

Abstract: Purpose. The purpose of this article is to clarify the concept of "cultural competence" contextually, thus providing clear conceptual foundation in nursing and in health care. **Background.** Other concepts have been used interchangeably in lieu of cultural competence; consequently, this elicited confusion and inconsistencies. **Method.** Rodgers' evolutionary method was used to clarify the concept of cultural competence. **Results.** Four attributes were identified: cultural awareness, cultural knowledge, cultural skills, and cultural humility which structured the pyramid of cultural competence. **Conclusion.** The four themes were echoed in nursing and in other disciplines.

Key Words: Cultural competence, cultural diversity, and transcultural nursing

CLARIFYING CULTURAL COMPETENCE IN NURSING: A CONCEPT ANALYSIS APPROACH

Introducing the Issue of Cultural Competence

The current growth of multiculturalism is profoundly changing the demographic landscape of the United States (U.S.) According to the 2018 U.S. Census Bureau, the majority of the population is composed primarily of White Caucasians of European descent (60.4%), whereas the remaining approximately 40% consists of other diverse ethnicities; this, however, is upending the facade of the demography of the U.S. Presently, ethnic minorities numbers are rapidly surpassing White populations projecting an absolute demographic shift (Jeffreys, 2006). Incidentally, health and health care disparities among racial groups have not improved significantly and remain in an ominous state (Betancourt, 2006; Jeffreys, 2006; Campinha-Bacotes, 2007; Purnell, 2009, 2013, 2014). Hence, cultural competence among health care professionals was introduced as a strategy to address the health needs and to reduce health disparities faced by various racial groups (Giger et al., 2007). Unfortunately, this strategy of translating cultural competence in health care created conceptual confusion and inconsistencies among users of what is really meant to be culturally competent or what constitutes cultural competence. Henceforth, the purpose of this analysis was to provide conceptual clarity on the concept of cultural competence in health care and in nursing.

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BACKGROUND

Cultural plurality in the U.S has been thriving greatly recently due to the effects of globalization and immigration of refugees seeking asylum (Campinha-Bacote, 2007; Jeffreys, 2006; Purnell, 2014). Consequently, this richness of multiculturalism enticed healthcare professionals and systems to pursue cultural competence as a tool to improve health outcomes and combat health disparities encountered by various racial groups. Furthermore, the Institute of Medicine's (IOM) in its 2001 milestone report *Crossing the Quality Chasm: A New Health System For The 21st Century* was the trigger to introducing cultural competence in health care and particularly to nurses since they compose the mainstream in health care. Nonetheless, during the movement of transforming cultural competence into nursing, practicing nurses and nursing educators were confabulatory using different jargons in lieu of the concept of cultural competence, such as cultural diversity, cultural awareness, cultural sensitivity, cultural congruency, cultural appropriateness, and cultural safety (Fantini, 2009; Garneau & Pepin, 2015). Consequently, these variations in terminology created additional ambiguity among nurses and nursing educators. Therefore, the drive for this article was to illuminate conceptual clarity and uniformity among health care users using Rodgers' evolutionary method (Rogers & Knafel, 2000).

Unquestionably, the significance of the concept is fundamentally rooted by its purposes and implications. Rodgers asserted that the significance or the "relevant purpose" of a concept should help in fulfilling a human goal, and this significance should be considered focal to the concept (Rogers & Knafel, 2000). Accordingly, the ultimate objective of incorporating cultural competence in

health care is to reduce health disparities among minority groups and to provide culturally competent and sensitive care to clients regardless of their racial or cultural backgrounds (Abualhaja, 2019; Purnell, 2014). Ultimately, this goal serves a philanthropic objective of improving patients' care which is focal and relevant to the concept of cultural competence.

METHODOLOGY

Rodgers' evolutionary method was used as a paradigm to provide conceptual clarity and consistency. This approach offers a schema that overcomes reductionism and positivism, thus moving toward the dynamics of holistically addressing contemporary concerns and their interrelationship with reality. Likewise, this method is inductive in nature, which allows for the development of concepts and follows a non-linear series of overlapping phases rather than sequential phases (Rodgers & Knafl, 2000).

Choosing this approach as a strategy was decisive because of its central underpinning of viewing concepts as dynamic, fluid, and evolving instead of being static and rigid. Likewise, this approach is heavily influenced by socialization and public interactions (Dudas, 2012). Thus, cultural competence is viewed as a dynamic concept that is heavily influenced by socialization and public interactions. Moreover, another assumption of Rodgers' method is that concepts develop over time and are influenced by the contexts in which they are used. Therefore, concepts are in constant motion of refinement and growth, resulting in redefining how the analysis of a concept occurs (Tofthagen & Fagerstrom, 2010). Rodgers and Knafl (2000) claimed that concepts have four properties. First, they are dynamic instead of being static; second, concepts are "fuzzy" instead of being finite and "crystal clear;" third, concepts are context-dependent, instead of being universal; and finally, concepts possess some pragmatic purpose or utility. Rodgers further asserted that the actual procedure of this method is consistent with the philosophical underpinnings of other approaches, such as that of Wilson (1963), Walker and Avant (1983, 1988), Chinn and Jacobs (1983), and Chinn and Kramer, (1991).

Rodgers highlighted the following steps to concept analysis: identifying the concept of interest, identifying surrogate terms of the concept, reviewing the literature with analysis, then identifying attributes, references, antecedents, and consequences of the concept (Rogers & Knafl, 2000). This method also concludes with identifying related terms, a model case, and then implications.

Identifying the Concept of Interest

Earlier in this discussion, the concept of cultural competence was proclaimed as needing further exploration to promote conceptual clarity and consistency among users. This concept has gained impetus in recent years in healthcare due to the constant and interchangeable use of other terminologies to refer to the same connotation. Many scholars have defined both culture and cultural competence. For example, in nursing, Madeline Leininger have defined culture as "the learned, shared, and transmitted knowledge of values, beliefs, and lifeways of a particular group that are generally transmitted inter-generationally and influence thinking, decisions, and actions in patterned

or certain ways" (Leininger & McFarland, 2002, p. 47). Competence is defined as "the quality or state of having sufficient knowledge, judgment, skill, or strength (as for a particular duty or in a particular respect)" (Merriam-Webster.com). Competence is Latin in origin and means to compete and refers to "pursue a goal in the company of others" (Gold, 2002, p. 92). Hence, it is thought of as having the cognitive, affective, and psychomotor capabilities to perform a function successfully (Jeffreys, 2006). Similarly, competence has been defined as "having the capacity to function effectively as an individual or an organization within the context of cultural beliefs, practices, and needs presented by patients and their communities" (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003, p. 68). Indeed, competence is viewed from a cultural stance, and conveys having the aptitude and the self-efficacy to work within the cultural contexts of patients (Abualhaja, 2019). Leininger (2002), the first scholar who coined the term cultural competence, defines cultural competence as:

The use of culturally based care and health knowledge in sensitive, creative, and meaningful ways to fit the general lifeways and needs of individual or groups for beneficial and meaningful health and well-being or to face illness, disabilities, or death. (Leininger & McFarland, p. 84)

Another definition of cultural competence developed by Purnell and Paulanka defines cultural competence as:

Developing an awareness of one's own existence, sensations, thoughts, and environment without letting it have an undue influence on those from other backgrounds; demonstrating knowledge and understanding of the patient's culture; accepting and respecting cultural differences; adapting care to be congruent with the patient's culture. (Purnell & Paulanka, 2008, p. 6)

Additionally, Jeffreys (2006) defined cultural competence as "a multidimensional learning process that integrates transcultural skills in all three dimensions (cognitive, practical, and affective). It involves transcultural self-efficacy (confidence) as a major influencing factor, and aims to achieve culturally congruent care" (p. 31).

These powerful yet meaningful definitions view the concept from a nursing lens; nonetheless, examining other disciplines' interpretations and perceptions might be critical to align nursing conceptual definitions with others. One of the most renowned definitions of cultural competence defines cultural competence as, "A set of congruent behaviors, attitudes and policies that come together as a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations" (Cross, Bazorn, Dennis, & Isaacs, 1989, p. 9).

Identifying Surrogate Terms of the Concept

The second step of Rogers' method is to identify surrogate terms of the concept. Generally, concepts are considered clusters of attributes; hence, the purpose of concept analysis is to dichotomize these attributes and determine if they are relevant to the concept (Rodgers & Knafl, 2000). Surrogate terms are words that express a

concept's philosophies through expressions different than the concept itself (Tofthagen & Fagerstrom, 2010). Both surrogate and related concepts constitute the remaining data to be collected; they are means of expressing the concept in other ways than has been previously described by the researcher (Rodgers, 2000). This approach would help by placing the concept contextually in a broader knowledge base. Some of the surrogate terms that have been used in nursing and in other disciplines were cultural awareness and culturally congruent care. The explanation of all of these terms is discussed.

REVIEW OF THE LITERATURE

Rodgers' concept analysis method calls for reductionism and induction in the data analysis phase of reviewing the literature. Hence, it was a warranted value of exploring both quantitative and qualitative inquiries.

Databases used in the search are MEDLINE, PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Google Scholar. Keywords used were cultural competence, cultural awareness, cultural proficiency, cultural diversity, and transcultural nursing. Inclusion criteria were imposed on a limitation of the English language, subject of interest, and journals covering a period from 2007 to the present. The search yielded enormous references; however, two content areas (cultural competence in nursing and multidisciplinary cultural competence) were selected.

Cultural Competence in Nursing

Cultural competence in nursing academia and practice is needed due to the increase of multiculturalism in the U.S.; hence, it was proposed as a strategy to reduce health disparities among ethnic minorities and vulnerable populations. The process of conceptualizing this term in the nursing profession is explained by exploring both quantitative and qualitative nursing studies.

Mareno and Hart (2014) conducted a descriptive quantitative study to compare levels of cultural awareness, knowledge, skills, and comfort among nurses with undergraduate and graduate degrees. The researchers used a prospective cross-sectional design using Campinha-Bacote's theoretical framework. Findings from the study showed statistical significance in participants' educational level. The mean scores of nurses with undergraduate degrees were lower in the cultural knowledge subscale ($M = 2.10$, $SD = 0.084$) compared to nurses with graduate degrees ($M = 2.29$, $SD = 0.079$); ($t(359) = -2.1$, $p < 0.05$). Nevertheless, participants' mean scores for the subscales of cultural awareness, skills, and comfort level did not differ considerably. The findings of this study delineated the need for incorporating continuously cultural competence education in both undergraduate and graduate nursing programs to enhance students' cultural competence.

Delgado et al. (2013) conducted a quantitative quasi-experimental study to evaluate cultural competence among front-line nursing staff before offering a cultural training program, and then compare their cultural competence scores at 3 and 6 months afterward. A convenience sample of ($n = 111$) nursing staff at a large Midwestern medical center was selected. The researchers found no statistical differences in demographic characteristics across the three-time intervals (baseline, 3, and 6 months). Conversely,

multiple regression analysis showed that while adjusting for the sample demographic variables, only the time period intervals showed statistical significance ($F(2, 204) = 3.45$, $p = 0.03$). Baseline cultural competence results indicated that the majority of the participants (91%) were in the subscale of culturally aware, but only 9% were in the subscale of culturally competent. At 3 months, 88% of the participants scored within the culturally aware subscale, 12.5% of the participants had an increase in the subscale culturally competent, and at 6 months, scores remained at a similar level. Cultural competence scores differed significantly across the three-time intervals, with both 3 and 6 months scores significantly higher ($p = 0.02$ and $p = 0.03$, respectively) than the baseline score. The results of this study further emphasized the importance of implementing cultural competence education to frontline nurses.

Kaihanen, Hietapakka, and Heponiemi (2019) conducted a descriptive qualitative study to explore nurses' perceptions about the content and utility of cultural competence training that focused on increasing cultural awareness among nurses. The purposive sample composed of registered nurses ($n = 14$) and practical nurses ($n = 6$) from different hospital units. The cultural competency training program consisted of four 4-hour sessions and included lectures, discussions, and short web-based learning tasks. Data collection consisted of semi-structured group interviews with 10 participants to examine perceptions about the content and utility of the training. Qualitative content analysis with a conformist approach was used to analyze the data. The analysis revealed that nurses' perceptions about the training were divided into three main categories.

The first category was general utility, which covered the general approach that the training provided on cultural care, the possibility to initiate an open discussion, and the opportunity to improve current practices. The second category was personal utility, which pertained to the opportunity to become aware of individuals' own cultural beliefs, how to change their way of thinking, and how to obtain a new perspective on their own communication practices. The last category was utility for patients, which emphasized fostering better awareness and acknowledgment of patients' differing cultural values and beliefs and increasing respect in healthcare delivery. Participants' perceptions and attitudes about the cultural training program were all positive. The positive outcomes of this training included increasing nurses' awareness of their own cultural values; this was perceived as useful and intriguing. Furthermore, increased awareness might facilitate and improve communication between healthcare professionals and patients, which is a crucial component of quality healthcare.

Chen and Huang (2018) conducted phenomenological qualitative research to explore the evolution of cultural competence in Taiwanese pediatric nurses. They used a purposive sample of 10 nurses who had served in pediatric nursing units for over 1 year and who also had experience caring for children of new immigrants. The sampling method of these nurses indicated that these nurses have never attended a cultural competency training program, and they were never exposed to any formal education on cultural issues. Data were collected using face-to-face in-depth interviews and were analyzed using Moustakas' method of data analysis.

Four major themes emerged from the data; these themes included perceiving difficulties related to caring for patients from different cultures. This theme included subthemes, such as failing to effectively communicate with patients and being too busy to provide individualized cultural care. The second theme was self-reflection on diverse cultures and findings. This theme included subthemes, such as exploration of the characteristics of new immigrants, impressions of the children of new immigrants, self-reflection, and sympathy for new immigrants. The third theme was finding approaches based on experiences with diverse cultures and new perceptions and identification with diverse cultures. This included subthemes, such as seeking assistance, providing experiences from similar cases, fair treatment, and adjusting care methods for new immigrants. The final theme was new perceptions and identification with diverse cultures. This theme had subthemes, such as coping with diverse cultures, expressing empathy, being grateful, and expecting to change the quality of care.

Findings from this study indicated that the cultural competence of these nurses was not attained through formal cultural competence education. Instead, their experience of cultural competence was based solely on their interaction with clients from dissimilar cultures. The implication of this study was that formal cultural competence educational offerings should be made available to nurses in Taiwan, as these nurses are more frequently exposed to other cultures, and there should be some strategies in place to improve nurses' cultural competence in the clinical settings.

De Peralta, Gillispie, Mobley, and Gibson (2019) conducted a descriptive qualitative study using Strauss and Corbin's grounded theory approach to explore participants' perceptions of cultural competence and cultural humility in mobile health clinic (MHC) service delivery, using the Cultural Competence Model (CCM) as a framework. This theoretical framework has five constructs: cultural awareness, knowledge, skills, encounters or interactions, and desire. Purposive sampling consisted of five ethnically diverse focus groups of English and Spanish-speaking women and men between the ages of 20 to 67 who lived in one of the five underserved neighborhoods in the local hospital's service area in a Southeastern U.S. city. Findings of the study concluded that across all focus groups, participants valued staff members who were well-trained, compassionate, and caring staff and practice cultural humility and displayed evidence of the CCM's five cultural competence abilities: cultural awareness, knowledge, skills, encounters or interactions, and desire.

Cultural awareness. Health care professionals who lack cultural awareness might provide treatment based on their own perceptions, preconceived notions, and biases about that specific culture, ultimately leading to a service provider that would likely have negative outcomes. Several participants reported receiving care that lacked empathy and sensitivity from their health care providers. For example, statements from some of the participants included the following:

"I'm in the process of changing my doctor, because when I go in there, they don't act like I'm received, you know, in a friendly manner. [They] don't act like they're concerned." (p. 1108)

Unfortunately, bad experiences due to a lack of cultural sensitivity might affect patients' compliance with the care and return for further treatment. For example, one participant stated:

"You just get fed up with them pushing you; through like it's a drive-through like it is fast-food time." (p. 1108)

"If you had a bad experience, if you go the first time and you have a bad experience, you won't come back." (p. 1109)

Social determinants of health such as socioeconomic status also play a major part in the prejudice, stigma, and biases experienced by patients. For example, a participant said:

"If you [have] no insurance, they'll treat you any kind of way ... and that they'll kick you off the bus!" (p. 1109)

Cultural knowledge. Participants expressed certain expectations regarding health care providers' knowledge about the populations they serve and the level of professionalism that patients expect in their interactions with health care professionals. A participant who expected a certain level of professionalism from MHC staff reiterated this point:

"So people's mood, the presence ... they must have the same formality that they have in the hospital." (p. 1109)

Cultural skill. Health care providers should have the competency to perform a culturally congruent physical exam using relevant data specific for that racial group (Campinha-Bacote, 2007).

Another level of cultural skill according to participants is that health care providers should make an effort to become familiar with the populations they serve. One informant stated that:

"You're taking care of people. You could be taking care of somebody else's parents." Another participant reiterated this theme: "... Because we're talking about taking care of our loved ones." They recommended that the facility choose "nurses or doctors with a good personality, a nice background and education." (p. 1109)

Cultural encounters or interactions. Cultural encounters are an important step in becoming culturally competent. Health care providers should seek more opportunities to interact and engage with different cultures in order to refine their skills and improve their self-efficacy. (Campinha-Bacote, 2007; Jeffreys, 2006) One important factor of cultural encounters and interactions is accommodating for racial concordance between the patient and the health care pro-

vider. Likewise, participants verbalized the importance of hiring staff who share similar life experiences or situations with the patient. One informant stated that:

"You know, most people out here are single parents, or have a whole bunch of children, so people with experience with children and single [parents] in the same situations, they will be good on relating to the community as well." (p. 1110)

Cultural desire. Cultural desire is the ultimate goal of becoming culturally competent. It is the soul of this process and the desire to "want to" engage rather than "have to" engage with other cultures (Campinha-Bacote, 2007). Participants in this study wanted to be respected and be treated like a human and not a statistic. One participant offered the following advice regarding the attitude that health care providers should demonstrate:

"When you go into these communities, you are going to have to act like: 'Okay, I'm not here, you know, being the big I or whatever. I am here with your concerns. I want to know what you are feeling. I am here to support you. I'm here to help you.' If you go in there with the right attitude, you're going to be well received ... They will shut you out if you go in there with the wrong attitude." (p. 1111)

The application of the CCM's constructs can have the propensity to promote cultural competence among health care professionals, which would have paramount benefits for culturally diverse patients.

Nursing studies emphasized the importance of rendering cultural competence in reducing health disparities among ethnic groups. Evidence in the literature affirms that rendering culturally competent care has positive consequences of improving clinical outcomes. Furthermore, the process of becoming culturally competent in nursing has such scales as cultural awareness, cultural knowledge, cultural skill, and cultural humility. Qualitative and quantitative studies recognized the implications of improving nurses' level of cultural competence. Cultural competence is considered an ongoing and dynamic process and not a one-time event. A review of the literature showed that the nursing profession considered the concept of cultural competence as a dynamic process that is always evolving. The essential constituents of this process are cultural awareness, knowledge, skills, and humility. These elements were validated by both quantitative and qualitative research. In quantitative research, the findings of most studies showed improvements in participants' cultural competence scores; whereas, in qualitative research and through the voices of the participants, cultural competence was articulated and stressed repetitively as evident by emerging themes.

Multidisciplinary Cultural Competence

Other disciplines parallel to nursing have also emphasized the significance of cultural competence as a strategy to improve the quality of their services. The rapid growth of multiculturalism in the U.S. brought challenges to clearly understand the cultural intricacies that clients hold. Accordingly, other disciplines should be sensitive and at-

tentive to the cultural and linguistic needs of their clients to sustain successes and survival.

In the field of physical therapy, Lee, Litwin, Cheng, and Harada (2012) conducted a quantitative correlational study to investigate whether there is an association between measures of social responsibility and cultural competence among two groups of physical therapists (PTs) with varying international experiences. Their hypothesis was that PTs who had multiple international experiences (≥ 3) would correlate positively with social responsibility. The convenience sample consisted of two physical therapist groups: one group who had a few international experiences ($n = 32$) and another group who had multiple international experiences ($n = 23$).

Findings from the study found no statistical significance in social responsibility total means scores between the two groups. However, a statistical significance existed between the two groups' mean total cultural competence scores ($F = 0.678, p = 0.023$). The correlation between social responsibility and cultural competence was greater for PTs who had multiple international experiences. Nonetheless, social responsibility was moderately and positively correlated with cultural competence ($r = 0.627, p = 0.001$). The findings of this study supported the hypothesis that PTs who had multiple international experiences had positive relationship scores between social responsibility and cultural competence. Additionally, a positive correlation existed between international experience and physical therapists' total cultural competence mean scores.

Soule (2014) conducted a qualitative grounded theory study to develop a conceptual framework in healthcare education curricula. The purposive sample was composed of ($n = 20$) English-speaking participants from different disciplines such as nursing, medicine, and social sciences. Data were gathered via semi-structured face-to-face and telephone interviews that lasted 60-90 minutes. Data were analyzed following the procedures of within-case and across-case analyses. The initial analysis included line-by-line coding to identify common themes. Three themes emerged from the data analysis, which crossed four domains of cultural competence: cultural awareness, engagement, and application. They cross four domains of cultural competence: interpersonal, intrapersonal, system/organization, and global. The awareness theme that was dominant in all domains emphasized an understanding of self, others, and systems as an integral construct in developing cultural competence. Engagement, on the other hand, underlined the development of cognitive, affective, and psychomotor adaptability, competent communication, empathy, and building superior relationships. Finally, the application theme stressed building personal aptitude, conflict negotiation, and receptiveness to the client, the family, and the community needs. Thus, the process of cultural competence is considered a fluid process that progresses from awareness to engagement and application. The researcher recommended the need to address cultural competence internationally and across different disciplines.

Kai et al. (2007) conducted a qualitative grounded theory study that highlighted the importance of offering cultural competence education to health care providers. In this study, the researchers stressed the importance of examining healthcare practitioners' perceptions and attitudes during the cultural encounters of patients from different racial

groups. The purposive sample consisted of 18 focus groups and composed of ($n = 106$) health professionals from different disciplines working in primary and secondary care settings in Midland, United Kingdom. Data analysis was completed by using constant comparison, enabling emerging themes to be incorporated and explored in subsequent interviews to develop categories.

Findings from this study amplified the extent of anxiety level health care professionals experience during cultural encounters. Moreover, the findings stressed the implication of empowering health care providers with cultural competence education to ease such anxiety. Nevertheless, two main themes emerged that provided the foundation for their grounded theory. The first theme was "uncertainty", which should be recognized to deliver more responsive care. The second theme was the view of shifting the emphasis away from "knowledge-based cultural expertise toward a greater focus on the patient as an individual."

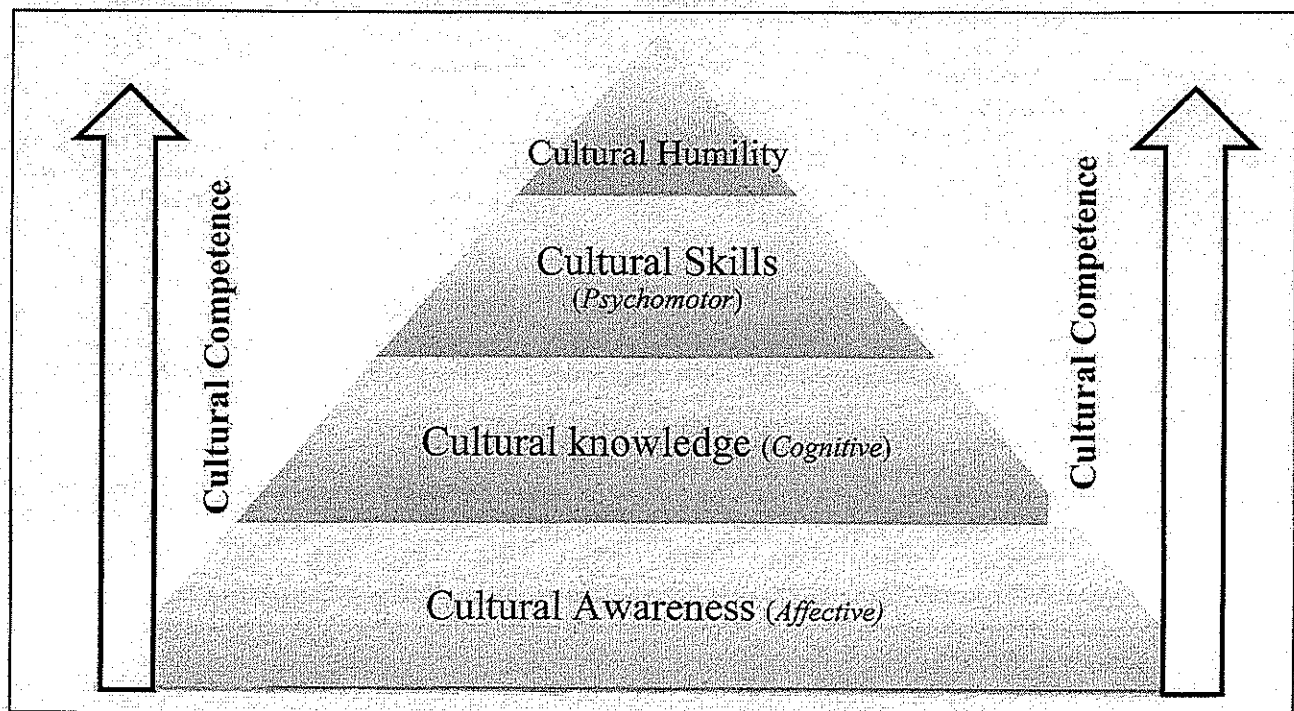
In the discipline of human services, Caldwell et al. (2008) conducted a qualitative descriptive study to explore the definitions of multicultural competence given by frontline human services providers (FLSP). The researchers defined FLSP as those providers, such as case management, social services, and agency staff members who have no formal training in counseling but serve in that role. The sample consisted of ($n = 99$) participants who were enrolled in two cultural competency workshops. Data for 34 participants were collected at the first workshop in 2001, and then data from the remaining 65 participants were collected in the fall of 2002 workshop. Data analysis was reached by using thematic analysis to provide different perspectives in defining cultural competence. Seven themes emerged from this data analysis: color blindness, client-focused, ac-

knowledgment of cultural differences, textbook consistent, resource-driven, skills-based, and self-integrated.

This study addressed the gap in multicultural competence counseling (MCC) literature. Six of the seven themes revealed some level of multicultural competence consistent with the literature. Nevertheless, the color-blindness theme confirmed a lack of cultural competence among participants. This theme focused on the similarities of people as an optimal outcome with disregard for differences between clients and counselors, which had a negative effect on the interaction. According to the researcher, the "color-blindness" theme was a direct artifact of White privilege and institutional racism in the U.S. The researchers further recommended that discussing multicultural competence should expand beyond MCC staff to include other disciplines. Moreover, the researchers affirmed that the pinnacle for the success of the multicultural movement will be greatly enhanced by the contributions of multicultural competence scholars to improving public health.

Other disciplines stressed the impact of cultural competence on the value of their services. Many accentuated the need to understand other cultures in order to appreciate clients' cultural views, attitudes, and values to better serve them. For example, providers should be aware of their own cultural beliefs, biases, and shortcomings to be truly sensitive to other cultures, thus preventing cultural imposition. Understanding and appreciating multiculturalism is a crucial skill to be successful in today's competitive markets. Qualitative research presented some themes that resonated with providers' cultural limitations. For example, Kai et al. (2007) reflected on cultural ambiguity and "uncertainty" when encountering clients of different cultures. "Uncertainty" was a theme that portrayed the scale of the complexity, anxiety, and uneasiness felt by

Figure 1. The pyramid of cultural competence (Abualhaija, 2020).



health care providers during cultural encounters. Likewise, Caldwell et al. (2008) identified a theme that is consistently covertly concealed during cultural encounters; this theme was "color-blindness" which represents a lack of cultural sensitivity. Different disciplines as in nursing recognized the significance of cultural competence to better meet clients' needs in a culturally humble way.

FINDINGS

Analysis of the literature review gave life to the concept's attributes, references, antecedents, and consequences. Additionally, the analysis gave birth to the process of becoming culturally competent, which is represented by a pictorial image of a pyramid (see Figure 1). This pyramid consists of four building blocks that are necessary to build genuine cultural competence.

Attributes of the Concept

Attributes are the characteristics, definitions, and dimensions of a concept; therefore, exploring attributes of the concept gives transparent conceptual clarity. Rodgers (2000) argued that defining attributes of a concept would fulfill the primary accomplishment of the analysis process. The review of the literature identified four attributes of the concept: cultural awareness, cultural knowledge, cultural skills, and cultural humility. The discussion of each construct is discussed below.

Cultural Awareness (Affective)

There are some prior requirements to achieve cultural competence; one of the earliest and most important requirements is cultural awareness. Cultural awareness was evident throughout the literature in both qualitative and quantitative inquiries, and in nursing and in other disciplines. Cultural awareness is a vital factor in the evolution of the concept of cultural competence because there can be no true cultural competence without initiating and appreciating cultural awareness from within each and every one of us. This construct targets the affective learning domain and starts with self-reflecting on our own cultural values and belief, then on the biases and false assumptions that we might hold against different cultures. Consequently, understanding how these false assumptions and biases might adversely impact the health outcomes of other cultural groups.

The review of the literature confirms that this construct conveys strong sentiments, such as "uncertainty" and the anxieties that were felt by healthcare providers during cultural encounters, and hidden within the composition of this construct is the notion of "color-blindness" that is institutionally covertly concealed. Cultural awareness is defined as "the deliberate self-examination and in-depth exploration of our personal biases, stereotypes, prejudices, and assumptions that we hold about individuals who are different from us" (Campinha-Bacote, 2007, p. 27). Similarly, cultural awareness is defined as "being knowledgeable about one's own thoughts, feelings, and sensations, as well as the ability to reflect on how these can affect one's interactions with others" (Geiger et al., 2007, p. 100).

Cultural awareness is considered the foundational building block for developing cultural competence (Fig.1). Both nursing and multidisciplinary studies recognized this construct as the gate that learners have to cross in order

to travel through the journey of becoming culturally competent. Qualitative studies, such as Caldwell et al. (2008); Kai et al. (2009); Soule (2014); Cai et al. (2017); Kaihlanen et al. (2019); De Peralta et al. (2019) have all validated that this construct is a foundational element to the evolution of the concept cultural competence. Undeniably, this construct was confirmed numerically by showing statistical significance in quantitative studies, such as Delgado et al. (2013) and Mareno and Hart (2014).

Cultural Knowledge (Cognitive)

The second construct that was repeated in the literature review across all disciplines was the construct of cultural knowledge. This construct addresses the cognitive learning domain of the learner (Jeffreys, 2006), and hence, it provides the second foundational block to building the pyramid of cultural competence (Figure 1). Healthcare professionals should be offered cultural educational opportunities. In nursing, for example, the emphasis is needed to purposely incorporate cultural competence education in both undergraduate and graduate programs. Nurse educators should consider in their curricular topics, such as ethno-genomic variations, ethno-pharmacology, ethno-pharmacokinetics, and disease processes and prevalence that are unique to certain racial groups. Additionally, nurse educators should include in their curriculum societal influences such as social determinants of health to enhance learners' cultural knowledge and sensitivity. Nursing students should evaluate and be attentive to how these societal influences play a substantial role in negatively impacting minorities' and vulnerable populations' health outcomes, and how public policy should institute measures to reduce social injustices in accessing health care faced by ethnic minorities.

Cultural knowledge is defined as "the process of seeking and obtaining a sound educational base about culturally diverse groups" (Campinha-Bacote, 2007, p. 37). In obtaining this knowledge, health care professionals should integrate three issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy (Campinha-Bacote, 2007). This construct was evident in quantitative nursing studies, such as Mareno and Hart (2014); and Delgado et al. (2013), and it was also evident in other disciplines, such as Marra, Covassin, Shingles, Canday, and Mackowiak (2010) and Lee, Litwin, Cheng, and Harada (2012).

Cultural Skills (Psychomotor)

The third construct is cultural skills which addresses the psychomotor learning domain. This construct enables health care professionals to deliver holistic care in a culturally sensitive manner. Subsequently, the health care provider is able to perform a complete physical exam considering bio-ethnic and genomic variations and follow-up with a treatment regimen that is specifically engineered toward that particular racial group. Cultural skills is defined as "the ability to collect relevant cultural data regarding the client's presenting problem, as well as accurately performing a culturally-based physical assessment in a culturally sensitive manner" (Campinha-Bacote, 2007, p. 49). It is important to consider physical, biological, physiological, and genomic variations such as body structure, skin color, visible characteristics, and laboratory when conducting a culturally physical assessment.