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Title: Cultural Competence in healthcare in the community: A concept analysis

Abstract

To conduct a concept analysis on cultural competence in community healthcare. Clarification of the concept of cultural competence is needed to enable clarity in the definition and operation, research and theory development to assist healthcare providers to better understand this evolving concept. Rodgers' evolutionary concept analysis method was used to clarify the concept's context, surrogate terms, antecedents, attributes, and consequences, and to determine implications for further research. Articles from 2004 to 2015 were sought from Medline, PubMed, CINAHL, and Scopus using the terms, 'cultural competency' AND 'health', 'cultural competence' OR 'cultural safety' OR 'cultural knowledge' OR 'cultural awareness' OR cultural sensitivity OR 'cultural skill' AND 'Health'. Articles with antecedents, attributes, and consequences of cultural competence in community health were included. The 26 articles selected included nursing (n=8), health (n=8), psychology (n=2), social work (n=1), mental health (n=3), medicine (n=3), and occupational therapy (n=1). Findings identify cultural openness, awareness, desire, knowledge, sensitivity, and, encounter as antecedents of cultural competence. Defining attributes are respecting and tailoring care aligned with clients' values, needs, practices and expectations, providing equitable and ethical care, and understanding. Consequences of cultural competence are satisfaction with care, the perception of quality health care, better adherence to treatments, effective interaction and improved health outcomes. An interesting finding is that the antecedents and attributes of cultural competence appear to represent a superficial level of understanding, sometimes only manifested through the need for social desirability. What is reported as critical in sustaining competence is the carers' capacity for a higher level of moral reasoning attainable through formal education in cultural and ethics knowledge. Our conceptual analysis incorporates moral reasoning in the definition of cultural

competence. Further research to underpin moral reasoning with antecedents, attributes and consequences could enhance its clarity and promote a sustainable enactment of cultural competence.

Keywords: cultural competence, cultural safety, cultural awareness, community health, cultural knowledge, cultural skills, cultural diversity, moral reasoning.

What is known about the topic:

- The concept of cultural competence is widely written and published
- The concept of cultural competence is evolving and continues to lack clarity
- A much clearer understanding of cultural competence antecedents, attributes, and consequences is recommended in the literature

What this paper adds:

- Provides another perspective to existing concept analysis of cultural competence i.e. the antecedent of 'moral reasoning'
- Helps to expand with examples on the already known aspects of cultural competence in the community and promotes clarification of defining attributes
- Suggests strategies that may be useful in enhancing moral reasoning in healthcare practitioners so that the provision of culturally competent care can be sustained

Introduction

Increasing diversity creates opportunities and challenges for healthcare practitioners/ providers, healthcare services, and health policy to develop and deliver culturally competent care and services that have the potential to reduce inequalities in health. Although several models of cultural competence exist, for example Deardorff (2006, 2009) and Bennett (1993), the conceptualisation and implementation of cultural competence is poorly understood among healthcare practitioners and providers due to a lack of clarity in its definition (Gebru and Williams 2010, Long 2012). Many terms and definitions exist in the literature as to the concept and meaning of cultural competence (Fantini 2009). For example, the National Health and Medical Research Council, Australia (NHMRC; 2006, p.7) defines cultural competence as 'a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations'. In this sense, cultural competence is the capacity of the health system to improve the health of consumers by integrating culture into the delivery of health services.

Cultural competence has also been defined as the complex integration of knowledge, attitudes and skills that enhance cross-cultural communication and effective interactions with others (Andrews 2003). Leininger and McFarland (2006) define culture as the values, beliefs, and norms that guide a specific group's thinking and decision making about actions it takes. Betancourt et al. (2002) define cultural competence as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients. Betancourt and Green (2010) also explain how the term cultural competence has evolved to reflect the development of skills that facilitate healthcare practitioners to embrace sociocultural factors. For example, identifying and bridging

communication styles to accommodate culturally diverse patients and paying attention to their understanding of illness and treatment which may include healing methods alongside Western medicine (p.583). Some definitions focus solely on cultural competence from the health providers' perspective. However, most of the definitions consist of combinations of a number of the defining attributes of cultural competency, such as, knowledge, skills, awareness, understanding and sensitivity. For example, Campinha-Bacote (2002, p. 181), a leader in the study of cultural competence, defines cultural competence as the 'ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community)'. Campinha-Bacote (2002) indicates that the ongoing process incorporates cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Campinha-Bacote (2011) also includes cultural competence as an extension of patient-centred care and offers a set of culturally competent skills that healthcare practitioners can use to provide patient-centred care (p.1). More specifically, Campinha- Bacote (2011) puts forward a framework for cultural competence skills that is mutually acceptable to the healthcare practitioner and the patient (p.1). In their theory of transcultural nursing care, Kim-Godwin et al. (2001) argue that cultural competence requires cultural sensitivity, knowledge and skills. Rosenjack Burchum (2002) concurs, stating that cultural competence is an ongoing process of knowledge and skill development in relation to cultural awareness, knowledge, understanding, sensitivity, interaction and skill.

Despite existing definitions incorporating similar terms, there remains a lack of conceptual clarity around the concept of cultural competence as the literature on the development of cultural competence is still evolving (Fantini 2009; Garneau and Pepin 2015). This lack of clarity has resulted in lower quality and less effective healthcare provision

for culturally diverse people (O'Connell et al. 2007). Increasing clarity can assist healthcare providers to better understand this evolving concept and provide care that is culturally appropriate and competent, improving quality, the effectiveness of healthcare provision, and reducing health disparities. Being aware of cultural differences does not necessarily equate to providing care that brings about positive changes in a relationship with another of a different culture nor does it mitigate racial, ethnic or cultural discrimination (Jenkins 2011). Further, healthcare providers perceive that by emphasising cultural differences they are showing respect for culturally diverse health consumers, which can lead to the promotion of ethnocentrism and not necessarily cultural competence (Williamson and Harrison 2010).

Even though cultural competence in healthcare has been widely accepted as essential, there remains ambiguity in the definition of cultural competency by health service providers (Campinha-Bacote 2002). Healthcare professionals also find it difficult to incorporate clients' traits with cultural competent care as what is culturally appropriate for one group of clients may not be appropriate for another group despite being of the same culture (Johnston and Herzig 2006). This has resulted in a lack of understanding of what cultural competence is and what it constitutes. In addition, there is incongruence in the meaning of cultural competence among health carers and in how it is applied in healthcare practice. Whilst policies highlight the importance of culturally competent healthcare, there is no direction on exactly how to ensure that health service providers are increasing their knowledge and awareness of the cultural needs of their culturally diverse clients (Campinha-Bacote 2002).

Considering that the concept of cultural competence is evolving and continues to lack clarity and operationalisation, a much clearer understanding of its antecedents, attributes and consequences is warranted. Therefore, the purpose of this concept analysis is to develop a

holistic understanding of the term 'cultural competence' and capture the key elements of the concept in the present. A contemporary understanding of cultural competence can assist health practitioners/providers to better operationalise and engage in providing culturally appropriate care and attain positive health outcomes. We aimed to analyse the concept of cultural competence using Rodgers (2000) evolutionary method.

Aims

The aims of this concept analysis of cultural competence are twofold.

1. To identify current theoretical and operational definitions of the concept cultural competence.
2. To identify the constructs that are antecedents, defining attributes, and consequences of cultural competence in the community healthcare setting.

Method

Concept analysis is a dynamic, objective, process, where through analysis, one is able to identify the current consensus on a concept, providing a foundation for further development (Rodgers 2000). Concept analysis method facilitates the identification of the critical elements of a given concept such as its antecedents, attributes and consequences, including "capturing fresh instances of a concept" (Baldwin 2008, p.50). Concept analysis method promotes the discovery of meaning of words that can assist to clarify their common usage within a discipline context (Foronda 2008). Clarification of words can form the basis for generating theory, education, and practice. Through clarifying concepts, healthcare providers can change their practise behaviour to reflect the identified antecedents and attributes including undertaking appropriate training (Foronda 2008). As well, making explicit the meaning of words can improve communication between healthcare providers through a shared

understanding of the core aspects of the behaviour that is needed to enact a particular behaviour (Higgins 2016). Importantly, as healthcare providers need to keep up to date with their practice so that they can provide evidenced-based care, gaining contemporary knowledge about healthcare concepts is crucial (Baldwin 2008, p.51). Thus, concept analysis method is beneficial in leading to recommendation for practice. Several methods of concept analysis exist (Tofthagen and Fagerstrom 2010). Walker and Avant's (2005) method of concept analysis, advanced from Wilson's (1963) method, has positivistic and reductionary views of concepts, whereby concepts are viewed as not being able to change over time and remain constant across contexts (Rodgers 2000). Rodgers (2000) evolutionary method of concept analysis is inductive processes of analysis where the aspect of meaning, usage, and application are the main drivers in concept development (Tofthagen and Fagerstrom 2010). For Rodgers (2000), the development of concepts are time, context bound and changeable. Culture is a dynamic and ever-changing process, influenced by social, historical and geographical factors (Kagawa Singer 2012). Therefore, as culture is not static we considered the use of Rodgers' (2000) method of concept analysis appropriate.

Rodgers (2000, p.85) method of concept analysis involves six steps: (step 1) identify and name the concept of interest surrogate terms, (step 2) identify and select an appropriate sample for data collection, (step 3) collect data relevant to identifying the attributes and contextual bases of the concept, (step 4) analyse data to identify characteristics (step 5) identify an exemplar concept, if appropriate and (step 6) identify implications and hypotheses for further development of the concept. Our study focussed on identifying scholarly articles through a systematic review of the literature, in which (i) cultural competence in community health was discussed, and (ii) antecedents, attributes and consequences could be extracted.

Data Sources

The data was sourced based on Rodgers (2000) six step method. Firstly, (step 1) we identified and sought the concept of cultural competence and its surrogate expressions, including defining attributes, antecedents, consequences and contexts, including frequently utilised terms depicting cultural competence in the health literature. We needed to capture varying aspects of cultural competence deemed relevant to a broader understanding of the concept. We explored surrogate or related terminology to cultural competence, such as 'cultural safety', 'cultural knowledge', 'cultural awareness', 'cultural sensitivity', 'cultural humility' and 'cultural skill'. Our inclusion criteria (step 2) specified that articles for consideration needed to include the concept cultural competence, to be about health practice in community settings and concern adults. In addition, each article had to include all three target aspects: antecedents, attributes and consequences (step 3). Articles needed to be in peer reviewed journals, have abstracts, and be published in the English language. Articles in hospital settings or about children were excluded. A ten year time window was considered sufficient to identify the most recent perspectives, and as this search was begun early in 2015, it was decided to included articles going back to 2004.

The Search Process

The PRISMA (Preferred Reporting Items for Systematic Review and Meta- Analyses) approach for data extraction was used. Four databases, OVID, Medline, CINAHL and Scopus were systematically searched in round one. A search of the OVID database using the terms: 'cultural competency' AND 'health', yielded 2720 results for the years 2014-2015. Initial inspection of the first four pages of results, involving reading all abstracts, and skimming articles in which the abstract suggested cultural competency was a key topic, showed very few articles contained a discussion or definition of cultural competency as a concept. Hence only seven articles that met the inclusion criteria were selected (step 4). The seven articles

were downloaded and incorporated into an Endnote library called 'cultural competence', a process repeated for all selections from each database search.

A search of CINAHL Plus with Full Text, utilised the search terms 'cultural competency' AND 'health'. This search produced 44 articles deemed relevant from examination of the titles and abstracts. Skimming through the articles led to 25 articles being selected as they met the inclusion criteria (step 4).

The Medline search using the terms 'cultural competency' OR 'cultural safety' OR 'cultural awareness' OR 'Cultural knowledge' OR 'cultural skill' OR 'cultural sensitivity' AND 'attributes' AND 'antecedents' AND 'Health' produced 2,701 results, of which 33 articles were imported into Endnote as they met the inclusion criteria (step 4). In the Scopus search, we used the terms 'cultural competency' OR 'cultural safety' OR 'cultural awareness' OR 'cultural knowledge' OR 'cultural skill' OR 'cultural sensitivity' AND 'Health'. This search yielded 4,253 results, of which 75 articles were selected upon reading the abstracts and skimming the articles. It was noted that as other databases such as PsychInfo and Proquest were added to the search process, several similar articles were emerging several times from these different data bases. A total of 140 articles were selected in round one from the four data bases.

In round two, the 140 selected articles were read by two of the researchers (RH and SH). Articles were accepted if some form of cultural competency or one of its selected synonyms was discussed in the article, and all three of antecedents, attributes and consequences could be identified from within the article (step 4). Articles that were duplicates were removed. This process was a useful phase of article selection, with 26 articles selected as the final number as shown in Figure 1. These 26 articles (Table 1) were a

combination of conceptual, quantitative, and qualitative research and reflected the point at which saturation occurred, as no new information was detected in the literature search. Figure 1 below depicts the data selection process.

Figure 1: Flow chart of article selection process

Data analysis Process

Analysis commenced with three of the researchers (SH, RH, EK) carefully and objectively reading all articles chosen for inclusion in its entirety. We examined theoretical articles for their current use in reflecting cultural competence. Research articles were checked for rigour such as issues with bias, sampling, method adequacy and attrition (Gillespie et al. 2007). Each of the three researchers independently read the articles highlighting fragments of the text that made reference to attributes, antecedents or consequences of the concept of cultural competence as per Rodgers (2000) analysis method. Inductive thematic analysis was applied to the highlighted texts in the articles, paying particular attention to frequently recurring themes. The themes were then clustered and identified as antecedents, attributes, and consequences of the concept.

Results

A concept analysis should capture the common and universal understanding and usage. Therefore, the definition of cultural competence, as defined by researchers and theorists in the literature, should incorporate the notions of someone demonstrating the capacity to transcend across cultures and integrate their behaviour that incorporates their thoughts,

actions, and communication style when interacting with people of other cultures (Campinha-Bacote, 2002).

In the following section the antecedents, attributes and consequences of cultural competence will be described. Antecedents and consequences serve to refine the attributes and highlight its contextual aspects and, therefore, will be described together. The attributes, according to Rodgers (2000), serve as the 'primary accomplishment of concept analysis' which in this instance represents the true definition of cultural competence (p. 91).

Antecedents and Consequences of Cultural Competence

Antecedents are preconditions that must be present prior to the occurrence of a concept (Rodgers 2000). Six antecedents of cultural competence were identified in the literature: (1) openness or being curious enough to want to learn about other cultures. The openness comes from the person's attitude towards being flexible and willing to reflect on one's own ethno-culture, beliefs, and behaviour (Garran and Werkmeister Rozas 2013; Garneau and Pepin 2015; Kleiman 2006; Majumdar 2004; Tayab and Narushima 2015); (2) awareness of the presence of other cultures than one's own culture and being able to recognise discrimination, stereotypes, prejudice and understanding Western medicine as a constraint to Eastern culture (Campinha-Bacote 2002; Carpenter-Song et al. 2007; Foronda 2006; Horvat et al. 2014; Lucas et al. 2008; Tayab and Narushima 2015; Wade and Bernstein 1991); (3) desire that is the motivation of the healthcare provider to actually want to become more culturally aware, knowledgeable, skilful and familiar with people from other cultures (Allen at al. 2013; Campinha-Bacote, 2002; Foronda 2006). Campinha-Bacote notes that a healthcare provider with a high level of cultural desire is characterised by compassion, authenticity, humility, openness, availability, flexibility and commitment, along with a passion for caring, regardless of conflict; (4) cultural knowledge, the cognitive component, is the foundation for cultural

competency. It involves an understanding of cultural differences, values and behaviours and can be acquired through training, education or experience with a culture in a variety of contexts (Foronda 2008; Gameau and Pepin, 2015). Cultural knowledge also involves "learning about other cultures' worldview, languages, and the elements of culture, such as historical, political, social and economic factors" (Suh 2004 p. 194); (5) cultural sensitivity which is both a cognitive and affective component of cultural competency. It involves attitudes, perceptions and values that show heightened awareness of one' own culture and recognition of and respect for another's culture (Briscoe 2013; Harper, 2006; Horvat et al. 2014; Kleiman 2006; Lucas et al. 2008; Stanhope et al. 2008; Tayab and Narushima 2005; Wall et al. 2013). Cultural sensitivity in the community health setting involves an understanding of cultural similarities and differences in how people perceive health and illness and how they communicate with health providers (Burnard 2005); (6) cultural encounter is an environmental situation that must arise for cultural competence to ensue (Caffrey et al. 2005; Campinha- Bacota 2000; Fronda 2008; Harper 2006., Kokko 2011; Tayab and Narushima 2015). For example, the encounter may involve a healthcare provider coming into contact with a client from a different culture than themselves, which then provides the context for cultural competency to occur.

Consequences are situations that result from the concept. The five consequences of cultural competency that have been identified in our analysis are all positive. The first consequence is perceived quality healthcare by clients when healthcare providers demonstrate cultural competence (Harmsen et al. 2005; Harper 2006; Lucas et al. 2008; May and Potia 2013; Tayab and Narushima 2015; Wade and Bernstein 1999). The second consequence is adherence to treatment and advice when there is cultural competence (Harmsen et al. 2005; Horvat et al. 2014; Ishikawa et al. 2014; Majumdar et al. 2004; May and Potia 2013; Owiti et

al. 2014; Wade and Bernstein 1991; Wall et al. 2013). The third consequence is satisfaction when clients perceive the health provider incorporates cultural perspectives (Dunagan et al. 2014; Foronda 2008; Gameau and Pepin 2015; Harmsen et al. 2005; Lucas et al. 2008; May and Potia 2013; Owiti et al. 2014; Stanhope et al. 2008; Tayab and Narushima 2015; Wall et al. 2013). The fourth consequence is effective interaction, which results from healthcare providers applying their cultural skills in communicating with clients (Carpenter and Garcia 2012; Carpenter-Song et al. 2007; Foronda 2008; Gameau and Pepin 2015; Garan and Werkmeister Rozas 2013; Harmsen et al. 2005; Lucas et al. 2008; Majumdar et al. 2004; May and Potia 2013; Stanhope et al. 2008). The perceived quality in care, adherence to treatment, and satisfaction with care due to health providers demonstrating cultural competence and engaging in effective interaction, resulted in the final consequence, which is improved health outcomes (Campinha- Bacota 2002; Carpenter- Song et al. 2007; Gameau and Pipin 2015; Lucas et al. 2008; Majumdar et al. 2004; May and Potia 2013; Owiti et al. 2014; Sue et al. 2008; Tayab and Narushima 2015; Wade and Bernstein 1991).

Defining Attributes of Cultural Competency

The defining attributes of a concept are the characteristics of the concept being analysed that appear repeatedly during the literature review (Rodgers 2000). Three defining attributes emerged from the literature synthesis which are, respecting and tailoring care; providing equitable and ethical care; and understanding.

Respecting and Tailoring Care

The first attribute is respecting and tailoring care where the healthcare professional is able to learn about a patient's beliefs, values and behaviours and subsequently tailors healthcare intervention so that it is effective and appropriate (Allen et al. 2013; Briscoe 2013;

Carpenter-Song et al. 2007; Foronda 2008; Horvat et al. 2014; Ishikawa et al. 2014). Tailoring care is defined as altering care to adapt to the cultural needs of individual clients (Carpenter and Garcia 2012; Carpenter-Song et al. 2007; Foronda 2008). In tailoring care, nurses for example, were found to use specific intercultural skills and knowledge to allow them to successfully interact and work with patients from a culture different to theirs (Kokko 2011; May and Potia 2013). Furthermore, through respecting cultural differences, healthcare providers were able to assess, diagnose and make treatment plans that were culturally informed and appropriate for clients. Foronda (2008) explains that the attribute of respect, defined as 'the willingness to demonstrate regard for others' (Oxford Dictionary 2010) is a crucial component of cultural competence as without respect healthcare professionals may find it difficult to appreciate the patients' needs and meet their expectations, which invariably are culture driven. Tailoring care also involves working with clients as partners, taking into account power relationships, social and political aspects of care (Garneau and Peppin 2015; May and Potia 2013). For example, Garran and Werkmeister Rozas (2013) found that social workers when tailoring care responded respectfully to all clients from different cultures in a way that recognised individual values and beliefs of clients, thus preserving their dignity.

Providing Equitable and Ethical Care

The second attribute is providing equitable and ethical care. The existence of inequalities in the provision of healthcare for culturally diverse people is reported in the literature (Stone 2008). Betancourt (2003) indicates that healthcare providers need to possess attitudes that omits biases, stereotyping, and prejudices and openly exhibit attitudes such as openness and respect if they are to provide just and equitable care (p.561). Stone (2008) adds that positive attitudes in healthcare providers can pave the way for person-centred care (Tayab and Narushima 2015; Wade and Bernstein 1991; Wall et al 2013), which underpins the provision

of individualised quality care (Allen et al 2013; Carpenter and Garcia 2012; Carpenter-Song et al 2007; Gameau and Pepin 2015; Garran and Wermeister Rozas 2013; Harmsen et al 2005; Harper 2006; Kleiman 2006; Majumdar et al 2004; Sue et al 2008; Tayab and Narushima 2015). Furthermore, Stone indicates that to change the attitude of healthcare professionals to provide equitable healthcare, they need to be given a sound grounding in ethics which Stone argues is the precursor to moral reasoning. Stone (2008) also puts forward the principle of equal and substantial respect together with the principle of justice, which can facilitate the empowerment of culturally diverse patients which subsequently can lead to the provision of equitable healthcare (Caffrey et al 2005; Campinha-Bacota 2002; Dunagen et al 2014).

Harper (2006) adds another dimension to the attribute of 'respecting' indicating that moral reasoning is the scaffolding upon which healthcare professionals are guided to, not only respect patients' cultural differences, but to also provide care that is ethical and equitable (Carpenter and Garcia 2012; Foronda 2008; Kleiman 2006; Steed 2010). Moral reasoning is defined as 'a cognitive process in determining a right or wrong ethical action' (Rest 1994 p. 24). Within the healthcare context, Hunter (2008) reports that healthcare providers' values and beliefs can cause ethical dilemmas, especially when moral reasoning is based on Western cultural norms that may not be congruent with other racial values and cultural norms. Hunter (2008), in his study, found that as moral development in people progresses from lower to higher levels in life, cultural competency training can help people with achieving higher levels of moral development. Hunter (2008) used the Defining Issues Test (DIT) on healthcare providers following education in ethics and cultural competency knowledge and found that this intervention increased moral development in participants.

Stead (2010), in his study involving the training of occupational therapists in cultural competence, found no difference in therapists' attitudes following the training. Stead (2010) also found that the therapists perceived that: (i) cultural competence did not play a role in effective healthcare delivery; (ii) health disparities did not result from racial discrimination, but rather the disparities were due to stress and people's own choices, especially those who were African- American and were of low socio-economic status. Stead (2010) equated this perception to 'cultural blindness', whereby participants believed "the health care system put in place by the dominant culture should work equally well for all cultures; any problems that arise for minority groups, when trying to access the system are attributed to lack of education, motivation , or social skills within the culture" (p. 147). Stead's study indicates that training in cultural competence alone may not be sufficient to change attitudes about racial discrimination, adding that strong beliefs were entrenched and often difficult to change. As Hunter (2008) suggests, ethics and cultural competency knowledge need to be taught together so health providers' moral development can be improved to facilitate changes in attitude towards providing equitable and ethical care. Benatar and Singer (2003) further suggest that moral reasoning allows health professionals to take into account the whole patient, embracing their values, beliefs and expectations; it allows health professionals to provide care beyond the Western standard prescribed care (Benatar and Singer 2003). For example, in providing care that is ethical, nurses were found to use their intercultural skills to conduct physical assessments that were culturally based (Campinha- Bacota 2002; Suh, 2004).

Understanding

Understanding, defined as 'showing insight or empathy' (oxford Dictionary 2010), is the third attribute. Having insight into the effects and importance of another's beliefs, values, experiences and behaviour is essential in providing care that is aligned with clients' cultural

needs (Campinha-Bacote, 1998; Foronda, 2008; Ishikawa et al. 2014; May and Potia 2013). May and Potia (2013) report healthcare professionals are culturally competent when they show understanding of the importance of considering cultural differences and develop rapport with their clients who are culturally different from them. Understanding is also demonstrated when healthcare providers overtly avoid cultural stereotyping and are flexible and caring (Foronda 2008). For example, due consideration given to the client's diet, customs and traditions demonstrates understanding of clients' cultural needs (Foronda 2008). An understanding healthcare provider is aware of the impact of culture on attitudes, expressions of distress, and help-seeking behaviour and can negotiate their way in various belief systems (Ishikawa et al. 2014; Kleiman 2006; Majumdar et al. 2004; Stanhope et al. 2015). A healthcare provider must not only understand the influence of a client's experiences on them, but convey that understanding as well (Foronda, 2008). Cultural understanding also requires that a healthcare provider recognises that there are variations within a particular culture and to avoid stereotyping (Leininger, 2006).

An exemplar of cultural competence

An exemplar (step 5) is a real-life example of the concept that illustrates all of its defining attributes (Rodgers 2000). This exemplar is based on research conducted by two of the authors (SH and EK). The authors explored Pacific Island peoples' perspectives on issues relating to their health and health service usage including interaction with healthcare providers. The participants indicated that when seeing a healthcare provider that was recommended to them by a Pacific Island friend or family member, the interaction was typically a positive experience. In these cases, the participants stated that the doctor was sensitive to and understanding of their cultural needs, and used their cultural knowledge and

skill to effectively provide healthcare. One female participant described an interaction she had with a male doctor she was consulting about her diabetes. The doctor was aware of the high incidence of diabetes in Pacific Island communities. Additionally, the doctor was willing to learn the different types of cultural foods that she ate, like taro and coconut cream, and recognised that as a Pacific Islander, the client was used to having a big 'kai' (i.e. good-sized meal). The doctor, recognising the client's moral worth, was sensitive in recommending that she limit these foods for her health instead of not eating taro altogether. This required the doctor to have ethical decision making skills to incorporate the patient's cultural attitudes and beliefs into his professional knowledge of healthcare. Here the doctor demonstrates healthcare that is just and acceptable to the client. His intercultural communication not only resulted in effective interaction, but also led to better health outcomes for the client. The client was able to adhere to a diet that was culturally appropriate albeit with a limited intake of taro and 'kai'. As can be seen from this exemplar, the doctor possesses all of the defining attributes of cultural competency. The doctor's cultural sensitivity, knowledge, skill, ethical decision-making and understanding in the consultation led to the consumer's satisfaction and trust in the health provider.

A theoretical model of the concept of cultural competence

Based on the findings, the following definition of cultural competence is provided: Cultural competence is using one's understanding to respect and tailor healthcare that is equitable and ethical after becoming aware of oneself and others in a diverse cultural encounter. Cultural competence occurs when one is sensitive and embraces openness, has a desire to want to know other cultures, and actively seeks cultural knowledge. Cultural competence is enhanced and sustained through possession of a high level of moral reasoning. Cultural competence

results in improved health outcomes, perceived quality healthcare, satisfaction with healthcare, and adherence to treatment and advise.

Figure 2 below depicts a theoretical model of cultural competence. The model affirms and clarifies the existing understanding of antecedents, attributes, and consequences of the concept of cultural competence in healthcare delivery. However, the model adds another antecedent which is moral reasoning that can be valuable in helping healthcare providers to sustain the provision of equitable care to culturally diverse people.

Put Figure 2 here: A theoretical model of the concept of cultural competence.

Discussion

This concept analysis has attempted to provide a clearer definition of cultural competence based on the identification of terms and surrogate expressions used to describe and explain the concept of cultural competence. A comprehensive literature review and analysis using Rodgers's evolutionary method (2000) was undertaken. In providing cultural competent healthcare in the community one must recognize and address the identified antecedents and attributes to obtain the positive consequences of cultural competence. Cultural competence implies self- awareness, knowledge and the skills required of healthcare practitioners and their ability to apply them in practice (Parsons 2000). An interesting outcome of our concept analysis was that simply having cultural knowledge and knowing about clients' culture is not sufficient to become a culturally competent healthcare practitioner (Suh 2004). Our analysis showed that for healthcare practitioners to sustain their culturally competent practice, they need to possess a higher level of moral reasoning. Furthermore, a higher level of moral reasoning played a key role in clinical decision making that is fair and equitable in the

provision of care (Batancourt 2003; Stone 2008). Healthcare practitioners need to develop conceptions of fairness in social practices and critical, moral, self-reflection with regards to existing social norms and systems in order to sustain culturally competent healthcare. This would help to reduce long-standing inequalities in the healthcare of people from diverse cultural, ethnic and racial backgrounds and to improve the quality of healthcare services and health outcomes (Betancourt et al 2005; Paasche-Orlow 2004).

The findings of this analysis, including the model (Figure 2) and proposed definition of cultural competence, provide a practical guide to develop healthcare education and practice strategies for culturally competent care in a culturally diverse society by respecting and tailoring care, providing equitable ethical care and understanding based on a foundation of moral reasoning. However, the development of moral reasoning occurs over time and through authentic encounter by health professionals in practice settings where they are faced with decision making that is ethical and just, especially one that involves vulnerable clients (McLeod-Sordjan, 2014). For example, a study with nursing students found that junior nursing students demonstrated moral reasoning much less than senior nursing students (Parks et al., 2012). McLeod-Sordjan (2014) further reports that according to Kohlberg's theory of moral reasoning, individuals' own values and beliefs play a major role in their decision-making, which suggest that physical maturity does not necessarily transcend into a high level of moral reasoning. Given this situation, it may be appropriate to assume that moral reasoning in itself as a concept is not precise but somewhat situational.

The authors propose that instead of focusing on training, skills and information about various cultures, cultural competency in community healthcare implies that one must attempt to develop a higher level of moral reasoning in community practitioners. This needs to be

mastered through exposure to authentic situations where health practitioners are required to make ethical decisions through reflection on their experiences, feelings and intuitions (McLeod- Sordjan, 2014). More importantly, cultural competency training should be mandatory in all health professional training. This view is endorsed by Betancourt and Green (2010) who report the importance of including cultural competence training for healthcare practitioners if quality and equitable care is to be delivered to culturally diverse patients. Betancourt and Green (2010) put forward the notion that cultural competency training be a core part of curriculum and assessed formally in health education.

Conclusion

In this paper, we provide clarification to the existing antecedents, attributes and consequences of cultural competence which contribute to the reduction in ambiguity of this evolving concept. A key strength of our analysis is the addition of moral reasoning as an antecedent for health practitioners to sustain cultural competence over time. On reflection of our findings it is clear that although our analysis only examined literature on cultural competency in the community setting, the findings can be applied to any health practice setting such as acute care settings. The limitation of our analysis is that we only found one article (Harper, 2006) that included moral reasoning as an important antecedent that guides healthcare providers to respect patients' cultural differences and provide care that is fair and equitable. Thus, future research to develop and evaluate strategies to increase moral reasoning in health practitioners is suggested.

Implications and hypotheses for further development (step 6)

The findings of moral reasoning being an important antecedent in cultural competence has implications for practitioners if healthcare disparities are to be reduced and better health

outcomes are to be achieved for culturally diverse communities. Moral development training and education is required to assist health practitioners to progress to higher levels of moral development. Future research to explore cognitive moral development is suggested (Hunter 2008). Furthermore, future research to develop and evaluate strategies to increase moral reasoning in health practitioners is recommended.

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Table 1: Antecedents, Attributes, and Consequences of Cultural Competence

Author	Context	Antecedents	Attributes	Consequences
Allen et. al. 2013	Nursing student placement in Peru	Cultural desire. Effort at fitting into new culture	Culturally competent care that is effective and corresponds with the client's needs, cultural values, and practices	Improved cultural competence Greater cultural knowledge and sensitivity; stronger sense of inequity
Briscoe 2013	International placement in Quatemala	Desire to be culturally sensitive; critical reflection on diversity experience	Alignment of client expectations with health-care provider's knowledge, attitude and behaviour.	Raised awareness; skill and confidence about international Midwifery
Caffrey et al. 2005	Integrated cultural content in 5 week international placement of nursing students	Values and attitudes as foundational; experience with culturally diverse individuals and communities	Self-awareness; comfort with cultural competence skills cognitive and affective development from cultural incompetence to competence	Cultural competence
Campinha-Bacota 2002	Cultural competence Model	Cultural awareness; recognition of biases; Cultural desire; recognition of more variation within than between ethnic groups	Integration of cultural awareness cultural knowledge; cultural skills; cultural encounters, and cultural desire	Ability to provide culturally responsive health care services
Carpenter and Garcia 2012	Voluntary immersion in study abroad nursing program in Mexico	Student motivation; faculty modelling respect and comfort in intercultural interactions; learning Spanish	Understanding cultural dynamics; demonstrates cultural awareness, cultural knowledge, and cultural skills in health care practices	Greater cultural respect and understanding
Carpenter-Song et al. 2007	Mental health	Increase in diversity; perception of racial differences; awareness of discrimination, stereotypes, prejudice; recognition of Western biomedicine as a cultural construction	A health care system capable of delivering highest quality care to every patient regardless of race, ethnicity, culture, and language proficiency; clinical encounters that are viewed as two-way learning encounters	A broader conceptualisation of culture or brokers; overcome miscommunication
Dunagen et al. 2014	Web-based survey of nursing students	Prior cultural experience; Integration of cultural knowledge in nursing education	Demonstrates cultural knowledge, cultural attitudes and cultural consciousness in care	Adequate nursing care provided
Fronda 2008	Concept analysis of cultural sensitivity	Diversity, awareness encounter , knowledge	Consideration; understanding respect; tailoring	Effective communication intervention; satisfaction
Gameau and Pepin 2015	Nursing education	Cultural awareness; open and flexible; Critical reflection on discrimination, prejudice and inequality; prior knowledge	Integrates power relations and social context; critical reflection and provision of culturally safe, congruent and effective care	Culturally safe effective care; satisfaction with care
Garran and Werkmeister Rozas 2013	Standards for social work	Self-reflection exploring own biases, beliefs, ethic differences	Responding respectfully and effectively to people of all cultures, languages races, ethnic background, religion	Culturally competent practice

Author	Context	Antecedents	Attributes	Consequences
Harmsen et al. 2005	General practice	Differences in cultural background and language proficiency; cultural gap	Reflects on culturally defined norms, views and communication style; knowledge in culturally determined differences in views and behaviour and uses strategies to solve gaps	Improved mutual understanding and patient satisfaction; perceived quality care
Harper 2006	Research in health care	Cultural knowledge; cultural awareness; cultural sensitivity; encounters; skill; understanding ethical principles	Moral reasoning; cultural competence;;considers beneficence/non-maleficence; respect for others	Preserves cultural norms; protects dignity and values of others
Horvat et al. 2014	Cultural competence education for health professionals	Cultural differences	Uses cultural knowledge in all dimensions of practice; effectively works in cross-cultural situations	Improved health behaviour; better engagement between health provider and client/patient
Ishikawa et al. 2014	Primary care Providers with Latino patients	Pre-existing working alliance with doctor	Functions effectively in a pluralistic democratic society; knowledge of other cultures, understands the impact of culture on attitudes and manages to interact within different belief systems	Increased patient follow up on referrals; increased physician rating by patients
Kleiman 2006	Nursing education program	Openness; experiential awakening	Uses cultural awareness, sensitivity, knowledge and skills to integrate care	Improved tolerance to other cultures competence in care
Kokko 2011	Nursing education	Reflecting to understand differences on encounter	Effectively applies cultural knowledge and skills across ethnic groups; Shows respect and appreciation of other cultural groups	Increased knowledge base, skills, language skills; tolerance
Lucas 2008	African American patients in urban medical clinic in Detroit	Cultural differences between provider and patient	Applies cultural knowledge and awareness to act instrumentally effectively in culturally Relevant manner	Reduction in health disparities; perceived provider cultural competency; trust between provider and patient; Satisfaction
Majumdar et al. 2004	Randomised control trial; cultural training health care providers and patient response	Self-awareness; willingness to examine own ethno-culture, attitudes, beliefs, and behaviour	Ongoing awareness of cultural differences; responsive to racial characteristics	Improved understanding of multiculturalism; ability to communicate with minority groups; patients increase using social resources to improve health

Author	Context	Antecedents	Attributes	Consequences
May and Potia 2013	Cultural training in Mumbai- Physio PG students	Awareness of considering cultural differences	Practitioners effective in trans-cultural interactions	Greater rapport, skill and understanding with patients; greater patient adherence to treatment positive patient feedback
Owiti et al 2014	Cultural consultation service	Cultural training session with mental health teams	broader and conceptual understanding of culture	Improved cultural competence of clinicians; better patient assessments; patient satisfaction and better outcomes
Stanhope et al. 2008	Cultural competency training in community agencies	Understanding and valuing cultural differences	Communicate effectively across cultures; making culturally informed diagnosis assessment and treatment	Patient satisfaction with culturally competent staff
Steed 2010	Cultural competency Training workshops	Degree of racial bias	Cultural awareness and beliefs, cultural skills; interventions that adapt to cultural needs	Culturally adapted programs; reduction in rates of depression in patients undergoing CBT
Sue et al. 2008	Mental health	Concern about health disparities in different racial and ethnic groups	Recognition of own cultural identity and differences with identities of minority groups and role of discrimination	Improved cultural competent care
Tayab and Narushima 2015	Aged care facility	Ethnocultural diversity; awareness; cultural knowledge; sensitivity; encounters; openness; flexibility	Cultural competency; strong connection to person-centred care	Holistic nursing; patient satisfaction; improved treatment and effectiveness
Wade and Bernstein 1991	Cultural sensitivity training With counsellors	Become aware of the 'blind spot'	Awareness; knowledge skills; aware of racial and class differences	Higher counsellor credibility and relationship ratings by clients; lower attrition rate for attendance to counselling by clients
Wall et al. 2013	Cultural Competency trained Office Staff in health centre	Culturally sensitive patients	Demonstrates culturally sensitive response to patients; interpersonal skills show behaviours, attitudes and professionalism that reflect cultural sensitivity care to patients	Patients adhering to treatments; patient satisfaction with health care