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ABSTRACT Despite the importance of cultural competence in health care, there has been no research to develop a framework for cultural competence in the Iranian context. This qualitative study at Mashhad University of Medical Sciences aimed to elucidate the views of medical faculty staff on the components of cross-cultural competence and compare these with similar studies published in English. Using a combination of archival studies, semi-structured interviews and focus group discussions among faculty members 3 major domains (knowledge, attitude and behaviour) and 21 components were identified to describe the cross-cultural competence of faculty members in medical schools. Participants expressed the importance of knowledge as a precursor to changing attitudes and the 6 knowledge components related to knowledge and awareness of values, beliefs and norms of different ethnic, racial and cultural groups. Experts mostly emphasized the importance of interaction between faculty members and clients (students and patients).

Points de vue des membres du personnel enseignant médical sur les composantes de la compétence interculturelle en République islamique

d'Iran : étude qualitative

RÉSUMÉ En dépit de l'importance de la compétence culturelle dans les soins de santé, aucune recherche n'a été

menée visant à établir un cadre pour la compétence culturelle dans le contexte iranien. La présente étude qualitative à l'Université des Sciences médicales de Mashhad visait à élucider les points de vue des membres du personnel enseignant médical sur les composantes de la compétence interculturelle et à les comparer avec des études similaires publiées en langue anglaise. À l'aide d'une association d'études d'archives, d'entretiens semi-structurés et de groupes de discussions thématiques impliquant des membres du corps enseignant, trois domaines principaux (les connaissances, les attitudes et les comportements) ont été dégagés et 21 composantes ont été identifiées pour décrire la compétence interculturelle des membres du personnel enseignant des écoles de médecine. Les participants ont insisté sur l'importance des connaissances comme élément précurseur permettant une modification des attitudes et sur les six composantes de ce domaine liées à la connaissance des valeurs, des croyances et des normes sociales des différents groupes ethniques, raciaux et culturels et à la sensibilisation en la matière. Les experts ont surtout souligné l'importance de l'interaction entre les membres du corps enseignant et les clients (les étudiants et les patients).

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Introduction

The cultural competence movement began almost 20 years ago (1). Although there is currently no standardized definition of cultural competence, Cross et al.'s definition is the most commonly cited (2). This defines cultural competence as "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" (3). Three major areas of health research provide a context that addresses the importance of culturally competent care: health disparities; access to health care; and quality of care (4). In the context of health care, the components of cultural competence bridge the cultural gap that exists between providers and patients (5) and play a critical role in reducing health disparities and improving health outcomes for patients (6). When care is provided that takes patients' values

and beliefs into account, it is likely to result, for example, in better access to health care and increased compliance with medication by patients (7). Conversely, a lack of cultural competence among health-care providers may lead to patient dissatisfaction (8).

The Islamic Republic of Iran has many ethnic and religious groups which have a variety of subcultures, languages, lifestyles, customs, traditions and different modes of livelihood (9–11). Nowadays, foreign migrants too constitute a large part of the country's population (12) and providing education for the increasing number of foreign students in the country has become an important issue in higher education (13). The cultural diversity of Iranian society raises challenges for the health-care system in trying to serve patients of diverse languages and cultures. Research in the Islamic Republic of Iran shows that beliefs about health care and people's perceptions of illness and health vary across ethnic and religious groups (9,14).

Despite its long tradition in disciplines such as psychology, it is only within the past decades that cultural competence has been studied in the context of health and become integrated into the medical education curriculum (15). In the educational realm, cultural competence has been defined as "the ability to successfully teach students who come from different cultures other than your own" (16). In their book, Diller and Moule stated that it entails developing certain personal and interpersonal awareness and sensitivities, developing certain bodies of cultural knowledge and mastering a set of skills that, taken together, underlie effective cross-cultural teaching (17). The available evidence on multicultural education addressing ethnic and religious diversity highlights the importance of providing cultural competence education and assessment of faculty staff members in the Islamic Republic of Iran. Faculty members act as role models and prepare their students to deliver culturally competent care (6). Yet cultural diversity poses a pedagogical and social challenge to educators (18); at all levels, they must develop cultural knowledge, awareness and sensitivity to help diverse learners (19).

Despite the clear importance of cultural competence in health care, there has been no research to develop a framework to specify the components of cultural competence in the Iranian context. The purpose of this study was to elucidate medical faculty members' perspectives on the components of cultural competence applicable to medical schools and how these compare with those found in the English language literature.

Methods

Study design and participants

Between October 2012 and September 2013, the authors conducted a qualitative study in Mashhad University of Medical Sciences. Since there was no existing framework for cultural competence of faculty members in the Islamic Republic of Iran, we used an inductive and

exploratory approach to understand the dimensions of cultural competence. We therefore chose a combination of methods, including archive study, semi-structured interviews and focus group discussions (FGD) to combine evidence and the collective perspective of experts. In the archive study, we reviewed the current evidence to identify the existing components of cultural competence and then we completed these components by semi-structured interviews and FGDs.

To obtain a range of perspectives on cultural competence, we recruited participants who were faculty members and educational experts at Mashhad University of Medical Sciences, who had had more than 15 years of experience in teaching, research and service and who were considered as role models in the university. The participants were selected through purposeful sampling (unique cases) and later on by snowball sampling. The inclusion criteria for the participants were having expertise in medical science, teaching and being active in medical education and ethics. Participants unwilling to participate were excluded. We invited 21 faculty members who had valuable educational experiences to participate in this study; 15 of them expressed their readiness to participate in FGDs and the remaining 6 faculty members were given individual interviews to accommodate their busy schedules,.

Data collection

Table 1 summarizes the study steps and the participants at each stage.

Step 1: archive study

We reviewed the published literature and frameworks to identify the existing components of cultural competency. Between October 2012 and April 2013, we searched the databases of Google Scholar, ScienceDirect, PubMed, ProQuest, OvidMD, Education Resources Information Center (ERIC), WhereIsDoc, OhioLINK electronic theses and dissertation centre, the Iranian databases Magiran and Scientific Information Database (SID), and the website of the Iranian Council of Cultural Revolution, with no specific timespan to limit the search. The keywords used were: cultural competence, multicultural education, framework AND cultural competence, components of cultural competence, cultural competence AND faculty members, cultural competence AND medical science. We also consulted the databases of colleges and associations and publications from government and nongovernmental organizations including the Association of American Medical Colleges; the National Center for Cultural Competence (an initiative based at the Georgetown University Center for Child and Human Development); and the Liaison Committee on Medical Education (an accrediting body for educational programmes at schools of medicine in America and Canada). The publications and documents were mostly in English language. Articles were included if they were available as full texts; were written in English; reflected the components, elements or domains of cross-cultural competence; and were applicable to faculty members of a medical school. The identified articles were then screened and assessed for eligibility according to the inclusion criteria. The included articles

were critically appraised with an assessment tool for descriptive and qualitative articles by 2 of researchers (M.M. and A.Z.). Another researcher (H.K.) moderated in the case of disagreement.

Based on their content and purpose, the aggregated results were classified into 3 categories related to the importance of cultural competence, education about cultural competence and assessment of cultural competence. This was done by the researchers in 12 discussion sessions lasting on average 2 hours. Afterwards, 112 components were extracted by reviewing the obtained data, extracting key phrases and organizing concepts and meaning through 28 discussion session lasting on average 3 hours. Components that had similar meanings were combined and duplicate components were removed. Finally, 20 components in 3 domains—knowledge, attitude and practice—were identified as suitable for defining the cultural competence of faculty members in the medical school. The components were developed in Persian language and translated into English for reporting purposes.

Step 2: interviews

The semi-structured interviews were conducted with 6 faculty members. For consistency we used a single interviewer (A.Z.), although all the researchers participated in developing the interview guide. Interviews were tape-recorded if the respondent agreed. If the respondent did not agree the interviewer took notes and dictated the responses as close to verbatim as possible immediately following the interview. Each interview lasted approximately 30 minutes and was scheduled at a time and place that was convenient for the interviewee. We continued data collection until theoretical saturation was reached. We used the archive study to design the interview questions, which included items covering the domains and components of cultural competence.

Step 3: first FGD

We conducted 2 FGDs. We invited 15 medical school faculty members by e-mail and letter to participate in our sessions. FGDs were audio-recorded with the agreement of the participants. During each session, researchers took notes of the important points and gave the opportunity to all the members to express their comments and ideas.

The first FGD consisted of 7 faculty members from clinical science and 7 members from basic science. We provided copies of the questions and the needed information for the faculty members. Afterwards, one of the researchers (M.M.) presented relevant explanations and asked questions and then in a brain-storming session participants discussed the issues together.

Step 4: questionnaire

The main goal of Step 4 was validation of the components. The 28 components obtained from the previous steps were used to construct a questionnaire. Participants were asked to score the importance of each component from 0 (lowest score) to 10 (highest score). They were also requested to add additional components that they considered important and to provide comments about deleting or modifying the free text at the end of the questionnaire. This step was conducted face to face.

Step 5: second FGD

The second FGD included 4 faculty members from clinical science and 4 from basic science. After providing a report containing the results of Step 4 participants discussed the issues together. Some of the components were integrated or revised. Then general discussions took place for each component. When we believed we had reached saturation we finalized the components in this step.

Data analysis

Qualitative data were analysed using qualitative analysis and the inductive approach. The recorded interviews and FGDs were transcribed verbatim by 2 of researchers (M.M. and A.Z.). The same 2 researchers independently read each transcript, extracted important statements and phrases and formulated meanings for these statements. Statements and phrases from all participants that were similar were grouped together or clustered into one list of themes. The researchers (M.M. and A.Z.) sent the other researcher (H.K.) a copy of their results along with original descriptions for validation and confirmation of the consistency between these clusters and the original descriptions. Similar results were obtained. Then all the researchers (M.M., A.Z. and H.K.) combined the results and wrote an exhaustive description. We returned these finding to the participants to validate the findings. No new data were revealed from the participants.

Quantitative data were analysed using SPSS, version 11.5. We used descriptive statistics, including mean and standard deviation (SD) to analyse quantitative data from the scoring steps.

Results

Table 2 shows selected demographic characteristics of the participants, including age, sex, subject and academic rank. Most of the participants (81%) were men and the largest proportion of participants were aged 46–50 years (38%).

Archive study

Box 1 lists the 20 components in the 3 domains of knowledge, attitude and practice, based on the results of the archive study. Knowledge was defined as "Having awareness of the values, beliefs and norms of different ethnic, racial and cultural groups"; attitude was "Having the values, beliefs and understandings that are the foundation of professional norms"; and practice was "Demonstrating knowledge and attitude in behaviours and encounters".

Box 1 Initial list of components of cross-cultural competence of faculty members in medical school based on the archive study

Knowledge

Having awareness of relevant sources to obtain cultural information

Having awareness of the risk of discrimination among people from different cultural backgrounds

Having awareness of the different needs of people from different cultures

Having awareness of non-verbal communication symbols in different cultures

Having awareness of beliefs in various cultural communities

Attitude

Accepting cultural diversity (customs, different ways of communication, beliefs, different traditions and perspectives)

Having an altruistic viewpoint

Understanding the risk of selecting one's own culture (her/his norms and professional values) as the correct culture (self-centred)

Believing in the need to be careful of one's behaviour regarding reactions to people from different cultural backgrounds

Practice

Demonstrating a desire to respond to the client's cultural needs (e.g. patients, patient's family, students, colleagues and other clients)

Having the ability to create a trustworthy relationship

Expressing empathy

Demonstrating a respectful attitude towards differences between people from different cultural backgrounds

Being flexible in choosing the appropriate approach with clients from different cultures

Allocating sufficient and appropriate time for clients

Practising active listening

Having good verbal communication skills

Having the ability to use non-verbal communication skills and body language

Having consideration for education about cultural competence for students in the area of professional activities

Practising self-development in fields related to cultural competence (e.g. attending educational programmes, cultural trips, etc.)

Interviews and FGDs

The 8 new components, including 1 component in the domain of knowledge and 7 components in the domain of practice, were added to the previous components after analysing the interviews and the first FGD and eliminating the duplicate components. The following components were added. In the domain of knowledge we added: "Having awareness of one's limitations regarding cultural context and issues". In the domain of practice the following were added: "Maintaining equity in professional behaviour in encounters with people from different cultures"; "Having appropriate behaviour in cultural encounters", "Having appropriate appearance (e.g. clothing) considering the beliefs of the local culture"; "Being open to criticism and tactful about giving criticism to others"; "Having modesty in expression"; "Cultural production (e.g. faculty members should make their own experiences and ideas viable and lasting)"; and "Having tolerance in encounters with different cultures in the area of professional activities".

In the validation step the mean scores ranged from 6.9 to 9.3 and the mean of all the components was greater than 5 (out of 10), indicating that all of them were considered important. The highest score [mean 9.3 (SD 0.57)] was given to the component "Accepting cultural diversity (customs, different ways of communication, beliefs, different traditions and perspectives)" from the attitude domain. The lowest score [mean 6.9 (SD 0.9)] was given to "Having awareness of non-verbal communication symbols in different cultures" from the knowledge domain. No new components were added by the participants.

In the second FGD, we changed the name of the "practice" domain to "behaviour". Six

components were combined—"Having the ability to use non-verbal communication skills and body language", "Having good verbal communication skills", "Practising active listening", "Expressing empathy", "Having modesty in expression" and "Having appropriate behaviour in cultural encounters"—and the component "Having good verbal and non-verbal communication skills" was created. Two components were eliminated—"Allocating sufficient and appropriate time for clients"; "Having tolerance in encounters with different cultures in the area of professional activities"—since other components already covered their concept. The components of "Having appropriate appearance (e.g. clothing, etc.) considering the beliefs of the local culture" and "Cultural production (faculty members should make their own experiences and ideas viable and lasting)" were transformed into "Having appearance appropriate to accepted norms of society" and "Making one's own experiences and ideas viable and lasting (cultural production)". Other components were modified in terms of their word structure and the final list of components were prepared and accepted by all the participants (Box 2).

Box 2 Final list of components of cross-cultural competence of faculty members in medical schools

Knowledge

Having awareness of information resources about different ethnic and religious cultures

Having awareness of the risk of discrimination towards people from different cultural backgrounds

Having awareness of the diversity of needs of people from different cultures

Having awareness of non-verbal communication symbols in different cultures

Having awareness of beliefs in various cultural communities

Having awareness of one's own limitations (knowledge, communication, practical) concerning different ethnic and religious cultures

Attitude

Accepting cultural diversity (e.g. customs, different ways of communication, beliefs, different traditions and perspectives)

Having an altruistic point of view

Understanding the risk of selecting one's own culture (own norms and values in profession) as the correct culture in professional behaviour (culturally self-centred)

Believing in the need to care about professional behaviour in interactions with people from different cultures

Behaviour

Demonstrating the desire to respond to the needs of clients from different cultures (e.g. patients, patient's family, students, colleagues and other clients)

Having the ability to build trustworthy relationships with clients from different cultures

Demonstrating a respectful manner towards cultural differences among people in the area of professional activities (e.g. being respectful to different experiences and perspectives)

Being flexible in choosing the appropriate approach with clients from different cultures

Having good verbal and non-verbal communication skills

Considering education in cultural competence for students in the area of professional activities

Practising self-development in fields of cultural competence (e.g. attending educational programmes, cultural trips, etc.)

Maintaining equity and fairness in professional behaviour in encounters with people from different cultures

Having appearance appropriate to accepted norms of society

Being open to criticism and tactful about giving criticism to others

Making one's own experiences and ideas viable and lasting (cultural production)

Discussion

A major portion of the cultural competence literature can be found in the fields of health care and social work (20). Most of the frameworks we identified originated from North America (21–23), although some had been developed in the United Kingdom (24) and New Zealand (25). Despite some differences, the existing frameworks for cultural competence have much in common (25). The components of cultural competence, however, need to be determined for each country, based on its specific goals, vision and population characteristics. These components are also likely to reflect a country's political, historical and sociocultural features.

There are now many examples of frameworks, standards and models for cultural competence—e.g. the Accreditation Readiness Standards for Culturally Competent Healthcare Practitioners under the Joint Commission's 21 standards and the Culturally and Linguistically Appropriate Services (CLAS) standards—but they have not been exclusively developed to relate to medical faculty members (26–28). Existing frameworks are used to assess the competence both of students and faculty members as well as other health-care personnel, and these place less emphasis on the interaction between faculty members and students of culturally diverse backgrounds and more emphasis on the faculty members being role models and training providers of cultural competence for students. In our study in the Islamic Republic of Iran, both of these situations were considered. Participants in the current study identified ethnic and religious diversity as important factors and emphasized the development of knowledge, attitude and behaviour based on this. Participants did not identify racism and discrimination as significant issues.

In current study, the 21 components of cultural competence identified were categorized into 3 major domains: knowledge (6 components), attitude (4 components) and behaviour (11 components). Many standards and guidelines that are currently used to define cultural competence—e.g. the standards of the Medical Council of New Zealand and frameworks of cultural competence from North America—are based on these same domains (25,29).

Our participants expressed the importance of knowledge as a precursor to changing an attitude; therefore, knowledge was placed before attitude in this study and included 6 components related to knowledge and awareness of values, beliefs and norms of different ethnic, racial and cultural groups. In some of the existing frameworks, e.g. that of Jirwe et al. (25), cultural sensitivity is seen as a precursor to culturally appropriate care. The 4 components of attitude in our study are similar to their study regarding cultural sensitivity. In our study, behaviour included 11 components related to demonstrating knowledge and to attitude in behaviour and encounters. More specifically, key aspects of cross-cultural competence include the ability to manage language barriers, communication styles, mistrust and prejudice, family dynamics, customs and spirituality, and sexual and gender issues. Cross-cultural competence depends also on demonstrating empathy, curiosity and respect, which are key factors for effective patient care in a multicultural context (30). In the current study, the identified components of behaviour also included these aspects.

Many studies and frameworks, e.g. the Tool for Assessing Cultural Competence Training (TACCT), and the models of Campinha-Bacote and Jirwe et al., have emphasized the importance of establishing effective communication skills in cross-cultural encounters (23,25,31). In the current study, the following components emphasized this issue: "Having the

ability to build trustworthy relationships with clients from different cultures" and "Having good verbal and non-verbal communication skills". Many existing frameworks and components, e.g. TACCT, have emphasized health disparities. In our study, the component of "Maintaining equity and fairness in professional behaviour in encounters with people from different cultures" focuses on disparities. Some of the components in the current study highlight the interaction between faculty members and students, e.g. "Making one's own experiences and ideas viable and lasting (cultural production)", "Having consideration for education about cultural competence for students in the area of professional activities" and "Being open to criticism and tactful about giving criticism to others". Furthermore, these 3 components are also relevant to interactions with other clients.

There are some limitations to this study that could be addressed and used to guide future research in this area. Although we invited faculty members who had had educational experience at universities of different areas in Islamic Republic of Iran, the number of experts was limited. Secondly, the study was only conducted at one institution. Further research is needed to among a wider group of faculty members.

Conclusions

Available evidence from multicultural education addressing ethnic and religious diversity highlights the importance of education and the assessment of cultural competence in faculty members and students of medical science. A comprehensive educational strategy must be developed for assessment among faculty members and students in the Islamic Republic of Iran. The components developed in this study will provide guidance for developing a tool to assess the cross-cultural competence of faculty members in Iranian medical schools.

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