

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

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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

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 uniform 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. The challenges and suggestions to overcome them are discussed in the full entry at [10.3390/encyclopedia3030068](https://doi.org/10.3390/encyclopedia3030068).

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