GUIDE: CULTURAL COMPETENCE TRAINING IN HEALTH ORGANIZATIONS

MARCH 2014

This document represents an expansion of the chapter dealing with cultural competence training that appeared in "Integrating Cultural Competence in Health Organizations in Israel: A Concise Guide" (The Jerusalem Intercultural Center, 2013[1]). This document will further develop the ways to manage a system of basic and ongoing training to give employees the knowledge, awareness and skills they need to provide clients with culturally competent service and clinical care.

Cultural competence training began in most health organizations in Israel only in recent years. Unlike in some Western countries, such training is not yet an integral part of the academic studies for health professionals in Israel. Although courses dealing with multiculturalism are given in some schools for health professionals, the courses are not necessarily adapted to what is actually happening in the health system itself, including the organizational changes that have occurred in recent years, and only rarely deal with skills involving cultural competence per se. Consequently, there is a special need to institutionalize training programs as part of the in-service learning within the organization itself in order to create a common language for the organization and to aid in integrating cultural competence principles, tools and skills on the level of individual, staff and organization.

The integration of the principles of cultural competence (both on the individual and organizational levels) can increase satisfaction on the part of both the health practitioner and patient, save treatment time and increase patient compliance. Some of the insights and tools used in cultural competence are intuitive; some are learned under a different heading in certain health professions, and their discussion in the context of training underscores the intercultural aspect; however, a significant portion of the insights and tools are specific to the subject and require learning and practice.

In this document, we will discuss training programs in cultural competence, starting with the initial organizational exposure to the subject, followed by the training routine. We will examine various training frameworks for the training and makeup of the participants and suggest recommended content for these training programs.

We will use the terms "health practitioner" and "patient" here for reasons of convenience, but the principles offered in this document apply not only to the clinical encounter, but also to the service process. Consequently, the training process along with the principles that underlie it also apply to members of the administrative staff, and not only to health professionals.

[1] See Appendix 1.

This document was written by the staff of the ***Jerusalem Intercultural Center*** as part of a joint project of the ***Jerusalem Intercultural Center*** and the ***Jerusalem Foundation*** to encourage cultural competence in health services. Support for this document was also provided by the ***New Israel Fund,*** which aids in the expansion of the activities of this project in Israel.

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Acknowledgements

We would like to thank Rachel Arieli from Maccabi Healthcare Services; Anat Baram from the Hillel Yaffe Medical Center; and Tal Cohen from Alyn Hospital for their comments and helpful suggestions.

We welcome additional comments and insights, which will be included in future versions of this guide. They can be sent to jicc@jicc.org.il.

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Introducing the concept of cultural competence to the health organization

The field of cultural competence, along with the necessary adaptations on the organizational and individual levels, is new to most organizations in Israel. Consequently, it is necessary to hold preliminary activity in the organization to explain the need for the cultural competence process on these two levels. In view of the fact that these preliminary processes are in essence a form of introductory training, we have decided to suggest a number of ways to implement them:

- **A "first-glance" session for the administrators** of the organization to introduce the subject to the management and enlist it to promote the subject later. We recommend that this session will present the added value of cultural competence in closing health gaps, improving the quality of service, staff satisfaction, risk management, efficiency and more. In addition, we recommend a discussion of the various implications (organizational, financial, legal, etc.) that the changes will have for the organization along with a presentation of the proposed steps for continued activity in this area.
- **A workshop on cultural competence for the management.** The workshop is designated only for the management team, but will be similar to the workshop that the other teams in the organization are given (see below for various models). This workshop will achieve a twofold goal: It enables the managers to understand the process that all the employees of the organization will undergo and also to serve as role models for them.
- **A study day/symposium for the employees of the organization** with the participation of guest lecturers and professionals from various organizations to familiarize them with the field of cultural competence. This day would include a variety of subjects to help enable the employees to learn about the approach and motivate them to desire to become culturally competent. It could also serve as an opportunity for the management to declare its commitment to the subject.

Integrating training programs into the regular work of the organization

The integration of training should be adapted to the needs of each organization. Options include integrating the training programs as part of existing training protocols (e.g. in the context of service-improvement training), and we recommend planning these training sessions in cooperation with the human-resources and training units in the organization. From a budget aspect, existing budgetary allotments can be used at the first stage. For example, if six annual training sessions have been budgeted for the employees, one of them can be designated for cultural competence. Similarly, cultural competence training can be integrated as part of existing trainings sessions on the subject of closing gaps.

We recommend that the training sessions be held at the same time as and in coordination with the other activities taken to improve cultural competence in the organization. For example, courses to train interpreters will not be beneficial unless employees are also trained in how to use them and in procedures for commissioning the work of the interpreter for health practitioner-patient meetings. Similarly, for example, opening a Muslim prayer room for the use of patients and staff members before a discussion with employees is held on the subject could create antagonism among some members of the staff (see the discussion on social and political tensions in a health organization later in this document). Organizational processes carried out at the same time (training and additional organizational changes) will encourage the staff to become involved in them and thus increase their commitment to the subject.

Workshop composition and number of participants

In principle, the best practice is for all the directly or indirectly employed workers and volunteers of the organization to participate in the training workshops. In this context, it should be noted that workers that have no direct contact with patients, e.g. bookkeepers, etc. can also benefit from the training: This is because cultural competence in a health organization impacts the relationships among the workers themselves, and also because the clients of the organization communicate with employees who may not provide them with a direct service.

It is also important that people who are not directly employed by the organization, such as workers engaged by contractors or employees of the Health Ministry and Third Sector organizations active in the organization, also participate in the training. Because these people engage in direct communications with the clients and employees, their cultural competence will impact the overall cultural competence in the organization. HMOs and clinics that employee independent or part-time physicians should find a way to enable them to participate in the training sessions as well.

There are various approaches regarding the most appropriate makeup of the cultural competence training sessions:

1. Professional training for an entire organizational unit (e.g. an entire clinic or hospital department). This approach enables group processes for the development of cultural competence among the entire staff of the organizational unit to take place. A framework of this kind allows for the discussion of actual cases involving treatment and services that occurred in the unit from the various perspectives of the staff members involved in or who observed them.
2. Training each profession separately (doctors, nurses, social workers, administrative staff, etc.). In this approach, the training can be adapted to the nature of the profession and to the core training relevant to it.
3. Training sessions attended by a variety of employees coming from all professions and parts of the organization, based on their availability for the date of the training session. This structure involves more complex planning regarding the subject matter of the training for participants coming from different backgrounds.
4. Separate training for the administrative staff. Sometimes, the administrative staff feels that the workshop discussion may focus exclusively on clinical issues, while administrative and service issues are ignored. A separate workshop for the administrative staff makes it possible to adapt the training to administrative issues, which are very important to the client and in many cases represent the principal interface between the client and the health organization.

A variety of options is also available regarding the number of participants in the training workshops. Workshops can contain small groups of 15-25 participants, or alternatively, sessions with a large number of participants (100 or more) can be held. A third option is to combine the different options, e.g. to hold the first session with a large number of participants and then to break up into smaller groups.

Sessions involving a relatively small number enables a high level of interactivity. The disadvantage is, of course, the cost and time involved in facilitating numerous sessions for the entire staff of the organization. The situation is just the opposite where large sessions are involved, in which the passivity of the participants, especially in frontal lectures, may make the learning process superficial, with few possibilities for individual practice and exercises. The advantage in sessions of this kind lies in the ability to convey a uniform message to a large number of participants within a shorter period of time than training done in small groups.

Work in small groups is especially important in cultural competence training because of the importance of holding active discussions of the principles of the approach and practicing and internalizing them. That is why, in most cases, the preferred path is to work in small groups. At the same time, in other cases, an integrated approach can be taken in which certain parts of the

training (e.g. watching and discussing a film) can be carried out in a large group, whereas other parts (e.g. practicing a case by means of simulation) will be carried out in smaller groups.

The training framework

Various possibilities are available for the core training of the staff members. Training can be held over a whole day or for parts of days. Here are a number of possible options:

Full Day (8 hours)

In this framework, the employees arrive for a concentrated training session to take place over a whole day. In this case, the employees must disengage from their day-to-day work in order to be able to concentrate on what they are learning. Here is an example of the general structure for such a training day:

1. Introduction – Basic concepts and insights related to the cultural competence of the health practitioners and health organization.
2. Stories from staff members, the analysis of which foregrounds successful or unsuccessful activities in culturally competent treatment. This method enables the participants to open up and share existing solutions in the organization that are appropriate for dealing with crises of a cultural nature.
3. Study of the core subjects of cultural competence (see the chapter that deals with training later in this document).
4. Practice using case studies or role-playing. A professional actor may be used. If the workshop participants come from different professions, it is important to set up role-playing sessions that are relevant to all the different health professions.
5. Concluding session to sum up the workshop and receive feedback.
6.

Half days (two sessions of 4-5 hours each):

In this framework, the training session is split into two half days. The advantage of this arrangement is that the normal day-to-day activities of the department or clinic are less disturbed, and that the interval between the meetings enables the employees to process what they have learned and increase their awareness of issues of cultural competence. The disadvantage is that the continuity of the learning is interrupted. In any event, it is important that the interval between the two sessions not be too long. An example of how to plan the training content: The first day presents the rationale behind cultural competence, basic concepts and some of the subjects and tools. The second day involves discussions of all the other subjects, along with exercises to practice and sum up.

We recommend that thought be given to ways to maintain continuity between the two days. This can be done, for example, by giving the participants tasks to carry out between the two sessions, such as:

1. To observe changes in behavior (of oneself or others) as a result of the first session of the workshop.
2. To observe organizational changes that have occurred in the organization since the first session.

4-5 brief sessions

This is a framework that enables organizations to hold training sessions within a very limited time frame, for example as part of staff meetings or in the intervals between shift changes in hospitals. The advantage of splitting the training up into a number of sessions is the minimal disturbance caused to the day-to-day functioning of the healthcare staff, and its obvious disadvantage is the difficulty in making sure that all employees participate in all the sessions. A further disadvantage is the difficulty in holding an in-depth discussion in the middle of the workday as well as in maintaining continuity of learning of the various subjects.

In the training framework involving short sessions, one or two subjects are discussed at each session, and part of the last session is devoted to summing up the subject matter. It is important to make sure that the entire series of sessions is conducted within a reasonable time frame (no more than three months) in order to assure continuity of study and integration of the material.

Use of online courseware

In the world and in Israel too, online courseware is commonly used to teach new subjects. E-learning is mostly carried out individually and involves no actual encounter among the members of the staff. At the first stage of cultural competence training in an organization, we do not recommend online training in the subject, despite the fact that this method is an accepted part of the learning process in some health organizations. This is because the knowledge and tools for culturally competent treatment are not familiar to most of the employees and the learning requires a process and an interactive change in approach. A further reason is that much of the courseware available tends to present the material in the form of closed multiple-choice questions that may make the subject superficial. Moreover, online courseware makes it difficult to adapt the training to the entire range of health professions. Training by means of e-learning can be helpful in supplementing the core training at a much later stage in the process.

Continued learning following the core training

After completion of the core training process, it is important to take the knowledge acquired to a deeper level and practice the staff's knowledge and awareness by means of regular review sessions (e.g. every three months). The sessions can take various forms, but all share the same goal: to gain deeper insight into the subject matter studied in the core training and analyze intercultural cases that the staff witnessed.

At this stage, a guest lecture can be given by experts in specific subjects, such as the religious aspects of health in different communities, the features of behavior and communications in certain communities, etc.

We highly recommend that the training support the ongoing activities of the organization so that cultural competence will become an integral part of its work. The activities can be associated with specific tasks or with a clearly defined annual timetable. An important way to continue to integrate the subject is to appoint cultural competence trustees or coordinators in the various units of the organization who will be responsible for integrating the principles into the organization, including training and ongoing education in the organization.

The integration of content related to cultural competence in workshops for new employees

In addition to the training of veteran employees, we highly recommend including cultural competence training in the orientation workshops for new employees. After these employees have spent time on the job, they can be included in the ongoing training on this subject in the organization.

Training methodologies

The subject of cultural competence is considerably varied and consequently, invites learning and exercises using a variety of methods. Each organization can choose the method, time frame and location where the training will be held most suited to it and to the degree of knowledge that exists among the staff members on the subject.

- **Films or case studies prepared in advance** – The films or cases will describe, for example, a communications situation between a health practitioner and a patient (or family member) in which there is a conflict between certain treatment and professional aspects on the part of the health practitioner and certain aspects in the world of the patient. These films and cases will serve as triggers for discussions with staff members regarding intercultural issues and the knowledge, awareness and tools needed for successful intercultural treatment. They can serve to introduce the study of cultural competence (as described later in this document) or to practice the understanding of these subjects after

they have been studied. The Jerusalem Intercultural Center has prepared a number of short training films that can help convey various subjects involving cultural competence (for further information on these training films, see Appendix 5). These films can be used by facilitators who are graduates of the JICC facilitator-training program.

- **Mutual interviews about cases from healthcare experience** – When using this method, participants can success stories from actual healthcare situations, discuss cases in which the staff was unable to identify and contend with an intercultural challenge. The discussion makes it possible to draw insights from the way the case was dealt with, reinforce positive skills found among the staff and find ways to improve the work in similar future cases. The role of the facilitator is especially important – without proper reflection and the right questions, the participants may conclude that they acted quite acceptably in cases in which their cultural skills could in fact have been significantly improved. In most cases, the interview method is less relevant for new employees who lack sufficient experience.

- **Role playing** – Role playing can be carried out in a number of ways. One way involves using a professional actor and a case prepared in advance. One or two participants hold a dialogue with the actor, who usually plays the role of the patient (or a family member). The other participants observe silently, do not interrupt or halt the event. The simulation's participants inside the circle can stop the conversation at any time to think, consult with colleagues or plan the next stages of the conversation. The facilitators can also halt the session in order to offer suggestions or constructive criticism. Each time the discussion in the circle is "frozen," a discussion is held with the participants and observers, but not with the actor. At the end of the session, the events are analyzed, and insights are offered, and then associated with the subjects discussed in the workshop. Sometimes, the participants switch places during the process itself. Afterwards, the "patient"/actor can present his perspective and describe how he felt in the interaction with him.

- **"The health practitioner in the shoes of the patient"** – This method was developed by the Jerusalem Intercultural Center. The health practitioner, usually the one that brought up the case for discussion (and which he himself may have experienced), is invited to play the role of the specific patient involved in the event. Another participant is asked to play the role of the health practitioner. This mechanism enables the health practitioner to give the patient's behavior a certain depth, since he knows the patient and can imagine how he would respond to various statements, at least to some extent. In addition, this exercise forces the health practitioner to gain a more nuanced understanding, usually from a positive perspective, of the patient with whom he had difficulty. It is important not to ridicule the patient's behavior because the aim of the role playing is to give the participants the ability to understand the patient's motivations and behavior on a deeper dimension.

- **Short dialogues from conversations that typify the communications in the health organization** – Excerpts from dialogues appear on slides in a presentation or handouts. An

analysis of the dialogues will enable the participants to better understand the intercultural features embedded in them.

- **An individual task for the training participants** – The participants are given guidelines for a task to be performed between the training sessions, followed by a discussion of the results. One intriguing possible task involves "focused organizational change." Its main goal is to create visibility and to set in motion a discussion on cultural competence during and following the core training process. Each participant chooses to assimilate a specific organizational change after having studied the core concepts in that area. The organizational change must be something that is feasible and that can be carried out within a relatively brief period, to enable success and feedback, and that is visible within the organization. In order to execute this task effectively, it is important at the start of the process to define the flaw that requires a change, the degree of the change's effectiveness and the barriers to carrying it out. During and after the workshop, the facilitators will work with the participants to help consolidate the concept for this organizational change and assimilate it into the organization.
- **Lectures on different cultures** – Lecturers from outside the organization or staff members can present the significance of cultural competence in their specific identity group. In most cases, this content is suitable as an extension of the core workshop, and should not come in place of study of the core content in cultural competence. It is important to emphasize to the audience that the staff member giving the lecture is speaking about his own perspective and perhaps that of his immediate vicinity, and that he does not necessarily represent all the members of his or her cultural group.
- **Further lectures on other subjects related to cultural competence** – either on the level of the health practitioner or organization. Examples could include a lecture by a doctor who specializes in culturally competent work with a particular cultural group, a health sociologist who studies a particular culture, etc.
- **Handouts** – We recommend handing out material to the participants to study after the workshop. The material can include data on populations that use the organizations services, telephone numbers of relevant contacts for intercultural work, a summary of the main subjects presented at the workshop, relevant articles, etc.

Principal training subjects

The aim of the training is to provide knowledge, awareness and tools for culturally competent work on the level of the health practitioner, staff and organization. In many of the workshops that we are familiar with, the following subjects appear as part of the core program:

- Introduction to cultural competence
- Improving the quality of intercultural dialogue
- Identifying and dealing with intercultural gaps
- Becoming familiar with culturally dependent health approaches among clients
- Using interpreters and cultural mediators to address service and treatment needs
- Dealing with social-political tensions in the health organization
- Analyzing professional and value-based dilemmas in culturally competent interaction in the workplace
- Organizational cultural competence
- Understanding the personal and cultural approaches of the health practitioners themselves, their biases and meanings, and the processes required in order to become more culturally competent at work.

Introduction to cultural competence

The introduction to the field of cultural competence clarifies the subject of the training, its context for the work of the staff members and the entire organization. Beyond the knowledge that is conveyed, the introduction aims to enlist the participants to undergo a personal process as well as to actively participate in the cultural competence process within the organization. Naturally, we recommended using the introductory sessions to explain the main concepts that will be used later and the principal insights in this field as a whole.

Important insights that should be emphasized in the introduction:[2]

1. Cultural competence training is an ongoing process of improvement and fine-tuning. Those who take cultural competence training are not entirely culturally incompetent when they begin the course, and nor do they become experts upon completing it. The training improves cultural competence because it deepens knowledge and conceptualization in areas that are largely familiar to the students, strengthens existing skills and enables the acquisition of additional ones, and reinforces awareness of and motivation for cultural competence in the day-to-day work of the organization.
2. Each encounter between a health practitioner and care recipient is an intercultural encounter, if only because there is a cultural gap between the culture of the service organization and that of the service recipients. It is important to be familiar with and use

[2] These insights are an expansion of Like's recommendation (Like, 2000). See the link: http://www.healthdisparities.vcu.edu/?id=1330&sid=10.

many of the subjects and tools studied in the training, even absent the intercultural context. Nevertheless, the wider the cultural gap between the health practitioner and care recipient, the more significant and meaningful are the subjects and tools studied in the training for the success of the clinical encounter and treatment.

3. The accepted emphasis in cultural competence training is not to emphasize the study of the characteristics of any particular cultural group. The study of a specific group could create generalized expectations and stereotypes in regard to a patient from that group. Instead, the emphasis should be placed on general tools and skills for working with people who may be different from the health practitioner. It is correct to use cultural hypotheses as working assumptions, which the health practitioner must examine in regard to the patient with whom he is working; however, the health practitioner should not expect a particular type of behavior from the patient simply because he belongs to a particular culture, and then to make decisions based on that behavior. Nevertheless, in certain contexts, it is a good idea to spend time getting to know a specific group at the stage of the introductory training, and not only during the latter part of the training process.
4. The participants in the training also come from varied cultural backgrounds, and like everyone else have their own biases and opinions that may impact the clinical encounter. Delving deeper into the area of cultural competence requires an examination of one's own personal biases and opinions, as well as their implications for one's work.
5. There are different levels of cultural competence. A special distinction is made between individual cultural competence (of the employee himself) and the organizational cultural competence (of the health organization). In addition, the various areas of cultural competence should be divided into further levels. For example, a distinction should be made between individual cultural competence (e.g. the ability of a staff member as an individual to contend with cultural diversity) and professional competency (e.g. the ability to adapt the professional approach of the specific area of care to the cultural approaches of health, illness and care of patients); or a distinction between organizational competency (which includes, for example, appropriate directional signage in the hospital, the operation of a system of training for the staff in cultural competence and adaptation of the organization's physical surroundings) and social competence (which includes processes to change social policy, etc.). In employee training, special focus is placed on individual and professional cultural competence, and in most cases, the other levels are referred to only in order to create a context for the training in the organization.

From a methodological standpoint, there are numerous ways in which the introductory training can be enriched. Here are some examples:

1. Present a case (or cases) that occurred in the organization demonstrating the relevance of individual and organizational cultural competence. This can be done with a case prepared ahead of time or with a pertinent one presented by the participants.

2. Show a film or video and discuss it.
3. Conduct an exercise that encourages the participants to identify with patients that come from a different culture, for example, one in which each participant recalls a relative or friend who had a frustrating experience trying to communicate with the health system. A discussion on the cultural gaps in these cases helps to understand their meaning.

Improving the quality of the intercultural dialogue

The basic assumption is that improving the quality of the dialogue with the patient and his family can significantly improve the quality of care. This assumption is true for every health practitioner-patient encounter, but when cultural gaps between the parties interfere with the dialogue, the need to employ tools to improve the dialogue is all the greater. Studies show that when there are cultural gaps between the health practitioner and patient, there is a tendency to significantly shorten the dialogue with him and make it shallow and superficial.

A major component in improving the quality of the dialogue involves devoting significant time to listening to the other party. This is especially important when there are gaps in language, jargon, speech style, body language, etc. Moreover, because there is often a feeling misunderstanding that underlies the lack of compliance on the part of the patient, the health practitioner tries to reiterate his explanation in different ways. This happens despite the fact that most negotiating practices suggest doing just the opposite: to speak less and listen more. There are two reasons for this:

1. The more the patient speaks, the more personal, social and cultural information about the patient becomes available. This information can help in managing the dialogue and choosing the right care.
2. Genuine and empathetic listening to the patient enables the patient to open up and listen to what the health practitioner has to say. Because in most cases, the principle of the patient's self-autonomy does not allow the health practitioner to force his view on the patient, it is especially important to create a "therapeutic alliance" between the health practitioner and patient. Moreover, meaningful dialogue, even when there are intercultural gaps in approaches, communication and language, makes it possible to provide optimal treatment that takes into account personal, cultural, religious and community gaps that may exist. This attitude also considers the way in which the patient perceives his situation, the factors leading to it and the ways it may be improved.

Often, based on the feeling that he is already familiar with the culture of the patient (because he has met many "like him" or heard a lecture about his culture), the health practitioner may think that he can skip the dialogue. In fact, cultural diversity between individuals can be quite considerable and the right way to use cultural generalizations is to view them as "working assumptions" that need to be tested in the context of the specific patient by means of holding a dialogue with him.

Based on this approach, during this part of the workshop, the participants will be familiarized with different models for improving the quality of the dialogue in an intercultural setting so that they can apply it to cases from their experience or cases prepared by the facilitators. The best-known model in this context is the Patient's Explanatory Model[3] by Arthur Kleinman et al. An expert on the encounter between medicine and culture, Kleinman maintains that in many cases in which there is a treatment failure or a serious misunderstanding between the parties, it is the result of the fact that the health practitioner was not familiar with the Patient's Explanatory Model regarding his situation (how the patient perceives his problem, what the possible solutions in his view are, etc.). The Patient's Explanatory Model is just one of a number of models that can aid the health practitioner in understanding the patient's own perception in regard to his illness and its treatment. Listening to the patient according to these models is not easy and requires internalization and practice, in part because it means that the health practitioner must make the effort to attentively listen to the patient's narratives, perceptions and considerations, some of which may be quite foreign to the health practitioner's own attitudes and medical training.

A model for improving the quality of dialogue developed by the Jerusalem Intercultural Center is made up of seven stages:

- Understanding the way in which service recipient perceives the problem.
- Clarifying the way in which the health practitioner perceives the problem.
- Acknowledging the differences and similarities between the different approaches.
- The health practitioner's recommendation.
- The response of the service recipient to the health practitioner's recommendation and other proposals.
- Negotiation and dialogue.
- A joint decision.

A blood test conducted on a member of the Bedouin community in the Negev showed evidence of the HIV virus in his blood, and the health practitioner was forced to give the blood donor the bad news. Upon hearing that he was an HIV carrier, the patient repeatedly collapsed, and the doctor, aided by a nurse, tried to help the patient recover his composure so that they could discuss the matter further. The staff reiterated to the patient that by taking the drug "cocktail" used to treat it, people today can live with the virus for many years. At the initial stage, it was unclear to the doctor and his staff why the donor's reaction was so extreme and why he was unwilling to take in any information about the possibility of living a normal life as an HIV carrier. Only after a number of conversations did the staff finally understand that the donor's main fear was related not to how it was possible to live with the virus but rather to the implications that his new status would have for his family, social and public standing.

[3] Kleinman, A., Eisenberg, L. and Goode, B. (1978). Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research. *Annals of Internal Medicine*, 88: 251-258.

The full model for improving the quality of the intercultural dialogue developed by the JICC can be found in Appendix 2.

Identifying and dealing with intercultural gaps

Most practices for identifying and dealing with intercultural gaps are based on two principal approaches. The first involves becoming familiar with culturally dependent behavioral norms. The second deals with core traits and intercultural dimensions.

According to the approach that focuses on **culturally dependent behavioral norms**, becoming familiar with the behavioral characteristics and customs of cultures helps to overcome intercultural gaps. Indeed, familiarizing oneself with the greetings used in certain cultures, the accepted practices when saying hello and goodbye, customary physical gestures, etc. can prevent misunderstandings and help to create an intercultural bridge. However, in order to become familiar with cultural norms, one must learn a large number of facts, and for those that come in contact with a variety of cultures, it would mean having to assimilate a large body of knowledge. In addition, the validity of norms can change in accordance with individuals and subgroups within each culture. It is highly recommended to try to become familiar with as many behavioral norms as possible and to take them into consideration. This is an initial list of subjects in which there is a wide variety of behavioral norms:

- Customs related to food, drink, behavior during the meal and fasting
- Religious laws
- Etiquette concerning how to relate to close family, more distant family, friends
- Attitude toward formal frameworks and service providers
- Lifecycle ceremonies and customs (birth, death)
- Behavior in the public sphere and behaviors reserved for the private domain
- Accepted protocols and rules of conduct in interpersonal encounters

As noted, the diversity in cultural norms across a particular cultural group may be too wide to model. That is why the norms that are learned must serve as no more than a hypothesis for the health practitioner, to see if these practices are indeed the accepted ones for a specific patient.

The second approach, that of **core traits**, proposes that one become familiar with the principal behavioral values and characteristics that significantly impact the communication and actions of the members of that cultural group.

Thus, for example, according to Shahar and Kurz,[4] the following traits typify people from Israel, on the whole:

[4] Shahar, L. and Kurz, D. (1995). *Border Crossings: American Interactions with Israelis*. Yarmouth, ME: Intercultural Press.

- A positive approach to crossing boundaries
- Informal patterns of social interaction
- Spontaneity
- Improvisational approach to problem solving
- Self-confidence
- A positive approach toward risk taking
- A very direct manner of speech
- Group orientation coexisting with strong individualism
- Readiness to question authority
- Casual attitude toward rules and regulations

Each of these traits justifies a discussion in its own right, one that goes beyond the scope of this document. Although many would apparently state that these traits typify Israelis, it is neither a final nor closed list. It is especially important to understand that because every individual is ultimately an aggregate of numerous cultures, and each such culture has different (even contradictory) core traits, we will see considerable diversity among people in accordance with the combination that personally characterizes them (and sometimes, the same person may behave in different contexts in a way that reflects different parts of his cultural belonging).

An interesting point is that core traits are perceived differently by people from different cultures. For example, many cultures that are characterized by an indirect discourse style tend to experience American culture as one of having a direct discourse style, whereas Israelis, whose discourse style tends to be even more direct, often experience American culture as being one that typifies indirect discourse.

Core traits are neither "good" nor "bad." That is why there is no judgment in the list of traits. At the same time, we often tend to ascribe a negative interpretation to the traits of the "other," and part of the study in the workshop deals with a conscious search for possible positive interpretations in order to understand and accept the core traits that are inconsistent with the health practitioner's cultural habits.

In the workshop, the subject of core traits can be learned in a variety of ways:

- A discussion of certain cultures that one can encounter, and the core traits that are traditionally ascribed to those cultures. This approach is less desirable because it may create generalizations about a person from a particular culture, which may fix the way the health practitioner thinks and limit the inclination to fully clarify specific issues hen working with a specific patient.
- A discussion of the core traits of Israeli culture as a reference point. This reference point makes it possible to understand how an Israeli health practitioner (even if he "belongs" to additional cultures in accordance with his own individual background, etc.) is perceived by

patients from different cultures (most of whom may be Israelis, but in the healthcare context, the other aspects of the culture become apparent).

Another important way to describe and learn about the intercultural gaps between core traits, in the context of the core-traits approach, is by means of Cultural Dimensions, in which contradictory traits are located on the two poles of an axis and different cultures are located on different places on the axis in order to describe their location relative to one another (see examples of cultural dimension in Appendix 3). One dimension, for example, is the axis between the approach of those who accept hierarchy and authority and the approach of those who challenge hierarchy and authority. Different cultures are located (based on international studies) at different points in relation to one another on this line. In a study Geert Hofstede conducted, he located cultures in Malaysia, Slovakia, Guatemala, Panama and the Philippines on the end of an axis denoting deference and a respectful attitude towards authority figures. As we move away from this pole of the axis, on the axis we can also find Arab countries, France, Greece and the United States. When we move to the diametric end of the axis, there we find Israel, which is characterized, as shown above, by a significant tendency to challenge authority and minimize the importance of the boundaries of position holders and hierarchy.

What is interesting is that contradictory traits located on both ends of the axis are assessed positively by almost all cultures. For example, even in cultures that tend strongly towards hierarchy and authority we find appreciation of those who nevertheless challenge authority. And even in a culture like Israel's, there is understanding and appreciation of the need to treat hierarchy and authority with respect. Nevertheless, despite the general acceptance of the legitimacy of both traits on both poles of the axis, different cultures tend to prioritize these traits differently. In any event, it should be borne in mind that the cultural axis is merely a metaphor that helps to understand this multidimensional phenomenon, and in fact, there are many further variables, such as the context, that dictate the meaning of the core traits in any given situation.

A variety of methodological tools, e.g. films, descriptions of events, dialogues, etc., can help to analyze the gaps among core traits. The principal message is to seek out favorable interpretations for behaviors based on the possible core traits that underlie these behaviors. Beyond awareness of the way in which one relates to the core traits and familiarity with some of the cultural dimension related to them, there is a great deal of room to expand practical skills. The ways to contend with gaps in the core traits include: ventilating; an effort to seek out favorable interpretations for the other's words and actions; exercising caution when drawing conclusions based on partial information; mitigation and adaptation of our own core traits vis-à-vis those of the patient; and seeking out "bridges" that will cause the patient to do what he can to make the most of each clinical encounter. By taking a patient and sensitive approach to cultural differences and gaining familiarity with one's own core traits and those of the other, a transition can be made from positions to needs, making it possible to find creative solutions to conflicts.

Becoming familiar with culturally dependent health approaches among clients

It is important for health practitioners and staff members to familiarize themselves with the health and illness approaches of the patients that they encounter on a day-to-day basis. This will help the health practitioners understand the patient's way of thinking about health, illness, healing and treatment, making it easier to suggest treatment methods and rehabilitation that are adapted to the patients' cultural background.

In order to learn about the clients' health perceptions, we suggest a number of methods that can be integrated into the training:

- Guest lectures by a professional who works with the community (preferably a member of the community), who will present the health and illness perceptions of the members of that groups, as he sees them (thus, for example, the way some members of the Ethiopian-Israeli community view hospitals, which is a result of the experiences they had before coming to Israel, or perceptions of some immigrants from the former Soviet Union regarding the services provided in their country of origin, which are different from those provided in Israel).
- An analysis of cases presented by the staff that are related to phenomena that can be defined as culturally depended health perceptions. Thus, for example, we can try to understand how the member of a specific community relates to social workers, physiotherapy or occupational therapy. A discussion of this kind will help to define culturally adapted methods to facilitate contending with barriers that are not relevant to a single patient, but rather to many people coming from the same group.

Using interpreters and cultural mediators to address service and clinical needs

In the context of this subject, the aim of the discussion is to raise awareness of the impact that language gaps can have on the quality of service and clinical care and to understand how to reduce them by working properly with an interpreter. The language gaps between the health practitioner and patient are usually only the "tip of the cultural iceberg" – the barrier that is most salient in the intercultural encounter. This is seemingly only a technical issue that health practitioners in Israel tend to dismiss by speaking simplified Hebrew, as they dispense with high-quality diagnostics and care. In cases in which these broken conversations prove insufficient, the health practitioners resort to using family members or an employee of the organization who speaks the language to translate. In fact, it has been proved that language gaps can cause real health damage and represent an unnecessary health burden on the system.

In recent years, efforts have been made to introduce institutionalized and more professional solutions to providing language accessibility, and to discontinue the approach according to which anyone who speaks the language can serve as an interpreter. Because of the increase awareness of the importance of this subject, as well as because of the guidelines of the law, we anticipate that

staff members will be given increased resources to provide language accessibility, including the use of medical interpreters who have received proper training. It is important to train health practitioners on how to work properly with an interpreter and how to define the interface between them, for the benefit of successful treatment.

In the workshop, a distinction should be made between the role of the interpreter – who helps facilitate communications between the parties who do not speak a common language, and engage in a certain measure of cultural mediation in the encounter – and a health mediator. The role of the mediator is to identify and address cultural gaps and barriers in the broader health and service context. In a medical environment, the role of mediators often includes aspects of health education, the health promotion via education and knowledge, helping clients navigate the health system and mediating conflicts.

During the workshop, we recommend practicing a conversation with a patient by means of an interpreter (see Appendix 4). A special emphasis should be placed on speaking to the patient directly, in the second person, rather than indirectly, via the interpreter (i.e. Don't say: "Ask him if he…" Say: "Do you…"), using simple language without medical jargon and giving the interpreter the opportunity to translate what was said.

After learning the rules, it is important to hold a short discussion on the subject of providing language accessibility in the organization: If there are already interpreters working in the organization, a discussion should be held on the role of the interpreter (or mediator) in the work of the organization's staff – how to book an interpreter, how to document an interpreted session, how the interpreter is integrated into the work of the staff, etc. Additional means of providing language accessibility in the organization should be pointed out, e.g. forms, signage, translation of written information, etc.

> In 2007, the Jerusalem Magistrate's Court ruled that a government hospital was negligent in providing explanations and verifying that they were understood to an Arabic-speaking pregnant woman and awarded the woman damages totaling NIS 250,000 for the death of her fetus (Maha and Saleem Dalashe v. the State of Israel, 2654/05).

Dealing with social-political tensions in a health organization

Social and political tensions are not normally discussed in an organization, and raising the subject enables staff members to acknowledge the existence of the difficulty in contending with social and political tensions that may be present in the organization. These tensions exist not only between the health practitioner and patient but also among the patients themselves as well as among the health practitioners themselves.

As noted earlier, crossing boundaries is a feature of Israeli society. Indeed, in Israeli society, the interpersonal, professional and political boundaries tend to be quite blurred – both among service

providers and recipients. In a clinic or hospital, the health practitioners may encounter a patient or community that harbor sensitivities associated not only with the core traits and customs of the various groups, but also claims that they are victims of discrimination. Some health practitioners respond to this with feelings of guilt, or alternatively, by going on the defensive or offensive with counter accusations and recriminations, which may be detrimental to the service or clinical care.

The health practitioner, whose role is to provide professional service, may be forced to act in a reality in which he feels challenged socially or politically. He may be accused of discrimination or racism and respond with recriminations; he may feel guilty towards the offended group, as he sees it, and act unprofessionally because of his guilt feelings. He may, because of his own identity, feel that he himself is being treated in a discriminatory fashion based on the stereotypes associated with the particular group that he belongs to.

The basic principle to bear in mind is the need to maintain professionalism and professional work at all times despite an atmosphere that may be politically challenging. Clearly, it is often difficult to apply this principle on the ground. It also appears self-evident – who would disagree that it is important for professionals to act professionally – but in many cases, professionals respond and act in a manner that is not entirely professional at that moment, even in their own view. In some cases, it is difficult for the health practitioner to remember that his or her role – as a doctor, nurse, administrative clerk, etc. – is not to educate the client or change his values, but to help him, as long as the client neither harms nor offend other clients or health practitioners.

Parents of religious families (Jewish and Muslim) whose children received treatment in a therapeutic swimming pool voiced complaints regarding the lack of modesty of the bathing suit worn by one of the physiotherapists. To address the issue, one solution was to purchase special bathing suits for the pool staff, but this created resentment among some of the physiotherapists, who felt that this was an example of religious coercion.

A further principle that must be understood is that there are no "universal/neutral" solutions in a public space that is used by people of different cultures. Tensions involving the rules of the common public space require genuine willingness to listen to different viewpoints regarding what is "right" or "wrong" in a public sphere.

In 2013, in Michigan, a new father attached a sticker to his new son's crib in the hospital nursery saying, "Please, no African American nurses to take care of baby, per dad's request." An African American nurse sued the hospital for racism because it acceded to the father's request and had her and other African American nurses reassigned to other duties to prevent them from taking care of the baby.[5]

[5] Up to the writing of these lines, no information is available regarding the verdict in this case. See: /http://www.usatoday.com/story/news/nation/2013/02/18/black-nurse-lawsuit-father-request-granted/1928253

In the Israeli reality, it is difficult in a workshop to ignore tensions of this kind, and one of the most important ways to address them is to suggest that the staff members find a safe place where they can ventilate and discuss their feelings after events in which they felt offended.

Analyzing professional and value-based dilemmas in culturally appropriate work

At a workshop, a Hebrew-speaking Jewish doctor learned to insist on professional interpreting for an Arabic-speaking Muslim woman who came with her husband, even though the patient expressed the desire to use her husband as an interpreter. After the workshop, he discussed the issue with some Muslim-Arab physician colleagues who told him that although there is no language gap between them and their Arab-Muslim patients, they often respect the couple's culture and address the husband – rather than the wife – because it is he who makes the decisions for his wife. The doctor consequently asked a question: If cultural competence means adapting to the culture of the patient – why insist on speaking directly with the woman when she asks otherwise? However, the (Western) professional medical approach must not relinquish the principle of communication that preserves the patient's autonomy.

Another example that was raised relates to cultures in which the practice is to tell the family about a patient's serious illness before telling the patient himself, and to let them decide whether or not he should be informed regarding his condition. This approach is inconsistent with the conventional professional medical approach that takes the view that the patient should be the first to be informed and that he should be the one to decide whether or not to tell his family members.

There are certain cases in which there is a contradiction between the staff's professional work principles and the desire and need to understand the patient's cultural needs and to adapt the treatment to them. In workshops held by the Jerusalem Intercultural Center over the years, staff members ask: "Where do we draw the line as human beings and professionals where the subject of cultural competence is concerned? In what cases would it be wrong to apply the principles of cultural competence and where is there a conflict between the need to adapt to the culture and needs of the patient and the work policy and rules of an organization or the professional work ethics of a health practitioner?

It is very important to enable the members of the staff to identify their own personal and professional boundaries in cultural competence and to develop a discussion on multicultural boundaries on the organizational level.

Organizational cultural competence

The subjects and tools discussed so far deal with cultural competence on the individual or staff level. As part of the subjects of the workshop, we recommend a discussion of the subject of

cultural competence in the organization in order to place the workshop in an organizational context. In this part, the participants are not given specific skills, but are rather provided with information on the features of a culturally competent organization in general terms, what steps have been taken in their health organization in this direction and who the person in the organization responsible for carrying them out is. For example:

- Creating a policy that encourages cultural competence in the organization.
- Adapting the organizational environment – how the health organization adapts its directional signage to the main languages used by its clients, places spiritual services at the disposal of health practitioners and patients of different religions, and adapts the physical environment so that patients from different cultures can feel comfortable in it.
- Dealing with relevant organizational issues – an assessment of activity hours, the nature of activity and special services with an eye to the abilities and limitations of the target populations that use the services.
- Connection with the community – an assessment of the existing connections with leading factors within the user community and ways to strengthen that connection.
- The role of the cultural competence coordinator in the organization and his function in cases of a culturally based challenge in clinical care and service.
- Culturally adapted solutions implemented in Israel and abroad can be presented along with an assessment of their relevance to the organization holding the workshop.

A discussion of cultural competence on the organizational level enables staff members to understand the context in which the training is held and to learn about the actions taken so far in the organization. It is important that they get to know the cultural competence coordinator as the one who integrates the activity on the subject and as the person to go to for consultation in specific cases.

Appendix 1: Training in a culturally competent organization

(Chapter 3 of the document: "Integrating Cultural Competence in Health Organizations in Israel: A Concise Guide" published in July 2013)

The desired outcome: The operation of basic and follow-up training that will provide staff with knowledge, awareness and skills to enable them to deliver culturally competent care and service. The cultural competence of an employee or team is an ongoing and continual process and cannot be reduced to a one-time lecture. The Israeli Director-General's directive from 2011 recommends training all the organization's employees, especially care providers, in courses dealing with cultural appropriateness. The directive does not go into the details or length of the desired training, but we recommend a full-day basic workshop followed by a number of follow-up in-service training sessions throughout the year.

Recommended initial steps:

- Hold a "first glance" workshop on the subject for the management, in order to create a buzz that will trigger the process, on behalf of the management. We recommend holding this workshop at the beginning of the organization's adaptation process in order to enlist the management in promoting it. An initial workshop that links the elimination of health inequities with cultural competence can be held to discuss the legal, organizational and economic implications that may be required for the change, and to outline steps for the continued activities in the organization. It is recommended that at the end of this kind of introductory workshop, the management of the organization release an announcement to its employees declaring its commitment to the cultural-competence process.
- Articulating the rationale of the trainings: what will the organization save/prevent, and how it will benefit as a result of the CC training; what is the training's added value for the employees.
- Incorporate training sessions into the organization's annual work plan.
- Set the most effective training frameworks within the organization, in cooperation with the training unit/department. There are various models available for the basic training sessions and courses, for example: an entire day, two half-days, or a few short meetings. This last model is more suitable for hospitals, for example, that cannot release staff members from the various departments for more than a few hours at a time. It is, however, important to hold all the parts of the training within a reasonable period of time (no more than four months) in order to assure continuity of learning and integration.
- Determine criteria for the makeup of the participants in each workshop (by organic teams? based on a professional cross section?). We recommend interactive learning, which is effective in groups of 20 participants.

- Decide on the content – The current approach is that the basic training does not focus on specific population groups, but rather on providing the knowledge, awareness and tools to deal with diverse populations. See possible training subjects later on in this chapter.
- Decide who will deliver the training – The training can be carried out by an outside entity (which will make the necessary adjustments of the core issues to the relevant organization), or by a trained employees from within the organization.

Recommended follow-up activities:

- Adapt the training to the various sectors (e.g. medical, paramedical, administrative). At the conclusion of the process, all the employees will undergo the training, including those who do not have day-to-day contact with patients. Our working assumption is that training on the core issues of cultural competence is relevant for all the organization's employees and volunteers, including those who do not have direct contact with the organization's clients. Hence, a cultural competence approach will be assimilated throughout the entire organization.
- The basic training in cultural competence must be at least eight hours long. Our experience shows that eight hours is the minimal period to receive basic tools for cultural competence. The basic training provides general tools to increase sensitivity to the intercultural differences between the patient and the provider – regarding forms of communication, core values and health perceptions, as well as ways to create an effective patient-provider dialogue, the effective use of a language and cultural mediator and how to deal with social and political tensions within the health organization. The first four subjects are similar to those found in other training courses throughout the world. The fifth is especially relevant for Israeli society, and is often ignored or neglected, despite its extensive impact on service and training.

Recommended maintenance activities

- Set up follow-up in-service training and frameworks for further training (e.g. study days, case studies, participation in staff meetings). At the in-service training sessions, the knowledge regarding specific populations, health and illness perceptions in a cultural context and the discussion of test cases that occurred in the organization can be broadened.
- Set up a mechanism for feedback and drawing conclusions from the training sessions.
- Assess the link between the training and improved treatment.

Appendix 2: A model for the improving the quality of intercultural dialogue

The following model was developed by the Jerusalem Intercultural Center and is based on accepted models in the world for improving the quality of the dialogue with a client coming from a different culture from that of the organization and/or service provider. This should not be viewed as a rigid structure, but rather as a reference point that can change in accordance with the situation and the interpersonal diversity in the clinical encounter.

1. **Understanding the way in which the client understands the subject under discussion (problem, opportunity to act, etc.)** – It is important to start by listening to the narrative, position and perspectives of the other party in the context of a description of the existing situation and of the gap between the existing and desirable situations. Sometimes, health practitioners think they don't need this part of the process because they possess a good understanding of the subject, and consequently, don't need to hear the other side. There may also be a concern that the more the other side speaks, the more invested they become in their current position. In fact, however, a patient finds it difficult to listen unless he is listened to and shown that there is some understanding of his position too (understanding of course does not necessarily imply agreement). The more the health practitioner gives the other party a chance to express himself, and if the health practitioner makes a genuine effort to try to understand his perspective, the patient (or the person accompanying him) will be more open to listening to what the health practitioner has to say too. Moreover, the information that can be elicited from this kind of exchange about the other's side's perceptions is important and can help the health practitioner explain his own approach, while mediating and using the perceptions, concepts and jargon of the other side, as far as is possible.

   To better understand the client's attitude open questions are usually best. Such questions help when there is an intercultural gap that makes it difficult for the client to hold the discussion in a manner suited to the needs of the accepted conversation in his culture. Even if it appears at first that his answers do not directly address the questions, we should bear in mind that this is apparently the best way for the client to explain himself.
   Examples of questions that will help to better learn about and understand the other side: What do you think caused the problem or caused the issue to be raised? Why did the problem begin when it did? Why is there an opportunity now? What causes the problem? What does this opportunity offer us? How does it impact (us)? How serious is the problem? Is it temporary or long term? What else happens as a result of this problem? What do you most fear in connection with this problem?[6]

[6] Some of the questions come from the Patient's Explanatory Model as formulated by Kleinman, Eisenberg and Good, 1978.

Of course, these are just examples of questions and the way they should be worded requires cultural sensitivity. The questions here relate to a problem that requires a solution, an opportunity that should be exploited or an issue that is not necessarily a medical "problem" or directly related to the health organization.

2. **Clarifying the way in which the health practitioner views the subject for discussion** – Now the health practitioner can clarify his perception, while making use of what he has heard.

3. **Recognizing the similarities and differences between the different explanations** – It is very important to define the agreements and gaps in understanding the reality and the various issues related to it. Interpersonal and intercultural sensitivity is a must in order to present the similarities and differences between the different "explanatory models." Sometimes, the gaps may be only implied, but it is important not to hide them. The more similarity there is between the two sides, the more those similarities should be emphasized as a basis for further interaction. Of course, it is easier to arrive at a treatment covenant if there is greater agreement between the sides, but in most cases, it is not a must. Bear in mind that health practitioners require consent regarding treatment guidelines – agreement on perceptions, albeit helpful, is not a prerequisite.

4. **A proposal by the health practitioner for action guidelines** – Professionals or service providers need to be the ones proposing clinical-care guidelines for the future in such a way as to take into consideration all the issues that have been raised thus far. The health practitioner's proposals should be a reference point for agreement, opposition or an alternative proposal. In certain cases, it may be appropriate to begin the other party's proposals (in which case, stage 5 would be carried out before stage 4) in order to increase the patient's sense of responsibility for finding a solution. This is definitely possible and is certainly legitimate. Nevertheless, without a concrete proposal from the patient on the table, the discussion may turn out to be pointless and futile, a needless digression from the path to finding a solution.

5. **Relating to the health practitioner's and others' proposals** – It is easier to manage the meeting if after this entire process, the patient agrees to everything that has been proposed to him. This situation can definitely occur if the health practitioner makes a real effort to understand the patient and address his situation in such a way that shows that he indeed understands the problem. Nevertheless, often disagreements remain regarding how to proceed. Is important to fully understand the way the patient relates to the health practitioner's proposal as well as to the other proposed alternatives.

6. **Negotiating and dialogue** – When there is a disagreement between the sides, health practitioners' intuition tells them to expound and add further explanations. It is apparently much more effective to ask clarifying questions that help the other side to assume part of

the responsibility for the solution taking shape and all that it implies. It is very easy to oppose the solution and suggest unrealistic alternatives – but the more the questions clarify, the better the sides will understand what does and does not work. Often, the health practitioner may discover that the knowledge, skill and wisdom of the person sitting across from him can prevent an action that may turn out to be mistaken. That is why it is recommended that the health practitioner not try to "convince," but rather that he try to continue looking for an optimal solution.

7. Here too, questions that help to better understand the position of the other person are mostly open questions that help the client to convey messages as well as overt and implied hits in his speech in accordance with his culture. For example: What did you do to deal with the problem? What type of solution/treatment do you think might help? What do you hope to get from it? When there's a problem, to whom do you usually go for help? Who would you like to see being involved in solving the problem? Is there anything that might clash with my recommendations for a solution? And if so, what do you suggest doing? Do you feel uncomfortable or unsure about the proposed solution?
8. Like in the previous case, these are only examples that need to be adapted to the relevant subject and culture.
9. **Decision** – It is important to make sure that the agreements arrived at are not ambiguous, and consequently, it is a good idea to document them in a way that is clearly understood by both sides. All too often, a meeting of this kind concludes with a feeling that an agreement has been reached, and immediately afterwards it turns out that each of the sides understood something different. That is why this is such an important stage. In some cases, there may be different versions of the decision – adapted to different cultures (from the perspective of language, jargon, etc.). In those cases, it is important to make sure that the actual action plan is identical in all versions. It is also important to ascertain what mechanisms will be used to ensure that the decision is indeed implemented and that monitors its progress. All too often, the parties don't feel committed to uphold what they have agreed to. It goes without saying, the discussion of the monitoring mechanism for implementation, which could imply a sense of distrust between the sides, requires a great deal of cultural sensitivity.

Appendix 3: Examples of cultural dimensions

These are a number of examples of cultural dimensions, in which contradictory traits can be found on either pole of the axis. Different cultures are located at different points on the axis in order to describe where they are relative to one another in regard to the values under discussion. Of course, every individual is the product of a number of different cultures, so that a person's location on the axis is affected by numerous factors.

- Direct speech ↔ indirect speech
- Border crossings ↔ respect for borders
- Challenging authority ↔ respect for authority
- Fatalism ↔ control
- Risk avoidance ↔ risk taking
- Individualism ↔ collectivism
- Pragmatism ↔ principle based approach
- Aspiring log term success ↔ aspiring for immediate success
- Excellence ↔ care for the weak/other

Appendix 4: Sample rules for communicating through a (professional and nonprofessional) language mediator

- Maintain eye contact with the patient; let the interpreter see you both. It is preferable to hold the conversation sitting down in a quiet location. If you are seated, the interpreter should also be seated.
- Let the interpreter introduce himself and his role in the conversation – if he is a staff member, he should note that he is currently functioning in his role as an interpreter. If the interpreter is a professional, he should state his name, role and the rules of the interpreted meeting.
- Brief the interpreter on the objective of the meeting – a few words about the meeting will contribute to the quality of the interpreting. If the interpreter is not a staff member in the hospital, emphasize the importance of maintaining confidentiality.
- Speak in short sentences at a reasonable rate and allow the interpreter to interpret every two to three sentences.
- Try not to use difficult medical jargon, especially when using an interpreter who is not an experienced professional.
- Speak directly to the patient rather than to the interpreter – don't say: "Ask the patient where it hurts." Instead, directly address the patient and ask: "Where does it hurt you." Ask the interpreter to interpret the same way.
- Make sure the patient understands: Ask the interpreter to tell the patient to explain the message in his own words and ask questions to make sure he understands.
- Don't be afraid to stop the conversation, to ask questions to clarify points or to reiterate the rules of an interpreted conversation.
- When using an interpreter over the phone, remember that the interpreter cannot see what is happening in the room and try to give the interpreter any visual cues that may be necessary. Try not to speak at the same time since it is much harder for a telephone interpreter to manage the conversation when he is not present in the room.

Appendix 5: Training films on cultural competence in Israel

As a result of cooperation between the Jerusalem Intercultural Center and researchers and lecturers at Bar-Ilan University, four training films dealing with cultural competence in the field of health and welfare were made.

The films, which are deeply rooted in Israel's reality, describe clinical encounters between health-service providers and a patient and present the culturally dependent gaps and barriers between them. The films provide a setting for an active discussion, which is a crucial part of the integration of the principles of cultural competence and the inculcation of practical tools in this area.

The four films are based on true cases.

The film "**Knows What She Wants**" describes a meeting between a patient from the Ethiopian community, who wishes to receive the Depo Provera contraceptive shot to prevent pregnancy, and her GP, who tries to convince her to use other methods of contraception.

The film "**Checkup**" presents a meeting between a Russian-speaking patient who comes for a regular diabetes follow-up visit accompanied by her Hebrew-speaking teenage daughter, and a Hebrew-speaking nurse.

In the film "**Our Decision**" a Muslim Arab woman is hospitalized after doctors discover a cancerous tumor of the thyroid gland; she is torn between the recommendation made by the doctor (also a Muslim Arab), who believes that surgery to remove the tumor must be performed

immediately, and the position taken by her husband, who insists that she should be released immediately from hospital.

The film "**For the Children**" takes place in a welfare office, the setting for a highly charged meeting between a social worker and an ultra-Orthodox couple in Jerusalem regarding the temporarily removal and transfer of the children to the home of a relative.

All the films are subtitled in Hebrew, Arabic and English. Each film focuses on a different cultural group, but each can contribute to a discussion of the principal core subjects in the field of cultural competence. The films are part of a comprehensive training project in cultural competence. Instructors trained by the JICC can make use of these films when providing training in their health organizations. To that end, the JICC proposes that health organizations hold training courses for facilitators in the field of cultural competence, which will enable the organizations to hold internal training in this field and adapt the content of the workshops to the needs of the specific health organization.