CHAPTER 8.
UNDERSTANDING THE IMPACT OF CULTURAL COMPETENCE AND PREJUDICE TOWARDS CULTURAL DIVERSITY ON CASES OF BURNOUT IN PATIENT-TO-PROVIDER INTERACTIONS

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Introduction

In the latest years an increase of the phenomenon of immigration at an international level has been observed, which severely affects the South European countries, including Italy and Spain.

According to the most recent estimates of the ISTAT[1] (2009), after an increase of approximately half a million respect to 2007, immigrants regularly residing in Italy, totaled almost 3,9 million, including citizens from other EU member states. Data on January 1st, 2009 refer that foreign residents coming from EU countries represent the 53, 6% (predominance of Rumanians with 20, 5% and Albanians with 11, 5%). At the same time, as demonstrated by INE[2] data (2009) 12% of the Spanish population is foreign. In Spain the number of immigrants has increased from 1,3 million in 2001 to 5, 7 million in 2009. Thus, during the last years Italy and Spain, were considered countries of emigration until the beginning of the 1970s-80s, are increasingly becoming a multiethnic society. The diversity of these populations regarding provenance and immigration characteristics has become an increasingly visible aspect of the Spanish and Italian society over the recent years, bringing the potential challenges in terms of adaptation, attitudes and behaviors on the part of the native population causing different issues related to acceptance, security and peaceful cohabitation. In this context, the integration of migrants into existing health system has become a fundamental issue for western democracies. If one takes into consideration the process through which immigrants are included in the health setting of their host countries, it can be noted how, in the majority of cases, there are significant differences between foreign and native pop-

1. The National Institute for Statistics, www.istat.it
2. The National Institute for Statistics, www.ine.es

ulation regarding the real access and equal enjoyment in a public system. Here one can identify what is defined in the literature as the implementation deficit that refers to a situation in which a fundamental right exists and is recognized, but its effective application becomes difficult to realize in concrete terms. The field of cultural competence has recently emerged as a key requirement that can be useful to overcome the barriers in access and to promote the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes (Davis & Donald, 1997).

A step beyond cultural competence training required also involves reducing or eliminating racial and ethnic health disparities that have been well documented in the scientific literature (Smedley *et al*., 2003, Adler & Rehkopf, 2008). Although universal access to healthcare is a main factor in the elimination of racial and ethnic disparities in health care, an equal access to healthcare does not ensure equal care to different segments of the population. In this paper, when we mention racial and ethnic disparities in health care, we refer to the differences in quality of care (IOM[3], 2003).

The causes of disparities are broad and complex. They range from societal and personal issues like racism, prejudice (IOM, 2003; Williams, 2005) and burnout to health system factors like the lack of cultural competence (Cooper *et al*., 2002) of health care professionals. Given the important role that interpersonal processes, including manifestations of prejudice, cultural competence (Taylor, 2003; Kagawa-Singer & Kassim-Lakha, 2003; van Ryn; 2003) and burnout (Leiter *et al*., 1998) may play in the disparities of health care, measures of these phenomena might be important indicators to address strategies to achieve good and quality provider-patient interactions.

The research explores the individual and combined effects of prejudice, cultural competence and burnout in two different contexts: Italy and Spain. Reason-based choice is that, despite similar geographical location and their modern migration history with large numbers of migrants from quite diverse cultures, in Italy and Spain there are obvious differences concerning the actual political approach and debates on immigration. Given the prevalence of stereotypic and racist public discourses among members of Italian government, which mainly targeted non EU-migrants and minority groups and which compromised the difficult process of peaceful integration and coexistence, we retained that Italian nurses' perception on immigration could have an impact on three dimensions explored. Public discourses, as political debates or speeches, could be, in fact, the privileged place of expression of a public opinion, encouraging dialogue, integration and participation. On the contrary, such as in the Italian case, in pose of favoring a national identity, politicians do not hesitate to resort a stereotyped language that encourages discriminatory and hostile manifestations towards minority group members (Douglas *et al.* 2008; Douglas and Sutton, 2003; Maass *et al*., 1996; Maass *et al.* 1989).

The goals of this paper were, in the first place, to examine the prejudice, cultural competence and burnout of health providers within two different hospital settings: the San Sebastian Hospital of Caserta and the Virgen Macarena Hospital of Seville. Participants in the study were 200 Italian and Spanish nurses, who daily face health challenges posed by the massive influx of immigrant patients.

3. Institute of Medicine, Committee on the National Quality Report on Health Care Delivery.

Taking these factors into account, the second purpose of this paper was to provide a perspective on the literature regarding the relationship between these dimensions and to generate an equation structural model which predicted a causal link where we assumed that the prejudice affect burnout through the mediator role of cultural competence.

The final section summarized our analyses research and some questions about the diversity in heath care systems. It also contains the limitations of our study and recommendations on how to examine other measures to better assist the research community in answering these questions.

Blatant and subtle prejudice, cultural competence and burnout: a starting point for a theoretical framework

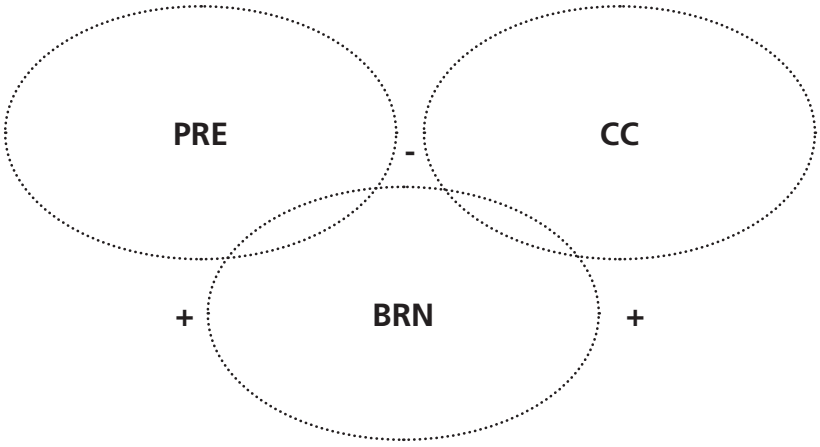
Based on the foregoing, we suggested a conceptual framework informed largely by a social psychological perspective and health literature which connected ethnic prejudice, cultural competence and burnout.

Figure 1 details a conceptual framework that includes the domains of:

- Prejudice
- Cultural competence
- Burnout

Each domain is related to another in a way that the presence or absence of an earlier domain can affect the subsequent ones. In other words, a high level of prejudice may be an indicator of high levels of burnout. This relationship is not direct but mediated by a negative attitude towards immigrants.

Figure 1. Conceptual Framework of Prejudice, cultural competence and burnout



These three circles depict the link between prejudice, cultural competence and burnout. The figure illustrates as prejudice is negatively related to cultural competence while positively related to burnout, whereas the cultural competence is negatively related to burnout. Finally, these dimensions lead to quality and effectiveness improvement oriented to the achievement of equity in health care services. In the following sections we have described the implication of three dimensions in providers-patient's interaction.

An important implication of this framework is that the relationship between prejudice and burnout, mediated by cultural competence, fundamentally influence the ways professionals interact with immigrant patients. Starting from this conceptual framework, we reviewed the literature referring these three domains related to quality care.

a) Could prejudice affect the quality of care for immigrant patients?

In this paragraph, we attempted to connect research on the social effects of ethnic prejudice with the literature on racial disparities in health care, with a particular focus of attention on studies published since the Institute of Medicine Report (2003).

The Institute of Medicine Panel (2003) identified race-based prejudice as a major cause of health disparities.

It has been well documented that stereotyping, prejudice, and discrimination[4] exist in nursing and health care (Abrums&Leppa, 2001; Barbee& Gibson, 2001; Bolton, Giger, & Georges, 2004; Huff & Kline, 1999; Porter & Barbee, 2004).

The IOM (International organization for migration) in the *Unequal Treatment* report (2003) expressed that "(al)though myriad of sources contribute to disparities in health care, some evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care."

Balsa & McGuire (2001) assumed that one view of the origin of causes of disparities in health care is that providers are simply prejudiced against members of minority groups and treat these patients with lower regard than majority groups.

Other studies [Healy (1991), Schulman *et al*. (1999), van Ryn and Fu (2003), Fincher *et al*. (2004) and Green *et al*. (2007)] shared that disparities and inefficiency of treatment are often ascribed to prejudicial providers.

Many times the vast majority of healthcare providers do not recognize manifestations of prejudice in their work (Lurie, 2005) and they find them morally and politically incorrect and in contrast with their professional values. The reason of this is that explicit expressions of prejudice is being replaced by subtle forms of prejudice (Pettigrew and Meertens, 1995), a contemporary form of prejudice that is less conscious and more indirect. In our study, we assumed that prejudice not only systematically affect the provider-patient interactions with a negative consequence on quality of care for minorities (IOM, 2003), but is also related with cultural competence and burnout of health professionals. In particular, we expect that subtle prejudice, considered as a result between negative implicit attitudes and egalitarian explicit attitudes can significantly impact on burnout syndrome through the mediation role of cultural competence.

b) Cultural competence as a prerequisite for a good provider-patient interaction

There is significant evidence that highlights the impact of providers' cultural competence on health and health care. Cultural competence has gained attention as a potential strategy to improve the quality and

4. The literature often uses the terms prejudice, bias, stereotyping and discrimination interchangeably. We use the term prejudice to refer to provider behaviors that result in allocative inefficiency.

eliminate racial/ethnic disparities in health care (Betancourt *et al.,* 2005). "Cultural competence refers to an ability to interact effectively with people of different cultures. Cultural competence comprises four components: (a) Awareness of one's own cultural worldview, (b) Attitude towards cultural differences, (c) Knowledge of different cultural practices and worldviews, and (d) Cross-cultural skills. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures" (Martin and Vaughn, 2007). It encompasses a set of values, behaviors, attitudes, knowledge and skills which enable the health care providers to offer patients the kind of care that is respectful and inclusive of their cultural backgrounds (Shakeri Shemariani, 2004). Numerous researches have indicated that, in order to work effectively with the immigrant population, professionals need to develop the knowledge, understandings and skills (Sonn, 2004; Sutton, 2000; Tyler, 2002; Westerman, 2004).

"The goal of cultural competence is to create a health care system and workforce that are capable of delivering the highest-quality care to every patient regardless of race, ethnicity, culture, or language proficiency" (Betancourt *et al.,* 2005). Although cultural competence was not seen as one only strategy to increase access to quality care for all patient populations, there is many evidence of a link between cultural competence and eliminating racial/ethnic disparities in health care (Betancourt *et al.,* 2003).

c) Burnout and job performance of health providers.

Finally, we have considered the burnout syndrome as another personal factor that may affect a cross cultural interaction between health providers and immigrant users. Burnout is "a process in which the professional's attitudes and behavior change in negative ways in response to job strain" (Cherniss, 1980). According to Maslach's multidimensional model (Maslach *et al*., 1996) consists of emotional exhaustion, depersonalization and reduced personal accomplishment. It is highly prevalent among nursing professionals because of their jobs, stressful and emotionally demanding, and repeatedly confronted with people's needs, problems and suffering. When professionals experience burnout and feel unable to continue their work in an adequate way, they are more likely to consider quitting (Jackson et al., 1986). This dissatisfaction with one's job may be reflected in the quality of care that patients receive and in patient ratings of satisfaction with care (Leiter, 1999). Despite the interest and relevance of the topic, the effects of burnout on quality care are not well defined by evidence. In fact, the link between burnout and patient satisfaction, considered as an indicator of quality, has been explored in few investigations (Vahey *et al*., 2004; Leiter *et al*., 1998). The connection between nurse burnout and concerns about quality of care was supported by the work of Aiken and colleagues (2004, 2002). They found that patients in units where nurses reported significantly lower burnout were more likely to report higher satisfaction with their care than other patients.

In line with a research conducted among a sample of teachers (Horenczyk & Tatar, 2002), we assumed that the stressors derived by new challenges for part of providers to respond to the needs of immigrant patients may negatively affect their personal and professional well-being and nurses' behavior such as turnover and work stress impacting on quality of care.

Overview of the study and hypothesis

The overall intention of this work is to investigate the way in which nursing professionals perceive immigrants and how they relate to them at work.

The approach underlying the research is psycho-political: the starting point is the assumption that the relationship of health care - which covers an area of primary importance in health - reflects the state of relationships present in a society between natives and immigrants. If healthcare providers are more open towards other cultures and willing to accept and exchange, working with foreign users should be less problematic. As suggested, state and governmental policies and political discourses may affect the construction of the social representation towards immigrants, their culture and lifestyle, as well as the overall idea of their nation as an entity mono-or multi-cultural. Hence, this research was carried out in two countries - Spain and Italy - with a high degree of similarity in terms of geo-cultural countries but that are currently pursuing opposing government policies with respect to immigration: the Spanish is marked by the tension towards acceptance and the integration of immigrants, while the Italian is marked by diffidence and the closure of identity. We compared two relatively small inland cities in the South of both countries, with a high number of immigrants - Seville and Caserta - and two hospitals with similar characteristics (two public hospitals with similar hierarchical and administrative organization): Hospital Virgen Macarena of Seville and San Sebastian hospital of Caserta. We considered the cultural competence and ethnic prejudice as indicators of multicultural behavior towards immigrants and the level of burnout as indicators of the perception of their work and the difficulties associated with it. In addition, we have evaluated a possible relationship between three dimensions. Based on the literature about factors which may affect the quality of interactions between nurses and immigrant patients, we assumed that ethnic prejudice, cultural competence and burnout in nurses are interrelated and vary depending on the socio-political context. Specifically, we hypothesize that a high degree of prejudice and a low level of cultural competence are directly proportional to burnout. From these considerations, and using structural equation modeling, we tested a theoretical model of relationships between the variables considered in which prejudice affects burnout through the mediation role of cultural competence.

Method

Participants and Procedure

The target population consisted of full-time or part-time registered hospital professionals, who worked as nurses in different wards (Emergency Room, Oncology, Traumatic room, Obstetrics and Pediatrics). Respondents were 200 Italian and Spanish female nurses of two public hospitals (San Sebastian of Caserta and Virgin Macarena of Seville). The average age was 36.28 and 43.86 years old for Spanish and Italian nurses, respectively. The average professional experience was 14.22 and 19.43 years for Spanish and Italian nurses, respectively. Only women were included in this study because both samples showed a female predominance. After the authorization by the supervisor of wards, participants were asked to return the completed questionnaires in the envelope provided to a collection box located in the hospital research unit.

Data collection instruments

Respondents were asked to complete a self-report questionnaire consisting of four sections:

Socio-demographic information. Participants provided personal information regarding age, knowledge of languages, years of experience.

Blatant and Subtle Prejudice Scale (Pettigrew & Meertens, 1995): Each scale – subtle and blatant - consists of 10 Likert-type items which options range from 1 («strongly disagree») to 4 («strongly agree»). Four of the 10 items in the subtle prejudice scale correspond to the «traditional values» dimension; four correspond to the «cultural differences» dimension; and two to the «denial of positive emotions» dimension. In the case of the blatant prejudice scale, six items were included in the «threat and rejection» dimension and four in the «anti-intimacy» dimension.

Cronbach alpha coefficients were 0.88 for the blatant scale and 0.63 for the subtle one and were used to assess the reliability levels of the measuring instruments.

Maslach Burnout Inventory (Maslach and Jackson, 1986)*:* It is designed to assess the three components of the burnout syndrome: emotional exhaustion, depersonalization and reduced personal accomplishment.

It was evaluated using the Spanish (Seisdedos, 1997) and Italian (Sirigatti e Stefanile, 1988) versions. It consists of 22 items, which are divided into three subscales: nine items for Emotional Exhaustion (EE); five items for Depersonalisation (DP); and eight items for Personal Accomplishment (PA).

The items are answered in terms of the frequency with which the respondent experiences these feelings, on a 7-point, fully anchored scale (ranging from 0, "never" to 6, "every day"). Higher scores of EE, DP and a lower score of PA indicate a higher level of burnout.

The internal consistencies (Cronbach's a) of scales were good: 0.77 for emotional Exhaustion, and alpha coefficient was 0.62 for depersonalization and 0.76 for Personal Accomplishment (PA).

Questionnaire of cultural competence: We developed a self-administered questionnaire consisting of 57 Likert-type items with responses ranging from one to six. The response sets included: 1 (strongly disagree) to 6 (strongly agree) to evaluate the multicultural attitudes of health professionals. The items formulations were designed to investigate the problems concerning the relationship between the health professional and immigrant users considering not only the difficulties associated to operator-user relationship but also the *cultural awareness* of the professional. The questionnaire was pre-tested with a sample of 400 people related to different services - schools, social services, health services and centers employment - to ensure the relevance and comprehensibility of the questions. Component Factor analyses (with varimax rotation) were conducted. An extraction procedure was used for main components; however, the best explanation for the existence of predicted factors occurred with a rotate model. The two-factor model produced the following factor labels: Cultural awareness and discomfort and inadequacy.

Items were retained if they maintained an adequate factor loading and fit conceptually with the other items that were identified as part of a factor. Items with low communalities (below .30) were not retained.

The measure of internal consistency assessed by Cronbach's alpha was 0.85 for the first subscale and 0.66 for the second.

Results

Statistical analysis was carried using the SPSS 15 and LISREL 8.71. The primary analysis involved descriptive summary statistics for evaluating differences among Spanish and Italian nurses using t-tests (age, work experience) and chi square tests (language and working area).

Table 1 shows means and Table 2 shows frequency distributions of the variables considered.

Table 1. Means related of the age and work experience of Italian and Spanish nurses

	City	N	Means	F	d.f	p
Age	Seville	100	36,28	8,217	198	0,005
	Caserta	100	43,86			
Work experience	Seville	100	14,22	8,303	198	0,004
	Caserta	100	19,43			

Table 2. Frequency distributions of language and working area in a sample of Italian and Spanish nurses

		City		Total
		Seville	Caserta	
Languages	.00	49	75	124
	Portuguese	11	1	12
	English/ French	40	22	62
	Other	0	2	2
Working Area	Hospitalization	85	90	175
	Emergency	15	10	25

The t-test showed that among the Italian nurses age (t = 6081, df = 198, p <.001) and work experience (t = 4056, df = 198, p <.001) were higher than in Spanish nurses. Chi square analyses indicated that Spanish nurses with at least one foreign language were more numerous than Italian nurses ($\chi 2$ = 16.82, df = 1, p <.001).

The two t-tests for cultural competence factor scores (see table 3) for the comparison of Italian and Spanish nurses means showed a significant difference for the "disease and inadequacy" factor: the Italian sample reports higher scores than the Spanish one (t = 5.75, df = 198, p <.001).

Table 3. t-test results on dimensions of cultural competence in Italian and Spanish nurses

	City	N	Means	F	d.f	p
Cultural awareness	Seville	100	-0,0268418	3,251	198	.705
	Caserta	100	0,0268418			
Disconfort and inadequacy	Seville	100	-0,3770901	1,902	198	.000
	Caserta	100	0,3770901			

The t-test on blatant and subtle scale and burnout scale (see table 4) indicated that Italian nurses scores are significantly higher than Spanish scores in the blatant prejudice scale (t = 4:54, df = 198, p <.001), in the subtle prejudice scale (t = 4:43; df =198, p <.001) and in emotional exhaustion (t = 1.99, df = 198, p <.05).

Table 4. t-test results on blatant and subtle prejudice and burnout'dimensions.

	City	N	Means	F	p
Blatant prejudice	Seville	100	18,83	2,004	0,000
	Caserta	100	22,70		
Subtle prejudice	Seville	100	25,89	0,001	0,000
	Caserta	100	29,07		
Personal Accomplishment	Seville	100	35,34	0,428	0,732
	Caserta	100	34,92		
Depersonalization	Seville	100	6,24	5,921	0,575
	Caserta	100	6,69		
Emotional Exhaustation	Seville	100	18,32	4,921	0,047
	Caserta	100	20,99		

Correlation between blatant and subtle prejudice, cultural competence and burnout dimensions.

The Pearson correlation coefficient was applied to determine if any relationship existed between prejudice, cultural competence and burnout. The correlations between results were measured on the dimensions' factor points derived from the factorial solutions of each instrument.

Cultural awareness was significantly negatively correlated with the blatant prejudice (r =-. 209, p =. 003), the subtle prejudice (r =-. 229, p =. 001), depersonalization (R =-. 293, p =. 000), emotional exhaustion (r =-. 228, p =. 001) and inadequacy (r =-. 317, p =. 000), while positively correlated with personal accomplishment (r =. 433, p =. 000).

In addition, discomfort and inadequacy was positively correlated with the blatant prejudice (r =-. 209, p =. 003), the subtle prejudice (r =. 215, p =. 002) and the emotional exhaustion (r =. 177, p =. 012), and showed a negative correlation with the nationality (r =-. 378, p =. 000). The results showed a positive correlation between the blatant prejudice and depersonalization (r =. 194, p =. 006), emotional exhaustion (r =. 145, p =. 000) and inadequacy (r =. 161, p =. 023) while it showed a negative correlation between the blatant prejudice and the realization (r =-. 160, p =. 024), and nationality (r =-. 307, p =. 000). Similarly, the subtle prejudice showed a positive correlation with depersonalization (r =. 359, p =. 000) and the emotional exhaustion (r =. 300, p =. 000), while it was negatively correlated with the personal accomplishment (r =.- 192, p =. 007), and nationality (r =-. 300, p =. 000). Concerning burnout dimensions, the emotional exhaustion was negatively correlated with nationality (r =-. 140, p =. 047).

Mediation analyses (SEM)

The structural equation modeling techniques were used to assess the relationships across the factors: blatant and subtle prejudice; cultural competence subscales and dimensions of burnout. LISREL 8.71 (Joreskog and Sorbom, 2004) was used to construct this model.

First, we tested a fully mediated model in which we hypothesized that ethnic prejudice (blatant and subtle) affects burnout indexes through a mediation role of cultural competence dimensions. Results indicate that this model demonstrates reasonable fit to the sample data (RMSEA: 0.070 Chi-Square: 9377.14; d.f: 4743; p-value: .00). The structural effects are shown in Fig 2.

Figure 2. Structural equation model. Coefficient are standardized. Only significant paths are reported

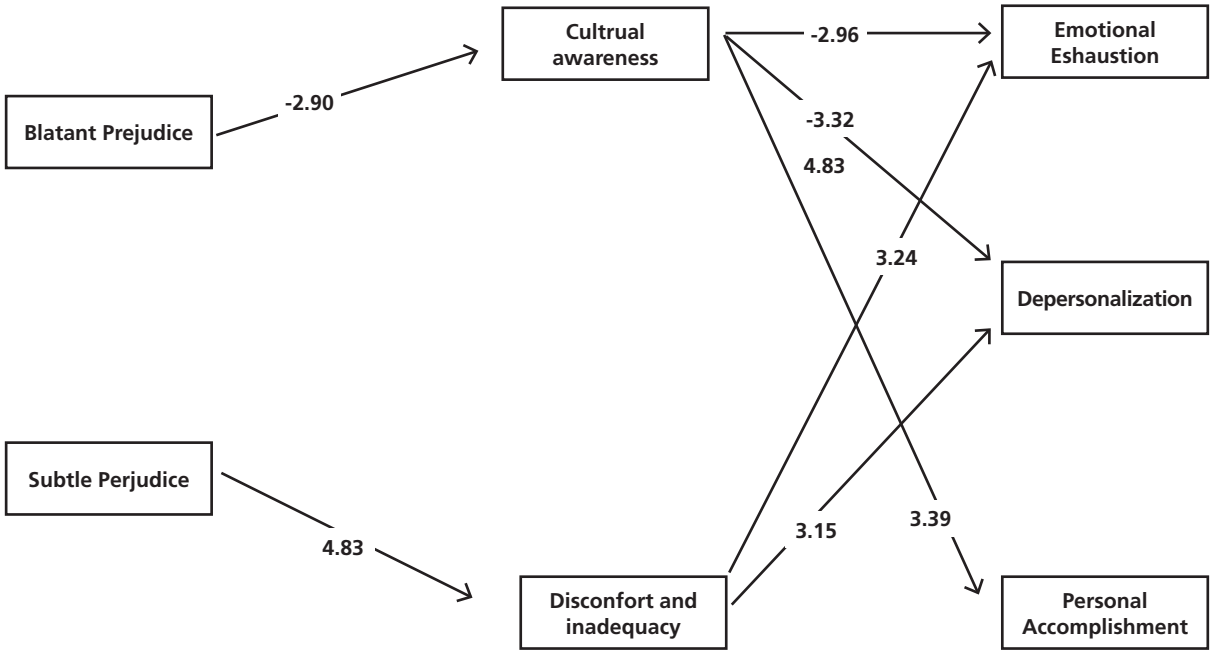


Figure 2 showed a significant initial direct effect of blatant prejudice on cultural awareness (standardized effect= -2.90) and a significant initial direct effect of subtle prejudice on inadequacy (standardized effect= 4.83). This suggests that a lower or a higher level of ethnic prejudice could determine a lower or higher level of multicultural ideology. The association between blatant and subtle prejudice and three dimension of burnout was mediated by multicultural ideology dimensions.

The indirect effects model for the blatant prejudice showed that it was positively related to personal accomplishment through cultural awareness (standardized effect= 3.39) and it was negatively related to emotional exhaustion (standardized effect= -2.96) and to depersonalization (standardized effect= -3.32) through cultural awareness. The indirect effects model for the subtle prejudice showed that it was positively related to emotional exhaustion (standardized effect= 3.24) and to depersonalization (standardized effect= 3.15) through discomfort and inadequacy.

Discussion

The first aim of this study was to explore the prejudice, the cultural competence and the burnout among a sample of 100 Italian nurses and 100 Spanish nurses. To measure ethnic prejudice the *Subtle and Blatant*

Prejudice Scale was used; for Burnout measurement we used the *Maslach Burnout Inventory* and to examine cultural competence, we have developed a *57-items questionnaire* after adapting it and validating it in two different countries: Italy and Spain. The high alpha coefficients obtained in every sub-scale demonstrated the strong internal consistency. We have compared two different socio-political contexts concerning the prejudice, cultural competence and burnout of nurses working in two public hospitals. The two samples of nurses differ regarding three dimensions that we have retained as important factors to influence the quality of care. The analyses showed significant differences between the Italian and the Spanish sample: Italian nurses have greater difficulties and feelings of inadequacy in their work with immigrant users, higher prejudice against immigrants and higher emotional exhaustion than Spanish nurses.

These results may support our suggestion that political speeches and debates of the Italian government may have encouraged discriminatory and hostile manifestations in certain groups of health providers with a repercussion on their work. We should, however, be cautious in our interpretation because we have not used a tool which has operationalized and measured the relationship between the socio-political context and public political debates, on the one hand, and the variables examined, on the other.

The second aim of the study was to test a theoretical model where prejudice affects burnout through the mediation role of cultural competence. The structural equation model shows that there is a link between three dimensions. More specifically, we tested a theoretical model in which subtle and blatant prejudice affect burnout through the mediation of the components of cultural competence.

Future directions and questions

It is evident that the increase of diversity in private and public organizations has raised challenges for health providers. Italy and Spain, as relatively recent immigration countries, need a workforce that is adequately trained and equipped to respond adequately and effectively to the needs of their multiethnic society. Our role in reducing disparities in health care is crucial. First, as social psychologists, our role is to integrate topics of social psychology as prejudice and burnout with topics related to health and healthcare as cultural competence. Traditionally, the two approaches have been studied separately and the practical consequences derived by interaction perspectives have generally been secondary.

Although these two areas are different, they have the common focus in the "diversity".

1) Diversity in healthcare is considered with the equitable provision of healthcare and services for members of diverse social groups. In our study, we assumed that prejudice, the lack of cultural competence and burnout syndrome may affect this equitable provision and may differ according to the socio-political context. Thus, measurement of community and environmental indicators will be important for evaluating differences in two contexts. We suggested an integration of these two perspectives that is likely to produce a more accurate and comprehensive understanding of the problem, which may ultimately yield viable solutions to the problem.

2) In addition, we have a critical need to develop ecological strategies that integrated individual, collective and political factors. Ecological approaches (Bronfenbrenner, 1989) in health promotion view health care as a product of the interdependence between the micro-meso and macro systems (e.g.,family, community, culture, and the social and political environment). To promote "diversity" in health, a macro-system must offer economic and social conditions leading to an equity access and care for the minority groups. In turn, meso system must also provide organizations culturally competent and health providers (micro) that engage in healthful behaviors. In an ecological context, such elements are viewed as determinants of health. They also provide support in helping individuals to modify their behaviors and reduce their exposure to risk factors.
3) Starting from these considerations, we suggest the need for interventions directed at several levels and with possible extensions to multiple sectors of a social system (e.g., health, education, welfare, commerce, and transportation).

References

Abrums, M. & Lepppa, C."Beyond cultural competence: Teaching about race, Agency for Healthcare Research and Quality". *National Healthcare Disparities Report, 2003*. Rockville, MD: Agency for Healthcare Research and Quality;

Adler, N. E. & Rehkopf, D. H. "U.S. Disparities in Health: Descriptions, Causes, and Mechanisms." *Annual Review of Public Health,* Vol. 29, (2008) P. 235-252.

Aiken, L.H, Clarke S.P. *et al.* "Hospital staffing, organization, and quality of care: Cross-national findings". *Nurs Nursing Outlook.* ; Vol. 50 (2002) P. 187–194.

Balsa, A.I, McGuire, T.G. "Statistical Discrimination in Health Care". *Journal of Health Economics.* Vol. 20 No. 6 (2001) P. 881–907.

Barbee, E., & Gibson, S. "Our dismal progress: The recruitment of non-whites into nursing". *Journal of Nursing Education.* Vol. 40 No. 6 (2001), P. 243-244.

Betancourt, J.R. *et al*., "Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care," *Public Health Reports* Vol. 118, No. 4 (2003). P. 293–302.

Betancourt, J.R. *et al.* "Cultural competence and health care disparities: key perspectives and trends". *Health Affairs.* Vol. 24. (2005). P. 499-505.

Bolton, L. Giger, J., Georges, C. A. Structural and racial barriers to health care. *Annual Review of Nursing Research,* Vol. 22, (2004) P. 9-58.

Bronfenbrenner, U. "Ecological systems theory". In R. Vasta (Eds.), *Annals of child development,* Vol. 6 (1989). P. 187-249. Greenwich, CT: JAI Press.

Cherniss, C. *Professional Burnout in Human Service Organizations*. New York: Praeger, 1980.

Cooper, L. A *et al.*. "Designing and evaluating interventions to eliminate racial and ethnic disparities in health care". *Journal of General Internal Medicine* Vol. 17. (2002). P. 477-486.

Davis, P., & Donald, B. (1997). "Multicultural counseling competencies: Assessment, evaluation, education and training, and supervision". Thousand Oaks, CA: Sage Publications.

Douglas, K. M., & Sutton, R. M.. "Effects of communication goals and expectancies on language abstraction". *Journal of Personality and Social Psychology*, Vol. 84, (2003). P. 682–696.

Douglas, K. M. *et al.* "Could you mind your language? An investigation of communicators' ability to inhibit linguistic bias". *Journal of Language and Social Psychology*, Vol. 27 (2008). P. 123–139.

Fincher, C. *et al.* "Racial Disparities in Coronary Heart Disease: A Sociological View of the Medical Literature on Physician Bias". *Ethnicity and Disease* Vol. 14 No.3 (2004). P. 360–71.

Green, A. *et al.* "Implicit Bias among Physicians and its Predictions of Thrombolysis for Blacks and Whites Patients". *Journal of General Internal Medicine.*Vol. 22. No.9 (2007). P. 1231–1238

Healy, Bernardine "The Yentl syndrome". *New England Journal Medicine*. Vol. 325, (1991). P. 274-276.

Horenczyk, G., & Tatar, M. "Teachers' attitudes toward multiculturalism and their perceptions of the school organizational culture". *Teaching and Teacher Education,* Vol. 18. (2002). P. 435-445.

Huff, R., & Kline, M Promoting health in multicultural populations: A handbook for practitioners. Thousand Oaks, CA: Sage, 1999.

Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care: Board on Health Sciences Policy (IOM, 2003). *Unequal treatment: Confronting racial and ethnic disparities in health care.* Washington, DC: National Academies Press, 2003.

Jackson, S. E., *et al.* "Toward an understanding of the burnout phenomenon". *Journal of Applied Psychology*. Vol. 71, (1986). P. 630–640

Joreskog, K.G., & Sorbom, D.. *LISREL 8.71* [Computer software]. Lincolnwood, IL:Scientific Software International, Inc, 2004.

Kagawa-Singer M, Kassim-Lakha S. "A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcomes". *Acad Med.* Vol. 78 (2003). P. 577–87.

Leiter, M.P, *et al.* "The correspondence of patient satisfaction and nurse burnout". *Social Science and Medicine* Vol. 47, (1998). P.1611–1617.

Leiter, M.P. *et al.* "The correspondence of patient satisfaction and nurse burnout". Soc Sci Med. Vol. 47 (1999). P.1611-7.

Lurie, N. *et al.* "Racial and ethnic disparities in care: the perspectives of cardiologists". *Circulation,* Vol. 111, (2005) P. 1264–1269.

Maass, A., *et al.* "Linguistic intergroup bias: Evidence for an in-group-protective motivation". *Journal of Personality and Social Psychology*, Vol.71 (1996), P. 512–526.

Maass, A. "Language use in intergroup contexts: The linguistic intergroup bias". *Journal of Personality and Social Psychology*. Vol. 57, (1989). P. 981–993.

Martin, M., & Vaughn, B. "Strategic Diversity & Inclusion". *Management magazine*, (2007). DTUI Publications Division: San Francisco, CA. P. 31-36

Maslach, C., & Jackson, S. E. *The Maslach Burnout Inventory.* Manual (2nd ed.). Palo Alto: CA: Consulting Psychologists Press, 1986.

Maslach, C., Jackson, S. E., & Leiter, M. P.. *The Maslach Burnout Inventory* (3rd ed.). Palo Alto, CA: Consulting Psychologists Press. 1996.

Pettigrew, T.F., & Meertens, R.W. "Subtle ad blatant prejudice in western Europe". *European Journal of Social Psychology.* Vol.25, (1995). *P.* 57-75.

Porter, C.P. & Barbee, E. "Race and racism in nursing research: Past, present, and future". *Annual Review of Nursing Research,* Vol. 22, (2004). P. 9-37.

Schulman, K.A *et al*. "The Effect of Race and Sex on Physicians'Recommendations for Cardiac Catheterization.". *New England Journal of Medicine* Vol. 340 No. 8. (1999), P. 618–26.

Seisdedos, N. *Manual MBI, Inventario Burnout de Maslach.* Madrid: TEA, 1997.

Shakeri Shemariani F. Culturally competent practice in hospice palliative care. Perspectives: BCASW newsletter. 2004.

Sirigatti, S., Stefanile, C. "Per una scala di misurazione del burnout". *Bollettino di Psicologia Applicata*,Vol. 187-188, (1988a), P..29-32.

Smedley, Brian D. *et al.* Institute of Medicine (U.S.). Committee in Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Unequal treatment: confronting racial and ethnic disparities in health care. Washington, D.C.: National Academy Press, c2003.

Sonn, C. "Reflecting on practice: Negotiating challenges to ways of working". *Journal of Community and Applied Social Psychology, Vol.14*, (2004). P. 305-313.

Sutton, M. "Cultural competence: It's not just political correctness, it's good medicine". *Family Practice Management* Vol.7, No 9 (2000). P. 58-60.

Taylor JS. "Confronting 'culture' in medicine's 'culture of no culture". *Acad Med.* Vol. 78. (*2003)*. P. 555–9.

The Henry J, Kaiser Family Foundation. Key facts: Race, ethnicity and medical care. Menlo Park: The Henry J. Kaiser Family Foundation, 1999.

Tyler, F. B. (2002). *Transcultural ethnic validity model and intracultural competence.* http://www.ac.wwu.edu/~culture/index-cc.htm.

Vahey DC, *et al.* "Nurse burnout and patient satisfaction". Med Care;Vol. 42(Suppl 2) (2004) P. 57-66.

van Ryn M, Fu SS. "Paved with good intentions: do public health and human service providers contribute to racial/ethnic disparities in health?" *Am J Public Health.Vol.* 93 No. 2(2003), P. 248–55.

Westerman, T. "Engagement of Indigenous clients in mental health services: What role do cultural differences play?" *Australian e-Journal for the Advancement of Mental Health, Vol.3*, No. 3 (2004). P. 88-93

Williams D.R "The health of U.S. racial and ethnic populations". *J Gerontol B Psychol Sci Soc Sci*; Vol. 60.(2005) P. 53–62.