

Toward Cultural Competency in Health Care: A Scoping Review of the Diversity and Inclusion Education Literature

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Abstract

Purpose

To explore best practices for increasing cultural competency and reducing health disparities, the authors conducted a scoping review of the existing literature.

Method

The review was guided by 2 questions: (1) Are health care professionals and medical students learning about implicit bias, health disparities, advocacy, and the needs of diverse patient populations? (2) What educational strategies are being used to increase student and educator cultural competency? In August 2016 and July 2018, the authors searched 10 databases (including Ovid MEDLINE, Embase, and Scopus) and

MedEdPORTAL, respectively, using keywords related to multiple health professions and cultural competency or diversity and inclusion education and training. Publications from 2005 to August 2016 were included. Results were screened using a 2-phase process (title and abstract review followed by full-text review) to determine if articles met the inclusion or exclusion criteria.

Results

The search identified 89 articles that specifically related to cultural competency or diversity and inclusion education and training within health care. Interventions ranged from single-day workshops to a 10-year curriculum. Eleven educational strategies used to

teach cultural competency and about health disparities were identified. Many studies recommended using multiple educational strategies to develop knowledge, awareness, attitudes, and skills. Less than half of the studies reported favorable outcomes. Multiple studies highlighted the difficulty of implementing curricula without trained and knowledgeable faculty.

Conclusions

For the field to progress in supporting a culturally diverse patient population, comprehensive training of trainers, longitudinal evaluations of interventions, and the identification and establishment of best practices will be imperative.

By 2050, 50% of the U.S. population will be of non-European origins.^{1–3} Additionally, more than 10 million Americans identify as lesbian, gay, bisexual, transgender/transsexual, queer/questioning (LGBTQ), and the middle class has shrunk from 57% in 1970 to 45% in 2018.⁴ Within this context of shifting demographics, our health care system must strive to provide treatment and services that are culturally appropriate and effective. Providers cannot deliver

health care without taking into account differences in ethnicity, religion, gender, age, sexual orientation, socioeconomic status, language, education, ability, and geographic background.

In addition to these sometimes overlapping identities, every patient possesses a distinct worldview, influenced by their cultures. Though culture is difficult to define,⁵ Leininger describes it as “the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular [group of individuals] that guides thinking, decisions, and actions in patterned ways [that are also often intergenerational].”^{6(p10)} Patients view health promotion and treatment through the lens of their cultures, which in turn impacts their overall health.⁷ Culture can influence everything from how people view Western medicine to their comfort with a doctor of the opposite gender. We assert that one’s culture has an inextricable and meaningful relationship with health needs, care, and outcomes.

Groups from different cultures have varying levels of health and wellness in

the United States. Health *care* disparities refer to differences in access to or availability of facilities and services. Health *status* disparities are the varied rates of disease and disability that exist between socioeconomic, racial/ethnic, geographically defined, and other groups.⁸ *Health disparities* encompasses both health care disparities and health status disparities as well as the process for connecting various types of disparities, leading to the health outcomes a person experiences. Both types of health disparities are largely the result of historic systemic inequalities. Without understanding the impact of the political, socioeconomic, and geographic factors that led to these inequalities, it is nearly impossible to address them. Regardless of a health care provider’s good intentions, a lack of cultural understanding can lead to decreased patient compliance and poor health outcomes.⁹ Thus, to this day, health disparities have continued or even worsened.

Research suggests that one way to address health disparities and increase positive health outcomes is to provide

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culturally appropriate care.^{10–13} The Accreditation Council for Graduate Medical Education, Liaison Committee on Medical Education, World Health Organization, and Institute of Medicine all endorse training health professionals and students in this area,^{14–20} as education that helps providers understand the cultural differences—and health beliefs and practices—of diverse groups makes a difference.²¹

But there are ongoing challenges to implementing diversity and inclusion training that enables students and professionals to deliver health care effectively to diverse populations or to garner cultural competence. The term cultural competence itself is contentious as it can be interpreted as suggesting that there is a theoretically finite body of knowledge that can be mastered to become culturally competent.²² Other terms, often used interchangeably, include culturally compatible, culturally appropriate, culturally congruent, culturally sensitive, cross-cultural, culturally informed, and culturally responsive.^{23,24} Tervalon and Murray-García²⁵ propose that cultural humility—which incorporates commitments to lifelong self-evaluation and learning, to redressing power imbalances in the patient–physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities—is a more suitable goal than cultural competence. However, cultural competence remains the most widely used term in the literature and thus is used in this paper with an acknowledgment of its shortcomings.

Many educators agree on the 4 major tenets of cultural competence noted by the Liaison Committee on Medical Education: awareness, attitudes, knowledge, and skills.¹⁶ Each tenet²⁵ (see Table 1) describes concepts that health care providers need to be sensitive toward people of differing backgrounds. However, there is a dearth of guidelines for imparting the 4 tenets effectually.¹⁵ Many educators feel less prepared to teach about diversity than science-related subject contents. They may provide basic knowledge on the influence of race or gender specific to patient care and health outcomes, for example, but disregard political, socioeconomic, and geographical impacts on health.

Table 1

Definitions of the Four Major Tenets of Cultural Competency^a

Tenet	Definition
Awareness	Awareness or insight into your own biases and reactions to various cultures that are different from your own.
Attitudes	Noting the “difference between just being aware of cultural differences” and “analyzing your own internal belief systems.”
Knowledge	Tervalon and Murray-García ²⁵ found that regardless of an individual’s morals, beliefs, and values, how they think may not align with how they act causing increased prejudice when interacting with those from a different culture. By noting this gap, focusing on improving understanding or knowledge is key to improving one’s own cultural competence.
Skills	“Taking practices of cultural competency” and working to integrate them as a part of one’s daily actions. A typical skill one needs to work on is effective communication with a focus on both verbal and gestural communication.

^aDefinitions derived from Tervalon M, Murray-García J. Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor Underserved*. 1998;9:117–125.²⁵

The assumption is that students can extrapolate material and generalize concepts to approach various situations specific to diversity and inclusion, but, in the end, this can lead to students not fully appreciating the complex, interdependent nature of the issues, which can actually be counterproductive.²⁶

Surveys show that health care professionals still remain unaware of the actual impact of health disparities nationwide.^{15,27} Developing and teaching a comprehensive curriculum that includes the entire scope of cultural competency is a recognized challenge. Reliance on a biomedical model of education is problematic, as many health care providers postulate that health care as an institution shoulders some responsibility for the persistence of health disparities.²⁸

Exploring the approaches used to teach cultural competency has the potential to enhance learning and application of culturally appropriate care. This analysis may lead to curricular changes that have the potential to increase awareness, reduce bias, increase health care accessibility, and provide effective health services for people from diverse backgrounds. To explore best educational practices for increasing cultural competency and reducing health disparities, we conducted a comprehensive scoping review of the existing literature. The use of a scoping review provides a cumulative map of the existing literature to assist in identifying knowledge gaps within a given topic. The use of a scoping review does not assess

the quality of the literature; however, it provides a comprehensive approach to investigating a topic from multiple disciplines and varying study designs.

Method**Research questions**

We focused our scoping review on answering the following questions: (1) Are health care professionals and medical students learning about implicit bias, health disparities, advocacy, and the needs of diverse patient populations? (2) What educational strategies are being used to increase student and educator cultural competency (i.e., awareness, attitudes, knowledge, and skills in providing culturally appropriate care)?

Search strategy

Designed by a medical librarian (A. Hardi, MLS), our search strategy focused on multiple health professions, including medicine, nursing, audiology, pharmacy, occupational therapy, and physical therapy, plus concepts of cultural competency or diversity and inclusion education and training. We did not look at specific groups (e.g., LGBTQ, certain ethnicities), as we sought to explore the larger global issue of cultural competency and health disparities. We used a combination of standardized terms and keywords that were implemented in Ovid MEDLINE, Embase, Scopus, CINAHL, Cochrane Database of Systematic Reviews, Cochrane Central Register of Controlled Trials, Database of Abstracts of Reviews of Effects, ERIC, ProQuest Dissertations

and Theses, and Clinicaltrials.gov. Our initial search was conducted on August 5, 2016. In July 2018, we conducted a secondary search of MedEdPORTAL. For all searches, we applied database-supplied language limits and confined results to English publications from 2005 to August 2016. We exported results to EndNote and removed 2,989 duplicates for a remainder of 4,267 unique citations. See Supplemental Digital Appendix 1 (at <http://links.lww.com/ACADMED/A748>) for the full search strategies.

Inclusion criteria

The research lead (M.R.B.) screened the literature with specific inclusion and exclusion criteria. D.M.C. and S.D.T. modified the inclusion criteria throughout the study selection process to narrow the focus of the selected articles. In phase 1 (title and abstract review), the initial 4,267 articles were reviewed and included if their abstracts had specific terminology that focused on health care professionals or students, followed an American or European school system, and discussed or explained an educational curriculum and instruction. Articles did not have to be peer reviewed to be included.

A full-text review conducted by M.R.B., R.H., and an undergraduate assistant (I. Chen) confirmed that 717 articles met all of the aforementioned criteria. Because there was still an overabundance of literature, we added the following criterion during phase 2 (full-text review): articles must discuss culturally relevant education, educational strategies, and instruction. The final screening process identified a total of 89 articles that met all of the inclusion criteria. A flow diagram (Figure 1) was adapted from the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses)²⁹ guidelines and used during the screening process. Starting with purposefully general criteria minimized the risk of potential bias. Any disagreements were resolved by D.M.C. and S.D.T.

Data organization and extraction

M.R.B. and R.H. used the Guideline for Reporting Evidence-Based Practice Education Interventions and Teaching (GREET)³⁰ checklist to organize our results. Educational intervention can be complicated to assess in scoping reviews due to educators frequently modifying

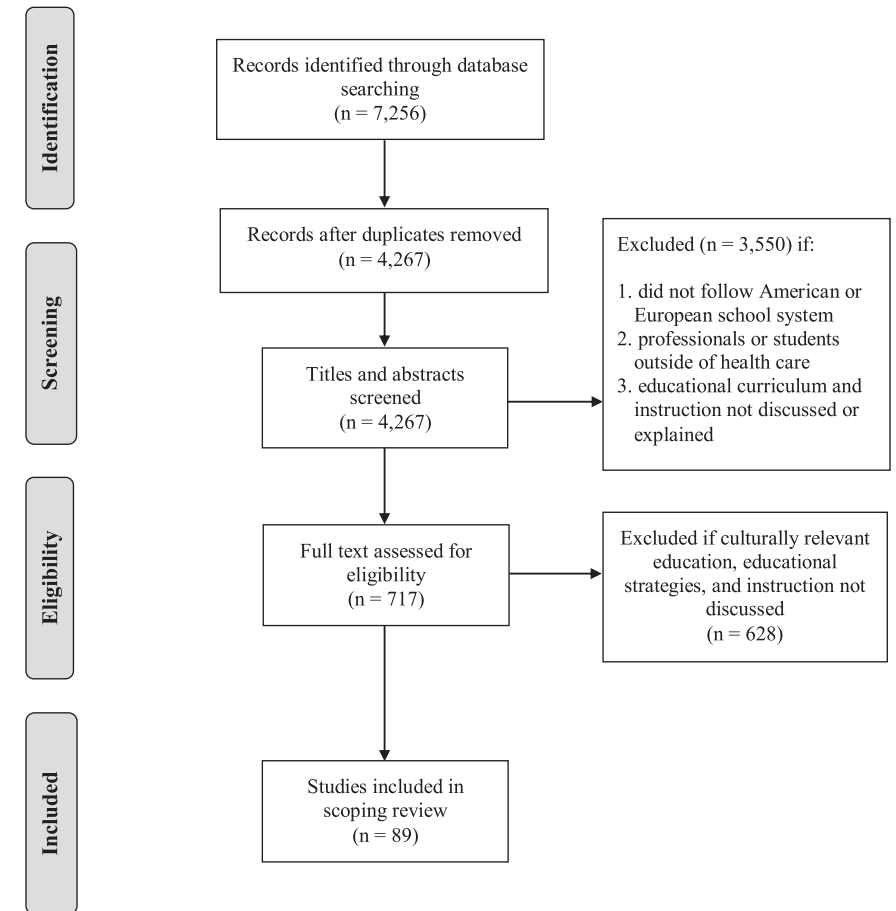


Figure 1 Adapted PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses)²⁹ flow diagram for an August 2016 scoping review exploring best educational practices for increasing cultural competency and reducing health disparities. A secondary search of MedEdPORTAL was conducted in July 2018. All numbers reported in the figure include articles from both searches.

lessons and curricula. Therefore, we used a modified GREET checklist to provide information on each educational intervention.³⁰ The modified checklist combined 17 categories into 7. This merging of items allowed us to analyze each article without having to separate details into constrictive subcategories. For instance, the full GREET checklist divides intervention outcomes into the categories of how well, planned changes, and unplanned changes, whereas the modified checklist incorporated all 3 of these categories into the single category of intervention outcomes.

Three reviewers (M.R.B., R.H., and I. Chen) extracted data regarding study design in the following GREET categories: participants; theory, model, or framework; learning objectives; educational strategies; delivery personnel; intervention schedule and/or length; and

intervention outcomes. Coding occurred in 3 distinct phases: coding, sorting, and synthesizing. First, codes were assigned to track common trends and patterns throughout multiple categories based on each reviewer's interpretation of the literature (e.g., use of simulators, role-play, standardized patients).³¹ The reviewers collaborated to generate a single list of codes to decrease individual bias. After the initial cycle of coding, they sorted each coded list into categories based on similarities and underlying meaning. From there, the reviewers generated themes encompassing all of the initial codes and the categories into which they were sorted. For instance, one intervention used objective structured clinical examination (OSCE), which was coded as simulation. From there, the intervention was categorized with similar intervention approaches (such as use of OSCE and role-play) and

placed into broader code families (such as simulation). Finally, we placed all simulation codes under the larger theme of educational strategies.

Results

Included studies

Our searches identified 4,267 studies after duplicates were removed, of which 89 articles related to cultural competency or diversity and inclusion education and training within health care.^{2,3,7,11,12,15,18–20,23,24,32–109} Detailed information on the included studies can be found in Supplemental Digital Appendix 2 (at <http://links.lww.com/ACADMED/A749>). Due to the diverse, inconsistent, and unstructured nature of education-based articles, we did not develop comparisons to rate papers or draw conclusions regarding specific outcomes.

Study characteristics

Interventions ranged from single-day workshops^{3,11,32–43} to a 10-year effort to integrate cultural competence throughout a curriculum.⁴⁴ Table 2 displays participant characteristics. Of 89 studies, 78 (87.6%) were conducted with graduate and undergraduate students; the remaining articles focused on health care professionals^{12,15,45–51} and educators.^{15,23,42,49,78,85,100,108,109} The maximum number of participants in a single intervention was 562.¹⁹ Nursing and medicine comprised the primary professions providing diversity and inclusion education and training.

Many of the studies were descriptive in nature and did not provide enough detail to draw comparisons, demonstrate outcomes, or evaluate the efficacy of interventions. Studies noted sequential outcomes of acquiring knowledge, awareness, attitudes, and skills. Of the 89 studies, 19 (21.3%) described an increase in students' cultural knowledge.^{2,19,20,36,38,50,52,53,55,57–59,61–65,70,77} Twenty-two (24.7%) studies observed changes in students' attitudes and level of cultural awareness.^{2,11,19,24,35,37,48,50–52,58,61,62,67–74,92} Fourteen (15.7%) studies noted a general increase in students' perceived level of applicable skills.^{3,18,19,34,36,38,43,52,53,72–74,77,78} Only 2 (2.2%) studies tracked outcomes to find that students developed new skills specific to culturally competent care, in addition to increased knowledge and awareness.^{19,52} Thirty-eight (42.7%) studies tracked at least one outcome, while over half of the articles did not report any specific outcomes.

Table 2

Participant Characteristics Among the Studies Included in an August 2016 Scoping Review Exploring Best Educational Practices for Increasing Cultural Competency and Reducing Health Disparities^a

Participant characteristic	No. (%) of studies
Health profession	
Medicine ^b	30 (33.7)
Nursing	28 (31.5)
Pharmacy	10 (11.2)
Dental	4 (4.5)
Physical therapy	4 (4.5)
Emergency medicine	2 (2.2)
Family medicine	2 (2.2)
Occupational therapy	2 (2.2)
Public health	2 (2.2)
Audiology	1 (1.1)
Radiology	1 (1.1)
Social work	1 (1.1)
Role	
Graduate or undergraduate student	78 (87.6)
Health care professional	9 (10.1)
Educator ^c	9 (10.1)
Residents/clerkships ^d	8 (9.0)

^aA secondary search of MedEdPORTAL was conducted in July 2018. For some studies, data on the specific target population were not available for extraction. One study could include more than one health profession or role, so percentages may exceed 100. The total number of included studies was 89.

^bThe overall category medicine was used when no specific type of practice was identified and includes both pre- and post-doctoral students.

^cSpecific to the articles that focused interventions on faculty members.

^dPre- and postdoctoral students.

The review revealed 5 themes—theories, models, and frameworks; teaching strategies; assessments; curriculum and course design; and educator training—which are discussed in more detail below.

Theories, models, and frameworks.

Various tools are used to organize different concepts and information within a specific context. Theories are tested knowledge that informs aspects of human behavior, models are visual representations that describe relationships among concepts, and frameworks are structures of concepts used to communicate ideas and values.¹¹⁰ This review found that 53/89 (59.6%) studies used at least one theory, model, or framework to guide the development of their educational intervention, while 37/89 (41.6%) did not.

The most frequently referenced model was Campinha-Bacote's¹¹¹ Process of Cultural Competence in the Delivery of Healthcare Services.^{2,23,48,49,51,55,64,70,72,79–82} This model identifies the development

of cultural competence as a process embedded within 5 constructs: cultural awareness, knowledge, skills, encounters, and desires.^{2,23,64} Other cited models were Giger and Davidhizar's⁹ Transcultural Assessment Model,^{23,51,65,81} Purnell's¹¹² Model for Cultural Competence,^{23,44,51,65} and Berlin and Fowkes's¹¹³ LEARN (Listen, Explain, Acknowledge, Recommend, Negotiate) Communication Model.^{2,62,68,71,83,84}

Teaching strategies. Almost all studies (80/88, 90.9%) cited mixed teaching strategies (outlined in Supplemental Digital Appendix 3 at <http://links.lww.com/ACADMED/A750>). One of 89 (1.1%) studies did not mention any teaching strategies used during their intervention, so it was not analyzed for teaching strategies.¹⁰⁹ Many studies recommended using multiple methodologies, such as lectures, discussion groups, and, less frequently, presentations and papers to develop knowledge, awareness, attitudes, and skills. Seventy-nine of

88 (89.8%) studies used more than one educational strategy; 36 of these 79 (45.6%) studies reported favorable outcomes.^{2,3,11,18–20,34,36–38,48,51–55,57,58,60–66,68,70–75,77,82,86,87} However, only 2/79 (2.5%) studies reported that the intervention improved participants' skills (beyond awareness, attitudes, and knowledge).^{19,52} Nine of 88 (10.2%) studies used only one educational strategy. Of those 9 studies, 5 (55.6%) cited favorable outcomes^{50,56,67,69,88} and 3 (33.3%) reported no significant change.^{89–91}

We identified 11 educational strategies, which are described in more detail below, used to teach cultural competency and about health disparities: immersion experiences, simulation, discussion groups, lectures, reflection, educational technology, case-based learning, papers, presentations, readings, and videos (Table 3 shows the distribution of these across the included studies).

Immersion experiences. Immersion experiences were employed in 30/88 (34.1%) studies. Of these 30, there were 12 (40.0%) studies that used clinical rotations to acquire cultural knowledge^{24,44,49,52,62,69,74,78,83,87,92,104} and 1 (3.3%) that provided 2 clinical placements to enhance the application of culturally competent care.⁷⁰ Another program provided an immersive

international experience that increased students' awareness and ability to understand a variety of environmental and sociocultural factors impacting health.⁷⁸ While promising, the program proved costly and was limited based on follow-up discussions.

Simulation. Simulation was incorporated in 40/88 (45.5%) studies. Twenty-eight of those 40 (70.0%) studies used role-play with students or standardized patients.^{33,34,37,40,45,46,48,51–55,59,61,63,66,71,73,79,85–88,93–97} Vyas and Caligiuri⁷¹ indicated that student-led role-play negatively influenced outcomes due to inaccurate simulation. In contrast, Mihalic and colleagues⁵³ found their student role-play intervention increased cultural knowledge and skills. Of the 40 studies, 6 (15.0%) used standardized patients,^{39,42,43,76,78,94} 3 (7.5%) used an OSCE,^{61,85,98} and 4 (10.0%) combined standardized patients and an OSCE.^{34,46,77,80} OSCEs proved an especially effective approach to increasing cultural knowledge according to self-reported measures⁶¹ and further facilitated tracking of performance over time.³⁴

Discussion groups. Discussion groups were cited in 52/88 (59.1%) studies as a means of cultural competency education. In 10 of these 52 (19.2%) studies, discussions occurred within small-group

settings of 8–15 students.^{11,41,43,47,75,85,93,95,99,100} Additional formats included panel, large-group, activity-based, and faculty-facilitated discussions. Smith and colleagues¹⁵ found that the use of smaller cohorts promoted a safe environment for students, enhancing self-reflection and evaluation. Discussion groups were not only employed with students but were also cited as a tool to train educators to facilitate meaningful dialogue.³³

Lectures. Lectures were used as a method of disseminating foundational information about health disparities in 50/88 (56.8%) studies. Lectures ranged from 15 minutes⁷³ to 2 hours^{56,58} and were conducted by various individuals including, but not limited to, community members and guest lecturers (without specification of expertise),^{37,45,54,75} experts within the field,^{48,53,54,90} and faculty.^{20,35,38,46,56,58,61,68,85,96,97,101} The effectiveness of lectures varied; 2/49 (4.1%) studies found that lectures proved less beneficial than active learning activities.^{11,101} Combining lectures with other educational strategies (such as role-playing, group discussions, etc.) generally led to more positive outcomes in terms of increasing knowledge and awareness, implying that lectures alone are not a sufficiently robust tool for educating individuals on the topics of cultural competency and diversity and inclusion.

Reflection. Reflection was included as an educational strategy in 36/88 (40.9%) studies. For example, students at one institution used Blackboard to develop a reflection portfolio.² The use of reflection positively influenced students' cultural knowledge, awareness, and skills.^{64,70,74} However, 1/36 (2.8%) studies reported needing more time for reflection due to minimal changes in behaviors and attitudes.¹¹ Another 2/36 (5.6%) studies paired reflection with activities like hands-on experiences and group discussions and found greater synthesis of the information previously learned.^{57,80} Finally, the benefits of reflection double as both a teaching tool and a means of appraising changes in students' knowledge and awareness.^{23,66}

Educational technology. Educational technology was used as an educational strategy in 15/88 (17.0%) studies in the forms of web conferencing⁶⁴; Internet training^{36,52,67,81,82,89}; online forums¹⁰²; e-lectures⁷⁶; distance learning¹⁰³;

Table 3

Distribution of Educational Strategies Across the Included Studies in an August 2016 Scoping Review Exploring Best Educational Practices for Increasing Cultural Competency and Reducing Health Disparities^a

Educational strategy	No. (%) of studies	Studies
Immersion experiences	30 (34.1)	12,19,20,23,24,36,38,44,46,47,49,52,55,57,62,68–72,74,78,79,83,87,92,93,97,103,104
Simulation	40 (45.5)	7,23,33,34,37,39,40,42,43,45,46,48,51–55,59,61,63,66,71,73,76–82,85–88,93–98
Discussion groups	52 (59.1)	3,11,15,19,20,32–41,43,44,46–49,51–55,57–60,62,64,66,71,72,75,79,82,84–87,92,93,95,99–102,106–108
Lectures	50 (56.8)	3,11,12,15,18–20,32–41,45,46,48–50,53,54,56,58,61–65,68,70,71,73–75,77,81,82,85,86,87,90,93,96,97,99,101,104
Reflection	36 (40.9)	2,3,11,15,18,23,24,32,36,38,40,44,47–49,57,62,64–66,70–72,74,78,80,82–84,91,94,96–98,103,105
Educational technology	15 (17.0)	7,36,40,41,52,54,64,67,76,81,82,89,92,102,103
Case-based learning	28 (31.8)	2,3,15,34,38,40,44,45,53,58,60,61,66,71,77,80–82,84,85,92,93,95,99–101,103,105
Papers	5 (5.7)	23,47,49,57,71
Presentations	5 (5.7)	20,23,81,83,85
Readings	17 (19.3)	2,12,20,35,40,46,51,52,54,64–66,75,80,100,103,108
Videos	24 (27.3)	2,3,34,40,45,51,54,58,62,63,65,66,71,72,80,84,92,97,101–103,106–108

^aA secondary search of MedEdPORTAL was conducted in July 2018. Out of a total of 88 studies; 1 study was not included here because it did not mention teaching strategies used during the intervention, so it was not analyzed for teaching strategies.¹⁰⁹

online self-, pre-, and postassessment tools^{40,41,54,92}; and high-fidelity simulators.⁷ Outcomes depended on the type of technology used. Two of these 15 (13.3%) studies concluded that the use of skill-based online modules and audiovisual tools did not change physicians' scores on cultural competency assessments or meet learning objectives.^{67,89} Another 2/15 (13.3%) studies found that using a combination of technology and reflection increased knowledge,⁶⁴ attitudes,⁵² and skills.⁵² The majority of educational technology interventions were not fully described, making replication challenging.

Case-based learning (CBL). CBL was cited in 28/88 (31.8%) studies. CBL focuses on developing student skills through real-life and clinical scenarios.¹¹⁴ Among other things, studies integrated CBL through simulation,^{38,82} vignettes,^{40,53,71} case-based reflections,⁸⁴ small-group problem-based cases,¹⁰¹ and case-based discussions.^{34,61,66,81,101} Two of these 28 (7.1%) studies made use of simulation games—BaFa' BaFa' cultural simulation⁶⁶ and the Clown Culture⁸²—to educate students on culturally competent care, but neither reported clear outcomes. Educators also used CBL in fieldwork experiences through discussing and applying cultural knowledge in role-plays of real cases.⁶¹ Sixteen of the 28 (57.1%) studies mentioned that they used CBL within their educational interventions without explaining how,^{2,3,15,44,45,58,60,77,80,81,85,93,95,99,103,105} making it difficult to fully articulate how this educational strategy works in practice.

Papers. Papers were incorporated in 5/88 (5.7%) studies. Martinez and colleagues⁴⁷ used essays as assessment and application tools in evaluating behaviors through case-based questions. In most studies, papers were used in conjunction with other educational strategies. The majority of studies did not provide details on how papers were structured or formatted.

Presentations. Presentations were used in 5/88 (5.7%) studies, including both oral^{23,83,85} and poster presentations.^{20,81} Vela and colleagues²⁰ had students present posters to illustrate a health disparities topic as part of a 5-day elective experience for health professions students. Similar to papers, presentations were used in conjunction with other educational strategies with little

description on the format or structure used.

Readings. Readings appeared in 17/88 (19.3%) studies as an optional assignment,^{20,40} a preparatory tool,^{2,12,51,54,64,66,75,80,100,103,108} and/or the focus of class discussion and reflections.^{35,46,52,65,66,103} Resources such as *The Spirit Catches You and You Fall Down*¹¹⁵ and *La Doctora*¹¹⁶ provided students with an understanding of culture within health care systems.⁶⁶ Poirier and colleagues² assigned readings before class to build foundational knowledge on cultural issues, then used class time to apply the information. They reported that their students demonstrated increased awareness and knowledge. Two of these 17 (11.8%) studies found that readings presenting real-life encounters increased participants' cultural awareness.^{35,66} For instance, one intervention used letters and factual accounts of individuals living in poverty to stimulate discussions about how these circumstances might compromise one's health.³⁵

Videos. Videos were incorporated in 24/88 (27.3%) studies in the form of clips, movies, documentaries, television shows, and training videos. Four of the 24 (16.7%) studies mentioned specific videos^{2,62,66,103} like *If These Walls Could Talk*¹¹⁷ and *Patient Diversity: Beyond the Vital Signs*.¹¹⁸ The most commonly cited film was *Worlds Apart*,¹¹⁹ about a Muslim man who refused chemotherapy due to cultural beliefs. Pilcher and colleagues⁶² used the facilitator's guide for this film¹²⁰ to assist in discussions that promoted reflection and introduced new perspectives. Studies combining videos with other educational strategies reported an increase in knowledge,^{2,58,62,65,97} awareness,^{2,51,62,71,72,97,106} and skills.⁹⁷

Assessments. Assessments evaluate the level of changed behaviors and acquired knowledge and skills related to an educational intervention. This review found many programs used papers, projects, and reflections to assess learning. Eight of 89 (9.0%) studies used a pre- and post-test method to assess learning^{20,48,50,52,60,66,69,87} and 1 (1.1%) study conducted a follow-up 30 days post intervention.⁸⁷ The 2 assessments most frequently cited were the Cultural Self-Efficacy Scale¹²¹ and the Inventory for Assessing the Process of Cultural Competency Among Healthcare

Professionals,¹²² which were each cited by 5/89 (5.6%) studies.^{2,51,87,103,105}

Curriculum and course design. The studies reviewed did not discuss how they developed or arrived at their interventions. There was great variance in the design of cultural competency training; examples ranged from a 20-minute intervention³⁴ to 600 hours of training embedded throughout a curriculum.⁸³ The interventions included workshops, curricula, courses, clinical rotations, and remote education. Fifteen of 89 (16.9%) studies used a single-day workshop varying in length and in the amount of information covered.^{3,11,32–43,76} Related to the theme of assessment, a large portion of short courses and workshops only measured immediate outcomes to determine the level of knowledge, skills, and behavior changes; no study established its format as a best practice for overall curriculum or course design.

Educator training. Studies have noted that successful implementation of a cultural competency curriculum begins with those delivering it: the faculty and teaching staff.^{23,44,61,97} Twenty of 89 (22.5%) studies noted the importance of effectively training those who are educating others about diversity and inclusion to the successful implementation of such curricula.^{15,23,33,40,42–44,46,49,56,61,78,85,91,93,97,100,103,108,109} Two of these 20 (10.0%) studies mentioned that a majority of educators teaching cultural competence have interest in the topic but lack extensive training.^{23,78} Seven of the 20 (35.0%) studies endorsed training faculty and teaching staff to deliver health disparity information^{15,23,42,49,78,85,100}; however, only 2 of these 7 (28.6%) described *how* to train them.^{15,100} Kumagai and Lypton³³ recommended group discussions, reflections, and simulation activities. Even with such training, however, students found that educators could not facilitate a thorough conversation.⁴²

Discussion

Health care educators acknowledge that cultural appropriateness grows increasingly critical in the face of changing demographics and widening health disparities, but it is clear that we need to do more work to identify best practices. For example, none of the studies included in our review declared

their approach to be a best practice for teaching cultural competency in health care.

Both the University of Rochester³⁷ and St. John Fisher College⁵⁹ used the Deaf Strong Hospital program developed at the University of Rochester School of Medicine and Dentistry. Although these institutions used the same program guide as the basis for their training, one incorporated a longitudinal self-assessment survey and the other included a reflective writing assignment. This shows how cultural competency training can be altered beyond the initial design and thus vary in content, delivery, and outcomes.

Within the literature, we note a scarcity of evidence citing the effectiveness of educational approaches⁷² with the majority of studies hesitant to state a clear positive outcome. Many articles used various models, theories, and/or frameworks to support their cross-cultural education interventions; however, none of them were reported as producing more favorable outcomes than the others. It may be that the *choice* of model, theory, and/or framework is not as critical as the *existence* of one to guide a curriculum or training. Beyond the general formatting for the curriculum or course, the approaches for assessing outcomes were vague. Many assessment tools followed a self-report format, which cannot always accurately determine changes in skills related to cultural competence. Unfortunately, many of the studies did not explain their process or appear to have an assessment process at all. This was one area where many studies fell short.

This scoping review reveals that educators seek resources and ways to combine educational strategies to increase the cultural awareness, attitudes, knowledge, and skills of their students. Considering the range of models, theories, frameworks, and educational strategies identified, education specific to diversity and inclusion and cultural competence seems to have been embraced by the health professions and will likely continue to proliferate.

Several barriers to progress in efforts to increase cultural competency and health disparities education and training are noteworthy. First, education for those

who are doing the educating has not been sufficiently addressed. Educators are being trained with a narrow focus that does not adequately prepare them to teach future health professionals about the complex topics of culture, bias, and health disparities. Many studies thus recommend relying on and training faculty to become experts within the field to most effectively deliver education based on diversity and inclusion and cultural competence.^{15,56,109} To implement programs with a diverse cultural focus into health professions education effectively, faculty and teaching staff need to have a level of comfort and proficiency with a variety of topics (i.e., understanding of various models, theories, and frameworks associated with culture; therapeutic use of self-concepts associated with effective communication; etc.). While methods used to teach students can also be effective for other audiences, there is no universal standard for training educators. Garet and colleagues¹²³ explored the factors that make professional development effective and found that a focus on content knowledge, opportunities for active learning, and connection to other learning activities all increased educator's knowledge and skills and improved classroom practices. Regular training of faculty and teaching staff using these strategies will lead to a more knowledgeable and skilled cadre of educators who can handle the breadth and depth of issues related to cultural competence.

This barrier may also resolve in time as health care students and professionals who have benefitted from cultural competency training and who have actively incorporated those lessons into their practice go on to become the next generation of educators. Until that time, the question remains how to fill the gap. Many programs make use of external experts, but they are scarce and in high demand. A train-the-trainer¹²⁴ model may be more productive.

This scoping review also shows that an assessment of what works the best in the short term and/or longitudinally has yet to be completed. Many of the studies indicated positive changes in student awareness or knowledge. But these were largely based on self-reported indicators, which may be biased and are unreliable for predicting future

behavior or long-term effectiveness. Our review of the literature found only a few assessment scales that were used in the included studies. Other tools need to be explored and validated so that the myriad of models, theories, frameworks, educational strategies, and interventions used can be accurately evaluated. As it stands, many health care professionals and students can claim that they have had some exposure to training in cultural competency. However, it is not evident that these efforts change behavior or lead to more culturally sensitive services that decrease health disparities.

The lack of assessment in cultural competency training explains why there is no consensus as to the most effective methodologies. Educators often employ a multimodal curricular approach, incorporating lectures, discussion groups, educational technology, and CBL. No particular approach is all-encompassing, nor is that necessarily feasible. There is no right way to address the complex, dynamic, and sometimes emotionally charged subject matter that is cultural competency training. The very nature of diversity and inclusion education implies that training can never be complete; rather, it is a lifelong process. It is impossible for a student to become proficient after a single educational session or even a year of training, and individuals will absorb and apply information differently, even if they share similar backgrounds. Both educators and students in health care must embrace this nuanced process as an essential aspect of their career-long endeavors to improve cultural competency within health care. A potential solution lies in introducing cultural competency training at the start of professional health studies and embedding these concepts throughout curricula and clinical experiences. Including cultural competence in accreditation standards and as part of continuing professional education can enhance the longitudinal presence and congruency necessary to fortify these efforts.

Health professions programs acknowledge that gaining knowledge, awareness, and skills are necessary for attitude and behavior changes but rarely measure outcomes to determine if those objectives are being met. A next step toward successful training might be future investigation into the effectiveness

of a variety of efforts undertaken at 3 partner institutions including 7 health professions programs: general medicine, occupational therapy, physical therapy, nursing, pharmacy, audiology, and deaf education. Washington University in St. Louis, the St. Louis College of Pharmacy, and the Goldfarb School of Nursing at Barnes-Jewish College offer programs such as a week-long immersive didactic and experiential initiative that focuses on health care disparities and their myriad causes, an interactive poverty simulation, an implicit bias workshop, and group discussions focused on providing culturally appropriate care. Educational institutions need to take a closer look into the design and assessment of programs like these to ensure educators are creating the necessary outcomes related to the 4 major tenets of cultural competency: skills, knowledge, attitudes, and awareness.

Future research has the potential to determine best practices for teaching cultural competency and about health disparities. Only when we can pinpoint what works, how, and why, can we inculcate cultural competency as an essential value for health care providers and begin to dismantle health disparities.

Limitations

Our review was limited to English titles and focused on educational practices rather than clinical studies. We only focused on school systems in the United States or Europe. Though it was as comprehensive as possible, our scoping review is likely an incomplete snapshot. Many health professions programs may be implementing cultural competency training without reporting it. Additionally, the programs that reported about their efforts may have since modified their approaches.

Conclusions

A wealth of examples in the area of cultural competency and health disparities education training for health professions exist. These varied interventions are acknowledged as important and provide critical opportunities for students to learn, empathize, and reflect. For the field to progress in supporting a culturally diverse patient population, however, comprehensive training of trainers,

longitudinal evaluations of interventions, and the identification and establishment of best practices will be imperative.

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Teaching and Learning Moments Stranded at the Intersection



"I buy a pack on Sundays and we eat one every night."

My patient, a 63-year-old woman seeking treatment for diabetes and hypertension, sat across from me shifting in her seat. She looked down at her hands and waited.

Five minutes before, we had reviewed her blood pressure readings from the past few clinics. Today it was 165/100. We had discussed whether or not she was taking her medications, all 3 of her antihypertensives, as prescribed. She was, she told me, taking them all. We had started talking about her fingersticks, given that her A1c was elevated at 9.8%. I had asked her what she had eaten for dinner the night before and she had responded, "Hot dogs." I asked, "Why hot dogs?" and she looked at me and said, "Well, my grandson lives with me and he likes hot dogs. It's what I can afford, and he likes it, so on Sundays I buy a pack and we each eat one every night until they are gone."

She paused just for a moment before saying almost to herself, "It's what I can afford." Then she waited, looking at her hands nervously.

In that moment, I saw all my years of education, training, certifications, and exams. My diplomas on the wall. My congratulatory letters for passing my

internal medicine and then my endocrine boards. They meant nothing then because I had no response that would help my patient. After 9 years of training, and now 2 years into professional life, all I knew how to do was change her medications. But I realized it wasn't the best thing to do.

That seminal moment forever changed my understanding of what it meant to be an educated physician. The curricula at medical schools continue to change, but there remain some persistent holes and silos of information that never connect, often to our patients' detriment. For decades medical education has lagged in providing nutrition instruction for students; I was one of many trainees who was not taught this critical information. The topic of the social determinants of health has now made its way into many a medical school curriculum but most often in the form of singular lectures or seminars scattered among the years of training. My own medical school education had included topics such as poverty, literacy, and domestic violence. However, they seemed like islands by themselves, and on the wards the task of addressing pertinent social issues was quickly handed off to the social worker assigned to our floor.

The intersection of nutrition and the social determinants is where my patient stood all those years ago, and I had no

compass to direct me on how best to help her. I did not know what food insecurity was or how it affected my patient. I had no knowledge of the resources in my community that could have provided assistance. I didn't know how to guide her to better food choices when she had limited resources. In this patient, I saw that I was unable as a mature provider to address all of her needs through simply identifying and discussing them. I could change her medications, or add more, but I could not address what was wrong.

In the years since, I have sought to fill my own holes in knowledge and taught my students how to bridge those gaps in patient care so they are better prepared than I was at the end of training. I encourage robust appreciation for and connection with community agencies that address people's nonmedical needs, such as food insecurity and domestic violence. Today I am as prepared to recommend healthy food options on a budget as I am to add another antihypertensive. That intersection of addressing medical and nonmedical needs is always my target now that I have a compass of my own.

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