Cultural Competence in Health Care
An Emerging Theory

Isabelle Soulé, PhD, RN

This study examined the current state of cultural competence in health care using a qualitative descriptive design. Interviews were conducted with 20 multidisciplinary experts in culture and cultural competence from the United States and abroad. Findings identified 3 themes: awareness, engagement, and application that crossed 4 domains of cultural competence: intrapersonal, interpersonal, system/organization, and global. Key words: cultural competence, culture, global health, health care education, population health, refugee/immigrant health, self-awareness, theory development

BACKGROUND AND SIGNIFICANCE

The impetus for the burgeoning health care literature on cultural competence is complex.1-3 As the United States population becomes more ethnically, racially, and linguistically diverse, health care providers realize the significant role culture plays in health care provision and reception through an increasing evidence base substantiating long-standing health disparities and health care disparities.4 Professional organizations and accreditation bodies have responded by mandating cultural competence training for health care professionals and health care education.5-7

Broadly speaking, cultural competence assumes an inclusive approach to health care practice that enables a health care professional or health care system to provide meaningful, supportive, and beneficial health care that preserves every client’s and every community’s human rights and dignity.7-9 The cultural competence movement was born, in part, in recognition that a single way of thinking or acting based on a single set of cultural norms is both unethical and unprofitable. It is unethical because it does not accommodate unique beliefs, values, or traditions.10-12 It is unprofitable because clients and communities look elsewhere for services when health care providers and health care systems are not aligned with their wishes and do not understand them.13-15

STUDY PURPOSE AND DESIGN

The purpose of this study was to contribute to the theoretical development of cultural competence as a framework to guide knowledge development and integration of cultural competence into health care education. The researcher chose a qualitative descriptive design because it allows for a comprehensive
understanding of an issue (eg, cultural competence), by discovering underlying context, values, and background meaning. Furthermore, cultural competence has multiple aspects and perspectives to consider and is applied across many disciplines and contexts.\textsuperscript{16}

**Sample**

The study used 3 types of sampling: purposive, maximum variation, and network. Multiple sampling methods were chosen to select participants whose unique abilities, experience, and articulation of their ideas would contribute to maximum discovery of the phenomenon; generate a novel and more holistic understanding of cultural competence; and recommend other experts for participation in this study.

Because cultural competence is a paradigm that emerged from the United States and health care, an international and multidisciplinary sample was sought. The researcher anticipated that this approach would generate novel and richer findings than those from participants from only one country or one discipline. Predominant authors in cultural competence in health care and experts from the Intercultural Communication Institute were identified by the researcher and the dissertation committee for the purposive sample.

The 20 English-speaking participants from disciplines including nursing, medicine, and the social sciences were selected, all experts by virtue of their formal education, professional roles, and publications on culture and/or cultural competence. A few participants intertwined personal stories of negative interactions with health care providers and systems along with their professional perspectives. These negative interactions were reported exclusively by participants of color. Several of the participants lived and worked across international borders and self-identified as global citizens, rather than with a single country of origin. Gender, race, ethnicity, and educational background provided diversity across the sample. Because findings were intended to inform the integration of cultural competence into health care education, the study was designed for half of the participants to be from health care including nursing and medicine (Table 1).

**Data collection and analysis**

A personal e-mail invited interviewees to participate in the study. Because they were practicing professionals, they were not vulnerable in the traditional sense, and the Internet, published articles, and/or referral from professional colleagues provided contact information. All participants permitted their names, disciplines, and places of employment to be listed in a table as an appendix to the final report despite an offer of anonymity. The Oregon Health & Science University institutional review board granted approval. Sources of triangulated data included multidisciplinary perspectives, text data from interviews, and participant publications. Electronic databases helped locate publications that were used to

**Table 1. Demographics**

<table>
<thead>
<tr>
<th>Gender, race, and ethnicity</th>
<th>N = 20, n (%)</th>
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<tbody>
<tr>
<td>Women</td>
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</tr>
<tr>
<td>Men</td>
<td>10 (50)</td>
</tr>
<tr>
<td>White Americans</td>
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<tr>
<td>East Indians</td>
<td>3 (15)</td>
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<tr>
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<table>
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</tr>
<tr>
<td>Anthropology</td>
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<tr>
<td>Nursing/anthropology</td>
<td>2 (10)</td>
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<td>Medicine</td>
<td>5 (25)</td>
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<tr>
<td>Intercultural communication</td>
<td>1 (5)</td>
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<table>
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<td>Medical doctor (MD)</td>
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<tr>
<td>Doctor of education (EdD)</td>
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confirm, challenge, and elaborate interview themes.

Interviews were conducted face-to-face and over the telephone. Each interview lasted 60 to 90 minutes. Semistructured interview questions focused participant attention on the current state of cultural competence, and open-ended questions included 3 topic areas: (1) strengths of cultural competence (eg, What are the most important elements of cultural competence?); (2) limitations of cultural competence (eg, What are the limitations of cultural competence and/or the cultural competence movement?); and (3) recommended next steps (eg, What do you think is needed now?).

Data analysis occurred shortly after each interview following the procedures of within-case and across-case analyses. Interview data, or interview data and cultural competence materials published by participant together, constituted each case. For within-case analyses, interview data analysis happened before reviewing published materials. Subsequent cases were analyzed in relation to each other (across-case analysis).

The initial phase of analysis included line-by-line coding using Atlas.ti v5.2 to identify relevant words, phrases, stories, or context that represented key elements describing cultural competence. Constant comparison across the data identified recurrent themes and elaboration on ideas mentioned in the interviews, ideas not mentioned, or ideas that seemed contradictory. The second step in coding was to categorize and distill all first-level codes. This process led to identifying 3 themes that crossed 4 domains of cultural competence. The criteria of credibility (trust value), dependability (audibility or consistency), transferability (applicability), and conformability (neutrality) evaluated the rigor of this qualitative study.

FINDINGS

The findings provided a new theoretical framework based on 3 themes that are core elements of cultural competence, awareness, engagement, and application, as they apply in different ways across 4 domains of cultural competence, interpersonal, interpersonal, system/organization, and global. Although definitions and descriptions of the themes and domains are presented independently, they were ultimately interdependent with reciprocal influence. The nested circles in the Figure represent these findings.

Participants emphasized topics that were of particular interest to them, their discipline, or their personal research regarding cultural competence. Therefore, this data analysis represents all participant views, although some individual participants’ views dominate within certain themes and domains.

The distribution of the data within the framework varied widely. The majority of the thematic data emphasized awareness, then engagement, and finally application. The majority of the domain data emphasized the interpersonal domain, then system/organization, next the intrapersonal domain, and finally the global domain.

Cultural competence themes

Each of 3 distinct but interconnected themes—awareness, engagement, and application—although presented in a linear
format, were not linear processes but iterative, entwined, and interrelated. All participants identified awareness as a precursor to both engagement and application.

**Awareness**

Awareness was characterized as a continuum of conscious knowledge and discernment of self, others, and/or systems. The participants characterized one end of this continuum, *lack of awareness*, as “mindlessness,” “reactivity,” “interference or impediment of a specific mind-set,” and “entrenchment.” Participants described the other end of the continuum, *awareness*, as “mindfulness,” “open to new information,” and the “ability to imagine from multiple perspectives.” One participant, a nurse researcher, observed:

I think that commitment to self-reflection is one that every individual has to make . . . and I try to be conscious about how I have been influenced. The emphasis is on being introspective and self-aware and why you’re motivated to relate this way, and the kind of questions that you ask or don’t ask, and what your own background causes you to see and not see or to be sensitive to or not sensitive to.

Awareness relied on reflection and included examination of context, situated-ness, and underlying assumptions (eg, who constitutes “us” and who constitutes “them”). This process of developing awareness was germane across all 4 domains of cultural competence. Intrapersonal awareness developed in 2 distinct ways. First, while most participants described an internal change in attitudes and thinking as reflected in external behavior, others identified external mandates for behavior, such as institutional standards from an employer, as the catalyst for the development of cultural competency. A sociologist said this:

“. . . We often believe that if I give you the information you will change . . . what works is working with behaviors. This is what you are going to do . . . this is how you are going to value and respect that client. I don’t think you can retain negative imagery if you begin to do things in a culturally competent way in the workplace. Control the mind and the body will follow. That’s one way of thinking . . . control the body and the mind will follow . . . that’s where I’m coming from.

**Engagement**

Engagement was represented in the data as thoughtful consideration and active involvement occurring in synchrony. It relied on receptivity and manifested in 3 phases: intention, process, and outcome. The intention, or willingness to engage, was both a precursor and a consequence of successful engagement. The intention to engage can be thought of as fueling the second phase, or the process of engagement, which one participant, a sociologist working in Africa, described as "getting to know the space, relationships, power structures, and a willingness to say ‘okay, we can work.’” Participants described positive outcomes of engagement as "empathy," "connectivity," and "high-quality relationships." A nurse researcher said this: "Understanding an individual and their context requires . . . nimbleness. With different individuals from different backgrounds how that happens is different . . . You need to solicit it. When you understand the context you can drop the judgment.”

**Application**

Application represented the process by which principles of cultural competence (including attitudes, knowledge, and skills) are used as guides toward inclusion, responsiveness, and negotiation. Application of cultural competence required different thinking in different domains and implicitly spiraled back to awareness and engagement, allowing for deeper consideration and meaningful change. Participants described application as moving beyond cultural knowledge into an action sphere, such as “intervention,” “demonstration of competence,” and “operationalization.” Application was the theme least addressed in the interviews, and some participants noted it as the least developed area of cultural competence.
Cultural competence domains

The data implicitly and explicitly presented 4 distinct but interrelated domains of cultural competence: (a) intrapersonal, (b) interpersonal, (c) system/organization, and (d) global.

Intrapersonal

Intrapersonal refers to the aspects of cultural competence that relate to understanding ourselves as unique cultural beings, termed positionality. It includes a distinctive blend of attitudes, beliefs, values, stereotypes, and biases, as well as the larger context of sociohistorical and personal experiences that have shaped them. One participant, a nurse researcher, noted that bias and stereotypes occurred “naturally,” given the context of upbringing and personal experience.

Interpersonal

Interpersonal refers to how cultural competence is manifested between and among individuals. Although most commonly referred to in the context of a provider-client encounter, participants added a wide range of relationships within the health care setting, including those among colleagues, assistants, and community partners. This domain encompasses understanding the context of another as a parallel process to understanding the context of self. Examining similarities and differences between worldviews, beliefs, and values can support mutual understanding and negotiating middle ground.

System/organization

The system/organization domain of cultural competence referred to institutions of health care delivery, including health care education. Participants described this domain in 2 distinct ways: intraorganizational and extraorganizational. Intraorganizational cultural competence referred to internal processes such as mission statements, strategic plans, policies and procedures, hiring practices, employee behavior expectations, and performance appraisals. Extraorganizational cultural competence included a system/organization’s relationship to the surrounding community, the willingness and ability to build effective partnerships and coalitions, and incorporation of cultural practices relevant to the populations being served.

Global

Finally, a few participants discussed cultural competence in the global domain through topics such as global citizenship, global competencies for health care professionals, and local and international diversity. Because there was a paucity of data in this area, the section on implications for future study addresses cultural competence in the global domain.

Intersection of cultural competence themes and domains

This section discusses the 3 themes, awareness, engagement, and application, as they relate to the 3 domains most discussed by participants intrapersonal, interpersonal, and system/organization cultural competence (Table 2).

Awareness

Awareness of context appeared in the intrapersonal, interpersonal, and system/organization domains of cultural competence. The context of intrapersonal awareness explicitly referred to the larger sociohistorical background, social position, and personal experience in which an individual’s attitudes, beliefs, values, and biases develop. Implicitly, context represented the situation or setting in which self-awareness was thought to increase and develop under some conditions and diminish or be suppressed under others. Denial of one’s own bias and guilt over the bias one discovers are common responses to views that are considered politically incorrect. This discomfort creates resistance and dissuades individuals from moving toward deeper
self-awareness. Participants identified bias as originating from external influences, most often in childhood, rather than from personal choice. This shift in paradigm regarding the development of prejudice and bias can lead to a deeper understanding of the societal influences that initiate and reinforce specific ideas, views, and beliefs. This helps reduce individual sensitivity and allow for openness toward greater inclusion and positive change toward the development of cultural competence.

Interpersonal awareness was one of the dominant aspects in the findings, and participant remarks emphasized the need for “acceptance,” “understanding context,” and “humility” when dealing with others. One participant, an international educator, observed:

“It’s a combination of accepting difference and withholding evaluation of that difference. We . . . judge . . . rather than . . . be in accepting mode. The key in dealing with others is humility and a respect for difference. Their view is just as valid as our own.

Understanding the role of arrogance was also useful in considering the concept of humility. Participants described arrogance as “filling the room too much with yourself,” “believing you are better than others,” and “ethnocentrism.” While humility was emphasized, participants also voiced doubt, and one, a physician, described the difficulty this way:

Getting to the point of being equals with a patient is a hard sell and will require major cultural shifts in our [health care] institutions and education. I don’t think providers go into an office visit willing to be equals with the patient . . . they don’t behave in a way that makes the patient an equal partner. We have the knowledge, they don’t.

Participants found the traditional focus of health care on interpersonal cultural competence (ie, interaction between a provider and a client) to be of little value in today’s dynamic, diverse, and complex health care environment. Furthermore, primarily emphasizing cultural competence between a provider and a client obscured the more influential aspects of health disparities, including social, economic, political, and environmental variables. Participants advocated that the development of cultural competence move beyond an interpersonal awareness to systems awareness, which they thought to be a more comprehensive viewpoint and therefore more effective in reaching health equity between and among populations.
Engagement

Many participants implicitly identified the need for flexibility to engage successfully with self, others, and systems. Taken broadly, flexibility included intellectual, attitudinal, and behavioral flexibility. This flexibility is vital in enacting skillful communication, including listening to understand, blending the role of an expert and a learner, and helping reduce the power differential that is nearly always present between a provider and a client, as well as between system and community. It can be difficult for members of privileged groups or systems to recognize their privilege and realize the distance privilege places between them and less privileged groups. Denial or minimizing the effect of privilege is a significant barrier to becoming self-aware and therefore to the development of cultural competence. Participants identified asking different questions as a key strategy in engaging successfully with others. One nurse researcher participant said:

We need questions that create different kinds of conversations. [For example] “Have you had experiences where you have been treated poorly as a result of the fact that you have dark skin . . . or look Hispanic? Is that something you’re afraid of happening here? And if so, what do we need to do to help with that?”

Participants observed that system/organization engagement required both intraorganizational and extraorganizational visions. This includes redressing the power differentials that are embedded in health care institutions, health care education, and practice as it exists today. Being acutely aware of the impact of power, privilege, and rank was deemed essential to develop capacity to build strong egalitarian partnerships across difference.

Application

Data on intrapersonal application of cultural competence emphasized building personal capacity to work effectively with others. Terms “aptitude,” “capability,” and “facility” described this capacity. Underlying these descriptors is the idea that capacity is adaptable and therefore susceptible to influences such as learning and experience. Capacity here represents intellectual and emotional capacity, and holistic health and well-being were essential as prerequisites before capacity could be developed. One participant, an expert in intercultural communication, observed: “There’s an assumption that . . . we are always in good health, emotionally, physically, spiritually, or economically . . . and cultural competence is very challenging to practice when we are going through our own issues and life changes.”

Interpersonal application of cultural competence required whole-body communication that uses multiple sensory pathways, including verbal, sensory, vision, hearing, and intuiting, simultaneously. Participants identified this as necessary for building rapport with others. One participant, an intercultural educator, noted:

There is research to support this. Clearly when we meet somebody we have a sense of a synchrony of energies or a dissonance of energies . . . I find that if that [cultural competence] skill set or behavior does not come with a certain level of authenticity . . . the client . . . gets a sense of how this doesn’t seem right, this doesn’t seem real, and most people tend to pick up on that pretty quickly.

Participants noted that conflict is a natural outcome of working with others, particularly when working across significant differences. Because of the inevitability of conflict, the lack of conflict negotiation skills taught in health care education worried participants. One nurse researcher spoke about her work with nursing leaders:

Much of nursing leadership is really around conflict resolution. Leaders had story after story of how one needs to be able to embrace differences and to have respectful places for difference . . . and they never learned how to do that in any of their nursing programs.

They argued the need for health care providers with creative conflict negotiation skills who will be more able to resolve
tensions that arise so they are not tempted to "avoid" and or "give in" to conflict.

When addressing application of cultural competence to systems and organizations, participants repeatedly emphasized the importance of leadership and infrastructure to elevate the priority of cultural competence, drive systematic efforts, and inspire staff support. Participants identified that cultural competence is an essential aspect of providing excellence in client care and building collaboration among workforce that often includes large rank and class differences. Furthermore, participants noted the need for infrastructure to link standards, behaviors, and performance appraisals in order to give rise to "institutional accountability" for culturally competent practice. Generating a critical mass of cultural competence within a system/organization, they believed, would support and reinforce the use of culturally competent care.

Several participants noted that relationship centeredness in the system/organization domain is a significant paradigm shift that refocuses the provider’s role from being in service to the health care system to being in service to clients, families, and communities. One physician participant noted that this paradigm shift requires skill sets from providers and systems different from what is currently emphasized:

We teach biomedicine. We don’t teach understanding the patient’s perspective, we don’t teach compassion and humanity. Very little emphasis is placed on communication and even less on . . . cross-cultural communication. In real practice . . . you can have all this medical knowledge, but if you can’t communicate with a patient . . . all is worth nothing.

In the extraorganizational realm, participants acknowledged cultural competence as vital in responding to, and building effective partnerships with, communities. Participants noted that there is no one-size-fits-all solution and that cultural competence is complex and differs for each system/organization in relationship with the communities they are engaged with. Understanding the unique needs of individual communities was vital in contributing to safe, quality care; decreasing health disparities; and helping providers collaborate with community in sharing information and resources and generating solutions to health priorities.

DISCUSSION

The traditional ways of conceptualizing, teaching, and learning cultural competence as a finite body of knowledge are both superficial and inadequate for the sweeping social and demographic changes occurring today. Instead, cultural competence is a fluid, dynamic process progressing from awareness to engagement and application and back again at ever-deepening levels across the intrapersonal, interpersonal, and system/organization domains.

Awareness

The data suggest that awareness is central to cultural competence and moves steadily outward from the intrapersonal domain to the interpersonal domain to the system/organization domain and finally to the global domain. The centrality of awareness is congruent with a study by Jirwe et al,19 who performed a qualitative content analysis of 9 theoretical frameworks of cultural competence developed across 3 continents. The theoretical frameworks they examined identified awareness as essential in 2 dimensions: awareness of self and awareness of other.

This study expands the conceptualization of awareness to include awareness of systems, the global domain, and the larger context (eg, the United States, biomedicine, and health care academics) in which cultural competence has emerged. The emphasis on awareness of context in each of these domains adds a critical and multidimensional component to the development of the positionality of individuals and systems not often found in the current cultural competence literature.
Self-awareness is a cornerstone of a culturally competent encounter and of effective cross-cultural relationships, suggesting that the concept of self-awareness is fully understood. The literature repeatedly addresses the importance of self-awareness, yet it does not address how it is specifically developed, identified, or assessed.\textsuperscript{20-22} Furthermore, this level of self-reflection and self-awareness is often at odds with the objectivity that many health care students believe they possess no matter what the client, family, or community looks like, how they act, or what they believe or want.\textsuperscript{23,24}

**Role of the body in cultural competence**

The separation of the mind from the body in modern Western thought, favoring the mind over affective and perceptive knowing, is found throughout the United States, biomedicine, and health care education.\textsuperscript{25,26} When a primary effort of cultural competence is cognitive knowing, the physical body, with its sensations and visceral responses, is excluded as another way of knowing. While cultural competence is widely promoted, inviting and integrating a significantly different worldview are fundamentally unnatural; and discomfort, resistance, and chaos are common responses.\textsuperscript{26} Given the innate link between the mind and the body, what is interpreted in the mind is also felt in the body. Therefore, anxiety, which is often present in the face of significant cultural difference, is consistently accompanied by physical tension.\textsuperscript{25} This stricture of the mind and the body leads to narrowed thinking and a skewing of perceptions, which may include withdrawal, defense, and/or hostility.\textsuperscript{26} Building high-quality relationships goes beyond cultural knowledge to include the bodily experience of feeling at ease with diverse individuals, families, and communities. Sidestepping traditional cognitive learning, techniques anchored in the body may add support to the development of cultural competence in the health care education environment.

**Relational nature of cultural competence**

The participants identified the ability to build high-quality relationships across all domains as a central aspect of cultural competence. This more complex and dynamic understanding of cultural competence includes the integration of the cognitive, relational, emotional, practical, aesthetic, and spiritual aspects of human experience. Scholars have repeatedly found that relational aspects of care, such as compassion and empathy, are far more related to affect than to cognition.\textsuperscript{27,28} That framework is consistent with this study’s findings, which emphasized intellectual, attitudinal, and behavioral flexibility, skillful communication, understanding context, and conflict negotiation skills as more important than culturally specific information when developing cultural competence.

Biomedicine as a singular framework is insufficient and limiting for health care professionals who work with diverse clients, families, and communities and ineffective in supporting the development of cultural competence. The focus of health care education on the biomedical aspects of science and technical procedures over the past 50 years, while essential, overshadows a much-needed focus on relational skills that have not yet evolved to fully accommodate the development of cultural competence. This is not meant as criticism but rather an acknowledgement of the many critical and conflicting challenges faced in health care education today. Participants identified relational skills (“soft science”) as undervalued and at odds with traditional health care education (“hard science”) and health care systems. Traditionally, these cultural competence trainings emphasize a reductionist discussion of the needs, behaviors, and expectations of diverse groups entering, or already in, the health care system.\textsuperscript{29-32}

The intrapersonal domain of cultural competence is acknowledged in the literature as important and relevant.\textsuperscript{25,33} However, there is a lack of consensus in several areas: the instructional context in which
self-awareness is best supported; strategies for achieving self-awareness; and the varying capacity, propensity, and/or desire of individuals to develop self-awareness. Furthermore, there is a lack of consensus regarding the application of self-awareness in the clinical encounter, observable behaviors that demonstrate self-awareness, and subsequent evaluation methods for studying the impact of self-awareness on the development of cultural competence in specific clinical encounters.

For example, scholars argue that students are finely attuned to hidden curricular, faculty, and institutional agendas within health care education. In this context, students may not feel safe in being different, or they may feel silenced when expressing differing viewpoints in the culture of health care professional education. Participants noted that the development of intrapersonal self-awareness required a “safe” context (including self-compassion), could be “painful” to get in touch with, and that discomfort could generate a resistance toward deeper self-awareness.

This study adds new knowledge to the intrapersonal aspect of cultural competence by identifying 2 divergent avenues for developing intrapersonal cultural competence: (a) internal transformation manifesting in behavioral change and (b) external or behavioral actions that lead to the possibility of transforming the internal experience of difference. Further research is needed on how these 2 divergent yet complementary approaches may lead to the development of cultural competence in the health care education environment.

System/organization cultural competence

The argument for integrating cultural competence into systems and organizations has been weak because of a lack of research that demonstrates positive or negative consequences of a culturally competence system/organization and workforce, that expands our understanding of how to be culturally competent, and that examines cultural competence from the perspective of clients, families, and communities. Participants agreed that more quality research is needed to determine the essential components of cultural competence, how it is best enacted at the systems level, and its relationship to health and health care disparities. Furthermore, examining the collective voices of clients, families, and communities can help health care providers and systems understand how to provide skillful culturally competent care for all.

System/organization cultural competence has a broader range of influence and possibility for bringing about significant change (eg, elimination of health disparities and health care disparities) than cultural competence at the interpersonal level alone. This expanded perspective brings about a new vision of cultural competence wherein diverse health care providers work effectively with diverse clients, families, and communities sharing knowledge and learning from and with each other. In addition, recognizing, acknowledging, and challenging the many forms of oppression present in society at large and specifically within the health care system are necessary to eliminate injustice, health disparities, and, therefore, unnecessary human suffering. Starting from the “top down” (ie, administration), linking organizational policies, procedures, behaviors, and performance appraisals can set the “tone” of an organization to meet the needs of these diverse clients, families, and communities, in settings where cultural competence is the expected norm. At the same time, developing a critical mass of employees who demonstrate and expect cultural competence in themselves and in their coworkers provides a framework of support for developing a skilled workforce that is effective with diverse groups. These top-down and bottom-up expectations can also support building high-quality relationships between health care institutions and surrounding communities.

These study findings mirror the current professional literature, which, over the past
20 years, has moved from a primary focus on the interpersonal aspects of cultural competence to a more systemic perspective. This expanded view includes increased appreciation of the impact of dissimilar worldviews, values, customs, and experiences of health, illness, and health care delivery. In addition, it recognizes health disparities, health care disparities, and social determinants of health as central in treatment processes and how decisions are made.\textsuperscript{42-45}

\section*{IMPLICATIONS FOR FURTHER RESEARCH}

\textbf{Underpinnings of cultural competence}

Because cultural competence is a theory that emerged from the United States, biomedicine, and academics, the lack of international and interdisciplinary cross-pollination may have contributed to similar ways of conceptualizing and considering cultural competence. International and interdisciplinary research is needed to build an evidence base that supports best practices in teaching, learning, evaluation, and operationalizing cultural competence in the health care and health care education environments.

While cultural competence is currently the most frequently addressed cultural paradigm in United States health care, it is not the only one. Concurrently, a plethora of cultural concepts (eg, cultural sensitivity, cultural awareness, cultural efficacy, cultural safety, cultural humility, cultural proficiency, transnational competence, cultural empathy, cultural relevance, cultural agility) have emerged in the health care literature. This creates confusion because most of the concepts are not clearly defined, described, conceptualized, or discussed in relation to each other.\textsuperscript{36} While there is still much that is unknown regarding cultural competence, there is even less known about how cultural competence may be interrelated to these other concepts, the degree to which each is distinct or overlaps others, and what the relationship is between and among these concepts. More research is needed to clarify these concepts individually and collectively.

\textbf{The role of the body in developing cultural competence}

This study introduces a promising new area of study toward the development of cultural competence. Whole-body communication goes beyond cognitive knowing to include the rich complexity of our physical experience. This includes being sensitive to feelings of appropriateness (multisensory awareness) in order to build interpersonal relatedness. Bennett and Castiglioni\textsuperscript{25} note that in one’s own culture, things simply feel right. This feeling right can be considered the physical manifestation of ethnocentrism that perceives our own culture as central to reality. Furthermore, without a similar sense or feeling for another culture, we are limited in our depth of understanding and ability to adapt and build rapport with others. Research is needed to explore the role of the body and techniques grounded in the body for their usefulness in supporting the development of cultural competence in health care education.

\textbf{Global cultural competence}

Cultural competence in the global domain places a priority on improving health and achieving health equity for all people worldwide where the heaviest burden of disease falls on low-income countries.\textsuperscript{47-49} Global competencies are in their infancy in health care and need further development toward implementation and evaluation to ensure that health care providers of the future have preparation to practice in a globalized world. In addition, the effects of war, dislocation, and migration, both unidirectional (emigration/immigration) and circular (return and repeat migration), must be addressed because these are defining elements in contemporary practice.\textsuperscript{9,50}

In order for health care providers to see themselves in this broader role of advocacy,
it is vital that they acquire global health skill sets. This shift will require letting go of familiar ways to embrace new ways of thinking and acting. It will also require collaborative innovation across disciplines and nations. Academic centers can play a major role in enhancing partnerships that will be crucial to eliminating the enormous health disparities that are present locally and worldwide. Global competencies used to guide health care curricula should include, but not be limited to, global health disparities, health care disparities, donor-recipient nations, migration and diaspora, population health, conflict negotiation, and the role of power, privilege, and rank in the provision and receipt of health care. One nurse researcher participant commented, “So do I think cultural competence has a nuance outside of health and human service? It absolutely does . . . . It matters in how we govern . . . . it matters in how we run the world.”

This exploration of cultural competence in health care and health care education is a small step toward achieving a more complex understanding of cultural competence that moves away from superficial approaches toward recognition of the interplay of the many economic, political, geographic, and social conditions that provide a context for health disparities and health care disparities in our world today. Negotiating a common understanding of the central tenets of cultural competence, practical application, and effective evaluation methods can help reduce the burden of human suffering.

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