A review on cultural competency in medical education

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Abstract

Cultural competency is a wide notion with a variety of academic bases and differing perspectives on how it should be implemented. While it is widely acknowledged that cultural competency should be an element of general practice, there is a paucity of literature in this area. It has been commonly claimed that cultural competency is a fundamental prerequisite for working well with persons from different cultural backgrounds. Medical students must learn how to connect successfully with patients from all walks of life, regardless of culture, gender, or financial background. Hence, National Medical Council (NMC) has included cultural competency as a course subject in the curriculum of medical education. The opportunities and concept of Competency Based Medical Education, the inclusion of cultural competency in medical course by NMC, various models and practice skill of cultural competence in medical education are discussed in this paper. This study will be useful to researchers who are looking at cultural competency as a research variable that influences study result.

Keywords: Competency-based medical education, cultural competence, culture awareness, healthcare quality, medical education, national medical council

Introduction of Cultural Competence, Differences Its Concepts and Characteristic

Cultural competence refers to a combination of knowledge, behaviours, policies, and attitudes that operate together in a system, organisation, or among specialists to allow successful cross-cultural work. “Culture” describes to integrated patterns of human behaviour that encompass ethnic, social, racial, and religious groups’ language, ideas, acts, conventions, beliefs, and organizations. “Competence” means to an individual’s or an organization’s ability to operate successfully in the context of patients’ and their communities’ customs, cultural beliefs, and demands. Some of the research examined cultural variations as disparities in health understandings across various population groups, such as indigenous people’s holistic health understandings and how they vary from mainstream approaches to health. Other research looked at communication challenges such as cultural differences and linguistic discordance, and how these effect clinical interactions, especially among Hispanic populations in the US.

Cultural competence is an important technique for minimising disparities in healthcare access, as well as the quality and efficacy of treatment provided. It aims to improve the capability and capabilities of healthcare organisations, systems, and practitioners to offer more culturally responsive healthcare. Cultural competency is often about how the notion of respect is operationalized to ensure that varied populations’ cultural rights are considered.

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diversity, values, beliefs, and expectations are acknowledged in the delivery of culturally relevant health care. “This right can only be protected if cultural concerns are core business at every level of the health system—systemic, organisational, professional, and individual” in today’s culturally and linguistically varied countries”.[4] Although there is strong evidence that Cultural Competence should work, there is no information concerning how to determine what combination of Cultural Competence methods works, when and how to apply them appropriately, or how to quantify performance in health systems at all levels.

For the last two decades, major textbooks and journals in the field have paid close attention to cultural competency. Despite many publications, conference presentations and symposia, the profession struggles to move the discourse around cultural competency forward. Most professionals, for example, are unable to confirm that their clinical practises are culturally competent. The well-intentioned but sometimes misguided investigation of academics and researchers in this field, we feel, is a fundamental factor for the disturbing inertia. There have been ambitious efforts to develop tests that evaluate cultural competency, develop models that represent its most conspicuous qualities, and inject fundamental ideas of this construct into training programmes.

The ongoing lack of dedication and knowledge regarding cultural competency in the medical profession and training programmes erodes the efficacy of assisting professionals and emphasises the need of further research. This review focus on providing all important knowledge regarding cultural competence along with its history, importance and different competency models. Returning to the past with a focus on integrative self-exploration and growth in which affective, cognitive, skill development, and behavioural learning occur in the training of practising professionals and trainees could lead to a greater appreciation of cultural competence and adoption of cultural competence as a powerful and emerging force in medical education which enhances ability and knowledge to serve all people.

**Culture Competency Concept**

Cultural competency is a wide notion with many different perspectives on what it is and how it should be manifested.[5] It is usually characterised as “a collection of consistent behaviours, attitudes, and rules that allow a system, agency, or person to successfully function within a cross cultural environment or circumstance”.[6] The scope, duration, content, and manner of delivery of cultural competence curricular frameworks and models differ significantly.[7] Furthermore, a broad range of methods for assessing cultural competence have been created, each with its individual theories about what constitutes cultural competence.[8]

Bean R,[9] Gopalkrishnan N,[10] Graf A[11] explained component of behavioural, or the skills essential to collaborate across cultures, may vary from individual skills, which is verbal and nonverbal, and skills in dealing with interpreters, to wider community development skills, or even policy creation skills. They explained the emotive component, which includes attitudes like respect, sensitivity, and openness to diversity, helps in the growth of the healthy cross-cultural relationships. They also elaborated the cognitive element which means previous awareness of cultural differences aids in the development of better connections and the avoidance of cross-cultural misunderstanding.

**Competency Based Medical Education (CBME)**

CBME is the inclusion of cultural competency in medical course by NMC. CBME, which is an outcomes-based approach to the implementation, design, evaluation, and assessment of doctors and physician training programmes, has sparked a lot of controversy and discussion.[12] The opportunities and constraints of CBME are discussed in thought papers, conceptual frameworks, implementation documents, consensus statements and institution-specific descriptions.[13] With the growing implementation of CBME, medical education is experiencing a transition. It is education dependent on the outcomes method for creating, executing, measuring, and evaluating medical education programmes that uses competences as an organisational framework. Programme delivery is directed by competences that are clearly described, sequenced progressively, and gained in workplace-based learning contexts, which are the practical day-to-day differences for both clinical instructors and learners.[14]

**Inclusion of Cultural Competency in Medical Education by CBME**

Over the last 20 years, a recent educational paradigm known as competency-based medical education has arisen, and many healthcare training programmes throughout the globe have embraced it. CBME’s mission is to create “a health professional who can practise medicine at a set degree of skill, in accordance with local circumstances, and to address local requirements”. Van Melle et al.[15] utilised a two-step strategy to determine the important and necessary parts of CBME. To ensure CBME authenticity, they recognised five critical components that must be involved in the implementation process. The degree of exactness with which anything is replicated or reproduced is characterised as fidelity, and it is regarded essential for the success of competency-based medical education implementation.

Health professionals that are skilled in taking care of patients and demographic groups that vary in age, gender, socioeconomic level, migratory status, and ethnicity are required in a health system that serves diverse communities. Cultural competence (CC) amongst healthcare professionals is seen as one technique for ensuring equitable access to healthcare for people of all races and ethnicities, as well as ensuring that patients get treatment tailored to their specific requirements. NMC established a one-month foundation course for MBBS students in 2019. The goal of this course was to assist organizations and teachers in preparing new
medical students with the necessary knowledge and abilities for human exposure interactions and interpersonal connections in a variety of contexts, such as hospitals, communities, and clinics.

**How is Cultural Competency Established?**

Two decades ago, the necessity of cultural competency in healthcare was recognised. Then, to address this issue, several investigations were conducted, and various hypotheses were established. The terms culture and competency make into the phrase cultural competency. Cross (1989)[1] coined the phrase “cultural competency” to describe a collection of acceptable attitudes, behaviours and policies that come together in an organisation or among professionals to allow them to function in cross-cultural circumstances. Some research focused on the term competency, defining cultural competency as a spectrum or a process, while others focused on the word culture, referring to cultural competency development approaches. For example, Campinha-Bacote (2002)[14] described cultural competency as a process that includes the five components of cultural knowledge, cultural awareness, cultural contact, cultural skill, and cultural desire. Leininger (2002),[17] on the other hand, characterised cultural competency in terms of the many components of culture, such as health beliefs, values, philosophy, and religion. To refer to the cultural competency idea, several research used the terms culturally congruent care, cultural congruence, congruent care interchangeably, and culturally competent care.

In General Practice, there are many different strategies to acquire cultural competency, and rigorous assessment.[18] In general practice, formal cultural competency training tends to be undeveloped and uneven, and most parts of cultural competency are acquired via, experiential and informal learning, and in-practice exposure.[15,16,19] Cross-cultural consultations were shown to be extra stressful for general practice registrars owing to their reported lack of knowledge, confidence, and abilities in this field.[21] Cultural diversity has been found to help in the development of cultural competency via experience and training over time, which is particularly important in general practice training.[22,23] Exposure to diversity may motivate for learning and operate as a trigger and developing cultural competency of the practice as well as the system or individual may be a synergistic process. Through modelling cultural knowledge, incompetent attitudes, and abilities of further clinical supervisors or staff, there is also the potential of perpetuating existing obstacles in the treatment of patient.[24] Stronger role models and exposure to a more diversified case of cross-cultural mix during training appear to enhance general practice registrars’ readiness and ability to give cross-cultural care.[25]

Medical colleges attempt to educate doctors who can treat patients from a variety of socioeconomic and cultural backgrounds. Medical students must learn how to connect successfully with patients from all ages of life, regardless of gender, culture, or financial background. Communication skills are related with clinical competency and the skill to elicit, analyse, and interact appropriate clinical details to patients in relation to being essential to physician-patient interactions in terms of patient satisfaction and involvement during the physician encounter.[26] During medical school, physicians’ subjective judgments of medical students’ clinical knowledge, interpersonal and communication skills and patient engagement are used to evaluate their clinical performance.[27] Assessment of knowledge, attitudes, and skills is challenging due to the complexity of conceptualising cultural competency. Cultural competency instruments and tests often contain reflect biases or assumptions. Cultural competency assessment among general practice registrars, on the other hand, might motivate them to learn and reflect a supportive training environment. The majority of educational intervention assessment research were process-oriented, even though complex behaviour evaluations must be multi-faceted.[28]

Multiple confounders, like as other environmental and social determinants of health access, and other systemic obstacles outside the individual control clinician contacts, are often present and must be taken into consideration, making assessment even more challenging. This information has been included into a suggested strategy for evaluating educational interventions on patient outcomes.

**Importance of Cultural Competence in Medical Education**

We are surrounded by people of different ethnic or racial origins, migrants, immigrants, and refugees. Cultural competency is critical since it is hard to form such connections without it. We’ll instead co-exist with individuals we do not understand, improving the likelihood of damaged emotions, misunderstandings, and bias—all of which can be avoided. Beyond the obvious instructional messages, the most essential socialisation mechanisms in medical education exist. The official curriculum, the informal curriculum, and the Hidden Curriculum are three possible sources of influence in medical school, according to Hafferty.[29] The Hidden Curriculum’s norms are largely communicated via structural and cultural variables such as institutional regulations, “slang” or colloquialisms, assessment systems, and resource allocation. The Hidden Curriculum’s messaging may contribute to a loss of idealism and a loss of ideals, which can lead to a lack of concern about unconscious prejudice.[30] The structural norms of an organisation may be significant guides for conduct, but they are typically unarticulated until they are challenged. Efforts to teach doctors to deliver high-quality, culturally aware treatment have steadily increased in medical education. Many countries are growing more diverse, cultural competency training has pushed to the forefront of medical education. Ethnic minorities today make up roughly demographic trends and 30% of the population, indicate that by 2050, they will be the majority.[31] Furthermore, there is a clearer understanding of the role of culture on health care and health inequalities.[32] Cultural norms influence health-seeking behaviour.[33] Some patients may put off seeking treatment because of a sense of cultural insensitivity, apprehension that they will get worse care, or the belief that they have been handled
unjustly because of their ethnic or race origin. Furthermore, inequities in health care have long been noted, with racial discrepancies in treatment remaining even after accounting for income level, health condition, and insurance status. The most popular paradigm in medical education for addressing culture and race as social determinants of health is cultural competence. By training medical students and professionals to better understand their patients’ culture and ethnicity, cultural competence attempts to enhance patient–provider communication. To assist alleviate the stigma of a mental health diagnosis for a patient in an Asian immigrant household, students may be trained to utilise sensitive terminology or work with cultural liaisons.

Bourgois et al. have released a systematic evaluation tool to help healthcare practitioners, address socioeconomic factors of health in their clinical practises. A practical guide for medical educators based on this paradigm might help with attempts to enhance race and culture education in medical school curriculum, as well as culture and race representation in national examinations, question banks, board preparation courses, and virtual-case-based learning modules. “A collection of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that allow that system, agency, or professions to perform successfully in cross-cultural contexts,” according to Cross et al. This term encompasses a variety of intervention strategies aimed at improving healthcare systems’ cultural competency. When it comes to getting health care, health professionals have a critical role in influencing the patient experiences and type of interactions. Miscommunication, as well as service user distrust, disempowerment, and poor satisfaction may emerge from cultural and language disparities between health service consumers and healthcare practitioners.

The majority of workforce interventions cultural competence have centred on training and educating health care professionals in the essential and significant educating attitudes, skills, and knowledge to appropriately react to socio-cultural barriers that emerge in clinical encounters.

Cultural Competency Development

Interventional majority of trials evaluated workshops of standalone delivered by certified medical educators. Educators believed that training and experience in cultural competency teaching was essential due to the subject’s complexity. Cultural competence training is regarded to have the potential to perpetuate existing myths, prejudices, and stereotypes in society especially if it is completed without the supervision of the cultural group and direct involvement in question. Patients, educators, and students recognise the benefit of cultural mentors in several research. Cultural mentors are recognised as community advocates who may share their knowledge while encouraging connections between communities and healthcare professionals. Community ownership of cultural knowledge is also respected by other community members and ensuring cultural mentors play a prominent role in training.

The researchers went on to say that cultural competence refers to “the integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group,” as well as “having the capacity to function effectively” among people with “the integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group.” Leininger (1991) defined the term as “the application of culturally based care knowledge in facilitative, assistive, creative, sensitive, safe, and meaningful ways to individuals or groups for beneficial and satisfying health and well-being or in the face of death, disabilities, or difficult human life conditions”.

Self-awareness and Health Professionals

Health practitioners are influenced by culture in an unconscious way. Self-awareness and comprehension foster strong professional perspectives, allowing healthcare workers to connect with others while maintaining personal integrity and respecting the individuality and diversity of each client. Self-awareness, also known as self-exploration, is the first step in the process of professional growth and diversity competency. Self-examination or knowledge of personal biases and prejudices, according to many theorists and diversity trainers, is a key stage in the cognitive process of gaining cultural competence. However, considering the possible effect of emotions and conscious sensations on behavioural outcomes, considerations of emotional responses evoked by this cognitive awareness are rather restricted.

Cultural Competence Models

In a 2001 HRSA research, two theoretical and methodological methods to understanding cultural competency were discovered in the literature. Cultural competency is characterised as a process or continuum by Cross et al. (1989) and Campinha-Bacote (1999). Leininger (1993a), among others, “provide a more methodical perspective that focuses on the strategies that a professional may employ to become culturally competent and deliver culturally competent treatment”.

The focus on either the culture or competence component is evidently mirrored in the creation of the domains of the models, as previously described in defining cultural competence. While the methodological models appear to be equally focussed on the culture component, with domains such as ethnicity, religion, healing practises and beliefs, and value orientations, the theoretical models appear to be focussed on the competence component, with domains such as knowledge, awareness, skill, and sensitivity.
In other words, if the traits of cultural competence are clearly specified with one component in focus, domains of a model, whether methodological or theoretical, may be drawn from them. In this manner, the domains of a cultural competency model may easily be determined by a well-defined idea.

**Sunrise model for cultural competence**
The growth of cultural competency models in nursing has been attributed to several methods, as stated below:

Theoretical frameworks from nursing and a few other disciplines, mostly sociology and anthropology, were used by early researchers. Orque (1983) designed the Cultural/Ethnic System Framework based on sociological concept, while Leininger developed the care component based on nursing theory and the culture component based on anthropological theory. According to Leininger (2002), the Sunrise Model with the cultural care theory was created using anthropological insights, as well as her wide and varied life experiences, nursing experiences, creative thinking, and values. The Sunrise Model was created to portray the concept of cultural care universality and diversity, according to Leininger (2002):

“The Model displays several variables or components that need to be thoroughly examined using the theory. It offers as a cognitive guide for deciphering cultural care phenomena from a holistic viewpoint of numerous aspects that may impact care and people’s well-being.” The Sunrise Model has served as the template for the creation of various culture-specific models and tools. Davidhizar et al. (1998) wrote. Indeed, both Giger and Davidhizar (2002) and Campinha-Bacote (2002) credited Leininger’s transcultural nursing theory and foundational work with helping them construct their models. Furthermore, Schim and Doorenbos (2010), Jeffreys (2010), Andrews and Boyle (2008), and Paccquiao (2012) all cite Leininger’s transcultural nursing idea and theory as a key influence. Finally, various researchers have found that concept analysis over literature review is a useful technique for developing theoretical models that derive their composite domains directly from the definition, or attributes, of cultural competence. There is minimum five domains (constructs, or phenomena) in general across the methodological models, including biological variability, social structure, communication, health beliefs and religion and practises. These five categories also correspond to the spirituality, body, and mind, components of Spector’s (2004) paradigm.

**Purnell model for cultural competence**
Some models are built using ideas from a variety of areas. For example, the Purnell model was based on ideas from anthropology, biology, geography, sociology, economics, political science, pharmacology, and nutrition, as well as communication, family development, and social support theories.

The Purnell Model for Cultural Competence, as well as the model’s organisational structure and assumptions. Additionally, non-native American healthcare professionals will benefit from an understanding of American cultural values, traditions, and beliefs. The American references are designed to depict actions and practises rather than dictate or forecast them. When investigating complex phenomena like culture and ethnicity, Western academic and healthcare institutions emphasize structure, systematisation, and formalisation. The Purnell Model for Cultural Competence presents a methodical, comprehensive, and simple framework for learning and comprehending culture, given the complexity of humans. The model’s empirical framework can help managers, administrators, and healthcare providers, across all culturally competent therapeutic interventions, health disciplines provide holistic, as well as illness and health promotion, disease, wellness, and injury prevention, health restoration and maintenance, and health teaching in educational and practise settings.

The following are the goals of this model:

- Create a framework for all healthcare practitioners to learn about cultural ideas and traits.
- In the framework of historical viewpoints, define the conditions that influence a person’s cultural worldview.
- Create a model that connects the most important cultural linkages.
- Connect cultural features to create congruence and make it easier to provide competent health care and deliberately attentive.
- Create a framework that considers human traits like intentionality, motivation, and meaning.
- Establish a framework for assessing cultural data.
- Consider the person, family, or community in the context of their ethnocultural surroundings.

The features of the other component of cultural competence remain abstract in both kinds of models since they focus on only single component of cultural competence and describe its domains openly. The areas of cultural skills, cultural sensitivity, and cultural knowledge are shared by most theoretical cultural competency models in Table 1 for example, yet the definition of culture is anything from apparent. The following are the goals of this model:

- **Utilize interactive educational methods, like self-reflective journal assignments, standardized patient encounters, and role play**

It is critical to adopt interactive teaching approaches that align with adult learning principles to successfully teach useful skills. Standardized patient interactions using patient actors may help residents and medical students practise new skills of interaction while receiving immediate comment from the trained actor. Role-playing exercises do the same thing. The ability to offer response to a colleague during role-playing might provide medical students with better insight into their
Table 1: Different models of cultural competence

| Model title                                      | Related assessment tools                      | Cultural competence elements                                                                 | Context                        | Methodology       | Reference                  |
|-------------------------------------------------|-----------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------|-------------------|---------------------------|
| A model for cultural competence                 |                                               | Cultural knowledge, Awareness, Sensitivity, interaction, and skill                              | Healthcare (nursing)           | Literature Review   | Burchum (2002)[58]        |
| Culturally Competence Community Care            | CCS (Cultural Competence scale)               | Cultural Caring, Sensitivity, Knowledge, and skill                                             | Healthcare (nursing)           | Literature Review   | Kim-Godwin et al. (2001)[99] |
| Culturally Competence Conceptual Model          | Cultural Competence Assessment Instrument     | Desire, Awareness/Knowledge, Skill, Organisational Support                                      | Healthcare (nursing)           | Literature Review   | Balleazur et al. (2009)[63] |
| The Process of Cultural Competence in Healthcare Service Delivery | IAPCC-SV and IAPCC-R                        | Cultural Desire, Encounter, Awareness, Skill, and Knowledge                                      | Healthcare (nursing)           | Literature Review   | Doorenbos and Schim (2004)[64] |
| Cultural Competence Model                       | CCA (Cultural Competence Assessment Tool)     | Cultural Diversity, Sensitivity and Awareness                                                  | Healthcare (hospice, nursing)  | Literature Review   | Papadopoulos et al. (2004)[83] |
| Model for Cultural Competence Development       | CCA Tool (Cultural Competence Assessment Tool) | Cultural Awareness, Knowledge and Sensitivity                                                  | Healthcare (nursing)           | Literature Review   | Suc (2001)[84]           |
| Cultural Competence Multidimensional Model      |                                               | Attitude/Awareness, Skill, Knowledge                                                           | Healthcare (counselling)       | Literature Review   | Teal and Street (2009)[85] |
| Communication of Culturally Competent           |                                               | Communication Skills, Situational and self-awareness, Adaptability, and Knowledge               | Healthcare (physicians)        | Literature Review   | Arasaratnam (2006)[86]    |
| Inter-cultural Communication Competence Model   | (Adjusting other measures developed)          | Global Attitude, Empathy, Motivation, Involvement, Experience, Communication Competence, InterCultural Interaction | Business (university)          | Qualitative study   | (Interview)               |
| The Model of Cultural Competence                |                                               | Cultural competence elements: Environmental Domain:                                               | Healthcare (nursing)           | Literature Review   | Suh (2004)[87]           |
|                                                |                                               | [Encounter] Cognitive Domain: [Knowledge, Awareness], Cultural competence attributes: openness, flexibility and ability, Affective Domain: [Sensitivity] Behavioural Domain: [Skills] |
| Army Leaders                                    |                                               | Affect/Motivation, Knowledge, Skill                                                             | Business (army)                | Literature Review   | Abbe et al. (2007)[88] |
| Cross-cultural Competence                       |                                               | Comprehension, Skill, and Knowledge, Motivation/Attitude                                        | Business (university education) | Delphi study       | Deardorff (2006)[89] |
| Intercultural Competence Process Model          |                                               | Environmental, Interpersonal, Cognitive                                                         | Business (information science & library) | Literature review | Overall (2009)[90] |
| Model for Information and Library of Science Professionals Cultural Competence |                                               |                                                                                                 |                                |                   |                           |
| In international business, a Model of Cross-Cultural Competence |                                               | Cultural Knowledge Personal Skills, Attributes                                                 | (International management)     | Literature Review   | Johnson et al. (2006)[91] |
| Facets of Cultural Intelligence                 | Cultural Intelligence Scale (CQS)             | Motivational, Behavioural Cognitive/Meta Cognitive                                              | (International management)     | Literature Review   | Earley (2002)[92]        |
| Domain of Cultural Intelligence                 |                                               | Culturally Intelligent Behaviour Cultural Skill, Knowledge, Meta-Cognition, Business             | Business                       | Literature Review   | Thomas et al. (2008)[93] |
| Intercultural Components and Competency         | AIC (Assessment of Intercultural Competence)  | Knowledge, Awareness, Attitude, Skill                                                           | Business                       | Literature Review   | Fantini (2006)[94]       |
| The Rainbow model of ICC (Intercultural Communication Competence) | ICCI (Intercultural Communication Competence Inventory) | Cultural Distance, Knowledge, Motivation, Skills, Effectiveness, Self-Awareness, Appropriateness, Contextual Interactions, Foreign Language Competence, Intercultural Affinity | Business                       | Literature Review   | Kupka and Everett (2007)[95] |
personal behaviours. Lastly, narrative writing invites them to freely reflect on their personal faiths, and values, as well as their own experiences with discrimination, prejudice, difficult patient contacts, and earlier errors.

- **Teach practical skills**
  Traditionally, cultural competency programmes have taken a knowledge-based approach. Lists of recommended phrases, pictures, or ways for handling minority groups are often included in such courses, depicting for every single group as having distinct beliefs, values, and behaviours depend on culture. As mentioned in Table 2 this simplistic approach ignores variation within groups while emphasising contrasts between them, thereby perpetuating stereotyping. Cultural competency programmes, on the other hand, should recognise variation in social groups and educate medical students how to use socio-cultural information at the personal level. Clinicians observe various behavioural patterns and health beliefs even within a family unit, depending on individual preferences, experiences, and acculturation degree. The capacity to extract an individual's impressions of sickness and health, also their treatment preferences and explanatory model, and skills that are transferable across cultures and patients.

- **Cultural competence as part of clinical education, rather than single seminars**
  Learning to be culturally competent is a lengthy and difficult procedure. Most cultural competency instruction for medical students, on the other hand, lasts shorter than a week, which is improbable to result in long-term behaviour change. Cultural competency training should be included into students' clinical education to enhance culturally appropriate knowledge and abilities. There are several chances for our students to address cultural concerns. Whether take care of a patient from a different culture or just one who does not share the Western biological concept of illness, the conversation during medical rounds should be wide and incorporate cultural background of patients, as well as educating about pathophysiology and treatment.

- **Observe and get direct feedback from faculty**
  Input from faculty members and direct observation of cultural competency training, in addition to feedback from standardised peers and patients, may create a memorable and helpful experience. Numerous factors influence an individual's culture, including religion, economic position, education, age, immigrant history, and vacation destinations. As a result, there may be a teaching opportunity in cultural competency in almost every physician-patient contact. A clinic preceptor, for example, might offer comment on the student's ability to do one of the skills, like eliciting the patient's grasp of the disease aetiology.

- **At all levels, support cultural diversity including medical students and medical school faculty**
  Patient satisfaction is also linked to racial disharmony between the physician and the patient, as well as less participative clinical encounters. Diverse healthcare practitioners should be promoted from the start and at various levels. Physicians may help by acting as role models for minority students considering a career in medicine, and medical schools must continue to attract a diverse student body. Minority pupils' education must be improved at all levels of schooling, which will need societal initiatives. Although minority doctors give disproportionately more treatment to marginalised groups.

- **Get buy-in from the top**
  Medical school “teachers and students must exhibit a grasp of the way in which individuals of many cultures and belief systems perceive health and sickness and react to varied symptoms, illnesses, and treatments,” according to the “Liason Committee on Medical Education. On these reasons, obtaining the backing of medical school deans as well as an assurance from curriculum directors to formal cultural competence training would help to ensure that cultural competence training is fully integrated into medical education. Some institutions have developed such a collaboration. The Dean of Medical Education at wake forest school of medicine, i.e., established a CCTT (Cultural Competency Theme Team), which is made up of people who supervise curricular components. Throughout the four years of medical school, the CCTT is in responsible of integrating culturally appropriate activities. Some top-level educators and administrators, especially those who attended medical school in a less varied culture, may benefit from fundamental cultural competency training to function as successful advocates and partners. Their personal involvement will also send a message about the importance of cultural competency education. Cultural training for administrators and healthcare practitioners at all levels is supported by the American College of Physicians. If medical schools are to mould future doctors' practises in the context of cultural competency, it is critical that the medical profession reconsiders long-held attitudes, beliefs, and prejudices that may not be in line with present societal diversity.

- **Make a cadre of enthusiastic faculty**
  Training an extra set of academics in CC will start to develop an “early majority” of backers to supplement the efforts of the medical champion. Beyond the early adopters, this group is crucial for the expand of new programmes. As previously said, cultural competency education should not be limited to seminars, and it should not be taught just by one or two physician advocates. Furthermore, teaching opportunities surrounding culture will be addressed more often because of training an early majority of dedicated staff doctors with the abilities required to consistently talk about diverse topics as part of patient care. The “hidden curriculum,” the informal element of medical education supplied via role modelling and other often subconscious activities, will be influenced by the frequent discussion of cultural concerns during rounds.
Reviewed there was strong evidence of enhanced practitioner knowledge and skills, as well as substantial data of better practitioner abilities and attitudes. However, there is less proof for the effects of training interventions and cultural competence education on patient health and healthcare outcomes, which is important for determining overall intervention effectiveness. The benefits of cultural competency education interventions on patient satisfaction have also been studied. However, there was little indication of patient compliance, and no outcomes of health were recorded.

Lie et al. (2011) Analysed cultural competence workforce strategies that incorporated health outcomes measurements. Despite the fact that seven studies were discovered, their methodological quality was poor to moderate, and there was no evidence of a favourable association between better health outcomes and cultural competence training efforts.

May and Potia et al. (2013) Studied when healthcare workers demonstrate a grasp of the relevance of cultural diversity and create relationships with culturally different clients from them, they are culturally competent.

McLeod-Sordjan et al. (2014) Stated that according to Kohlberg's theory of moral reasoning, an individual's personal beliefs and values play a significant influence in their decision-making, implying that physical maturity does not always imply a high degree of moral reasoning. Given this context, it may be reasonable to conclude that moral reasoning is not an exact idea but rather situational.

Beancourt and Green et al. (2010) Proposed that the training of cultural competence made a key element of the curriculum and officially evaluated in health education.

Beagan et al. (2018) Described that though cultural competency is the most popular approach to diversity, it has significant conceptual flaws. Culture is portrayed as permanent, homogeneous, and too determinant of others' lives, whereas it is underemphasized in professionals' lives. Professionals with cultural competency are assumed to be members of dominant groups, making racialized, and ethnic minority professionals invisible. It is seen as a goal that may be achieved, thereby individualising failure to do so. This is a misinterpretation of structural power relations that cannot be changed individually. Worse, competency is judged in terms of learner confidence and/or comfort, which may have nothing to do with productively collaborating across differences. Cultural humility with critical reflexivity, on the other hand, is an ethical posture that requires accepting responsibility for one's privilege and reflecting on one's own actions in respect to power systems.

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Conclusion
Cultural competency has arisen as a critical weight to the evidence-based mental health care movement, which often results in a “one-size-fits-all” approach. Efforts within health-care systems to build cultural competency or other modalities of responding to diversity may act as a counterweight to the homogenising processes of assimilation and marginalisation of minority groups. Current methods to cultural competency, on the other hand, have been chastised for essentializing, commodifying, and appropriating culture, which has resulted in stereotyping and additional disempowerment of patients. Researchers came up with the term “cultural competence” and developed conceptual models to define the features of culturally competent persons in response to this demand. The purpose of this study was to identify the most recent cultural competency frameworks and to explain in what way this notion has been operationalized in distinct models. It also showed in what manner these models have been utilised in empirical investigations of cultural competency in practise.

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There are no conflicts of interest.

Table 2: Studies about culture competence by authors

| Author | Study | Reference |
|--------|-------|-----------|
| Beach et al. (2005) | Reviewed there was strong evidence of enhanced practitioner knowledge and skills, as well as substantial data of better practitioner abilities and attitudes. However, there is less proof for the effects of training interventions and cultural competence education on patient health and healthcare outcomes, which is important for determining overall intervention effectiveness. The benefits of cultural competency education interventions on patient satisfaction have also been studied. However, there was little indication of patient compliance, and no outcomes of health were recorded. | [83] |
| Lie et al. (2011) | Analysed cultural competence workforce strategies that incorporated health outcomes measurements. Despite the fact that seven studies were discovered, their methodological quality was poor to moderate, and there was no evidence of a favourable association between better health outcomes and cultural competence training efforts. | [7] |
| May and Potia et al. (2013) | Studied when healthcare workers demonstrate a grasp of the relevance of cultural diversity and create relationships with culturally different clients from them, they are culturally competent. | [92] |
| McLeod-Sordjan et al. (2014) | Stated that according to Kohlberg's theory of moral reasoning, an individual's personal beliefs and values play a significant influence in their decision-making, implying that physical maturity does not always imply a high degree of moral reasoning. Given this context, it may be reasonable to conclude that moral reasoning is not an exact idea but rather situational. | [93] |
| Beancourt and Green et al. (2010) | Proposed that the training of cultural competence made a key element of the curriculum and officially evaluated in health education. | [94] |
| Beagan et al. (2018) | Described that though cultural competency is the most popular approach to diversity, it has significant conceptual flaws. Culture is portrayed as permanent, homogeneous, and too determinant of others' lives, whereas it is underemphasized in professionals' lives. Professionals with cultural competency are assumed to be members of dominant groups, making racialized, and ethnic minority professionals invisible. It is seen as a goal that may be achieved, thereby individualising failure to do so. This is a misinterpretation of structural power relations that cannot be changed individually. Worse, competency is judged in terms of learner confidence and/or comfort, which may have nothing to do with productively collaborating across differences. Cultural humility with critical reflexivity, on the other hand, is an ethical posture that requires accepting responsibility for one's privilege and reflecting on one's own actions in respect to power systems. | [95] |
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