

Cultural Considerations in Interprofessional Education: A Scoping Review

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Résumé de l'article

Background: Global culture influences health behaviors and attitudes and the way we communicate and solve problems; it can also significantly affect the efficiency of the multicultural and interprofessional healthcare team. This scoping review aims to understand and identify global cultural considerations that exist in interprofessional education (IPE) and that influence the development, implementation, and effectiveness of IPE.

Methods and Findings: The search included peer-reviewed articles focused on both IPE and global culture, also referred to as national, ethnic, or racial culture. There was no limitation placed on levels of learners nor specific health professions. Articles were excluded if they did not explicitly discuss global cultural considerations in IPE. The authors screened 1094 records, and 155 full-text articles were assessed for eligibility. No eligible papers were found for inclusion yielding an empty review. The most common reasons for exclusion were failure to address global culture and a focus on provider-patient cultural competency as opposed to cultural aspects of IPE.

Conclusions: Despite the recognition of the importance of global culture in all interactions, it is not explicitly addressed within the interprofessional healthcare team or the development and implementation of IPE. Studies addressing culturally congruent teamwork and IPE, and the relationship to culturally inclusive patient care, are needed.



Cultural Considerations in Interprofessional Education: A Scoping Review

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ABSTRACT

Background: Global culture influences health behaviors and attitudes and the way we communicate and solve problems; it can also significantly affect the efficiency of the multicultural and interprofessional healthcare team. This scoping review aims to understand and identify global cultural considerations that exist in interprofessional education (IPE) and that influence the development, implementation, and effectiveness of IPE.

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Keywords: interprofessional, education, culture, national, ethnic, global, cultural competence, cultural humility, diversity

Introduction

This scoping review focuses on global culture, also referred to as national or ethnic culture, and its role in interprofessional education (IPE). Different aspects of national culture that affect personal and professional interactions have been described throughout the literature [1,2]. Hofstede's widely used framework describes six comparative dimensions across national cultures—power distance, uncertainty avoidance, individualism/collectivism, masculinity/femininity, long-term/short-term orientation, and indulgence/restraint—to facilitate cross border communication and

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productivity [3]. In healthcare, the overarching goal of increasing awareness in cultural differences has been to provide a culturally safe space for patients and to promote health in a respectful and sensitive manner [4]. Culturally inclusive and sensitive healthcare environments are influenced by the cultural awareness of their providers. The influence of culture on health attitudes and behaviors mandates that healthcare providers be sensitized to cultural norms to meet the needs of a multicultural community [5,6]. Interprofessional education is increasingly recognized as a powerful way to teach and practice communication skills and attitudinal change, including cultural considerations. While this focus is not new or unique to health professions education, the promulgation of equity, diversity, inclusion, and social justice in all spheres of life has been further activated as a result of the antiracism movements of 2020. Institutions and organizations are laboring to evolve and adopt policies that reflect the diversity of the societies they serve. This is seen in the growing diversity of healthcare teams; however, cultural considerations in the interprofessional setting and their relative importance have not been clearly defined.

Background

The healthcare arena is an increasingly diverse and multicultural space. International migration plays a role, with steadily increasing rates of migration over the past four decades and an estimated 272 million international immigrants globally. Migration has an extraordinary impact on the sociocultural development of both destination and origin countries, with the infusion and fusion of cultural perspectives, habits, and health beliefs [7].

The health of the diverse and multicultural community remains a focus of research and an area of prioritization for healthcare policy [4]. It is intimately linked to the acknowledgement of healthcare disparities in ethnic minority groups, and the socioeconomic, geopolitical, structural, and cultural underpinnings of this issue. The interprofessional healthcare team has been shown to enhance healthcare delivery in the community via collaborative practice that spans health, economic, and social domains [8]. Although the six dimensions of national culture identified in Hofstede's seminal work likely affect team dynamics, little is known about the impact of culture on the interprofessional team. In addition to influence on lifestyle and health beliefs, culture shapes behavior and communication style, which are integral to the collaborative effort of any healthcare team [9].

Interprofessional education has been defined as "occasions when two or more professions learn with, from, and about each other to improve collaboration and the quality of care" [10]. It is the foundation for effective interprofessional healthcare teams, and has been endorsed by national and international healthcare organizations for its impact on the delivery of safe, high-quality care and improved patient outcomes [11]. The move to inclusivity is critical to the efficient functioning of a high-performance team [12] and is an important concept for IPE where mutual respect for varied professional roles facilitates holistic patient-centered care. Incorporating global culture into this paradigm, inclusivity provides an increasingly psychologically safe space for students and faculty to be their authentic selves and

allows for bidirectional professional and cultural exchange (acculturation), where individuals are accepting of and learn from each other in contrast to forcibly adopting and adapting to a perceived hierarchy or to the dominant culture (assimilation).

This study aims to understand and identify global cultural considerations that exist in IPE and that influence the development, implementation, and effectiveness of IPE.

Methods

The PRISMA-ScR extension [13] was used to guide the conduct and reporting of this scoping review. This review does not have a protocol. A librarian led the development of the search strategy, with all authors contributing subject matter expertise. The complete search strategy is available in the Appendix.

Inclusion Criteria

The resulting studies were included if they were peer-reviewed articles in any language with a focus on interprofessional education (development, implementation, and evaluation) and global cultural considerations during IPE. Study methods were either qualitative, quantitative, or both. The review included any health-related profession and level of learner.

For the purposes of this study, we chose to use the definition by Matsumoto and Juang [14] for global culture (also referred to as national or ethnic culture): “The set of attitudes, values, beliefs, and behaviors shared by a group of people, but different for each individual, communicated from one generation to the next.”

Exclusion Criteria

Articles were excluded if the reviews were not peer-reviewed, the subjects of the studies were not health-related professionals or students, the aims did not primarily or explicitly focus on IPE, or the focus did not include considerations related to *global* culture. Articles that were not primary sources, including but not limited to editorials or review articles, were not viewed as research studies and were thus excluded.

The final search was executed on February 1, 2021. The following databases were searched: Medline (in PubMed), CINAHL via Ebscohost, and ERIC via Ebscohost. A set of common keywords was consistent across all three databases. MeSH terms, CINAHL headings, and ERIC thesaurus terms were appended as appropriate. No date or language restrictions were placed on the search results. The bibliographies of hand-selected articles from the initial search results were ancestry searched for additional records to screen.

Covidence [15] was chosen as the review management tool. Records of search results were imported into Covidence and all screening, full-text reviews, and data extraction were done within the platform. Initially, 10 titles and abstracts were screened by all reviewers (SD, MC, JP). When interrater reliability was achieved, reviewers screened titles/abstracts independently. Each title/abstract was screened by two reviewers. Conflicts were resolved via consensus before moving ahead to the next stage. Likewise, the reviewers performed a full-text review for five articles.

When interrater reliability was achieved, SD independently reviewed each full-text article that passed the screening stage which was double-checked by either MC or JP. Conflicts were resolved between the reviewers weekly. Two articles were chosen for data extraction reliability training as well as refining of the data extraction table. When interrater reliability was achieved, SD and MC extracted articles independently tagging a need for additional review when needed. Articles tagged for additional review were verified by the other reviewer (JP).

Analysis & Findings

Database searches retrieved 986 records. An additional 339 records were identified by hand-searching bibliographies. A total of 1325 items were imported into Covidence, of which Covidence identified 231 duplicates. As such, 1094 records were screened and 155 full text articles were assessed for eligibility. Data extraction was performed on 17 articles to ensure closer scrutiny of inclusion/exclusion. Ultimately, no eligible papers were found for inclusion yielding an empty review. Empty reviews comprise approximately 9% of the Cochrane Database of Systematic Reviews and three main issues at the heart of the empty review have been identified: novel areas of research, a highly specific question, or stringent focus on methodological rigor [16]. In this review we used a relatively narrow concept of culture (i.e., global, ethnic, national, racial), but otherwise conducted a broad review with inclusion of varied methodology in a topical area that has dominated healthcare discussions for decades. There is some concern that empty reviews can mislead the reader

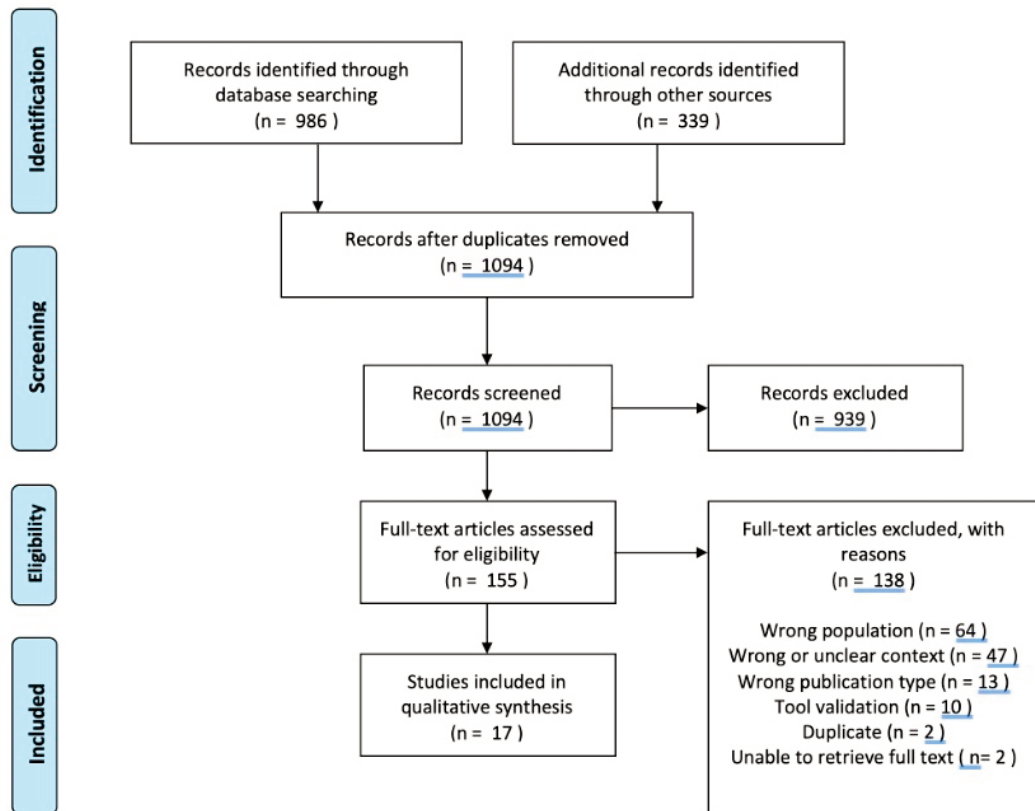


Figure 1. PRISMA flow diagram

when conclusions are drawn with no substantiating evidence, and it is suggested that sharing insights gleaned from analysis of articles may provide clarity on the research process and further inform the literature [17,18]. In our discussion we reference eight articles that the team agreed provided unique understanding into cultural considerations in IPE. Figure 1 displays the selection process in a PRISMA flow diagram.

Overall, we identified eight articles that provided insights into an element of the research question. Hoping for additional interpretation, we decided to extract all eight articles for data analysis (see Table 1). We found in the end that all eight articles were excluded. The articles covered different aspects of culture and were diverse in methodology and content with two qualitative studies, five mixed methods studies, and one paper, which was not considered research (i.e., did not have a research question and did not report outcomes). Many of the papers were based in North America, with one article each from Australia, Honolulu, Japan, and the United Kingdom. The final article was a systematic review that included papers from several international regions. There was no explicit definition of culture in five of these papers [19-22] and when used, the term was widely applied beyond national and ethnic culture. Furthermore, one article specifically referenced professional culture [23]. There was minimal reference to models of national culture [24] and only one article described specific aspects or dimensions of national culture [25]. Overall, a few guiding attributes emerged from the literature that may help to inform guidance on cultural considerations for the interprofessional team, especially as it relates to education.

Table 1. Related articles found to be most relevant

Reference	Design and aim	Findings
Durey, A., Taylor, K., Bessarab, D., Kickett, M., Jones, S., Hoffman, J., ... & Scott, K. (2017). "Working Together": An Intercultural Academic Leadership Programme to Build Health Science Educators' Capacity to Teach Indigenous Health and Culture. <i>The Australian Journal of Indigenous Education</i> , 46(1), 12. Location: Australia	Design: Mixed methods, pre/post survey Aim: To present the theoretical framework and preliminary evaluation findings of the "Working Together" program, a compulsory first year Aboriginal and Torres Strait Islander culture and health unit for over two thousand interdisciplinary health science students, to build their capacity to deliver culturally safe care.	96% of participants felt fair to extremely confident about teaching indigenous content after the program compared to 22% before the program
Haruta, J., Breugelmans, R., & Nishigori, H. (2018). Translation and cultural adaptation of the Japanese version of the interprofessional facilitation scale. <i>Journal of interprofessional care</i> , 32(3), 321–328. Location: Japan	Design: Validation of translation of survey instrument and factor analysis Aim: To develop a Japanese version of the IPFS and to explore whether the developed version is usable in terms of cultural adaptation.	Most items were translatable with some cultural adaptation beyond strict translation. Two items were adapted to a point that they did not match other studies.
Hawala-Druy, S., & Hill, M. H. (2012). Interdisciplinary: Cultural competency and culturally congruent education for millennials in health professions. <i>Nurse education today</i> , 32(7), 772–778. Location: United States of America	Design: Mixed methods, pre/post survey Aim: To design and implement creative, evidence-based interdisciplinary educational activities that promote positive and culturally competent learning outcomes for millennial students.	Learners improved their level of cultural competency post-educational intervention

Table 1 (continued)

Reference	Design and aim	Findings
Horacek, T., Brann, L., Erdman, M., Middlemiss, M. A., & Raj, S. (2009). Interprofessional learning community: Educating dietetic and other health profession students through an interdisciplinary, service-learning experience. <i>Topics in Clinical Nutrition</i> , 24(1), 6–15.	Design: Mixed methods. Pre/post self assessment, and evaluation of course via survey Aim: This article describes the successes, barriers, and effectiveness of an interprofessional learning community with integrated service-learning experiences and an evaluation of the same	This course was instrumental in widening students viewpoints to include a multidisciplinary view of health care and in enhancing students cultural and interprofessional competence.
Lewis, L. D., & Steinert, Y. (2020). How culture is understood in faculty development in the health professions: a scoping review. <i>Academic Medicine</i> , 95(2), 310–319. Location: Articles were from US, China, Canada, India, Saudi Arabia, Sweden, Vietnam, Botswana, Denmark, Haiti, Iran, Japan, Mongolia, Netherlands, Qatar, Russia, South Korea, South Africa, UK, Zimbabwe	Design: Scoping review of the literature Aim: To examine the ways in which culture is conceptualized in faculty development (FD) in the health professions	Of 70 articles, culture was only explicitly defined in 3 articles and 53% were designed for multidisciplinary groups. In general, culture centered on issues of diversity aiming to promote institutional change. Cultural considerations was not routinely described in international faculty development.
Matsunaga, D. S., Rediger, G., Mamacalay, B., Sato, D., & Yamada, S. (2003). Building cultural competence in a interdisciplinary community service-learning project. <i>Pacific health dialog</i> , 10(2), 34–40. Location: Honolulu	Design: Qualitative study — review of student journals Aim: A qualitative evaluation of a community-based model for teaching a cross-cultural competence.	Five themes identified: gaining insight: examining one’s own culture and values; Understanding the interaction of culture and health; Learning to ask - eliciting client and community perspectives; working with differences in a diverse health care team; Learning by teaching - practical engagement with community residents
Morgan, G. (2017). Allied healthcare undergraduate education: international students at the clinical interface. <i>Journal of Further and Higher Education</i> , 41(3), 286–300. Location: United Kingdom	Design: Qualitative study — focus groups with thematic analysis Aim: To investigate how allied healthcare international students perceive their clinical placement.	Identified 4 themes: communication especially nonverbal communication and use of slang, cultural differences in professional roles, acceptance within the health care team, survival strategies
Nelson, A., Anis-Abdellatif, M., Larson, J., Mulder, C., & Wolff, B. (2016). New faculty orientation: discussion of cultural competency, sexual victimization, and student behaviors. <i>The Journal of Continuing Education in Nursing</i> , 47(5), 228–233. Location: United States	Design: Descriptive paper This article describes the addition of discussion on cultural competency, sexual victimization and unprofessional student behaviors to the new faculty orientation program in an undergraduate interprofessional health program at a midwestern liberal arts university.	None reported

Thematic Findings and Discussion

The role of culture in health and society has dominated healthcare discourse over the last 50 years. Given the pervasive nature of these discussions, with emphasis on cultural competency and cultural humility in the professional environment, it was surprising to find few relevant articles that explicitly addressed cultural considerations in IPE. The reasons for this were many, but one central observation was the evolving application of the term culture to any group of individuals with shared identities regardless of nationality or ethnicity, and a failure to clearly define the authors’ view of culture.

The articles that were excluded evaluated organizational, professional, and LGBTQ+ culture or discussed the significance of national or ethnic culture from the sole perspective of patient outcomes. Most papers describing cultural immersion and international medical electives failed to evaluate the relationship between visiting and national team members and focused exclusively on learning around culturally com-

petent patient care or interactions. Several papers evaluated ways to improve the health of Indigenous peoples, and although all promoted partnership between varied healthcare providers in this setting, there were missed opportunities to explore this relationship, and the focus was on cultural safety for the Indigenous patient.

Few articles referenced cultural differences as understood by Hofstede's six dimensions of culture and were generally focused on ways to improve cross-cultural and intercultural communication. Four overarching themes were identified that reinforced the value of early instruction in cultural diversity and harnessing the attributes of inclusivity and cultural humility for the success of IPE.

Themes 1 and 2 emphasize the importance of discussing cultural diversity and creating opportunities for cross-cultural communication amongst team members during early professional training. Themes 3 and 4 provide guidance for achieving a psychologically safe "intercultural space." The latter reflects the current period of enlightenment by capturing fundamental concepts that should be leveraged by facilitators and educators for the benefit of IPE. The following examples illustrate the applicability and current implementation of these themes in practice but should encourage even wider adoption of these concepts across all realms of interprofessional education.

Theme 1: Cultural awareness and sensitivity training begins with education

In their article, Hawala-Drury and Hill [19] posit that culturally competent education should be a precursor to culturally competent care. Multicultural students enrolled in an interprofessional course on culturally competent care were encouraged to examine their own personal biases, and through this process, recognize the elements of diversity amongst their family, friends, and team-members as well as their patients. It is imperative that educators are "aware of their own cultural assumptions and preferences," and how these viewpoints can present obstacles to learning, effective communication, and teamwork [19]. Horacek et al. [20] describe an interprofessional learning community (LC) for undergraduate and graduate students. The course included, amongst others, a theme of cultural awareness facilitated through a shared meal where students and faculty brought culturally relevant dishes. Student evaluations of this interprofessional LC were notable for the strong agreement on increased cultural awareness and competence [20]. In an interprofessional community service-learning project for undergraduate health science students, weekly journal entries reflected the development of cultural awareness and an emerging appreciation for working within a diverse healthcare team. The authors reflect that "cultural differences affect several aspects of group dynamics," and students were able to "identify and refine their own strengths and weaknesses as group members" [21].

Additionally, educators should be trained in culturally responsive pedagogy, bolstering students' cultural strengths for academic achievement [26]. In offering advice to educators, students suggest that educators try to be aware of their students' backgrounds and not assume that lack of familiarity with nation-specific operating procedures is due to a lack of competence. In other words, educators should be aware that

they may be judging students through a culturally tinted lens [24]. Nelson et al. [22] address this idea in their descriptive paper of an innovation in new faculty orientation at their institution. Discussion around cultural competency was incorporated into faculty orientation with specific reference to creating a nurturing environment for diverse students and faculty. They specifically describe the harmful effects of microaggressions, which can “interfere with students’ learning and faculty work productivity” [22]. Faculty underwent sensitivity training to identify and address microaggressions and were encouraged to account for diverse religious holidays or customs that may affect student participation. Overall, participant feedback highlighted that sensitivity training led to internal reflection and challenged “embedded stereotypes” [14]. Furthermore, Hawala-Druy & Hill [19] describe the culturally competent educator as one that respects individual cultures, reflects on personal cultural biases, recognizes and successfully mediates potential cultural conflicts, educates themselves about their students’ cultures, and ensures incorporation into institutional policy so that the needs of the diverse student population are met [19].

Ultimately, cultural considerations should be thoughtfully woven into the health sciences curriculum at both the undergraduate and graduate levels, and educators should be trained to create a culturally inclusive environment where students of all identities can learn and thrive.

Theme 2: Harmonizing and respecting individual perspectives strengthens the team

The importance of facilitating complex IPE interactions is highlighted by Haruta et al. (2018) in their description of the translation and cultural adaptation of the Japanese version of an interprofessional facilitation scale. Specifically calling attention to the tension that may occur in managing “professional differences and hierarchies within the learning group” [25]. In the cross-cultural validation of the tool amongst Japanese healthcare professionals, a new factor—“respect for others”—was extracted. Japanese culture is described as “relational” where adherence to the medical hierarchy constitutes belonging; to do otherwise would be to break societal norms. Hence “explicit respect” for other professionals was required to facilitate IPE in an environment where team members could contribute without damaging recognized relationships [25]. This insight provides guidance on the approach to IPE in a multicultural setting.

Matsunaga et al. [21] evaluated a community-based program for cross-cultural competence where students created and evaluated health related education sessions for children and parents at a local elementary school. Students completed weekly journal entries which were later reviewed for qualitative analysis. One theme that was extracted from the review of participant journals was “working with differences in a diverse healthcare team.” It was clear that group dynamics were influenced by culture, and this was evidenced in the way individual students participated within the group and in approach to conflict resolution. As students rotated group roles, they were able to reflect on their own weaknesses and strengths and recognized the value of each person. This allowed group members to adapt personal behaviors to facilitate learning from each other [21].

It is important that each member of the interprofessional team understand that their unique perspective and contribution is respected and valued. Furthermore, it was clear that fostering a culturally inclusive and psychologically safe environment allowed opportunities for IPE that transcended the goals of the exercise to a true collaboration and meeting of diverse minds.

Theme 3: Inclusivity and belonging are fundamental to IPE

Durey et al. [27] describe the “Working Together” program, a compulsory course on Aboriginal and Torres Strait Islander culture for first-year interdisciplinary health science students in New Zealand. Both Indigenous and non-Indigenous faculty members attended facilitator training together and co-moderated student small group sessions to model “working together equitably and respectfully in the intercultural space.” The program was modeled on the theory of the “third space,” conceptualized as an intercultural space that allows for the intersection of cultural beliefs and world views. Five key capabilities were described, but of most interest was the “relational capabilities,” which include “interpersonal communication skills that are inclusive, collaborative, foster intercultural partnerships and reach shared understandings.” This provides a guide for the approach to culture within the interprofessional healthcare team. Educators reflected that the feeling of being isolated in the intercultural space was mitigated by working together, which facilitated a sense of belonging and broadened individual perspectives [27].

Morgan et al. [24] looked at the experiences of international allied healthcare students in a clinical placement in the United Kingdom. Focus group discussions from this qualitative study of 12 students revealed that being accepted by their supervisor and by the team was an important consideration and defined whether students had a negative or positive experience. Students were aware of the value of being able to “interact” with team members, and one student expressed the anxiety that occurs when this does not happen, which adds to the inherent pressure of clinical work [24].

By extension, from the relevant studies (Table 1), it is apparent that the interprofessional healthcare team needs to create an atmosphere that fosters acceptance, inclusivity, and belonging. Team members should learn about each other’s cultural backgrounds and feel empowered to have open dialogue around cultural differences and perspectives.

Theme 4: Identifying and acknowledging personal bias is critical for cultural humility in IPE

Most studies failed to define culture concretely. This is likely because culture, an amorphous, multi-faceted, intersectional, and highly individual-specific construct as discovered in this scoping review, is acknowledged as dynamic in nature, with variations within the same culture as well as between cultures. Cultural competency in healthcare is “The ability to provide or facilitate care which respects the values, beliefs and practices of the client, and which addresses disadvantages arising from the client’s position in relation to networks of power” [28]. The idea of “cultural competence” has come under fire due to the perception that it is an achievable and measurable goal as opposed to cultural humility, a “lifelong process of self-reflection

and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of her/his own beliefs and cultural identities" [29,30]. Students who participated in a semester-long course on Culturally Congruent Care for Clinical Health Professions reinforce this concept [19]. In written remarks upon course completion, students discussed overestimating their cultural competence at the beginning of the course. They went on to express an understanding that cultural competence was not an end-product but an ongoing process, despite an improvement in their pre- and post-scores (pre mean = 60.8; post mean = 70.6; $p < 0.001$) on The Inventory for Assessing The Process of Cultural Competence Student Version (IAPCC-SV) [19]. Lewis & Steinert [23] further reinforce this point in their scoping review evaluating how culture is understood in faculty development in health professions. Of 70 articles reviewed, 13 articles looked at faculty development programs on cultural competence [23]. Generally, the faculty development programs described were successful with change in faculty perception of cultural competence and ability to integrate cultural competency into teaching. It was notable, however, that several articles also discussed "critical consciousness, described as reflection and examination of personal assumptions, biases, and social inequalities" [23].

In IPE, the continuous cycle of learning, reflection, and openness to cultural differences should be encouraged at all levels. Faculty, facilitators, and individual team members should practice reflection on their own personal biases in recognition that becoming culturally competent, aware, and humble is a lifelong process.

Limitations

One limitation of this review was the narrow definition of culture as "national" or "global" culture. The term culture has evolved in its application, but by describing "shared worldviews" regardless of nationality or ethnicity, one can argue that the same considerations can apply in generational culture, professional culture, and/or organizational culture in IPE.

Aside from the reported articles, there were studies that focused on patient care skills and did not address cultural considerations beyond the provider-patient relationship (e.g., student to student, faculty to student, or culturally congruent teaching methods). We focused our review on research that was anchored in cultural aspects of the education provided, as opposed to cultural competency in the provider-patient relationship. Interprofessional education designed to promote culturally competent patient care may have unmeasured learning outcomes regarding cultural considerations in IPE. Students may apply what they have learned about patient culture to other learners of the same ethnicity, and discussions at the patient level likely surfaced to the learning level and influenced team practice.

Conclusion

Considerations surrounding culture are important in education and interprofessional teamwork. Despite widespread promotion of diversity and inclusivity in the classroom and workplace, there is little guidance for the interprofessional team with respect to national or ethnic culture. The literature tended to avoid explicit reference to rigid cultural dimensions as described by Hofstede et al. and instead pre-

scribed a more general approach. Key concepts extrapolated from the available literature include the promotion of culturally congruent education, cultural humility for educators and learners, and an accepting and inclusive environment and respect for all team members. More studies are needed to explore the impact and the role of all cultures on IPE.

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Appendix: Search strategy

Cultural Considerations in Interprofessional Education

Dowell, Charnetski, Tarbet, & Palaganas

Search engine	Search query
PubMed (481 results)	(Interprofessional[tiab] OR Multiprofessional[tiab] OR Interdisciplinary[tiab] OR Multidisciplinary[tiab] OR Cross-disciplinary[tiab] OR Transdisciplinary[tiab] OR "Interprofessional Relations"[Majr] OR "Interdisciplinary Communication"[Majr] AND (Education[tiab] OR Learning[tiab] OR Teaching[tiab] OR Student[tiab] OR Learner[tiab] OR Faculty[tiab] OR Teacher[tiab] OR Instructor[tiab] OR Educator[tiab] OR Curricul*[tiab] OR Graduate[tiab] OR Undergraduate[tiab] OR Residency[tiab] OR Fellowship[tiab] OR Fieldwork[tiab] OR Clerkship[tiab] OR Preceptorship[tiab] OR "Preceptorship"[Majr] OR "Curriculum"[Majr] OR "Education, Professional"[Majr] OR "Schools, Health Occupations"[Majr] OR "Education, Continuing"[Majr]) AND ("Cultural considerations"[tiab] OR "Cultural awareness"[tiab] OR "Culturally sensitive"[tiab] OR "Cultural sensitivity"[tiab] OR "Cultural* competen*"[tiab] OR "Cultural humility"[tiab] OR "Culturally effective"[tiab] OR "Cultural knowledge"[tiab] OR "Culturally appropriate"[tiab] OR "Cultural diversity"[tiab] OR "Culturally diverse"[tiab] OR "Cross-cultural*"[tiab] OR "Cultural characteristics"[tiab] OR "Cultural Competency"[Majr] OR "Culturally Competent Care"[Majr] OR "Cross-Cultural Comparison"[Majr] OR "Cultural Diversity"[Majr] OR "Culture"[Majr:noexp] OR "Cultural Deprivation"[Majr] OR "Cultural Characteristics"[Majr] OR "Acculturation"[Majr]) AND (Healthcare[tiab] OR Medic*[tiab] OR Nurs*[tiab] OR Rehab*[tiab] OR Therap*[tiab] OR Patholog*[tiab] OR Clinic*[tiab] OR Dental[tiab] OR Dentist*[tiab] OR Pharmac*[tiab] OR "Social work*" [tiab] OR Provider[tiab] OR Physician[tiab] OR Counselor[tiab] OR Counseling[tiab] OR "Health Occupations"[Mesh] OR "Allied Health Occupations"[Mesh] OR "Health Personnel"[Mesh] OR "Allied Health Personnel"[Mesh])
CINAHL (370 results)	((MM "Interprofessional Relations+") OR (MM "Education, Interdisciplinary") OR TI (Interprofessional OR Multiprofessional OR Interdisciplinary OR Multidisciplinary OR Cross-disciplinary OR Transdisciplinary) OR AB (Interprofessional OR Multiprofessional OR Interdisciplinary OR Multidisciplinary OR Cross-disciplinary OR Transdisciplinary)) AND ((MM "Education") OR (MM "Curriculum+") OR (MM "Education, Clinical+") OR (MM "Education, Competency-Based") OR (MM "Education, Health Sciences+") OR (MM "Education, Allied Health+") OR (MM "Education, Associate+") OR (MM "Education, Baccalaureate+") OR (MM "Education, Continuing+") OR (MM "Education, Diploma Programs+") OR (MM "Education, Graduate+") OR (MM "Education, Medical+") OR (MM "Education, Nursing+") OR (MM "Education, Theory-Based+") OR (MM "Preceptorship") OR (MM "Schools, Health Occupations+") OR TI (Education OR Learning OR Teaching OR Student OR Learner OR Faculty OR Teacher OR Instructor OR Educator OR Curricul* OR Graduate OR Undergraduate OR Residency OR Fellowship OR Fieldwork OR Clerkship OR Preceptorship) OR AB (Education OR Learning OR Teaching OR Student OR Learner OR Faculty OR Teacher OR Instructor OR Educator OR Curricul* OR Graduate OR Undergraduate OR Residency OR Fellowship OR Fieldwork OR Clerkship OR Preceptorship)) AND ((MM "Cultural Competence") OR (MM "Cultural Safety") OR (MM "Cultural Bias") OR (MM "Cultural Sensitivity") OR (MM "Cultural Deprivation") OR (MM "Transcultural Care") OR (MM "Cultural Values") OR (MM "Acculturation") OR (MM "Culture+") OR TI (("Cultural considerations" OR "Cultural awareness" OR "Culturally sensitive" OR "Cultural* competen*" OR "Cultural humility" OR "Culturally effective" OR "Cultural knowledge" OR "Culturally appropriate" OR "Cultural diversity" OR "Culturally diverse" OR "Cross-cultural*" OR "Cultural characteristics") OR AB (("Cultural considerations" OR "Cultural awareness" OR "Culturally sensitive" OR "Cultural* competen*" OR "Cultural humility" OR "Culturally effective" OR "Cultural knowledge" OR "Culturally appropriate" OR "Cultural diversity" OR "Culturally diverse" OR "Cross-cultural*" OR "Cultural characteristics")) AND ((MH "Allied Health Professions+") OR (MH "Rehabilitation+") OR (MH "Social Work+") OR (MH "Dentistry+") OR (MH "Medicine+") OR (MH "Midwifery+") OR (MH "Nursing as a Profession+") OR (MH "Pharmacy and Pharmacology+") OR (MH "Veterinary Medicine+") OR (MH "Health Occupations+") OR (MH "Health Personnel+") OR (MH "Allied Health Personnel+") OR (MH "Alternative Health Personnel+") OR (MH "Dentists+") OR (MH "Expert Clinicians+") OR (MH "Health Personnel, Minority+") OR (MH "Medical Staff+") OR (MH "Mental Health Personnel+") OR (MH "Midwives+") OR (MH "Novice Clinicians+") OR (MH "Nurses+") OR (MH "Physicians+") OR (MH "Operating Room Personnel+") OR TI (Healthcare OR Medic* OR Nurs* OR Rehab* OR Therap* OR Patholog* OR Clinic* OR Dental OR Dentist* OR Pharmac* OR "Social work*" OR Provider OR Physician OR Counselor OR Counseling) OR AB (Healthcare OR Medic* OR Nurs* OR Rehab* OR Therap* OR Patholog* OR Clinic* OR Dental OR Dentist* OR Pharmac* OR "Social work*" OR Provider OR Physician OR Counselor OR Counseling))
ERIC (135 results)	(DE "Interprofessional Relationship" OR TI (Interprofessional OR Multiprofessional OR Interdisciplinary OR Multidisciplinary OR Cross-disciplinary OR Transdisciplinary) OR AB (Interprofessional OR Multiprofessional OR Interdisciplinary OR Multidisciplinary OR Cross-disciplinary OR Transdisciplinary)) AND (DE "Allied Health Occupations Education" OR DE "Clinical Experience" OR DE "Clinical Teaching (Health Professions)" OR DE "Medical Education" OR DE "Graduate Medical Education" OR DE "Nursing Education" OR DE "Pharmaceutical Education" OR DE "Veterinary Medical Education" OR DE "Dental Schools" OR DE "Medical Schools" OR DE "Medical Students" OR DE "Nursing Students" OR TI (Education OR Learning OR Teaching OR Student OR Learner OR Faculty OR Teacher OR Instructor OR Educator OR Curricul* OR Graduate OR Undergraduate OR Residency OR Fellowship OR Fieldwork OR Clerkship OR Preceptorship) OR AB (Education OR Learning OR Teaching OR Student OR Learner OR Faculty OR Teacher OR Instructor OR Educator OR Curricul* OR Graduate OR Undergraduate OR Residency OR Fellowship OR Fieldwork OR Clerkship OR Preceptorship)) AND (DE "Culture" OR DE "African American Culture" OR DE "African Culture" OR DE "American Indian Culture" OR DE "Asian Culture" OR DE "Folk Culture" OR DE "Foreign Culture" OR DE "Islamic Culture" OR DE "Korean Culture" OR DE "Latin American Culture" OR DE "Middle Class Culture" OR DE "Non Western Civilization" OR DE "Spanish Culture" OR DE "Acculturation" OR DE "Cross Cultural Studies" OR DE "Cross Cultural Training" OR DE "Cultural Awareness" OR DE "Cultural Differences" OR DE "Cultural Education" OR DE "Cultural Literacy" OR DE "Culture Conflict" OR DE "Intercultural Communication" OR DE "Intercultural Programs" OR TI (("Cultural considerations" OR "Cultural awareness" OR "Culturally sensitive" OR "Cultural* competen*" OR "Cultural humility" OR "Culturally effective" OR "Cultural knowledge" OR "Culturally appropriate" OR "Cultural diversity" OR "Culturally diverse" OR "Cross-cultural*" OR "Cultural characteristics") OR AB (("Cultural considerations" OR "Cultural awareness" OR "Culturally sensitive" OR "Cultural* competen*" OR "Cultural humility" OR "Culturally effective" OR "Cultural knowledge" OR "Culturally appropriate" OR "Cultural diversity" OR "Culturally diverse" OR "Cross-cultural*" OR "Cultural characteristics")) AND (DE "Health Sciences" OR DE "Health Personnel" OR DE "Allied Health Personnel" OR DE "Mental Health Workers" OR DE "Nurses" OR DE "Physicians" OR DE "Psychologists" OR DE "Health Occupations" OR DE "Allied Health Occupations" OR DE "Health Services" OR DE "Community Health Services" OR DE "Hospices (Terminal Care)" OR DE "Medical Services" OR DE "Prenatal Care" OR DE "School Health Services" OR TI (Healthcare OR Medic* OR Nurs* OR Rehab* OR Therap* OR Patholog* OR Clinic* OR Dental OR Dentist* OR Pharmac* OR "Social work*" OR Provider OR Physician OR Counselor OR Counseling) OR AB (Healthcare OR Medic* OR Nurs* OR Rehab* OR Therap* OR Patholog* OR Clinic* OR Dental OR Dentist* OR Pharmac* OR "Social work*" OR Provider OR Physician OR Counselor OR Counseling))