

Cultural competency: a concept analysis in TUMS (Tehran University of Medical Science)

Mandana Shirazy (1)
Foruzan Khatamidoost (2)
Hamid Khankeh (3)
Nemat Allah Musapour (4)
Majid Sadeghi (5)
Kamran Soltani Arabshahi (6)

(1) Associate professor in medical education in EDC Tehran University of medical sciences, Tehran, Iran
 (2) PhD candidate in medical education, Tehran University of Medical Sciences, Tehran, Iran
 (3) Professor of nursing in University of Social Welfare and Rehabilitation Sciences, Tehran, Iran
 (4) Professor in curriculum planning in Institute for Social and Cultural Studies, Farhangian University, Tehran, Iran
 (5) Professor of psychotropic Roozbeh hospital, Tehran University of medical sciences, Tehran, Iran
 (6) Professor of internal medicine, Iran University of Medical Sciences Tehran, Iran

Correspondence:

Foruzan Khatamidoost
 Tehran University of Medical Sciences,
 Tehran, Iran

Email: f-khatamidoost@yahoo.com

Abstract

Introduction: In the current century, we are faced with new needs and problems, and we should have appropriate responses. One of these changes is cultural diversity, and our response to it should be cultural competency. But subjectivity of these concepts provides several definitions that makes use of it difficult so we conducted a study in order to represent relevant constructs in the context of Tehran university of medical science.

Method: This study was conducted in two phases: in the first phase concept analysis by evolutionary approach, and in second phase, interview with faculty members conducted to determine appropriate formulation in TUMS.

Results: In the first phase of concept analysis; antecedents, attributes, consequences and surrogate terms and exemplars are extracted from articles and documents and in the second phase they were matched with script gained by interviews with faculties. Results are presented in tables. Antecedents and priorities in this context somewhat varies with others, although need to cultural competency increasingly persist.

Conclusion: Here, there are special historical, social and cultural conditions that form antecedents and also drive our attributes and expectations of consequences of cultural competency. So, we can define this term based on TUMS context.

Key words: cultural competency, concept analysis

Introduction

At the beginning of the twenty-first century, change is a feature of this new century and we are faced with rapid changes in various spheres of technology, social systems, population movements and all of these changes help to increase cultural diversity. That's why we need skills such as change leadership and adapt to changes in the new millennium (1). The World Health Organization recognizes "ability to move toward a changing environment" as a core competency of staff who work in the health system (2) and these changes will not be limited only to technology but also in social, cultural, educational and service areas. The health domain, as well other domains, are affected by these extensive changes. Health is a multidimensional concept that is defined as: The state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Health has many dimensions (anatomical, physiological and mental) and is largely culturally defined (3).

These changes on one side effect on individuals and family health, and on the other side on society, service provider organizations, health systems and human resources staff. Although backgrounds and consequences of change vary in different countries, all communities are faced with it. Also change effects on different social structures such as: communication, Information, education, economy and culture, and this transformation causes:

- Homogeneous culture changes and these would be plural and hybrid (4)
- Production and access to information would be easy,
- New media for communication such as internet and social networks will develop,
- Social and personal growth and development would be facilitated,
- Education would be more individualized (4)
- Encounter within cultures and influence of cultures on each other increases.

We are faced with different local cultures, national and transnational cultures, and subcultures that effect on identity formation, family function and social structures. The sum of these factors cause more important roles of culture in health and service delivery, and need for cultural competency training increases.

Cultural competency is defined by the U.S Department of Health and Human Service as: "a set of values, behaviors, attitudes and practices within a system that enables people to work effectively across cultures. The term refers to ability to honor and respect the beliefs, language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services" (5). According to references, different definitions of cultural competency, results to limited evaluation and research in this area that causes a defect in program development (6).

We see:

- This concept contains various dimensions and aspects in different countries (7, 8).
- This concept has evolved over time (9, 10).
- This concept in different fields and professions has different characteristics (11, 12).

According to above, this concept is highly context dependent and analyzing it is essential for application in different contexts. In this study, we analyze the concept of cultural competency by evolutionary approach (13) and its compliance with the TUMS.

Method

This study was conducted in two phases: the first phase was conducted to analyze the concept by evolutionary approach. In the second phase, interview with faculty members was conducted to determine appropriate formulation in the present context. Following steps was used for evolutionary analysis (13):

- 1-identify and select appropriate realm (setting and sample) for data collection
- 2-collect relevant data to identify:
 - a) the attributes of the concept
 - b) the contextual basis of the concept, including interdisciplinary. Socio-cultural, and temporal (antecedent and consequential occurrences) variations.
- 3-analyze data regarding above characteristics of the concept.

At the end of the first phase of study we analyzed codes in categories: antecedents, attributes, consequences, and surrogate term. In the second phase, based on gained results, semi-structured interviews with faculties were conducted to determine the appropriate approach in the present context.

A) Search sources and strategy for data collection: we used electronic resources and databases: PubMed, Google scholar, Science Direct, Scopus. OVID, Web of Science, by 2016, which resulted in more than 1500 articles. We limited results to documents that focused on definition, concepts, and models of cultural competency so that there remained 350 articles and after reading the abstracts 135 articles were introduced into the study.

B) Data analysis (first phase): Coding was conducted in regard to antecedents, attributes, consequences, and surrogate terms.

C) Interview: in order to determine appropriate approach to context of Medical University, semi-structured interviews with 10 faculties in different groups were carried out, and after preparing the transcript of interviews, data were analyzed.

D) Data analysis (second phase): Data of first stage and second stage of study were compared and formulation of concept was determined according to context.

Results and Findings

A) History

Records about cultural competency go back to the 1980s. Social work and psychology were among the first areas that paid attention to this issue. Sue in psychology and Cross in social work presented their models (38,40), but utilizing this topic in medical science was by Lininger in the nursing profession. Leininger presented her first model of cultural competency in 1980s (14) and completed it within two decades. Medical anthropology in medicine studied relationship between culture, health and disease (15), although, because of the dominant paradigm of Bio-Medicine in the medical profession, culture was not in focus of this profession. In the last decades in medicine, registry organizations such as ACGME, LCME introduced cultural competency into their requirements (16,17), due to increasing awareness of physicians learning knowledge and skills in this area and its effect on patient adherence, lead to establishment of training courses, mandatory or optional, at many universities in the U.S (18) Also among different countries, those who accept more immigrants such as America, Australia and New Zealand are involved with this issue. According to the latest statistics, rank of Iran in reception of immigrants /refugees is 5 and the largest group of these are from Afghanistan (19). Iran is in southwest of Asia in the heart of the Middle East. This region is composed of different races: Arabs, Turkish and Persians. Also, this country consists of more than 32 states and several ethnicities such as: Turks, Baluch, Kurds, Arabs, Fars etc., and each of them have their own culture and language (20). This rich variation of culture causes diversity of believers and behaviors in health and disease and also different treatment choices: Traditional medicine, herbal medicine and western medicine. Education of health and medicine professions in Iran is integrated in the health system and medical universities deliver health services and training of the needed workforce for their services (21).

B) Antecedents

Antecedents are those instances that precede the concept (13). Antecedents of cultural competency varies in different studies. SUH in an analysis that was conducted in nursing in 2004 categorized it in four domains: cognitive, emotional, behavioral, and environmental that consisted of cases such as knowledge, sensitivity, awareness, skills, and cultural exposure (22). Also, other researchers offered cases such as: cultural diversity, cultural encounter (23, 24, 25).

Inability to communicate with other cultures, lack of attention to interests and beliefs of another culture, desire to reject people from other cultures result from lack of cultural competency such as globalization of societies, health inequalities, cultural arousal (25) cultural diversity, racial diversity, ethnic, economic and social status, education, religion, language, etc. Reductions in the quality of health care due to cultural differences between health care providers and recipients of services (26) have been recorded. In this study, these cases extracted as antecedents of cultural competency are decreasing in: quality of physician – patient communication, effectiveness

of care, patient compliance occurrences, and also cultural competency as: a requirement for customer satisfaction, patient safety, and as a requirement for professional, moral and ethical competency, as a requirement for enhance effectiveness of health organizations, and as a legal requirement.

Cultural diversity and encounter between them result in the need for cultural competency training in communities that are in globalization process. This encounter (without necessary competency) results in lack of effective and efficient communication and also stereotypes and prejudice in dealing with people from different and “other” cultures.

In order to explain antecedents of cultural competency in this study, we classified them into:

1- Values: Political systems and social values impact on formation of concepts widely .in this document analysis, values of justice, equality, and ethics are at the basis for demands in various spheres including in health. In fact, this term applies to these values in the health field.

2- Legal: Philosophical views, values and also needs of society, are foundations for definition of “right” in terms of human rights and civil rights. Cultural competency is influenced by laws and social attitudes, as superior structures of the health system. Different people from various cultures have the “right” to receive appropriate and effective health services, and be safe in front of stereotypical thoughts and prejudice of health care teams. This right leads to formation of the term “cultural safety” which emphasizes on “right” of patients to be safe of malfunctions caused by lack of understanding and recognition of cultural differences. Terms such as racism, minority rights and social accountability strengthen the legal approach to cultural competency. Cultural competency as a solution and also a response to avoidance of discrimination in services is a legal assumption in defining cultural competency.

3- Professional level: after Legislation for meeting “social needs”, different professions apply superior rules and laws to their specific needs. Education, leadership, social services and sociology, anthropology and psychology have performed measures on cultural competency. Undoubtedly, the first step in each of these actions is definition. Actually, profession is the location that superior needs (values and laws) meet with inferior needs (social and customer needs) and Theoretical bases. So, this term has been defined in each profession or specialty according to their theoretical foundations and paradigms. Sometimes professions borrow some elements of definition from adjacent professions and cause a variety of different approaches to the concept. For example, customer-oriented approach, quality improvement approach, managerial approach, business approach, etc. In medical and health professions, according to share issue of “health”, concepts are close together, the main focus of these professions are: patient safety, professional capabilities and best practice, patient-centered services, professional ethics, physician – patient communication form professional needs of this concept.

4- The nearest factors are in last level as: “encounter factors”, cultural diversity and encounter between them. As long as there is no diversity, cultural competency will not be

needed, therefore, cultural diversity and exposure to it, is a direct antecedent in this level, factors such as globalization, immigration and development of communications and media can be effective in increasing diversity and cultural encounter.

C: Attributes

Attributes of the concept constitute a real definition, it is the cluster of attributes that makes it possible to identify situations that can be characterized appropriately using the concept of interest (13).\

In previous studies that conducted conceptual analysis, the following features are mentioned:

Ability - Openness - Flexibility - (22) - knowledge awareness - understanding - sensitivity - Interaction - Skills - competence - a dynamic process – desire - (26,23,24) domains: affective, cognitive, behavioral - characteristics: sensitive, justice, activity. Three dimensions of consciousness, openness, and integrity (25)

Three dimensions: awareness, attitude and behavior, and a key way: dynamic and continuous process (26) - awareness, ability to take care of people, openness, long-term and continuous process.

We summarize attributes as below:

- 1- Ability- Openness- flexibility (22)
- 2- C. Awareness- C. Knowledge- C. Understanding- C. Sensitivity- C. Interaction- C. Skill- C. Proficiency (27)
- 3- C. Awareness- C. Sensitivity- C. Knowledge- C. Skill- C. Dynamic process (23)
- 4- C. Awareness- C. Knowledge- C. Skill- C. Encounter- C. Desire (24)
- 5- Three Domains: Cognition- affection. Behavior Attributes: sensitivity-equality-activity. Three dimension: awareness-openness-coherence (25)
- 6- Three dimension: awareness, attitudes, behaviors a key aspect: there is no end point to achieve. As a fluid dynamic process from the point of unconscious incompetence to unconsciously competent (26)
- 7- Awareness - Ability to care for individuals- Non-judgmental openness- C.C as a long term continuous process (28).

Consequences

Consequences: it is of interest to note the consequences that result from the concept that is under study (13)

According to values, assumptions and antecedents and attributes, expected consequences are different. Overall, the results are listed below;

- Equality and reduce discrimination in health services (29)
- Improving the quality and effectiveness of care (31)
- Increased satisfaction with services (31)
- Increased patient compliance and increased employee effectiveness of care (31)
- Ensure justice and equality in service
- Promotion of attitudes, knowledge and skills of individual

employees.

- Participation of social, political, historical processes, on the health of people (32)
- Improving physician - patient communication (31)
- improving accessibility and acceptability and effectiveness of services for people of diverse communities (33 and 34)
- Improve clinical outcomes and reduce discrimination of health (31)
- Improving cultural responsiveness and appropriateness (30)
- Awareness of the prejudices and assumptions and stereotypes (35)
- Accountability of services to cultural features (36)
- Flexibility in relations with "different" people (32)
- Increased cultural awareness in practice, good practice in fair access to care and treatment for patients, equal opportunities of education and employment, employee promotion, and protection of forces and minority groups (37)

For ease of explanation results can be classified as follows:

Based on target group:

Service provider - recipient of the service - the organization / society

Based on antecedents:

Values - rights laws - professional - cultural encounter

Based on attributes:

Cognitive - Attitudes - Skills – meta-competencies (reflection on competencies)

D) Surrogate Term

Multicultural competencies (38 and 39) – transcultural care - Civil competencies (37) - Culturally Sensitive Care - Critical cultural care (36) - cultural safety, cultural sensitivity (36) Cultural understanding (35) - cross-cultural interaction (39) intercultural competency (refers to the interaction between two cultures) (40) - cultural sensitivity (41) - language ability (42) - cultural knowledge (35) - cultural awareness (35) cross-cultural communication (35) - cultural humility (43) - culture safety (44) - cross cultural competence (36) These terms are used according to specific scope or need of programs or researchers or societies to cultural competency. Multicultural competency focuses on knowledge and understanding different cultures in society (45), while cultural special care refers to create settings for specific cultures such as hospital for Hispanics or Asians. Cross-cultural encounter focuses on communication skills that are applied to handle cultural differences(39). Language competency focuses on interpreter services for reduction of language barrier between service providers and customers(44) Cultural safety refers to patient's right for receiving services without discrimination and without prejudice and judgment(46). Also, other terms of cognitive, affective, cultural competency emphasize on special skills. In different contexts, based on condition and situations each of these terms is used. Consequently, targets and methods and educational content are prepared in relevant terms.

Exemplars:

The identification of exemplars in some form is a common and useful part of concept analysis. Because the evolutionary method is an inductive technique, exemplars should be identified rather than constructed by the investigator. The purpose of an exemplar is to provide a practical demonstration of concept in relevant context (13). In most resources these cases are mentioned: minority groups (race and ethnicity, religious), gender, disabilities, sex orientation, and elderly (30).

In our context:

In interview with medical faculties of TUMS:

Appropriate term is defined as cultural competency and antecedents of this term in our context is: fair service, professional values and increasing encounter factors such as: globalization, international education, international service, development of new media. Unfortunately, there is no law or requirement for implementing programs of cultural competency.

Attributes of the term are classified as:

a) what : it contains domains of cognitive, attitudes and skills in different degrees

b) how: quality of articulation of the constructs is an important factor in achieving it, fluidity, non-judgmental openness, dynamic process, flexibility, long term continuous process, can explain way of arrangement of constructs. **c)** Areas: individual, organization, society.

Consequences: improvement of: quality of care, adherence of patient, communication of physician and patient, effectiveness of treatment, cost-effectiveness, fairness in service, accessibility to health service, are main consequences of cultural competency.

Exemplars: in our interviews, all of the exemplars in review are accepted except sex orientation that in Muslims is a taboo of course, there is different emphasis and priorities in them.

Conclusion

During four decades, multiple models of cultural competency in different professions have been developed. These models are based on various contexts and professions that are affected by their ultra-structure and also regulation systems. LCME in U.S introduced it in their standards: ED-22. Medical students must learn to recognize and appropriately address gender and cultural biases in themselves and others, and in the process of health care delivery (17). ACGME outlined general or common program requirements for specialty as the basis for accreditation of programs (16). In New Zealand indeed indigenous Maoris, a large number of immigrants with various cultures live and cause diversity of population because more health care providers are from new residents, regulatory bodies authorized laws for delivery of appropriate cultural services in terms of cultural safety (47). In US, Native Americans and coloured people are more suppliant for these programs. Here in RAN historical

and geographical situation of our country is a source of diversity and seems to be a priority for our society and also educational and professional structures for designing and implementing relevant programs.

Acknowledgement:

This project was supported by a grant from the Tehran university of medical science as a PhD project "Developing medical students' cultural competency conceptual model in TUMS", approved in medical education department of educational development center of TUMS.

References

- 1- Accelerating change in medical education; American medical education (AMA) 2015.
- 2- Who GLOBAL COMPETENCY MODEL http://www.who.int/employment/competencies/WHO_competencies.2016
- 3- WHO center for health development, Aging and health technical report, V6, A glossary of terms for community health care and services for older persons. 2004
- 4- Alan Breakley. John Bligh. Julie Brown. Medical education for the future; identity, power and location. 2009. Springer
- 5- National Center for Cultural Competence: <http://www11.georgetown.edu/research/gucchd/nccc/>
- 6- Amy V. Blue. Carolyn Thiedke. A.W. Alexander and et al. Applying theory to Assess cultural competency. Med Edue online (serial online) 2005.10.13. Available from <http://www.med-ed online.org>
- 7- Tiatia J. Pacific Cultural Competencies: A literature review. Wellington: Ministry of Health. February 2008.
- 8- Cultural Competence and Cultural safety in first Nations, in unit and Metis Nursing Education: an integrated review of the literature. Canadian Nurses Association
- 9- Leininger, M. (1995). Transcultural nursing: Concepts, theories, research, and practices (2nd. ed). New York: Mc Graw Hill.
- 10- Campinha-Bacote, The process of cultural competence in the delivery of healthcare services: A model of care. Journal of Transcultural Nursing, (2002). 13 (3) 181-184.
- 11- Tsang, A. & George, U. Toward an integrated framework for cross-cultural social work practice. Canadian Social Work Review, (1998). 15 (1) 73-93
- 12- Purnell, L. D. The Purnell's model for cultural competence. Journal of Transcultural Nursing, (2002). 13(3) 193-196
- 13- Beth I. Rodgers, K.A. Knafi "Concept Development IN Nursing" W. B. Saunders Company 2000.
- 14- Transcultural Nursing Theory and Models, Priscilla Segar. Springer publishing company. New York.2012.
- 15- Arthur Kleinman, Peter Benson, Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It. Plos Med. Oct 2006. 3(10): e294. doi: 10.1371/journal.pmed.0030294
- 16- Accreditation council for graduate Medical Education. List of ACGME -accredited specialties and subspecialties <http://dconnect.acgme.org/acwebsite/RRc>.accessed February 21, 2013.

Table 1: some of antecedents, attributes, consequences, and surrogate terms for cultural competency

	antecedents	attributes	consequences	surrogate terms
1	-Discrimination and inequity in health resulted from cultural, racial, ethnic and gender differences		-Equality and reduction of discrimination in health services -justice in health services - Equality in training, recruitment and retention, and promotion of minority groups - good Practice in relation to fair access and appropriate care and treatment for patients -	-Cultural safety -multicultural competency -transcultural care -civil competency -sensitive cultural care -cultural sensitivity -cultural understanding -transcultural interaction -Intracultural interaction -linguistic competency -cultural knowledge -cultural awareness -cultural humility -intracultural competency
2	-Social accountability to pluralistic cultural societies	-Cognitive and cultural understanding of the patient to provide services tailored to different cultures	- Contributing social, political, and historical processes to the health of people - Services for people of diverse societies will be accessible and effective - improving cultural responsiveness and appropriateness - Customer Service Responsiveness (301) - Equality of training, recruitment and retention, and promotion of minority groups	
3	-Globalization and increasing cultural diversity and encounter			
4	-Reduction of health service quality because of cultural difference between health professions and recipients of services -Reduction of quality in practitioner– patient communication -reduction of effectiveness of care -reduction of compliance	-improving intracultural skills	-Increasing quality and effectiveness of services -increasing satisfaction of services - Increasing compliance of health practitioners and improving effectiveness of care -improving clinical consequences and reduction of health disparities -improving accessibility, acceptability and effectiveness of services	
5	Cultural competency as one of requirements for Customer Orientation	-sensitivity, awareness and understanding of patient needs	-improving attitude, knowledge and skills of practitioners – improving cultural responsiveness and appropriateness - flexibility in relation between different patients.	
6	Cultural safety	Respect and patient rights to receive appropriate cultural services.		

Table 1: some of antecedents, attributes, consequences, and surrogate terms for cultural competency (continued)

7		As a requirement for professional competencies, professional ethic and ethic requirement	
8	A Necessity in the Patient Manage and Increasing the Effectiveness of Health Organizations		-improving patient- practitioner communication - improving cultural responsiveness and appropriateness
9	As a law requirement		
10	Stereotype and labeling and prejudice to other cultures		-to gain self-awareness to stereotypes, prejudices and assumptions.
11	Prevalence of dominant culture to minority and other cultures		

17- Liaison Committee on Medical Education Full Text of LCME Accreditation Standards LCME (<http://www.lcme.org/standards.htm>)

18- Augustus A. White, Heidi L. Hoffman, C Culturally Competent Care Education At Harvard Medical School: Background, History And Accomplishments. Harvard Medical School. June 2006.

Heidi L. Hoffman, MPH, Independent Health Care Consultant

19- Ranking of countries for accepting refugees in 2014: <http://rade1.com/social/ranking-of-countries-accepting-foreign-refugees-in-2014/>

20- Nematollah Fazeli. Politics of culture in Iran. Routledge. 2006. Taylor and Francis group.

21- Medical education in the Islamic Republic of Iran. Three decades of success. Iran J pub Health 2009, 38:19-26.

22- Eunyoung Eunice Suh, Msn, RN. The model of cultural competence through an evolutionary concept analysis. Journal of transcultural Nursing. vol 15, NO 2. April 2004

23- Duan-Ying CAI. A concept analysis of cultural competence. Journal of Nursing Sciences 2016

24- Patricia E. Zander, PhD, RN. Cultural Competence: Analyzing the Construct. The Journal of Theory Construction & Testing. Vol 11, NO2. Fall 2007

25- Jeong, Geum Hee. Park, Hye-Sook. Kim, Kyung Won. A concept Analysis of Cultural Nursing Competence. Korean J Women Health Nurs. vol.22 No2. June 2016

26- Kimberly I. Dudas. Cultural Competence: An Evolutionary Concept Analysis. Nurs Education perspective, vol33 (5), Ser-Oct 2012

27- Jacqueline L. Rosenjack Burchman, RN, DNSc. Cultural Competence: An Evolutionary Perspective. Nursing Forum. Vol 37, No.4, oct.dec, 2007

28- Maria Jirwe, Cultural competence in Nursing. Karolinska Institute, Stockholm, Sweden. 2008

29- Council in graduate medical education; seventeenth report. Minorities in medicine an ethnic and cultural challenge for physician training. U.S department of health and human services HRSA 2005.

30- Miguel A. Pérez, Raffy R. Luquis. Cultural Competence In Health Education And Health Promotion by American Association of Health Education/American Alliance for Health, Physical Education. Library of Congress Cataloging-in-Publication Data 2008

31- Josepha Campina-Bacote, Delivering patient-centered care in the Midst of a cultural conflict: the role of cultural competence. ANA. Periodicals OJINT table of contents V16, N2, 2011

32- Guidelines for cultural safety, New Zealand psychologists Board 2009.

33- Laurence J. Kirmayar. Rethinking cultural competence, Transcultural psychiatry 49(2) .2012.

34- Rosalie Thackra, Sandra C Thompson. Refining the concept of cultural competence: building on decades of progress. MJA 199 (1). July 2013.

35- T Parish. Cultural competence: do we agree on its meaning and should it be considered a core competency in training program? , The internet Journal of Academic Physician Assistants V3.N2.2002

36- Aru Narayanasamy, Etherlene White, A review of transcultural nursing. Nurse education today. 25, 102-11, 2005.

37- Joseph S. Gallegos, Cherie Tindall, Hila A. Gallegos. The need for advancement in the conceptualization of cultural competence. Advances in social work V9.N1, 2008.

38- Derald Wing Sue .Multidimensional Facets of Cultural Competence. The counselling psychologist. V:29. No, 6. 2001.

39- Ronnie L Leavitt. Developing cultural competence in a World, parts 1&2 . PT: Magazine of Physical Therapy; Dec 2002, Vol. 10 Issue 12, p36. 2002.

40- Gow, K. M. (1999). Cross-cultural Competencies for Counsellors in Australasia. Paper presented at the Culture, Race and Community Conference, Melbourne.

41- Larry D. Purnell, Betty J. Paulanka, Transcultural Health care: a culturally competent approach .3TH edition. Davis company 2008.

- 42- Josepha Campinha- Bacote, Debra Claymore-Cuny, Denice Cora-Bramble, Jean Gilbert et al, Transforming the Face of Health Professions through Cultural & Linguistic Competence Education: The Role of the HRSA Centers of Excellence, government project of US department of health & human services 2005.
- 43- Curricula enhancement module series cultural competence:
<http://www.ncccricula.info/culturalcompetence.html>
- 44- Raman Bedi. Cultural competence and the art of wisdom. Diversity Gains LTD 2010
- 45- MichelA.Godkin, Judith A. Savagean. The effect of a global multiculturalism track on cultural competence of preclinical medical students. Fam Med.2001.V33. N3:1
- 46- Joseph R. Betancourt. Cross- cultural medical education: conceptual and frameworks for evaluation. Academic medicine, V78.N67. June2003.
- 47- Wellington: ministry of health. Pacific cultural competencies: A literature review. New Zealand Feb 2008.