

A REVIEW OF CULTURAL COMPETENCE IN HEALTHCARE

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ABSTRACT

This paper explores the literature regarding cultural competence and how it is taught in the health care professions. The review of the literature yields themes related to the teaching of cultural competence in a variety of health disciplines. It is important to note that cultural competence is an important topic in nursing and other health care and human services fields. Culturally competent care improves health disparities and advances the general health of the country through preventive care initiatives. There is not a golden standard related to cultural competency education, and the systematic review yields three themes essential to cultural competency education: knowledge, skill, and desire.

Keywords: culture, cultural competence, education, teaching, learning.

INTRODUCTION:

‘Cultural competence’ is a familiar term to those who serve in the health care sector or other human services professions. ‘Culturally- competent care’ is a phrase used to mean that a professional has completed the training with regards to interactions with those from diverse backgrounds. Culturally competent care entails an acceptance of the individual and humility related to differences that may exist. It is a complex phenomenon, and health care professionals are charged with the task of providing culturally competent care with varying degrees of education related to this task. Culturally competent care is important to any patient who has ever encountered the health care system.

LITERATURE REVIEW:

Cultural competence is a key component to the delivery of the health care system in the United States. The percent of the US population considered to be culturally diverse continues to increase (US Census Bureau, 2016). Despite the increase, there is significant evidence that those from culturally-diverse backgrounds face health disparities and poor health outcomes (Robinson, Benzies, Cairns, Tak, & Tough, 2016; Yanez, McGinty, Buitrago, Ramirez, & Penedo, 2016). Evidence suggests that providing culturally competent health care is the strongest method to combat the health disparities (Brusin, 2012; Noe, Kaufman, Kaufmann, Brooks, & Shore, 2014). Educational programs around the globe lack a standardized approach in teaching cultural competence (Prosen, 2015), even though the first curriculum for cultural competency was written in 1986 (Campinha-Bacote, 2006). There is an urgent need to address the cultural competency in the health care system as preventive care becomes an integral part of the new US health care system. There is a very large gap in meeting the needs of the culturally diverse patients that encounter numerous health disparities, and culturally competent health care providers can bridge that gap.

There are many tools exist to teach cultural competency, including reflective journaling, workshops, immersion programs, service learning programs, and providing direct care to the underserved. These programs target the groups from student level to professional level, and the goal is to increase cultural competence. The professional who is trained in cultural competence, then provides culturally competent care to diverse patient groups in a manner that helps eliminate health disparities.

The current system lacks the effect that is needed to dramatically decrease health disparities in culturally diverse groups. It is necessary to determine a method of teaching cultural competence that will have the much needed effect required for the US health care system. An educational standard related to cultural competence could be the key solution to decreasing and eliminating health disparities.

The literature review concentrated on cultural competence education research published within the last five years using CINAHL, MEDLINE, and Google Scholar search engine which included disciplines such as education, psychology, medicine, and social work. The subsequent terms were searched independently and collectively: culture, cultural, competence, and education. Inclusion criteria included the following: education on cultural competence, pre- and post- test quantitative analysis, qualitative reflections and analysis, expert reports, perceptions related to cultural competence change, or attempts to provide an educational model within a curriculum.

METHODOLOGY:

The literature is ripe with information on cultural competence and cultural competence education and interventions, and the first search provided a plethora of results. Due to the timeliness of the review, the first fifty abstracts were read and reviewed for appropriateness. Upon further culling of the data, 32 abstracts were eliminated because they focused on assessing the cultural competence of individuals, but they did not mention an intervention to change the cultural competence of individuals. The remaining 18 articles were read in their entirety, and upon additional review, 14 were determined to be appropriate for the systematic review of the literature. The articles comprise a rich source of data, from social work to nursing to medical education, and they include US and international experiences.

FINDINGS AND DISCUSSION:

Theme 1: Knowledge

Education and knowledge are often used synonymously so it is not a surprise that a review of the literature found ‘knowledge’ as a key component to cultural competency education. Boutte, Kelly-Jackson, & Johnson (2010) discuss the importance of meeting people at the level where they are comfortable. For instance, if the

population is highly faith-based, find a way to reference their faith. In charismatic, Black cultures, it may be appropriate for the care provider to ask the patient if they can pray with them. Knowledge regarding the appropriateness of this action is one of the key components to cultural competence. A study using the Campinha-Bacote student version tool found that knowledge regarding social customs related to different cultures was highly valued amongst the student respondents (Fitzgerald, Cronin, & Campinha-Bacote, 2009) while Hunter & Krantz (2010) used constructivism to impart knowledge to the respondents using the same tool in both seated and online learning environments. In another study, medical education related to cultural competence was evaluated and found that general knowledge related to cultural competence education was useful to the medical providers (Like, 2011). In two studies, it was found that knowledge, either gained in an immersion environment or in a classroom setting was essential to increase the cultural competence (Michajlyszyn, Thompson, Stiller, & Doherty, 2012; Munoz, DoBroka, & Mohammad, 2009). All findings related to knowledge involved the experience of a student-type learner, but a study by Wilson, Sanner, & McAllister found that providing knowledge regarding cultural competence to the educator had lasting benefits as cultural competence scores increased in the educator at three, six, and 12 months (2010).

Theme 2: Skill:

In nursing and other health professions, education, knowledge and skill are often taught separately. The knowledge basis is provided before moving towards skill acquisition. In cultural competency education, skills often need to be taught as a focus. Some curricula interweaves knowledge and skill in a conceptual model to support culturally competent education (Seeleman, Suurmond, & Stronks, 2009).

Social work uses intergroup dialogue to teach cultural competency skills, and it has proven to be a successful teaching strategy to provide a skill aimed at providing culturally competent care, (Humphreys, 2011). McMillan (2012) reported the use of reflective journaling as a way to increase cultural competency skills, and Echeverri, Brookover, & Kennedy (2010) found that cultural competency skills need to be taught even to those that are considered culturally diverse as measured with the Clinical Cultural Competency Questionnaire (CCCQ). Skill acquisition is an important aspect of cultural competency education.

Theme 3: Desire:

Desire is an important aspect of the human condition. If there is not a general desire to do something, it seems that it is much harder, if at all possible to accomplish a task. When discussing cultural competence education, the learner must desire to be culturally competent. In evaluating the Campinha-Bacote tool, students who expressed a desire to be culturally-competent scored higher than their peers who did not express that desire (Fitzgerald, Cronin, & Campinha-Bacote, 2009). In a voluntary service learning experience using reflective journaling, a common theme expressed was the desire to be more culturally competent. The study highlighted this as a key finding to the cultural competency process (Green, Comer, Elliott, & Neubrandner, 2011). Additional studies explored a domestic use of cultural competency education and found desire to be a key finding in analysis of reflective journals (Parker, 2010; Schuessler, Wilder, & Byrd, 2012).

Critique:

The search of the literature and review of the articles included within the systematic review included four qualitative articles, three quantitative articles, three mixed-method designs, and four expert opinions and case studies. The articles explored the topic of cultural competence education and provided insight into different tools used to measure the level of cultural competence. All but one article was conducted in the US, and the primary investigator is a US citizen teaching abroad. This limits the generalizability of the study to a global initiative to provide cultural competence education.

The articles tended to stress the importance of culturally competent education, but the articles did not offer a one size fits all approach, or a remedy to instantly ameliorate the need to provide culturally competent education. This suggests that although it may be generalizable to say culturally competent education is essential to knowledge and advancement, there is not a generalizable approach to meet this need.

CONCLUSION:

Results from the systematic review of the literature strongly suggested that knowledge, skill, and desire are integral components to cultural competency education. Culturally competent education is important in all human services disciplines, including health care, and knowledge is an essential component to the educational process. In addition to general knowledge transfer related to cultural competency, skill acquisition is an

important component to preparing culturally competent care providers. Knowledge and skill are two more obvious components to cultural competency, but desire is equally important while remaining less obvious with regards to the importance desire plays with regards to cultural competency. Health care providers that do not desire to treat patients with cultural competency tend to be less culturally competent. The lack of desire dramatically harms the care and increases the risk of health disparities. Although there is a lack of standardized curriculum related to cultural competence, it is thought that health care educators will continue to strive for a solution to this essential educational need. Educators will continue to try different modalities and report their findings, while some educators and practitioners will come together to attempt to create a solution. If effort is made to improve and better cultural competency education, patients will benefit from the additional effort, and health disparities may be decreased with baby steps.

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