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Entry

Need for Widely Applicable Cultural Competencies in the Healthcare of Humans and Animals

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Definition: This entry discusses the importance of cultural competence in the healthcare of humans and animals, its challenges, its mixed research results, and the need for widely applicable competencies. Although there is research evidence showing that cultural competence is linked with patient satisfaction, better doctor–patient relationships, adherence to therapy, and to some extent, better health outcomes, there is a huge variety of models and competencies in the literature, which has sometimes resulted in inclusive outcomes, confusion as to what constitutes the necessary competencies, and patchy implementation. In spite of the development of cultural competence in human healthcare, its implementation in veterinary medicine remains poor. On this note, the aims of this entry are to provide a brief overview of the cultural competence in healthcare and veterinary medicine and education, to outline the important facts, and to highlight the need for more standardisation in implementing and testing widely applicable cultural competencies for both human and veterinary healthcare.

Keywords: cultural competence; diversity; healthcare; healthcare education; veterinary medicine and education; one health

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1. Introduction: The Importance of Cultural Competence in Healthcare

Cultural competence in healthcare is a large field, which has been theorised and studied thoroughly. However, such a large field has yielded challenges, including many different definitions, uses of the term, and approaches, sometimes resulting in inconclusive results regarding its usefulness and effectiveness, and confusion about the necessary cultural competencies. This brief overview focuses on the importance of cultural competence in healthcare, highlighting important facts, such as its implementation and effectiveness in medical practice; its problematic integration in healthcare curricula; its only recent integration in veterinary practice and education; and the too many different competencies in the literature for working effectively with diversity. In this entry, what is highlighted is the importance of an increased standardisation and a reduction in the number of competencies, which would be broadly applicable to all settings. This entry will commence with brief definitions of cultural competence in the healthcare of humans and animals.

The cultural competence of human healthcare professionals generally refers to the knowledge of the ways that social and cultural factors shape the experience of health and illness, as well as the development and management of health conditions, and skills that ensure that care is provided in relation to patients' backgrounds [1]. In veterinary medical care, cultural competence has been defined in similar terms to refer to the ability to "demonstrate an understanding of the manner in which culture and belief systems impact delivery of veterinary medical care while recognising and appropriately addressing biases in themselves, in others and in the process of delivering their professional practices" [2] (p. 65).

In the healthcare of humans, there is research evidence to show that cultural competence is an important set of skills, attitudes, and knowledge for helping healthcare professionals to ensure that equitable care is provided to all patients. That is, several systematic reviews have revealed how cultural competence has helped both patients and

healthcare professionals and their relationship. Price et al.'s [3] review of studies between 1980 and 2003 indicated that cultural competence improved patient satisfaction, while one study showed an improvement in the adherence to therapy. Horvat et al.'s [4] review focused on randomised control trials published until 2014 in order to explore a possible causal relationship between cultural competence and health outcomes. No causal relationship between cultural competence and health outcomes was identified. However, there was a clear link between cultural competence and the adherence to therapy, and improved doctor–patient relationship. Alizadeh and Chavan [5] reviewed research published between 2000 and 2013 and found similar results. That is, patient satisfaction and adherence were enhanced, but they did not find a link with health outcomes. Some more recent systematic reviews showed a relationship between cultural competence and outcomes. More specifically, Chae et al. [6] reviewed randomised control trials published until 2019, and the results indicate that professional, educational, and patient outcomes improved. In support, a systematic review by Skipworth [7] showed that cultural competence helped improve the quality of care.

In general, the studies outlined above indicate that cultural competence can improve healthcare, although the results regarding the impact of cultural competence on health outcomes are mixed. This shows the potential benefit of integrating cultural competence in healthcare education to prepare future healthcare professionals; however, the integration of cultural competence in relevant curricula is problematic. In 2004, Kachur and Altshuler [8] wrote that the certification of medical teachers in cultural competence had yet to be achieved, and that the lack of such competence resulted in the poor quality of education to trainees and made it more difficult for practitioners to provide good care to patients with no waste of resources. Interestingly, more than a decade later, Hudelson et al. [9] concluded that integrating cultural competence in medical curricula was an underdeveloped field, while Min-Yu Lau et al. [10] (p. 36) highlighted that the integration of cultural competence in healthcare education was neither uniformed nor systematic, focusing largely on theoretical learning rather than practical learning.

The insufficient integration of cultural competence in healthcare education has been supported by research. More specifically, Hudelson et al. [9] conducted the project C2ME (Culturally Competent in Medical Education) in which 11 medical schools in Europe participated. Some of the aims of the project were to learn from each of these medical schools, exchange good practices and challenges, and explore common ways of moving forward. From this experience, Hudelson et al. alluded to some common challenges, including the following: (a) the integration of cultural competence in medical curricula was not systematic and was only led by a small number of academics; (b) train-the-trainers programmes or initiatives were rare; (c) the recognition of teaching cultural competence was absent; (d) the amount of time reserved for cultural competence in the curriculum was limited, while specialised courses in cultural competence were lacking; (e) when relevant teaching occurred, it was isolated and not linked with other parts of the curriculum; and (f) the assessment of cultural competence was poor. Hudelson et al. suggested a greater exchange of good practices, and as a start, they proposed guidelines regarding integrating cultural competence in medical education. In support, Sørensen et al. [11] constructed a new instrument based on the TACCT (Tool of Assessment Cultural Competence Training) to explore how well cultural competence has been integrated in 12 medical schools across Europe. The instrument had 19 questions covering three domains, namely learning outcomes (curriculum), the allocation of resources, structures, support, and policies. The scale included the answers "Yes, Partly, and No". The results show that there were attempts to integrate cultural competence in medical education, but it seemed that this happened because there were a few academics who were interested in the field, rather than as a result of a more structured and systematic approach. Apart from medical education in Europe, Jernigan et al. [12] evaluated 18 medical programmes in the USA with the use of the TACCT tool and found that teaching and assessment in cultural competence was not consistent, resulting in varied levels of quality. In a review of cultural competence in

medical education, Rukadikar et al. [13] made a series of recommendations to enhance its integration in medical curricula. These recommendations included using interactive teaching methods and simulated patients; placing emphasis on practical skills; ensuring cultural competence is not ad hoc, but a part of clinical education; ensuring cultural competence training and education are supported by people from more senior positions; obtaining feedback from members of faculty to inform development; ensuring cultural competence is integrated at all levels of medical schools; and ensuring cultural competence is backed up by research and science. These recommendations addressed the lack of uniformity and the lack of a structural and systematic approach to integrating cultural competence in medical education.

A recent scoping review by Arruzza and Chau [14] of studies exploring the effectiveness of cultural competence education in health science students found only 10 relevant studies, which were largely from the fields of pharmacy and physiotherapy. Although no studies from medicine, nursing, or veterinary medicine were included, the reviewed studies showed that their knowledge, confidence, and attitudes were improved, but there were no findings in relation to long-term educational and health outcomes.

The integration and evaluation of cultural competence in veterinary medical care and education is even poorer than in other healthcare sciences, and it has only been recently taken on board. More specifically, the Royal College for Veterinary Surgeons (RCVS) [15] (p. 10) published "Day One Competencies 2022" to set standards and guidelines required for veterinary students. Under "Reflective Relationships", one of the objectives was to "Demonstrate inclusivity and cultural competence, and encourage diverse contributions within the workplace." Another objective placed emphasis on working effectively with diversity. Along similar lines, the American Association of Veterinary Medical Colleges (AAVMC) published the Competency Based Veterinary Education (CBVE) and developed "entrustable professional activities" to provide sufficient guidelines about the necessary competencies. Under "Consultation", there is the following activity: "Demonstrate cultural competence in interactions with clients, recognizing the potential for bias" [16]. In response to international guidelines regarding the integration of cultural competence in veterinary curricula, some universities have responded in ways to enhance their students' and graduates' competence to work with diverse animal owners. For example, at the Texas A&M University College of Veterinary Medicine & Biomedical Medicine, they introduced a medical Spanish course in order for students to learn the basic terminology in Spanish to enhance their communication with the Hispanic population [17]. Gongora et al. [2] published a more detailed structure of integrating cultural competence in the veterinary curriculum at the University of Sydney. For this purpose, cultural humility, intercultural competence, and multicultural competence were introduced in the curriculum. Gongora et al. explained that a roadmap was developed to integrate cultural competence across the board. In the early years of the curriculum, cultural awareness and knowledge prevailed, such as, for example, the knowledge of Indigenous cultures and human–animal relationships. In later years, more practical aspects were embedded such as cultural sensitivity, responsiveness, and cultural humility. Authors emphasised the importance of a spiral and continuous implementation so that students can master the skills and instil cultural competence in their medical practice. It would be interesting to see how well and by how many school's cultural competence will be integrated in veterinary medicine and education, and how well it will be tested for its effectiveness in working with diverse animals' owners and services.

What is derived from this brief overview of the relevant literature is that research shows that cultural competence is beneficial for patients, students, and healthcare professionals, while its association with better outcomes in the healthcare of humans is currently unclear and is still untested in the healthcare of animals. Such mixed results have possibly been derived from the fact that cultural competence has been defined many times, in many ways, and there is no consensus regarding the competencies that are necessary for healthcare professionals, while culture is not a term that can be operationalised and measured. These challenges are further discussed below.

2. Challenges with the Use of Cultural Competence and the Need for Widely Applicable Competencies

Cultural competence has been defined many times [18], and many instruments have been designed to measure it [19]. However, the use of the term and any attempts to operationalise it have been problematic because, as Kleinman and Benson [20] have emphasised, culture has been misused as a synonym with ethnicity and has been assumed to be a fixed set of skills in which healthcare professionals can be trained to the extent that they would develop expertise. Kleinman and Benson suggested moving away from the concept of cultural competence, adopting an approach to training healthcare professionals in performing ethnography in the clinic, whereby they would delve deeper into their patients' world to understand the illness and treatment from the patients' points of view. Other scholars proposed other terms as substitutes to cultural competence, such as "structural competence" [21] and "cultural humility" [22]. Structural competence refers to recognising how structures influence patients' experience of health and illness and developing interventions to improve care. Cultural humility encompasses a process of continuous self-evaluation and reflection for healthcare professionals to not only better understand themselves, but also their patients, by being non-judgmental and more open to learn from others. The problem with structural competence is that structures are cultural products, while intercultural communication is missing [23]. By the same token, cultural humility focuses largely on self-reflection and development, missing the importance of social structures and intercultural communication [23]. Constantinou et al. [23] suggested that cultural competence was still very useful because it constituted a holistic approach and encompassed all necessary elements, from intercultural communication to structures, humility, diversity, etc. Constantinou et al. clarified that cultural competence should not be approached as an operationalisable and measurable concept or set of skills, but as an umbrella term that consists of separate competencies that can be measurable, and in which healthcare professionals can be trained.

Reflecting on the different ways of approaching the term of cultural competence, in the literature, there are many models and approaches, while Delphi studies have shown different numbers of the necessary competencies required in order to provide culturally competent care. More specifically, Alizadeh and Chavan [5] identified 18 models of cultural competence, which were derived from reviewing the literature. These models suggested various competencies, including awareness, caring, sensitivity, diversity, communication skills, cultural intelligence, and so forth. A few popular models were the LIVE & LEARN model, the Sunrise model, and the Purnell model. The LIVE & LEARN model places emphasis on competencies such as listening, evaluating, acknowledging, recommending, and negotiating [24]. The Sunrise model suggests a focus on cultural values, religious beliefs, economics, education, politics, legal factors, technological factors, as well as on kinship and social ties [25]. The Purnell model outlines the importance of having knowledge on different influential factors, such as high-risk behaviours, family roles, heritage, and communication [26]. Apart from these models, different Delphi studies suggested different competencies. Delphi studies employ a special procedure of collecting the opinion of experts, and they look for the items, skills, or competencies on which the experts reach a consensus. For example, a Delphi study by Hordijk et al. [27] alluded to a few competencies including self-reflection, good communication, empathy awareness of intersectionality, and knowledge of social determinants of health, while Ziegler, Michaelis and Sørensen [28] listed more than fifty components of diversity competence to which experts had reached consensus. Other Delphi studies had even more items and components for culturally congruent care [29].

Considering the variety of models and competencies, there are a couple of questions that need urgent attention. Why is there such a variety of cultural competencies? Are there indeed different types of cultural competence? As already outlined, this variety was derived largely because of the misuse of the concept of cultural competence, and the assumption that culture can be measured and trained [20]. In support, Liu, Gill, and

Li [30] clarified that the inconsistency in the terminology and the necessary competencies may result in problematic cultural education. This pointed out the need to identify core and widely applicable competencies. In addition, such variety of competencies implies a utopic implementation of cultural competence. That is, a healthcare professional can be culturally competent in one society but not in another, which means that there are many cultural competencies depending on where we are. This indicates that cultural competence in current times of social mobility and globalisation is highly unachievable. Definitely, healthcare professionals should be able to adjust based on the populations they treat. For example, they should learn more about the health, illness, and cultural practices in the community that they provide healthcare. However, the competence here would be their ability and urge to learn constantly and not the content of such learning. Therefore, what is needed is to work on a small number of core competencies that would be trainable and measurable and can be applied to all settings. Cultural competence should be one set of core competencies that can work everywhere.

To solve the problem of variation in cultural competencies, to reduce confusion, and to provide achievable guidelines, Constantinou and Nikitara [29] recently made an effort to systematically review all Delphi studies and identify the core competencies on which experts in diversity and cultural competence have reached consensus. The 15 studies that met the eligibility criteria focused on cultural and diversity competence in medicine, nursing, and occupational therapy, while the authors could not identify a Delphi study of cultural competence in veterinary medical care. In the reviewed studies, 443 experts from 37 countries around the globe suggested hundreds of competencies or components of cultural competence. By coding and categorising all of these components, the authors alluded to only six competencies. These competencies made the abbreviation RESPECT, which stands for Reflect, Educate, Show interest and Praise, Empathise, and Collaborate for Therapy. Constantinou and Nikitara suggested that the effectiveness of each of these competencies and all of them together can be tested in randomised control trials in order to better understand their impact on practice and outcomes, although there is evidence that these competencies work largely in the context of clinical communication [31]. In spite of the lack of Delphi studies of the core cultural competencies in veterinary medicine, it seems that the RESPECT competencies are applicable, and they reflect the competencies outlined in published guidelines. More specifically, the competency *Reflect* captures the American Veterinary Medical Association's (AVMA) [32] guidelines for cultural humility, whereby veterinarians would reflect on their own experiences and their cultural understanding of animals' health and illness. The competency *Educate* would encompass veterinarians' engagement with knowledge in people's perceptions of animals and pets, and how animals have been understood, utilised, and socially positioned across cultures. The competency *Show interest and Praise* would relate to veterinarians' skills to listen and learn from their clients as well as to participate in the community to raise awareness, as per Gongora et al.'s [2] suggestion about how veterinarians can build up their cultural competence. *Empathy* is a skill that is essential in every type of healthcare and would help veterinarians to build strong and positive relationships with their clients and animals' owners. Empathy is not only about showing an understanding of others' feelings, but also showing an understanding of others' cultural perspectives or what Deardoff [33] called "cultural empathy", which refers to one's capacity to show another's feelings, thoughts, perspective, and views informed by culture. It also reflects Kleinman and Benson's [20] suggestion for training healthcare professionals in performing ethnography to engage in deep empathy and understand their patients' points of view. Finally, *Collaboration for Therapy* with their clients or animals' owners to better understand the living condition of animals and animals' nutrition and health history would be crucial for providing the best quality of treatment and care.

Apart from Constantinou and Nikitara's effort to review Delphi studies for simplifying cultural competencies, other scholars have also sought to clarity and consolidate cultural competencies. That is, the various models outlined earlier in this entry were generated by

reviewing the existing literature, and they alluded to a few competencies for healthcare professionals to provide culturally congruent care. In addition, Kleinman and Benson proposed training healthcare professionals in the process of approaching their patients along the lines of ethnographic inquiry. In any case, it is vital for experts in cultural and diversity competence, and for accredited bodies of university healthcare programmes and healthcare providers, to require the use of specific sets of competencies that are supported by research. These should be core competencies so that they can be applied to all settings. Having core widely applicable cultural competencies would contribute to the further enhancement of the One Health principles that highlight the importance of an integrated approach for the health and wellbeing of humans, animals, and ecosystems. Core competencies for One Health initially included policies and interventions that were culturally relevant [34]. However, the updated core competencies by the Network for Ecohealth and One Health (NEOH) [34] encompassed more elements of cultural competence. More specifically, the following cultural competence elements were added: communication with people from different backgrounds and collaboration with diverse population; transdisciplinarity for work with different groups in society; social, cultural, and gender equity and inclusiveness; reflection and humility; and knowledge of various healthcare systems. Laing et al. [34] (p. 10) explained that the updated core competencies from NEOH aim to strengthen the curricula and create new ones; formulate trainings for staff, government officials, and students; and provide a life-long learning pathway for healthcare professionals and policymakers. Laing et al. clarified that these core competences were added following the review of the literature, showing their importance and effectiveness.

3. Conclusions and Prospects

This entry outlined the importance of cultural competence in the healthcare of humans and animals and discussed the challenges of the concept of cultural competence, as well as the need for core competencies that are necessary for providing culturally congruent care. These core competencies should be widely applicable to all settings and allow for large variation in their content in order for healthcare professionals to fine-tune their competence with the needs of their patients and clients in the community. Having core competencies would facilitate the design of a randomised control trial to test the effectiveness of each of the competencies separately and all competencies together in health outcomes, and would enhance the standards and guidelines under One Health. In addition, having core competencies would facilitate the integration of cultural competence in healthcare education. That is, it would be easier for healthcare educators to conceive examinable learning objectives and design teaching methods for developing these competencies. Furthermore, having core competencies would help to train staff and faculty members and develop organisations' policies and guidelines, gradually creating the organisation's cultural competence ecosystem. Carrying on with a variety of models and competencies means carrying on with inclusive results, patchy implementation, and confusion as to what constitutes the necessary cultural competencies.

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