do depending on where you come from, or where we've been in or like on your genetics like where you're born and if you're an immigrant, it increases the risk of tuberculosis."* (*Student, Female, MED 12*); "*Yeah, but it's not cultural. In my opinion, it's got little to do with culture and more to do with endemicity. Like, where the disease is more prevalent. Yeah, and if it's endemic or not: It's not because of Filipino culture that they have more tuberculosis, it's because it's endemic to the Philippines."* (*Student, Male, MED 12*).

Another interesting reflection from the students featured a more pragmatic approach to addressing challenges brought about by conflict between patients and doctors on the care process. "*My point is that I don't think you need the "why", you just need the "how". It doesn't matter why you have these ideas; why you don't want to have a male gynecologist; or why something else; but the important thing is: How do we get around it; How do we solve the problems on the patient's terms; or how can we make a compromise? But the reasons why the patient wants what they want, it doesn't really matter."* (*Student, Male, MED 12*). The forgoing indicates a gap between the intended teachings on the influences of culture on health and the knowledge of the students.

According to majority of our teacher and student respondents, there are specialized teachings during the medical education that focus on training doctors to provide equitable health service to diverse groups in the society. Students, during FGD sessions recount having gone through a course that teach adaptive communication with patients; how to be "cautious and professional"; communicating with older patients; patients' religious backgrounds; and communicating with patients who have been through traumatic experiences. Some teachers who have been involved in these teachings also corroborate their accounts: *"I was teaching in some of those semesters myself about inequalities, health, the healthcare system and about a number of different other things about public health that Norwegian medical students should learn."* (*Teacher, Female, Norwegian*). They however raised concerns about the tendencies for the curriculum to omit the creation of specialised learning categories that concern cross-cultural competence. These modules then have to be "tucked" under public health: *"...anything that is not covered by others tends to end up being often tucked under the umbrella of public health and cross-cultural competence is not clearly a public health issue but it's one of those that we realized was, maybe, not properly covered by others and then we put it on our list of things that we should make sure that the students, somehow, were aware of..."* (*Teacher, Female, Norwegian*)

The seeming disarray in organizing these aspects of the studies is further echoed by students, who expressed appreciation for the "little" they learn but attest to the need for more: *"I think it would be possible to teach in school but there's not much time for it and there's not much time for a lot of things in our studies, like we should learn about a lot of things but I think, especially now in this semester when we have international health as a, like part of the curriculum, we could have more than two 45 minutes, it would be helpful to learn more .... I think we should definitely have more of that and it will be very useful to, it's very useful to hear other experiences that others have had, we have like group work and people talk about like*

what they experience at work, some examples came up that's very useful as well." (*Student, Female, MED 10*). The student groups generally expressed appreciation for the teachings they had because they afforded them the opportunity to collectively reflect on their preconception of immigrant patients which they were hitherto unaware of having and "feel ashamed" of: *"…it was very nice to talk openly about it and to (be) more aware of (it)."* (*Student, Female, MED 10*). Additionally, they reflected that it may potentially be beneficial to their studies to have open discussions with immigrant patients who have experienced the Norwegian healthcare system and may be able to share experiences, and the effects of inequitable healthcare delivery on them.

3.3. Ability to reach the expected RETHOS outcomes

We asked the student participants in this study about how much their studies help them to prepare for encounters with immigrant patients. Majority of participants in the student sample opined that their teachings were inadequate to achieve this. They explained that there were some teachings designed to prepare them for encounters with patients that have been through traumatic experiences: "*We did have a short course in global health in mid-term, where they spoke about migrant health and also focusing on torture victims or torture survivors, and being open to the needs and how to meet them - people who have survived torture, and migration and other traumatic events, but not that much. It's also been mentioned sometimes, like, if there are specific national background groups that have different risk profiles. They sometimes speak about different people with different financial backgrounds having a risk profile, or having opinions regarding, for example, vaccination or often, reproductive health. Other than that, it hasn't really been much of a theme. I feel like some of it is just outside of the studies, that this is something a lot of students think is important, but it hasn't really been mirrored by the formal education."* (*Student, Male, MED 11*).

They further explained that some of their studies taking narrow perspectives in addressing health issues requiring treatments, that must be adapted to the peculiarities of immigrant patients: "*…Just like for the dermatology as well, like there was no diversity in the colors of the pictures of the skin was for white people - all white people, and sometimes when I asked the lecturers the questions, I didn't know they were a bit uncomfortable when I asked. If you were, for example, looking at a person with darker because that's, of course they have less risk of melanoma, but then they were like: Oh, but it's just like the rest; but it's not, they're looking different. I feel like there are some barriers still in our curriculum."* (*Student, Female, MED 11*)

About whether it was possible to reflect on these preconceptions through classroom teaching, as opposed to learning them in practice, majority of the students believed that it was indeed possible to achieve critical reflections in classroom. They believe that this area of knowledge is just not prioritized as much as some others and thus will require more attention in the curriculum: "*I think it would be able to teach in a classroom setting it's just that it hasn't been done, I think absolutely I think it would be possible to teach in school but there's not much time for it and there's not much time for a lot of things in out studies, like we should learn about a lot of things but I think, especially now in this semester when we have international health as a, like part of the curriculum, we could have more than two 45 minutes, it would be helpful to learn more and during those lectures I also felt like, I will agree with you that experience at work is what has given me more knowledge but I think that I got a lot of eye openers during that lecture as well and you are kind of confronted with your own stereotypes that you are not fully aware that you have and then when we talk about it in classroom setting it's like okay, this is also like a safe place, to like go into yourself like okay maybe I have some preconceptions I wasn't aware of, but in the, like not in an uncomfortable way and so I think we should definitely have more of that and it will be very useful to, it's very useful to hear other experiences that others have had, we have group work and people talk about like what they experience at work, some examples came up that's very useful as well."* (*Student, Female, MED 10*)

Although many of the teachers condemned discriminatory practices, they explained that immigrant patients would be better off investing in their own integration into the Norwegian healthcare system, rather than relying on the latter to adapt to their health needs: *"...so the more patients understand the Norwegian way of looking at things, Norwegian way of life, how a doctor hear things, the more they know about my world the easier it is..."* (*Teacher, Male, Norwegian*)

Some recounted own experiences of having approached immigrant patients, bearing preconceived notions of what the encounter may or may not feature; they recall feeling the need to prepare better for what they expected to be a difficult process: *"it being more complicated and trickly to work with people whose language is not Norwegian, whose way of thinking is not Norwegian that I recognise in myself, it's much easier and I can feel relieve when I'm sort of "no foreign names on my list today", because it's hard work and I don't feel so competent because very often than the problems are connected with things that are not necessarily within the medical realness as we tend to think of it but these other things that have to do with life, it's harder, takes more improvisation."* (*Teacher, Male, Norwegian*)

Some of the teachers described their teaching methods, pointing at specific aspects that they focus on, including those not addressed: *"...for myself I call it a course in creating structured curiosity and I haven't in those, during those 12 hours we relate with some of the base line for their understanding of what it means to be a patient and how a doctor can be of help…we have not talked about culture and cultural differences."* (*Teacher, Male, Norwegian*). While not justifying the omission of specific cultural issues, this teacher believed that the extent of their teachings would at the very least ascertain the training of students who are "curious to everybody and will have a general humility, interest, empathy and willingness to learn from patients" in a bid to create quality dialogue between themselves and the care-seekers and help the former to "navigate these cultural complexities". An example of how this knowledge is interpreted by the students is described by a student during Focus Group Discussion thus: *"the easy answer is to be open minded, to ask: What information do you have already about this disease or this problem; Have you thought about what you think this might be? So that you open for them and that you actually have the same basis when you start the consultation afterwards."* (*Student, Female, MED 12*). It is however uncertain about whether this was directly benefitted from classroom encounters with the teachers or through reflective interactions with colleagues during practice. An early career doctor, in responding to questions on the adequacy of their studies to prepare them for the provision of equitable healthcare said: *"…not in my education, I don't think they talked about it too much, but it usually helps when I talk to other colleagues that have more experience…"* (*Early career Doctor, Female, Norwegian*)

3.4. The RETHOS Design and Implementation process

While our findings so far have been associated with practical issues about the teachings designed to achieve the RETHOS outcomes, the ensuing findings will be critical to the process of development and implementation of the reform, as well as presenting specific suggestions by study participants on improvement points for both RETHOS and its teaching. Firstly, some teachers expressed displeasure with the way the RETHOS reform was introduced. They believed that strict guidelines such as these limit the ability to take a discretionary stance towards the development and achievement of learning objectives: *"...I am not entirely happy about this approach to generate quality, I think also there are things that get lost when you take away the responsibility to think about what we should achieve and just state what we should achieve because that's the way the impose to, in education to have a reflective approach to how and what you teach."* (*Teacher, Male, Norwegian*).

While agreeing with this participant about feeling alienated from the process of developing the RETHOS outcomes, another IDI participant further added that it gave a sense of direction to them in teaching and provided for uniformity in the teachings across medical schools in Norway; an element which was hitherto missing: *"The environment that I was part of was never invited to contribute to it, just made aware that it was going on. I just wonder whether it was initiated by the by the ministry or by the Directorate. I'm not sure but I think it has been a very positive process because previously, we could say that: Yeah, we know they teach this and that in Trondheim but we don't have to do that, it's up to us to decide what we want to teach the students. Which I don't think is good because I think obviously, they need to come out and be able to face the same challenges."* (*Teacher, Female, Norwegian*).

The students in our study who were immigrants or belonged to multicultural backgrounds were more engaged in the topic and had personal stories and experiences to share about they and their family members' experiences with the healthcare system. They were more interested in learning about cultural competence. It was however interesting to learn that asides this inclination to learn, there also exist a greater interest to teach subjects related to cultural competence, among immigrant teachers: "*So, it has been something (some teachings), but very little. Because I'm multicultural myself, I have thought about it a lot of times actually that during the study, we focus not a lot on it. But now on the last years, we do have some courses and that's often from our professors that are multicultural themselves and they have some specific courses for example, we had one with women and gynecology. How to address that with women from different cultures, but very little."* (*Student, Female, Med 12*).

Participants in our student and early career doctor samples provided various insights on improvements they believe could be made to the medical curriculum, in a bid to ascertain the training of culturally competent doctors. Some of our respondents emphasized the need for their classroom sessions to include contacts with persons from minority groups who have experienced differential treatments in their encounters with healthcare professionals, to share such experiences in order make the problem more apparent: *"…I agree very much that having people if they are willing to come and talk to us about their own experiences, it makes a really good impression because everybody sits there and it's like how could this happen and you get, and when you get associated with the person not just statistics or the numbers, I think that will be very helpful and also kind of smack it in the face that we have to do better, when you see how it's not working"* (*Student, Female, MED 10*).

Furthermore, having reflected on the nonmandatory status of all the courses on cultural competence in the medical curriculum, our respondents were turn between changing the status

of these courses to mandatory or simply making them "more attractive" to students to encourage attendance: *"The patient contact course is already mandatory, and yes maybe for the, for example the lectures that we had should have been mandatory because we only have one and of course you can say that you should take responsibility for yourself , you should see that this is important and come and that's a good point but again we have a lot of mandatory teachings already and it's spread out on different days and you have to plan around the days you have mandatory courses I think that they, anything that is not mandatory might, you might feel like you should skip it instead of skipping something else and a lot of times I feel like, a teaching I really feel like I should have gone to it, like most of it really but sometimes you are not just able, so if something is mandatory you might prioritize it more."* (*Student, Female, MED 10*).

Students in the latter group further added that as opposed to having a short, one-time course, courses could be spread out. The argument here is that this will allow for time to reflect in between the teachings and possibly have relatable experiences in clinics rather than simply relying on the theoretical knowledges gotten from the class:*"like spreading it around, having it a bit at the start and coming back to it later I think is very good so that you get the time to start the wheel kind of early and you think about it and the meetings you have with patients and you reflect about it….people probably have a lot more experiences to share and hearing from the other students what they have experienced is very valuable I think, and how situations were handled and what could have been done better".* (*Student, Female, MED 10*)

4. Discussion and Conclusion

What we have found in this study indicates a gap in the understanding of how cultural competence can be taught as an essential skill from teachers to students in medicine. There are emphases on: person-centered patient care, featuring loosely defined notions of curiosity and open-mindedness; teachings on specific diseases that are endemic among certain groups and; the mismatch between teaching and practice, regarding communication barriers. We will argue for a medical education model that is collaborative with professional interpreters and members of immigrant communities in order to ensure that teachers and students gain insights on the needs of these patient groups.

4.1. Teaching to communicate with Immigrant patients

From a teacher point of view, our study, supported by literature identifies factors such as time constraints, accessibility as well as lack of training on interpreter use as responsible for the irregular use of professional interpreters and, or the use of ad hoc interpreters such as family

members (16, 17). We found that the available teachings on the use of interpreters to ease communication between health professionals and immigrant patients seem adequate, to the extent of its practical usage, including the administrative processes involved in ordering the service. However, these efforts are largely assumed, among teachers and students as designed to "solely benefit the patient while burdening the health professional and system" (18). Thereby, deemphasizing the need for an assessment of the language and communication proficiencies of the students themselves; a step that emphasizes the usefulness of language assistance efforts, not only for patients but also would be clinicians.

Following Ortega's et al. emphasis of the need to assess health professionals' communication proficiencies, we recommend that an assessment of communication skills should be incorporated in the teachings regarding interpreter use in order to ensure that professionals take ownership of their duty to effectively communicate with patients as opposed to treating language need interventions as extra burdens whose advantages are limited to the patients.

4.2. How cultural competence should be taught

Studies on health disparities report scarce literature describing the processes involved in incorporating cultural competence in health education curriculum (19, 20, 21). In their literature review, Drame et al. found that classroom strategies to incorporate cultural competence in medical education involved "teaching a single course or a series of courses" (19). This supports our findings which indicate that courses currently taught on the topic are short, one-time courses which are sparsely scattered across study levels, and are not compulsory for students to take. Our study further found that students indicated interest in learning activities that would include direct interactions with immigrant communities to learn of their experiences with healthcare providers and potentially be made aware of the effects of inequitable healthcare delivery on them. They believed that this would better facilitate the recognition and participation of patients as partners in the development of healthcare delivery strategies. This is supported by findings from researchers on the teaching of cultural competence that present activities involving "case-based and community engagement" (22, 23) exercises as effective strategy for teaching cultural competence. Furthermore, to incorporate Cultural competence in medical education, studies also recommend: the assessment of students understanding of health disparities; Increasing students' engagement with diverse patient groups; Implementation of cross-cultural communication models at clinical sites and; Co-curricular and interprofessional activities including service learning, study abroad, symposia, and forums (24, 25, 26).

We believe these strategies will potentially attract a lager student group to courses on cultural competence, since the current course are mostly attended by students who already have some interest in immigrant health due sometimes to their own immigrant statuses or personal experiences with or interest in the healthcare provision to immigrant patients.

4.3. Person centered or Cultural competence

The foregoing are practical ways by which cultural competence can be incorporated in medical education and acquired by medical professionals as a useful skill in practice. However, the notion that person centered healthcare delivery (which according to our respondents is constituted by the "respect and equal treatment of individual patients based on curiosity, openness and 'avoidance of stereotypes'") can serve the same purpose as cultural competence was popular among our respondents, both teachers and students. The teachers were rightly so, more inclined to promoting the treatment of immigrant patients with caution, respect, curiosity, and open-mindedness. These concepts are however subjectively defined and thus interpreted differently by students. The challenge with this approach, as presented in our findings is that it fails to eliminate preconceptions about immigrant patients. If anything, it encourages an unhealthy preparation for what the caregiver already expects to be a problematic encounter which would require from them, a needless amount of effort to deal with. This reinforces what Johnson and colleagues referred to as othering, describing "a process that identifies those that are thought to be different from oneself or the mainstream, and can produce positions of domination and subordination" (27) between healthcare providers and their patients respectively. If conscious efforts are not put into the development of medical curriculum incorporated with strategies for teaching cultural competence, othering of immigrant patients can continue to reinforce inequitable healthcare delivery to them. Moreso, findings from our study already align with existing literature that cultural competence can be taught. They only point at a lack of commitment to infuse the relevant teachings in the curriculum, on one hand, and the scarcity of qualified and interested teachers on the other.

Some, in their teaching, associated cultural competence training to the provision of knowledge about specific health conditions that are considered rare in Norway, and among Norwegians. Therefore, associating these with immigrant populations or geographical locations. Because of the emphasis on endemicities of disease conditions rather than their cultural dimensions, these teachings and other associated learning outcomes get tucked under the umbrella of public health and therefore taught by clinicians and other public health professionals. There is no doubt that understanding the effects of culture on health enriches care

providers' understanding of health challenges and the needed care. Equipping medical professionals to provide "culturally sensitive, responsive, and competent healthcare" (28) however remains the domain of medical anthropology. We recommend that in order to better respond to the RETHOS objectives, medical anthropologists should be engaged in curriculum development and teaching of courses that will equip medical professionals to effectively communicate with and manage the cultural dimension of clinical interactions with patients from immigrant origins.

5. Conclusion

In conclusion, our study finds that teaching inadequacies such as: insufficient training on interpreter use; a focus on endemicities of diseases; lack of qualified teachers and an emphasis on curiosity and open-mindedness as strategies for handling encounters with immigrant patients are the four main issues in achieving the RETHOS outcomes. Our recommendations for improving on them are that: the communication skills of students themselves should be assessed as part of the teaching process; medical anthropologists should be engaged to develop curriculum and teach courses aimed at achieving cultural competence; and cultural competence should be treated as a required skill for medical practice. It should be taught through structured efforts rather than assumed to be attainable by ad hoc behavior modifications such as curiosity and open-mindedness.

Conflict of interest

There is no conflict of interest that might bias the outcomes of this research.

REFERENCES

1. Horvat L, Horey D, Romios P, Kis-Rigo J. Cultural competence education for health professionals. The Cochrane database of systematic reviews. 2014;5:CD009405.
2. Cross T, Bazron B, Dennis K, Isaacs M. Towards a culturally competent system of care, Volume 1. Washington, DC: CASSP Technical Assistance Center. Center for Child Health and Mental Health Policy, Georgetown University Child Development Center. 1989.
3. Qureshi A, Collazos F, Ramos M, Casas M. Cultural competency training in psychiatry. European psychiatry. 2008;23:49-58.
4. Diaz E, Kumar BN. Health care curricula in multicultural societies. Int J Med Educ. 2018;9:42-4.
5. Berre I, Dæhli TW, Nordløkken A. Hva Lærer Fremtidige Leger om Migrasjon og Helse?: En Kartlegging av medisinstudiet i Oslo. 2010.
6. Håkonsen H, Lees K, Toverud E-L. Cultural barriers encountered by Norwegian community pharmacists in providing service to non-Western immigrant patients. International journal of clinical pharmacy. 2014;36(6):1144-51.
7. Czapka EA, Sagbakken M. "Where to find those doctors?" A qualitative study on barriers and facilitators in access to and utilization of health care services by Polish migrants in Norway. BMC health services research. 2016;16(1):1-14.
8. Kvamme E, Ytrehus S. Barriers to health care access among undocumented migrant women in Norway. Society, Health & Vulnerability. 2015;6(1):28668.
9. Scheppers E, Van Dongen E, Dekker J, Geertzen J, Dekker J. Potential barriers to the use of health services among ethnic minorities: a review. Family practice. 2006;23(3):325-48.
10. Sime D. 'I think that Polish doctors are better': newly arrived migrant children and their parents′ experiences and views of health services in Scotland. Health & place. 2014;30:86-93.
11. Linton S. Black and Asian doctors still face discrimination when applying for jobs in the NHS. bmj. 2021;375.
12. Linton S. White doctors in London are six times more likely to be offered jobs than black doctors. British Medical Journal Publishing Group; 2021.
13. LEGEFORENING DN. General statistics on doctors in Norway 2023 [updated 2023; cited 2023 28th may]. Available from: https://www.legeforeningen.no/om-oss/legestatistikk/english/.
14. Díaz E, Hjörleifsson S. Immigrant general practitioners in Norway: a special resource? A qualitative study. Scandinavian journal of public health. 2011;39(3):239-44.
15. Kumar BN, Diaz E. Migrant Health : A Primary Care Perspective. Milton, UNITED KINGDOM: Taylor & Francis Group; 2019.
16. Diamond LC, Schenker Y, Curry L, Bradley EH, Fernandez A. Getting by: underuse of interpreters by resident physicians. Journal of general internal medicine. 2009;24:256-62.
17. Karliner LS, Pérez-Stable EJ, Gildengorin G. The language divide: the importance of training in the use of interpreters for outpatient practice. Journal of general internal medicine. 2004;19(2):175-83.
18. Ortega P, Shin TM, Martínez GA. Rethinking the term "limited English proficiency" to improve language-appropriate healthcare for all. Journal of immigrant and minority health. 2022:1-7.
19. Drame I, Gibson CM, Nonyel NP, Addo-Atuah J, Butler L, Riley A, et al. Strategies for incorporating health disparities and cultural competency training into the pharmacy curriculum and co-curriculum. American Journal of Pharmaceutical Education. 2022;86(3).
20. Bachmann C, Pettit J, Rosenbaum M. Developing communication curricula in healthcare education: an evidence-based guide. Patient Education and Counseling. 2022;105(7):2320-7.

21. Antón-Solanas I, Rodríguez-Roca B, Vanceulebroeck V, Kömürcü N, Kalkan I, Tambo-Lizalde E, et al. Qualified Nurses' Perceptions of Cultural Competence and Experiences of Caring for Culturally Diverse Patients: A Qualitative Study in Four European Countries. Nursing Reports. 2022;12(2):348-64.
22. Schroeder K, Garcia B, Phillips RS, Lipman TH. Addressing social determinants of health through community engagement: An undergraduate nursing course. Journal of Nursing Education. 2019;58(7):423-6.
23. Mathews J, Parkhill A, Schlehofer D. a., Starr, MJ, & Barnett, S.(2011). Rolereversal exercise with deaf strong hospital to teach communication competency and cultural awareness. American Journal of Pharmaceutical Education.75(3).
24. Prescott GM, Nobel A. A multimodal approach to teaching cultural competency in the doctor of pharmacy curriculum. American Journal of Pharmaceutical Education. 2019;83(4).
25. Brown B, Warren NS, Brehm B, Breen P, Bierschbach JL, Smith R, et al. The design and evaluation of an interprofessional elective course with a cultural competence component. Journal of allied health. 2008;37(4):316E-37E.
26. Wilby KJ, Taylor J, Khalifa SI, Jorgenson D. A course-based cross-cultural interaction among pharmacy students in Qatar and Canada. American journal of pharmaceutical education. 2015;79(2).
27. Johnson JL, Bottorff JL, Browne AJ, Grewal S, Hilton BA, Clarke H. Othering and being othered in the context of health care services. Health communication. 2004;16(2):255-71.
28. Winkelman M. Culture and health: Applying medical anthropology: John Wiley & Sons; 2008.