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Caring ethics as the foundation for cultural competence: views of health professionals working in student healthcare context

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Abstract

Background: Cultural competence is recognized as a leading component in the delivery of high-quality healthcare. However, a lack of concept clarity has led to lower quality and less effective healthcare provision for culturally diverse groups. Understanding of cultural competence in a healthcare context will be improved through the exploration of health professionals' perceptions of the matter.

Aim: The aim of this study was to explore health professionals' perceptions of cultural competence in a student healthcare context.

Methodology: The material consists of texts from interviews with ten health professionals in a student healthcare context. A hermeneutical approach was used and the method was inspired by content analysis.

Findings: One main theme and four subthemes were seen. The main theme was: "Caring ethics as the foundation for enabling cultural competence", and the subthemes were: "Cultural competence as knowledge and acting accordingly with open-mindedness and respect", "Cultural competence as being willing to understand and learn through a process", "Cultural competence as responsiveness and adaptability" and "Cultural competence as humility and discretion".

Conclusion: Ethics can be considered a core component of cultural competence in student healthcare. In further research, a focus should be placed on cultural competence as perceived from other (e.g., students') perspectives.

Keywords: Content analysis, cultural competence, ethics, health professionals, hermeneutics, student healthcare

Introduction

Social justice, fairness and the adequate right to healthcare comprise the cornerstones of cultural competence in healthcare practice (1). Prominent and important institutions such as the World Health Organization (2) and the Institute of Medicine (3) have recognized the importance of cultural competence, and the concept is considered integral to the reduction of racial and ethnic health disparities (4). Still, the concept of cultural competence is complex and difficult to define (5). Although many definitions and meanings of the concept exist, it is still evolving (6) and inadequately understood and described (7, 8, 9). It is important to explore cultural competence from the perspective of health professionals who encounter patients from diverse cultural backgrounds, because these professionals have awareness of what such cultural encounters entail. To my knowledge, research on this topic from such a perspective is scant.

Background

As early as the 1950s, Leininger started investigating what she called "culturally congruent care", which would develop into the concept of transcultural nursing (10). Her beliefs were based on the idea that understanding cultural diversity as associated with health and illness was a fundamental part of nursing knowledge. Leininger (10) saw that cultural diversity was a challenge for professionals in all healthcare contexts. Leininger emphasized that knowledge of cultural systems (a patient's cultural beliefs, attitudes and behavior) is essential for enabling culturally competent care (11). In 1989, Cross et al. (12) [p. iv] defined cultural competence as, "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable the system, agency, or those professionals to work effectively in cross-cultural situations". According to Purnell and Paulanka (13), culture not only refers to a collective and shared system of values, beliefs, traditions and behaviors but also verbal and non-verbal configurations of communication that distinguish one group with similar features from another.

Andrews (14) defines cultural competence as the multifaceted integration of knowledge, attitudes and skills that facilitates cross-cultural communication and interactions with other people. Cultural competence also involves the development of skills that, for example in the healthcare context, enable healthcare practitioners to embrace sociocultural factors (15). Campinha-Bacote (4) [p. 181] defines cultural competence as an "ongoing process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community)". Still other researchers base the definition of cultural competency on the ability of people from dissimilar cultures to work together (16, 17). Cultural awareness, cultural encounters and cultural desires are all part of the ongoing process of cultural competence (16, 17). For individual healthcare professionals and organizations, the National Center for Cultural Competence in the United States (18) specifies that the process of cultural competence involves a dynamic movement that includes stages, from cultural destructiveness, incapacity, blindness, pre-competence and competence to proficiency. Other researchers note that cultural competence also involves cultural sensitivity, knowledge and skills (19, 20) as well as understanding and interaction (20). Armstrong, Waters and Jackson (21) maintain that cultural competence entails that professionals are sensitive to cultural impact and take their own culture into account while also enthusiastically considering the understandings of people from other cultures. Similarly, Lin and Mastel-Smith (22) suggest that the foundation for cultural competence in healthcare and practice is the understanding of the impact of culture on an individual's perceptions of health. Henderson, Barker and Mark (23) note that patients are sensitive to cultural differences and that effective communication is crucial (23). Karabuga Yakar and Ecevit Alpar (24) also emphasize that to ensure holistic and high-quality care, healthcare professionals should have cultural sensitivity, i.e., basic knowledge of culture(s), cultural awareness and culturally sufficient communication skills to strengthen communication, and be able to adapt these into practice.

Cultural competence is recognized as a leading component in the delivery of high-quality healthcare (25). It increases the efficiency in healthcare through the avoidance of redundant and inconvenient services (26, 27) and can be used to make healthcare services more available, tolerable and effective for people from different ethnocultural communities (27). Cultural competence also decreases job stress, healthcare personnel burnouts and prejudices (25). Chen and Wang (28) highlight that nurses, in providing holistic care to patients from other cultures, are responsible for and have the capacity to build effective communication with patients. In delivering healthcare services that are efficiently and culturally

responsive, cultural competence remains an essential component (29, 30) that makes services in healthcare more accessible, adequate, and effective for people from diverse ethno-cultural communities (31).

Although cultural competence has been extensively accepted as being essential (29), O'Connell, Korner, Rickles and Sias (32) note that a lack of concept clarity has led to lower quality and less effective healthcare provision for culturally diverse groups. Waters, Gibbs, Riggs, Priest, Renzaho and Kulkens (33) point out that cultural competence is much more than awareness of cultural differences. According to the National Health and Medical Research Council (NHMRC) (34) in Australia, the focus of cultural competence should be the ability of a health system to advance health and well-being by integrating culture into the delivery of health services. When seeking to define the concept of cultural competence, Cai (35) references the Office of Minority Health in the United States of America (36), stating that they include words such as "policies", "systems", and "agency" in their understanding of cultural competence and that they describe the concept of cultural competence as professionals' attitudes and behaviors, in a system or agency, that enable cross-cultural effective work. Cai concludes by identifying cultural competence as an umbrella term that includes individuals' attitudes and behaviors as well as system or organizational policies or procedures. Jirve, Gerrish and Emami (37) and Shen (38) maintain that cultural competence is a cultural-related and ever-changing concept.

Understanding that culture is an essential component that affects all lives and forms of behavior is part of cultural education, as are honoring and accepting cultural differences, being able to efficiently utilize culturally adapted and culturally specific practices, and continuously reducing own prejudices (39, 40, 41, 42). To be able to recognize, respect and manage interpersonal cultural differences with tolerance and enable effective communication in diverse cultural surroundings (43, 23), communicating in an interculturally competent way is needed.

What culturally competent care entails has been delineated. For example, an Expert Panel for Global Nursing and Health part of the American Academy of Nursing along with members of the Transcultural Nursing Society (1) have developed twelve standards for culturally competent care.

The positive outcomes of culturally competent nursing care cannot be overestimated (31). Cultural competence is vital for reducing health inequalities and the prevention of racism in healthcare contexts (44, 28). It is also important for increasing patient satisfaction (45, 46), health outcomes (38, 16, 17), treatment adherence (47), and information seeking and sharing (46).

Cultural competence in a healthcare context entails that health professionals have cultural awareness (29), sensitivity, knowledge, skills (19, 20) and understanding (20) and also use these during interactions with others. Cultural competence in a healthcare context is also related to health professionals' knowledge of and skills in caring for patients from different cultural backgrounds than their own (4, 9, 10, 30). Cultural competence in a healthcare context also entails health professionals' awareness of own culture (21) when striving in humility to understand patients from other cultural backgrounds. To improve cultural competence in healthcare, it is essential to support health professionals' ability to practice care in a culturally competent way (5).

According to Kartari (48), the improvement of intercultural communication skills as part of cultural competence occurs in certain stages. The first stage is intercultural awareness, the second intercultural sensitivity and the third intercultural effectiveness. Marchal (49) suggests that a constructive way of obtaining cultural knowledge is an all-embracing tactic that includes using concepts such as "learning, asking, avoiding polarity/opposition, and empathizing". Chen and Starosta (50) developed an intercultural communication competence model to help people recognize and approach cultural differences with respect and tolerance, in which intercultural competence was classified into three dimensions: affective,

cognitive and behavioral. In their model, the cognitive dimension included intercultural awareness, the affective dimension included intercultural sensitivity, and the behavioral dimension included intercultural effectiveness.

Betancourt, Green, Carrillo and Ananeh-Firempong (51) emphasize that the focus of workforce interventions aimed at increasing cultural competence has primarily been placed on the education and training of healthcare staff in the knowledge, attitudes, and skills they need to effectively respond to sociocultural issues that can arise in clinical encounters. Tanriverdi (31) points out that in addition to cultural knowledge, nurses should develop cultural awareness related to, e.g., judgement and prejudice, discrimination, stereotyping, cultural imposition and cultural ignorance. Haarmans, Noh and Munger (52) likewise note that to implement cultural competence nurses should be aware of own cultural heritage and cultural ability, be able to perceive cultural differences and cultural dynamics in interpersonal interactions, and be able to assimilate cultural knowledge.

While the focus of earlier research has to a large extent been on defining cultural competence as a concept, in this study I seek to explore cultural competence from the perspective of health professionals in a student healthcare context. Other research including such a specific approach and context, where health professionals on a regular basis encounter students from different foreign countries with diverse cultural backgrounds, is scant.

Aims

The aim of this study was to explore health professionals' perceptions of cultural competence in a student healthcare context.

Theoretical framework

The theory of caritative caring part of the caring science tradition originally developed by Eriksson provided the theoretical framework for this study (53, 54). In the caritative theory, the human being is viewed as a vulnerable, unique entity of body, soul and spirit, who calls for an encounter that is in all situations permeated with dignity and love. Health and well-being may evolve as a result of the human being's (the patient's) possibilities to use his/her own will and through being and becoming the one he/she truly is. Caring therefore involves (nurses) wishing the other (patients) well and wanting only the best for the patient by acting out of faith, hope and love. The patient as a unique human being always longs for communion and to be recognized as worthy and thereby confirmed as a dignified human being. The source of strength and meaning in caring, the caring communion is characterized by, e.g., closeness, respect, honesty and tolerance, and presupposes a conscious effort to be with the other, which entails creating possibilities for the other. Caritative theory encompasses caring ethics, with the core of caring ethics being determined by the caritative movement.

Caring ethics, which is the core of nursing ethics, relates to the way in which a nurse meets the patient. It entails to without prejudice view all humans with respect, confirm their absolute dignity and be willing to sacrifice something of oneself. In the ethical act, the good is brought about through ethical actions. The patient is the suffering human being, a human being who suffers and patiently endures but longs to be met and seen by the other (the nurse). The caring culture transmits an ethos and can radiate caritas, i.e., love and charity, and in such a caring culture (that is, a caring communion), the patient as the suffering human being experiences that he/she is invited and welcome (53, 54).

Methodological aspects

The present study has a qualitative design with a hermeneutical approach (55), and the method was inspired by content analysis (56). The data consist of in-depth interview texts with health professionals in a student healthcare context.

Data material and data collection

Ten health professionals between 26 and 61 years were interviewed about their perceptions of cultural competence in a student healthcare context (see Table 1). The participants were from an urban area of Ostrobothnia, Finland, had similar socioeconomic backgrounds, and all worked with students (primarily aged between 16 and 25, but even up to middle age) in a student healthcare context. The students were enrolled in upper secondary vocational studies or further/specialist vocational studies. The students were a mixture of native Finns (Finnish-speaking or Swedish-speaking) and exchange students from different countries. Thus while a number of students were from the same culture as the health professionals, the health professionals also encountered students from different cultural backgrounds on a regular basis (everyday, once a day, a few times a week or a few times a month). The participants were recruited from a public care organization in cooperation with the organization's leading head nurse. The role of the leading head nurse was to recommend suitable participants for the interview. The researcher was given a list of people with names and phone numbers, and she then contacted these people by phone and invited them to participate in the study. Those who accepted to participate also received an email with additional information about the study. In-depth interviews were performed in 2019 in the previously mentioned student healthcare settings. The interviews lasted between 30-60 minutes and were transcribed verbatim. An interview guide was used and the participants questioned about their perceptions of cultural competence, including how they define the concept, examples of challenging cultural situations in daily practice, and their reflections on their encounters with students from other cultures.

Insert Table 1 here.

Hermeneutics in accordance with Gadamer (55) guided the interpretation during data analysis. The material was approached with openness and attentive vigilance and the data were initially read several times, in order to grasp an overall understanding of the whole. After the initial reading, the data were re-read to gain an understanding of the parts, whereafter the understanding of the parts was reflected against the understanding of the whole. This allowed me in the capacity of researcher to move between interpretation and understanding and between the whole and the parts, always returning to an understanding of the data as a whole. I was careful to guarantee that my pre-understanding as researcher did not steer the interpretation process, which occurred through active awareness of the pre-understanding. The pre-understanding was also challenged during the reading of the data. Thus, the interpretation constituted an iterative process, where the pre-understanding was eventually welcomed by myself as researcher into the scientific discourse via the creation of subthemes and a main theme that characterized the overall understanding. For an example of the analysis process, see Table 2.

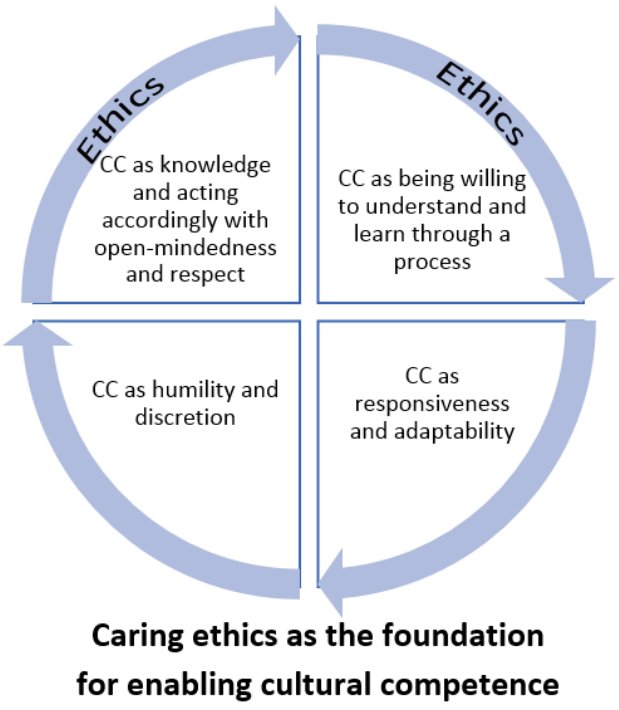
Insert Table 2 here.

Ethical considerations

The ethical guidelines outlined in *The Finnish National Advisory Board on Research Ethics* (57) were used to guide this study. As researcher I contacted potential participants, who had been chosen for participation in this study, by telephone. The potential participants had been chosen for the study based on the head nurse's recommendation. The participants were given information (informed consent both orally and in written form) about the purpose of the study, confidentiality, and the possibility of withdrawal of consent. They were also informed, both orally and in written form, about the intention to publish the findings. Informed consent from the participants was sought regarding study participation and storage. The public health organization where the participants worked also provided ethical approval (in written form) and gave permission to conduct the study.

Findings

One main theme and four subthemes were identified (see Figure 1). The main theme was "Caring ethics as the foundation for enabling cultural competence". The subthemes were "Cultural competence as knowledge and acting accordingly with open-mindedness and respect for others", "Cultural competence as being willing to understand and learn through a process", "Cultural competence as responsiveness and adaptability" and "Cultural competence as humility and discretion". All are further described below.



Caring ethics as the foundation for enabling cultural competence

In the main theme, caring ethics is considered key to cultural competence. As seen in the findings, caring ethics is inherent in all cultural competence and activity in the student healthcare context. In all of the subthemes, caring ethics is seen to be the prerequisite that enables culturally competent actions. The participants perceived that caring ethics were the foundation upon which cultural competence lay. This could include, e.g., that the participants took a genuine interest in each and every student they met in the caring relationship and that they as health professionals used caring ethics to guide their every action. As one participant stated:

> *"Yes, this is correct… Ethics is the basis for being able to be culturally competent. … if you are not ethical you will not get anything out of the cultural encounter in caring, nothing will be done. …and I can see this sitting here with the students …that the interaction between us becomes superficial if I do not bring [that which is ethical] with me … I cannot just sit and stare at the computer screen or take notes when they are here, because then they will know that I am not genuinely interested. If you do not have an ethical attitude everything else falls flat…" (P1)*

The participants observed that cultural competence is needed to be able to provide correct and good care that suits each patient and that this requires ethical caring from within, i.e., from the heart, in which they as health professionals respond to the other in a considerate way. One participant noted:

> *"You need [cultural competence] to be able to provide the right care. You act blindly if you do not take cultural competence into account. Then I may do something automatically as a duty, but I do not want it to be that way…I want them to feel that we want to provide care so that the person recovers and try to find solutions that suit them… I want to care from my heart and take care of them so that I show an interest in the person who arrives and that I care about why they are here." (P2)*

Cultural competence as knowledge and acting accordingly with open-mindedness and respect

In the first subtheme, knowledge, open-mindedness and respect as central components of cultural competence were highlighted. The participants perceived cultural competence to entail that one has a basic knowledge of different cultures, cultural habits and behaviors and that one shows respect for these. It also entails using this knowledge alongside experience in one's practice. As one participant expressed, *"I would define it as how much you know about a culture and how you can adapt to working with it if it's a different one from your own. Also to know their way of thinking, acting, the whole system." (P5)* It could also mean that one should not be prejudiced against any culture but instead view every student as a unique human being, not someone from another culture. The participants maintained that knowing about or being familiar with a patient's culture allowed them to understand the student's culture-dependent behavior better, because it improved interaction and communication. The participants even noted the importance of understanding cultural differences with regard to what is considered "good" or "bad" in a specific culture. One participant stated:

> *"Cultural competence can help you to understand why people are acting the way they are. For example, there are many students who are Muslims and they observe Ramadan, when they do not eat or drink during the day, but during the night. It is good to know if they observe Ramadan and they come here and*

do not feel good, which can be because of that. Ramadan lasts for about a month, during Ramadan, then, they just skip school lunch." (P8)

The participants perceived a need to be respectful of other cultures and build trust through communication, and for them cultural competence implies openness. *"It means not judging and assuming things about people based on their culture. It also has the meaning to try to learn from other cultures by being open-minded." (P4)* The participants also described cultural competence as including taking students seriously and listening and trying to put oneself in the student's position in an effort to try to understand the student. The participants here related that they try to interpret what a student means by reading the student's body language, using automated online translation services (e.g., Google translate), and using various forms of communication. They noted that patience on the part of the health professional is required: to persevere in one's willingness to understand and discover what the other means.

The participants maintained that, for them, cultural competence entails trying to be open and listening to each student's story without judgement. When health professionals and students do not share the same culture and/or language, a visit can take several hours. Time is a crucial component in cultural competence, because as seen in the setting here it enables health professionals to hear students' stories about themselves and where they come from. This occurred, for example, when the health professionals asked students questions and showed interest in the students. The participants maintained that remembering that a student is a whole, unique human being when encountering him/her for the first time helped them treat everyone equally and avoid judgement or prejudice. The participants emphasized that it was important to not let their own culture and values dominate their professional actions, and stated that training could help facilitate such professional "cultural neutrality". As one participant noted:

"It helps you to serve if you can help and provide care in the best possible way if I manage to respect them, for my role is not to provoke them… or form an opinion about their cultural principles, but my role is only to help and provide care…" (P3)

Cultural competence as being willing to understand and learn through a process

In the second subtheme, being willing to understand and learn through a process as components of cultural competence were highlighted. The participants mentioned that they learned more about different cultures every day. One participant reflected:

"You have to be motivated and interested in learning more about different cultures in your encounters by asking, for example, how things are in our or your culture, and maybe read some articles or both. And maybe it comes with time as you work along. The place, I mean. You meet people from other cultures when working. I think you can learn from that as well." (P9)

The participants maintained that cultural competence is not a static condition, but an ongoing process of improvement, in which one willingly learns new things. The participants related that each encounter with a student from another culture provides a learning opportunity, if they are willing to get to know and understand the other. *"Cultural competence has to do with that I want to get to know the other and understand from the other's point of view." (P2)* The participants also emphasized that each individual has his/her own story; even if two students share the same culture or come from the same

country, one should not presume that they are the same. Cultural competence, therefore, can be considered an ongoing process in which new things are learned, because every culture is different and each student has his/her own individual background and story. One participant stated:

> *"Cultural competence is something that I will never fully learn. I have to ask [students from different cultures] all the time…and to have them tell me more about different aspects. It's more of a process, that's going on all the time… Learning new things and then also the other way around, that students understand what kind of advice I try to give [them]." (P6)*

The participants revealed that they perceived educating themselves about other cultures to be important. This could occur through reading about or trying to expose oneself to different cultures, or getting to know people from different cultural backgrounds. One participant noted that asking about cultural issues that one does not understand was also an essential component of cultural competence. Another participant stated:

> *"I think the first thing is to get to know more about the culture of different places. …If you ever have the opportunity to travel to those places and actually experience the culture there, and not only see how it is portrayed in texts, in movies and media… So if you have a chance to visit those places and learn from them, that's the best option in my opinion, but not only talking with people from those places, but like getting to know them." (P5)*

Cultural competence as responsiveness and adaptability

In the third subtheme, responsiveness as a component of cultural competence was highlighted. The participants stated that they needed more responsiveness and sensitivity when dealing with students from other cultures. The participants noted that there was no such thing as a "routine" visit; even if students present with the same concern, they are nonetheless unique human beings with individual needs. They related that what may suit one student does not necessarily suit another and that they needed to be responsive to each student's manner of expressing and understanding his/her concerns. As one participant commented:

> *"And I need to ask what they have understood …and through follow-up questions I realize what they have understood. Simultaneously this builds trust, they get a sense of trust, that I am interested in their well-being." (P2)*

In addition, the participants related that to facilitate communication and ensure that the student understood what he/she was being told they needed to adapt and formulate questions and follow-up questions for each student. The participants perceived that responsiveness was needed with regard to how they expressed themselves and when checking what the other has understood.

> *"You also have to be responsive in relation to how you express yourself, especially when meeting these [students from different cultures]. You sort of have to feel your way… and ask questions in a way that the other understands what I mean… based on what they say you can check later… because I cannot ask*

students from another culture questions in the same way even though they have the same complaint or problems, but I must rephrase the question so that it fits the student in front of me, so that I know that they understand what I mean by this…" (P2)

The participants noted that follow-up questions were crucial to ascertaining whether a student from another culture understood, and one participant gave an example illustrating how easily miscommunication can occur:

"I can give you an example, I had an exchange student from the Czech Republic, and told the student to take this medication for a headache…and then he said 'Do you mean I should drink it?' And I was a little confused by this… to drink pain medication, I understood it but…like, they drink pain medication, while we take pain medication. …that there are various names for how to take pain medication." (P2)

The participants maintained that to facilitate communication it is important to be creative in situations where no common language exists, e.g., by drawing a picture. They noted that reading a student's body language could be very helpful with regard to communication, as well as showing acceptance of the student's culture, customs and/or beliefs through own body language, follow-up questions or adaptability in the form of "cultural compromises". One participant stated that:

"Just through nodding, for example… or that one does not have to remove all veils etc. when taking a hearing test. One must bend the rules a little, and compromise until both parties are happy…One can show acceptance also by showing that one understands, one can ask follow-up questions that are more detailed… [which shows that I am on their side]." (P1)

Cultural competence as humility and discretion

In the fourth subtheme, acting with humility and discretion as components of cultural competence were highlighted. The participants perceived that to know oneself was important, because health professionals' work is based on the self. The participants linked knowing oneself well with being able to treat the other ethically and demonstrating humility before the other's culture and values. A broad range of cultures, religious groups and countries can be seen in the student healthcare context. While to a certain extent cultural knowledge can be taught, in practice health professionals gain cultural knowledge through experience when treating people from other cultures. With regard to demonstrating humility, one participant mentioned:

"And that I can ask the client if I do not know… could you please explain more… I am not familiar with… this… Then this is also ethically right, and this is where humility comes in, that I should not believe that I know everything about everyone. Humility is key… to the cultural…" (P3)

The participants emphasized that in a student healthcare context cultural humility (i.e., sensitivity) and special discretion should be shown religious groups, e.g., with regard to modesty and privacy. The participants noted, among others, that care for followers of Islam (Muslims) should be provided by a healthcare professional of the same gender as the patient

and that screens or "in-use lights" should be used to protect patients' modesty during examinations. They also maintained that discretion was important, e.g., that one should not discuss a patient/patient situation with a colleague within earshot of the patient. They furthermore observed that while all procedures should be thoroughly and carefully explained, this was of especial importance when treating students from other cultures. One participant stated:

> *"I always explain what I am doing… I always prepare them. The explanation must be tailor-made for patients from another culture…I also sometimes have to explain several times and ask if this suits the client or not…" (P2)*

The participants specifically mentioned that discretion and a careful approach were especially important with sensitive students, noting that there was a need to adapt one's manner to such students so that the students would begin to trust the advice being given to them. One participant revealed that, *"Someone who is very sensitive so you have to take that into consideration… then I try to reach such a level where we are on the same level, and from there you can gradually move on… and then I can give her the advice she dares to trust." (P2)* Discretion as a component of cultural competence also facilitates the building of trust in the caring relationship. The participants even perceived that cultural competence could help them understand that some cultures could consider certain issues, such as anxiety and depression, to be taboo. As one participant noted:

> *"It was a male student from Africa. He came to see me quite a lot of times and just talked about loss of appetite and sleeping problems. And when I got to know him better, I found out that one of the reasons was that he was suffering from a really bad depression. But I could never mention the word depression to him, because in African culture or so, you don't talk about mental problems." (P6)*

Discussion

The aim of this study was to explore health professionals' perceptions of cultural competence in a student healthcare context. In the main theme, I found that caring ethics is considered key to cultural competence. Caring ethics is also interwoven into all of the subthemes as a prerequisite that enables culturally competent actions. Consequently, caring ethics can be considered a core component of culturally competent care. The participants here stated that they cared from the heart, took a genuine interest in each and every student they met in the caring relationship and used caring ethics to ensure *that their actions match the needs and desires of the patient in the moment.* This can be compared to Eriksson's theory of caritative caring (54), in which the suffering human being wishes to be cared for by someone who wishes him/her well. It also emerged that cultural competence is needed to in order to be able to care for patients in an adequate way (1) and in order to give the correct care. I saw that without culturally competent health professionals who are able to understand cultural nuances and "hear" a patient, misunderstandings and care errors can occur. Cass, Lowell, Christie, Snelling, Flack, Marrnganyin and Brown (58) also find that cultural differences between healthcare providers and patients can lead to severe miscommunication. Other researchers have even found that cultural differences can lead to patient mistrust (59), reduced satisfaction and disempowerment (60). Campinha-Bacote (4) views cultural competence as a precondition for an ethically acceptable nurse-patient relationship. Here, however, caring ethics were seen to be the prerequisite for culturally competent actions. It would appear that the subthemes found in this study are intertwined and

that caring ethics is the prerequisite for cultural competence and culturally competent nursing actions, which are required for ethically sustainable care.

I also saw here that knowledge and acting accordingly with open-mindedness and respect are central components of cultural competence. This includes having a basic knowledge of and respect for different cultures and using this knowledge alongside experience in practice. These findings are in line with Eriksson (54), who highlights respect and tolerance as being essential to caring. Caring ethics and cultural competence were even seen in this study when participants stated that one should not be prejudiced against any culture but instead view every student as a unique human being and not merely someone from another culture, also when the participants related that they take the students seriously and listen and try to put themselves in the student's position in an effort to try to understand the student, which can be interpreted as an effort to communicate efficiently and thereby enable high-quality care. The participants related that when meeting students for the first time, they sought to avoid judgement or prejudice by thinking of the student as a whole human being. I therefore maintain that it could be helpful for health professionals to think of each encounter as a first. Such a method involves seeing the uniqueness of each human being and viewing each human being and encounter as full of potential, which can be compared to Eriksson (54). The present study also reveals that cultural competence entails being willing to understand and learn through a process. Other researchers consider further multicultural nursing education to be important for cultural competence (61, 62). Schim, Doorenbos and Borse (61) find that a higher level of education is associated with cultural competence, while other researchers associate cultural competence with linguistic skills (62, 63). The participants here perceived that there was always something new to learn about cultural competence and that each individual had his/her own story, which indicated that cultural competence is an ongoing process. This can be compared to Campinha-Bacote (29) and even Shen (38), who note that cultural competence for health professionals is a lifelong and dynamic developmental process aimed at enabling effective healthcare for diverse patients. In a similar vein, Marchal (49) mentions that learning is a central part of cultural competence. Here being willing to understand those from a different culture was seen to be a crucial part of cultural competence, because it touches upon health professionals' inner ethics of being willing to understand and care for the other and confirm the other's absolute dignity as a unique human being (54). The findings seen here confirm what Waters et al. (33) maintain about cultural competence being more than alertness about cultural variances; cultural competence also concerns health professionals' attitudes and behaviors (35). Also similar to the findings seen here, Alpers (64) notes that an open mind and the ability to understand the need to ask patients from other cultural backgrounds relevant questions are needed if one is to understand their needs and wishes.

Responsiveness and adaptability are also seen here to be central components of cultural competence. Communication and ensuring understanding were seen to be important, including how one expresses oneself and asks questions. The participants emphasized that responsiveness and sensitivity to each student's manner were also important, because each student is a unique human being with individual needs. This can be interpreted as a need to tailor one's statements to the other. Other researchers also underscore sensitivity as a central element of cultural competence (19, 20, 21, 24), and Campinha-Bacote (29) point out that health professionals should seek to be able to work successfully with a patient, which can be compared to the component of adaptability seen here. Asking follow-up questions, being creative to facilitate communication and reading body language were considered here to be important to inhibiting miscommunication. Also, adaptability was here linked with responsiveness; if health professionals are responsive but do not adapt, then the equation is incomplete. One can presume that it is caring ethics that guides health professionals when they do what they believe is best based on cultural knowledge and competence. Chen and Wang (28) also highlight that, as part of their cultural competence, nurses need skills whereby they can create effective communication with their patients.

Humility and discretion even emerged as central components of cultural competence. Knowing oneself allowed the participants to admit that their cultural knowledge could be lacking, thus
humility can be considered a component that can "unlock" cultural competence. Caring ethics were seen here in the form of the health professionals' discretion, when they made the extra effort to meet patients where they were at a particular moment and together go forward. Such discretion creates the foundation for a trustful caring relationship between health professional and patient (54).

The findings here can be reflected against Papadopoulos, Tilki and Taylor's *PTT model* of *cultural competence* (65) also later described by Papadopoulos (66), because the subthemes here correspond to the four stages mentioned in the PTT model: *cultural awareness*, *cultural knowledge*, *cultural sensitivity*, and *cultural competence* (18). In the first stage of the PTT model, cultural awareness, health professionals' own values and beliefs are viewed as vital for becoming aware of cultural identity and ethnocentricity. Here this is seen as the health professionals' inner ethics and their listening and caring for the students from the heart to be able to provide culturally competent caring. In the second and third stage of the PTT model, cultural knowledge is seen as an essential element of cultural competence together with learning, and cultural sensitivity is seen as empathy and true partnership, along with communication skills, trust, respect and acceptance. Here understanding and encountering students with responsiveness where they are situated, and following the students from that point forward toward becoming in health through a process involving adaptability, humility and discretion emerged. It is my understanding that cultural competence can be gained through the actions inherent in all of the subthemes together.

Nevertheless, I maintain that it is caring ethics that underlies the whole: caring ethics brings unity and strength, provides meaning and vitality to cultural competence in the student healthcare context. This is in line with the PTT model (66), in which Papadopoulos, Tilki and Taylor's emphasize that a synthesis of several factors must occur to form the final phase of cultural competence in nurses, during which they also become skilled on a practical level in managing patients' caring needs. The foremost finding in this study was that the most fundamental aspect of cultural competence can be discerned in health professionals' inner ethics and how they from the heart care for students from different cultures and backgrounds, without judgement or prejudice. This can be compared to the fourth and final stage of the PTT model (66), cultural competence, in which the most vital skills are recognizing and challenging racism and discrimination.

Strengths and limitations

The findings might have been somewhat different if more male participants had been included, and this may limit the generalizability and comparability of the findings. The inclusion of a second researcher, e.g., to conduct a second individual analysis of the data, could have strengthened the validation process. Nonetheless, a trustworthy depiction of the subject matter was seen and an inductive study of health professionals' perceptions of cultural competence in a student healthcare context realized. The healthcare context where the data were collected had potential for yielding reliable data, because the participants (ten in total) encountered students from different countries and diverse cultural backgrounds on a regular basis and the participants were seen to honestly and openly express their views, which generated rich data. This study can be seen as defensible because the knowledge ascertained can potentially help health professionals in understanding cultural competence. While in this study interviews were used, in the future observation studies could be conducted.

Conclusion

Caring ethics can be considered a core component of cultural competence in student healthcare. At its core, cultural competence entails caring from the heart without judgement or prejudice, regardless of cultural differences. In further research, a focus should be placed on cultural competence as perceived from other (e.g., students') perspectives.

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