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A critical review of cultural competence frameworks and models in medical and health professional education: A meta-ethnographic synthesis: BEME Guide No. 79

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ABSTRACT

Background: Cultural competence resides at the core of undergraduate and postgraduate medical and health professional education. The evolution of studies on cultural competence has resulted in the existence of multiple theoretical frameworks and models, each emphasising certain elements of culturally appropriate care, but generally lacking in providing a coherent and systematic approach to teaching this subject.

Methods: Following a meta-ethnographic approach, a systematic search of five databases was undertaken to identify relevant articles published between 1990 and 2022. After citation searching and abstract and full article screening, a consensus was reached on 59 articles for final inclusion. Key constructs and concepts of cultural competence were synthesised and presented as themes, using the lens of critical theory.

Results: Three key themes were identified: competences; roles and identities; structural competency. Actionable concepts and themes were incorporated into a new transformative ACT cultural model that consists of three key domains: activate consciousness, connect relations, and transform to true cultural care.

Conclusion: This critical review provides an up-to-date synthesis of studies that conceptualise cultural competence frameworks and models in international medical and healthcare settings. The ACT cultural model provides a set of guiding principles for culturally appropriate care, to support high-quality educational interventions.

KEYWORDS
Cultural competence; model; framework; medicine; healthcare

Introduction

The provision of culturally appropriate care resides at the core of medical and health professional education, with a multitude of policies demonstrating an expectation that healthcare professionals can work effectively with an increasingly diverse population (e.g. General Medical Council 2009; Department of Health 2012; Singapore Medical Council 2014; Association of American Medical Colleges 2019). Regulatory bodies stipulate that medical and healthcare graduates are required to provide culturally sensitive and appropriate care. This is evidenced in guidelines and/or outcomes published by, for example, the Liaison Council on Medical Education in the United States, the General Medical Council in the United Kingdom, the Australian Health Practitioner Regulation Agency, the Association of Faculties of Medicine in Canada and Singapore Medical Council in Singapore. An international study (Dogra et al. 2010) found that medical and healthcare educational institutions aiming to meet the above outcomes are seen to have varying degrees of teaching, resulting in a patchy and mixed picture internationally. The situation remains the same since this study (George 2015; Dogra et al. 2016).

Practice points

- Cultural competence training should include meta-cognitive skills which help students to learn that cultural knowledge is a dynamic entity.
- Curricula should be co-created with all stakeholders who contribute to different aspects of students' development.
- Longitudinal cultural curricula are more sustainable compared to standalone teaching to develop students' lifelong commitment.

Cultural competence theoretical frameworks and models

Cultural competence education has been informed by an assortment of theorisations on what constitutes cultural competence. As a subject, it was initially proposed as a strategy for eliminating racial/ethnic healthcare inequalities, with recent definitions more expansive in addressing the healthcare needs of socially marginalised and disadvantaged cultural groups. It has dual emphases, culture and competence, so its definitions vary depending on which

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component is in focus (Shen 2015). Among several definitions, the most commonly cited is *"a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations"* (Cross 1989, p.2).

The evolution of cultural studies in medicine and healthcare has resulted in the existence of multiple theoretical frameworks and models, each emphasising certain elements of culturally appropriate care, but generally lacking in providing a coherent and systematic approach to teaching this subject (George et al. 2019). Since its introduction in the 1980s, a range of cultural frameworks and models have flourished, and the conceptualisation of the subject has evolved through several phases from a reductionist approach focusing on cultural knowledge, towards a more dynamic approach underpinned by critical social theory (Kumagai and Lypson 2009; Dogra et al. 2016). Traditionally, cultural frameworks and models emphasised the importance of developing cultural knowledge or "cultural expertise" as a way of becoming proficient in serving culturally diverse populations. These notions of cultural competence were reflected in definitions of culture which favoured group-based distinctions, categorising sets of individuals based on factors such as religion, race or ethnicity (Bhui et al. 2012). Over the years, cultural competence models have increasingly attracted negative criticisms concerning the underpinning assumptions that healthcare professionals can learn or know enough about other cultural groups and develop a full understanding of cultures different from their own. Criticisms were made of the inherent disregard for the complexity of culture and the assumption that one could become culturally competent by simply acquiring general facts about certain cultural groups (Kai et al. 2007). Consequently, alternative terms were used to challenge the limitations of conventional behavioural-based cultural competence, such as cultural care (Rosenbaum 1990), cultural sensibility (Dogra 2003), cross-cultural efficacy (Núñez 2000), cultural safety (Fraser et al. 2018), cultural humility (Foronda 2020), and critical consciousness (Kumagai and Lypson 2009).

Recent research on cultural competence demonstrates a theoretical progression away from knowledge-based models to process-oriented models, where understanding one-self takes precedence over gaining knowledge and expertise about others (Bintley and George 2020). Therefore, in this study, we use cultural competence as an umbrella term for its merit of emphasising healthcare professionals' ability to deliver optimal care and make cultural changes. The more recent publications have also incorporated the principles embedded in other cultural terms as mentioned above, covering the requirements at interpersonal, institutional and systemic levels.

Limitations of existing systematic reviews

Our initial search identified an absence of systematic reviews that specifically synthesise cultural competence conceptualisation. Existing reviews mainly focus on studies of educational/training interventions, most of which use one or several published frameworks/models as a guiding structure for their interventions. This is evidenced in Alizadeh and Chavan's (2016) systematic review that explores cultural competence dimensions and learning outcomes. While this review identifies descriptive lists of cultural competence models relating to specific outcomes, it is limited in elaborating on the distinctions between models, the meanings of desired attributes and the interconnectivity across different dimensions. George (2015, p.110) conducted a critical interpretive review of cultural competence training in UK healthcare settings and similarly provides only a descriptive list of interventions and concludes that the education is "*under-developed, under-theorised and piecemeal in nature*". Other recent reviews have similarly tended to focus on synthesising interventions to improve cultural competence (Truong et al. 2014) or evaluative/outcome measures used to determine the effectiveness of teaching (Anderson et al. 2003; Bhui et al. 2007; Kumaş-Tan et al. 2007; Renzaho et al. 2013; Shen 2015).

Various theoretical frameworks to achieve cultural competence have been applied in medical and healthcare education, but the literature infrequently refers to a clear theoretical position. The reviews highlighted above, illustrate the limited clarity and rigour in identifying a sound theoretical framework to guide education. Different educational philosophies and theoretical frameworks view culture differently, leading to educational programmes with differing intentions (Dogra et al. 2016).

Societal and political influences on cultural competence

Cultural competence education is laden with issues of sensitivity, notions of "political correctness" and entrenched in historical contexts around healthcare inequalities and social justice. For a long time, it has been seen as a separated part of the healthcare curriculum, as opposed to being embedded within all aspects of patient care (George 2015; Dogra et al. 2016; Hudelson et al. 2016; Hordijk et al. 2019). Studies report that medical and healthcare educators feel ill-equipped and poorly prepared to facilitate discussions on social and diversity issues that commonly provoke discomfort and resistance (Abrams and Gibson 2007; Stith-Williams and Haynes 2007). The passing of the Equality Act (2010) in the UK, for instance, generated immediate responses from regulatory bodies of health schools in the country, which subsequently fuelled the theoretical and educational development of cultural competence as a curriculum subject in its own right. The Black Lives Matter movement and the COVID-19 pandemic have foregrounded the long-standing inequality in society and healthcare, making the provision of culturally appropriate care more necessary than at any other time (Liu et al. 2022).

In this context, training has been shifting from conventionally reductionist learning of static cultural knowledge, towards a more dynamic internalised development. The more recent scholars (Kumagai and Lypson 2009; Almutairi et al. 2015; Halman et al. 2017) align themselves more closely with the transformative approach and critical theory, emphasising that cultural competence development should actively address marginalisation and social injustice. Critical theory focuses on reflective assessment and critique of society and culture to change power structures and society as a whole (Deetz 2005). Applying it to health

inequalities can advance the scholarly exploration of the root causes of health disparities and actively seek solutions. This review was therefore designed with this ideology, which guided us to actively problematise current issues and seek solutions in our data synthesis and conceptualisation.

Methods

As a valuable qualitative synthesis technique, meta-ethnography allows the interpretive properties of primary data to be analysed (Sharma et al. 2015), and reviewers to produce new interpretations that go beyond the findings of individual studies (France et al. 2015). It is also useful for understanding the inter-relationships across studies and considering the contextual and social factors underpinning theoretical frameworks and models (Bearman and Dawson 2013). The seven-phase interpretive meta-ethnographic approach of Noblit and Hare (1988) guided this review (Supplementary Appendix 1). The eMERGe meta-ethnography reporting guidance was followed to report the important aspects of this review. Critical theory was applied to inform the delivery of this review.

Inclusion criteria

A systematic search was conducted for theoretical frameworks and models of cultural competence in medical and healthcare settings. We limited the search results to include only peer-reviewed journal articles published in English (that all reviewers can speak) from 1990 to 2022. Qualitative studies were included if they presented a distinctive conceptualisation of cultural competence in a theoretical framework/model in the context of medicine and healthcare. Literature reviews, descriptive studies, opinion pieces and qualitative components of mixed methods studies were also included if they provided a distinct conceptualisation of cultural competence. The reason for inclusion of literature reviews and opinion pieces is that many of these articles were written by scholars who developed influential cultural competence models in the past. Important discussions were elicited from these articles although they did not contain primary data collection.

Search strategy and study inclusion

Five databases were used to conduct the search: 1) Web of Science (core collection); 2) Medline; 3) CINAHL; 4) PsycINFO (APA); 5) ERIC. Following a pilot scoping search using three of the selected databases (Medline, CINHAL, and Web of Science), the search strategy was refined iteratively. It was augmented through reference chaining, consultation with experts and key-terms checking listed within relevant studies.

The final search strategy encompassed three key concepts: (a) cultural competence/diversity, (b) health/healthcare, and (c) theoretical frameworks/models (Supplementary Appendix 2). Concepts (a) and (b) were searched in study abstracts but Concept (c) was only searched in study titles. The reason for this was that searching for frameworks/models in abstracts generated a large number of irrelevant studies. The authors performed citation searching of the included articles to minimise potential bias due to only searching Concept (c) in titles. It was also found, by trialling our search strategy, that the search strategy was appropriate.

The search terms were customised according to the requirements of each database (Supplementary Appendix 3). The search was initially carried out in 2020 and updated in 2022, with the final search covering publications from 1st January 1990 to 30th September 2022. EndNote X9.3.3 and the systematic review software "Rayyan QCRI" (rayyan.qcri.org/welcome) were adopted to facilitate the screening process. A calibration exercise, performed by the whole research team, ensured consistency and clarity when screening papers. The resulting citations were divided between the research team and each publication was screened by at least two review members in all stages of review. Disagreements were collaboratively discussed until consensus was reached and reasons for inclusion/exclusion documented.

Appraisal of studies

The quality of the included articles was assessed using the CASP criterion, which includes criteria about the aims of the study, suitability of the methodology, design, and methods of data analysis (CASP 2014). The nature of meta-ethnography allows the researchers to draw on a range of publications that are relevant to the review aims and can inform the new theorisation of cultural competence. The CASP checklists were adapted for quality assessment of each type of included study and the feasibility of using the adapted CASP checklists (Supplementary Appendix 4) was tested. Each article was appraised by KM and another review member independently and disagreements were resolved through discussion with team members. This quality assessment is not used as an inclusion/exclusion criterion. Although previous research points out that opinion papers and low-quality empirical studies usually add less weight to the synthesis (Dixon-Woods et al. 2007), this review incorporated important discussions elicited from these articles, many of which were written by scholars who developed influential cultural competence models in the past.

Data extraction and synthesis

Before commencing data analysis, the authors randomly selected 10 articles using a random number generator to explore how to best extract and synthesise the data. Pilot coding of the 10 articles was carried out using NVivo 1.6.1 software. A data extraction table was developed using an Excel spreadsheet. Revisions were made and agreement was achieved in discussion with the team members.

Identifying recurring concepts

The 59 included articles were listed alphabetically by KM and then divided between the six team members. Each member repeatedly read their share of 9 or 10 articles. The iterative reading allowed us to identify the recurring concepts in each article. NVivo software was used and collaboratively a coding tree was developed. When developing

the coding tree, we undertook a critical approach by focusing more on the concepts that were about reflection and critique of society and actionable changes. Each author coded the cultural competence components from their share of articles within NVivo in an inductive process and codes were added or collapsed as required. All new concepts were sought, and both confirming and refuting points were coded. These concepts led to the identification of first-order (participants' interpretations in their own words) and second-order constructs (original authors' interpretations based on first-order constructs). During this stage, we combined first- and second-order constructs since not all articles presented original data (e.g. quotes from interview participants). Even for studies that did contain such data, some of the datasets were incomplete and were presented as an integral part of the authors' interpretations.

Determining how studies are related

Noblit and Hare (1988) recommended creating "a list of key metaphors, phrases, ideas and/or concepts used in each account, and to juxtapose them" (p.28) in order to conceptualise how the extracted studies may relate to each other. In this stage, we tabulated an Excel document to conduct further analysis of each study. Detailed information was extracted from each article including the publication year, author names, discipline, type of study, sample/data collection method (if relevant), and name/aim of each model. This information assisted the authors to explore the interrelations among different studies in terms of the conceptualisations of cultural competence, the study contexts and disciplines. Diagrammatic presentations of models were analysed separately by two authors (RG and SL) to explore the interrelations of competence components within and across different models.

Reciprocal translation of studies

As a key component of a meta-ethnographic synthesis, the concepts or codes in each study and their interactions were continuously and systematically compared or translated within and across accounts. To conduct this level of synthesis, three authors (SL, JL and KM) reviewed all codes using a shared NVivo file and compared the concepts/codes in one article with that in others. We approached the reciprocal translation following a chronological order, by comparing an earlier study with the most adjacent later publication, and so on. In this process, we examined the similarities or discrepancies of concepts or codes across studies in relation to a range of contextual factors such as their geographic location, year of study, and healthcare discipline. We also noted participant demographic factors (if available), such as participant gender, ethnicity and socio-economic status, and considered the influence of these on the translation. We synthesised both first- and second-order constructs collectively and presented these as themes and subthemes (see Table 2). The definitions of each theme and subtheme are our synthesised results.

Synthesising translation

The data synthesis proceeded through several iterations of conceptualisation to develop overarching review author (third-order) constructs and a final line of argument synthesis. According to critical theory, contemporary ideology constrains certain social groups from fully accessing social resources and, therefore, leads to marginalisation (Fay 1987). Social researchers should not be satisfied with just describing observable social phenomena, or iterative understanding of the literature (Madison 2011). Instead, they should use their expertise to advocate for the marginalised by transforming existing social constructs and empowering human beings. Adopting critical theory allowed us to organise the recurring concepts into further conceptual categories, which resulted in the development of higher third-order constructs. We presented our third-order constructs as actionable themes/subthemes and a transformative cultural model was generated (see Table 3 and Figure 2). Regular team meetings facilitated discussion of conceptualisations and presentation of the results.

Cross-checking was applied throughout the data extraction and synthesis. At least two team members checked the coding and analysis of any paper. Any discrepancy in decision making was discussed until agreement was achieved. JL, KM and SL held meetings on a regular basis to discuss the identification and synthesis of the three orders of constructs and the presentation of themes. All authors discussed the synthesis in a series of face-to-face/-online group meetings and agree with the results.

Applying critical theory

Critical theory informed our data extraction, data synthesis and model development, during which we bore in mind two questions: 1) what are the social problems and 2) what may be the solutions. When identifying key concepts, we focused on the concepts that are about the critique of society with indications for cultural and social transformation. This has influenced the development of our coding tree and subsequent theme development. Critical theory particularly informed the development of our third-order constructs, which we presented as actionable themes. The results section was structured to foreground the problems and our conceptualisation was oriented toward resolving these problems.

Results

Overview of studies included in the review

A total of 1,364 publications were generated after searching in the five databases. The results were exported to EndNote and deduplication occurred. Title and abstract screening resulted in 250 papers for full-text review. After full-text review, 57 papers were agreed as suitable for inclusion. The search was updated in all five databases from 1st January 2021 to 30th September 2022 with the identification of 2 further articles. This led to a total of 59 articles for final inclusion (Figure 1).

The 59 articles were published between 1990 and 2022. The studies were conducted in North America (30), global/-mixed countries (11), Europe (9), Asia (7) and Australia (2).

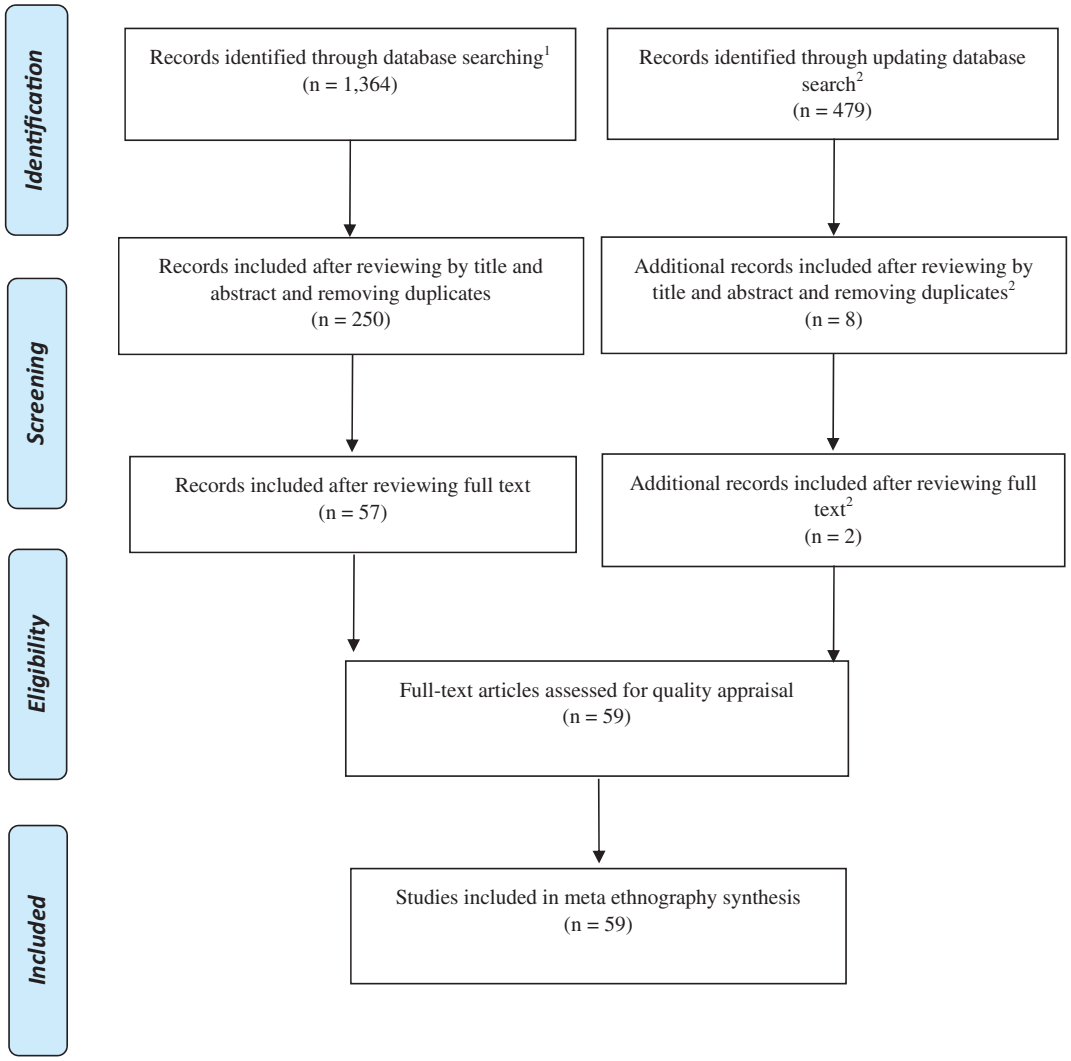

Figure 1. PRISMA flow diagram for the study selection process. [1]The initial search had two stages of search. The first search was conducted between 1 Jan 1990 to 31 Dec 2020 in WoS (core collection) ($n = 726$), Medline (within WoS search engine) ($n = 158$) and CINHAL ($n = 129$). When searching Medline, duplicates within the WoS (core collection) were excluded. The second search was conducted between 1 Jan 1990 and 31 Dec 2020 in PsycINFO ($n = 305$) and ERIC ($n = 46$). [2]The search was updated from 1 Jan 2021–30 Sept 2022 in WoS (core collection) ($n = 166$), Medline ($n = 138$), CINHAL ($n = 5$), PsycINFO ($n = 168$) and ERIC ($n = 2$).

The two main disciplines in the included articles were general healthcare (23) and nursing (20), followed by mental health/psychiatry (7), public health (3), education (2), midwifery (1), occupational therapy (1), paediatrics (1), and rehabilitation (1). Seventeen articles were qualitative research, and other types of articles included were opinion pieces (21), literature/systematic reviews (12), qualitative aspects of mixed methods studies (4), cohort studies (3) and theoretical studies (2). All articles presented conceptualisations, theories or models of cultural competence. Underlying theoretical perspectives were made explicit in sixteen articles and briefly mentioned in another three articles. The method of data analysis was described in twenty-one articles and was most commonly content or thematic analysis. The characteristics of included studies are shown in Table 1.

Description of themes

Combining the first- and second-order constructs allowed us to generate three primary themes and 38 secondary themes (Table 2). These themes were based on the two orders of constructs but were further synthesised. The definitions of each theme are the result of our synthesis taking into account the original authors' interpretations. The first primary theme, *competences*, discerns the categorical competences that can be developed as part of cultural competence education for medical and healthcare professionals. The granular level actionable competences are further defined in the 17 secondary themes. The second primary theme, *roles and identities*, correlates with the competences, although not strictly. Professional roles and identities are being formed as a result of relevant competences that are gradually developed, sustained and internalised. There are 11 roles and identities that emerged from the reviewed literature. The last primary theme is *structural competency*, which deals with systemic discrimination and restrictions for marginalised and vulnerable communities through the means of socially, historically and culturally constructed norms, systems and policies. Structural competency goes beyond individual and interpersonal development but acknowledges the power of culturally competent individuals in transforming the restricting status quo in society.

Guided by critical theory, we further synthesised and developed the themes and sub-themes presented in Table 2 to give third-order constructs (Table 3). These third-order constructs are actionable themes and subthemes reflecting our interpretations and synthesis using the lens of critical theory. Through the lens of critical theory, the review reveals

Table 1. Summary of study characteristics.Thompson-Robinson et al. (2006) Orr and Unger (2020)

No.	Author (Year)	Context	Discipline	Type of Study	Sample	Data Collection Method	Name of model	Aim of model
1	Airhihenbuwa (1990)	Developing countries	Health Education	Opinion	n/a	n/a	PEN-3 Model	To help health education programs in developing countries to be culturally sensitive and appropriate
2	Bernal (1993)	USA	Nursing	Opinion	n/a	n/a	The Culturally Relevant Community Practice Model	To provide direction for the development of a system that will promote culturally relevant care in community health agencies
3	Campinha-Bacote (1999)	USA	Healthcare	Opinion	n/a	n/a	A model and Instrument for Addressing Cultural Competence in Health Care	To concretely guide nursing actions
4	Brach and Fraser (2000)	USA	Healthcare	Systematic review	n/a	Literature search	Conceptual model 9 cultural competency techniques	To reduce health disparities
5	Purnell (2000)	USA & global	Healthcare	Opinion	n/a	n/a	Purnell Model for Cultural Competence	To provide an organising framework for nurses to use as a cultural assessment tool
6	Kim-Godwin et al. (2001)	USA	Nursing	Mixed methods	13	Literature search, interviews, questionnaire	Culturally Competent Community Care (CCCC)	To predict public health outcomes of culturally competent health care in communities
7	Campinha-Bacote (2002)	USA	Healthcare	Opinion	n/a	n/a	Campinha-Bacote's Model of Process of Cultural Competence in the delivery of healthcare services	To help healthcare providers to develop and implement culturally responsive health care services
8	Leininger (2002)	USA	Nursing	Opinion	n/a	n/a	The Sunrise Model	To discover and explain diverse and universal culturally based care factors influencing the health, well-being, illness, or death of individuals or groups
9	Betancourt et al. (2003)	USA	Healthcare	Systematic review	n/a	Literature search	Framework for Cultural Competence	To eliminate racial/ethnic disparities in health and health care
10	Hart et al. (2003)	UK	Midwifery	Mixed methods	Not specified	Questionnaire, focus groups, interviews	Inequalities Imagination Model	To incorporate issues of individual and structural agency and a broader definition of disadvantage to develop an 'inequalities imagination'
11	Vaught (2003)	USA	Healthcare	Theoretical	n/a	n/a	A Pragmatic Model for Multicultural Education	To provide moral justification for cross-cultural normative claims in healthcare

(*continued*)

Table 1. Continued.

No.	Author (Year)	Context	Discipline	Type of Study	Sample	Data Collection Method	Name of model	Aim of model
12	Giddings (2005)	New Zealand /USA	Nursing	Qualitative	26	Semi-structured interviews	The Model of Social Consciousness	To provide a theoretical framework for understanding how people position themselves in relation to social injustice and social action
13	Gustafson (2005)	Canada	Nursing	Opinion	n/a	n/a	Transcultural Nursing Theory	To focus attention on the concept of culture, the goal of providing culturally competent care and the processes to achieve that outcome
14	Mahoney et al. (2006)	USA	Psychiatry/ Mental health nursing	Opinion	n/a	n/a	A Framework for Cultural Competence in Advance Psychiatric Nursing Practice	To provide a framework for teaching about cultural competence that includes both content and process
15	USA & global	Public health	Qualitative	13	Literature search, expert panel reviews	Conceptual Framework for the Provision of Culturally Competent Services in Public Health Settings	To conceptualise culturally competent services in public health settings	
16	Willis and Porche (2006)	USA	Nursing	Opinion	n/a	n/a	Marginality-Cultural Competence Integrative Framework (M-CCIF)	To help clinicians and scholars to envision and advance culturally competence scholarship related to marginalized men's health disparities
17	Conviser and Pounds (2007)	USA	Healthcare	Opinion	n/a	n/a	The Care System Assessment Model	To assess care systems and their components and to identify features of care systems that contribute barriers to care access
18	Schim et al. (2007)	USA & global	Healthcare	Opinion	n/a	n/a	3-D Puzzle Model	To provide culturally congruent care
19	Wikberg and Eriksson (2008)	Finland	Nursing	Literature Review	n/a	Literature search	Model for Intercultural Caring	To help nurses understand complexity of intercultural caring and develop cultural competence
20	Gamst et al. (2009)	USA	Mental health care	Cohort	1153	Self-report questionnaires	Multicultural Assessment Intervention Process Model	To systematically embed cultural issues in mental health service delivery
21	Hernandez et al. (2009)	USA	Mental health care	Systematic review	n/a	Literature search	No name given for model	To give a measurable approach to the pursuit of cultural competence in mental healthcare
22	Seeleman et al. (2009)	Netherlands	Healthcare	Opinion	n/a	n/a	Framework of Cultural Competencies	To provide practical translation of learning objectives into competencies
23	Teal and Street (2009)	USA & global	Healthcare	Opinion	n/a	n/a	Culturally Competent Communication Model	To provide culturally competent patient care

(*continued*)

Table 1. Continued.

No.	Author (Year)	Context	Discipline	Type of Study	Sample	Data Collection Method	Name of model	Aim of model
								with models of effective patient-centred communication
24	Westerholm (2009)	USA	Nursing	Opinion	n/a	n/a	Cultural Learning Model	To help nurses learn how to be with others in a way that enhances and changes their understanding of others and themselves
25	Gertner et al. (2010)	USA	Healthcare	Qualitative: Case study	2 hospitals	Case report of tertiary care hospitals ($n = 2$), community health provision, physician group (400 members) and health network (1100 members)	Conceptual Cultural Competence Model for Mental Health Services	To support organisational change and promote high-quality, safe, and equitable care through culturally competent care delivery across the entire network
26	Janzen et al. (2010)	Canada	Mental health care	Mixed methods	328	Literature search, interviews ($n = 22$), focus groups ($n = 21$), case studies ($n = 10$), questionnaire ($n = 111$)	The Emerging Framework	To guide future mental health policy and practice
27	Castillo and Guo (2011)	USA	Healthcare	Opinion	n/a	n/a	Framework for Cultural Competence in Health Care Organizations	To help health care organisations integrate strategies for cultural competence in every area of the organization
28	Tirodkar et al. (2011)	USA	Healthcare	Qualitative	75	Semi-structured interviews	Explanatory Models of Health and Disease Among South Asian Immigrants in Chicago	To identify concepts of health and disease as part of a study on designing culturally-targeted heart disease prevention messages for South Asians
29	Durey et al. (2012)	Australia	Nursing	Systematic review	n/a	Literature search	Model of Organisational Change	To increase Aboriginal participation in health workforce, build capacity in non-Aboriginal health professionals to deliver quality care and facilitate collaboration between Aboriginal and non-Aboriginal people
30	Koskinen et al. (2012)	Europe	Nursing	Opinion	n/a	n/a	Framework for a European Curriculum in Cultural Care	To nurture educational development and networking among member institutions
31	Hammell (2013)	Canada	Occupational therapy	Opinion	n/a	n/a	The Canadian Model of Occupational Performance and Engagement	To depict individuals embedded within physical, institutional, social, and

(*continued*)

Table 1. Continued.

No.	Author (Year)	Context	Discipline	Type of Study	Sample	Data Collection Method	Name of model	Aim of model
								cultural environments that afford occupational possibilities
32	Owiti et al. (2014)	UK	Mental health care	Cohort	94	Evaluation forms and questionnaire	Clinical Consultation Service (CCS) Model	To promote cultural competence of clinicians and directly improve patient experiences and outcomes
33	Soulé (2014)	Global	Healthcare	Qualitative	20	Interviews	Refined Cultural Competency themes and domains	Provide a new theoretical framework based on themes that are core to cultural competence
34	Almutairi et al. (2015)	Saudi Arabia	Nursing	Opinion	n/a	n/a	Almutairi's Critical Cultural Competence Model	To provide a model that enables healthcare workers to gain critical awareness, knowledge and skills for cultural competence, and critical knowledge about the fluidity of culture and consideration of power dynamics.
35	Moore et al. (2015)	USA	Pediatric care	Qualitative	15	Semi-structured interviews	Family-Centred Care Model	To provide a frame for family-centred care in the context of children
36	Nastasi et al. (2015)	India	Public health / Medicine	Qualitative	n/a	Participant narratives	Local Narrative Intervention Model	To create an evidence-based reconstructed behavioral change model
37	Nguyen and Baptiste (2015)	Canada	Rehabilitation	Opinion	n/a	n/a	No new model presented, applied Acculturation Theory	To apply acculturation theory to rehabilitation practice to enhance patient-centred care
38	Garneau (2016)	Canada	Nursing	Systematic review	n/a	Literature search	Framework for critical reflection in cultural competence	To help nursing students develop a perspective transformation to be open to different practice realities
39	Lor et al. (2016)	Global	Nursing	Systematic review	n/a	Literature search	Model of Person-, Family-, and Culture-Centred Nursing Care	To encourage nursing orientated patient care
40	Michael (2016)	Australia	Nursing in elderly care	Mixed methods	n/a	Literature search, focus groups, client narratives, questionnaire	The Diversity Conceptual Model for Aged Care	To support the aged care sector by incorporating the consideration of diversity (from ethnicity to LGBT+)
41	Olaussen and Renzaho (2016)	Global	Health care	Systematic review	n/a	Literature search	A Cultural Competence Model for MWD (Migrants with disabilities)	To address disability-related challenges to healthcare inequality targeting migrants
42	Ahn (2017)	South Korea	Nursing	Cohort	275			

(*continued*)

Table 1. Continued.

No.	Author (Year)	Context	Discipline	Type of Study	Sample	Data Collection Method	Name of model	Aim of model
						Self-report questionnaires	Adapted Transcultural Nursing Immersion Experience Model	To explain the relationship between cultural competence and influencing factors
43	Carnegie et al. (2017)	Scotland	Healthcare	Qualitative	40	Focus groups ($n = 7$), paired interviews ($n = 4$)	Cross-cultural Community Engagement Model	To help practitioners and policymakers raise the profile of HPV across diverse communities
44	Dijkman et al. (2017)	Europe	Healthcare	Qualitative	96	Literature search, interviews, Delphi technique	Competence Framework	To describe the outcomes professionals working with older people are expected to achieve and be able to demonstrate
45	Peterson et al. (2017)	USA	Mental health care	Systematic review	n/a	Literature search	1. Ecological Validity Model; 2. Cultural Adaptation Process Model; 3. Psychotherapy Adaptation and Modification Framework	1. To best serve the needs of Hispanic clients; 2. To guide the cultural adaptation of interventions; 3. To adapt treatments to cultural and linguistically diverse populations
46	Wesp et al. (2018)	USA & global	Nursing	Theoretical	n/a	n/a	An Emancipatory Approach to Cultural Competency	To uphold the nursing value of commitment to social justice
47	Andrews and Boyle (2019)	USA	Nursing	Opinion	n/a	n/a	The Andrews/Boyle Transcultural Interprofessional Practice (TIP) Model	To provide a systematic, logical, orderly, scientific process for delivering safe, culturally congruent and culturally competent care; facilitate delivery of nursing that is consistent with cultural backgrounds of people
48	Di Stefano et al. (2019)	Italy	Healthcare	Systematic review	n/a	Literature search	The Client-orientated Model of Cultural Competence	To link managing cultural diversity with cultural competence in health organisations within the framework of client orientation
49	Handtke et al. (2019)	Germany	Healthcare	Systematic review	n/a	Literature search	Model of Culturally Competent Healthcare Provision	To help design interventions
50	Foronda (2020)	USA	Nursing	Systematic review	n/a	Literature search	Theory of Cultural Humility - Rainbow Model of Cultural Humility	To guide individuals for the practice of cultural humility - key concepts, context, inter-relationships, influences and outcomes
51	López et al. (2020)	USA	Psychiatry	Qualitative	16	Video observation of consultations ($n = 35$)	The Shifting Cultural Lenses Model	To operationalise culturally competent in-session behaviors
52	Ojo et al. (2020)		Nursing	Qualitative	181	Focus group ($n = 23$)	Cultural Analytical Framework	

(*continued*)

Table 1. Continued.

No.	Author (Year)	Context	Discipline	Type of Study	Sample	Data Collection Method	Name of model	Aim of model
		England, Slovenia, the Philippines, New Zealand						To understand student nurses' cultural values and beliefs of dementia
53	Israel	Nursing	Opinion	n/a	n/a	TOLERance Model	To promote structural competency in nursing	
54	Shattuck et al. (2020)	USA	Education	Qualitative	187	Interviews ($n = 75$), focus groups ($n = 32$)	No new model presented but applied the Structural Competency Framework	To leverage structural competency within school health initiatives that can address the vulnerabilities of sexual and gender minority youth (SGMY)
55	Travers et al. (2020)	USA	Healthcare	Qualitative	464	Structured interviews with the administration of a survey	Adaptation of the Anderson's Expanded Behavioral Model of health services use to include older adults receiving long-term services and supports	To understand both the relevancy of factors for older adults who currently use LTSS (Long Term Services and Supports) vs. those who intend to use LTSS (as described in Andersen's original exploration)
56	Yang et al. (2020)	Taiwan	Healthcare	Qualitative: Case study	1 hospital	Literature search, hospital case report ($n = 1$), interviews	Cultural Sensitivity Cultivation Model	To provide a conceptual framework to help improve service quality and experience for international patients
57	Zahiruddin et al. (2020)	India	Public health	Qualitative	44	Curriculum scan, literature search, focus groups ($n = 6$)	Framework for cultural competencies for Masters of Public Health programs in India	To promote the inclusion of cultural competencies in MPH curricula to achieve more equitable public health practice
58	Broughten et al. (2021)	USA	Healthcare	Qualitative	11	Steering committee	Framework for Interprofessional Colleaborative Practice, Cultural Fluency and Ecological Approaches to Health	To provide core competences to increase students' interprofessional practice, cultural fluency and ecological approaches to health, in order to reduce health disparities
59	Wang et al. (2022)	Taiwan	Healthcare	Qualitative	25	Semi-structured interviews	Socio-ecological Model of Factors affecting Culturally Competent Care	To categorise factors associated with healthcare providers' behaviour and intention to offer culturally competent care to Taiwanese sexual and gender minority older adults

Table 2. Themes and Subthemes Synthesised from First and Second Order Constructs.

Themes	Subthemes	Description
Competences		**The actionable cultural competences that can be developed by medical and healthcare professionals**
	Adaptation to diversity	Provide a safe environment for patients to discuss their cultural health beliefs and practices; Address the needs of diverse patients through its commitment to serving diverse patients
	Advocacy	Advocate for health with and on behalf of marginalised patients
	Attitudes	Demonstrate openness, respect, non-judgemental and non-egoistic attitudes toward cultural differences
	Awareness	Develop awareness of different cultural backgrounds, diversity and potential biases/assumptions
	Capacity building and empowerment	Recognise and minimise power differences between patients and clinicians; develop individualised care not only for the other but also for the self, have flexibility, make bias explicit, and make cultural competence development an ongoing process
	Collaboration	Have multi- and inter-professional cooperation and community outreach for public health practitioners; Collaborate with all stakeholders, including policymakers, health organisational managers, specialists, communities, patients, family and important others, as well as researchers
	Compassion	Demonstrate compassion for the disadvantaged/vulnerable groups, leading towards commitment to advocacy actions
	Critical thinking	Think beyond individual care (to a much more analytic and creative approach that recognises both the structural and individual factors that determine and define needs in contemporary society)
	Cultural formulation and application skills	Formulate a comprehensive understanding of patients' culturally laden illness experiences and help-seeking behaviours to allow for a broader assessment of patients and adaptations
	Engagement	Possess the motivation to engage in the process of developing cultural competence by thinking and acting creatively in reducing healthcare inequalities
	Knowledge application	Assess and respond to cultural problems, and potentially plan/develop interventions based on existing cultural knowledge and knowledge of methodology for assessment and interventions
	Organisation and leadership	Build an inclusive environment with a diverse workforce that is representative of its patient population; Aspire to take leadership in addressing cultural barriers both with patients and within the healthcare team
	Professional commitments	Show commitments to ethics, actions for change, lifelong learning, and constant self-evaluation
	Scholarship	Conduct research and analytic activities that advance the relevant knowledge base about culturally competent care, and expand professional expertise in terms of clinicians' own professional practice for innovating care and support
	Self-assessment and reflection	Reflect on past events with the intent of identifying opportunities for future improvement and learning and transforming one's frame of reference
	Sensitivity	Be sensitive to differences in patient experiences/responses and social justice issues for vulnerable groups; Have the desire and spend efforts to develop programs and services that respect the cultural diversity of populations
	Skills	Possess skills such as rapport building, relationship building, self-reflection, effective communication, culturally inclusive clinical skills, managing complexity in care, and prioritising social justice
Roles and identities		**Professional roles and identities being formed by medical and healthcare professionals as a result of gradually developing, sustaining and internalising the above-mentioned cultural competences**
	Humble learner	One who is humbled by the cultural knowledge of others, depth of the cultural knowledge system, and who is constantly seeking opportunities to learn cross-culturally
	Advocate	One who advocates for health with and on behalf of marginalised patients
	Collaborator	One who works in collaboration (not exclusively within healthcare) with family members, and community members
	Communicator	One who communicates to establish rapport and trust, formulates a diagnosis and goal interventions, delivers information, strives for mutual understanding, and facilitates a shared plan for treatment
	Expert	One who has the appropriate cultural knowledge and effective methods for cultural assessment and interventions
	Leader	One who elevates the priority of cultural competence, drives systematic efforts and inspires staff support, and applies cultural competence to organisations and systems
	Organiser	One who organises and manages care and services, focusing on integral connectivity, and continuity of care and support for patients of diverse cultural backgrounds
	Professional	One who is guided by professional regulations/laws and committed to the life-long development of cultural competence at all levels
	Reflective practitioner	One who constantly reflects on their cultural encounters and evaluates their own practices for improvement
	Resource allocator	One who ensures sufficient resources are available to foster cultural competence practice
	Scholar	

(*continued*)

Table 2. Continued.

Themes	Subthemes	Description
		One who is a lifelong learner that conducts research and assessments and renews the methods being used
Structural competency		**Competences beyond the individual level concerning the institutional and systemic structure**
	Recruitment & management strategy	Recruit a diverse workforce and establish professional and staff training programs that enhance their cultural competence; Implement strategic and organisational management to ensure health equity
	Formal references in policies	Produce formal statements about organisational values, principles, goals, policies, and visions that can serve as references for the provision of culturally competent care
	Partnership between professionals	Establish connections and network with multidisciplinary team and local community members
	Partnership with community	Collaborate with community partners, such as other public, private, or non-profit organisations that help minority groups
	Physical environment	Build a positive and inclusive work environment for multicultural staff
	Professional development	Dedicate to professional development through activities such as organised/self-directed training, participation in professional organisations, enrolment in training programs, and research
	Research and information gathering	Conduct research activities that improve understanding and practice of the provision of culturally appropriate care
	Structural innovations, interventions, evaluation	Design and create a physical and symbolic multicultural environment that ensures users' open access to services through the elimination of socio-cultural barriers
	Contextual influence	Understand the social context within which the vulnerable and marginalised groups live
	Systematic barriers	Aspire to remove barriers that might be related to beliefs, values, and assumptions of clinicians and patients, professional standards of practice, organisational structures, and national policies

Table 3. Third order constructs/themes.

Third Order Constructs/Themes	Description
Activate consciousness	**The development of individual cultural awareness, acquisition of cultural knowledge and demonstration of cultural sensitivity**
Awareness	Develop cultural awareness at intrapersonal, interpersonal and systemic/organisational levels
Knowledge and sensitivity	Acquire the two-dimensional knowledge that includes both cultural knowledge and critical knowledge; Demonstrate sensitivity to cultural differences and similarities between people without assumptions and judgement
Connect relations	**The connection and collaboration among all stakeholders to achieve culturally competent care provision**
Personal connectivity	Work together with patients, caregivers and their families to make sure the care provision is patient- and family-centred
Community connectivity	Involve and collaborate with community healthcare professionals, healers, and spiritual leaders in carrying out health program planning, implementation, and continuous formal and informal evaluation of the provision of programs
Interprofessional connectivity	Connect with multiple health workers from different professional backgrounds
Transform into true cultural care	**The transformation to culturally appropriate care in healthcare and the development of social justice at the systemic level**
Empowerment strategies	Utilise strategies whereby individual healthcare professionals enact their agency to go beyond merely recognising cultural differences, to also addressing power imbalance operating within the social, historical and political context
Cultural skills	Master good practices in care provision, interaction, communication, decision making, and policy making, as well as essential skills such as cultural consultation and clinical cultural formulation
Professional commitment	Demonstrate commitment to internalise holistic cultural competence as part of their professional identity

the covert expression of the suffering of people who are identified as from the *other* culture. The sufferings systemically prevail across intrapersonal, interpersonal and environmental encounters. To inform clinical education, the authors particularly looked for actionable themes and concepts that can be incorporated into educational development so that trainees can apply them to transformative clinical cultural practice in all types of encounters. As a result, the third-order constructs (Table 3) form a new ACT cultural model (Figure 2), the name of which indicates the transformative nature of this model. A, C and T stand for ***A****ctivate consciousness*, ***C****onnect relations*, and ***T****ransform to true cultural care*.

Activate Consciousness

Most of the authors (e.g. Durey et al. 2012; Hammell 2013) of the reviewed studies propose obtaining knowledge, increasing awareness and heightening sensitivity as the starting point of internal cultural competence development.

Awareness

The *awareness* resides at intrapersonal, interpersonal and organisational/systemic levels. *Intrapersonal awareness* is about the larger sociohistorical background, social position

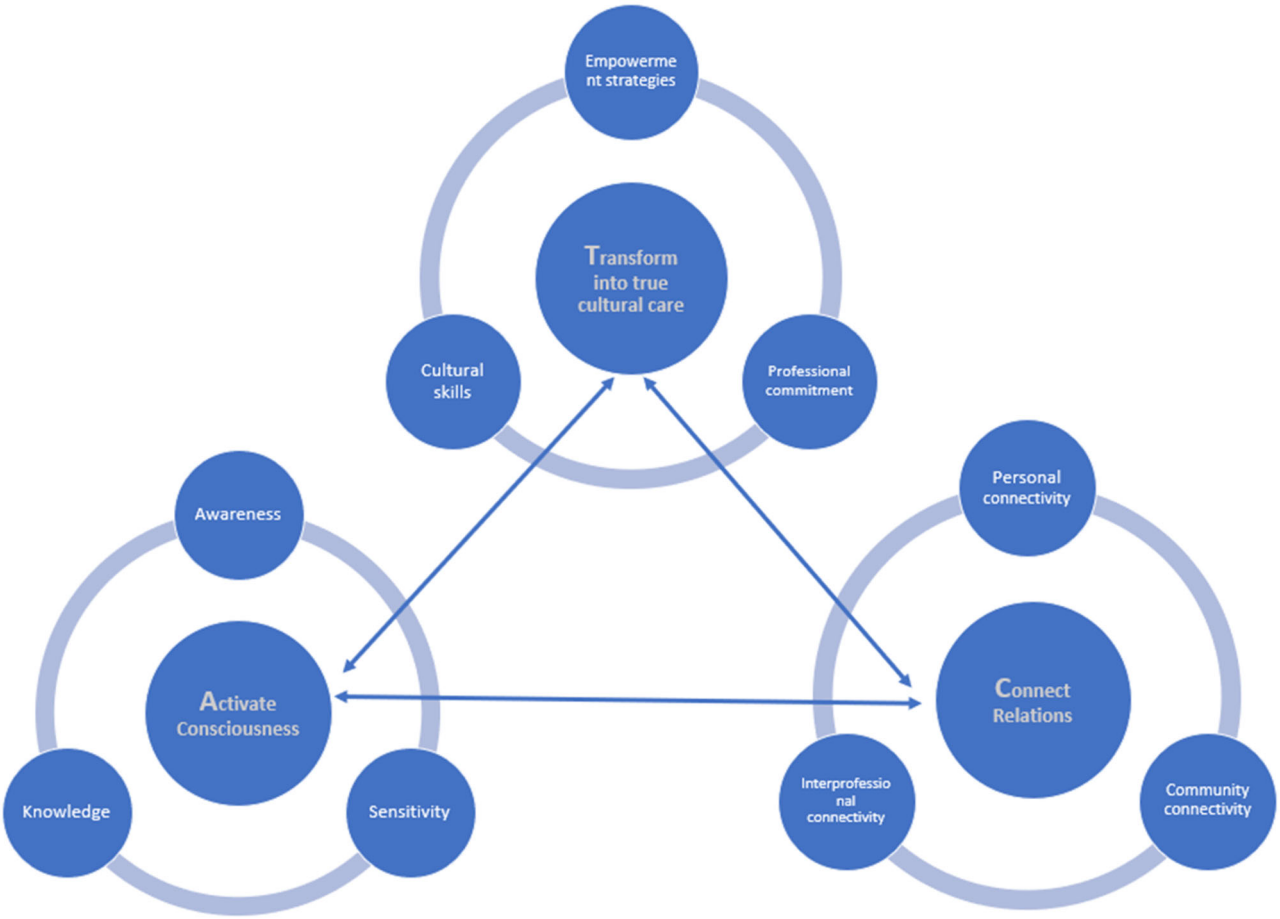

Figure 2. The ACT Cultural Model.

and personal experience in which an individual's attitudes, beliefs, values and biases develop. The starting point is to be aware of one's cultural heritage and present context (Bernal 1993; Schim et al. 2007; Seeleman et al. 2009; Nastasi et al. 2015), while acknowledging the (dis)advantages and different power status that derive from multiple dimensions of one's social position (Willis and Porche 2006; Hammell 2013; Wesp et al. 2018). This contributes to the individual's readiness to learn and act (Bernal 1993).

Intrapersonal awareness is about firstly being aware of contradictions, oppressive relationships and structures within professions and organisations (Giddings 2005), and secondly potential clashes and conflicts of different beliefs, norms and behaviours as a result of cultural diversity (Leininger 2002). A lack of such awareness may lead to *cultural imposition*, where one imposes their values upon others (Campinha-Bacote 2002). This usually leads to disempowerment, vulnerability and inequities among marginalised cultural groups (Koskinen et al. 2012; Almutairi et al. 2015). Intrapersonal awareness is also about self-care and nurturing an attitude towards self that allows one to "let go" of trying to please others from the mainstream cultures and follow the rules they set. Instead, the recommendation is that one should focus on their own needs and those of marginalised groups (Giddings 2005; Wesp et al. 2018).

Awareness at the *interpersonal level* means to be aware of the cultural differences associated with different norms, values, practices, behaviours, religions and languages (Seeleman et al. 2009; Almutairi et al. 2015). Clinically this can be the awareness of the differences in biocultural ecology, high-risk behaviours, nutrition/diet, pregnancy and childbearing practices, death rituals, spirituality (Purnell 2000), as well as disease prevalence, incidence and treatment efficacy in different populations (Brach and Fraser 2000; Campinha-Bacote 2002; Betancourt et al. 2003). Increased awareness can reduce intercultural uncertainty (Ahn 2017) and increase professionals' satisfaction at work (Castillo and Guo 2011).

Systemic/organisational awareness is to be aware of the institutional and social norms and structures that are historically and temporally shaped by a given society. They govern the healthcare system, the constitution of biomedicine, and the culture of healthcare academics (Leininger 2002; Hernandez et al. 2009; Soulé 2014). From a critical theory point of view, these norms and structures naturally deprive certain communities of the equal opportunity to participate in social activities, including accessing healthcare, as a result of power asymmetry caused by social determinants, such as class, racialisation, gender, geographic location and poverty (Clingerman 2011; Almutairi et al. 2015).

Cultural awareness cannot be static. Culturally competent healthcare professionals should be aware of the fluid nature of culture and its dynamic process, and acknowledge the danger of having fixed and rigid views of other cultures, which often results in inappropriate stereotypes and false assumptions (Almutairi et al. 2015). Such awareness can motivate healthcare professionals to seek positive actions to break and transfer the unsatisfactory status quo (Clingerman 2011; Zahiruddin et al. 2020).

Knowledge and sensitivity

Obtaining *knowledge* is a critical means of developing awareness. Soulé (2014) characterises awareness as a continuum of conscious knowledge and discernment of self, others, and systems. The more one knows, the more they are aware of the potential collisions between different cultures and the need for change. In return, the accumulative growth of knowledge can sensitise one's awareness and contribute to their *sensitivity* towards differences and social justice issues for vulnerable groups (Clingerman 2011; Koskinen et al. 2012). *Cultural sensitivity* in a way is a heightened awareness that leads to openness to learning, which will in turn improve knowledge (Kim-Godwin et al. 2001). To acquire knowledge, one needs to have empathy, sensitivity and an appropriate knowledge base (Hart et al. 2003; Koskinen et al. 2012).

The review shows that the lack of knowledge is a barrier to providing competent cultural care (Wang et al. 2022). Knowledge here can be defined into two categories, *cultural knowledge* and *critical knowledge*. *Cultural knowledge* is the understanding of the worldview of others but also of the epidemiological, biological and psychological aspects of colleagues, patients and families (Campinha-Bacote 2002; Hart et al. 2003). It also includes knowledge of the healthcare system, such as understanding the healthcare management systems and available resources to address cultural issues (Betancourt et al. 2003). Static cultural knowledge may be useful to guide healthcare professionals to approach a familiar encounter, but when applied without caution, it can lead to stereotyping of certain cultural groups, which usually impedes good practice (Kim-Godwin et al. 2001; Wesp et al. 2018).

Critical knowledge recognises knowledge as an active process, through which it is constructed and reconstructed over time and space. Prior knowledge is questioned, and new knowledge gets integrated into a dialectical relationship between reflection and action. This process not only renews knowledge but also transforms ways of thinking (Nastasi et al. 2015; Garneau 2016), which pushes the boundaries and limitations of marginalised social groups. Therefore, a culturally competent healthcare professional should be one who can reconceptualise culture and the notion of cultural knowledge, which includes the specific knowledge of communication challenges and knowledge of cultural skills (Almutairi et al. 2015; Ojo et al. 2020).

Connect relations

In addition to activating consciousness, the ACT cultural model denotes that culturally competent care can only be achieved when all stakeholders are connected. Our review reveals three relations to be connected – personal connectivity, community connectivity, and interprofessional connectivity.

Personal connectivity

At the *personal level*, culturally competent healthcare professionals should connect among themselves, with patients and their families to make sure the care provision is patient- and family-centred (Brach and Fraser 2000; Moore et al. 2015; Nastasi et al. 2015; Olaussen and Renzaho 2016; Broughten et al. 2021). Treatment goals should be set taking into account the perspectives of each of the healthcare team, the patient, their family and significant others (Nguyen and Baptiste 2015; Dijkman et al. 2017; López et al. 2020). Family should be not only the immediate nuclear family but also extended kinships (Airhihenbuwa 1990). This is crucial when dealing with long-term conditions and dealing with community health services in general.

Community connectivity

The involvement of community members is critical (Airhihenbuwa 1990). Members should include community healthcare professionals, healers, and spiritual leaders (Carnegie et al. 2017). They can contribute to assessing unmet health needs in the community and be a part of health program planning, implementation, and continuous formal and informal evaluation (Airhihenbuwa 1990; Bernal 1993; Carnegie et al. 2017). Such connectivity empowers the community to help healthcare professionals overcome structural barriers that cause health inequality (Shattuck et al. 2020). The community members also provide support in patient care, which could be preferred by the patients (Carnegie et al. 2017). Close collaboration with the community may make healthcare professionals more aware of different worldviews (Garneau 2016) and increase their empathy and compassion, which may lead to health policy changes (Leininger 2002; Clingerman 2011). However, the caveat is that interacting with just some members of a community group does not make one an expert on this cultural group, nor is it effective for the development of cultural competence (Campinha-Bacote 2002). Instead, it may lead to false confidence, which should be avoided.

Achieving such connectivity requires skilled negotiation (Teal and Street 2009) and reciprocal collaboration, which seeks to establish *relational synergy*; that is to seek "new, mutually respectful and beneficial connections" between the community and the health system (Rich et al. 2010, p. 59). Cultural consultants, who have established relationships with healthcare professionals, can be identified from the community (Owiti et al. 2014).

Interprofessional connectivity

The *interprofessional* working of healthcare team members is key to achieving equitable and culturally competent care (Dijkman et al. 2017; Broughten et al. 2021). Andrews and Boyle (2019, p. 326) define interprofessional working as "multiple health workers from different professional backgrounds working together with patients, families, caregivers, and communities to deliver the highest quality of care". Interprofessional connectivity is in essence a partnership that includes all involved healthcare professionals working together to deliver patient or family-centred care (Mahoney et al. 2006; Lor et al. 2016; Dijkman et al. 2017; Andrews and Boyle 2019). Such partnership requires multiple disciplines to work together as a synergistic team drawing on their strengths, to comprehensively address patient and family healthcare needs (Mahoney et al. 2006; Andrews and Boyle 2019). In this process, mutual trust and an appreciation of each team member's role are central to effective interprofessional collaboration (Andrews and

Boyle 2019). This means that healthcare professionals need to recognise their scope of practice and experiences and have a clear understanding of and appreciation for other members' capacity to contribute to the delivery of care (Mahoney et al. 2006; Andrews and Boyle 2019). Effective communication among members is critical for optimal teamwork, which is the foundation for effective transcultural care (Lor et al. 2016; Dijkman et al. 2017).

The Andrews/Boyle Transcultural Interprofessional Practice (TIP) model also highlights the importance of a systematic, scientific problem-solving process, which can guide interprofessional team members in determining what decisions, actions and interventions are needed to achieve optimal patient care (Andrews and Boyle 2019). In our view, research-informed and evidence-based interprofessional collaboration, as a means to facilitate collaborative problem-solving, forms a unique approach to interprofessional working. This approach is congruent with the patient or service users' cultural needs and personal preferences and has the potential to inform innovation in policies and practices (Willis and Porche 2006; Andrews and Boyle 2019).

Higher-level interprofessional connectivity is required to achieve structural cultural change. This involves policy-makers, planners, and practitioners (Rich et al. 2010), who can recognise and minimise power differences and promote respect for others as well as self (Foronda 2020). High-level connectivity leads to positive changes because healthcare professionals and patients would become more open (which leads to changing attitudes), better informed and equipped (which leads to changing the knowledge system), and more effective (which leads to changing skills) in dealing with challenges arising from cultural diversity. Therefore, both patients and professionals will become more empowered as they have increased ability and confidence to act in challenging situations (Almutairi et al. 2015), enabling them to promote culturally responsive policy, planning, and service delivery more collaboratively and effectively (Rich et al. 2010).

Transform into true cultural care

The last part of the ACT cultural model is to understand existing barriers and transform practice into true cultural care. The major barrier to culturally competent care is the structural barrier caused by disadvantage as a consequence of marginalisation and the lack of social justice (Michael 2016). Therefore, transformation into true cultural care has to reinstate social justice at the systemic level so that healthcare professionals and the healthcare system can adapt based on the understanding of the patterns of disadvantages encountered by minority groups (Betancourt et al. 2003). The studies we reviewed illustrate the cultural strategies, skills and commitments that can transform activated consciousness, and connected relations into true culturally competent care.

Empowerment strategies

Critical empowerment is a strategy whereby individual professionals *enact* their agency to go beyond merely recognising cultural differences, to also address power imbalance operating within the social, historical and political contexts (Almutairi et al. 2015; Wesp et al. 2018). The key to this is to evaluate and avoid the disempowerment of individual professionals because of their gender, economic circumstances, cultural perspectives, geographic location or institutional racism in their working environment (Almutairi et al. 2015). With more agency, healthcare professionals have a better chance to work, in a collective force, towards increasing the diversity of the organisation's leadership and the workforce that can represent their patient population (Betancourt et al. 2003; Castillo and Guo 2011). This can subsequently incur changes in the administrative and organisational procedures, such as decisions on clinic locations, hours of operation, network membership, physical environments, and written materials, as they affect patients' access to care and utilisation of services (Brach and Fraser 2000).

Cultural skills

Cultural skills refer to the mastery of good practices in care provision, interaction, communication, decision making, and policy making. Our review also identifies other skills that are less discussed in established cultural competence models. Owiti and colleagues (2014) designed a new model called "cultural consultation services", involving a set of *cultural skills* applied in ethnographic interviewing that can be mastered by healthcare professionals through working alongside healthcare researchers. These skills lead to a *clinical cultural formulation*, which is the process whereby healthcare professionals learn and contextualise patients' culturally laden illness experiences and help-seeking behaviour to make a holistic assessment of the patients. Such a cultural consultation approach, informed by research, leads to improvement in patient engagement with care and establishes a therapeutically effective relationship, which is echoed by Gustafson (2005) and López et al. (2020). Cultural formulation helps healthcare professionals to gain clinical skills as part of their cultural competence development. In return, higher cultural competence allows them to reconfigure the diagnosis and treatment plans for patients and cultivate culturally safe environments that respect each patient's unique identity (Zahiruddin et al. 2020).

Cultural communication is widely mentioned as one of the cultural skills in the reviewed literature. To ensure that intended meanings are conveyed appropriately, healthcare professionals need to develop skills in understanding and utilising different communication styles (Castillo and Guo 2011), using multiple methods (Moore et al. 2015) and providing information to patients who speak different languages (Brach and Fraser 2000; Carnegie et al. 2017). The skills to work with a trained interpreter are crucial as they can promote effective communication with patients and their communities (Brach and Fraser 2000; Campinha-Bacote 2002; Andrews and Boyle 2019).

Other meta-cultural skills are identified, which include the ability to conduct systematic cultural assessments of beliefs, values and practices of individuals, groups and communities the healthcare system is serving (Leininger 2002; Koskinen et al. 2012; Peterson et al. 2017). These assessments should reflect the cultural complexity of healthcare practices (Purnell 2000; Wikberg and Eriksson 2008; Peterson et al. 2017), healthcare professionals or patients' divergent expectations and goals (Owiti et al.

2014) and transitions during the healthcare journey (Nguyen and Baptiste 2015).

Professional commitment

True cultural care relies on committed healthcare professionals to internalise holistic cultural competence as part of their professional identity. Professionals need to be committed to adhering to ethical standards and professional regulations (Dijkman et al. 2017). On a daily basis, they are committed to best practices through continuous reflection on their actions and creatively and meaningfully improving and innovating such practices in response to ever-evolving cultural diversity (Seeleman et al. 2009; Janzen et al. 2010; Nastasi et al. 2015; Dijkman et al. 2017). The key to reflection is the ability of critical thinking, which fosters compassion to inspire and solidify the commitment to the transformation of cultural care (Westerholm 2009; Shattuck et al. 2020). Over time, reflective healthcare professionals, who are also critical thinkers, can achieve a deeper awareness of themselves and expand their frame of reference to examine their own biases and prejudices (Hart et al. 2003; Clingerman 2011; Garneau 2016; Foronda 2020; Zahiruddin et al. 2020). Such commitment nurtures the growth of *cultural desire* (Campinha-Bacote 2002), which in return encourages a lifelong self-evaluation and self-critique, through which healthcare professionals can redress the power imbalances in patient-professional dynamics and develop partnerships for advocacy (Foronda 2020). Individual healthcare professionals should also be committed to developing their scholarship to learn to utilise evidence-based research to expand professional expertise and support the innovation and transformation of care (Willis and Porche 2006; Dijkman et al. 2017).

In addition, professional commitment needs to go beyond the individual level to the systemic and structural level. Structural competency is restricted by ingrained systemic barriers (Owiti et al. 2014), including discriminatory attitudes, or less inclusive organisational structures and policies (Giddings 2005; Garneau 2016; Di Stefano et al. 2019). Supporting transformation in patient-centred care requires commitment from healthcare professionals to adopt a critical approach to challenge societal norms and inequalities in the health system (Hart et al. 2003), as well as commitment from leadership to enact strategies and interventions for structural change (Gertner et al. 2010). A long-term commitment to the innovative reconstruction of healthcare systems is required (Janzen et al. 2010; Foronda 2020). Advocacy for change requires a professional commitment to develop community and professional partnerships and to utilise the resources available within these partnerships (Di Stefano et al. 2019; Shattuck et al. 2020). Professional commitment needs to recognise and understand the interconnectivity of components of the ACT model, such as awareness, knowledge, skills and resources, and apply these to empower system-wide transformation to true culture care.

Discussion

Overall, the findings of this review reveal the complexity of defining, developing, and enacting culturally appropriate care. All the papers included in this review presented variable conceptualisations, theories, or models of cultural competence, with only a minority of articles including an underlying theoretical perspective that drives their understanding of cultural competence. The three primary themes of competences, roles and identities and structural competency inhabit themselves within three interconnected and mutually synergistic domains: namely the intrapersonal (individual level), interpersonal (team or community level) and the institutional (organisational or systems level). Definitions of cultural competence included in this review vary in their focus regarding these domains and the findings of our review reveal a more expansive definition is required that accounts for the coactive and reciprocal relationship between them in enacting and transforming cultural care. The ACT transformative cultural model, developed based on the authors' collective interpretation and synthesis of the findings, demonstrates the intricacies involved in teaching this subject, developing cultural competence in one's professional identity and the challenges in enacting meaningful systemic changes. Cultural competence is not confined to individual actions but rather, is situated within a historical and ever-changing context that is influenced by the relationships one has with others and the systems within which we operate. It necessitates the ability to deconstruct commonly held premises and foundations of healthcare; dismantling systems of categorisation, exclusionary practices of "othering" and labelling of social spaces and people.

Collectively the first part of the ACT model, "activating consciousness", denotes the importance of developing one's awareness, demonstrating sensitivity and acquiring knowledge of self, others and the systems in which they operate. This habitual practice contributes to one's sense of professional identity which should not be perceived as different parts additive to one another or as (solely) the prescribed protected characteristics as outlined in the Equality Act (2010), but rather infused, with certain parts becoming more salient depending upon the encounter and the context. This has been noted by a few authors who have critiqued the notion of intersectionality (Anderson and Collins 1992; West and Fenstermaker 1995; McCall 2005; Anderson and McCormack 2010). For example, Anderson and Collins (1992) highlighted the significance of *"interlocking categories of experiences"*, describing how one experiences the intersection of one's identities in different interactions. Kessler and McKenna (1978, p.42) made prior note of this, explaining how different social identities intersect with each other, or to *"abrade, inflame, amplify, twist, negate, dampen or complement each other"*. Some authors included in this review have attempted to create graphical models which distil one's different and overlapping identities and roles pertinent to cultural competence using Venn diagrams (Bernal 1993; Leininger 2002; Wesp et al. 2018), demonstrating that one's cultural identity cannot be reduced to fixed social categories, but should be seen as emergent, fluid and interconnected. This first part of the ACT model also warrants further discussion on the context in which cultural competence education is received, perceived, and put into practice. In particular, the way cultural information/knowledge regarding groups of individuals is presented has been criticised by authors in this review as stereotypical, reductionist and fixed, stipulating a discord

between how culture is defined for a group of individuals and how it is defined for an individual. Several papers in this review highlighted how individuals' experiences of assumptions made about their culture were incongruent with how they defined their identity, reiterating the importance of continually questioning cultural information/knowledge and for cultural information to be presented as both an individual and shared notion. Supporting this research, studies stemming from the Social Identity Theory (Tajfel and Turner 2004) and Self-Categorisation Theory (Turner et al. 1987) have documented the plethora of negative outcomes that arise from solely focusing on social/cultural categorisation including prejudice, stereotyping, outgroup homogeneity and ingroup favouritism (Fuller 2002; Vignoles and Moncaster 2007). Moreover, it is important to note that the notion of "activating consciousness" is closely consistent with a term frequently cited in cultural competence literature titled "critical consciousness" (Kumagai and Lypson 2009; Azzopardi and McNeill 2016). Critical consciousness has conceptual roots in research concerning the critical theories of Paulo Freire (Moraes 1992) and posits that one's practice of self-awareness and reflection does not exist in isolation but rather in relationship to others in the world. These scholars describe the development of critical consciousness as the reflective awareness of the difference in power and privilege and the inequalities that are embedded in social relationships. This development of critical consciousness leads to cognitive and affective changes, engaged discourse, collaborative problem solving and "re-humanisation of human relationships" (Hurtado 2005; Kumagai and Lypson 2009). The intrapersonal dimension in this review describes the internal experience of how we see ourselves in relation to others as well as the different ways one can categorise, position, and align oneself with others. The findings demonstrate a strong over-lap with the concept of critical consciousness and arguably build upon this theory in a more tangible and action-orientated manner.

Together, the second part of the ACT model, "connecting relations", incorporates the interpersonal relationships and attributes defined under "roles and identities" and the importance of recognising the multi-faceted identity healthcare professionals embody and the acknowledgment that their role extends beyond the consultation room to encompass issues around advocacy and scholarship to achieve meaningful culturally competent care. The dimensions of personal, community and interprofessional connectivity signify the relational and social aspects necessary to achieve structural cultural change (e.g. capacity building and leadership). These relationships or spheres of connectivity can contribute to locally defined patterns of behaviour that are based on inherited, written, or unwritten social agreements, assumptions, and norms. Although often unrecognised and unarticulated, the findings of our review illuminate their importance in influencing one's professional identity and subsequently systematic cultural practices. From the literature the prior conceptualisation of professional identity as a single and distinct entity has shifted to a dynamic conception of multiple identities situated in different clinical and social situations (Shotter and Gergen 1994; Eisenberg 2001; Gergen and Davis 2012; Goldie 2012). Frost and Regehr's (2013) review of papers exploring the discourses between standardisation (describing the importance of uniformity, consistencies, and commonalities among healthcare professionals) and diversity (emphasising one's unique, personal, and multiple social identities) in one's professional identity construction, highlight the need for greater connection between the intrapersonal and interpersonal domains. They concluded that constructing one's professional identity becomes challenging primarily due to the increasing diversity among healthcare professionals. To effectively address this, faculty and trainers must first invest in acknowledging that these tensions between standardisation and diversity arise and adopt a social constructivist understanding of identity. These conclusions are arguably endorsed by the findings of this review, in the recognition that cultural competence at the intrapersonal, interpersonal and organisational/systemic levels are not mutually exclusive, but rather interconnected and subject to influence one another.

The last part of the ACT model, "transform to true cultural care", underpins the aspects highlighted in the theme of structural competency and the acknowledgement of the institutional factors at play (e.g. systematic barriers and contextual influences). The notion of true cultural care closely aligns with the well-defined concept of "patient-centred care", or "person-centred care" in advocating the importance of acknowledging the patient as a person, customised, individualised care and attention to the whole person and their needs (Morgan and Yoder 2012). Similar to cultural competence, although patient-centred care is frequently used in the literature, ambiguity remains in its meaning and how its principles are translated into practice. Patient-centred care shares many of the same challenges as cultural competence training/education in terms of establishing a consistent definition, identifying best practices and addressing uncertainty over measures to assess effectiveness. A review by Mead and Bower (2000) proposed a conceptual framework that outlined the following key dimensions: patient as a person, sharing power and responsibility, therapeutic alliance and "doctor as a person". Whilst the dimension "doctor as a person" is included to emphasise the influence of their attitude, personality, and cultural background on the doctor-/healthcare professional-patient relationship, it is unclear how this is acknowledged and in what way it affects the clinical relationship. The findings of this review hopefully alleviate this in conveying the causal and influencing factors present at the intrapersonal/individual level (within the healthcare professional), the interpersonal level (with patients and relations with others more broadly) and the institutional level (in the creation of social practices and norms) and the mobility required at each level to enact meaningful cultural change.

Furthermore, drawing on critical theory, our review paid special attention to problematising the status quo and seeking methods for positive change during the iteration of interpretation and synthesis of the reviewed articles. The ACT model attempts to provide educational guidance to alleviate disabling factors that lead to the lack of culturally appropriate care and inequality in health and access to care.

Practical implications and recommendations

Activate consciousness requires cultural competence development to begin with sensitising one's own culture and

behavioural patterns (*intrapersonal awareness*). Classroom-based reflexive discussion may create a safe environment for students to explore themselves and their positionality in relation to others. The ACT model highlights the importance of self-care and respect in learning. This approach puts all students at the centre of education and, therefore, makes it relevant to all and not just to the few who tend to be from minoritised backgrounds. Even with a seemingly homogeneous group of students, this approach can effectively foreground the diversity of culture and behavioural preferences and help students develop their *cultural knowledge*. The appreciation of one's desire to be treated fairly and respectfully will lead to their willingness to do the same for others (*interpersonal awareness*). This can be followed by skills training to discuss how to be fair and respectful in social interactions. Awareness development should allow students to recognise the limitations and frustrations of the structural barriers in society. The ACT model suggests that the curriculum should not shy away from discussing contentious social-political issues and engage with cultural change at the structural level (*systemic/organisational awareness*).

Knowledge is important but should be learned as a dynamic entity constructed and reconstructed over time and space. Prior cultural knowledge should be questioned, and new knowledge generated and integrated into clinical practice. To develop critical knowledge, the curriculum should teach students knowledge of research skills so students can participate in knowledge generation. At the same time, it is crucial that educators also engage with research themselves to ensure their teaching reflects the evolving social challenges.

Connect relations requires a collaborative approach involving all relevant stakeholders to contribute to different aspects of students' development. Development should go beyond classrooms and into clinical placements, as well as the local communities where healthcare services are provided. These opportunities will allow students to gain first-hand cultural knowledge and build connections with other professionals and people in the communities they will serve in the future. Co-creating teaching with community advocates/leaders, and patient educators can empower them and make teaching more relevant to the communities. However, financial remunerations should be provided to pay for people's contributions to education. Only then can we make sure the marginalised and vulnerable are able to participate. To achieve systematic and sustainable learning, students should be taught how to learn in these experiential contexts, including the skills to take care of themselves as well as the vulnerable people they may encounter. Regular reflexive sessions should be held with experienced educators to help students consolidate their experience.

Transform into true cultural care points out the need to develop students' empowerment strategies, cultural skills and professional commitment. Students need to develop the ability to critique current procedures, regulations, policies and laws. Scholarly/research modules, for instance, can provide methodological training and allow students to problematise care provision and interrogate health disparity. Cultural skills learning should be incorporated into clinical simulations, reflexive discussions and clinical placements (also see Liu & Li 2022). Our model particularly highlights the value of *clinical cultural formulation*, which suggests that skills teaching should incorporate transferrable scientific methods. It points out that *professional commitment* is key to sustainability but takes time to achieve. A longitudinal curriculum is preferred over one-off sessions. Teaching should be embedded at different stages of the curriculum with increased integration of all ACT components.

Informed by critical theory, the ACT model suggests that researchers can use their research to advocate for the marginalised by transforming the existing social constructs and empowering human beings (Madison 2011). Future research should not only describe but also aim to eliminate disabling factors to address inequality in healthcare.

Strengths, limitations and reflexivity

The results of this review provide clarity and a comprehensive picture of existing literature around the debated terms of cultural competence and diversity. Adopting the lens of critical theory allowed the authors to generate actionable themes that led to an improved understanding of the social responsibilities of healthcare professionals in addressing healthcare inequalities. At the same time, we acknowledge that the adoption of critical theory means that we were more selective of actionable concepts or constructs during the data extraction and synthesis. Putting more weight on reflective assessment and critique means that our review aims to provide theoretical guidance to initiate positive changes and challenge power structures around cultural competence. The results provide useful and practical points for healthcare professionals, educators and policymakers, and contribute to solving healthcare disparities at the root cause.

One potential limitation of this review is the inclusion of a number of opinion papers, the results of which were not empirically tested. This decision was deemed appropriate as these studies have contributed significantly to our conceptualisation of cultural competence. This also points out a general lack of empirical research in this field. Another limitation of this review is that the majority of studies are found in developed regions. This unavoidably limited our global perspectives and the model's international relevance. Future reviews, with more resources for language translation services, may extend the search to include publications in other languages and from other countries. Lastly, the included studies in this review rarely discussed the potential influences of wider political or socio-cultural changes on the study. This limited incorporating the political and socio-cultural influences specifically into our methods.

The authors also reflected on the impact of the research team on synthesising the findings. As a group of reviewers from diverse subject fields, we found that each reviewer had their specific focus during the data extraction and synthesis. Therefore, calibration exercises were carried out to ensure consistency during the review. A second reviewer was assigned to cross-check all review stages to ensure trustworthiness. Moreover, we believe the multidisciplinary perspectives of the research team contributed to a more nuanced understanding of the subject field.

Conclusion

Definitional ambiguities around "cultural competence" have existed for decades. Associating the word "competence" with "culture" has triggered discussions throughout the literature on the interpretation of what being competent in culture means. The two terms appear at opposite ends of a spectrum, with *competence* perceived as a term that is fixed, measurable and specific and *culture* as a concept that is fluid, nuanced and evolving; with obscurity about how these two different notions become one concept. The findings of this research and in particular the ACT model provide a way of operationalising the definition of cultural competence in terms of educational faculty development and training. Contrary to many theoretical frameworks on cultural competence, the ACT cultural model is action-orientated and transformative in its conceptualisation and approach. Efforts to enhance culturally competent care without the professional understanding of oneself and the impact of the professionals' relationships with their colleagues (others) and the organisation have the potential to exacerbate existing disparities in care and result in a lower quality of care for all patients. Whilst the ACT model warrants further research, it aims to provide conceptual clarity on how cultural competence can be educational driven and enacted in practice; thereby ensuring health services are aligned to meeting the needs of all patients.

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Glossary

Cultural competence: Is understood as the application of awareness, attitudes, knowledge, and skill required by medical and healthcare professionals to provide appropriate care and services compatible with the cultural characteristics of their diverse patients. Developing cultural competence necessitates a continual inquiry and awareness of one's values, cultural norms and behaviours and one's potential for the development of assumptions and stereotypes of others.

Framework, or conceptual framework: Is a chosen set of conditions representing the general assumptions and operational definitions of a phenomenon, thereby creating boundaries for investigation. Frameworks are a set of assumptions that gives rise to models which explain the mechanics of these processes. A framework provides an overarching structure and connectivity for a chosen topic and indicates the directions of a study prior to the selection of methodological approaches for the review.

Models: Define the theoretical concepts that underscore the dimensions and components of empirical investigations. A model is developed within a framework and is a descriptive tool that can help impose some order on how dimensions/variables are potentially interrelated. In this critical review, we allow the concept to be used interchangeably as we aim to identify both frameworks and models in cultural competence in medical and health professional settings.

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