

Chapter 5

Wearing the same shirt doesn't make you a team! Patient safety and the challenges of multicultural healthcare teams

Irena Papadopoulou

1. Introduction

In the last 50 years we have witnessed an increasing interest on the part of healthcare professionals in the cultural aspects of health and illness. Transcultural nursing and medical anthropology came on the scene, and stimulated research and learning about the impact that people's cultures have on their health behaviours. Large scale migration of people - for whatever reasons - coupled with an increased awareness of human rights, continues to force governments to strive to meet the needs of newcomers and settled minority communities. Service providers continue to face the challenges of establishing and running services which can respond to the needs of multicultural societies in sensitive and appropriate ways. In a number of developed countries, healthcare educators have been endeavouring to develop programmes which produce practitioners who are both knowledgeable and skilful in delivering care to people from different cultural and ethnic groups.

These efforts are linked by some to a notion of cultural competence (Cross *et al.*, 1989), as a matter of social justice and a mechanism to ensure the observance of consumer rights - such as the right to respect and the right to non-discriminatory care - and as a mechanism to tackle discrepancies in the health outcomes of minority groups (Brach & Fraser, 2000).

The most frequent reference to cultural competence is at the level of **patient-professional carer**. Educational activities, research projects, models, theories and tools aim primarily at helping the practitioner to understand the cultural needs of his/her patient/s in order to provide culturally competent care. Another level to which considerable attention has been given is that of **healthcare institutions** and their ability to provide culturally competent services. This is important, because, however competent practitioners are, they need to be supported by the institutions in which they work. Notwithstanding the volume of outputs that address these two levels, cultural competence has not, thus far, been focused on what in my opinion is a third level, that of **teams**. It is essential to do this as individuals do not work in isolation, but in groups or teams. In the 21st century healthcare world, it is almost certain that teams are multidisciplinary, and highly probable that they are multicultural too.

This chapter will explore some of the issues related to multidisciplinary, multicultural teams, such as the need for them, the possible challenges which they have to overcome in order to become culturally competent, and their potential characteristics once they have reached this. Because most cultural competence models and frameworks appear to be focusing primarily on the sensitivity, appropriateness and acceptability of care - all of which are desirable and much needed - this chapter will focus on the safety of patient care, an aspect which has not been adequately nor

directly addressed in the existing literature, thus attempting to establish the link between cultural competent teams and patient safety.

2. Does my ideal healthcare world match the evidence?

If I were sick I would like to be cared for in a culturally competent and safe institution, where culturally competent and safe healthcare teams operated, whose members were knowledgeable and skilled in delivering culturally competent and safe care to me and the other patients. I assume that most, if not all, people who live in multicultural societies would have similar wishes to mine. So what do we know about multicultural, multidisciplinary teams and their ability to deliver culturally competent and safe care?

2.1 Teams

The rich and voluminous team-related literature confirms that we actually know quite a lot about teams. Social scientists and management experts have been researching and writing about teams for many years. Bruce Tuckman's (1965) seminal work on the developmental sequence in small groups or teams is as relevant today as it was almost fifty years ago. Besides the actual application of the original model, its theoretical underpinnings have provided the building blocks for many of the contemporary theories and team building tools.

Tuckman's model consists of four stages:

- 1. The forming stage.** During this stage individuals do not know each other and spend some time checking one another out. Individuals wonder whether they can trust the others and commit to the purpose of the team. This is a high learning time.
- 2. The storming stage.** The team starts to address their purpose by suggesting ideas. Roles and responsibilities are articulated. This is a high anxiety time. Relationships between team members will be made or broken.
- 3. The norming stage.** Teams agree on the rules and values by which they operate. In the ideal situation members of the team trust each other and accept the vital contribution that each member can make.
- 4. The performing stage.** Team members feel motivated and have high trust and pride in the team. Individuals take pleasure in the success of the team. Decision making is collaborative and dissent is expected and encouraged as there will be a high level of respect in the communication between team members.

2.2 Cultural competence

We also know quite a lot about cultural competence if the oceans of published works were to be used as an indicator. To begin with, there are scores of models which aim at the development of culturally competent practitioners. There is some convergence between the most popular and used models in that they all suggest - but not all to the same degree - that to achieve cultural competence one must have:

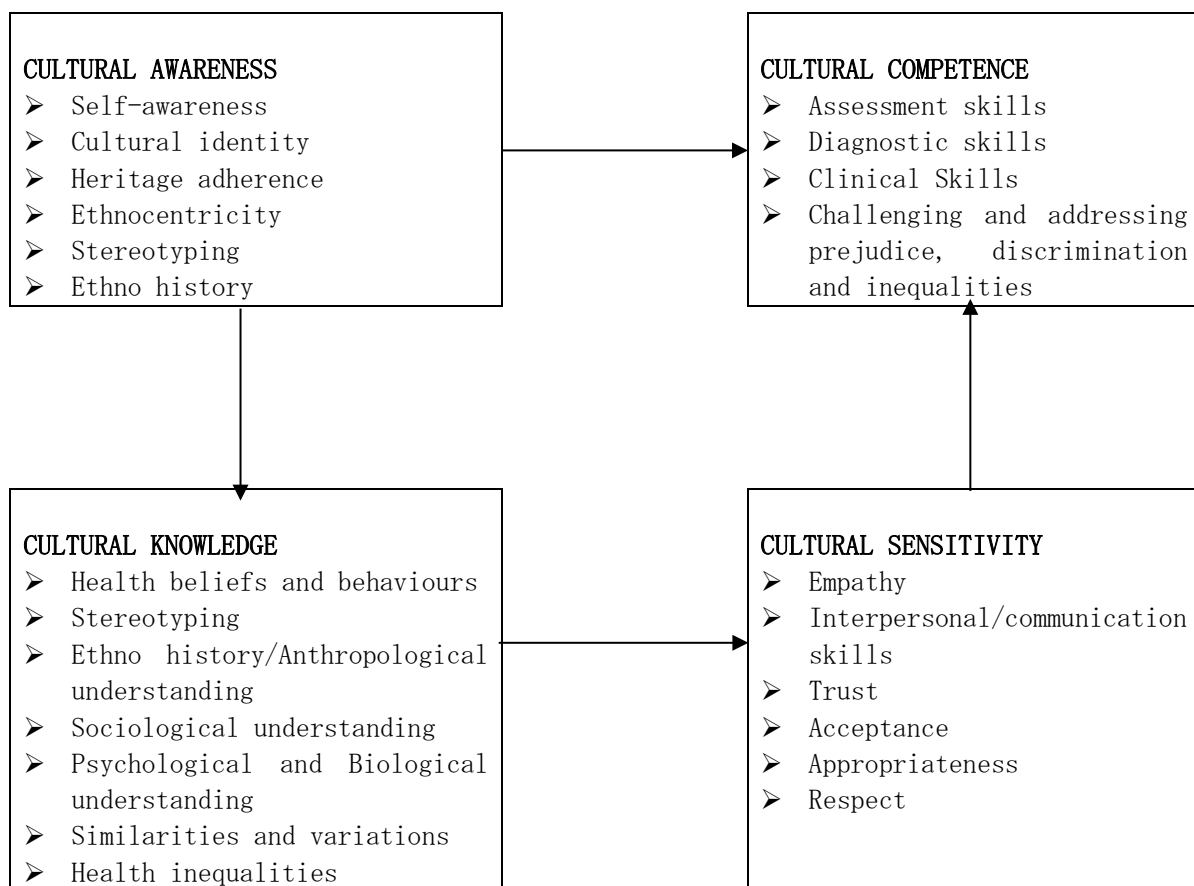
- A. considerable awareness about the importance of culture, cultural identity and how this impacts on people's health and self-care;
- B. enough knowledge about the health and illness patterns of the members of cultural groups with whom s/he is working;
- C. sufficient sensitivity and skills to develop trusting therapeutic relationships with his/her patients/clients; and

D. extensive understanding of the structural health, societal factors and health inequalities in general.

There is also consensus that cultural competence is a life-long process and not something we achieve once and hold for ever. One example of a model which is based in these principles is the Papadopoulos, Tilki and Taylor (1998) model (Fig. 1). This model was originally developed in the early 1990s but was further expanded upon by Papadopoulos a decade later (Papadopoulos, 2006).

There are also considerable research findings on the health needs, health behaviours, utilisation of services, epidemiology and health status, for many cultural and ethnic groups, from numerous disciplinary angles (such as medicine and nursing) and from many sciences such as biology, psychology, sociology, pharmacology and so on.

Fig.1 The Papadopoulos, Tilki & Taylor model of transcultural health and cultural competence (1998)



The cultural competence of organisations has also been examined and organisational indicators and standards have been developed, such as the American ‘National Standards for Culturally and Linguistically Appropriate Services in Health Care’ (OMH, 2001) and the Australian ‘National Cultural Competency Tool (NCCT) for Mental Health Services’ (MMHA, 2010), while elsewhere in the world, such as in the UK, in the absence of national standards, guidelines for achieving culturally competent services are based on related legislation and published literature and can be found in local policies and plans.

However, the makings and workings of multicultural healthcare teams and their impact on patient safety have, thus far, been overlooked.

2.3 Patient safety

It is no surprise to learn that we actually know a fair amount about patient safety, which the Council of the European Union (2009) defines as ‘the freedom for a patient from unnecessary harm or potential harm associated with healthcare’. In 2004, the World Health Organization launched the World Alliance for Patient Safety (WHO, 2005) in response to World Health Assembly Resolution 55.18 (WHA, 2002) urging WHO and Member States to pay the closest possible attention to the problem of patient safety. In 2005 the European Commission’s ‘Luxembourg Declaration on Patient Safety’ recognised that access to high quality healthcare is a key human right to be valued by the EU, its institutions and the citizens of Europe (EC, 2005). The European Commission, in its White Paper *Together for Health: A Strategic Approach for the EU 2008-2013* (EC, 2007) identified patient safety as an area for action; a year later, it drew attention to this topic in a Communication (EC, 2008). It also maintains a website on Patient Safety. ¹In Britain, the NHS National Patient Safety Agency was established in 2001. The USA has even a longer history of activities in this area. The USA National Quality Forum which was established in 1999 has also been focusing on patient safety.

Nevertheless, the WHO recognises that even though a considerable body of knowledge has accumulated in the last 10 years, this area is fairly new territory for researchers. In order to stimulate new research and debate in patient safety research, they present on their website² a series of lectures using examples of research studies in key areas.

3. The need for culturally competent and safe healthcare teams

Despite the separate achievements and considerable intellectual and material resources invested in the areas of teams, cultural competence and patient safety, the failure to bring these together in an effective and practical way is disappointing. We must urgently find ways to connect the dots. The recent publication by the WHO (2011) of the *Patient Safety Curriculum Guide. Multi-professional Edition* devotes, amongst its 270 pages, half a page to cultural competence. Using the Australian Patient Safety Education Framework and the Canadian framework entitled *The Safety Competencies: Enhancing patient safety across the health professions* (Frank & Brien, 2008), the developers identified eleven topics for this Curriculum Guide which claims to operate on universal principles that are applicable globally, though delivery should be customized to local needs and culture.

But if we accept the evidence amassed by the considerable research on cultural competence and its impact on the quality of care, the failure to include cultural competence as a vehicle for quality improvement and patient safety is a missed opportunity. This extensive text should have embedded patient safety within the multicultural world which most of the health professionals work in. All topics would have benefited if at least some of the case studies which were presented in each of them was presented and analysed in ways which highlighted the multicultural complexities of societies, healthcare systems and teams. For example, whilst it was encouraging to read about the emphasis on teamwork, it was equally discouraging to

realise that the guide made no mention to the multicultural challenges that exist within teams or how personal cultures and values may impact on patient safety.

Even the brief explanation about cultural competence provided in the guide stops short from recommending how this can be used in the curriculum because, as stated in the document, a) the debates on how this will affect healthcare services have not yet taken place and thus research is needed, and b) the belief that while doctors should be culturally competent, it should also be recognized that the patient safety movement is about a cultural change in the health-care system.

3.1 Some facts about the need for culturally competent and patient safe teams

Having outlined some key issues about teams, cultural competence and patient safety, we will now consider some facts.

- In 2005 the Chief Medical Officer for England stated that healthcare related illness cost England alone £ 1bn (€1.5bn; \$1.9bn) a year, with more than 100,000 infections and 5,000 resultant deaths (Frauenfelder, 2006).
- The Council of the European Union (2009) reported that an estimated 8 -
- 12% of patients admitted to hospital in the EU suffer from adverse events whilst receiving health care, for example:
- Health care-associated infections (accounting for approximately 25% of adverse events)
- Medication-related errors
- Surgical errors
- Medical device failures
- Errors in diagnosis
- Failure to act on the results of tests.

Much of the harm to patients is preventable, but the implementation of strategies to reduce harm varies widely across the EU.

More evidence about the need to seriously consider how multicultural teams are prepared for practice and how their decision-making abilities may impact on patient safety comes from a report by Slowther *et al.* (2009) on research commissioned by the UK's General Medical Council, on non-UK qualified doctors. Some of the key findings are:

- Many non-UK qualified doctor's find a distinct difference in practices between UK and the country they were trained regarding:
- The emphasis on individual autonomy and patients' rights
- The emphasis on confidentiality and informed consent
- The shared decision making model used in the UK
- Many identified concerns about communication on entering practice in the UK (language, dialects etc.)
- Many had concerns about lack of knowledge regarding social, cultural and behavioural norms of the host country
- Many stated that they had not considered the ethical, legal and cultural context of UK health care until they were in practice
- Almost all expressed the need for training.

3.2 The challenges to developing culturally competent and safe multi-disciplinary teams

The published literature acknowledges that managing the cultural diversity that exists in health care poses many challenges. These are made more acute by the barriers which exist between multidisciplinary teams, such as:

- The different professional cultures resulting from different education and professional socialisation.
- The traditional hierarchies which exist between professions.
- The fact that individual values, attitudes, perceptions and patterns of behaviour may be different among individual members of multi-disciplinary multicultural teams.

Imagine for a moment that you are a doctor who trained in India. You arrived in the UK a week ago and today you joined the team in the surgical unit where you have been employed to work. You obviously have your personal reasons for moving to the UK and you bring with you the professional code doctors use in India. This code will be very similar in principle to the UK code of professional practice, but the interpretation and the contextual detail of the principles will vary. You will have very little knowledge of the UK's national and local health policies, and as a newcomer you will have no knowledge of the organisational culture in which you have started working. You will bring with you - just as the other members of the team will - your own cultural background and personal and professional values which, without doubt, will guide and influence your professional decision making and practice. It is possible that other members of the team will be fairly new too, as we know that the kind of teams we are discussing usually have numerous transient members for educational and practical reasons.

If we recall Tuckman's stages of team development, to begin with you will be trying to get to know the other team members, as they will be trying to get to know you and to assess how well they can trust you. Naturally you will be quite anxious during this stage as you are also trying to establish your role and responsibilities and find out the rules and values which operate in the team. Team decisions about the care of patients are based on trust, but care is invariably given by individual members, and undoubtedly you will be 'putting your stamp' on them as you try to operationalise them.

3.3 A framework for analysis and understanding and a case study

To help us understand further the challenges and complexities of multicultural teams and their impact on patient safety, I would like to introduce Hofstede's (1997) five fundamental dimensions of national culture. To avoid misunderstandings, it is important to state that not all individuals in a particular culture fit into these dimensions or hold these characteristics. The five dimensions can be summarised as:

1. *Hierarchy* - or 'power distance' - relates to the extent to which individuals within a culture accept unequal distribution of power. At one end of this continuum are cultures that value hierarchy, place emphasis on leaders who are expected by the team to provide direction and make decisions. Individuals within these cultures tend to be accepting of rules and questioning authority may be discouraged. At the other end of the continuum are cultures that emphasise team involvement, with wide consultation and group decision-making being common. Questioning authority is likely to be accepted or even encouraged.

2. Ambiguity - or 'uncertainty avoidance' - deals with the degree to which individuals feel comfortable with ambiguity. At one end of the continuum are cultures that encourage risk taking; individuals are likely to feel very comfortable trying new and different ways of approaching things. At the other end of the continuum are cultures that place more value on routine, regulation and formality. Individuals in these cultures are likely to prefer tried and tested ways of doing things rather than taking risks with unknown methodologies.

3. Individualism/Collectivism - This dimension relates to the extent to which self-determination is valued. In an individualistic culture people will place a lot of value on individual success and the need to look after oneself. At the other end of the dimension are collectivist cultures in which individuals will place more value on group loyalty and serving the interests of the group.

4. Achievement orientation - One end of this dimension is labelled 'masculine' and the other end 'feminine'. A culture at the masculine end of the continuum will be achievement-oriented, valuing things such as success, achievement and money. At the other end of the continuum are cultures that place more value on aspects such as quality of life, interpersonal harmony and sharing.

5. Long-term orientation - This dimension was a later addition to Hofstede's work. At one end of the continuum are cultures that focus on long-term rewards; at the other end are cultures that are more concerned with immediate gain.

3.3.1 Case study

Using Hofstede's five dimensions, let us briefly explore, through the case of 'Mrs Andrews', a UK resident, how her safety may be compromised by the culturally diverse team which is looking after her.

Mrs Andrews is a 70-year-old woman suffering from dementia. She is being nursed in hospital for a chest infection. While there, she is refusing to eat. Her daughter becomes concerned and asks to discuss her mother's care with the doctor. It so happened that earlier in the day the medical team discussed Mrs Andrews' plan of care. The team consists of:

- A 50 year old male English consultant
- A 55 year old male Indian registrar
- A 30 year old female English junior doctor
- A 30 year old female qualified nurse from Sierra Leone
- A 25 year old male student nurse from Russia.

Both the qualified nurse and the student nurse have been living in the UK for a short period of time.

Analysis I feel obliged to remind the reader again that real life is far more complex than my representation and real people do not always fit neatly in the boxes I have put them in. Their education, level of acculturation, gender, age, life experiences and so on are factors which differentiate individuals from the general characteristics related to Hofstede's dimensions. The main questions for the team looking after Mrs Andrews are:

- Should they actively pursue providing nutrition, even though she refuses to eat, or should they respect her wishes?
- Should she be resuscitated if she collapses or should she be placed on the 'do not resuscitate' list?

Hierarchy

As a person who values teams, the **consultant** expects each team member to make a contribution to the discussion and participate in the decision making. He recommends that the team should continue to actively pursue methods of providing food and fluids to Mrs Andrews. The **registrar**, who views the consultant as the leader of the team, shows his respect by agreeing with his decision. Although he does not verbalise this, he also expects everyone else to respect both the consultant's recommendations as well as any actions that he, as the second most senior person in the team, may have to take following this recommendation.

However, the **student nurse** questions this decision, saying that Mrs Andrews has lived a long life and if she does not want to eat they should let her die. The **qualified nurse** agrees with the young student, but does not say anything because she has been taught from a young age to respect authority. In her mind she thinks similarly with the student. She comes from a country torn by ethnic conflict and lack of healthcare services, where people are lucky to live beyond their 50s. Nevertheless she appears to agree with the recommendation. The **junior doctor**, who values the team and patient/family involvement in decision making, suggests that they should speak to the family before making any decisions.

Can the above scenario compromise Mrs Andrews' safety? Potentially it can. Healthcare has been and remains fairly hierarchical, which prevents equal exchange of opinions. Culture-bound 'unspoken' and 'assumed' messages often create a recipe for miscommunication which can result in unsafe individual practice.

Ambiguity

Mrs Andrews' daughter - who speaks with a heavy Scottish accent - is invited to a team meeting. She wants the team to investigate why her mother does not want to eat and wants the carers to try different ways of tempting her mother to eat. She also wishes that her mother is resuscitated. She believes that once her mother's chest infection is cleared she will return to her lovely nursing home and continue to live a comfortable - albeit confused - life.

The team, led by the **consultant**, agree to respond to the daughter's wishes with a plan of action which includes:

- The nurses carrying out a thorough inspection of Mrs Andrews' mouth in case she has mouth ulcers which would make eating painful. Soft foods, nourishing drinks will be ordered based on her daughter's advice regarding her mother's favourite foods.
- The doctors will order a number of blood tests and X-rays of the chest, head and throat. They will also request an assessment from a colleague who specialises in dementias. Naturally, they will continue with intravenous antibiotic therapy for the chest infection.

The plan is accepted by those who feel comfortable with ambiguity, such as the **junior doctor** and the **student nurse**, although they both wonder (perhaps for different reasons) whether Mrs Andrews' daughter will wish this plan to be kept going even if her mother continues to refuse food and any alternative interventions may become equally stressful to her. At the other end of the ambiguity continuum we find the **qualified nurse**, who also accepts the plan as it provides her with clear instructions of conducting routines she is used to. But how do these individuals make decisions

when they are providing care to Mrs Andrews? Could the **qualified nurse** try to force the patient to drink even when she struggles not to? Could the nurse avoid informing the team about the patient's reactions, but continues to pursue the plan even though the patient is in distress? Could perhaps the **student nurse** give up feeding the patient too easily? Both approaches have the potential to harm the patient.

Individualism/Collectivism

At the team meeting the next day the **junior doctor** reported that the **qualified nurse** should have informed her that Mrs Andrews' intravenous infusion (IVI) had dislodged, instead of discovering this herself when she arrived on the ward just before the meeting. She stated that the incident could have happened some hours ago as the IVI site was inflamed and swollen. Coming from an individualist culture, the **junior doctor** probably regards quality of care as the result of good training and hard work and any failures in this patient's care as a backward step in the successful execution of the plan they had all agreed. The **qualified nurse** explains that she had been extremely busy due to shortage of staff, and since Mrs Andrews was quiet and peaceful she did not attend to her. Coming from a collectivist culture, she dislikes confrontation and does not openly display her displeasure of the criticism; neither does she disclose that the **registrar** had seen the patient less than an hour ago. In this case Mrs Andrews' safety and comfort has been compromised because the IVI was providing much needed fluids and medication.

Achievement-orientation

The IVI is reinstated after trying several times to find a suitable vein. At the same time blood samples are taken. Soon after, Mrs Andrews becomes distressed, shouting at and fighting with the staff even though she is obviously very weak. She is also short of breath and cyanosed as she does not like keeping the oxygen mask on her face. She is due to have her chest X-rayed in the afternoon, but before this happened she suffers a respiratory arrest. Despite the team's efforts Mrs Andrews dies.

The death of Mrs Andrews is seen by those at the 'masculine' end of the continuum, such as the **consultant** and the **junior doctor**, as a failure, but by those at the 'feminine' end of the curriculum, such as the **qualified nurse** and the **registrar**, as a natural consequence which may probably be for the best, as if Mrs Andrews had lived her quality of life was not guaranteed.

Long-term orientation

Those members of the team, who are focused on the long term-orientation end of the continuum such as the **registrar**, would stress their solidarity with the team and remind them that they acted professionally in looking after this elderly lady who had huge physiological and communication problems. Those at the other end of the continuum, such as the **consultant** and the **junior doctor**, would stress that the result of their efforts was disappointing and may question whether the whole team acted with the sense of urgency that was required.

4. From differences to similarities

The brief analysis offered above, using Hofstede's dimensions of national cultures, has highlighted some of the differences in beliefs, values and behaviours between the members of the multidisciplinary / multicultural team. But as human beings we share more similarities than differences, something which Hofstede also acknowledges. Almost two and a half thousand years ago the Greek philosopher Aristotle (384-322BC) espoused that one fundamental similarity of all humans is their wish to flourish (or

be happy). He suggested that to achieve this, all humans need to cultivate the following five virtues: compassion, courage, friendship, self-love and forgiveness.

Briefly, he defined compassion as the ability to recognize the suffering of others, and to allow others to know that we really care. In the context of this chapter, the suffering of others could be that of the patient and his/her family but also that of team members who are facing all sorts of anxieties for many reasons, such as being new to the country, being new to the team, being unsure of the standards and procedures of the workplace, and so on. Whether one is a patient or a member of the caring team, there will be situations, behaviours and practices that must be challenged, for if they are not they may lead to dangerous and unsafe outcomes. To challenge, one requires courage. However, Aristotle taught that courage without wisdom is also dangerous for both the person who is committing the unwise courage and the persons for whom this is committed. Friendship is liking another person and wishing good for him/her. Genuine friendship is not based on advantage or possible profit, but on shared commitment for goodness, based on equality. This is a very appropriate virtue for a team of health professionals, but, like all other virtues, it needs to be cultivated through example and practice. Genuine friendship will help develop trust within the team as well as peer support and a culture of openness, all of which will lead to patient safety. Self-love is defined as the deep self-awareness which opens the door to genuine respect and care for others. Lastly, forgiveness is about the desire to understand rather than blame others for their mistakes, a principle which is fundamental to patient safety.

5. The characteristics of culturally competent and patient safe teams

Taking into consideration the evidence presented and discussed in this chapter, it may be reasonable to liken a culturally competent and safe team to an orchestra. Just like an orchestra, the team we have been talking about needs to have a common language to communicate. Effective communication between team members, the patient and family is of utmost importance. Most catastrophes in patient safety have an element of miscommunication, such as incomplete handovers, illegible handwriting, unclear instructions, as well as other barriers, such as cultural values, which result in people staying silent or not feeling confident to express their views. Effective leadership is another characteristic of good orchestras and healthcare teams. An effective leader provides clear explanations, encourages and listens to everyone's views, s/he is the embodiment of a good practice model, challenges and corrects the members of his/her team in a wise, constructive and sensitive way. A wise leader understands the importance of team building that promotes self-awareness and awareness of fellow team members. S/he understands the importance of training so that the basic individual skills of each member can be further developed and refined in ways that they complement each other. An effective culturally competent and patient safe team, just like an orchestra, must have a common purpose and plenty of opportunities to practice together. These characteristics help individuals and teams flourish, the result of which is fewer errors and safer patient care.

6. My ideal world.... Conclusions

In this chapter, I have discussed the links between cultural competence and patient safety, emphasising the fact that, despite the acquisition of more knowledge and the development of considerable levels of understanding in each of the conceptual areas under discussion, the complex healthcare teams of today need to improve their ability to exploit and use the synthesis of these crucial elements and factors. This can be

achieved through professional education and continuous practice, assisted by the frameworks discussed in this chapter.

The reference for this chapter is:

Papadopoulos I (2012): Wearing the same shirt doesn't make you a team! Patient safety and the challenges of multicultural healthcare teams. In D. Ingleby, A. Chiarenza, W. Devillé & I. Kotsioni (Eds.) *Inequalities in Health Care for Migrants and Ethnic Minorities. COST Series on Health and Diversity*, Volume II. Antwerp/Apeldoorn: Garant. ISBN 978-90-441-2932-8

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