III.
Healthcare professionals

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Diversity-sensitive healthcare delivery across Poland's clinical landscapes

Abstract
Healthcare systems are obliged to serve patients in a diversity-sensitive way. The recent decade confronted public healthcare in Poland not only with ongoing processes of modernization, marketization, reorganization, not to mention the Covid-19 pandemic. The health system in Poland is dealing with an intensely diversifying society. It is confronted with emerging or hitherto marginalized, discriminated against or underrepresented health interests and needs of women, people with disabilities, LGBTAQI, a growing number of older people, people with different levels of education, low income, poor health insurance; and, finally, the presence of people from diverse national, ethnic and cultural backgrounds. To gain insight into how clinicians have recently dealt with patient from diverse backgrounds, a survey-based pilot study was conducted with invited key informants (N = 26) representing a variety of medical specialties, settings and universities. The results obtained confirm hypothesis of medium-high to low levels of diversity-sensitive clinical competence and, additionally, reveal a variety of facts, positions and challenges related to this deficiency.

1. Theoretical background

Social, economic and demographic inequalities in access to healthcare in Poland became the subject of regular monitoring and research only after the reform of the public health sector 1999,[1] while inequalities

[1] Tadeusz Kaczmarek, Jerzy T. Marcinkowski, Monika Zysnarska, Tomasz Maksymiuk, Aleksandra Majewicz: Nierówności społeczne w dostępie do zdrowia [Social

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related to ethnicity, culture, gender, age, sexual orientation, etc., even later, as modernization, Europeanisation, increase of sociocultural complexity proceeded after a long post-war period of homogeneity. The Polish anti-discrimination legislations are of relatively recent date. The Anti-Discrimination Act of 3 December 2010 indicates the following premises of discrimination: gender, race, ethnicity, nationality, religion, creed, belief, age, sexual orientation.[2] The Polish Constitution from 2 April 1997 in Articles 2, 32 and 68 declares that every citizen of the Republic of Poland as »a democratic state (...) implementing the principles of social justice«, »has the right to equal treatment by public authorities« including »the right to health protection«. In addition, victims of discrimination can bring a civil action under Articles 23–24 of the Civil Code and the Code of Civil Procedure. Retaliation against persons who have exercised their right against discrimination is prohibited. Polish society and its public institutions continue to learn to respect difference, diversity and complexity, and to unlearn axiologies, habits and routines maintaining marginalization, stigmatization, and exclusion. Socialization and education should play a great role in this transformation, though our study rather confirms that medical studies and clinical practice do not offer sufficient pro-diversity training.

Inequalities in access to health services are usually examined either systemically and abstractly or with reference to the patient, e.g. health neglect, but much less frequently with regard to health

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inequalities in access to healthcare]. In: Problemy Higieny i Epidemiologii 88 (2007), pp. 259–266; Agnieszka Genowska, Iwona Grzegorzewska, Magdalena Zalewska, Justyna Fryc: Nierówności w dostępie do opieki zdrowotnej według statusu społeczno-ekonomicznego [Inequalities in access to healthcare by socio-economic status]. In: Hygieia Public Health 50 (2015), pp. 383–388; Agnieszka Sowa-Kofta, Anna Szetela, Stanisława Golinowska: Health promotion for the oldest seniors in the social sector. Examples of policies and programmes from Poland and the Czech Republic. In: Epidemiology Biostatistics and Public Health 14 (2017), https://doi.org/10.2427/12512; Viktoriya Pantyley: Health inequalities among rural and urban population of Eastern Poland in the context of sustainable development. In: Annals of Agricultural and Environmental Medicine 27 (2017), pp. 477–483; Justyna Rój, Maciej Jankowiak: Socioeconomic determinants of health and their unequal distribution in Poland. In: International Journal of Environmental Research and Public Health 18 (2021), https://doi.org/10.3390/ijerph182010856.

2 Act of 3rd December, 2010 on the implementation of some regulations of European Union regarding equal treatment. https://bip.brpo.gov.pl/en/content/act-3rd-december-2010-implementation-some-regulations-european-union-regarding-equal (accessed on 7.2.2023).

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providers' competencies and virtues[3] and their training. Therefore, the authors of the following study decided to investigate how health providers themselves rate their pro-diversity knowledge and competencies in ensuring equitable access to health services for minority groups present in their clinical landscapes. Such investigations can test not only the levels of knowledge and competence, but also the extent to which actual health provision in Poland is compliant with »the vocation of the doctor who wants to treat everyone and to do so in the best possible way«.[4] The Code of Medical Ethics in Article 3 states that »A doctor should always fulfil his duties with respect for the human being, regardless of age, sex, race, genetic equipment, nationality, religion, social affiliation, material situation, political views or other conditions«. However, »In doing so, it is clearly unacceptable that the reasons for ›inequality‹ are of different nature than the clinical condition of the patient«, Duława adds.[5] In turn, »(…) how a doctor treats a patient does not depend on the age of the patient, but on the doctor's individual character traits and attentiveness.«[6] Since 2013, the medical community in Poland has been encouraged to »actively purge healthcare of discrimination based on skin color, gender, socioeconomic status, ethnicity, religion, etc.« and to ensure the availability of »uniform and adequate healthcare«; to »individually and collectively remove barriers to equitable access to health resources and services – barriers depending on the

3 Ala Szczepura: Access to health care for ethnic minority populations. In: Postgraduate Medical Journal 81 (2005), pp. 141–147; Marek Olejniczak: Jakiej sprawiedliwości wolno oczekiwać od lekarza? [What justice can be expected from a physician?] In: Diametros 44 (2015), pp. 78–88; Jerzy Kiszka, Dorota Ozga, Arkadiusz Mach, Romuald Krajewski: Providing help to multicultural patients in the context of contemporary population migrations in Europe. In: Pielęgniarstwo XXI wieku 17 (2018), pp. 30–36; Marcin Orzechowski, Marianne Nowak, Katarzyna Bielińska, Anna Chowaniec, Robert Doričić, Mojca Ramšak, Paweł Łuków, Amir Muzur, Zvonka Zupanič-Slavec, Florian Steger: Social Diversity and Access to Healthcare in Europe: How does European Union's Legislation Prevent from Discrimination in Healthcare? In: BMC Public Health 20 (2020), https://doi.org/10.1186/s12889-020-09494-8.
4 Olejniczak: Jakiej sprawiedliwości (Note 3).
5 Jan Duława: Kilka uwag na temat zasady niedyskryminacji chorych przez lekarzy [A few remarks on the principle of non-discrimination of patients by doctors]. Commentary to Andrzej Muszala: KEL: O równym traktowaniu pacjentów przez lekarza [About equal treatment of patients by the doctor]. In: Medycyna Praktyczna dla Lekarzy (11.12.2013). https://www.mp.pl/etyka/podstawy_etyki_lekarskiej/92503,kel-o-rownym-traktowaniu-pacjentow-przez-lekarza (accessed on 7.2.2023).
6 Duława: Kilka uwag (Note 5).

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level of education, legal system, financial position, place of residence and social discrimination« so that access to health and healthcare, including health promotion and prevention, becomes equitable:[7] for health and healthcare belong to primary social goods and, according to human rights, must be equally accessible in a democratic and plural society[8].

Before shifting the focus to the recent findings on (non)discrimination determinants inherent in the knowledge and competence of healthcare providers, let us draw attention to two main barriers blocking the development of pro-diversity attitudes in the Polish medical community. The first barrier identified by the community itself is macro-structural change, whereby traditional medical teleology clashes with the allocation and distribution of limited healthcare resources:

> (…) there has been a paradigm shift. Equal treatment of a patient depends less and less on the level of moral sensitivity and personal sense of responsibility of a particular physician dealing with this patient. (...) The doctor-patient relationship was transformed into a commercial activity, involving the sale of limited services and the creation of waiting lists, justified by the need for a fair distribution of limited resources. Worse still, it has decided to create institutional structures to ensure that patients are treated equally, no longer by doctors, but by the health service as an organization.[9]

The second barrier seems rooted in the organizational culture of the healthcare:

> The danger of conservatism is one of the key cultural risks of hospitals operating in a highly variable environment. Central to this is the desire to maintain and transmit the same values, traditions are cultivated (...) and the status quo (...) Conservative organizations insulate themselves from information and resist change (...) Organizational cultures of large public hospitals are particularly rigid and conservative (...) The preference for hierarchy involves the belief that people differ (...) in the powers, privileges and benefits of different groups of employees. Particular importance is attached to maintaining discipline and reinforcing

7 Piotr Gajewski, Anna Juda, Jacek Mrukowicz, Wojciech Strojny: Karta Lekarza [Physician's Charter]. In: Medycyna Praktyczna dla Lekarzy (18.6.2013). https://www.mp.pl/etyka/dokumenty/86822,karta-lekarza (accessed on 7.2.2023).

8 Rui Nunes, Sofia B. Nunes, Guilhermina Rego: Health care as a universal right. In: Journal of Public Health 25 (2017), pp. 1–9.

9 Duława: Kilka uwag (Note 5).

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> the authority (...) acceptance of a strong hierarchy among employees prevails. There is a clear preference for elitist thinking.

In contrast, »the drive for equality stems from the belief that people are entitled to similar rights and the organization reflects this elementary equality.«[10]

According to organizations monitoring discrimination against patients, for instance the Polish Society of Antidiscrimination Law, gender discrimination may be understood, for instance, as a situation in which a hospital denies a woman access to prenatal tests despite the existing indications.[11] Age discrimination manifests itself e.g. by a physician's opinion that illness belongs to unavoidable signs of ageing; here age is used as a diagnosis and premise to not to call an ambulance to an elderly person as it »no longer makes sense«. Further, adults with intellectual disabilities are refused a medical procedure on the grounds that they are »unable to consciously consent to the procedure«, so they »should be placed under guardianship«. An act of discrimination will be a refusal of blood donation if a donor has non-heterosexual orientation, thus creates »an increased risk of HIV infection«.[12] Persons with foreign nationalities may face the refusal of access to certain services due to »lacking PESEL/ID number«. It is already discriminatory to have difficult access to clear and reliable information, in a language the patient understands, on eligibility for

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10 Łukasz Sułkowski: Zmiana kulturowa w polskich szpitalach – wyniki badań [Cultural change in Polish hospitals – research results]. In: Przedsiębiorczość i Zarządzanie 14 (2013), pp. 83–96, here p. 89; Reema Harrison, Merrilyn Walton, Ashfaq Chauhan, Elizabeth Manias, Upma Chitkara, Monika Latanik, Desiree Leone: What is the role of cultural competence in ethnic minority consumer engagement? An analysis in community healthcare. In: International Journal for Equity in Health 18 (2019), https://doi.org/10.1186/s12939-019-1104-1.

11 Joanna Z Mishtal: Matters of »conscience«: the politics of reproductive healthcare in Poland. In: Medical Anthropology Quarterly 23 (2009), pp. 161–183; Jacqueline Heinen, Stéphane Portet: Reproductive rights in Poland: when politicians fear the wrath of the church. In: Third World Quarterly 31 (2010), pp. 1007–1021.

12 Marcin Rodzinka: Praktyczny przewodnik po zdrowiu LGBTI dla lekarzy [A practical guide to LGBTI health for doctors]. Warszawa 2017; Robert Kowalczyk, Marcin Rodzinka (Eds.): Zdrowie LGBT. Przewodnik dla kadry medycznej [LGBT Health. Guide for medical staff]. Warszawa 2016; Wiktor Dynarski, Izabela Jąderek: Transpłciowość a opieka zdrowotna w Polsce: Raport z badań [Transgenderism and healthcare in Poland: Research report]. Warszawa 2015.

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assistance, how healthcare works and where to get help.[13] It will be discriminatory to deprive Muslim women staying in refugee centers of the right to choose a female doctor.[14]

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13 Ulrike Kluge, Marija Bogic, Walter Devillé, Tim Greacen, Marie Dauvrin, Sonia Dias, Andrea Gaddini, Natasja Koitzsch Jensen, Elisabeth Ioannidi-Kapolou, Riveta Mertaniemi, Rosa Puipcinós i Riera, Sima Sandhu, Atilla Sarvary, Joaquin J.F. Soares, Mindaugas Stankunas, Christa Straßmayr, Marta Welbel, Andreas Heinz, Stefan Priebe: Health services and the treatment of immigrants: data on service use, interpreting services and immigrant staff members in services across Europe. In: European Psychiatry 27 (2020), pp. S56–S62; Karima Karmali, Linda Grobovsky, Jennifer Levy, Margaret Keatings: Enhancing cultural competence for improved access to quality care. In: Healthcare Quarterly 14 (2014), pp. 52–57; Melanie Wasserman, Megan R. Renfrew, Alexander R. Green, Lenny Lopez, Aswita Tan-McGrory, Cindy Brach, Joseph R. Betancourt: Identifying and preventing medical errors in patients with limited English proficiency: key findings and tools for the field. In: Journal for Healthcare Quality 36 (2014), pp. 5–16; Stefan Priebe, Sima Sandhu, Sónia Dias, Andrea Gaddini, Tim Greacen, Elisabeth Ioannidis, Ulrike Kluge, Allan Krasnik, Majda Lamkaddem, Vincent Lorant, Rosa Puipcinósi I Riera, Attila Sarvary, Joaquim Soares, Mindaugas Stankunas, Christa Straßmayr, Kristian Wahlbeck, Marta Welbel, Marija Bogic: Good practice in health care for migrants: views and experiences of care professionals in 16 European countries. In: BMC Public Health 11 (2011), https://doi.org/10.1186/1471-2458-11-187; Philipa Mladovsky: Migrant health in the EU. In: Eurohealth 13 (2007), pp. 9–11.

14 Ewa Kocot, Anna Szetela: Assessing health systems' preparedness for providing care for refugees, asylum seekers and migrants: a scoping review. In: The European Journal of Public Health 30 (2020), pp. 1157–1163; Sarah Hamed, Suruchi Thapar-Björkert, Hannah Bradby, Beth Maina Ahlberg: Racism in European health care: structural violence and beyond. In: Qualitative Health Research 30 (2020), pp. 1662–1673; Anna Górska, Maryla Koss-Goryszewska, Jacek Kucharczyk (Eds.): W stronę krajowego machanizmu ewaluacji integracji: Diagnoza sytuacji beneficjentów ochrony międzynarodowej w Polsce [Towards a national integration evaluation mechanism: Diagnosis of the situation of beneficiaries of international protection in Poland]. Warszawa 2019; Augustus A. White, Beauregard Stubblefield-Tave: Some advice for physicians and other clinicians treating minorities, women, and other patients at risk of receiving health care disparities. In: Journal of Racial and Ethnic Health Disparities 4 (2017), pp. 472–479; Mona Lindqvist, Åsa Wettergren: Migrant women's negotiation of belonging through therapeutic relationships. In: International Journal of Migration, Health and Social Care 14 (2017), pp. 41–54; Jay J. Shen, Christopher R. Cochran, Olena Mazurenko, Charles B. Moseley, Guogen Shan, Robin Mukalian, Scott Neishi: Racial and insurance status disparities in patient safety indicators among hospitalized patients. In: Ethnicity and Disease 26 (2016), pp. 443–452; Eli Kvamme, Siri Ytrehus: Barriers to health care access among undocumented migrant women in Norway. In: Society, Health and Vulnerability 6 (2015), https://doi.org/10.3402/shv.v6.28668; Dorota Cianciara, Paweł Goryński, Wojciech Seroka: Hospitalizacja migrantów w Polsce [Hospitalization of migrants in Poland]. In: Problemy Higieny i Epidemiologii 92 (2011), pp. 497–503; Peter B. Bach: Unequal treatment: Confronting racial and

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2. Objectives

In embarking on this study and taking into account the historical, socioeconomic and structural premises indicated in Section 1, we adopted the following hypotheses:

I. The overall sociocultural diversity related levels of knowledge, awareness and competence of fellow clinicians as assessed by key informants are medium-high to low.
II. Respondents' age, gender, specialty, and length of professional service are not significantly related to their insights and assessments of diversity-sensitive clinical competence and professional medical practices in their clinical environments.
III. Due to the workplace (e.g. a hospital/clinic vs a medical practice), assessments may differ when it comes to diversity sensitive knowledge, competence and awareness among fellow clinicians. Healthcare encompasses clinical environments with a variety of behavioral and interactionist patterns towards patients from socioculturally diverse backgrounds.

In addition, a number of specific results were expected according to the research tool used.

3. Method and procedure

A pilot study using a survey method was carried out. Designing the survey was possible with the support and permission of Prof. Robert Like, MD MS, Director of Center for Healthy Families and Cultural Diversity, Dept. of Family Medicine and Community Health, Rutgers University, whose Clinical Cultural Competency Questionnaire (CCCQ-PRE, 2001) was originally used in a project »Assessing the Impact of Cultural Competency Training Using Participatory Quality Improvement Methods« funded by the Aethna Foundation. The research tool shall eventually include demographic characteristics followed by several subscales: clinicians' 1. knowledge on diversity, 2. competence to deal with sociocultural issues, 3. self-confidence (comfort) in dealing with actual cross-cultural challenges, 4. attitudes

ethnic disparities in health care. In: New England Journal of Medicine 349 (2003), p. 1296.

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toward factors contributing to health disparities, 5. competence to identify and distinguish sociocultural identity in clinical contexts, 6. awareness of stereotypes and prejudices in clinical contexts, 7. training.

The »Attitudes« subscale was divided into two, one relating to the ability to identify sociocultural identities across the clinical environments and the other relating to awareness of stereotypes and prejudices. For a more detailed assessment, the Likert scale in which participants make their ratings was extended to 0–5 (0 for »none« and 5 for »a lot/very«) from the original version, in which it was 1–5.[15] Rather than to self-assess their personal knowledge, skills or attitudes, participants were asked to rate knowledge, competences, attitudes and awareness of fellow clinicians involved in their home clinical environments. The perspective of an observer situated in the local professional community – in terms of a setting such as hospital/clinic vs medical practice – was expected to provide more cross-sectional insights into clinical practices and interactions taking into account sociocultural diversity, rather than a perspective based on data obtained from subjective self-reports and self-declarations.[16] A pilot study was conducted in January 2022. The survey was not made available in the public domain. Participation was voluntary, consents were collected together with the completed surveys. Data and results obtained are solely the responsibility of project investigators and do not necessarily represent the official views of the Aetna Foundation and its affiliates.

15 Nicole Mareno, Patricia L. Hart, Lewis Van Brackle: Psychometric validation of the Revised Clinical Cultural Competency Questionnaire. In: Journal of Nursing Measurement 21 (2013), pp. 426–436.

16 Annette Boaz, Stephen Hanney, Teresa Jones, Bryony Soper: Does the engagement of clinicians and organisations in research improve healthcare performance: a three-stage review. In: BMJ Open 5 (2015), http://dx.doi.org/10.1136/bmjopen-2015-009415; Peter Zeh, Ann-Marie Cannaby, Harbinder K. Sandhu, Jane Warwick, Jackie A. Sturt: A cross-sectional survey of general practice health workers' perceptions of their provision of culturally competent services to ethnic minority people with diabetes. In: Care Diabetes 12 (2018), pp. 501–509; Nina B. Wallerstein, Bonnie Duran: Using community-based participatory research to address health disparities. In: Health Promotion Practice 7 (2006), pp. 312–323.

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3.1. Sample

We invited key informants representing outpatient and inpatient care, including residents and trainees. They were previously recommended for this role by randomly selected representatives of medical institutions. 26 persons accepted the invitation (response rate was 74 %). Of them, 73.1 % were female and 26.9 % male; Polish speakers only; aged 25–64 (SD = 7.56), of them 36 % < 40 and 64 % > 40. 88.5 % came from large cities and 11.5 % from small cities. 84.6 % of them were employed or were doing internships and work placements in hospitals or clinics, 11.5 % in medical practices and 11.5 % in non-public units. 15.38 % of the participants reported that they had been abroad, for an average of several months, for professional purposes. A total of twelve medical facilities in six cities were involved. Nearly ten various specialties have been approached (Table 1). Other significant descriptive variables are length of service and length of internship abroad in years (Figures 1 and 2).

Specialty distribution	%
Anesthesiology & intensive care	28.0
Neurology	20.0
Pediatrics	12.0
Others	40.0

Table 1: Specialty distribution in the sample

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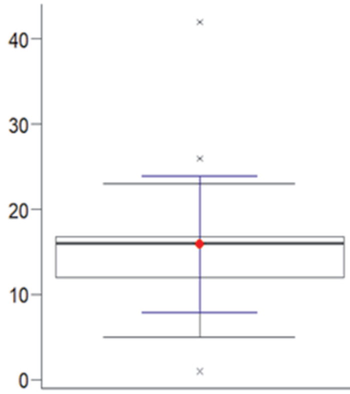

Figure 1: Length of service (in years)

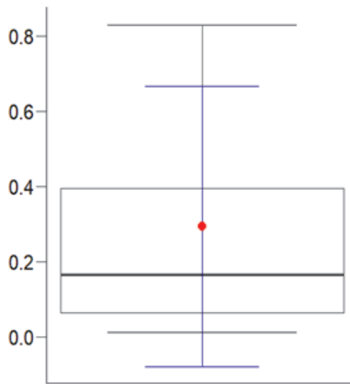

Figure 2: Length of internship abroad (in years)

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The research conducted was a pilot study. Written permission was obtained for the adaptation and non-commercial use of the CCCQ-PRE scale. Respondents participated voluntarily. As neither personal questions were asked nor sensitive data collected, approval from the Ethics Committee was not necessary. The questionnaire was prefaced by an opt-out informed consent form. Privacy and confidentiality were protected by anonymization. There was no special funding for this research. No conflict of interest was identified. Data and results obtained are solely the responsibility of project investigators and do not necessarily represent the official views of the Aetna Foundation and its affiliates.

4. Results

Analyses included descriptive analysis, factor and correlation analysis. As for the statistical analysis, we note that $p = 0.05$ was taken as the significance level. The significance level is the maximum acceptable error probability of rejecting the true null hypothesis H0, which assumes that the groups under study do not differ in terms of the characteristic of interest. Results of $p < 0.05$ will indicate the presence of significant relationships between variables. Parametric tests (Student's T-test or ANOVA analysis of variance) or their non-parametric equivalents (Mann-Whitney U-test, Kruskal-Wallis test) were used to examine quantitative variables presented by group (subscale).

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Factor	N	M	SD	Min	Max	Me
1. Clinicians' knowledge on diversity	26	2.08	0.93	0.56	4.00	2.03
2. Clinicians' competence to deal with sociocultural issues	26	2.09	1.05	0.53	4.00	2.07
3. Clinicians' self-confidence (comfort) level in dealing with actual cross-cultural challenges	26	2.15	1.01	0.33	4.33	1.92
4. Clinicians' attitudes toward factors contributing to health disparities	26	2.85	0.79	1.54	4.54	2.89
5. Clinicians' competence to identify and distinguish sociocultural identities in clinical contexts	26	3.10	1.08	0.00	5.00	3.13
6. Clinicians' awareness of stereotypes	26	3.02	1.12	1.00	5.00	3.00

Table 2: Factor solutions by subscale in terms of descriptive statistics. Abbreviations: M for mean scores, SD for standard deviation, Min for minimum scores, Max for maximum scores, Me for median

Table 2 presents descriptive statistics (for N = 26) including mean, minimum and maximum values, as well as median values of scores grouped into six subscales of the survey. For the six subscales, the mean values were medium-high to low. Respondents rated highest their fellow clinicians' competence to identify and distinguish diverse sociocultural identities in clinical contexts including patients and fellow clinicians (Me = 3.13), their awareness of stereotypes circulating among clinicians about patients and vice versa (Me = 3.0) and attitudes toward factors contributing to health disparities (Me = 2.89), as displayed in Figures 3, 4 and 5.

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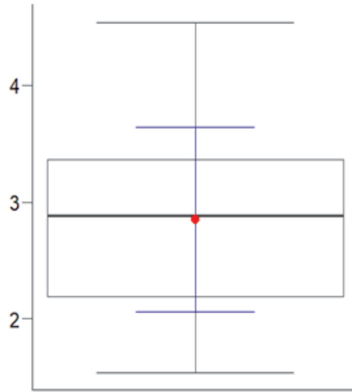

Figure 3: Clinicians' attitudes toward factors contributing to health disparities (median) rated by respondents

Figure 4: Clinicians' competence to identify and distinguish sociocultural identity rated by respondents

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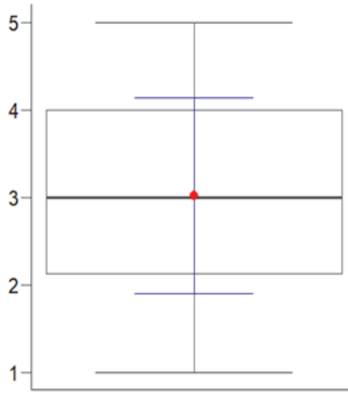

Figure 5: Clinicians' awareness of stereotypes rated by respondents

Below we tabulate detailed results by variable grouped into seven subscales contained in the survey:

Variable		*N*	*M*	*SD*	*Min*	*Max*	*Me*
Subscale 1	Demographics of diverse racial and ethnic groups	26	2.08	1.23	0.00	4.00	2.00
	Sociocultural characteristics of diverse racial and ethnic groups	26	2.31	1.32	0.00	4.00	2.00
	Health risks experienced by diverse racial and ethnic groups	26	2.04	1.34	0.00	4.00	1.50
	Health disparities experienced by diverse racial and ethnic groups	26	1.96	1.28	0.00	4.00	1.50
	Sociocultural issues in health promotion	26	2.08	1.06	0.00	4.00	2.00
	— in reproductive health	26	2.39	1.06	0.00	5.00	2.00

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Variable		*N*	*M*	*SD*	*Min*	*Max*	*Me*
	— in child health	26	2.27	1.12	0.00	5.00	2.00
	— in adolescent health	26	2.15	1.26	0.00	5.00	2.00
	— in adult health	26	2.50	1.14	0.00	5.00	3.00
	— in geriatrics	26	2.19	1.10	0.00	4.00	2.00
	— in women's health	26	2.31	1.12	0.00	5.00	2.00
	Ethnopharmacology	26	1.35	1.20	0.00	4.00	1.00
	Different healing traditions	26	1.31	1.12	0.00	4.00	1.00
	Historical and contemporary impact of racism, bias, prejudices, discrimination in healthcare in Poland	26	2.00	1.41	0.00	4.00	1.50
	Domestic policy guidance on non-discrimination	26	2.35	1.55	0.00	5.00	3.00
	Domestic standards for socioculturally sensitive health services	26	2.04	1.59	0.00	5.00	1.50
Subscale 2	Greeting patients in a culturally sensitive manner	26	2.62	1.39	0.00	5.00	3.00
	Eliciting the patient's perspective about health and illness	26	2.77	1.07	0.00	5.00	3.00
	Eliciting information about use of folk and alternative remedies	26	2.12	1.21	0.00	4.00	2.00
	Eliciting information about use of folk and alternative healers	26	1.96	1.40	0.00	4.00	2.00

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Variable		*N*	*M*	*SD*	*Min*	*Max*	*Me*
	Performing a culturally sensitive physical examination	26	2.15	1.52	0.00	5.00	2.00
	Prescribing or negotiating a culturally sensitive treatment plan	26	2.15	1.32	0.00	4.00	2.00
	Providing culturally sensitive education and counseling	26	2.08	1.35	0.00	4.00	2.00
	— clinical preventive services	26	1.69	1.46	0.00	4.00	1.00
	— end of life care	26	2.04	1.46	0.00	5.00	2.00
	Assessing health literacy	26	1.81	1.27	0.00	4.00	2.00
	Collaboration with medical interpreters	26	1.92	1.35	0.00	5.00	2.00
	Dealing with cross-cultural conflicts related to diagnosis or treatment	26	2.19	1.23	0.00	4.00	2.00
	Dealing with cross-cultural adherence/compliance problems	26	2.08	1.20	0.00	4.00	2.00
	Dealing with cross-cultural ethical conflicts	26	1.89	1.31	0.00	4.00	2.00
	Apologizing for cross-cultural misunderstandings/errors	26	1.92	1.38	0.00	4.00	2.00

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Subscale 3	Caring for patients from culturally diverse backgrounds	26	2.96	1.34	0.00	5.00	3.00
	Caring for patients with limited Polish proficiency	26	2.96	1.40	0.00	5.00	3.00
	Caring for a patient who insists on using or seeking folk healers or alternative therapies	26	1.65	1.33	0.00	5.00	2.00
	Identifying patients'/ caregivers' silent beliefs that might interfere with the treatment regimen	26	1.89	1.31	0.00	5.00	1.50
	Being attentive to nonverbal cues, culturally specific gestures that might have different meanings in different cultures	26	1.69	1.32	0.00	5.00	1.00
	Interpreting different cultural expressions of pain, distress, suffering	26	2.00	1.33	0.00	5.00	2.00
	Advising a patient to change behaviors or practices rooted in cultural beliefs that impair one's health	26	2.15	1.57	0.00	5.00	2.00
	Speaking in an indirect rather than direct way to a patient about their illness if this is more culturally appropriate	26	2.23	1.39	0.00	5.00	2.00

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Subscale 3	Breaking ›bad news‹ to a patient's family first rather than to the patient when it is more culturally appropriate	26	2.00	1.47	0.00	5.00	2.00
	Working with healthcare providers from culturally diverse backgrounds	26	2.23	1.39	0.00	5.00	2.00
	Working with a fellow clinician who makes derogatory remarks about patients from socioculturally diverse backgrounds	26	2.04	1.22	0.00	5.00	2.00
	Treating a patient who makes derogatory remarks about doctors' socioculturally diverse backgrounds	26	1.96	1.28	0.00	5.00	2.00
Subscale 4	Attitudes toward impact of genetics on health disparities	26	4.08	0.94	2.00	5.00	4.00
	—– impact of lifestyle …	26	4.58	0.76	2.00	5.00	5.00
	—– impact of environment …	26	4.42	0.81	2.00	5.00	5.00
	—– impact of poverty …	26	4.04	0.82	2.00	5.00	4.00
	—– impact of educational status …	26	3.77	1.07	1.00	5.00	4.00
	—– impact of illiteracy …	26	3.62	1.30	0.00	5.00	4.00
	—– impact of ageism …	26	2.62	1.44	0.00	5.00	3.00

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Subscale 4	—– impact of sexism …	26	2.04	1.54	0.00	5.00	2.00
	—– impact of racism …	26	1.65	1.36	0.00	5.00	1.50
	—– impact of classism …	26	2.00	1.39	0.00	5.00	2.00
	—– impact of ableism …	26	1.92	1.55	0.00	5.00	1.50
	—– impact of sexual orientation discrimination …	26	1.89	1.40	0.00	4.00	1.00
	—– impact of other factors …	26	0.42	1.03	0.00	4.00	0.00
Subscale 5	Competence to identify patients' sociocultural identity …	26	2.65	1.16	0.00	5.00	3.00
	—– fellow healthcare providers' sociocultural identity …	26	3.42	1.24	0.00	5.00	4.00
	—– residents' and medical students' socio-cultural identity...	26	3.15	1.12	0.00	5.00	3.00
	—– staff's sociocultural identity …	26	3.15	1.12	0.00	5.00	3.00
Subscale 6	Clinicians' awareness of racial, ethnic, cultural stereotypes	26	3.08	1.13	1.00	5.00	3.00
	Clinicians' awareness of biases and prejudices	26	2.96	1.15	1.00	5.00	3.00
	Number of fellow healthcare providers displaying stereotypes and prejudices	26	5.08	6.43	0.00	25.00	3.00
	Number of patients displaying stereotypes and prejudices	26	6.77	9.09	0.00	30.00	4.00

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Subscale 6	How strong is the need for training in diversity-sensitive healthcare	26	3.23	1.77	0.00	5.00	3.00
Subscale 7	How often is such training offered in the medical curriculum	26	0.42	0.64	0.00	2.00	0.00
	—– during the internship	26	0.35	0.63	0.00	2.00	0.00
	—– healthcare facilities	26	0.27	0.45	0.00	1.00	0.00

Table 3: Detailed results by item-referring variables grouped into subscales. Abbreviations: M for mean scores, SD for standard deviation, Min for minimum scores, Max for maximum scores, Me for median

Key informants rated highest the awareness of fellow clinicians about which factors influence health disparities (as for subscale 4), among them especially genetic, environmental, lifestyle, and education level related factors (Me = 4 to 5). Medium-high to very low ratings were given to remaining knowledge, awareness and competence of their clinical collaborators in dealing with patients from diverse backgrounds. Regarding education (subscale 7), key informants estimated the frequency of training offerings in diversity sensitive health services at all education and career stages to be close to zero (M = 0.37 to 0.42; Me = 0.00). The results generally confirm the first of our hypotheses.

When it comes to the second hypothesis, 1) regarding age, the study showed no statistically significant differences in the examined assessments between participants aged up to 40 years and participants aged over 40 years. Participants aged over 40 years scored slightly higher on fellow clinicians' self-confidence (comfort) in dealing with actual cross-cultural challenges, attitudes toward factors contributing to health disparities, and competence to identify diverse sociocultural identities in clinical contexts. However, they scored slightly lower fellow clinicians' diversity knowledge, competence to deal with sociocultural issues and awareness of stereotypes and prejudices. 2) Regarding gender, among male participants, the mean score for rating fellow clinicians' attitudes toward factors determining health disparities was M = 2.33; SD = 0.81, while among female participants

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the mean was higher, M = 3.04; SD = 0.72. Female participants rated their fellow clinicians' attitudes toward factors increasing health disparities significantly higher, $t(24) = 2.17$; $p < 0.05$. In addition, they evaluated their collaborators' competence to identify diverse sociocultural identities slightly higher than did male participants. Regardless, this and other gender related differences were statistically marginal. 3) With respect to participants' professional specialties, no significant differences were found in individual assessments between those with the specialty in anesthesiology, neurology and other specialties involved. Anesthesiologists evaluated slightly higher than others their fellow clinicians' knowledge on diversity, competence to cope with cross-cultural issues, competence to manage actual cross-cultural challenges and to identify diverse sociocultural identities in clinical contexts, and awareness of stereotypes. Respondents with other specialties rated slightly higher fellow clinicians' attitudes toward factors affecting health disparities. However, these differences were statistically non-significant. To summarize, the specialty held does not significantly differentiate peer reviews of diversity knowledge or cross-cultural competence in home clinical contexts. 4) As for length of professional service, there were no statistically significant differences in the assessments between participants with up to 15 years of service and these with more than 15 years of service. Participants with longer professional experience slightly higher scored fellow clinicians' self-confidence (comfort) in dealing with actual cross-cultural challenges, ability to identify diverse sociocultural identities, and attitudes toward the impact of factors increasing health disparities. The same participants slightly lower scored their fellow clinicians' knowledge on diversity, competence to deal with sociocultural issues, awareness of stereotypes. However, these differences showed little statistical significance.

As for the hypothesis III that workplace significantly differentiates the discussed evaluations of healthcare workers invited to the study, because – as previously hypothesized – their units may differ (in particular, hospitals/clinics vs medical practices; public vs non-public healthcare settings) in terms of diversity-sensitive patterns of clinical practices, the study yielded selectively confirmable findings. For a reliable analysis, it was necessary to merge the small number of non-public healthcare facilities and practices (they are included under ›other‹, as in Table 4).

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Variable	*Workplace*	*t/U*	*df*	*p*	*M*	*SD*	*Min*	*Max*	*Me*
Clinicians' knowledge on diversity		3.24	24	0.004					
	Hospital/ clinic				2.36	0.86			
	other				1.17	0.44			
Clinicians' competence to deal with cross-cultural issues		1.73	24	0.097					
	Hospital/ clinic				2.28	1.08			
	Other				1.47	0.66			
Clinicians' self-confidence (comfort) in dealing with actual cross-cultural challenges		1.15	24	0.263					
	Hospital/ clinic				2.27	1.11			
	Other				1.74	0.39			
Clinicians' attitudes toward factors having impact on health disparities		-2.65	24	0.014					
	Hospital/ clinic				2.65	0.68			
	Other				3.53	0.83			
Clinicians' competence to identify and distinguish sociocultural identity		29.50		0.065					
	Hospital/ clinic						0.00	5.00	3.50
	Other						1.00	3.50	2.88
Clinicians' awareness of stereotypes		0.88	24	0.389					
	Hospital/ clinic				3.13	1.10			
	Other				2.67	1.21			

Table 4: Correlation analysis between workplace (hospital/clinic vs other) and scores obtained for six essential subscales. Abbreviations: t for test statistic; U for test statistic; df for degrees of freedom; p for statistical significance; M for mean; SD for standard deviation; Me for median; Min for minimum score; Max for maximum score

Table 4 demonstrates that respondents employed in hospitals or clinics rated diversity related knowledge in their collaborators higher, M = 2.36; SD = 0.86, compared to respondents employed in other healthcare units. The second group rated the knowledge of their collaborators lower, M = 1.17; SD = 0.44. Hospital employees

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statistically significantly higher rated diversity related knowledge in their collaborators, $t(24) = 3.24$; $p < 0.01$. However, hospital employees rated fellow clinicians' attitudes toward factors increasing health disparities lower, M = -2.65; SD = 0.68, when compared to their counterparts employed in other healthcare units. The latter rated attitudes of their fellow clinicians higher, M = 3.53; SD = 0.83. Thus, hospital employees statistically significantly lower rated attitudes toward factors increasing health disparities, $t(24) = -2.65$; $p < 0.05$, among fellow staff. For the remaining scores, only statistically non-significant differences were noted between hospital vs other units' staff.

Finally, when asked about barriers to the inclusion of training in socio-culturally competent healthcare, the following responses were received: lack of time (42.11 %); lack of resources (21.05 %); lack of awareness (21.05 %); prejudices (5.26 %); other factors (36.84 %).

5. Discussion

The explanation of findings obtained can be multicausal. Some potential causes have already been identified in the introduction, and these were systemic changes in healthcare at the level of funding, resource distribution, structural hierarchies and cultures, affecting the patterns of medical professional-patient relationships. These macro phenomena may slow down the development of discussed competences crucial to ensure equitable accessibility of healthcare for patients from socioculturally diverse groups. In turn, the barriers identified by the respondents themselves are 1) poor education, and 2) the rarity of international and intercultural professional experience (work placements) that would allow familiarization with diversity among patients and relevant good practices among healthcare professionals. Nor does the community seem interested in its own internationalization. While the Ministry of Health has facilitated hiring procedures for non-EU medical workers, medical chambers slow down nostrification procedures, which is publicly perceived as »discriminatory« and not in line with the expectations of hospitals and clinics. On the other hand, the argument that by employing a doctor from the eastern border on a single job, the employer can save PLN 120,000 per year

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also sounds discriminatory.[17] The barriers may also lie elsewhere. For instance, less than a freestanding, declarative and contemplative purely normative ethics, what is needed here is an applied ethics, or more precisely, an engaged and transformative practice, as Matthias Kettner suggests.[18]

Additionally, the respondents stated, among other things, that »the question of culturally appropriate information about the patient's condition is at odds with the official requirement of culturally undifferentiated information transmission«. The comments from respondents suggested absolutely equal treatment. They point to a conception of equality that could be called a French relic. The French Constitution speaks of absolutely equal treatment for each individual. The aim is integration. In practice, this makes minorities invisible and produces systemic forms of discrimination against different ethnic, linguistic, religious, etc. populations.

> The »absolute« nature of equality is part of [the Revolution of 1789] legacy, with equality seen as the overarching principle in the constitutional edifice. This has been protected and enforced by the Constitutional Court on many occasions. For example, in 1999 the court decided that ratifying the European Charter for Regional or Minority Languages would be unconstitutional on grounds of ›absolute equality‹ (…). Legally, the constitutional principle of equality has been interpreted as prohibiting the government from collecting data or statistics on the racial, ethnic or religious backgrounds of its citizens, in any context. This means for example that the socioeconomic status of groups across any indicators based on racial, ethnic, religious or other grounds is unknown, and that the national census does not include any questions about race or ethnicity.[19]

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17 Iwona Hajnosz: Czy lekarze z Ukrainy to zagrożenie dla pacjentów? Według izb lekarskich tak! [Are doctors from Ukraine a threat to patients? According to medical chambers, yes!]. In: Gazeta Wyborcza Kraków (6.2.2022). https://krakow.wyborcza.pl/krakow/7,44425,28076221,czy-lekarze-z-ukrainy-to-zagrozenie-dla-pacjentow-wedlug-izb.html?utm_source=facebook.com&utm_medium=SM&utm_campaign=FB_Gazeta_Wyborcza&fbclid=IwAR0dXJoNWdRu20cci5CxTr52awLdc7PI7x7zJdPnCQpy2PgJhDDuk14I8u0 (accessed on 7.2.2023).

18 Matthias Kettner: Miseren des Krankenhauses, institutionelle Pathologien und klinische Organisationsethik [Hospital misery, institutional pathologies and clinical organizational ethics]. In: Ethik in der Medizin 33 (2021), pp. 159–175.

19 Jeremie Gilbert, David Keane: How French law makes minorities invisible. In: The Conversation (13.11.2016). https://theconversation.com/how-french-law-makes-minorities-invisible-66723 (accessed on 7.2.2023).

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Meanwhile, the Polish Constitution (Article 35) recognizes minorities and their rights.

Moreover, the respondents stated that »the patient's maladjustment to hospital or country conditions should also be investigated«; and »instead of equality studies, it is better to study something more useful«. The latter suggestion reorients our considerations toward education, as well as research on discriminatory behaviors among students of medical schools. For instance, Lewandowska's study has demonstrated that the number of foreign medical students in Poland is increasing successively to around 7,400 in 2020.[20] Lewandowska interviewed 121 students majoring in »Public Health« at one of the leading medical universities, undergraduate and graduate studies, about the level of acceptance of foreign students by Polish students. Among them, 29.50 % of women and 56.30 % of men declared a negative attitude towards foreign students. Interestingly, the opinions of graduate students were more neutral compared to undergraduate students, indicating that education has a moderately positive effect on acceptance levels. This impact would certainly be greater if the Polish and English-speaking groups shared classes and communicated with each other. The study raises awareness of the structural challenges facing medical education if it intends to promote sensitivity to diversity in overall clinical context among future healthcare professionals.

The research was not without limitations, e.g. supplementary evidence through further studies seems advisable, as well as the inclusion of a first-person perspective using community-based research methods, and finally the perspective of patients from diverse sociocultural backgrounds. One of the limitations may have been the privacy and confidentiality that clinical interactions between clinician and patient require, however, both clinicians and trainees have a broader perspective on this than patients.

6. Conclusion

The results presented above showed medium-high to low diversity-sensitive competence levels across about ten clinical environ-

[20] Katarzyna Lewandowska: Foreign students seen through the eyes of Polish Public Health Students. Unpublished bachelor thesis provided by courtesy of the author. Warsaw Medical University 2019.

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ments. This type of community-based participatory evaluation was conducted for the first time in Poland, as a pilot study. Growing diverse populations in society – and in healthcare professions – justify the question of whether the health sector is prepared to deal competently with patients from diverse backgrounds, to address the barriers they face in accessing healthcare services, and to bring about a social change.

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