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Review

The Culturally Competent Healthcare Professional: The RESPECT Competencies from a Systematic Review of Delphi Studies

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Abstract: Background: In the existing literature, there are many guidelines regarding cultural competencies for healthcare professionals and many instruments aiming to measure cultural competence. However, there is no consensus on which core cultural competencies are necessary for healthcare professionals. **Aim and Methods**: This study employed the PRISMA 2020 statement to systematically review Delphi studies and identify the core cultural competencies on which experts, who have been working with diverse populations in the fields of healthcare and allied healthcare, have reached a consensus. For this purpose, we searched, retrieved, and reviewed all Delphi studies conducted between 2000 and 2022 in the databases Scopus, PubMed, CINAHL, Medline, and PsycInfo and coded and synthesised the results qualitatively. **Results**: The systematic search resulted in 15 Delphi studies that met eligibility criteria and in which 443 experts from 37 different countries around the globe had participated. The review of these Delphi studies showed that the core competencies necessary for healthcare professionals to ensure that they provide culturally congruent care were: Reflect, Educate, Show Interest and Praise, Empathise, and Collaborate for Therapy. **Discussion and Conclusion**: These competencies make the abbreviation and word RESPECT, which symbolically places emphasis on respect as the overarching behaviour for working effectively with diversity. The study also provides a new, comprehensive definition of the cultural competence of healthcare professionals and opens new directions in formulating standardised guidelines and research in cultural competence in healthcare and allied healthcare.

Keywords: cultural competence; diversity; Delphi study; systematic review; healthcare; allied healthcare

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1. Introduction

1.1. Background

Cultural competence has been acknowledged as an important set of knowledge, skills, and attitudes that can help tackle health disparities [1]. Although it has been defined many times, in general, cultural competence refers to knowledge of social and cultural factors that influence disease and illness experience and to any actions taken by the healthcare provider to ensure a high quality of care in relation to patients' background [2]. There is research evidence that shows that cultural competence has contributed to the improvement of care for diverse populations. More specifically, there are a few systematic reviews involving studies from the 1980s to 2019. Price et al. [3] reviewed research from between 1980 and 2003 and discussed how cultural competence improved attitudes, skills, and patient satisfaction; one study showed a link between cultural competence and adherence to therapy. The review by Renzaho et al. [4] focused on studies published between 2000 and 2011 and revealed that training in cultural competence improved clinicians' cultural awareness and sensitivity. Interestingly, later systematic reviews of evidence did not yield any different results. That is, Horvat et al.'s [5] review aimed to focus on randomised control trials in

order to identify a causal relationship between cultural competence and health outcomes. Although they did not find a direct relationship between cultural competence and health outcomes, the study showed a clear improvement in adherence and understanding between patients and doctors. Alizadeth and Chavan's [6] study reviewed research between 2000 and 2013 and found that patient satisfaction and adherence were enhanced when clinicians were culturally competent, but the researchers failed to find a clear link between cultural competence and positive health outcomes. Similarly, Vella, White, and Livingston [7] did not find a link between cultural competence and health outcomes, although patients' perceptions of healthcare professionals' cultural competence improved. However, more recent systematic reviews, which explored studies published until 2019, have shown a different picture in terms of cultural competence's influence on outcomes. That is, Chae et al. [8] reviewed randomised controlled trials and found that 9 out of the 12 eligible studies showed improvement in professional educational outcomes, while 3 of these studies indicated improvement in patient outcomes. Skipworth's [9] systematic review found a strong association between cultural competency and quality of care, with healthcare professionals who had higher levels of cultural competence providing even better care. It seems that studies agree that cultural competence contributes to the improvement of healthcare professionals' knowledge and skills, patient satisfaction, and adherence to therapy, while there is some evidence that shows improvement in health outcomes. Such mixed results in terms of the link between cultural competence and health outcomes might largely be due to the scarcity of well-designed randomised control trials and possibly due to the difficulty of properly measuring cultural competence [10]. As explained below, our systematic review aimed to simplify and categorise all the skills and behaviours suggested by experts in order to identify a few core competencies that can potentially inform new research instruments, projects, and trainings.

1.2. Rationale

Due to the acknowledged importance of cultural competence in healthcare, many frameworks and models have been developed to provide guidance. For example, the 2003 special issue of the journal Academic Medicine [11] included strategies for cross-cultural communication and cultural competence trainings, and the Association of Medical Colleges in 2012 issued a handbook in cultural competence education for medical students [12]. In addition, the LIVE & LEARN model included skills such as listening, evaluating, acknowledging, recommending, and negotiating [13]. The Sunrise model suggested by Leininger [14] highlighted that healthcare professionals should focus on cultural values; religious and philosophical beliefs; economic, educational, political, legal, and technological factors; and kinship and social ties. The Purnell model was largely a list of knowledge items ranging from high-risk behaviours to family roles to heritage and communication [15]. Alizadeh and Chavan [6] reviewed the relevant literature and found 18 models of cultural competence. All these models, largely derived from literature reviews (one model was generated from a Delphi study), outlined various components of cultural competence. The components included awareness, understanding, caring, sensitivity, diversity, attitudes, openness, communication skills, self-awareness, contextual interactions, intercultural affinity, and cultural intelligence.

In addition to generating competencies from reviewing the literature, some scholars have conducted a Delphi study to identify the competencies needed to ensure cultural competence in healthcare [16–18]. However, these studies indicated both similar and different competencies, and they did not seem to agree on the number of necessary core competencies. Some generated only a few competencies or skills [16], while others suggested more than one hundred [18]. Delphi studies have been used many times in the healthcare scholarship, as they rely on expert opinions and follow a structured and controlled procedure to reach safe conclusions on the items that experts reach a consensus on. Delphi studies have been used for formulating policies and guidelines in healthcare [19].

Because of the contribution of cultural competence in healthcare, the importance of Delphi studies in formulating guidelines, and the variety of skills and competencies found in the published models of cultural competence, with this paper, we aim to review all Delphi studies conducted in healthcare practice, healthcare education, and allied health sciences in order to identify the core or overarching competencies that a healthcare professional in any discipline should have to ensure high quality of care in relation to a patient's background and needs. We have not identified another systematic review of Delphi studies on the subject, and therefore, this paper is a major contribution to scholarship. Below, we describe our objective and how we generated our research question.

1.3. Objective and Research Question

Having explained the rationale and need for this systematic review, our objective was to thoroughly and systematically search, retrieve, and review all Delphi studies that focused on the cultural competencies needed for professionals in the healthcare and allied healthcare sectors. We approached cultural competence in its broadest sense, on par with Constantinou et al.'s [20] suggestion that cultural competence should be an umbrella term because "culture" is difficult to measure, as it encompasses anything that human beings have created by living in societies [21]. On this basis, in addition to cultural competence, we aimed to search other related terms such as diversity, cultural humility, structural competence, cultural sensitivity, cultural awareness, and intercultural communication [20].

Our aim was to qualitatively synthesise and analyse Delphi studies, and therefore, we used the PICo framework for qualitative studies in order to determine a research question [22]. PICo provides three questions to be considered by researchers before they finalise their research question: (a) What is the problem, condition, or disease you are interested in? The problem we are interested in is the core or overarching cultural competencies for professionals providing care in any field. (b) Interest relates to a defined event, activity, experience, or process. The interest in our case is the experiences of experts who have worked with cultural competence and diverse populations. (c) Context is the setting and its distinct characteristics. Therefore, the context in our study is healthcare settings and diverse populations globally. On the basis of the PICo framework, we have formulated our research question as follows: "What are the core cultural competencies for healthcare professionals on which experts have reached consensus in Delphi studies?" We also used the PICo framework to clarify the eligibility criteria, as described in our methods below.

2. Methods

In order to adequately meet our objective and address our research question, a systematic review was employed, as per PRISMA 2020 statement [23]. Below, we describe the methodology in detail.

2.1. Eligibility Criteria

All selected studies included in this systematic review had to meet specific inclusion criteria on the basis of the PICo framework (described in previous section) [22] and as per Table 1 below.

Table 1. Inclusion/exclusion criteria.

Inclusion	Delphi studies published in journals or conference proceedings. Delphi studies that clearly had expert panels. Studies that explored experts' views on the skills or competencies for cultural competence in healthcare and healthcare education, including medicine, psychiatry, nursing, and allied professions including physiotherapy, occupational health, pharmacy, social work, and psychology. Delphi studies that used the terms cultural competence, cultural humility, structural competence, cultural awareness, cultural sensitivity, intercultural communication, and diversity competence. Published from 2000–2022 in English in any country.
Exclusion	Studies that did not use the Delphi method. Studies conducted for fields other than medicine, nursing, and other allied healthcare. Published before 2000 and/or in a language other than English.

2.2. Information Sources and Search Strategy

We used databases that provided breadth of resources, were most relevant to our research question, and were able to be accessed by our institution. On this note, we searched the databases Scopus, PubMed, CINAHL, Medline, and PsycInfo. Google Scholar was used as a supplementary resource [24] and consulted after searching of the databases above was completed. For our search, we initially formulated keywords that were relevant to our research question and captured all components involved. Therefore, the following keywords were used: "Delphi study", "experts' views", "cultural competence", "cultural humility", "intercultural communication", "diversity competence", "structural competence", "health", "allied health", "medicine", "nursing", "physiotherapy", "pharmacy", "psychiatry", "occupational health", "social work", "psychology", and "education". To ensure a systematic approach, we carried out our search based on guidelines by Atkinson and Cipriani [24] and developed streams of search, as per Table 2.

Table 2. Streams of systematic search with the use of keywords.

Delphi study (OR Expert Views) AND cultural competence (OR cultural humility OR structural competence OR cultural awareness OR cultural sensitivity OR intercultural communication OR diversity competence) AND health (OR healthcare OR medicine OR nursing OR psychiatry OR allied health OR physiotherapy OR pharmacy OR occupational health OR social work OR psychology OR education)

2.3. Selection of Studies Process

Two researchers independently searched, retrieved, and selected the studies initially based on three main criteria, namely (a) if Delphi method was used, (b) whether cultural competence or any other related concept was included, and (c) whether the study was related to healthcare, allied healthcare, or healthcare education. Then, other criteria were used for further filtering, such as peer-reviewed articles published in journals or conference proceedings and date of publication. Once the selection was completed, the two researchers discussed and made any necessary additions/removals.

2.4. Data Collection Process

Data from the included studies were collected by two researchers independently by extracting the components, items, statements, or competencies on which experts reached consensus during the final round of each Delphi study. Once extracted, the two researchers read the data multiple times and started coding and generating themes, as per the procedure described below.

2.5. Synthesis Methods

For the qualitative synthesis and analysis of the Delphi studies, we relied on Thomas and Harden's [25] thematic synthesis technique in order to understand the meaning of the

skills suggested by experts and therefore group them together to create core competencies. Thematic synthesis consists of three stages. Firstly, the researchers thoroughly read the articles multiple times to become familiar with the exact Delphi procedure involved and the findings. Secondly, the findings in each article were coded based on the research aim of this study. Thirdly, the codes were grouped together to construct overarching themes or, in this case, core competencies. After generating the core competencies, the analysis was drafted and refined by revisiting the articles, coding, and categorisation. To ensure the validity of the results, we employed a two-level quality assurance process, whereby the authors of this paper and researchers followed the review procedure (i.e., coded and categorised, revisited the Delphi studies, refined the codes and categories) independently. They then met, discussed, refined, and finalised the core competencies necessary for healthcare professionals based on experts' opinions.

3. Results

3.1. Studies Selection

As per the PRISMA Figure 1 below, the systematic search initially resulted in 780 papers. When duplicates were removed, 717 papers were screened by abstract. From screening, 696 papers were excluded, as they were irrelevant to the study's research question. The remaining 21 papers were further reviewed for eligibility. After a more thorough reading of the papers against the eligibility criteria, 15 Delphi studies were included.

It is important to note here that we decided to include a couple of studies that initially seemed to fall outside our criteria. For example, Mohammadpour et al.'s [26] study was written in Persian, but it had a long abstract in English, which provided useful insights and added to our qualitative analysis. Additionally, Deardorff's [27] study was largely in the field of education, but we decided to include it because some of the experts had worked in the healthcare sector. Similarly, Montecinos and Grunfelder's study [28] was a more generic Delphi study, but we included it because some of the experts were psychologists and cross-cultural trainers. On the other hand, six Delphi studies were excluded, as they did not relate to healthcare or did not explore competencies that should be demonstrated by healthcare professionals.

3.2. Study Characteristics

The 15 Delphi studies generated a variety of cultural competencies resulting from suggestions or recommendations from 443 experts in 37 different countries around the world. Experts were medical doctors, nurses, social scientists, educators, public health workers, members of cultural groups, and decision-makers in organisations. Table 3 below includes more information regarding each study's title, aim, consensus level, Delphi rounds, number of experts, countries, and experts' backgrounds.

3.3. Study Assessment

As per Table 4, all Delphi studies included in this systematic review have been assessed against the CREDES guidelines for Conducting and REporting DElphi Studies [19]. All studies met most of the CREDES criteria, as they had detailed descriptions of the methodologies and procedures. The only criterion that was not met by any of the studies was "external validity", which refers to having the final outcomes reviewed by an external board before publication. Furthermore, a couple of studies were lacking in terms of reporting their results [31,33]. This happened in studies where the Delphi method was not the main or only methodology used but was part of a larger study where other methods, such as surveys and qualitative interviews, were employed.

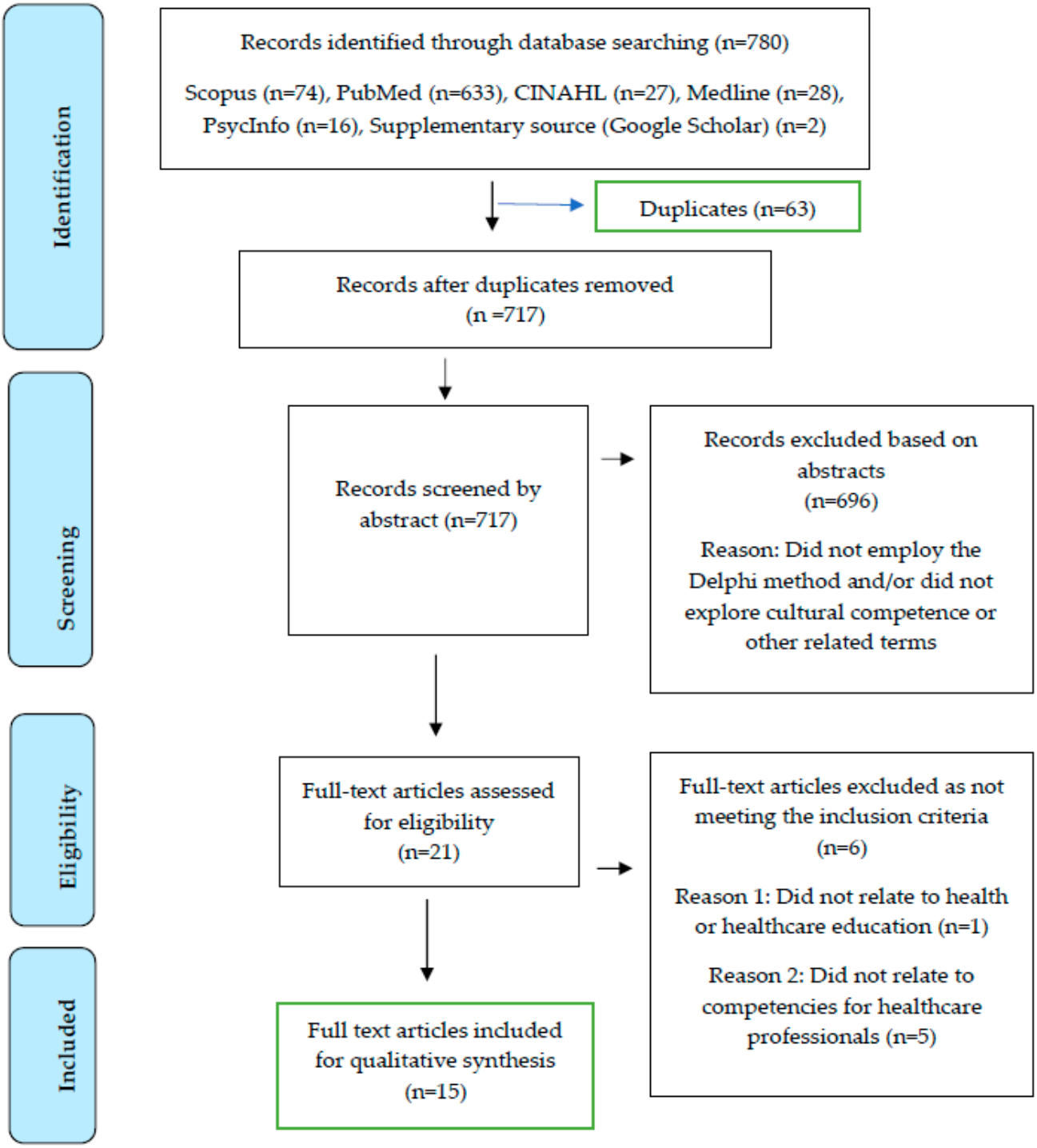

Figure 1. PRISMA 2020 flowchart of the process of identification, screening, eligibility, and inclusion.

Table 3. Characteristics of the Delphi studies included in this systematic review.

Citation Number	Study	Key Information	Number of Experts	Countries	Experts' Background
[16]	Hordijk, R., Hendrickx, K., Lanting, K., MacFarlane, A., Muntinga, M., & Suurmond, J. (2019). Defining a framework for medical teachers' competencies to teach ethnic and cultural diversity: results of a European Delphi study. *Medical teacher*, *41* (1), 68–74.	Aim: To formulate a framework of competencies for diversity teaching in medical education. Consensus level: 75% Delphi rounds: 3 Summary of findings: The competencies for medical teachers, on which experts reached consensus, are: self-reflection, good communication, empathy, awareness of intersectionality, awareness of ethnic backgrounds, knowledge of social determinants of health, ability to reflect with students on the social and cultural context of the patient.	34	Belgium, Denmark, Germany, Hungary, Ireland, Norway, Spain, Switzerland, the Netherlands, United Kingdom	Medical doctors, Nurses, Social scientists, Educational specialists, and Psychologists, other Public Health Scientists
[17]	Ziegler, S., Michaëlis, C., & Sørensen, J. (2022). Diversity competence in healthcare: experts' views on the most important skills in caring for migrant and minority patients. *Societies*, *12* (2), 43.	Aim: To explore which knowledge, attitudes and skills are most important to provide good quality of care to diverse populations. Consensus level: 80% Delphi rounds: 2 Summary of findings: Authors ranked the twelve competencies that received the highest scores from experts, and these were: respectfulness, communicating understandably, identifying patient needs, addressing patient needs, self-reflection, non-discrimination, working with interpreters, finding solutions with patients, ability to listen, empathy, avoiding generalisations, open-mindedness.	31	Austria, Bulgaria, Denmark, France, Germany, Greece, Italy, the Netherlands, Norway, Spain, Sweden, Switzerland, United Kingdom	Medicine and Public Health, Nursing and nursing sciences, Psychology, Social and Cultural Sciences

Table 3. *Cont.*

Citation Number	Study	Key Information	Number of Experts	Countries	Experts' Background
[18]	Ojanen, T. T., Phukao, D., Boonmongkon, P., & Rungreangkulkij, S. (2021). Defining Mental Health Practitioners' LGBTIQ Cultural Competence in Thailand. *Journal of Population and Social Studies [JPSS]*, *29*, 158–176.	Aim: To investigate which competencies are important for culturally competent practice for mental health practitioners with LGBTIQ clients in Thailand. Consensus level: Interquartile ranges (IQRs) not higher than 1.5 for consensus and majority agreement Delphi rounds: 2 Summary of findings: Experts reached consensus or agreed on 100 competencies necessary for LGBTIQ cultural competence. Competencies were organised into knowledge and awareness (e.g., addressing needs, accepting gender diversity), skill (e.g., effective communication), and action competencies (e.g., showing respect).	23	Thailand	Mental Health Practitioners with experience in working at a LGBTIQ-focused service or have researched LGBTIQ mental health, 11 were practitioners, 12 were clients
[26]	Mohammadpour, E., Irandoost, M., Lorestani, H., & Sahabi, J. (2022). Identifying the Factors Affecting the Cultural Competence of Doctors and Nurses in Government Organisations in the Health and Medical Sector of Iran. *Journal of healthcare management*, *12* (4), 119–128.	Aim: To identify the factors affecting the cultural competence of physicians and nurses of government organisations in the health sector in Iran. Consensus level: Kendall coefficient (./704 in round 2) Delphi rounds: 2 Summary of findings: Experts reached consensus on 26 components of cultural competence, organised into cultural diversity, cultural attitude, cultural desire, cultural humility, humanistic competence, and readiness for education and organisational support.	10	Iran	Participants with organisational position at healthcare organisations

Table 3. *Cont.*

Citation Number	Study	Key Information	Number of Experts	Countries	Experts' Background
[27]	Deardorff, D. K. (2006). Identification and assessment of intercultural competence as a student outcome of internationalisation. *Journal of studies in international education*, *10* (3), 241–266.	Aim: To identify and assess intercultural competence as a student outcome of internalization. Consensus level: 80% Delphi rounds: 3 Summary of findings: Experts reached consensus on 22 specific components of cultural competence. A few examples are understanding others' views, cultural self-awareness, cultural empathy, skills to list, and flexibility.	23	USA	Intercultural scholars with PhDs in Communication, Political Science, Education, International Relations, Anthropology, Political Science, Psychology, and Business. Most of the participants were cross-cultural trainers and two of them were international education administrators.
[28]	Montecinos, J. B., & Grünfelder, T. (2022). What if we focus on developing commonalities? Results of an international and interdisciplinary Delphi study on transcultural competence. *International Journal of Intercultural Relations*, *89*, 42–55.	Aim: To rethink the competencies for transcultural competence. Consensus level: Percentage, with no specific threshold Delphi rounds: 3 Summary of findings: Competencies that related to cultural competence were: cultural awareness, open-mindedness, active listening, critical self-reflection, being non-judgmental, respect, creating a "third culture" (not yours or mine), sharing experiences, and flexibility.	47	Austria, Canada, Chile, China, France, Germany, Ireland, the Netherlands, Slovakia, South Africa, Sudan, UK, USA, Zambia.	Experts in anthropology, cultural sciences, economics, psychology, sociology, philosophy, communications, linguistics, cross-cultural trainers and coaches.
[29]	Jirwe, M., Gerrish, K., Keeney, S., & Emami, A. (2009). Identifying the core components of cultural competence: findings from a Delphi study. *Journal of clinical nursing*, *18* (18), 2622–2634.	Aim: To identify the core components of cultural competence from a Swedish perspective. Consensus level: 75% Delphi rounds: 4 Summary of findings: These Components of cultural competencies were grouped into five general categories, namely cultural sensitivity, cultural understanding, cultural encounters, understanding of health, ill-health and healthcare, and social and cultural contexts.	24	Sweden	Nurses working in with a multicultural population, Researchers working on research within the field of multiculturalism, Lecturers teaching cultural issues within the nursing curriculum

Table 3. *Cont.*

Citation Number	Study	Key Information	Number of Experts	Countries	Experts' Background
[30]	Chae, D., Kim, H., Yoo, J. Y., & Lee, J. (2019). Agreement on core components of an e-learning cultural competence program for public health workers in South Korea: A delphi study. *Asian nursing research*, *13* (3), 184–191.	Aim: To seek agreement on the core components of an e-learning cultural competence program for Korean public health workers. Consensus level: 75% Delphi rounds: 2 Summary of findings: Contexts of cultural competencies were grouped into four areas: awareness (e.g., culture, ethnicity, diversity, self-awareness), knowledge (e.g., health-related cultural differences), attitude (e.g., acceptance of migrants' health beliefs), and skills (e.g., establishing trust, effective communication skills, negotiation).	16	South Korea	Nursing professors, Social welfare professors, Education professors, Public administration professor, Anthropology professor
[31]	Castro, D., Dahlin-Ivanoff, S., & Mårtensson, L. (2016). Development of a cultural awareness scale for occupational therapy students in Latin America: a qualitative Delphi study. *Occupational Therapy International*, *23* (2), 196–205.	Aim: To develop a scale to assess cultural competence for Latin American occupational therapy students. Consensus level: not specified Delphi rounds: 4 Summary of findings: Experts reached consensus on items for a cultural awareness scale. The scale had 30 items that largely related to knowledge of cultural, ethnic groups, migration, gender, and social vulnerability.	11	Argenitna, Chile, Colombia, Mexico, Venezuela	Faculty members of Occupational Therapy Programme in Latin America working in a Spanish-speaking country in the region of Latin America
[32]	Johansson, C., Lindberg, D., Morell, I. A., & Gustafsson, L. K. (2022). Swedish experts' understanding of active aging from a culturally sensitive perspective–a Delphi study of organisational implementation thresholds and ways of development. *Frontiers in Sociology*, *7*.	Aim: To explore Swedish experts' understanding of active aging from a culturally sensitive perspective. Consensus level: 80% Delphi rounds: 3 Summary of findings: Experts reached consensus on 33 statements of cultural competence. These statements ranged from involving the elderly in decisions about their care to active listening to knowledge of other cultures and self-reflection.	23	Sweden	Participants in municipal decision-making positions

Table 3. *Cont.*

Citation Number	Study	Key Information	Number of Experts	Countries	Experts' Background
[33]	Farokhzadian, J., Nematollahi, M., Dehghan Nayeri, N., & Faramarzpour, M. (2022). Using a model to design, implement, and evaluate a training program for improving cultural competence among undergraduate nursing students: a mixed methods study. *BMC nursing*, *21* (1), 85.	Aim: To design, implement, and evaluate a culturally care-training program to improve cultural competence of undergraduate nursing students. Consensus level: unspecified Delphi rounds: 2 Summary of findings: Examples of the competencies that experts embraced were familiarity with culture and components of cultural diversity, importance of curiosity and empathy, and the use of negotiation and problem solving in decision making shared with patients.	10	Iran	Nursing faculty members
[34]	Hart, L. M., Jorm, A. F., Kanowski, L. G., Kelly, C. M., & Langlands, R. L. (2009). Mental health first aid for Indigenous Australians: using Delphi consensus studies to develop guidelines for culturally appropriate responses to mental health problems. *BMC psychiatry*, *9* (1), 1–12.	Aim: To develop guidelines for culturally appropriate responses to mental health problems among Austrian Aborigines or Torres Strait Islanders. Consensus level: 90% Delphi rounds: 3 Summary of findings: Examples of cultural competence statements experts reached consensus on were taking into account the spiritual and cultural context of the patient, learning about the behaviours that are considered signs of suicide in the person's community, obtaining consent, and collaborating.	28	Australia	Participants were Aboriginal people experienced in mental health and worked in various departments such as: Private psychology clinics, Aboriginal medical services, Government health services, Universities, Cultural resource and counseling services, prisons, social services, and drug and alcohol

Table 3. *Cont.*

Citation Number	Study	Key Information	Number of Experts	Countries	Experts' Background
[35]	Franzen, S., Papma, J. M., van den Berg, E., & Nielsen, T. R. (2021). Cross-cultural neuropsychological assessment in the European Union: a Delphi expert study. *Archives of Clinical Neuropsychology*, *36* (5), 815–830.	Aim: To examine the current state of cross-cultural neuropsychological assessment in EU-15 countries and to provide recommendations for researchers and policymakers. Consensus level: First and third quartiles (Q1–Q3) and medians Delphi rounds: 3 Summary of findings: Cultural competence knowledge and skills: knowledge of patients' cultural and linguistic background, views, social roles, rules, religion, and traditions, working with formal and information interpreters, being flexible and patient, recognising limitations, reflecting on own culture.	12	Denmark, Germany, Belgium, England, Italy, Austria, the Netherlands, France, Spain	Experienced in neuropsychological assessment in patients from minority ethnic groups.
[36]	Smith Jervelund, S., Vinther-Jensen, K., Ryom, K., Villadsen, S. F., & Hempler, N. F. (2021). Recommendations for ethnic equity in health: A Delphi study from Denmark. *Scandinavian Journal of Public Health*, 14034948211040965.	Aim: To formulate recommendations on both structural and organisational levels to reduce ethnic health inequalities. Consensus level: Scale from 1–5, finalised recommendations and then requested final comments Delphi rounds: 3 Summary of findings: Recommendations made by experts were health policies to reflect patient needs, health promotion in co-creation with people from minority communities, interdisciplinary collaboration, cultural knowledge and awareness to ensure equal access to services, and interpreting assistance.	9	Denmark	Decision-makers representing municipalities, regions, the private sector and voluntary organisations.

Table 3. *Cont.*

Citation Number	Study	Key Information	Number of Experts	Countries	Experts' Background
[37]	Kim-Godwin, Y. S., Alexander, J. W., Felton, G., Mackey, M. C., & Kasakoff, A. (2006). Prerequisites to providing culturally competent care to Mexican migrant farmworkers: a Delphi study. *Journal of cultural diversity*, *13* (1).	Aim: To identify what is necessary to provide culturally competent care to Mexican migrant farmworkers. Consensus level: 80% Delphi rounds: 2 Summary of findings: Cultural competence items were organised into caring (e.g., attitudes) cultural sensitivity (e.g., self-awareness and respect of other cultures), cultural knowledge (e.g., understanding patients' culture), and cultural skills (e.g., effective communication).	142	USA	Nurses

Table 4. Assessment of Delphi studies.

Citation Number	Study/CREDES Criteria	Justification	Planning and Process	Definition of Consensus	Information Input	Prevention of Bias	Interpretation and Processing of Results	External Validation	Purpose and Rationale	Expert Panel	Description of the Methods	Procedure	Definition and Attainment of Consensus	Results	Discussion of Limitations	Adequacy of Conclusions	Publication and Dissemination
[16]	Hordijk et al.	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√
[17]	Ziegler, Michaëlis and Sørensen	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√
[18]	Ojanen et al.	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√
[26]	Mohammadpour et al.	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√
[27]	Deardorff	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√
[28]	Montecinos and Grunfelder	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√
[29]	Jirwe et al.	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√
[30]	Chae et al.	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√
[31]	Castro et al.	√	√	√	√	√	√		√	√	√	√	√		√	√	√
[32]	Johansson et al.	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√
[33]	Farokhzadian et al.	√	√		√	√	√		√	√		√	√		√	√	√
[34]	Hart et al.	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√
[35]	Franzen et al.	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√
[36]	Jervelund et al.	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√
[37]	Kim-Godwin et al.	√	√	√	√	√	√		√	√	√	√	√	√	√	√	√

3.4. Results of Qualitative Synthesis

From the coding of the Delphi studies above, five categories of competencies have been generated, namely (a) knowledge of diverse social and cultural contexts (b) knowledge of own culture and critical reflection on own beliefs and practices, (c) showing interest and valuing patients' perspectives, (d) showing empathy, and (e) working together with the patient. Each of these categories is analysed below.

3.4.1. Knowledge of Diverse Social and Cultural Contexts

Knowledge of social and cultural contexts was an important competence that was highlighted in all reviewed studies. Experts clarified the content of the knowledge that healthcare professionals should have to work effectively with diverse populations. The most dominant content related to social determinants of health, social and cultural factors influencing health, and knowledge of the various cultures [16,17,28–37]. Other studies highlighted the importance of having knowledge of more aspects. For example, Hordijk et al. [16] placed emphasis on intersectionality so that healthcare professionals can understand the dynamics and the impact of multiple intersecting factors such as gender, ethnicity, socioeconomic background, and so forth. Along similar lines, Ziegler, Michaëlis, and Sørensen [17] explained that experts thought that knowledge of patients' needs, ethical and human rights, and the impact of policies, legal contexts, and asylum processes was essential for acquiring cultural competence. Jirwe et al. [29] showed that experts also agreed on the need to know about religions and fasting requirements, the importance of education, and how the role of the family differs across cultures. In addition, Jirwe et al. stressed other areas that healthcare professionals should know about, such as alternative healthcare systems, reasons for seeking help, differences among people even from the same culture, and clear ideas of the meaning of culture. Similar findings were generated by Chae et al.'s [30], Castro, Dahlin-Ivanoff and Martensson's [31], and Faronkhzadian et al.'s [33] studies. Interestingly, other Delphi studies revealed more specific contexts of knowledge. That is, Kim-Godwin et al. [37] and Deardorff [27] discussed how important it was for healthcare professionals to always be open to leaning, while Hart et al. [34] highlighted that healthcare professionals should know which behaviours are culturally appropriate so that they are not confused with mental illness, be able to identify what are considered signs of suicide in the patient's community or group, understand that pathological self-injury is not the same as any similar actions that are ritualistic or culturally accepted, and understand the meaning of grieving customs. Deardorff [27] also talked about the importance of knowing the relationship between language use and contextual meanings.

3.4.2. Knowledge of Own Culture and Critical Reflection on Own Beliefs and Practices

The experts in nine Delphi studies did not only highlight that healthcare professionals should know about other cultures and social determinants of health but also reached a consensus on the importance of healthcare professionals knowing about their own culture and society and developing the ability and practice for self-reflection. More specifically, healthcare professionals should know about their own sociocultural background, habits, reactions, views on health and illness, positions of authority, biases, prejudice, and stereotypes [17,29,33,35,37]. However, self-awareness and knowledge of their own culture are not enough for healthcare professionals to be culturally competent. They also need to develop the competency to critically self-reflect. Apart from general self-reflection [16,26], this competency involved reflection on own beliefs and ideas [16,32], biases, prejudice, stereotypes [17,32,33], practices, behaviours, habits, and contexts [17]. While self-reflection has been identified as a necessary competency for healthcare professionals, it was Hordijk et al.'s [16] study that found that critical reflection on one's own beliefs was the behaviour that achieved the highest score of consensus among experts. Critical self-reflection is fundamental because healthcare professionals can better understand othera if they first delve into their own beliefs and practices and if they are humble enough to listen and learn from their patients. The experts in Deardorff's [27] study agreed on the skill of

"cognitive flexibility", whereby one could move from one frame of thought to another on par with the etic and emic cognitive and research approach in anthropology.

3.4.3. Explore and Value Patients' Perspectives

Five studies discussed the need for healthcare professionals to learn from their patients [2,9,10,28,36]. However, experts from twelve studies reached a consensus on other competencies that were required for learning from patients and valuing their patients' perspectives. For example, Hordijk et al. [16] explained that communicating in a non-discriminatory and non-judgmental way was essential for patients (also found in Deardorff's [27] study), while Ziegler, Michaëlis, and Sørensen [17] found that the necessary competencies to work with diversity were respectfulness, non-discrimination, avoiding generalisations, open-mindedness, and having the ability to listen and remain curious. In support, experts in Jirwe et al.'s [29] study reached a consensus on having a humane outlook, showing respect, being open to cultural differences, showing interest in the patients' views, having good verbal and non-verbal communication, and respecting patients' wishes and the fact that their families might wish to be involved. Other relevant competencies were politeness [17], communicating sensitively [30,37], ensuring trust [37], participating in or seeing the practices of other cultures [27,28,31,36], accepting gender and sexual diversity [18], ensuring equality and justice, and promoting health literacy [33]. Furthermore, Chae et al. [30] presented experts' opinions about the importance of exploring and valuing the patients' ideas, while Johansson et al. [32], Ziegler, Michaëlis, and Sørensen [17], and Deardorff [27] talked about active listening, and Forkhzadian et al. [33], Jirwe et al. [29], and Deardorff [27] talked about the importance of being curious and asking questions. Experts in Deardorff's [27] study agreed on the importance of openness in regard to to learning from other cultures.

3.4.4. Showing Empathy

Empathy seems to be a critical competency for working effectively with diversity, as was agreed upon by experts in seven Delphi studies. There have not been any elaborated explanations in these seven Delphi studies, but Ziegler, Michaëlis, and Sørensen [17] explained the importance of communicating in a way that shows understanding and communicating in open-ended enquiries so that patients are given the time to express their feelings, ideas, and concerns. Jirwe et al. [29] mentioned that allowing patients enough time was among the competencies agreed upon by experts. Moreover, Jirwe et al. [29] and Kim-Godwin et al. [30] mentioned compassion as part of the competency of showing empathy, while Mohammdpour et al. [26] showed humanistic competence as having been agreed upon by experts. Interestingly, Deardorff [27] explicitly found that experts reached a consensus on "cultural empathy", which largely refers to one's capacity to show a genuine understanding of another's culturally specific feelings, thoughts, and views. A recommendation made by experts in Montecinos and Grunfelder's [28] study was about creating a "third culture", which would be neither "yours" nor "mine". Such a common culture would provide solid grounds for healthcare professionals and patients better understanding and respecting each other.

3.4.5. Work Together with the Patient

Experts in eleven studies considered that working in partnership with patients was necessary for achieving cultural competence and better health outcomes. Ziegler, Michaëlis, and Sørensen [17] explained that experts agreed upon the importance of addressing patients' needs, finding solutions in partnership with the patients, being flexible and adaptive (also found in Deardorff's [27], Frazeon et al.'s [35], and Montecinos and Grunfelder's [28] study), and working with interpreters in order to provide patient-centred care. Jirwe et al. [29] highlighted the competencies of providing culturally sensitive care, agreeing with the patient on the way forward, discussing alternative therapies with patients, identify patients' preferences, and identifying patients' literacy. Along similar lines, Chae et al. [4] and

Farokhzadian et al. [9] showed the importance of cultural health assessment, working with interpreters, negotiating, and solving problems. The importance of working with interpreters was also found in Kim-Godwin et al.'s [5] study.

Interestingly, experts in Ojanen et al.'s [18] study placed emphasis on other aspects of collaboration with patients. That is, they reached a consensus on the need to understand patients from a gender perspective and consider patients capable regardless of their sexual or gender identity. In addition, the experts thought that healthcare professionals should work with patients to understand any religious impacts on the expression of symptoms. Johansson et al. [32] also presented more competencies, such as making information accessible to all patients, creating opportunities for support and active ageing, providing individually adjusted care, enabling active ageing for older people, and working with relatives for the benefit of the patient. Hart et al. [34] presented the agreed competencies of obtaining consent and collaboration with the patient, taking into account the cultural context while providing care to patients, and establishing support mechanisms for the patient. Finally, experts in Jervelund et al.'s [36] study recommended that health promotions for ethnic minority groups should be co-designed with people from these communities.

4. Discussion: Core Cultural Competencies and Guidelines

This systematic review showed that a variety of competencies, skills, and behaviours have been suggested by 443 experts who have worked with cultural competence and diverse populations in 37 countries around the globe. Experts' specialties ranged from medical doctors to nurses, public health workers, members of cultural groups, social scientists, educators, and decision-makers in organizations. Interestingly, these cultural competencies had striking similarities and were grouped or categorised in core competencies, which are essentially the sections analysed under the results. Here, we present in a more simplified fashion, along with brief supportive guidelines, five behaviours or competencies in order to achieve cultural competence in healthcare and contribute towards tackling health disparities. These competencies make the abbreviation RESPECT and are follows: Reflect, Educate, Show Interest and Praise, Empathise, and Collaborate for Therapy. RESPECT competencies do not aim to simplify the complexity of socio-cultural factors influencing health and illness. Instead, RESPECT competencies simplify the process of cultural competence for healthcare professionals but still capture the need for systematic training in the complexity of the issue. This is on par with Costa's [38] discussion about the complexity of diversity in healthcare and how the matter is not only about diversity knowledge but also about diversity management. On this note, RESPECT competencies aim to equip healthcare professionals with a set of abilities to understand, manage and work effectively with complexity. To achieve this, RESPECT competencies should be demonstrated in a specific order and work as a protocol, as presented below.

4.1. Reflect

Reflection is an important and demanding competency that requires knowledge and practice. Healthcare professionals should have knowledge of their own social and cultural context and the idea that their beliefs, ideas, and practices, as well as sciences, are cultural products. Having such knowledge, healthcare professionals should engage with critical reflection on their own beliefs and practices by approaching them from a mental distance and considering the origin and functions of their beliefs and practices and how they are beneficial while also considering what could be enhanced or improved. This can be achieved initially by thinking of a cultural practice healthcare professionals exercise in their daily life and might use in medical practices too. For example, in many cultures, "touching wood" is both a belief and action people engage with without much thinking, and they do so in order to control their luck. On par with Wright Mills' "Sociological Imagination" [39], such a cultural practice could be approached by anybody in a critical manner by imagining it as unfamiliar to them and starting to develop questions in order to understand it from different angles and within the wider socio-cultural context. Healthcare

professionals could then approach all of their practices, including their professional work, in the same critical way. More specifically, healthcare professionals could approach western biomedicine from a critical perspective, as it is a cultural product rather than purely a result of objective science, and hence delve into biomedicine's limitations. Healthcare professionals could be trained on how to critically self-reflect and be appraised on such behaviour periodically. It is important that the competency of self-reflection should come first because if healthcare professionals are not aware of their own social and cultural context and they cannot see its impact on their own behaviour, they may not be able to show the necessary interest to learn about the social and cultural contexts of their patients from either the literature or the patients themselves, show understanding of how culture can shape patients' health understanding and behaviour, and work with their patients in a collaborative and open-minded manner.

4.2. Educate

"Educate" in this context means the healthcare professionals' competence to continuously educate themselves in the social determinants of health and how the social and cultural context of their patients plays a crucial role in the way patients understand disease, illness, and therapies. Such a socio-cultural context should encompass an understanding of the intersectionality of how various social factors (e.g., socio-economic background, ethnicity, gender, age, etc.) intersect together, causing people to be vulnerable to ill health [38]. The education of healthcare professionals takes place in universities, largely in medical sociology and anthropology sessions, but healthcare professionals could educate themselves through life-long learning by attending social sciences conferences and reading research studies and books that present principles, theories, and research findings on social and cultural influences on health and illness experiences. In other words, healthcare professionals could engage with this knowledge and promote it to their colleagues and their students. However, it should be acknowledged that it is not always feasible for busy healthcare professionals to spend so much time learning the social and cultural aspects of health. On this note, healthcare institutions or individual professionals could collaborate with social scientists specialised in health and illness to provide trainings or prepare reports on the cultural characteristics of various groups in the communities where they practice healthcare. Social scientists could also be recruited by healthcare institutions to work as members of healthcare teams. Even with life-long learning, healthcare professionals will not be fully aware of the vast cultural beliefs and practices in societies. Therefore, they could also explore and learn from their patients, as discussed below.

4.3. Show Interest and Praise

Healthcare professionals with good knowledge of the social and cultural context of health and illness should be keen to know more, especially if their patients tell them something different from what they learned from the literature. Therefore, showing genuine interest in learning from patients and valuing or praising patients' knowledge and views sends a clear message to patients that the healthcare professionals care and that everything the patients consider important it is important for the healthcare professional too. For example, if a patient with diabetes wishes to fast due to religious reasons, a healthcare professional should neither be judgmental of their patient's preferences nor ignore such a cultural belief by focusing on the impact of fasting on diabetes control. A healthcare professional should give their patients time and show interest in learning from patients about the importance of fasting for the patients themselves and in patients' cultures. In addition, healthcare professionals should praise patients for sharing their knowledge because it is useful for gaining a deeper understanding of what the best management plan should be. Then, working in partnership (see Section 4.5. Collaborate for Therapy) with patients to find the best management plan will be critical for achieving positive health outcomes. By valuing or praising patients' beliefs and ideas, healthcare professionals value the patients' cultures and identities. This can be achieved by careful listening, giving

patients enough time, developing questions, picking up verbal and non-verbal cues, and valuing or praising what the patient has expressed. Showing interest and praise would cause the patient to feel respected and valued and more prone to collaborate with their healthcare provider. Importantly, this competence is the bridge between self-reflection and prior knowledge and showing empathy and collaboration.

4.4. Empathise

Empathy cannot be demonstrated on its own without the previous competencies and without giving time to the patient to narrate and express themselves. Empathy, as the skill of understanding patients' feelings and concerns, is one of the key skills in clinical communication, and it has been linked with patient satisfaction, motivation, adherence, and patient outcomes [40]. In the context of cultural competence, empathy is not only about understanding patients' feelings but also about recognising, acknowledging, and validating the patients' beliefs and perspectives even when they are completely different from the scientific perspectives that healthcare professionals rely on. Using the same example of a patient with diabetes who wants to fast, a healthcare professional could demonstrate empathy indirectly by not being judgmental and by showing interest in and praising the patient (see Section 4.3. Show Interest and Praise). In addition, a healthcare professional could demonstrate empathy more directly by expressing words or phrases indicating that the patient has a rationale, which is appreciated. Understanding patients' cultural beliefs and perspective is facilitated by healthcare professionals' prior knowledge (see competence "Educate"), showing interest and giving value to the patient's perspective (see competence "Sow interest and Praise"), and considering that healthcare professionals also have their own beliefs, which might not always be on par with science (see competence "Reflect").

4.5. Collaborate for Therapy

It seems that collaboration is very important for achieving cultural congruent healthcare and therapy, but healthcare professionals should demonstrate all of the previous competencies first. For example, focusing on the medical perspective or giving scientific information prior to all other competencies might seem as though patients' ideas, concerns, and experiences are being dismissed and, as a result, patients might be hesitant to disclose information or collaborate with the healthcare professional or participate in the management and therapy of their conditions. Therefore, all previous competencies would help establish trust, good rapport, good doctor–patient relationship, mutual understanding, and respect, which would facilitate collaboration. Specifically, a healthcare professional could approach a patient with diabetes who would like to fast for a period of time due to religious reasons by being humble and ready to self-reflect, having knowledge of the patient's social and cultural context, having shown interest to learn from the patient, having valued the patient's perspective, and having shown an understanding of the patient's ideas, concerns, and beliefs. Such an approach would help a healthcare professional to establish good grounds to work with this patient in partnership through shared decision-making techniques. Shared decision-making has been well-integrated into clinical communication curricula [40], and it has been linked with patient-reported good health outcomes and quality indicators [41]. Therefore, the patient with diabetes who would like to fast would possibly be keener to work with a healthcare professional who was not judgmental and valued their beliefs and wishes, which were considered for establishing the best plan for controlling diabetes during a fasting period.

The five core competencies described above make the abbreviation RESPECT (see Figure 2), which is a real word to symbolically place emphasis on the essence of working effectively with diversity, which involves respecting and practically showing appreciation or admiration for patients as social and cultural beings. We think that RESPECT can work as a protocol for the culturally competent healthcare professional, inform research in each of the core competencies or in all competencies together, help researchers formulate instru-

ments to measure RESPECT, and inform trainings and curricular sessions in healthcare, healthcare education, and allied health sciences.

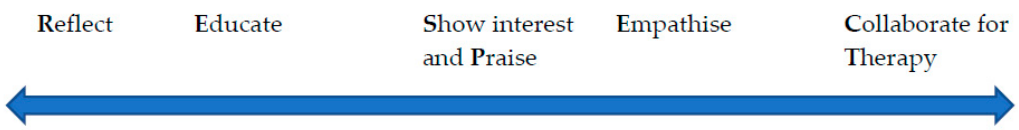

Figure 2. The RESPECT competencies pathway for culturally competent healthcare professionals.

4.6. Comprehensive Definition of Cultural Competence of Healthcare Professionals

Having organised and qualitatively analysed the competencies on which experts in Delphi studies have reached a consensus, we developed a new comprehensive definition that reflects the RESPECT competencies, and it can inform future studies, measuring instruments, and trainings. We define cultural competence of healthcare professionals as:

> "The set of abilities to continuously learn, appreciate, and reflect on the diverse social and cultural context of their own and their patients' experiences of health and illness, value and show understanding of their patients' behaviour, beliefs, ideas, and concerns influenced by culture and society, and work in partnership with their patients to provide culturally congruent care."

4.7. Limitations

We have identified a couple of limitations of this systematic review. Although a Delphi study relies on a rather rigid methodology, the procedures of the Delphi studies included in this systematic review varied. For example, Ziegler, Michaëlis, and Sørensen [17] in round one requested for experts to individually suggest the necessary competencies and then asked to score them, while Chae et al. [30] formulated many statements, drawing information from the literature, and sent the list of these statements to the experts to score. Farokhzadian et al.'s [33] study was about formulating a training programme and then sending it to experts for them to discuss various aspects of it. In addition, the Delphi studies did not use the same method of reaching a consensus among the experts. Such a variety of approaches made universal conclusions more challenging. Moreover, it was not possible to comparatively measure the suggested competencies across all Delphi studies and come up with, for example, the ten competencies with the highest consensus scores. In spite of these limitations, the competencies across the Delphi studies had striking similarities and could therefore be grouped or categorised easily. This indicates that experts who have experience in cultural competence see similar competencies or skills as necessary for effectively working with diverse populations.

5. Conclusions

This systematic review focused on Delphi studies on the cultural competence of healthcare professionals and showed that all the competencies on which experts reached a consensus could be grouped under the core competencies and behaviours of RESPECT (Reflect, Educate, Show Interest and Praise, Empathise, and Collaborate for Therapy). RESPECT competencies are put in a specific order and could be used as a protocol for healthcare professionals and for universities to develop trainings and educational sessions for healthcare and allied healthcare students. This study is the first systematic and scientific attempt to simplify and categorise the core cultural competencies suggested by experts, and it is therefore a major contribution to scholarship and to the development of healthcare trainings and education. The RESPECT competencies and the new definition of the cultural competence of healthcare professionals can open new directions in research, further contributing to the reduction of disparities in healthcare.

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