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Chapter 4

Assessment of Care for Cultural Competence in Healthcare Services: A Systematic Rewiev of Qualitative Studies

Seyma Demir and Yasemin Yildirim Usta

Additional information is available at the end of the chapter

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Abstract

Background: Societies have a multicultural structure characterized by the spread of cultural diversity and having to live together with different ethnic origins, languages, and racial individuals. This requires that health professionals should adopt a care approach regarding cultural competence in order to prevent health inequalities due to cultural differences, to meet the health needs at desired level, and to enable maintenance of evidence-based care. **Objective:** To assess the cultural competence of the care provided in healthcare services. **Methods:** Academic Search Complete, CINAHL, Proquest, Sage, and ScienceDirect databases were scanned; seven articles matching the criteria were evaluated. **Findings:** (1) The number of articles that examined clearly and comprehensively in the context of qualitative research relationship between cultural competence and healthcare services was few, (2) the results couldn't be combined into a common pavilion because many of the studies have processed on independent topics by addressing different dimensions of cultural competence, (3) in studies, it has been found that important components of care such as mutual communication, trust-based care environment, positive and non-judgmental approaches of health professionals, clinical skills, and linguistic differences were effective for cultural competence of healthcare services.

Keywords: culture, cultural competence, care, qualitative studies, healthcare services

1. Introduction

In recent years, with emphasis on evidence-based health care, systematic review techniques are confronted in researches in the sense that they synthesize the data obtained on a subject and reveal important points about the subject [1]. Qualitative research also is one of

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the processes of producing knowledge that is meant to understand people's lifestyles, their stories, their behavior, organizational structures and social change. Contrary to quantitative research, qualitative research aims to explore the subjective viewpoints of events for people and is therefore reported to be superior than quantitative research [2]. According to this, in this section of the book is devoted to the interpretation of qualitative studies dealing with the concept of cultural competence in health services. For this reason, there are two main factors in the selection of this topic: (1) increased health inequalities caused by cultural differences in health care with the presence of a growing immigration world in the world and (2) encounter the difficulties of health professionals when they serve individuals with different cultural characteristics and occurrence of cultural conflicts between service providers and customers.

According to the statistics of the global immigration report of the United Nations at the end of 2013, the number of international immigrants in the world is increasing every year [3]. The increasing activities of multinational corporations, international business and money markets, non-governmental organizations and the emerging tourism sector are causing millions of people to shift internationally every day. Migration events for various reasons lead to the encounter of different cultures, and the necessity of maintaining the coexistence of people from different cultures brings about important problems of harmony and conflict [4]. This changing nature of societies presents challenges for all healthcare professionals in the world, where patients are faced with diverse healthcare needs and expectations [5]. Thus, professional organizations and accreditation bodies have responded by mandating cultural competence training for healthcare professionals and healthcare education in United States of America (USA) [6].

Cultural norms such as language, beliefs, and practices can easily be misunderstood in a multicultural environment. For this reason, cultural and language difficulties between both patients and healthcare providers and the healthcare team have the potential to adversely affect the ability of healthcare professionals to work competently and safely [7].

The health literature on cultural competence which includes components such as cultural understanding, cultural sensitivity and cultural encounters in healthcare services has gained momentum in recent years. "Cultural competence" is a widely accepted approach to focus on diversity in health care [5]. In addition, this concept is one of the most frequently used cultural paradigms in health care, but it is not the only one. Concurrently, the existence of cultural concepts (e.g., cultural sensitivity, cultural awareness, cultural efficacy, cultural safety, cultural humility, cultural proficiency, transnational competence, cultural empathy, cultural relevance, cultural agility), many of which are not clearly defined, described, conceptualized, or discussed in relation to each other creates confusion [6]. There is a lot of unknown about cultural competence. For this reason, increased work is needed to minimize this chaos that emerges among concepts, to fully explain cultural competence and to integrate it into the health system in different ways.

In this part of the book, discussion will be given on the findings of qualitative studies related to the subject as well as basic information on cultural competence based on the information obtained, aware of the lack of knowledge and the lack of information in the current literature.

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2. Background

2.1. The concept of cultural competence should be explained in the presentation of health services

Cultural competence is at the core of high quality, patient-centered care, and it directly impacts how care is delivered and received [8]. It is based on the principle of "*eliminating health inequalities and realizing an objective and equal representation of health services"* aimed at the primary level in a society. The main points in such a care approach should be cultural factors affecting health perceptions and health practices such as language, communication style, religious beliefs and practices, attitudes and behaviors as well as the diversity of the patient population [9]. Indeed, the lack of universal, full and clear meanings of the concept of cultural competence leads to confusion about the objectives, scope and content of educational activities to be provided to the cultural competence of health personnel.

Generally, culture is defined as the "integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group" [10] and an undeniable element in the delivering of health services. Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities [11]. A health personnel who has provided cultural competent care should know that each culture is different from each other and their health needs will vary and he/she should take being able to express clearly their own cultural assets as the fundamental human right of all individuals naturally.

Cultural competence is essential for working with indigenous and ethnic minority individuals in all areas of healthcare services in a society. Culturally, competent health personnel must understand the views of the world and of their patients while avoiding stereotyping and misapplication of scientific knowledge [12]. In order to prevent inequality in health, culturally competent care is especially important for minorities who live in that community and who apply for health care and receive this service from the majority members of that community. Indeed, the most common causes of health inequality in minority communities include missed opportunities for screening because of lack of familiarity with the prevalence of conditions among certain minority groups; failure to take into account differing responses to medication; lack of knowledge about traditional remedies, leading to harmful drug interactions; and diagnostic errors resulting from miscommunication [8]. If the cultural factors are ignored, the healthcare quality will reduce, and the negative health outcomes will arise.

It should not be forgotten, in addition to ethnic and racial minority communities in care related to cultural competence, other groups (such as women, the elderly, gays and lesbians, people with disabilities, and religious minorities) [10] exposed to health inequality in the community should also be considered in depth. For example, in a particular society, gender norms may lead to differences in access to resources and health services as well as social status and power between men and women. In male-dominated societies, it is known that men control women's access to health services, which makes it more difficult for women to receive

preventive and treatment services [13]. One of the most common cases is the desire of patients to select health personnel according to their genders. Or, on the other hand, despite the lack of a professional approach, avoiding interfering with a patient of opposite sex under the name of privacy intimidation by health personnel is one of the preferences that create inequity in health. For example, options like, especially, electing female physicians of women with pregnant or gynecological problems; trying to find male health personnel of female nurses for a male patient who will be urinary catheterization in the clinic are actions prolonging and limiting the service process even though they are not directly visible. Such situations also occur because of cultural norms as well as social role and religious perception of the individual. Cultural competence care should include awareness-based educational activities without undeniable cultural differences and anticipations at the level where comprehensive and effective results can be achieved in order to remove sexually related health disparities.

Cultural competence in the field of health should be examined and studied in order not to be exposed to prejudice and discrimination in terms of health personnel who are a minority in a particular society. Ethnic minority personnel who do not know their beliefs, attitudes and practices can experience a negative communication process with the patient/relatives because he/she cannot effectively develop his/her professional skills in the institution where he/she works. Developing a competence involves challenging one's prior knowledge and developing new knowledge in a dialectic manner through an iterative cycling of reflection and action. Hence, it should be continued throughout life [14].

In the literature, regarding cultural differences, it is emphasized that the incidence of cardiovascular diseases is low in France due to the presence of red wine consumption which compensates for the negative effect of high saturated fat intake [15]. Or, in the United States, it is known that African Americans may be likely to attribute illness externally to destiny. They believe that the disease comes from God and believe in the healing power of prayer [16]. In Muslim societies, while illness and disease may be regarded as a test from Allah, they carry tidings of forgiveness and mercy. Also, drinking zam-zam water to a patient in terminal period and reading the Qur'an at his/her head by family caregivers is believed that the spirit will come out easily from the body and he/she will die faithful [17]. Again in some cultures, especially in end-of-life care, pain is a symptom that should be relieved, in others is seen as a symptom that should be experienced as proof that the body struggles to come from above the disease [18]. Despite the cultural differences between health practices Leininger, person who first explained the term "cultural competence" related to health suggests that health personnels should have information about the cultural values, beliefs and practices of individuals in order to provide meaningful and harmonious care to people around the world [19].

2.2. Is the cultural competent care useful and important?

The understanding of cultural competent care has shown itself to be more evident and widespread in recent years. One of the most fundamental factors is the rapid population migration, and therefore, the multicultural communities have begun to live together. This increase in immigration among countries in the world has also led to an increase in the number of ethnic minority patients and ethnic minority health personnel in the health system [20]. In addition to this, the recognition of more equally equal rights within the society to the minority groups

compared to the old and the expected satisfaction has demonstrated the importance of the concept of cultural competence in almost all service areas, including health services. Cultural competence as a concept beyond cultural awareness and sensitivity requires not only knowledge of different cultures but also skills, abilities, powers and competencies necessary for establishing respectfully and culturally appropriate relations [10, 18].

Cultural competence waits for health workers to recognize and respect the cultural diversity of the community or the individual's individual beliefs, health priorities, and cultural-specific practices rather than recognizing the specific beliefs, attitudes and behaviors of all cultures [19]. While providing culturally competent care has removed health inequalities caused by socioeconomic and cultural differences, it increases the quality of care and efficiency of the service, improves the health outcomes, and increases the satisfaction of the customers and healthcare provider [11, 13].

As a further opinion, cultural competence provides an inclusive approach to healthcare practice that enables a healthcare professional or healthcare system to provide meaningful, supportive, and beneficial health care that preserves every client's and every community's human rights and dignity [6].

2.3. What are components of cultural competence?

The concept of cultural competence is widening and the definitions, models and strategies of practice continue to evolve [5]. The concept of cultural competence is handled by different thinkers and theorists, and the results of the studies have also found subcomponents that are related to the concept. For example, according to a Swedish study, cultural competence includes nurses' cultural understanding, cultural sensitivity and cultural encounters [20]. Again, in the work done by Soulé [6], four independent but interrelated areas of cultural competence emerged: intrapersonal, interpersonal, system/organization, and global.

Components are also found in the models of cultural competence introduced by various theoreticians. Campinha-Bacote and Munoz offered a 5-component model for developing cultural competence: cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire [21]. Qualitative study results related to the concept in the literature also revealed similar components in this model [6, 20]. Also, a task force of the Expert Panel for Global Nursing and Health of the American Academy of Nursing, along with members of the Transcultural Nursing Society, has developed 12 standards from social justice to evidence-based practice and research for cultural competence in nursing practice [22]. Even if they are not directly based, these standards are the titles that can indirectly lead to the maintenance of cultural competence in health services. However, in general, when the literature on the concept is examined, it is seen that the components most closely related to cultural competence are person-centered care, communication, system and organization.

2.4. Culturally competent care in health services requires technical skills

Language competence and providing interpreting services. By providing interpreting services for individuals from different cultures who speak different languages, the inadequacies and disruptions caused by language differences can be eliminated. Nowadays, health services can

be provided to the patients who apply for medical tourism by considering the cultural differences in the units opened in the hospitals. Some of them have 24 h continuous interpreter services [10]. Language often mediates the experience of health care, difficulty adapting to new environment/culture and communication can affect the ability of healthcare personnel to meet the needs of their patients/relatives and the interaction between them for ethnic minority health personnel or patients [20]. Indeed, the inability of hospitals and health personnel to perform equally in languages other than their native language is an important factor in reducing the level of access to health care for many people. It is a condition that service providers need to understand in order to understand all the patients' information and explanations, to identify requirements and to be able to effectively manage the process [5].

Providing employment for minority individuals in health services can create an effective communication environment that can meet the needs of minority communities, common cultural beliefs and common language. Thus, a structured and developed health system will also occur, as well as existing health services will be a more welcoming environment for individuals from different cultures. Accordingly, to recognize the possibility of placement and scholarship for minority personnel, to create minority staff job notices, to make regulations by creating a safe working environment for minority personnel are basic interventions that can be done [10].

Cultural competence training programs aim to enhance cultural awareness, knowledge, and skills that cause changes in staff behavior and patient-staff interactions. Thus, it is important that health professionals should be acquired the necessary knowledge and skills to be able to provide culturally competent care to patients from different ethnic origins [20]. Such educational programs may be taken into the curricula of schools as part of their vocational education program, or in the institutions, personnel awareness and training can be provided by in-service training. At the same time, public information for minority groups, health screening programs, public audiovisual educational activities can be organized in order to create incentives to protect health [10]. But for all this to happen, healthcare personnel should also be open-minded and show a positive interest in learning about other cultures [20].

Coordinated study with appropriate traditional treatment methods allows that the healthcare service can be presented in a conceptual framework compatible with the current health system by taking into account the cultural beliefs and traditions of the individual. This increases the positive attitudes of individuals to treatment and care proposals and, commitment to the treatment process [10].

3. Methods

3.1. Objective

The primary objective of the current study is to assess the cultural competence of the care provided in healthcare services. To identify the current state of perceptions and views of

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health professionals related to cultural competence within the context of healthcare services, to identify the influencing factors cultural competence among recipients and caregivers, to improve care for cultural competence and to assess existing regulations used in the improvement of health practices also are secondary objectives of the study.

3.2. Searching and selection of papers

The study was carried out as a retrospective screening of publications related to the subject. The study was conducted by checking Academic Search Complete, CINAHL, Proquest, SAGE ve Science Direct databases. Scanning all databases was performed by "cultural competence/competency," "care," "health care services," and "qualitative research/study" key words. Article selection criteria included the studies carried out between 2006 and 2017, qualitative researches, English-language articles and studies that can be reached in full text. The sample group of the study does not include a single population. Within the context of health services, all sample groups included in cultural competence studies were included in the study. The quantitative researches, mix research methods (both qualitative and quantitative), thesis studies related to the subject and verbal or poster notifications presented in the congresses were not included in the scope of the study.

Because of their extensive experience for over a decade, each of the scanned articles was evaluated based on the Critical Appraisal Skills Program (CASP) 10 questions established for qualitative research. Each question has a number of sub-questions in order to determine the quality of qualitative articles and to decide whether it is consistent with the current research topic [23, 24]. According to this, seven articles matching the criteria have been reached and were evaluated.

3.3. Synthesis of the data

In the study, interpretation and evaluation of qualitative data were performed using metasynthesis techniques. Descriptive and content analysis were used together in the analysis of the data obtained at the end of the research process. First, the researcher gave a code to each article (A, B, C vs.). Second, in each article, the previously identified themes were made into a table. Third, common themes were created by the researcher using the previous literature information from each article. After, direct citations were made from the opinions of the individuals in relation to the topic within the text. In addition, under the identified common themes, the data in the studies have been thoroughly examined and interpreted (**Figure 1**) [25].

4. Findings and discussion

4.1. Description of studies

As a result of scanning the databases via current keywords, initially, 142 articles were found potentially relevant titles or abstracts. In these articles, eight duplications in multiple databases were removed from study. From the remaining articles, irrelevant records, quantitative

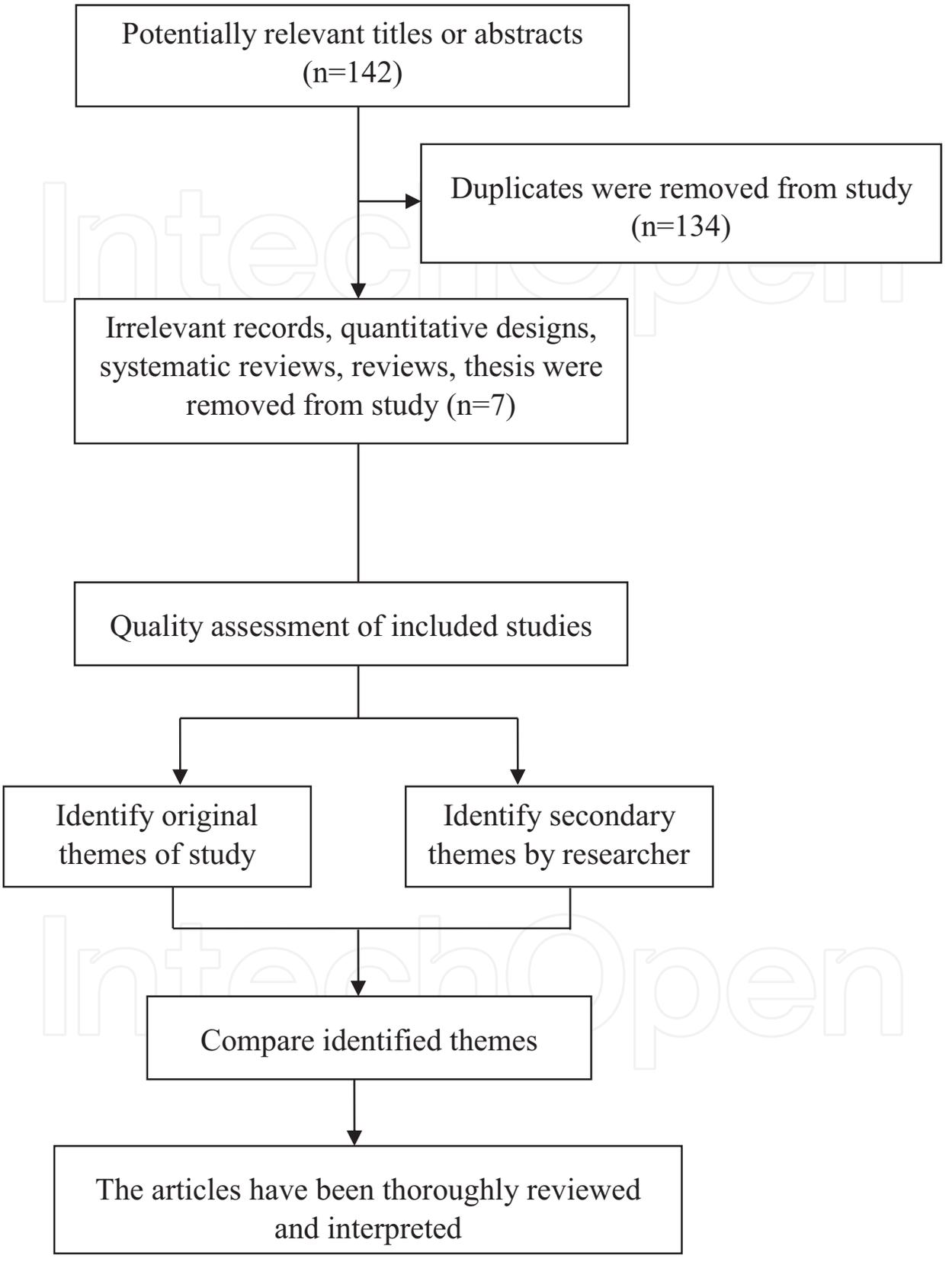


Figure 1. Showing the process of article selection and meta-synthesis.

designs, systematic reviews, reviews and thesis were removed from study (n = 127). As a result, seven articles meeting the inclusion criteria of the study were evaluated.

It appears that seven qualitative studies on determining the status of cultural competence in health services have been conducted in several different sample groups. It has been seen that the indispensable components of healthcare services such as cultural competence-related care and views of health professionals, educational activities and their effects on patient outcomes are involved in five of seven studies. Two of these five studies were based on improving nursing students' care ability about cultural competence. In the remaining two articles except for these five articles were established current status of cultural competence in the care of pediatric patients and were evaluated care activities related to cultural competence of health professionals in the eyes of patient families. In addition, a constructive theory was used to develop cultural competence in one of the two studies; in the other, ethnic nurses' views on cultural competence were determined by using the cultural competence model (**Table 1**).

4.2. Description of themes

As shown in **Table 1**, the themes deduced by the researchers are found that have been determined by the researchers of the articles included in the study. Second, in the seven studies examined, certain common themes on cultural competence in healthcare services were established. These themes are shown below:

- Cultural differences and cultural adaptation
- Cultural sensitivity
- Language skills and communication difficulties
- Ethical issues and uncertainty
- Nursing education, professional skills, and experiences

Besides the nature of evaluation by qualitative study design from a broad perspective of the cause of an event, the diversity of sample groups also provides an effective contribution to an in-depth analysis of the concept of cultural competence that we want to achieve in this section. The integration of all studies under common themes will allow a more holistic understanding of the subject.

4.2.1. Cultural differences and cultural adaptation

Today's businesses have a lot of people from different cultures, and at the same time, they have to work with individuals with different cultural backgrounds on the basis of their activities in international markets. While individual differences are experienced even in the society in which the individual lives, it cannot be said that individuals from other cultures are not affected by cultural differences. Indeed, if cultural influences on human behavior, mimics and speech patterns are considered, people from different cultures may find it difficult to understand and interpret, and communication difficulties may arise [26]. In this direction, the importance of intercultural adaptation arises. The concept of intercultural adaptation is

Publications	Database	Samples	The themes obtained from analyses related to cultural competence
Tavallali et al. [20]	Academic Search Complete	14 parents (seven mothers and seven fathers, not couples)	• ***Main categories:*** • Influence of nurses' ethnicity • Significance of cross-cultural communication • Cross-cultural skills • The importance of nursing education • ***Subcategories:*** • Nurses' ethnicity does not matter • Experiences of minority ethnic nurses • The importance of language skills • The importance of adaptation and awareness of the Swedish culture • Cultural encounters and personal attributes • Cultural sensitivity
Croot [5]	CINAHL	11 Pakistani parents and one grandparent from nine different families	• Being listened to and having expertise recognized • Control of care • A relationship of trust and mutual respect • Honesty • Non-judgmental • Genuine concern for welfare of the child • Relevant goals of treatment
Koskinen et al. [28]	CINAHL	48 European (n = 21) and Canadian (n = 27) nursing students	• Cross-cultural ethical issues • Cultural and social differences • Healthcare inequalities • Population health concerns • Personal and professional awareness
Kwong [30]	PROQUEST	College professors and/or experienced practitioners with 15 or more years of experiences in multicultural research, teaching, and practice in the USA	• Attitudinal components • Emotional components • Intellectual components • Integrative practice components

Publications	Database	Samples	The themes obtained from analyses related to cultural competence
Soulé [6]	CINAHL	20 participants from disciplines including nursing, medicine, and the social sciences	• ***Cultural competence themes*** • Awareness • Engagement • Application • ***Cultural competence domains*** • Intrapersonal • Interpersonal • System/organization • Global
Almutairi et al. [7]	SAGE	24 nurses comprised registered expatriate or Saudi nurses who had worked in the hospital for a minimum of 12 months	• ***Deductive analysis*** • Cultural awareness • Cultural knowledge • Cultural skill • Cultural encounter • Cultural desire • ***Inductive analysis*** • Culture Shock • Disempowerment
Garneau and Pepin [14]	Science direct	Nurses (n = 13) and students (n = 11)	• The development of cultural competence is a process of reflection and action • Building a relationship with the other, working outside the usual practice framework, and reinventing practice in action dimensions should be developed • This process involves three levels of development triggered by clinical immersion experience, whether local or international • Students' or nurses' learning environment fosters this process

Table 1. Methods and results of studies.

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also expressed as the ability to adapt to life in another culture or to relate to other culture members. People, who are respectful, flexible, patient, concerned, curious, open, empathic, have a sense of humor, tolerance to uncertainty, motivated and able to evaluate individuals after a certain period of time can draw a successful profile in terms of cultural adaptation [27].

The concepts of cultural differences and cultural adaptation play a major role in all of the examined articles. Although the statements in the studies show that cultural differences are generally problematic in the execution of healthcare services, but there are also participants who do not hold this idea… as in Tavallali et al. [20]. Tavallali et al. [20] emphasized the importance of adaptation of minority ethnic nurses to Swedish culture in a study conducted on Swedish parents. According to some parents, minority ethnic nurses should provide their current cultural adaptation and integrate themselves into new cultures in their professional work, and implement them in this direction. But, some parents have stated that ethnicity is not effective in the care of their babies, but on the contrary, they are more pleased with regard to nurses from different ethnic origin.

"I have not experienced cultural differences as a barrier or something uncomfortable or anything like that at all, not at all"

"I personally think that foreign nurses are talented and much warmer and personal"

"The fact that they certainly have practiced where they come from and that they have adjusted to another culture,….. give them an advantage."

In the articles included in the present study, cultural differences and adaptation were mostly studied on nursing and nursing students, because they are at the center of care 24 h a day without interruption. Also, they are the biggest discipline in the field of health and the health workers who have the greatest interaction with the individuals who apply to the health institution. Of course, these are the main reasons for this.

Garneau and Pepin [14] also included nursing students in their studies, and it is stated that the interaction between patients, nurses and students can be overcome obstacles in the way of effective and quality care by bringing together different cultural specific facts such as beliefs and values, spoken language, professional standards, organizational structures and national policies and meeting a common payer. In the same study, participants stated that care would be effective and qualified if the individual's age and gender as well as cultural differences such as sexual orientation, social status, religious beliefs, or ethnicity were taken into consideration and individualized care needs were met.

In the study of Koskinen et al. [28] which European and Canadian nursing students are faced with a different cultural health system through mutual exchange, they tried to reflect unknown cultural and social differences in comparison with their own cultures. By doing this in a variety of ways in team work, in a range of health programs, services, techniques and methods ranging from unusual aseptic and safety issues to different or limited nurse roles, they have begun to understand and adapt to the primary healthcare system, especially those they do not know. As a matter of fact, they have begun to experience positive experiences when they are faced with these difficulties of cultural diversity and accepting those cultural

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specific practices. Students have also encountered surprising situations that differ from their cultural beliefs within the scope of this change program, and they have also suffered dilemmas in health practices.

"This particular event was based on a home visit to a rural family…. there was a baby carriage sitting on the front step…. I for sure was shocked, as we do not do this at home…. then making tea and coffee, bringing out cakes, cookies, and much more....this is not normal in our culture…we are told not to accept anything from any of the clients that we visit"

"If her family doctor was a male… there had to be a female nurse present in the room during the gynaecological examination… It is a good thing to secure women's sexual integrity but this sounds as overprotection"

In fact, this situation could be examined under the heading of ethical issues, but what sets this dilemma is the cultural values, attitudes and behaviors of these students. Although one of the most important obstacles to the presentation of health services in multicultural societies is laid as intercultural differences and cultural conflict, it can be considered that the main problem arises from the ineffectiveness of individuals' desires and behaviors in order to recognize and understand different cultures mutually. As a matter of fact, intercultural differences are not an issue that cannot be surpassed in the presentation of health services. In particular, beneficial intercultural experiences that can be organized for nursing students can contribute to the development of a new perspective of nursing care and understanding of professional philosophy.

4.2.2. Cultural sensitivity

Culturally, sensitive care in terms of health services is one of the most fundamental components of cultural competence in a significant majority of studies based on models or concept [29]. In the examined articles, besides the direct expression of cultural sensitivity in the examined articles, expressions including subcategories such as cultural awareness, cultural understanding, respect for cultural norms and values, trust relation and honesty, and interest without prejudice were frequently encountered in addition to direct expression of cultural sensitivity. It is also emphasized that cultural sensitivity is an unalterable challenge to culturally competent care [5, 6, 14, 20, 30].

Results of a study with children with disabilities revealed the interaction between the participants, the parents and the health personnel rather than quality of care of parents. In these studies, parents underlined that their caregiver roles should be considered important by health personnels and the necessity of mutual respect, listening and empathic approach [5]. *"I understand what he needs but they didn't know."* In this context, the parent would like to emphasize that healthcare professionals should be sensitive about to the fact that they have sufficient expertise in the care of the child with disabilities and that the parent's views must be respected in decisions regarding the care of the child. Indeed, culture shapes the views of individuals and health professionals accept and respect cultural differences [18].

Some parents have emphasized the importance of trust relationship in these studies, and they have stated they did not trust the health personnels. Because, according to them, the

professionals involved in the care of the child did not fully understand their concerns or the complexity of the child's problems. Or they were more worried about the care of their children when they thought personnels were not being honest [5]. *"They will have known he had got a problem but they didn't tell us." P*arents felt that nurses should have a humanistic perspective and be sensitive to the cultural needs of the patients. According to them, nurses should be open to cultural differences and have confidence in asking questions. Although there were individual and religious differences, respect and empathy were important components in maintaining the care [20].

In another study, aiming to contribute to the integration of cultural competence into health education and the theoretical development of cultural competence reflects cultural sensitivity as one of the indicators of healthcare quality and assessed by experts in the field of cultural competence has been reported the importance of expressions of the humility, empathy, voluntary participation without color and race discrimination, intention. According to interviews with participants in different disciplines of the health field, the following expression of an expert participant *"Understanding an individual and their context requires…When you understand the context you can drop the judgment"* or the expression of the other *"It's a combination of accepting difference and withholding evaluation of that difference. The key in dealing with others is humility and a respect for difference…"*or the other "*"Have you had experiences where you have been treated poorly as a result of the fact that you have dark skin…or look Hispanic?"* are indications for this [6].

In the other two studies examined, similar expressions evaluated by expert health personnels were also included. Specialists emphasized the need to know religious practices and health beliefs while respecting the cultural identities and, need to respect the cultural identities and therapeutic preferences of individuals. Also, it has been suggested that personnels should be encouraged to see a different culture from a different perspective and it has been stated that maintenance should be continued with an objective and sensitive approach [14, 30].

It is clear that the themes of cultural competence in the presentation of cultural competence health care cannot be considered independently of each other. Factors affecting cultural sensitivity such as empathy, mutual respect, and trust in the above expressions can be influenced by important components of cultural competence such as language differences, ethnicity, cultural understanding, education and professional skills. For this reason, professional healthcare providers should not forget that each person represents a culture, they must have adequate communication skills, and they should maintain their professional autonomy without breaking the ethnic and language differences, without breaking, judging and empathizing. The requirements of cultural sensitive care can only be achieved in this way [31, 32].

4.2.3. Language skills and communication difficulties

Language is the primary means of communicating cultural beliefs, values and norms. Language also expresses the cultural heritage of an individual and is a source of identity and pride. Accordingly, establishing and maintaining a professional therapeutic relationship depend on the ability of the practitioner to communicate effectively with the client and on language skills [30]. Language barriers play a crucial role in creating culture shock that culture shock has a number of negative consequences, such as discomfort, feelings of helplessness, frustration and

depression [7]. When interactions with multicultural and multilingual individuals in health services are introduced, effective execution of verbal or non-verbal communication will enable the satisfaction of the quality of the service, the care and the caregiver.

One article has shown that the difficulties in communicating between the nurse and the patient create anxiety and uncertainty and reduce parental health satisfaction [20]. The common language of the majority population of studies examined was English.

"I was going to drop him off at 1.00 p.m. today because he doesn't eat at school, I want him to go just in the afternoons. "Because they don't eat the school meals… I send their lunches." In these expressions, a parent disabled child who does not speak English has wanted to send her child to the school only at certain times because she has not sure if he could eat lunch. These expressions make us think that language difficulties have created uncertainty and anxiety in this parent. On the other hand, the fluent English speaking of another parent allowed to communicate more easily with the child's school and provided easy management this process, increased individual satisfaction [5]. The study was conducted in Pakistan, but English language is a common language between parents and staff. It can be considered that the source of the problem there, basically, is that institution and staff cannot be effective in the native language of the present society. For this reason, the staff and the families are not able to express their mutual expectations sufficiently. As a result, adversely affected people by care are unfortunately children with special care needs.

Students who have experienced cultural competence in different continents have emphasized that they have experienced a more effective process and have received positive feedback when they have adapted to cultural differences and have overcome language difficulties. Expression of a Canadian student "*a 7-year-old female who came into the clinic upon referral from a community health doctor to help diagnose Asperger's syndrome through observed characteristics in the home. We communicated very effectively, even with the language barrier…hand gestures and simple Finnish words."* Or another participant *"If there is a language barrier, well you have to make sure the patients understands you. In that case you have no choice but to find an interpreter so the patient can receive and participate in his care"* have explained the importance of the language in the interaction [14, 28].

The workforce of the nurse in Saudi Arabia is largely composed of foreign nurses recruited from North America, South Africa, Europe, Asia, Australia, New Zealand and the Middle East. Hence, Almutairi et al. [7] also were stated in their study that many participants express the difficulty of communicating with nurses. Of course, the source of the problem is the language differences. In fact, in some cases, violent discussions take place between nurses and patients because words have different meanings in cultures:

"…in our language (Futa) it means bad word like prostitute, and this baba said "ateeni Futa" (which means towel)…[the nurse] was almost fighting"

In this study, the common language used in the hospital (English) is an intensified barrier as most of the participants are not the primary language. Many participants have tried to communicate with their patients using body language and signs [7]. But, it should not be forgotten that your gestures and mimics may not be acceptable in every culture. It can even be

uncomfortable. In this case, being guilty can be inevitable. Difficult communication can lead to a lack of confidence in the care delivered to the patient. For this reason, the adaptation of the foreign staff of the health institution to the native language of that community should be included in their in-service training.

4.2.4. Ethical issues and uncertainty

Cultural interactions can create confusion at the cognitive level. Hence, in a study conducted by Almutairi et al. [7], participants found that there was a high level of uncertainty about which applications were acceptable during care practices in the Saudi culture. This usually prevented nursing care or continued to feel that the care was not clinically safe. Tavallali et al. [20] stated in his study that when parents experienced difficulty communicating with the nurse, they experienced anxiety and uncertainty, and that their satisfaction with health decreased.

In the study with students of Koskinen et al. [28], the ethical process was at the forefront. When students who encountered with different cultures, cross-continental were witness to the practices they were not familiar with from their culture, they have experienced dilemmas on their mistakes or their correctness. The ethical issues were mainly related to the discordance related to nursing care, stressful nursing-patient interaction, in-service inequality and the anxieties caused by sexual health practice. A student's expression "*....If every family doctor was a male, it was astonishing that there was a female nurse present in the room during the gynaecological examination. It is a good thing to secure women's sexual integrity but this sounds as overprotection…"* has revealed this dilemma. It has been described that intercultural ethical problems are due to nonsense in nursing care, stressful nurse-patient interaction, in-service inequality and worries arising from sexual health practice.

It should not be forgotten that no culture is superior to another. Of course, each society has its own ethical codes and values. Ethical principles and moral values can vary even among individuals within the same culture as intercultural. For this reason, cultural differences may set the stage for creating a dilemma on healthcare ethics. As a matter of fact, this dilemma emerges clearly in the exchange programs of the students from different cultures as mentioned above. The dilemma experienced by students may also bring about uncertainty in their future professional practice. In approaching ethical issues, the educational process can play an important role in overcoming cultural differences.

4.2.5. Nursing education, professional skills, and experiences

Whatever the area, professional knowledge and skill are quality indicators in providing efficient service. Service providers that are not adequately trained in their professional field or who do not train themselves in the field of knowledge and experience cannot protect the safe relationship between the individual receiving the service, the uncertainty comes in the person who receives the service. Because health care is a field of study where human life is an individual frontline, knowledge, skills and experience of health personnels is the basis of service. A customer who feels that you do not have enough equipment gives you less confidence, even

if it is true, you will be doubtful about your suggestions and, is also a decrease in respect to the professional experience.

Along with being the main factor of migration in the world, multicultural care in health services has developed. The concept of intercultural nursing as it constitutes a crowded discipline of the health field emerges as a favorite concept in the presentation of health services. As Leininger notes, the intercultural nursing approach refers to the implementation of effective care, taking into account differences and similarities in cultural values, beliefs and practices in order to provide culturally correct, sensitive and adequate nursing care to people of different cultures [33]. To obtain positive health outcomes through the cross-cultural approach, of course, the nurses must have adequate knowledge, equipment and skills. In this process, nursing education should be regulated to include intercultural approach continuity of education should be ensured besides nurses' professional development of themselves. Soulé [6] emphasizes that traditional health education is still insufficient in acquiring cultural competence, studies showing the effects of health education should be done, systems/organizations should be structured in this direction.

In study of Tavallali et al. [20], nurses' ability to have information and sufficient information the primary factors for quality of health care services and parent's satisfaction. In this study conducted in Sweden, some of the participants stated that the vocational ability of foreign national nurses is better, and they serve with an individual approach. Participants stated that:

"I personally think that foreign nurses are talented and much warmer and personal." "I think they have an extra skill that makes them even better at what they do." One of the expectations of the Swedish parents was that they were given adequate and correct information. The important point here was, again, that language difficulties were beginning. Even though nurses had sufficient knowledge and skills, they could not demonstrate their abilities to be foreign to a different language. Hence, in the parents, the nurse had the feeling that the medical and nursing knowledge was inadequate. As a result, parents' confidence was diminishing and disappointing.

In conclusion, education, vocational skills and experience in providing cultural competence care will be useful for accurate collection of data from patients, effective interpretation of data based on cultural differences, prevention of medical errors, and reduction of health disparities.

5. Conclusion

Because competence is more closely related to how to overcome obstacles to better health care, cultural competence is more closely related to personal and social responsibility to others, and clinical cultures that take more responsibility should be developed. All professionals who sweat in the healthcare system can respond to the challenges of the increasingly diverse society, they can respond to increasingly diverse becoming cultural make.

Studies conducted to improve cultural competence-related care skills of health professionals, especially nurses, show missing part of the literature. The current study has several limitations.

First, only inclusion of English language publications into the study led to the exclusion of studies that might be useful in relation to the subject in other languages and cultures. Second, inclusion of only qualitative researches into the study has limited the generalizability of the results from study. Third, the original data are not available by the nature of qualitative studies, and it is only limited by the published format. In particular, one of the missing aspects of the nursing literature is absence of studies on the development of cultural competence-related care skills for only nurses.

As a result, together with the data obtained from this study, we can say that health professionals and institutions that play a key role in maintaining the highest level of care must respect the cultural values of individuals with different cultural health needs and that cultural traditions of the community must be aware of and that cultural heritage must be identified as a primary goal of attaining cultural competence.

Author details

Seyma Demir* and Yasemin Yildirim Usta

*Address all correspondence to: seymademir@ibu.edu.tr

Department of Internal Medicine Nursing, Bolu Health School, Abant Izzet Baysal University, Bolu, Turkey

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