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Cross-Cultural Competence in Health Care: Development and Evaluation of a Multiprofessional Training

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Abstract: Culturally and linguistically diverse patients face an increased risk of developing mental health disorders due to pre- and post-migration stress and are more likely to experience unequal medical treatment and higher rates of misdiagnosis, contributing to a persistent treatment gap. Cultural competence training has been shown to improve the quality of care for these patient populations. This study aimed to develop and implement a multiprofessional cross-cultural training program within a health care setting. Developed in collaboration with subject matter experts, the training comprised seven modules and was evaluated using a mixed methods approach. A mixed methods approach was used for the evaluation. Seventeen professionals from 11 different professional groups took part in the training. Pre and post-evaluations showed significant increases in participants' cross-cultural skills and knowledge. The qualitative evaluation showed that, according to their assessment, participants benefited from the interdisciplinary collaboration. The desire for sustainable support beyond the training was expressed. The results indicate that multiprofessional cross-cultural training is efficient in the short term for clinical workforces who are interested in the subject. To transfer the training content sustainably into the hospital work setting and to address a larger target group, we have developed a framework for cultural brokers consisting of a multi-stage training and mentoring program for employees.

Keywords: Cross-Cultural Broker, Cross-Cultural Competence, Multiprofessional Training, Health Care, Cross-Cultural Mentoring

1. Introduction

The increasing scale of global migration has significantly transformed the demographic landscape of health care systems worldwide. This shift is marked not only by a growing number of patients from culturally and linguistically diverse (CALD) backgrounds but also by an increasingly heterogeneous clinical workforce (Destatis, 2023; Habermann & Stagge, 2015). While diversity enriches patient care, it also presents complex communication and interaction challenges in clinical settings. Patients from ethnic minority groups often experience disparities in health care, including unequal treatment, diagnostic errors, and reduced access to appropriate services. These inequalities are frequently attributed to language barriers (Lebano et al., 2020), culturally divergent health beliefs (Byrow, Pajak, Specker, & Nickerson, 2020), conflicting value systems (Dumke, Wilker, Hecker, & Neuner, 2024; Mösko, Gil-Martinez &, Schulz, 2013), and implicit bias or time constraints among health care professionals (Salam, Odenigbo, Newbold, Wanoush, & Schwartz, 2022; Karger, Lindtner-Rudolph, Mroczynski, Ziem, & Joksimovic, 2017).

A substantial body of literature confirms that culturally competent care can mitigate such disparities, leading to improved health equity, higher patient satisfaction, and better adherence to medical advice (Cheng, Emmanuel, Levy, & Jenkins, 2015; Curtis et al., 2019; Drewniak, Krones, & Wild, 2017; Horky, Andreola, Black, & Lossius, 2017). In response, cross-cultural training has become a widely adopted intervention across health systems. These programs aim to enhance health professionals' cultural awareness, knowledge, and communication skills, and have demonstrated positive effects on individual competencies (Beck et al., 2024; Jongen, McCalman, & Bainbridge, 2018). Although evidence linking these trainings to patient-level outcomes remains limited, preliminary studies suggest promising results (Chae, Kim, Kim, Lee, & Park, 2020; Horvat, Horey, Romios, & Kis-Rigo, 2014). Additionally, higher cultural competence has been associated with reduced malpractice risk (Betancourt, 2006) and lower treatment costs due to improved communication and fewer misunderstandings (Schiaffino et al., 2020).

Despite these advancements, most cross-cultural training programs are profession-specific, designed primarily for doctors, nurses, or psychologists, and fail

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to reflect the inherently interdisciplinary nature of patient care in hospital environments. In practice, quality care depends on the coordinated interaction of multiple professionals, including not only clinical staff but also support roles such as cleaning personnel, interpreters, and administrative teams. These groups often have direct and meaningful contact with patients, yet are typically excluded from formal training efforts. This fragmentation limits the effectiveness of cultural competence initiatives and overlooks the broader organizational dimensions of intercultural communication in health care.

To address this critical gap, the present study develops, implements, and evaluates a multiprofessional cross-cultural training program aimed at a wide range of hospital staff engaged in direct patient interaction. The training incorporates evidence-based content drawn from existing cultural competence frameworks and adapts it to the needs of an interdisciplinary audience. Through a mixed-methods approach combining quantitative and qualitative data, the study assesses both the short-term impact of the training and the feasibility of integrating such programs into routine hospital operations. By targeting the often-overlooked non-clinical workforce alongside health professionals, this study offers a novel and inclusive model for institutional cultural competence development. To our knowledge, it is one of the first interventions to promote intercultural understanding across such a broad spectrum of hospital roles in a single unified training format.

2. Literature Review

Betancourt (2003) identified three distinct conceptual approaches to cross-cultural education: (A) the awareness/sensitivity approach, (B) the multicultural/categorical approach, and (C) the cross-cultural approach. Approach A emphasizes the development of attitudes such as curiosity, respect, and empathy among health care providers. It encourages participants to recognize how socio-cultural factors influence health beliefs and behaviors, engage in cultural self-reflection, and examine their own stereotypes and implicit biases.

Approach B focuses on the transmission of cultural knowledge. While this method can be beneficial in certain contexts—such as familiarizing professionals with the dominant culture of their practice environment—it carries the risk of reinforcing stereotypes or oversimplifying complex cultural identities if not handled with care. Finally, Approach C emphasizes the development of cross-cultural skills and practical tools, such as effective communication techniques and participatory decision-making strategies. Although these approaches are presented as distinct, Betancourt (2003) emphasizes that effective cross-cultural training often integrates elements from all three to comprehensively strengthen participants' cultural competence.

Numerous studies have evaluated the effectiveness of various cross-cultural training designs for health professionals and medical students. These include multi-method curricula (Sarvarizadeh, Miri, Darban, & Farokhzadian, 2024), web-based cultural competence courses (Rahimi, Khodabandeh Shahraki, Fatehi, & Farikhzadian, 2023), community immersion programs (Pak-Gorstein et al., 2018), and interactive workshops (Kelley, Haas, Felber, Tracis, & Davis, 2019)—all of which have been shown to improve cultural competence in different professional settings. However, such trainings are typically tailored to individual professional groups—physicians (Corral, Johnson, Shelton, & Glass, 2017), nurses (Gradellini et al., 2021; Osmancevic, Steiner, Großschädl, Lohrmann, & Schoberer, 2025), or psychotherapists (Benuto, Casas, & O'Donohue, 2018)—and rarely reflect the interprofessional nature of clinical practice. Yet, in everyday hospital care, collaboration among diverse professional roles is essential.

Although a few initial efforts have been made to implement multiprofessional cross-cultural training in hospital settings (e.g., Dimitrova, Siebert, Borde, & Sehouli, 2022), systematic evaluations of their effectiveness and broader institutional integration remain limited. This highlights a significant gap in the current literature and underscores the need for inclusive training programs that address the diverse roles involved in patient care.

The *Healthy Diversity* project—Curriculum to Enhance Cultural Competence in Patient Care—was developed in response to this gap. Drawing on Betancourt's integrative framework and informed by previous national initiatives on transcultural training (von Lersner, Baschin, Wormeck, & Mösko, 2016; Mews et al., 2018), the program combined all three educational approaches to address attitudes, knowledge, and skills comprehensively. It was specifically designed as a multiprofessional, interdisciplinary training involving a wide spectrum of hospital staff, including medical-technical assistants, nurses, physicians, and non-clinical personnel such as service and security staff. The program not only aimed to enhance individual cultural competence but also to foster cross-functional collaboration within increasingly diverse health care teams. Based on the positive evaluation outcomes, a follow-up initiative was launched to establish a sustainable training and mentoring system through the development of hospital-based cross-cultural brokers..

3. Methodology

3.1. Training development

To develop an application-oriented curriculum for a cross-cultural training program tailored to a multiprofessional target group, we first conducted a review of existing literature on evaluated training models.

The developmental process involved three key stakeholder groups, firstly an international advisory board comprising four experts in adult education, cross-cultural medicine, migrant organizations, and the Hamburg

Medical Chamber. Secondly, a stakeholder group of 13 representatives from various hospital-based professions involved in patient care, including emergency room staff, medical laboratory assistants, nurses, patient hotline operators, physical therapists, physicians, physiotherapists, service assistants, cleaners, social workers, spiritual care providers, and supply-chain assistants. Thirdly, a trainer group consisting of six academics with interdisciplinary backgrounds in Clinical Interpreting, Cultural Coaching, Modern Philology, Health Care Chaplaincy, Islamic Studies, Law, and Psychology.

Over the course of four structured workshops, the participants identified key cross-cultural challenges commonly encountered in day-to-day clinical practice. Based on these insights, the training concept was iteratively refined to ensure practical relevance. A comprehensive list of learning objectives was subsequently compiled and categorized into three domains: attitudes, knowledge, and skills (see Online Resource 1). These objectives served as the foundation for developing the curriculum and instructional materials for each training session.

3.2. Training Implementation

The resulting pilot program, titled *Healthy Diversity: Cultural Competencies in Everyday Hospital Routines*, consisted of four full training days (7.5 hours each), covering a total of seven modules (see Table 1). The sessions were facilitated primarily in tandem by the six academics mentioned earlier, each of whom brought both academic expertise and practical familiarity with clinical settings. A variety of didactic methods were employed, including case reports, role-plays, mindfulness-based exercises, and small-group work, to ensure the training was both interactive and practice-oriented.

The training was open to all hospital employees with direct patient contact. At the time of implementation, this included more than 6,000 individuals such as physicians, nurses, therapists, and support staff. The program was held on-site at the hospital in June 2018, with daily sessions running from 9:00 a.m. to 4:30 p.m. Participation was voluntary and free of charge. Upon successful completion of all training modules, participants received the certificate *Intercultural Competencies in Everyday Hospital Life*, as well as continuing education credits from the state's Medical Association and the Registry of Professional Nurses.

To promote enrollment, the training was advertised through several internal channels, including the hospital's newsletter, the website of its Academy for Education and Career, departmental meetings, mailing lists for various professional groups, and printed flyers.

The training was part of the broader initiative *Healthy Diversity – Curriculum for Strengthening Intercultural Competencies in Patient Care*, funded by the Robert Bosch Stiftung and additionally supported by the hospital's Academy for Education and Career.

Table 1: Multiprofessional Cross-Cultural Training in Health Care: Module, Scope, and Content

Module	Scope (in hrs.)	Content (Main Topics)	Description
Cross-cultural communication – basics, challenges, tools	6	Culture & cultural imprint	• Introducing basic terminology: *culture, cultural competence, cultural awareness, cultural sensitivity, cultural imprint, environmental conditioning* • Introducing concepts: *action knowledge* and *cultural standards* • *Stereotypes*: functions (categorization, distinction, identity building, orientation. i. a.), reflective approach
		Communication and perception	• *Intercultural (mis-)communication* in hospital context: divergent social role conceptions, divergent concepts of illness and healing, divergent symptom patterns • Training to deal with cross-cultural challenges/conflicts: ambiguity tolerance, communication strategies, changing perspectives, perception training • Clinical case management
Cultural aspects in religion and spirituality	6	Religion as resource	• Introducing basic terminology: *religion, spirituality, religious traditions and symbols* • Self-reflecting one's own spirituality and impact on one's work; reflecting the region's religious diversity • Rising emotions facing death and dying
		Understanding illness and death in the context of religions (focus on Christianity and Islam)	• *Religious traditions* (esp. Christian and Muslim) concerning illness, dying and death • Professional approach to death and dying in a clinical setting • Clinical case management

Module	Scope (in hrs.)	Content (Main Topics)	Description
Legal aspects in health care services for asylum seekers and undocumented patients	3.75	Legal aspects in health care services for asylum seekers	• Who arrives and *who is allowed to stay*? • Course of *asylum procedure* • In case of rejected asylum application: course of *deportation* • Aspects and risks of living illegally • *Entitlements to (medical) health care* for undocumented patients
		Legal aspects in health care services for undocumented patients	• Difficulties when revealing personal information • Effects on patients' (mental-) health • Clinical case management
Language barriers and interpreting at the hospital	2.25	Language barriers	• Introducing *models of language and communication* • *Language and communication barriers* in hospital setting and how to handle them – exchange of personal experiences • Causes of *cross-cultural misunderstandings*
		Interpreting	• Medical interpreting in Germany – summary of the current state • *Differing qualification levels* (professional vs. ad-hoc interpreting) – consequences for interpreted communication at the hospital • *Guidelines (ethical, legal) for interpreting* • Characteristics of *triadic interaction*; interpreter-assisted conversations – preparation, conduction, follow-up; *techniques* of interpreting • Clinical case management • Role-plays
Migration, culture and health	2.25	History of migration in Germany since 1950s	• Introducing basic terminology: *migration background* • Introducing *Germany's recent migration history* (since 1950s) and the impact of a failed immigration policy in patient and health care • Deepening *theories of culture and identity* • Identity building-processes and identity conflicts linked with migration history
		Current challenges in patient care	• Migrant patients' anticipations and worries concerning medical treatment, disparities and barriers in medical treatment
Discrimination and group-specific misanthropy	1.5	Discrimination and group-specific misanthropy	• Introducing basic terminology: *discrimination* (different levels, forms and mechanisms) • Training: *experiencing* and/or *observing discrimination*; *responding to discrimination* • Discrimination in the hospital setting– information on guidelines, policies and guidance
Clinical case management	2.25	Clinical case management	• Self-reflection and practical application • Clinical case management • Role-plays

Source: By the author

3.3. Training Evaluation

The Cross-Cultural Competence Instrument for Healthcare Professionals (CCCHP) was developed by Bernhard et al. (2015 as a multidimensional self-report tool to assess the cultural competence of various health care professional groups. The development process involved a narrative review of existing literature to identify conceptual frameworks and relevant instruments, followed by an evaluation of their applicability to the German health care context. In addition, expert surveys and interviews were conducted with physicians, nurses, psychotherapists, and other practitioners to explore their understanding of cultural competence in clinical practice.

Based on a qualitative content analysis of the findings, the developers proposed a five-dimensional model that became the basis for the CCCHP questionnaire. These dimensions include cross-cultural motivation and curiosity, cross-cultural attitudes, cross-cultural skills, cross-cultural knowledge and awareness, and cross-cultural emotions and empathy. Sample items include statements such as: "Encounters with people from other cultural backgrounds help me to perceive my own culture more accurately" (motivation/curiosity), "In public and in institutions, too much consideration is given to the special wishes of migrants" (attitudes), "I address the patient's values in relation to family, religion, etc., if these seem relevant to the treatment" (skills), "Concepts of disease of patients with a migration background are not relevant for the success of my treatment" (knowledge/awareness), and "I get impatient when I can't make myself understood while communicating with patients" (emotions/empathy).

The final instrument comprises 32 items rated on a 5-point Likert scale, ranging from 1 ("absolutely true") to 5 ("not true at all"), with an additional sixth option for "not applicable." Internal consistency for the overall scale has been demonstrated to be high (Cronbach's alpha = .87), supporting its reliability in evaluating health professionals' cultural competence across multiple domains.

3.3.1. Teaching Evaluation Instrument

At the end of each training day, participants completed a brief questionnaire based on established evaluation tools (e.g., Mews et al., 2018). Using a 6-point Likert scale (1 = "fully agree", 6 = "fully disagree"), they rated the training module's content, structure, practical relevance, and overall satisfaction. Participants also assessed their perceived learning gains and were invited to provide suggestions for improvement. An example of the evaluation form is available in Online Resource 2.

3.4. Data Analyses

Quantitative data were analyzed using IBM SPSS Statistics 27. Descriptive statistics were calculated, including absolute frequencies and percentages for categorical variables, and means and standard deviations for metric variables. To evaluate the effectiveness of the training, paired sample t-tests and sign tests (used when normal distribution was not assumed) were conducted, comparing participants' pre- and post-training self-ratings of cultural competence, knowledge, and skills. The significance threshold was set at $\alpha < .05$, and Bonferroni-Holm correction was applied where appropriate. Sensitivity analyses were conducted using G*Power (Faul, Erdfelder, Buchner, & Lang, 2009) to determine statistical power.

Qualitative data were analyzed using qualitative content analysis in accordance with the methodology proposed by Mayring (2010) and Mayring and Fenzl (2014), enabling systematic coding and thematic evaluation of participants' open-ended responses and group discussion feedback.

4. Results

4.1. Sociodemographics

Relevant sample characteristics are presented in Table 2. All 17 participants reported regular contact, at least once a month, with individuals from a migration background, both professionally and privately. Six participants had previously attended intercultural training sessions.

Table 2: Sociodemographic Data of the Training Participants (N = 17)

Categories	N (%)
Age	
21 - 30 years	4 (23.5%)
31 - 40 years	4 (23.5%)
41 - 50 years	4 (23.5%)
51 - 60 years	5 (29.4%)
Gender	
Male	1 (7.7%)
Female	12 (92.3%)
Not indicated	*4 (18.2%)*
Migration background	
Yes	3 (17.6%)
No	14 (82.4%)
Lifetime in Germany	
Since birth	17 (100%)
Mother tongue (multiple answers possible)	
German	17 (100%)
Other	1 (5.9%)
Profession	
Art Therapist	1 (5.9%)
Cleaning Staff	1 (5.9%)
Educator	1 (5.9%)
Human Resource Manager	1 (5.9%)
Medical Student	2 (11.8%)
Nurse	5 (29.4%)
Occupational Therapist	1 (5.9%)
Physical Therapist	2 (11.8%)
Radiologic Technologist	1 (5.9%)
Security	1 (5.9%)
Service Assistant	1 (5.9%)
Duration of employment at the hospital	
Range	0 - 31 years; *M* = 9.8 years

Source: Calculated by the author

4.2. Training results

Participants' cultural competence, measured using the CCCHP at three time points (pre-treatment, post-treatment, and four-month follow-up), showed a descriptive improvement in three of the five measured dimensions: cross-cultural attitudes, cross-cultural skills, and cross-cultural knowledge/awareness. However, paired sample t-tests and sign tests comparing pre- and post-training scores did not reveal statistically significant changes in any of the five dimensions (see Table 3).

Table 3: Quantitative Evaluation of Participants' Cultural Competence Measured by the CCCHP

	PRE *M (SD)*	POST *M (SD)*	*t-value*	*df*	*p-value*	FOLLOW-UP *M (SD)*
Cross-Cultural Skills	1.9 (0.6)	1.8 (0.5)	1.64	13	.062	1.8 (0.4)
Cross-Cultural Emotions/Empathy	2.1 (0.6)	2.3 (0.5)	-1.09	13	.147	2.1 (0.5)
Cross-Cultural Attitudes	2.7 (0.5)	2.5 (0.6)	1.74	13	.053	2.4 (0.7)
Cross-Cultural Motivation/Curiosity	1.4 (0.3)	1.4 (0.4)	1.44		.146	1.4 (0.4)
Cross-Cultural Knowledge/Awareness	2.0 (0.7)	1.8 (0.5)	0.95		.344	1.8 (0.7)

Note: Participants' (N = 14) cultural competence before (PRE) and after (POST) the training, with statistical results from paired sample t-tests and sign tests. Follow-up values (N = 11) are presented descriptively. Lower values indicate higher competence on a 5-point Likert scale (1 = "absolutely true"; 5 = "not true at all"). Source: Calculated by the author

Table 4: Quantitative Evaluation of Participants' Cross-Cultural Knowledge and Skills (Single-Item Evaluation)

	Pre *M (SD)*	Post *M (SD)*	*z'-value*	*p-value*	Follow-Up *M (SD)*
Knowledge about culture and cross-cultural communication	2.6 (0.9)	1.9 (0.7)	-2.00	.039	2.6 (0.9)
Ability to understand cross-cultural problems	2.4 (0.9)	1.9 (0.5)	-0.67	.508	2.3 (0.5)
Ability to meet cross-cultural challenges	2.7 (0.9)	2.1 (0.8)	-2.67	.004	2.6 (0.5)
Awareness of one's own stereotypes	2.3 (0.9)	1.8 (0.7)	-1.77	.070	1.6 (0.7)
Ability to use the patient's religiousness as a resource	3.1 (1.3)	2.2 (1.0)	-2.27	.016	2.1 (0.8)
Knowledge about legal aspects in health care services	4.0 (1.0)	2.1 (0.5)	-3.47	<.001***	3.1 (0.7)
Ability to conduct interpreted conversations	3.1 (1.5)	2.5 (1.7)	-2.00	.039	2.0 (0.8)
Knowledge about migration and migration background	2.9 (1.1)	2.2 (0.9)	-1.77	.070	2.5 (0.9)
Ability to react appropriately to experienced or observed discrimination	2.4 (0.9)	1.8 (0.6)	-2.85	.002	2.3 (0.7)

**Note: Participants' (N = 14) knowledge and skills before (PRE) and after (POST) the training with statistical results from sign tests. Follow-up values (N = 11) are described descriptively. Lower scores indicate higher competence on a 6-point Likert scale (1 = "very good"; 6 = "insufficient"). **p < .001 after Bonferroni-Holm correction.* Source: Calculated by the author

Despite the lack of significance in the overall CCCHP dimensions, participants' cross-cultural knowledge and skills, measured by nine single items, showed statistically significant improvements in three areas from pre- to post-training, after applying Bonferroni-Holm correction (Table 4). Sensitivity analyses indicated a minimum detectable effect size of dZ = .92 (one-tailed, α = .05, power = 0.95, n = 14), representing a large effect according to Cohen (1988). At the four-month follow-up, participants continued to report descriptively higher knowledge and skills in eight out of nine dimensions, with three of these scores even higher than at post-treatment. Due to the small number of participants at follow-up (N = 11), additional t-tests or sign tests were not conducted.

4.3. Quantitative Training Evaluation

Overall, participants expressed high levels of satisfaction with the training program (M = 1.2, SD = 0.4; N = 14). The majority (N = 10) considered the duration of the training to be appropriate, while three participants preferred a longer version and one preferred a shorter format. All participants found the group size to be suitable.

Each training module was also evaluated individually. Mean satisfaction scores ranged from M = 1.1 (SD = 0.4) for Module 3 (legal aspects in cross-cultural care) to M = 1.8 (SD = 0.9) for Module 4 (language barriers and interpreting), indicating consistently positive feedback across modules.

4.4. Qualitative Training Evaluation

After each training day, participants completed evaluation questionnaires (see Table 5) and participated in brief group feedback sessions. They provided overwhelmingly positive assessments of both the training content and its delivery. Methodologically, the diverse instructional approaches—especially case studies, role plays, and other practical exercises—were particularly well received. Participants also appreciated the tandem-teaching format and the integration of theoretical and practical elements, which they described as well-balanced.

The group dynamics were described as open, respectful, and constructive, with participants valuing the opportunity to engage across professional boundaries. Many reported that the training would positively influence their future work routines. One participant stated,

> *"I appreciated the interesting and respectful communication within the team; great case studies, easy to put into practice, great teachers!"*

Regarding content, participants noted a deeper understanding of behaviors previously seen as unfamiliar or unsettling, as well as a strengthened awareness of their own cultural biases. The training fostered self-reflection and increased intrinsic motivation to consider cultural aspects in clinical practice. Another participant remarked,

> *"I'm glad for the many occasions for self-reflection and self-improvement, and I liked the big variety of discussion material."*

In addition, several participants reported a greater appreciation for the challenges faced by migrant patients and an increased willingness to respond empathetically to intercultural misunderstandings. They also noted a reduction in their own insecurities when working with diverse populations and felt more confident addressing sensitive situations appropriately.

However, participants also offered constructive criticism. Some felt the time allocated for the training was too limited, expressing a desire for more time to deepen their understanding and practice new skills. There was a preference for interactive, participatory sessions over lecture-style presentations. Participants recommended closer alignment with their everyday work realities, suggesting that more time be dedicated to sharing personal experiences and discussing practical applications. While case studies were generally praised, some felt the content was too physician-centered and lacked relevance to other professional roles and the broader hospital setting.

By the end of the program, 16 out of 17 participants expressed interest in attending follow-up modules to consolidate their learning, acquire new skills, and continue their professional development in a supportive environment. One participant commented,

> *"I hope there will be more training, so that other colleagues may attend them."*

Table 5: Participants' Qualitative Evaluation of each Training Day.

Category	Comments by participants (based on teaching evaluation instrument)
Day 1	
General conditions/ atmosphere	• Very pleasant atmosphere
Methodology – positive assessment	• Good combination of theory and practice • Alternating lectures by different lecturers • Methodological heterogeneity: discussions, case studies, images, practical exercises as e.g. role plays
Methodology – suggestions for improvement	• Discussions, case studies and exchange about personal experiences should be given more space
Structural aspects	• More time would be good to explore the topics in more depth • The introductory part (90 minutes) seemed too extensive
Content	• Topics that were highlighted as particularly interesting: Individualism vs. Collectivism, "German" symbols
Day 2	
General conditions/ atmosphere	• The openness and communication among the participants and lecturers was pleasant
Methodology – positive assessment	• Impulse for self-reflection was welcomed: How open am I to religion? • Methodological heterogeneity: small groups work; lecture presented in form of a dialogue; practical case studies (e.g. in dealing with the deceased and their relatives; very easy to put into practice)
Methodology – suggestions for improvement	• Wish for short role plays
Structural aspects	• Amount of time was appropriate and sufficient
Content	• Fears of contact with religious traditions (Islam in particular) were reduced • Feeling encouraged to approach others and to motivate colleagues to do so, as well • Topics were interesting for atheists as well

Category	Comments by participants (based on teaching evaluation instrument)
Day 3	
General conditions/ atmosphere	• Dedicated lecturer
Methodology – positive assessment	• Very well structured and congruent • Exciting case studies
Methodology – suggestions for improvement	• Inviting an opposing party to the lecturer [a lawyer] – e.g.: police officer, foreigners authority employee – to obtain different opinion • The training remained quite theoretical, many frontal lectures; which for more methodological heterogeneity
Structural aspects	• Suggestions for improvement: Splitting the topics of legal aspects and language barriers into two separate days
Content	• The desire for more information was fulfilled • Although there was a lot of input (legal aspects), the lecture was presented very interestingly
Day 4	
Methodology – positive assessment	• Personal examples from participants • Case work, structure and interaction all great!
Methodology – suggestions for improvement	• Preference to work on case studies individually (instead of group work)
Content	• Grateful for the opportunity to reflect on/consider one's own cultural perspective, which enables a gain in understanding of foreign/possibly irritating behaviour • Greater respect for the limits and capabilities of integration

Source: Calculated by the author

4. Discussion

5.1. Achievements and Constraints

As part of this project, a multiprofessional cross-cultural training program was developed, piloted, and evaluated to address the needs of all professional groups involved in direct patient care. The training curriculum was designed through an iterative and collaborative process involving professional experts and academics. This approach ensured the program was tailored to the hospital setting and responsive to the diverse educational backgrounds of the target participants. Previous research has shown that involving target groups in the development of educational interventions enhances their quality and relevance (Brett et al., 2014). In our case, this inclusive process brought attention to issues—such as discrimination against segments of the clinical workforce—that might have otherwise been overlooked if the curriculum had been designed solely from a top-down perspective.

When asked about the skills and knowledge they gained, participants reported increased understanding of behaviors previously perceived as unfamiliar or "foreign," deeper reflection on their own cultural heritage and biases, and reduced insecurities when working with culturally diverse patients. These outcomes align with the training's intended learning objectives (Online Resource 1). While the quantitative pre-post analysis showed descriptive improvements in cross-cultural attitudes, skills, and knowledge/awareness, the changes were not statistically significant. This mirrors findings from other studies where the short duration of training was cited as a possible limitation (Majda, Zalewka-Puchala, Bodys-Cupak, Kurowska, & Barzykowski, 2021). Furthermore, given that many participants may have already possessed a relatively high baseline level of cultural competence—particularly in the motivation/curiosity dimension—the CCCHP may have been subject to ceiling effects, limiting its ability to detect meaningful change. This concern is supported by the original validation study, which reported positively skewed subscale distributions (Bernhard et al., 2015).Sensitivity analysis revealed that a large sample size would have been necessary to detect medium effect sizes reliably. For instance, a sample of at least 45 participants would be required to detect a medium effect with adequate power (Cohen, 1988). Consequently, the small sample size likely reduced the statistical power of our findings. Nevertheless, significant improvements in participants' self-rated ability to meet cross-cultural challenges, knowledge of legal aspects in health care, and capacity to respond appropriately to discrimination are particularly noteworthy. Future studies would benefit from complementing self-assessment tools with external evaluation methods, such as structured field observations, to yield more objective assessments of cultural competence development.

A substantial body of evidence confirms the effectiveness of cultural competence training in improving the knowledge, attitudes, and skills of health professionals (Beck et al., 2024; Chae et al., 2020). However, the vast majority of these studies focus on single professional groups. Our findings suggest that similar positive outcomes may be achievable through multiprofessional interventions, though further research is warranted to validate these preliminary insights.

The limited participation in our study is another important constraint. Only 17 participants enrolled, representing a small fraction of the hospital's total workforce. Several factors may explain this. The training consisted of four full-day sessions, which are difficult to accommodate within rotating shifts. Some participants had to be officially released from work, and two even attended during their personal vacation time. It is plausible

that supervisors were not uniformly supportive of release time, and that only those staff with strong intrinsic motivation participated. The absence of physicians in the training further suggests systemic barriers, such as time constraints during clinical duties. Prior research has shown that physicians—particularly in high-pressure specialties like oncology—may show less interest in cultural competence training than other professional groups (Weber, Sulstarova, & Singy, 2016). To improve participation, institutions should consider offering protected time or designing more flexible training formats, such as modular or online sessions.

The strengths of this study include the preceding needs assessment, the participatory development process, and the inclusion of traditionally overlooked professional groups such as cleaning staff and service assistants. These individuals are frequently in contact with patients and often play informal roles, including ad-hoc interpreting (Jors, Tietgen, Xander, Momm, & Becker, 2017; Vance, Ackerman-Barger, Murray-García. & Cothran, 2022). Many of these staff members themselves have migration backgrounds (Mueller, 2022), further underscoring the importance of equipping them with cultural competence tools.

5.2. Recommendations

A general challenge in providing voluntary training for staff is the lack of participation (Ilvig et al., 2018), as seen in our pilot, in which only 17 out of more than 6,000 staff members attended the voluntary training. Thus, a sustainable goal is to strengthen those staff members who are interested in cultural sensitivity and enable them to become advocates for this topic within their units or departments.

In order to sustainably strengthen intercultural communication within a hospital, it is necessary to view intercultural openness as an organizational development process. Consequently, to empower participants of single cross-cultural training sessions in the long term, a sustainable training concept to become a cultural broker (Figure 1) was developed, following the same procedure as the pilot program described above. The education program for Ethnic Patient Coordinators at Odense University Hospital in Denmark served as a guiding framework (Nielsen, Korsholm, Mottelson, & Sodemann, 2019).

As part of a holistic training initiative for so-called “cultural brokers,” the pilot program will be expanded to include advanced training courses, a peer-group network, and a coordinating and counselling center. These components are intended to support long-term learning outcomes and emphasize the institution's responsibility in promoting intercultural competence.

Such structures have already proven successful in other fields where health care organizations needed to be empowered to manage complex challenges (Sampson, Vickerstaff, Lietz, & Orrell, 2017). Strengthened and sensitized by the pilot training, those interested in becoming cultural brokers will receive several days of further in-depth instruction. This will include, for example, a detailed study of intercultural communication, the relationship between migration, identity, and health, and quality management in intercultural and interprofessional contexts. After training, they will serve as contact persons for colleagues and patients on culturally sensitive issues, functioning in a mentoring role. They may also conduct short internal training sessions (e.g., on cross-cultural awareness) or initiate small projects within their units (e.g., designing a poster on different religions and their impact on health and illness concepts). In this way, they will act as an interface between employees and hospital management.

Cultural brokers will receive monthly supervision and attend additional training sessions (six times per year) to deepen their expertise and receive continuous support. Clinic-wide, they will benefit from peer networks, especially for cross-unit projects. Employees will be released on an hourly basis to accommodate the additional responsibilities involved in their work as cultural brokers. The program will be accessible to all professional groups involved in patient care.

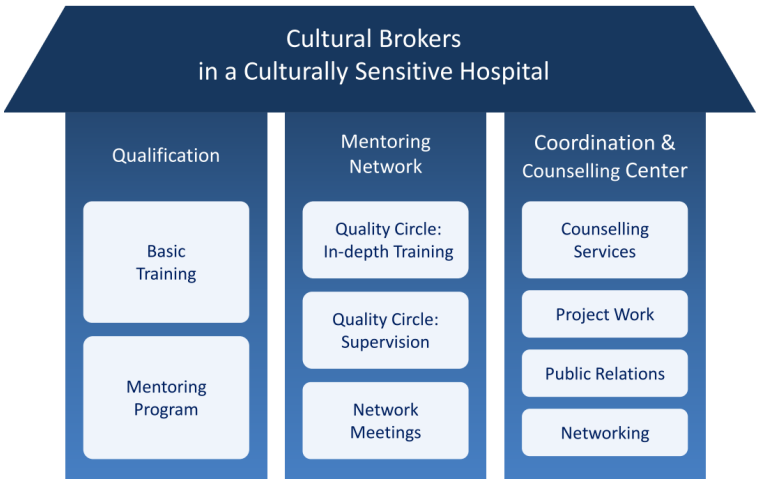

Figure 1: Framework of a Training and Mentoring Program for Cultural Brokers in a Culturally Sensitive Hospital (figure by the author)

To ensure institutional support and alleviate the individual burden of responsibility, a coordination and counselling center will serve as a backup for cultural brokers and a central resource for the clinical workforce. This center will provide guidance and information, organize clinic-wide training days, lectures, and events, and be responsible for documenting critical incidents reported by cultural brokers or other staff members.

Due to the disseminator effect, even employees who face barriers to attending the full multiprofessional training will still have the opportunity to expand their knowledge through the support of cultural brokers. The low-threshold educational role of the cultural broker is expected to contribute to the ongoing empowerment of hospital staff in dealing with discrimination and cross-cultural conflict, ultimately leading to improved care quality (Drewniak et al., 2017).

5. Conclusion

Interdisciplinary teamwork is known to improve patient satisfaction (O'Leary, Sehgal, Terell, Williams, & High Performance Teams and the Hospital of the Future Project Team, 2012), and organizational cultural competence has been linked to better teamwork climate (Kumra et al., 2020). Therefore, offering cultural competence training to multiprofessional teams is not only equitable but essential for improving the overall quality of care.

After participation in the training, participants showed significant increases in their cross-cultural competencies. Furthermore, we assume that developing and implementing a sustainable mentoring program for cultural brokers will contribute to the long-term establishment of a culturally competent hospital. In the short term, we foresee three primary advantages: (1) a culturally competent workforce will improve patient satisfaction and reduce clinical risk (Govere & Govere, 2016); (2) enhancing cultural competence will improve staff safety, satisfaction, and team cohesion (Kumra et al., 2020); and (3) in response to increasing shortages of skilled workers and the effects of brain drain, providing accessible and supportive training programs may help retain qualified staff (de Vries et al., 2023; Mosadeghrad, Ferlie, & Rosenberg, 2011).

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