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Editorial

Cultural Competence in Healthcare and Healthcare Education

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Cultural competence in healthcare has been defined in many ways; however, it generally refers to knowledge of social and cultural factors that influence illness and related behaviour, and actions taken to provide the best of quality care considering each patient's background [1]. Cultural competence is an important skillset and mindset with regard to providing high-quality care and reducing social disparities in healthcare. Price et al.'s [2] systematic review showed that cultural competence was linked with improved patient satisfaction and adherence to therapy, while a later review by Renzaho et al. [3] indicated that cultural competence enhanced doctors' knowledge and cultural sensitivity. More recent reviews of studies by Horvat [4] and Alizadeh and Chavan [5] confirmed the previous findings. Despite the demonstrable effectiveness of cultural competence in healthcare, systematic integration of cultural competence in medical curricula has been inconsistent [6,7]. Interestingly, when integrated, a scoping review of ten studies revealed that students benefited from relevant training in terms of enhancing their competencies in working with diverse patients [8]. To overcome the challenge of integrating cultural competence in medical curricula, Constantinou et al. [9,10] proposed a general pathway of integration, but also described how this could be achieved in a specific medical programme.

Despite evidence of the benefits of cultural competence in healthcare and related education, the concept has been criticized for either being too broad, impossible to operationalize and measure, or for being linked largely with ethnicity and cultural background, triggering more stereotypes than it intended to overcome. Thus, new concepts have been proposed as replacements, including cultural humility [11] and structural competence [12].

Based on the acknowledged importance of and the identified challenges related to cultural competence, this Special Issue was conceptualized in order to collate research articles, concept papers and reviews relating to any aspects of cultural competence. In this Special Issue, we have not approached the concept of "cultural competence" as a set of operationalizable and measurable skills, but as an umbrella term which can provide a home for other relevant concepts. We have approached "culture" in its broadest possible sense, which encompasses anything human beings have created by living in social groups, on a par with Tylor's [13] definition: "Culture, or civilization, is that complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man as a member of society". Therefore, related concepts under the umbrella of cultural competence include diversity competence, structural competence, intercultural communication, cultural awareness, cultural humility, cultural sensitivity, cultural empathy, and cultural intelligence. These concepts capture the breadth of cultural competence by working effectively, appropriately, and sensitively in an understanding and reflexive manner, not only with regard to ethnicity and cultural background, but also gender, age, lifestyles, personal choices, etc.

This Special Issue is comprised of nine articles, seven of which are research articles; one is a concept paper and one is a review. The authors originate from Spain, the UK, Germany, Denmark, Cyprus, France, Portugal, and Brazil. These articles discuss a range of concepts and aspects of cultural competence, such as cultural communication, cultural

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humility, diversity competence, and structural competence. Below, we summarise the articles in order of appearance.

Medina [14] explored "the impact of information sessions on women's anxiety when facing a voluntary termination of pregnancy". Medina employed a variety of methods to collect data, from reviewing the literature to participant observation, as well as online survey and focus groups. From the results, the author formulated a protocol which aimed to guide doctors in working more effectively with women who decide to terminate their pregnancy by focusing on consent and shared decision making, adopting and using standardized language and effective internal communication channels, and engaging in health education programmes. Medina highlighted the importance of integrating social sciences in medical protocols in order to enhance quality of care.

Mota, Trad and Dikomitis [15] conducted participatory qualitative research in the state of Bahia in Brazil to understand how sickle-cell disease was neglected in health policies. The authors found that there were many issues surrounding the organisation and implementation of good care for patients with sickle-cell disease, and generated recommendations for different stakeholders. Recommendations were formulated for researchers (e.g., epidemiology, quality of life of older adults with sickle cell disease), social movements (e.g., strengthening patient associations; enhancing awareness about sickle-cell disease), and policy makers (e.g., activating relevant networks within states; ensuring access to multidisciplinary care; and access to diagnostics and follow-ups).

Relying on (auto)ethnographic data and reflections from medical schools in the UK, Dikomitis et al. [16] aimed to better explore how medical students understand the importance and usefulness of behavioural and social sciences in medical practice. The authors highlighted that although behavioural and social sciences were part of medical curricula, students did not always consider them useful or clinically relevant. Dikomitis et al. explained that to overcome this challenge and change students' experiences, it is important to systematically and thoroughly promote cultural competency in medical curricula by vigorously integrating content of behavioural and social sciences.

Alarcão et al. [17] discussed the training programme "Health in Equality", which aimed to train the primary healthcare providers in Portugal. The training consisted of nine 4 h online modules and covered a variety of topics, such as ethnic/racial minorities, global mobility and refugees, sex and gender, spirituality and religion, mental health and wellbeing, reproductive and sexual health, sexual orientation, gender identities, and intersectionality. In each module, trainees were required to promote awareness, knowledge, and skills. The authors carried out a SWOT (Strength, Weaknesses, Opportunities and Threats) analysis to assess the effectiveness of the programme. The results showed that the training was effective in terms of improving trainees' cultural competences, knowledge, and skills. Trainees indicated that their level of awareness increased, which helped to tackle prejudices and discrimination. Alarcão et al. concluded that cultural competence training should be integrated in medical and nursing curricula.

With a survey conducted in France and Germany, Geeraert [18] aimed to understand the importance of structural competence, in addition to cultural skills and cultural humility that caregivers were expected to have, for providing good quality of care to migrants with precarious residency status. The study revealed that structural competence was essential for improving healthcare provided to migrants, and this could be achieved by developing legal and administrative skills about residency and health rights, as well as institutional and practical competencies regarding access to healthcare. Geeraert continued by explaining that structural competence could also help reduce stigma and discrimination in healthcare systems.

García-Izquierdo and Montalt [19] focused on the role of patients' mother tongue in clinical communication and organized two focus groups with doctors and nurses in Spain in order to further explore healthcare workers' perceptions. The author found mixed perceptions, ranging from positive to negative. Some healthcare providers explained that allowing patients to talk in their mother tongue helped communication because they could

express themselves more freely. On the other hand, some doctors and nurses were unsure if patients should have the right to talk in their mother tongue during medical consultations and felt that the use of patients' mother tongue did not facilitate communication.

Ziegler, Michaëlis, and Sørensen [20] conducted an important Delphi study to identify the most important skills in caring with migrant and minority patients. The authors asked 31 clinical and academic migrant health experts from 13 European counties and presented the skills on which these experts reached a consensus. As per the study's findings, the key diversity competences were respectfulness, empathy, diversity awareness, reflection on own biases, knowledge about social determinants of health, ethical, and human rights approaches, attentive listening, understandable communication, individual-needs-based care, finding solutions with the patient, and professional work with interpreters.

The use of interpreters in medical education was discussed in Constantinou et al.'s [21] literature review of 20 papers, which showed that the use of interpreters as part of medical curricula was scarce, although students were trained in how to work with interpreters in programmes largely outside their curriculum. The trainings showed that students improved their skills and helped them provide better care to patients. Because of the limited use of interpreters in medical education, and evidence that such use could potentially benefit students, the authors suggested a pathway of integrating the use of interpreters in medical education and further research to assess the effectiveness of such integration.

In their article about "cultural competence in healthcare leadership education and development", Gulati and Weir [22] explained that cultural competence should not be approached the same way across disciplines and professions but should be understood and used in specific contexts. By exploring the relevant literature and leadership development programmes in the English National Health Service, Gulati and Weir concluded that in addition to awareness about cultures space for reflection, skills of reflexivity and discussion were essential for building cultural competencies in healthcare education leadership.

The nine articles described above have indicated the importance of cultural competence in healthcare and healthcare education as a context of knowledge, but also a set of skills and attitudes which can help one work effectively with diverse patients in order to ensure the best quality of care. In addition, this Special Issue has supported our initial approach to cultural competence as an umbrella term, and it concurs that replacing the concept all together would not be beneficial because there is no concept which can adequately capture all sets of skills and knowledge necessary for working appropriately with diverse patients. For example, cultural humility does not cover knowledge about the impact of structures, and structural competence does not consider intercultural communication skills. Finally, this Special Issue has opened new directions in research and policy making, such as the effectiveness of cultural competence in medical curricula, the usefulness of social sciences in medical practice, the introduction of social scientists as part of a multidisciplinary team in healthcare settings, the impact of cultural competence on health outcomes, measuring the impact of diversity competencies, and understanding the link between working with interpreters and health and educational outcomes.

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