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CULTURAL COMPETENCE AND HEALTHCARE

Experiences from Slovenia

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This paper seeks to contribute to critical reflection on the importance, dilemmas and problems that arise in educating health professionals about the socio-cultural dimensions of health and healthcare. In the first part of the paper the authors show that although educational programmes in the field of cultural competences have experienced a remarkable upswing, they are accompanied by many ambiguities and shortcomings. Based on numerous anthropological criticisms, the authors highlight the major conceptual and methodological problems that accompany many cultural competence efforts. The second part of the article focuses on an analysis of the multi-year process of introducing a training course in cultural competence in Slovenia, in which over 500 health professionals have been trained since 2016. Based on the results of the participants' quantitative evaluation and educators' self-evaluation, the authors critically analyse the contributions of this training course, while highlighting some of the key dilemmas and difficulties that have accompanied this process.

Keywords: cultural competence, healthcare, education, anthropological critique, Slovenia

Introduction

The importance of socio-cultural dimensions in health and healthcare is undeniable. As Arthur Kleinman and Peter Benson stated several years ago: "Cultural factors are crucial to diagnosis, treatment, and care. They shape health-related beliefs, behaviors, and values" (Kleinman and Benson 2006: 1673). Culture not only shapes the emotional, cognitive and behavioural dimensions of individuals' experiences of health and illness (Jenkins 1998), but also the whole healthcare system: from its epistemological to organizational and practical levels. Since the 1970s, medical anthropologists who have examined Western medicine or biomedicine as a cultural system have called for increased attention to the social and cultural context of wellbeing and illness (Jenks 2011). Yet, to date, socio-cultural dimensions have remained mainly irrelevant or neglected in everyday clinical practices across the globe. Those

collaborating with *The Lancet* and the University College London Commission on Culture and Health claimed that "[t]he systematic neglect of culture in health is the single biggest barrier to advancement of the highest attainable standard of health worldwide" (Napier et al. 2014: 1630). Therefore, they have called for a critical examination, understanding and recognition of culture in health:

> In all cultural settings – local, national, worldwide, and even biomedical – the need to understand the relation between culture and health, especially the cultural factors that affect health-improving behaviours, is now crucial. (ibid.: 1607)

However, it cannot be argued that all fields of healthcare neglect the socio-cultural dimensions of health equally. One area to which this does not apply is the cultural-competence movement, which developed in response to critiques made by medical anthropologists (Jenks 2011: 213). Besides the already-mentioned critique of neglecting the socio-cultural dimensions in healthcare, cultural-competence efforts have been driven by a growing recognition that biomedicine, derived from the traditions and values of Western societies, is neither neutral nor universal and ought not be forcefully imposed on others of different cultures (Muaygil 2018: 17).

At the same time, cultural-competence efforts arose as a response to calls for new medical models that address the shifting demographics of ethnic immigrants (Napier et al. 2014). Namely, many medical professionals who were in daily contact with heterogeneous groups of immigrants reported being unprepared for the provision of adequate healthcare to these populations (Pulido-Fuentes et al. 2017: 366). This resulted in many language and intercultural miscommunications and unfavourable health outcomes (Lipovec Čebron 2017), and in growing health disparities faced by minority communities (Barker and Beagan 2014). This clearly demonstrated that a "one-size-fits-all" healthcare model is incapable of adequately meeting the needs of an increasingly heterogeneous population (Carpenter-Song et al. 2007; Barker and Beagan 2014).

The first steps in the field of cultural competences were taken in the USA as far back as in the early 1970s (Muaygil 2018: 15). Initially, healthcare professionals "utilized an individualized model: clinicians were urged to recognize and understand the unique needs, preferences, and values of each patient individually in order to ensure effective delivery of a service" (ibid.: 16). Over time, however, many different methods, approaches and models of cultural competences have evolved. These various efforts had a similar foundation: the acknowledgement that "culture matters" in healthcare, as well as a commitment to respect for cultural differences. Moreover, different cultural-competence efforts had the common goal of ensuring equitable healthcare access for, and quality healthcare delivery to, persons with diverse cultural, socio-economic backgrounds, i.e. people with a variety of values, norms, social practices, health beliefs, and health practices (Carpenter-Song et al. 2007; Barker and Beagan 2014; Cai 2016; Muaygil 2018; Halbwachs 2019).

Over the following decades, training courses in cultural competence have increasingly become a part of many health-education programmes in North America and Europe. These training courses vary in length (from a one-day course to a continual year-long course), in methods (from lectures to different workshops), in number of participants (from a few participants to large groups) and in form (from online courses to immersion programmes designed to expose providers to various groups of patients) (Jenks 2011: 211). Moreover, cultural-competence training courses are not limited to medical students since they are common also in educational programmes for other health professionals and in continuing medical-educational programmes (ibid.). In recent years, the field of cultural competences has also gained an important place in scientific research, which is obvious from the remarkable number of studies and scientific articles on this subject. Moreover, many cultural-competence efforts have the ambition not only of influencing the clinical level in terms of patient–provider interaction, but also in terms of institutionalized healthcare policies and services (Carpenter-Song et al. 2007; Barker and Beagan 2014). In this context, they were incorporated into the internationally recognized standards for healthcare quality assessment (Jenks 2011),[1] and a range of tools to measure the cultural competence of healthcare providers, as well as healthcare institutions, were created (Diallo and McGrath 2013; Pulido-Fuentes et al. 2017).

As mentioned above, much has already been written about cultural competences in healthcare in recent decades. Many authors point to the need for culturally competent healthcare and see it as one of the key strategies of healthcare institutions in overcoming the problem of unequal care for increasingly heterogenous populations. Numerous studies have also proved that cultural competences can significantly improve the accuracy of diagnosis and improve clinical outcomes (Napier et al. 2014; Cai 2016) by addressing the needs of different groups – not only marginalized and deprivileged ones, but also others. As a result, both healthcare professionals and patients are more satisfied with the treatment process and quality of care, and overall satisfaction with the work and employee relationships in healthcare facilities is increasing (Cai 2016; Barker and Beagan 2014). Despite this recognition of achievements in cultural-competence efforts, the authors rarely engage in critical examination of the theoretical concepts behind cultural competences and in the different aspects of the training process. As Sarah Willen et al. stated "it is striking how little is known about the on-the-ground challenges, problems, and pitfalls" (Willen et al. 2010: 247) of cultural-competence education.

Due to this notable lack of critical reflection on the dilemmas, problems and challenges, all of which accompany the training of health professionals in this field, the second part of this article will focus on a critical analysis of the multi-year process of implementing cultural-competence training in Slovenia. More specifically,

[1] In 2001, national Culturally and Linguistically Appropriate Service (CLAS) standards were established in the USA – a series of 14 requirements and recommendations for the development of CLAS (Office of Minority Health 2001). On the basis of these standards, cultural-competence efforts include a range of activities (from using interpreters to recruiting providers from underrepresented ethnic groups, and creating ethnically specialized clinics as well as educating and training health providers) (Jenks 2011: 210).

we will analyse the process of planning and implementing a 20-hour-long cultural-competence training course that was piloted in 2016 for 41 healthcare professionals in three health centres, then upgraded and carried out in different places in Slovenia, where 13 cycles of training were attended by 485 healthcare workers and other professionals working in primary-level healthcare in 2018 and 2019. Based on the results of the participants' quantitative evaluation and educators' self-evaluation, we will point to the importance of this type of training for healthcare professionals, while highlighting some of the key dilemmas and difficulties that have accompanied this process. Before this, in the first part of the paper, we will present a short overview of different definitions of cultural competences and the main conceptual and methodological problems of educational programmes, which many anthropologists have been emphasizing for a long time.

Anthropological critiques of cultural competence

When studying the scientific literature in this field, the reader will likely first notice the lack of a unanimous definition of cultural competences and a lack of clarity regarding what the concept includes. Similar observations have been made by other authors (Kleinman and Benson 2006; Diallo and McGrath 2013; Cai 2016; Pulido-Fuentes et al. 2017), who see a lack of a clear, standardized definition of cultural competence as one of the key limitations of cultural-competence efforts. Researchers of cultural competence see it as an abstract and theoretical concept that seems difficult to define and that is therefore difficult to teach and understand well (Diallo and McGrath 2013: 122). As a result, the term cultural competence can encompass various initiatives, practices, research or education projects that have little or nothing in common:

> [Cultural competence] has become a "magic" word, used arbitrarily for anything and everything, regardless of its original meaning. It is now a "politically correct" concept accepted widely, and almost mechanically, as something positive. (Pulido-Fuentes et al. 2017: 370)

Such ambiguous and inconsistent conceptualization results in cultural competence not being clearly defined in relation to similar concepts, such as intercultural health, culturally appropriate care, multicultural healthcare, cross-cultural healthcare, cultural sensitivity, cultural intelligence, cultural responsiveness, cultural safety and cultural humility, etc. (Cai 2016: 268; Diallo and McGrath 2013: 122; Jenks 2011: 210). As a result, different uses of the term occur: besides cultural competence or cultural competency, there is intercultural, intracultural or transcultural competence, and these terms are used in both singular and plural forms (Cai 2016: 268). To make this confusion even greater, in the scientific literature various names, definitions and perspectives regarding the notion of cultural competence are also used interchangeably or based on personal preference (ibid.).

Despite the terminological and conceptual confusion that arises in describing cultural competence, we will briefly focus here on the most referential definitions. Although Madeleine Leininger (1970, 1980), a nursing theorist, was the first individual to coin this term,[2] cultural competence was first mentioned in an article by Terry Cross et al. in 1989. In this early definition, which is still in use, cultural competence is defined as a "set" of specific elements, or, as Cross et al. write, cultural competence "is a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" (Cross et al. 1989: 13). The weakness of this definition stems from the fact that it describes cultural competence only as "behaviours, attitudes and policies" (and not as, for example, knowledge), without regarding the connections between these three dimensions. The definition's contribution, however, is that it focuses not only on the importance of cultural competences for health professionals, but also on health organizations and, more broadly, on the whole healthcare system.

The role of the system is further emphasized in Betancourt et al.'s (2002, 2003) definition, which is among the most cited in the field-specific scientific literature. In this definition, cultural competence is described as "the ability", namely "the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural, and linguistic needs" (Betancourt et al. 2002: 293). According to this interpretation the aforementioned shortcomings of the previous definition remain, while new shortcomings are established, since the concept of a "system" is abstract and elusive (Lipovec Čebron et al. 2019).

If the previous two definitions were not process-oriented, and therefore made cultural competences appear static, then certain other authors (Suh 2004; Smith 2013) depicted cultural competence as an "ongoing process" undertaken by healthcare professionals to prepare themselves with the specific awareness, knowledge and skills to work with diverse groups. This continual and non-linear process can be understood "as a life-long learning journey through consistent encounters with diverse clients in practice" (Cai 2016: 269). In conceiving of cultural competences as a process, certain authors go even further and define the developmental or hierarchical stages at which individual professionals, organizations, or both, "ascend" to different levels of increasing cultural competence: for example, the six-level continuum is defined as a process moving from cultural destructiveness, incapacity, blindness, pre-competence, competence, to proficiency (ibid.). Such definitions are reminiscent of surpassed cultural evolutionary models, since all healthcare professionals are expected to "progress" through the same stages of development, with the same final goal, which makes the definitions inappropriate.

[2] As early as in 1970 Madeleine Leininger proposed the anthropological concept of culture in nursing and understood the cultural-competence process as a combination of the fields of transcultural nursing and medical anthropology, with a multicultural orientation (Leininger 1970; see also Cai 2016: 269).

A similar tendency to schematically simplify and quantify this complex and heterogenous field has been demonstrated by the many models of cultural competences that have received increasing attention in recent decades in their attempts to define cultural competences (Halbwachs 2019). When designing models of cultural competence, authors usually draw on the work of Josephe Campinha-Bacote (1996, 1998, 2002) and identify the various components of cultural competence that are intertwined in different ways (Papadoupoulos 2006; Purnell 2012; Almutairi et al. 2015; Cai 2016, etc.). These different models of cultural competence usually share a common concern with three main components: cultural sensitivity, which refers to a healthcare provider's appreciation of, respect for, and comfort with patients' cultural diversity (Cai 2016: 270); cultural knowledge, which deals with a knowledge and understanding of different cultural worldviews and practices (Gunaratnam 2007: 471); and cultural skills, which refers to the ability to collect relevant cultural data concerning a patient's health problem, and also to incorporate relevant data into care planning and provision in a culturally sensitive manner (Cai 2016: 270; Gunaratnam 2007: 471; see also Halbwachs 2019).

There have been various attempts to define cultural competences, such as the aforementioned, many of which anthropologists have sharply criticized, alongside critiques of the conceptual background and implementation of various cultural-competence educational programmes. Most authors attribute the problems in this area to a misinterpretation of the concept of culture, or as Kleinman and Benson note: "This problem stems from how culture is defined in medicine, which contrasts strikingly with its current use in anthropology – the field in which the concept of culture originated" (Kleinman and Benson 2006: 1673). While anthropologists have largely retreated from approaching culture as homogenous, stereotypical and fixed, creators and educators in cultural-competence programmes may still employ such understandings (Napier et al. 2014: 1616; Barker and Beagan 2014: 2). Some authors (Taylor 2003; Muaygil 2018) attribute the reason for moving away from an anthropological interpretation of culture to biomedicine's methodology and epistemology, since the systematized and scientific nature of medicine requires clear and indisputable standards (Muaygil 2018: 17). The need for health professionals to present cultural dimensions as schematic, concrete and measurable has often led to the description of certain cultural characteristics or of a culture as a whole as static, homogenous and oversimplified. Thus, in many cultural-competence training courses, culture was often reduced to a technical skill (Kleinman and Benson 2006: 1673), while cultural-competence tools became "so categorized and rigid that they can be likened to diagnostic criteria one may use to diagnose and manage a disease condition such as Pneumonia" (Muaygil 2018: 17). As a result, participants in cultural-competence training learn about cultural dimensions through "pocket guides" with alphabetized lists of racial and ethnic groups (Jenks 2011: 216) that stereotypically outline certain characteristics of various cultures (Muaygil 2018: 17) or a superficial "checklist" (a series of "dos and don'ts") that define how to treat a patient of a given ethnic background (Kleinman and Benson 2006: 1673).

Another series of anthropological critiques of cultural competence argue that culture is often made synonymous with ethnicity, nationality and race. Although cultural competence has been expanded beyond its initial definition to include gender, social class, and sexual orientation, in practice it tends to still be equated with ethnicity and race (Kleinman and Benson 2006; Kumas-Tan et al. 2007; Barker and Beagan 2014). This is evidenced by Kumas-Tan et al.'s systematic review of the cultural-competence literature and tools, in which these tools generally equate culture with race and ethnicity (Kumas-Tan et al. 2007; see also Pulido-Fuentes et al. 2017). Such use of the concept of culture opens up many new problems. On the one hand, it points to an uncritical use of the concept of race. On the other hand, the equation of culture with nationality or ethnicity is misleading because it does not take into account the fact that there are different population groups within a national or ethnic community, and that the cultural differences within these groups may be even greater than the differences between one and the other groups (Chiarenza et al. 2016). Or, as Elisabeth Carpenter-Song et al. wrote: "Stagnant views of culture fail to effectively address diversity within cultural groups and leave little room for cultural change" (Carpenter-Song et al. 2007: 1363), which only reifies existing racial and ethnic categories rather than deconstructing barriers to healthcare (ibid.). Instead of eliminating stereotypes and biases, several cultural-competence courses reinforce them and add new ones, which in clinical practice can result in significant harm: "For example, the belief that Muslim women uniformly defer to male relatives for medical decision making […] can lead to a systematic and widespread exclusion of Muslim women from healthcare discussions" (Muaygil 2018: 18). In addition, researchers often point out that in cultural-competence courses and tools, culture is conceptualized as an attribute possessed by the "other" race, or an ethnic group different from ours (Kumas-Tan et al. 2007). This focus on the "exotic" cultures of "others" (be they migrants or refugees, indigenous communities or other ethnic minorities) gives health professionals an incentive to not face their own socio-cultural conditionality. At the same time, it reinforces the assumption that biomedicine is culture-free and fails "to recognize Western biomedicine as a cultural construction to be considered within a historical context" (Carpenter-Song et al. 2007: 1364).

The last common critique points to the fact that, in cultural-competence training courses, the notion of culture is often used to hide social and economic inequalities. While educators on such courses devote a great deal of space to describing many cultural differences, they often withhold the fact that these differences may result from social or economic exclusion (Pulido-Fuentes et al. 2017: 366; Muaygil 2018: 20; Lipovec Čebron et al. 2019: 39). Thus, David Napier et al. note that healthcare providers who have been trained in cultural competence "can often misattribute cultural reasons to patient issues, rather than recognise that patient difficulties can be equally economic, logistical, circumstantial, or related to social inequality" (Napier et al. 2014: 1616). In this context healthcare providers learn to recognize cultural differences

> without developing an understanding of the social and historical conditions in which these differences have been produced or currently operate. As a result, cultural competence education, while designed to address socially produced health disparities, can ultimately reinforce a depoliticized understanding of cultural difference. (Jenks 2011: 212)

Some researchers view these criticisms as exaggerated, while pointing out that although they were justified in the early days of the cultural-competence movement, over the years, educators have become aware of these shortcomings and tried to remedy them. As Angela Jenks, who conducted ethnographic research among cultural-competence course educators and participants, notes:

> Many of the cultural competence educators I spoke with expressed familiarity with these critiques, have similar concerns, and struggle to present a more complex approach to culture. A closer examination of these efforts show that they are not always successful. (ibid.: 230)

To eliminate these failures and weaknesses, anthropologists are calling for a more sophisticated, anthropologically informed conceptualization of culture (Carpenter-Song et al. 2007: 1364). More specifically, a more process-oriented and meaning-centred approach to culture that emphasizes dynamism and flexibility as key dimensions of culture instead of behaviour-based orientations to culture in which culture is understood to be located in patterns of action and customs (ibid.). This approach to culture as mutable and multiple (Gregg and Saha 2006) should include ethnographic methods in the form of mini-ethnographies (Kleinman and Benson 2006) through which healthcare providers will be able to understand "what is really at stake for patients, their families, and, at times, their communities, and also what is at stake for themselves" (ibid.: 1676). This will allow healthcare professionals to enter into processes through which new knowledge can be obtained, and help them understand the need to learn about the unknown and neglected socio-cultural dimensions of health (Napier et al. 2014: 1616).

We can conclude that anthropologists have been crucial in emphasizing the importance of socio-cultural dimensions of health for many years and in highlighting the negative effects of neglecting these dimensions. At the same time, medical anthropologists have played a vital role in delivering essential critiques of the way culture is defined and taught to healthcare providers on cultural-competence courses. These criticisms have significantly changed the cultural-competence movement, but educational programmes in this field still face many difficulties and shortcomings. Therefore, Angela Jenks suggests that in the future

> greater attention must be paid to the way these critiques have been received and to the contexts, both small and large, within which efforts to reform cultural competence education operate. [...] [I]ncreased attention must be paid not just to how cultural competence is *taught* but to how it is *learned*. (Jenks 2011: 230)

Introducing cultural-competence training in the Slovene healthcare system

Unlike in many countries where cultural competences are included in compulsory course modules at medical and health sciences faculties (Beach et al. 2005; Jenks 2011; Napier et al. 2014, etc.), there seems to be little interest in this subject in Slovene higher-education institutions. Based on available data, it can be assumed that there is only one course within the accredited programmes of medical faculties and faculties of health sciences in Slovenia that could be described as engaging with cultural competences.[3] One exception to this is the three-day educational programme, "Developing the Cultural Competences of Healthcare Professionals", which was set up in 2014.[4] The educational programme was created as part of the project "Towards Better Health and Reducing Inequalities in Health – Together for Health", coordinated by the National Institute for Public Health.[5] As part of the project, qualitative research was conducted that showed that, in addition to many other barriers to health, marginalized groups face unequal and discriminatory health treatment. Namely, the interlocutors described a number of linguistic and cultural misunderstandings between healthcare providers and patients, which often contributed to inappropriate and discriminatory treatment (Lipovec Čebron et al. 2016).[6] The reasons for this have often been viewed as due to a lack of information from healthcare professionals about the specific problems and needs of marginalized people and a lack of knowledge of their socio-cultural environment. Among the suggestions that could reduce barriers to access to quality healthcare, the employees of different public institutions as well as non-governmental organizations emphasized the need to train healthcare professionals to be more sensitive to the needs of marginalized and vulnerable groups and to raise awareness of the socio-cultural dimensions of health and healthcare (Lipovec Čebron et al. 2016; Lipovec Čebron and Pistotnik 2018). A nationwide survey hinted at a similar need, in which nearly half (218 out of 498) of the healthcare workers chose cultural-competence training as among the strategies that would help them overcome language and intercultural barriers (Kocijančič Pokorn and Lipovec Čebron 2019: 86).

[3] http://www.vzsce.si/si/projekti/494 (accessed 1. 6. 2018).

[4] Several other training courses were organized later, but they were shorter and non-continual. One such example was a training course entitled "A Patient Doesn't Speak Slovenian! A Challenge for Healthcare Professionals in Slovenia", held in 2017, which also included cultural competences (more at: http://multilingualhealth.ff.uni-lj.si/, accessed 20. 3. 2020). Another related educational training course was "Cultural Competence, Doctor–Patient Communication, and Minority Health", which took place in 2018 as a summer school.

[5] The project "Towards Better Health and Reducing Inequalities in Health – Together for Health" upgraded prevention programmes for children, adolescents and adults, with a particular focus on the greater inclusion of marginalized, vulnerable groups in preventive healthcare, reducing health inequalities and improving health in local communities. For more information, see: https://eeagrants.org/archive/2009-2014/projects/SI05-0002 (accessed 20. 3. 2020).

[6] The research included interviews with 121 individuals (healthcare workers, employees of public-health institutions as well as different professionals from the non-governmental sector, and users of healthcare services).

In response to the training needs of healthcare professionals, and as a result of qualitative research in the "Together for Health" project, an interdisciplinary working group has been established to start preparing the training curriculum.[7] Besides anthropologists and sociologists, the group included experts from different fields of health. They were confronted with a lack of research in this field in Slovenia, and in the absence of reviews of relevant sources, scientific literature and professional guidelines, they had to first build a foundation. In addition to reviewing international and national legal documents and key scientific references in the field, the design of the training programme was based on an analysis of related educational programmes abroad as well as already-presented anthropological critiques of some of these programmes (Lipovec Čebron et al. 2019). At the same time, the group also produced a comprehensive manual on cultural competences and healthcare, *A Handbook for Developing the Cultural Competences of Healthcare Professionals* (Lipovec Čebron 2016), to complement the training.

In the first half of 2015, the first training proposal was formed, and it proposed a distinctly interdisciplinary group of educators (from the fields of medicine, health sciences, psychology, law, linguistics, anthropology and sociology). The proposal consisted of a curriculum of a minimum of 39 hours in which, in addition to lectures, more than a third of the time would be devoted to fieldwork in the form of mini-ethnographies (Kleinman and Benson 2006) and a series of interactive, workshop activities with participants. Although the project coordinators approved the proposal's conceptual framework, they expressed many doubts about its implementation. A key criticism was that the training course was too long and that, instead, could be completed within a few hours or at most in a day. The argument was made that "health workers are accustomed to short training courses because they do not have the concentration or time for longer training courses due to many work commitments" (Meeting Minutes, 19. 11. 2014). Similar obstacles that relate to apparently different perceptions of time in healthcare institutions (Pizza and Ravenda 2016) have been observed in other cultural-competence efforts:

> [I]t has been my experience that most cultural competency trainers are often given a one or two hour shot at introducing clinicians to the concepts underlying the intersection of culture and healing. On the one hand, there is an almost subliminal feeling that such a request is an insult to our discipline. […] On the other hand, it is a chance to educate in an area we feel is really critical. (Jenks 2011: 216)

As with the quotation from a medical anthropologist, who saw such a short period of training as an "insult to the discipline", but was at the same time aware of the "chance" offered by the opportunity to present this topic to healthcare professionals, the working group decided to make a compromise. After a series of controversial and demanding negotiations, the final curriculum was 20 hours long. Due to a number

[7] The authors of this paper were members of the aforementioned interdisciplinary working group from the very beginning. They were responsible for content design and training, as well as for mentoring the educators.

of financial and organizational constraints, they halved the number of educators and therein radically reduced the content and level of interdisciplinarity (there were only two sociologists, three anthropologists and one doctor left), and the opportunity of doing fieldwork was removed (Farkaš-Lainščak et al. 2015). In other words, the public-health experts who were coordinating the project did not consider fieldwork or ethnographic methods as necessary. Discussions with them revealed what other anthropologists have already observed (Parker and Harper 2005: 3; Pizza and Ravenda 2016: 35), i.e. that these methods are usually unknown or unfamiliar in the field of public health, and ethnographic methods are a stark contrast to the methodology of most public-health institutions, which are characterized by the search for an "objective", quantitative methodology and a "top-down approach".

Nevertheless, the first training course entitled "Developing the Cultural Competences of Healthcare Professionals" ran in 2016, organized as a five-day pilot course in three health centres (in Vrhnika, Celje and Sevnica). As earlier mentioned, we proceeded from the anthropological critiques of cultural competences in designing and implementing this pilot course. Thus, the introductory lectures that present different aspects of the socio-cultural dimensions of health were meant to challenge health professionals' stereotypical perceptions of the socio-cultural dimensions of health, and encourage them to move towards a less essentialist and static understanding of the concept of culture.[8] As it turned out, participants often found this topic "interesting, I didn't know anything about that before" (participant, Celje), "refreshing, something completely different" (participant, Sevnica), but it was criticized for being too abstract, complex and "not useful enough for our work" (participant, Vrhnika). Other educators in cultural competences had similar experiences:

> As a medical anthropologist attempting to help clinicians understand how culture and healing interact in patients from different cultures, I have found it difficult to present to them what I know to be a highly complex and nuanced set of ideas that are considerably different from the concrete kinds of information that make up their medical educations… (Jenks 2011: 216)

This is why in this pilot training course, as well as in later ones, we tried to present abstract concepts through concrete case studies from everyday clinical practice. Such an approach often received positive responses from participants and stimulated numerous reactions and discussions, but nevertheless lacked a more in-depth analysis of certain aspects and neglected many complex issues.

We bore in mind one of the key pitfalls of the previous educational programmes abroad, namely, a perception of culture as an "attribute" that belongs to "other" groups and not to health professionals. To counter this, we included as many self-reflective activities as possible, through which participants could learn what conditioned their beliefs and behaviours in health practice. In so doing, we challenged participants' frequent beliefs about biomedicine as an objective, neutral, universal

[8] The titles of these lectures were "How does culture manifest in the field of health and illness?"; "The body – why do we not perceive it universally?"; "Perceptions of health and illness in different cultural contexts", etc.

and culture-free system. Although the majority of participants agreed in principle with this understanding of biomedicine, their reactions were completely different when they were encouraged to confront their own stereotypes and prejudices in one of the workshops, at which they usually insisted that in their work they are "always objective and never make differences between patients" (participant, Vrhnika). Thus, this workshop only achieved its effect in one of the three health centres, and even there, after a long discussion, some participants acknowledged that fear prevented them from confronting their own prejudices: "fear of appearing unprofessional" (participant, Celje), "fear of being accused of making a mistake" (participant, Celje). This fear that the participants mentioned indicates the presence of "defensive medicine" (Sekhar and Navya 2013; Šadl 2018), in which healthcare professionals are constantly subjected to fear of lawsuits or other types of punishment, which drastically influences their capacity for self-reflection.

Furthermore, we tried to avoid the previously mentioned pitfalls of equating culture with ethnicity or race by not focusing the training content on a specific ethnic group, and instead highlighting problematic or thematic areas that different groups face in their access to health. Some researchers would refer to such an approach as cross-cultural, in contrast with a categorical approach:

> a *categorical* approach, in which providers are taught information about specific groups, and a *cross-cultural* approach, in which the focus is on general methods for communicating with and caring for patients from diverse backgrounds. (Jenks 2011: 216–217)

In line with this approach, a special part of the training was focused on communication between health professionals and people from different backgrounds.[9] Although the educators avoided reinforcing the stereotypical perception of different groups, we cannot say that we managed to overcome many of the existing stereotypes and prejudices of healthcare professionals in the short period of training. This is evidenced by certain participants' problematic culturalist statements who, on the last day of the course, stated that "the Roma culture is such that they run to the doctor for every little thing" (participant, Sevnica) or "Albanian women shout during labour, it is their culture" (participant, Vrhnika).

Due to the aforementioned problem of the culture concept concealing social and economic inequalities (Napier et al. 2014: 1616), and with different culturalisms, we attempted to place the course contents in the wider socio-economic and political context. In other words, we were aware of the danger of anti-political approaches that see difference as a consequence of individual choice and as an individual responsibility (Inda 2006; Leskošek 2013) and not as a result of the social production of health inequalities (Jenks 2011: 230). With this in mind, during the last part of the training, we devoted more space to the various systemic barriers that arise in accessing the health-insurance system and healthcare institutions, as well as other

[9] This section was entitled "Culturally competent communication in healthcare".

structural forms of exclusion that certain populations experience in Slovenia.[10] Participants' responses to the presentation of a series of legal and administrative barriers that prevent many of the residents of Slovenia from accessing healthcare have shown that health professionals are poorly aware of these barriers, and at the same time, their reactions demonstrate that they have mostly understood political, economic and social considerations behind health inequalities.

Despite the weaknesses in these pilot trainings, 41 participants evaluated the training as useful and important.[11] In addition to good quantitative assessments (see Table 1), participants often mentioned four key criticisms at the end of the questionnaire: (1) individual contents are not sufficiently interconnected, (2) the content is primarily taught by anthropologists rather than health professionals, (3) cultural competences are not sufficiently related to the work of health professionals, and (4) cultural competences are not related to the local environment.

These criticisms, in addition to the educators' self-evaluation, were crucial in guiding the formation of an upgraded training course,[12] which occurred in 2018 and 2019 as part of the project "Model Community Approach to Promote Health and Reduce Health Inequalities in Local Communities" (MoST).[13] Unlike the pilot training course, which took place in only three cycles, the new training course was attended by a total of 485 participants,[14] and was carried out on 13 occasions in six different locations in Slovenia.[15] Although the course length seemed to be a key weakness from the beginning, this upgraded training – due to the previously described different perceptions of time, as well as financial and organizational barriers – remained 20 hours long.

In response to the first criticism about the insufficient linking of the contents, a thorough evaluation of the entire programme was completed before the start of the new training cycles. The main theoretical orientations of the pilot training that

[10] The lectures and workshops were entitled: "Legal aspects: barriers to access to and within the healthcare system"; "Poverty: how does the socio-economic situation affect health?"; "The marginalized population in the healthcare system".

[11] The training was attended by nurses and graduate nurses, graduate physiotherapists and a graduate psychologist. The evaluation took place at the end of the training as a group discussion as well as through questionnaires that were distributed after each day of the training.

[12] On the first day of the training, participants were confronted with prejudices and stereotypes that demonstrated in practical cases why cultural competences are needed, and they moved on to linguistic and intercultural misunderstandings with solutions for interpretation and intercultural mediation. The second day dealt with the various intersections of culture and health in the healthcare institutions. The concept of culture was presented through an analysis of past pitfalls of cultural competence. The ethnographic method was introduced to participants, and in the interactive workshop there was space for reflection on socio-cultural and other barriers in everyday clinical practice. The socio-economic aspects related to health, inequalities and vulnerabilities were the focus of the third day, when participants were confronted – through lectures and workshops – with various barriers in access to and within the healthcare system.

[13] More about the MoST project is available at: https://www.nijz.si/sl/most-model-skupnostnega-pristopa-za-krepitev-zdravja-in-zmanjsevanje-neenakosti-v-zdravju-v-lokalnih (accessed 23. 3. 2020).

[14] The upgraded training was attended by healthcare professionals from the primary level of healthcare, namely graduate nurses and graduate medical workers, psychologists, dietitians, physiotherapists, kinesiologists, midwives, nurses and medical doctors.

[15] To get closer to healthcare professionals in their local environment, the training was organized in various towns across Slovenia, namely in Celje, Maribor, Murska Sobota, Novo mesto, Ljubljana and Nova Gorica.

resulted from anthropological critiques were unchanged in the upgraded training, and most of the thematic sections remained the same or similar. However, the focus of certain sections changed (e.g. the general topic of communication was replaced by a more focused engagement with linguistic and intercultural misunderstandings, and the roles of interpreter and intercultural mediator were presented), and in the new version of training, we tried to interweave and reorganize the contents more coherently. This was also the reason why we switched from a five-day to three-day training with the same number of hours. The key challenge was not only to connect the content, but also the educators, who needed to be better acquainted with participants' expectations as well as with the advantages and pitfalls of previous cultural-competence training courses. In so doing, joint meetings of all the educators before and after each training proved to be crucial, as did the educators' initial and ongoing mentoring. It was equally important to pay more attention to the evaluation that followed every training cycle (evaluation via questionnaire, educators' self-evaluation and participant observation) and to prepare promptly the analysis of the evaluation after each training course.

In response to the second critique of anthropologists' overstated role in the training, two linguists and four health professionals were included as educators. Health professionals carried out introductory lectures aimed at sensitizing participants to the socio-cultural dimensions of health and disease, as well as workshops on biomedicine as a socio-culturally determined system and workshops on questioning their own stereotypes and prejudices during clinical practice. Unlike in the pilot training, participants appeared to be more willing to open up and trust "their colleagues" than was the case with the previous educators who were anthropologists.[16] The increased presence of health professionals in the role of training providers also sought to address the third criticism of the incompatibility of training with the work of healthcare professionals (see Table 1), as health workers consistently drew on their clinical practice in the lectures. At the same time, a longer workshop on linguistic, intercultural and socio-economic barriers was held as part of the revised training in response to this criticism. In this workshop, health professionals divided up into small groups and participated in a guided discussion about their own experiences of misjudgements and misunderstandings with patients and about finding different causes for these situations. The educators who acted as discussion coordinators had the opportunity, on the one hand, to encourage greater self-reflection on their work. Through their own examples, they showed that the reasons for misunderstandings and misjudgements were often linked with the socio-cultural and economic-political dimensions.

In response to the fourth criticism, linked to the training's unrelatedness with the local context, the most sensible options would be to introduce the planned fieldwork in the training design, but this did not occur for similar reasons as in the past.

[16] From the reactions of these health professionals, we could assume that those who have not been "initiated" into the medical profession, in their opinion, cannot make credible judgments. Anthropologically put, only those who have an emic view have the right to criticize.

The compromise solution was to present participants with the findings of qualitative research on vulnerability and health inequalities in their local communities, conducted in parallel as part of the MoST project. In addition, before each training all educators were provided with information about specific inequalities, identified in each community, in order to incorporate the information in their lectures. Moreover, a workshop was held at the end of the training course, which confronted the participants with specific obstacles that had been detected in a particular local community.

As with the pilot training course, the participants assessed the upgraded version of the training very positively. At the end of each training day, participants received an evaluation questionnaire that asked them to assess each single lecture on a five-point Likert scale (1 – very poor; 2 – poor; 3 – good; 4 – very good; 5 – excellent) as well as the training day as a whole. Table 1 shows the results for both training courses implemented, and the responses have been summed up for all the training days (piloted in "Together for Health" (TfH) and upgraded in MoST).

Table 1. Evaluation for the training course "Developing the Cultural Competences of Healthcare Professionals" (TfH and MoST). Source: results of the evaluation questionnaire; authors' own calculation.

	Excellent	Very good	Good	Poor	Very poor
SATISFACTION WITH THE CONTENTS					
TfH (n = 180)	65.55%	27.22%	5%	2.22%	0%
MoST (n = 812)	57.26%	34.11%	7.88%	0.49%	0.24%
USEFULNESS OF THE CONTENTS AT WORK					
TfH (n = 180)	61.11%	31.66%	5%	2.22%	0%
MoST (n = 813)	49.07%	32.34%	15.86%	2.46%	0.24%
TRAINING ORGANIZATION					
TfH (n = 164)	65.24%	29.26%	3.65%	2.82%	0%
MoST (n = 811)	67.07%	26.26%	6.16%	0.49%	0%

Table 1 shows that more than half of the participants of both training cycles rated their satisfaction with the contents (65.55%, 57.26%) and training organization (65.24%, 67.07%) as excellent in both training courses (TfH and MoST). The difference between the two cycles is noticeable in their assessing the usefulness of the contents at work: in the TfH, 61.11% of the participants rated it as excellent, while 49.07% did so in the MoST. Moreover, the data gathered through the questionnaire also showed that 84.23% (n = 736) of the participants in the upgraded version of the training content would recommend it to their colleagues.

Although this evaluation suggests that the training was generally well-received among healthcare professionals and, in following the entire process, we have been able to see significant progress in certain aspects of the training, there are still many things to be improved. As Table 1 shows, despite various attempts at better relating the training contents to the work of healthcare professionals, participants evaluated the new

course contents as less useful for their work than in the previous training cycle. In relation to the weaknesses previously exposed in the educators' self-evaluation, we would highlight the following here. Given the short duration of the training, and its one-off nature, it is necessary to understand this training as an initial and very basic step for participants in the field of cultural competence. This is why it is necessary to integrate the contents of this and other similar training courses into undergraduate and postgraduate education programmes for health professionals. In this way, a necessary continuity in such education could be provided, and at the same time, certain elements could be upgraded with more field-oriented work, which was missing in our training. Moreover, in addition to the developed training in cultural competence for practising health professionals, which addresses basic topics in this field, it seems meaningful to place more attention on supplementary education in specific topics that our training could not cover. At the same time, the contents of the cultural-competence course should be much better integrated with other training courses and should not be seen as a "politically correct" supplement that is conceptually completely different from other, more medically oriented, training courses. Indeed, our training course, as part of the TfH and MoST projects, was only one among a number of other trainings that were substantially different from, or even contrary to, the content of cultural competence. Or, as a training participant from Sevnica notes:

> I think the training [in the field of cultural competences] was good. I heard a lot of new and interesting facts. The only bad thing was that it was the last. Previously [on other training courses] we've heard a lot about healthy eating, exercise, but it was said as if it was … a common truth that applies to everyone, to everyone in the same way – this way and not any other way. In this last training course, however, everything was turned upside down, and I began to wonder: why should someone who has never used olive oil be forced to use it? I started thinking differently. (participant, Sevnica)

Conclusion

Over the last few decades, cultural competence in healthcare has vastly developed in research and education, which is reflected in the ample array of articles on the subject and the increasing integration of cultural competences into educational curricula for healthcare professionals in different parts of the world. Despite this vast increase in cultural-competence projects in healthcare, as has been shown in the first part of this article, many conceptual and methodological pitfalls remain hidden. These stem primarily from an erroneous understanding of culture that is in stark opposition to anthropological understandings of this concept. The most troubling feature is the misguided equation of culture with race, nationality and ethnicity, and the use of the concept of culture to conceal social and economic inequalities, which has many negative or even harmful consequences in practice.

Although the first part of the article was dedicated to several weaknesses and negative consequences of cultural-competence efforts, it is worth noting that various anthropologists highlight many positive aspects in these efforts. Thus, David Napier et al. note, "the view prevails that cultural competence can improve clinical outcomes by addressing the needs of those who are different from whatever dominant sociocultural groups provide care" (Napier et al. 2014: 1613). Other authors also maintain that quality cultural-competence training courses significantly improve communication between healthcare providers and patients, which increases levels of satisfaction with medical care and adherence to prescribed regimens for patients. This helps healthcare professionals establish cooperative relationships and successful interactions with clients (Cai 2016). At the same time, culturally competent working teams usually result in care being less costly, with fewer claims of malpractice (ibid.).

Anthropologists played an important role in the remarkable upswing in cultural-competence efforts. As has been shown, anthropological calls for increased attention to the socio-cultural dimensions of health contributed vitally to the development of cultural competences in healthcare. When these competences began to be introduced on a large scale to different fields of healthcare, it was precisely anthropological criticisms that significantly influenced the improvement of cultural-competence trainings. Even though these criticisms have not been widely considered and many training courses still have several weaknesses and difficulties, anthropologists have proved to be irreplaceable in this area. However, as Elizabeth A. Carpenter-Song et al. state: "In this regard, it is crucial, however, for anthropologists to move beyond ivory-tower critique and toward clinically relevant and practical recommendations" (Carpenter-Song et al. 2007: 1364). It might be added that in this descent from the ivory tower, anthropologists are needed also in the process of forming and implementing cultural-competence training courses.

In line with this attitude, we embarked on a challenging and somewhat roundabout path of planning and implementing cultural-competence training for health professionals in Slovenia. Based on this six-year process, from 2014 to the present, we can draw several conclusions. At the beginning of this process we had an ambitious plan regarding the training's content and methodology. We intended to educate healthcare workers on crucial medical-anthropological themes in all their complexity and variety, and introduce these themes through a series of lectures, workshops and fieldwork research led by an interdisciplinary team. However, even in the early stage of this process we learned that being an anthropologist in a healthcare institution means making painful compromises between our own profession on the one hand, and the content-organizational limitations of training and the expectations of health professionals on the other. As was described in the second part of this article, we needed to accept hard organizational (halving the hours of the training, reducing the interdisciplinary team, etc.) and content-related compromises (reducing the number of training themes, cancelling the fieldwork, etc.). Although these compromises have often resulted in content-impoverished and methodologically limited

approaches, we never gave in at the epistemological level. By strictly following the anthropological critiques of cultural competence presented in the first part of this article, we managed to avoid the field's "traditional" pitfalls, such as some combination of essentialized, exoticized and static notions of culture, commonly regarded as "technical skills" or a "list of traits" associated with various racial and ethnic groups. These critiques formed not only the fundamental guidelines around which our training was structured, but were also an essential part of our lectures and workshops in which they were presented as a series of approaches to be avoided.

Although we succeeded in overcoming many pitfalls of earlier cultural-competence educational programmes held abroad, we encountered one problem for which anthropological writings in this field could not prepare us properly. Namely, when educating the healthcare workers on socio-cultural dimensions in healthcare, we inevitably questioned the universality, neutrality and objectivity of biomedicine. The majority of training participants perceived this as an epistemological and methodological assault not only on their discipline, but also on their work. Even though it seemed that many participants were beginning to doubt the indisputable and decontextualized standards of biomedicine during our educational process, they usually accepted this "epistemological shift" only declaratively. From the workshops and final evaluations, it became clear that in this short, 20-hours-long training course, they did not embrace it fully as an integral component of their practical knowledge and skills.

Although many of the presented concepts, themes and questions probably remained at the level of interesting yet abstract ideas for several participants, we ensured that more than 500 healthcare professionals became acquainted with the field of cultural competence at least at a basic level. Moreover, since 2020, the training course "Developing the Cultural Competences of Healthcare Professionals" is no longer only project-related, but has been systematically introduced as additional training for employed healthcare professionals at the primary level of healthcare and as compulsory for those practising prevention programmes at health centres and health-education centres.

It may seem important that training in cultural competences is systematically introduced to Slovene medical and health sciences faculties in the future, however, it is crucial to emphasize that even continual and high-quality cultural-competence training courses offer no guarantee that the socio-cultural dimensions of health are actually considered, or that health inequalities diminish. Even well-implemented educational programmes in this field can only contribute a small share, which is pointless if changes to equal and universally accessible public health do not happen at the systemic level, and if these changes do not cover all levels of healthcare and other social realities.

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Kulturne kompetencije i zdravstvo. Iskustva iz Slovenije

Ovim se radom želi pridonijeti kritičkom promišljanju o važnosti, dvojbama i problemima u obrazovanju zdravstvenih djelatnika o društveno-kulturnim dimenzijama zdravlja i zdravstva. U prvom dijelu rada autorice pokazuju da obrazovne programe u području kulturnih kompetencija, iako su doživjeli izvanredan uspon, prate mnogobrojne nejasnoće i nedostaci. Na temelju brojnih antropoloških kritika autorice ističu glavne konceptualne i metodološke probleme koji prate aktivnosti u području kulturnih kompetencija. Drugi dio članka usmjeren je na analizu višegodišnjeg procesa uvođenja obrazovnog programa iz područja kulturnih kompetencija u Sloveniji, koji je od 2016. godine pohađalo više od 500 zdravstvenih djelatnika. Na temelju rezultata kvantitativne evaluacije polaznika i samoevaluacije predavača, autorice kritički analiziraju doprinos tog programa, naglašavajući neke od ključnih dilema i poteškoća koje su pratile taj proces.

Ključne riječi: kulturne kompetencije, zdravstvo, obrazovanje, antropološka kritika, Slovenija