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Cultural Competence and Ethical Decision Making for Health Care Professionals

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Cultural Competence and Ethical Decision Making for Health Care Professionals

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Abstract: Cultural competence and ethical decision making are two separate, yet intrinsically related concepts which are central to services rendered by all health care professionals. Cultural competence is based on ethical principles and informs ethical decision making. In spite of this important connection, the interrelationship of these two concepts does not receive the attention it deserves in the literature. This issue is addressed by appraising the training and assessment of cultural competence and ethical decision making in the health care professions. The integrated relationship of these two concepts is illustrated within the broader contexts of higher education, research and clinical practice. Health care professionals who incorporate cultural competence and ethical decision making will be empowered to provide the best services to their clients/ patients in multicultural contexts to ensure optimum outcomes.

Keywords: Cultural Competence, Ethical Decision Making, Health Care Professionals, Higher Education, Research, Clinical Practice

1. Introduction

Cultural competence and ethical decision making are two separate, yet intrinsically related concepts which are central to services rendered by all health care professionals. For the purposes of this article cultural competence is described as a dynamic, complex and continual evolving process of skill development by health care professionals to respond appropriately to their clients'/patients' unique combination of cultural variables (which may include e.g. ability, age, beliefs, customs, ethnicity, language, gender and gender identity, sexual orientation, religion etc.) to ensure efficacy in working within the cultural context of their clients/patients.

Ethical decision making can be defined as a complex process used by health care professionals to resolve ethical dilemmas. It is dependent on and involves many different factors such as ethical principles, morals, values, beliefs, regulations, legal issues and personal and professional experiences. Ethical decision making involves ethical sensitivity, ethical judgement and ethical choice. The decision making process should follow a sequence of logical steps to guide and support health care professionals.

The importance of cultural competence for health care professionals has been formalized by the inclusion thereof in professional codes of ethics, such as stated in e.g. the American Speech-Language Hearing Association Code of Ethics, Cf. the Ref [1]. These codes require competent services be provided to all populations and recognition of the cultural/linguistic and life experiences.

Recent developments such as changes in health care systems, evidence based practice, new technology used in the delivery of health care and international migration have accentuated the significance of cultural competence. In addition, political correctness and diversified health professional workforces are important factors which necessitate cultural competence, Cf. e.g. the Ref. [2]. Research findings in different health care professions have led to the recognition that culture may influence clients'/patients' communication styles, beliefs about health, and their attitudes towards health care which can include help seeking behavior and treatment compliance, Cf. e.g. the Refs. [3] and [4].

Culturally competent health care requires respectful responses to individual clients'/patients' values, preferences and languages. Health care professionals need to develop

appropriate responses to diversity by understanding culture in all its facets, Cf. the Ref. [5]. Provision of culturally appropriate services to individuals and their families is a basic role of all health care professionals, which requires cultural competence and ethical conduct. This is only possible when health care professionals are educated and trained in developing cultural competence, ethical practice, and continue to increase their effectiveness through clinical experiences and continuing education. Both of these constructs are dynamic and ongoing processes, which need constant attention during professional careers.

There is an abundance of research on cultural competence and professional ethics in the various health care professions. However, the ethical underpinnings of cultural competence has received limited attention in the literature. E. Donate-Bartfield and L. Lausten, Cf. the Ref. [6], describe the historical ethical underpinnings of the multicultural movement. They highlight the morality thereof in that the movement intended to enhance the dignity, rights and recognized worth of marginalized groups. They point out that the multicultural movement went beyond the understanding of different views and perspectives, to include a social justice aspect as it supports equal access and opportunity.

Health care professionals have an ethical obligation to respect cultural differences in all health care settings, Cf. the Ref. [6]. Basing cultural sensitive care on ethical principles will provide additional clinical reasoning tools when faced with ethical dilemmas related to different cultural values. M. Paasche-Orlow, Cf. the Ref. [7], points out that the literature on cultural competency seldom explicitly discusses the role of ethics. He proposes that the essential principles of cultural competence are the acknowledgement of culture in people's lives, respect for cultural differences and minimization of any negative consequences of cultural differences, Cf. the Ref. [7]. It is clear that cultural competence and ethical decision making are interconnected and interdependent, but that this interrelationship does not receive the overt attention it deserves. Contemplating the interrelatedness of cultural competence and ethical decision making, and the significance for health care professionals, it is postulated that these constructs be viewed multi-dimensionally in a broad context.

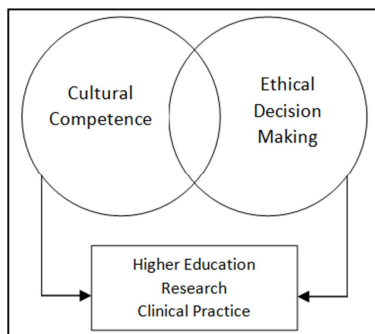


Figure 1. Interrelatedness of cultural competence and ethical decision making.

The purpose of this article is therefore to address the interrelationship of cultural competence and ethical decision

making. An overview of the constructs of ethical decision making and cultural competence are provided, and their interconnectedness is described in three contexts relevant to health care professionals as illustrated in figure 1, namely higher education, research and clinical practice.

2. Ethical Decision Making

Professional ethics is inherent to all health care professional practice. Health care professionals are required to be knowledgeable about ethical principles and rules that govern their practice such as e.g. their professional ethical codes, scope of practice documents workplace code of conduct or licensing laws. According to A. M. Naudé and J. Bornman, Cf. the Ref. [8], maintaining a high level of professional ethics has become more difficult due to competitive pressure and productivity requirements of the health care environment. Throughout their careers, health care professionals are likely to face ethical dilemmas which will need to be resolved. In addition to their personal knowledge base and resources provided by their professional associations, they will also need to rely on their own ability to reflect critically and make immediate ethically responsible decisions, Cf. e.g. the Ref [9].

Ethical decision making in the health care professions is a multifaceted process that involves a range of simple to complex professional issues. As stated earlier, the process of ethical decision making entails ethical sensitivity, ethical judgement and ethical choice. Ethical principles that guide decision making in health care are respect for autonomy, beneficence, nonmaleficence and justice, Cf. e.g. the Ref. [10]. Health care professionals are further guided by models of ethical decision making described in the literature, see the Ref [10].

Common themes and steps have been identified to facilitate the process of making decisions to resolve ethical dilemmas. These include describing the external and internal factors that are relevant to the situation. The steps of the process are generally accepted as identifying and gathering relevant information; identifying relevant ethical issues and possible violations, identifying possible courses of action, identifying the need for external consultation and studying the impact of each action, selecting a plan of action, and implementing that plan, see the Ref. [10]. Critical analysis and definition of the situation is a crucial skill that needs to be developed as the first step in the process of ethical decision making and practice, Cf. e.g. the Ref. [9].

For years the issue of whether ethics can actually be taught has been discussed and debated in various fields and forums. The general conclusion was reached that education can indeed enhance and guide students' and professionals' ethical development. Health care professional training programs are required by professional associations and boards to include ethics training. It appears to be most effective when infused into the curriculum in both theoretical courses and clinical practica, and presented through the use of case studies in a problem based learning approach.

Strategies such as active listening, role play, visualization of others' viewpoints and discussion of innovative solutions to define and respond to ethical issues will facilitate the development of an ethical framework in which ethical reasoning abilities can develop. Ethical sensitivity can also be developed by enhancing prosocial behaviors, which are relationship skills that encourage other people to feel positive and engage in interaction. According to A. M. Naudé, Cf. the Ref. [9], prosocial skills facilitate reflective emotional regulation which in turn enhances effective ethical decision making. She argues that training of ethical sensitivity is the first step and is key to educating students and health care professionals to identify and resolve ethical dilemmas in clinical practice, Cf. the Ref. [9].

Seven skills of ethical sensitivity were described by A. M. Naudé, Cf. the Ref. [9], namely controlling social bias, taking the perception of others, relating to others, understanding emotional expression, perceiving and responding to diversity, interpreting ethics in situations and effective verbal and non-verbal communication. These skills relate to three main functions of basic cognitive processes that can be taught, namely acquiring information about the ethical situation (perception, inference), organizing the information (critical thinking and reflection) and using or interpreting information (divergent thinking, prediction).

The assessment of health care professionals' development of ethical decision making is challenging across disciplines. Traditionally written and oral exams focusing on case studies involving ethical rules such as e.g. confidentiality and respect have been used for evaluation. A. M. Naudé, Cf. the Ref. [9], explored the importance of ethical sensitivity and developed an innovative multidisciplinary *Measuring Instrument for Ethical Sensitivity in the Therapeutic Sciences* (MIEST). This tool can be applied to audiologists, occupational therapists, physical therapists and speech-language pathologists. The assessment is based on a series of vignettes which were custom developed to portray ethical dilemmas that can be encountered by health care professionals, and includes vignettes on ethical issues in different cultures. The *MIEST* can also be used as an instructional tool in a multitude of ways to e.g. assess the impact of the training on trainees, to monitor the development of ethical sensitivity and by using the custom-developed vignettes for training workshops based on problem-based learning principles, Cf. the Ref. [9].

Health care professionals often collaborate with interpreters and translators when working in culturally diverse contexts. Interpreters' and translators' roles are diverse and include being a cultural broker, client/patient advocate, co-therapist, team member and institutional gate keeper. It is often health care professionals' responsibility to train interpreters and translators working under their supervision in procedures and ethics. Health care professionals are responsible for the actions of interpreters and translators and to ensure that they act ethically, which may not always be easy to implement, Cf. e.g. the Ref. [11]. Interpreters' and translators' are required to respect for all involved, respect confidentiality, interpret accurately, convey

cultural information and remain impartial. Case studies and role play can be used to assess ethical principles and decision making skills of interpreters and translators. They should also be encouraged to follow a code of ethics. H. W. Langdon and T. I Saenz, Cf. the Ref. [11], suggest that the National Code of Ethics for Interpreters in Health Care be applied and adapted for different professions. Interpreters and translators need to be encouraged to participate in continuing education to develop and grow in their vital roles.

Should an ethical dilemma arise during such collaborations, the health care professionals, interpreters and translators all need to participate in identifying the ethical issue and collectively following the steps recommended in the literature to seek a solution to the dilemma. Healthcare professionals, interpreters and translators form a team that can most effectively serve clients/patients and their families in a multicultural context.

3. Cultural Competence

3.1. Cultural Competence Framework

Health care professionals around the world who work in settings in which diverse populations are served, need to be aware that multiculturalism goes further than race and ethnicity. The concept of multiculturalism has advanced beyond the conceptualization of multiculturalism involving primarily ethnicity and language to include e.g. ability, age, gender, gender orientation, SES, religion etc. There has been a shift from interpreting multicultural as "special" and limited to certain populations or groups of people to an acknowledgement that we are all multicultural, Cf. e.g. the Ref. [12]. Self-awareness of one's own culture is the first step in developing cultural competence, Cf. e.g. the Ref. [11]. Health care professionals need to develop skills to interact and communicate with clients/ patients and families from a variety of cultures with a myriad of cultural and linguistic variables, and should be able to communicate appropriately, both verbally and non-verbally, in each culturally different context, Cf. e.g. the Ref. [5].

Many different terms are used to describe these skills such as intercultural competence, multicultural competence, cross-cultural competence, cultural sensitivity, global competence, global citizenship and cultural proficiency. For the purposes of this article the term cultural competence will be used. Intercultural competence is defined as the ability to communicate effectively and appropriately in intercultural situations based on one's [inter] cultural knowledge, skills and attitudes, Cf. the Ref [13]. Cultural competence involves knowledge of others; knowledge of self; skills to interpret and relate; skills to discover and/or to interact; valuing others' values, beliefs and behaviors; and relativizing one's self. Cultural competence is an essential component in rendering effective and culturally responsive services to diverse clients.

Becoming culturally competent can help health care professionals understand, appreciate, and support their clients/patients and their families more effectively, and

enable them to develop and implement culturally appropriate services. Culturally competent care improves client, patient and family outcomes. Many different descriptions have been proposed of how individuals develop cultural competence. The models of J. Campinha-Bacote and M. J. Bennett, Cf. the Refs. [14-16], will be described since they can be directly related to the education and assessment of cultural competence.

The Process of Cultural Competence in the Delivery of Healthcare Services (PCCDHS) model of Campinha-Bacote, Cf. the Refs. [14] and [15] holds that cultural competence is a process, not an event and health care professionals should view themselves as becoming culturally competent rather than being cultural competent. The model divides cultural competence into five interdependent constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire.

Cultural awareness is described as the self-examination and exploration of one's own cultural and professional background, and recognition of one's own beliefs. This is important to avoid biases, prejudice and assumptions when working with clients and patients. *Cultural knowledge* is the process of developing insight and knowledge about disease incidence and prevalence amongst cultures, as well the ability to appreciate and understand clients'/patients' values, beliefs and health-related beliefs. *Cultural skill* is the ability to conduct an accurate and culturally appropriate history, assessment and examination. *Cultural encounters* refer to the process that encourages health care professionals to competently engage in cross-cultural interactions with clients and patients from diverse backgrounds. Cultural encounters also involve an assessment of the client's/patient's linguistic needs. These are mindful interactions with presence, which refers to health care professionals being open or available. *Cultural desire* is the motivation of health care professionals to want to, rather than have to, engage in the process of becoming culturally competent. Campinha-Bacote, Cf. the Refs. [14] and [15], identifies cultural desire as the key to unlocking cultural competence.

The constructs of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire have an interdependent relationship with each other, and no matter when the health care professional enters into the process, all five constructs must be addressed and/or experienced. The *PCCDHS* is a cyclical model that begins and ends with the seeking and experiencing of many cultural encounters, to develop cultural competence. In conclusion the *PCCDHS* model provides a framework for health care professionals to render culturally competent and culturally responsive healthcare to all clients and patients, see the Refs. [14] and [15].

M. J. Bennett's *Developmental Model of Intercultural Sensitivity (DMIS)*, Cf. the Ref. [16], focuses on how attitudes towards intercultural sensitivity can be related to intercultural competence. The model proposes a continuum of six stages of increasing sensitivity to difference. It identifies the underlying cognitive orientations individuals

use to understand cultural difference. Each position along the continuum represents increasingly complex perceptual organizations of cultural difference, which in turn allow increasingly sophisticated experiences of other cultures. By identifying the underlying experience of cultural difference, predictions about behavior and attitudes can be made and education can be tailored to facilitate development along the continuum. The first three stages (denial, defense and minimization) are ethnocentric as an individual views their own culture as central to reality. Along the continuum, one develops a more ethnorelative point of view, through experiencing one's own culture as in the context of other cultures. Ethnorelative views develop in the next three stages of the model, namely acceptance, adaptation and integration, which allows for the integration of cultural awareness in everyday interactions, Cf. the Ref. [16].

The skills required for ethical sensitivity, as described earlier, namely controlling social bias, taking the perception of others, relating to others, understanding emotional expression, perceiving and responding to diversity, interpreting ethics in situations and effective verbal and non-verbal communication, see the Ref. [9], can be directly applied to developing cultural competence. The interrelatedness of the two constructs is unequivocal.

There is a close relationship between the level of competence of health care professionals and their ability to provide culturally responsive health care services, which is deemed to be sound ethical practice. Health care professionals need to be trained to develop skill sets for serving diverse populations in a variety of settings and both on pre-professional and professional levels.

3.2. Facilitating the Development of Cultural Competence Through Training

Cultural competence is also viewed to be a graduate attribute, an outcome of internationalization of the curriculum, a requirement for effective global citizenship and a professional competency, see the Ref. [13]. Programs in higher education have an ethical responsibility to train future health care professionals to develop cultural competency in order to empower them to provide appropriate services to diverse populations and to function efficiently in the diversifying health service professional workforce.

Training programs for the various health care professions are committed to facilitating the development of cultural competence of their students, as required by their professional Code of Ethics. Professional associations support this endeavor and provide resources and policy documents for this purpose. Training programs are required to include cultural competence in both the classroom and clinical experiences. They need to provide opportunities for students to develop clinical skills with multicultural populations. Working with interpreters and translators is a key in providing cultural competent care, see the Ref. [11], and health care professionals require training to collaborate with interpreters and translators. Aspects such as how to adequately prepare interpreters and translators in conveying

their questions and concerns and how to bridge the communication gap between the professionals and clients/patients, and their families due to language barriers need to be addressed. Attention also should be paid to resolving ethical issues which may occur during these collaborations.

A plethora of approaches to the training of cultural competence for health care professionals are available in the literature. For example P. R. Rose, Cf. the Ref. [2], discusses key components and different approaches to cultural competence training for health care professionals in a generic manner. Others are discipline specific e.g. R. Lubinski and M. A. Matteliano, Cf. the Ref. [17], developed a guide as a resource for integrating cultural competency education throughout speech-language pathology curricula.

Educational approaches addressing cultural competence have evolved from the additive teaching model (teaching content includes global concepts), to the integrated teaching model (some elements of global concepts are embedded within teaching) to the transformative model in which teaching and learning experiences are embedded throughout teaching within a dynamic and interactive approach, see e.g. the Ref. [18]. The transformative model is widely supported as evidence-based education. Irrespective of the approach followed, all training should be evaluated regularly to ensure that training modules, courses and programs on cultural competence are of a high standard.

The *PCCDHS* model of Campinha-Bacote, Cf. the Refs. [14] and [15], described earlier, can be used to guide curriculum development for cultural competency for health care programs. This model is ideally suited to curricula as it views cultural competence as a developmental process, and not a onetime event. R. Lubinski and M. A. Matteliano, Cf. the Ref. [17], implemented the *PCCDHS* model into curriculum design for transdisciplinary instruction for cultural competence, which can be adapted for implementation by any health care training program. Their educational approach is one of integration of cultural competency into existing courses, rather than the creation of new courses. They developed a series of exercises, Cf. the Ref. [17], to provide students with positive cultural experiences that improve their confidence, engage their interest, develop their ability to emphasize, and result in the desire to provide culturally responsive rehabilitation services across settings. Specific strategies to facilitate the development of cultural competence have been proposed in the literature such as engaging in open dialogue with students to discuss culture and biases and personal perspectives; self-exploration of own values and biases and how that may influence their behaviors; respect and effective listening; service learning activities critical reflection of their development of cultural competence, Cf. the Ref. [4]. Formal cultural competence training can prevent health care professionals from engaging in discriminatory practices and providing services which are not culturally and linguistically appropriate and sensitive, Cf. the Ref. [2], and therefore unethical.

The explicit role that ethics plays in cultural competence

curricula has been lacking, see the Ref. [7]. E. Donate-Bartfield and L. Lausten, Cf. the Ref. [6], recommend that teaching culturally sensitive care should integrate an understanding of ethical issues and that culturally sensitive care be viewed as consistent with core ethical principles. The integrated approach, Cf. the Ref. [17], is validated by H. Minkoff, Cf. the Ref. [3], who cautions that if cultural competence and ethics are presented separately from other content areas, they risk becoming de-emphasized as fringe elements or of marginal importance.

When teaching cultural competence, integrating an understanding of ethical issues is crucial. For example respecting differences is not only important to establishing rapport with clients and patients, and promotes compliance, but it is consistent with the core ethical principles of intervention, see the Ref. [6]. The ethical underpinnings of cultural competence need to be explicitly linked to the ethical principles of health care service delivery, namely autonomy which is the respect of clients'/patients' decisions, justice which requires health care professionals to treat clients/patients fairly and beneficence which requires working for the clients'/patients' well-being by engaging in competent delivery of services with consideration of the needs, desires and values of clients/patients. Justice and beneficence combined with cultural sensitivity facilitate ethical practice as health care professionals will be mindful of the discrepancy in social power between themselves and their clients/patients, and not use their role to impose their own values and beliefs. Cross-cultural communication skills enable health care professionals to consider the clients'/patients' viewpoints and denote beneficence. Integrating the teaching of ethical principles and cultural competence will better prepare health care professionals to deal with conflicts that may arise in clinical practice.

According to M. Paasche-Orlow, Cf. the Ref. [7] and H. Minkoff, Cf. the Ref. [3] conflicts between autonomy and cultural sensitivity may arise in clinical practice and students need to be prepared for ethical decision making. For instance clients'/patients' beliefs may involve practices that interfere with established best practice of health care professionals. Cultural competence involves understanding of the importance of cultural differences, respect for those differences and minimization of the consequences of such differences, Cf. the Ref. [3]. Health care professionals may perceive a conflict between ethical practice and cultural sensitivity to the mores of other cultures. In developing cultural competence health care professionals need to understand and appreciate that in some cultures other moral domains such as community (emphasizing importance of family roles) and sanctity (emphasizing sacred and spiritual side of human nature) hold equal value. In order to be able to reconcile such differences, students require practice in ethical reasoning through e.g. analyzing case studies, and class discussions to practice weighing autonomy, justice and beneficence in seeking solutions to ethical dilemmas in a culturally competent manner. This will enable them to fully understand the complexity and interrelatedness of cultural

competence and ethical decision making. The skills required for ethical decision are similar to those of cultural competency e.g. controlling for social bias addresses both ethical sensitivity and cultural competence, as do adopting the perspective of others and relating to others. These skills can all be trained, Cf. the Ref. [9]. Recognizing this relationship will facilitate training in an integrated manner. Focusing on ethical decision-making when facilitating the development of culturally competent care places the emphasis on individual clients/ patients, their values, beliefs and needs and stresses the importance of communication, see the Ref. [6].

Disparities between diverse populations exist in terms of access to and quality of care due to social, economic and other factors. Training in cultural competence makes health care professionals aware of these disparities and equips them to meet the diverse needs of such populations, see the Ref. [2].

Finally, health care professional boards require their members to participate in continuing education. Continuing education programs address cultural competence in innumerable ways. However, such offerings also need to integrate ethical principles and decision making to ensure that health care professionals are supported in their cultural desire to provide the best services to the populations they serve, Cf. the Ref. [17].

3.3. Assessment of the Development of Cultural Competence

Cultural competence is viewed to be an outcome of the curriculum which needs to be assessed as such in training programs. However, the assessment of the development of cultural competence is a controversial topic and poses a challenge, especially as cultural competence is an ongoing process. A panel of internationally known intercultural scholars discussed the assessment of cultural competence, see the Ref. [13]. Their conclusion was a recommendation to use a mix of quantitative and qualitative methods to assess [inter]cultural competence, including objective measures, interviews, observation, and judgment by self and others.

There is an abundance of qualitative assessment tools for health care professionals in the literature, which range from informal to formally researched surveys. For example J. Campinha-Bacote's *PPCCDHS* model, Cf. the Refs. [14] and [15] includes self-examination questions regarding the personal level of awareness, skill, knowledge, encounters and desire. The *ASKED* mnemonic model assists health care professionals with informally assessing their level of cultural competence. Campinha-Bacote, Cf. the Ref. [15] later developed a formal and robust self-assessment tool, based on the *PCCDHS* model, namely *The Inventory for Assessing the Process of Cultural Competence among Health Care Professionals*. P. S. Seibert, P. Stridh-Igo and C. G. Zimmerman, Cf. the ref. [19], developed a checklist to facilitate cultural awareness and sensitivity consisting of 10 items. In the development of their checklist a primary theme that emerged was the significance of verbal and non-verbal communication. This finding resonates with the

communication skills required to develop ethical sensitivity.

Quantitative assessment tools include the *Cultural Competence Assessment Survey* developed by P. R. Rose, Cf. the Ref. [2]. This tool consists of three surveys, namely the Executive Team and Management survey; Staff survey and Health Professionals survey. Research results established the reliability and validity of the tool which can be used to determine the level of cultural competence preparedness of health care professionals. The *Intercultural Development Inventory (IDI)*, Cf. the Ref. [20] is a quantitative instrument that measures stages within a developmental model of intercultural sensitivity that progress through ethnocentric to ethnorelative orientations, as described by M. J. Bennett, see Ref. [16]. The *IDI* measures cognitive structure rather than attitudes, which makes it a more stable and generalizable test that is less susceptible to situational factors. It has 50 items that can be taken on-line or in a paper and pencil form. It has been translated into fifteen languages and is widely used in higher education.

In conclusion assessment of cultural competence should be an integral part of both training and clinical practice in order to assist health care professionals in the continued process of developing cultural competence. Results can be used to address weaknesses and strengthen the development of cultural competency. A. M. Naudé, Cf. the Ref. [9], applied the stages of developing cultural competence to the development of ethical sensitivity, and concluded that training to facilitate the development cultural sensitivity can enhance ethical sensitivity which is crucial to ethical decision making.

4. Cultural Competence and Ethical Decision Making Within the Higher Education Context

4.1. Internationalization of Higher Education

According to Figure 1, the context of higher education is important when reviewing cultural competence and ethical decision making within a broader framework. Two aspects of higher education are addressed in this section: the internationalization of the curriculum and the integrated training of cultural competence and ethical skills.

Internationalization of higher education is viewed to be a response to globalization. It has gained momentum and cultural competence is viewed as one of the outcomes of internationalization, Cf. the Ref. [13]. Internationalization within the higher education context can be traced back to the 1960's and has evolved into a global phenomenon. It has become a powerful and persistent driver in education around the world during the past two decades, Cf. the Ref. [21]. Reference to internationalization can be found in e.g. university strategic plans, national policy statements, international declarations, and academic articles which, according to Knight, Cf. the Ref. [22], all indicate the centrality of the concept in higher education.

The concept has been debated extensively and different terms and definitions have been used to describe this phenomenon in higher education over the past 50 plus years. According to Knight. Cf. the Ref. [22], *Internationalization* is the term most often used. There are a plethora of definitions and descriptions which reflect debates and different perspectives on the topic, but all add in different manners to the application of the concept to higher education. Knight, Cf. the Ref. [22] proposed a neutral definition: “the process of integrating an international, intercultural or global dimension into the purpose, functions or delivery of post-secondary education” to reflect the richness, breadth, and depth of internationalization. Hudzik, cf. the Ref. [23], relates internationalization to the mission of higher education by stating that, “Comprehensive internationalization is a commitment, confirmed through action, to infuse international and comparative perspectives throughout the teaching, research, and service missions of higher education. It shares institutional ethos and values and touches the entire higher education. It shapes institutional ethos and values and touches the entire higher education enterprise.” Comprehensive internationalization not only impacts all of campus life, but the institution’s external frames of reference, partnerships, and relations, Cf. the Ref. [23].

Various authors have identified key aspects of the internationalization of higher education, which include e.g., the increasing number of international students and scholars with greater mobility; interest in producing globally competent graduates; new quality assurance and accreditation regulations; increasing emphasis in cooperative networking among higher education institutions; global higher education ranking systems and increased privatization, and commercialization of higher education systems. Political and economic rationales for national policies on internationalization appear to be increasing at the cost of academic and cultural motivations, which could be detrimental to the process, Cf. the Refs. [21] and [22].

In spite of internationalization being debated around the world and being implemented in different ways, it is viewed as a positive response to globalization as international connections are enriching and offer a fresh cultural insights, Cf. the Ref. [13]. Cultural competence is central to internationalization in higher education since it is one of the desired outcomes.

4.2. Internationalization of the Curriculum (IoC)

A new focus has emerged within the broader institutional approach to internationalization, namely the internationalization of the curriculum (IoC) which emphasizes the implementation of internationalization for teaching and learning. Different approaches have been described to the IoC e.g. across-border education, internationalization at home, translational education, transnational education and people mobility. However, according to B. Leask, Cf. the Ref. [13], IoC is poorly understood and has been a low priority in many disciplines to date. IoC requires that academics think outside of these

traditional restrictive, boundaries and recognize that disciplinary knowledge is not culture-free, Cf. the Ref. [13]. IoC is based on an understanding of the cultural foundations of knowledge and practice within disciplines and related professions which frequently requires members to challenge commonly held beliefs. Encouragement of and support for students to engage productively with difference, including different ways of thinking, both within and beyond the classroom.

B. Leask, Cf. the Ref. [13] proposed a conceptual framework for IoC. It situates the disciplinary teams who construct the curriculum as the center of the process. The framework contains layers of context namely institutional, local, national, and global. The interaction of these layers determines how internationalization is conceptualized and enacted in the curriculum. The framework includes curriculum design. The key components of IoC can be summarized as engagement of students with internationally informed research, cultural and linguistic diversity and the purposeful development of students’ international and cross-cultural perspectives. The foundation of knowledge remains within the context of the discipline, but the complexity of the problems must be understood from a broader perspective that acknowledges cultural, social, and linguistic diversity, as well as an international viewpoint of the field of study, Cf. the Ref. [13].

Internationalization of curricula for health care professionals aims to facilitate the acquisition of broader international perspectives through an awareness of culture and intercultural communication skills. Topics such as equity, access to healthcare, public health and the burden of disease address a global perspective. Development of cultural competence, as mentioned earlier, is a key outcome, and together with professional skills, will allow graduates to be empowered to serve communities in the best way possible, Cf. the Ref. [18].

Two frameworks for internationalization were proposed by J. Knight, Cf. the Ref. [22], one for “Internationalization At Home” and one for “Cross-Border Education”. She identifies categories of each, provides descriptions of activities and stipulates forms or conditions of mobility for these frameworks. It is clear that cultural competence plays a central role within both of these frameworks. On a personal level, students would be required to evidence cultural competence to e.g. interact with international students, to participate in study abroad programs or international internships, collaborate on research projects and take on-line courses offered by institutions in other countries. Cultural competence could be facilitated by students participating in extracurricular activities e.g. social clubs, international days on campus and by liaising with local community based cultural and ethnic groups. Faculty would require cultural competence to e.g. authentically infuse existing curricula with international and cultural content, participate in teaching exchanges, conduct collaborative international research, spend a sabbatical in a different country, teaching distance education courses across borders and, participate in

international visits for quality control purposes as an external evaluator, Cf. the Ref. [22].

A. L. Williams, B. Louw, M. Keske-Soares, K. M. Bleile, I. Trindade, T. Kessler, L. Maximino, and A. P. Fukushima, Cf. the Ref. [24], approached IoC in a different manner. They adopted the concept of scientific multiculturalism as the core of their international curriculum. Scientific multiculturalism refers to the differences in research cultures across countries with regard to student training models, interactions between faculty and students, and interactions among students, Cf. the Ref. [25]. In addition to research cultures, research can be a mechanism for students to not only gain knowledge of the professions, but also to develop cross-cultural competence. As part of a multi-institutional collaboration jointly funded by the U. S. Department of Education Fund for Improvement of Postsecondary Education (FIPSE) and the Brazilian Ministry of Education (CAPES), a research-based global curriculum was developed with the dual goals to foster research and culturally competent practitioners, Cf. the Ref. [12].

Through a research-based study abroad program, the students learned social and cultural differences that exist in working with families from a bioecological model of child development; Cf. the Ref. [26], understand communication disorders from a holistic perspective (International Classification of Functioning, Disability and Health: Children and Youth Version (ICF-CY), Cf. the Refs. [12] and [24]; and assess the impact of communication disabilities within the unique socio-cultural contexts of families and communities that exist in different countries. This research-focused approach to study abroad showed students that science in their field is not the exclusive domain of researchers in the U. S. Research was the nexus between cross-cultural competence and professional knowledge of the field and provided a safe environment for active discovery of cultural differences and/ or similarities. It fosters change from an ethnocentric perspective on scientific discovery to a broader perspective, or cultural relativism. Exploring international literature expands students' world perspective and motivates them to become culturally aware, acquire cultural knowledge and skills, and foster a cultural desire, Cf. the Refs. [2] and [14].

4.3. Internationalization and Ethical Decision Making

Implementing internationalization in higher education poses ethical challenges to administration and educators alike. According to L. E. Rumbley, P. G. Altbach and L. Reisberg, Cf. the Ref. [21], although internationalization in higher education has the potential of enormous opportunities and benefits, the global playing field is inherently uneven. Institutions with more resources have the advantage with more opportunities to internationalize which leads to inequity in terms of the quality and quantity of internationalization activities. B. Leask, Cf. the Ref. [13] cautions against universities exacerbating the negative effects of internationalization such as inequities between collaborators. A call for ethical implementation of internationalization to be guided by core principles of ethical engagement is made, Cf.

the Ref. [21]. Internationalization requires a commitment to fundamental values such as transparency, quality of programs and support services, academic freedom, fair treatment of partners and stakeholders and respect for local cultures. They recommend that principles should exist to guide ethical decision making in internationalization with a long term perspective firmly rooted in ethics and quality, Cf. the Ref. [21]. J. D. Heyl and J. Tullbane, Cf. the Ref. [28], address the issue of ethics in international educational leadership. Educational leaders are faced with the complexity of interactions with global partners, different legal systems, and cultures when required to make critical decisions regarding internationalization. It is their responsibility to identify risks for new partnerships and endeavors and to make transparent, ethically based decisions in the best interest of all stakeholders.

Given the centrality of cultural competence in higher education, practical ethical decision making is challenging and wide ranging. It could involve issues such as e.g. policies and procedures on student admission criteria; the choice of pedagogical approaches to address cultural competence, e.g. selecting a transformative teaching model in which teaching and learning experiences are embedded throughout teaching within a dynamic and interactive approach as opposed to the traditional additive teaching model where global aspects are included, Cf. the Ref. [18]. Ethical sensitivity is just as appropriate in this context as in the clinical context. The ethical dilemma needs to be identified and choices made regarding the resolution of issue.

In conclusion, internationalization of higher education has become an attainable goal but remains complex and needs to be based on sound values of ethics and quality. Including cultural competence and ethical decision making as competencies in training programs in higher education, provide an essential foundation for clinical ethical decision making as these skills are considered to be central to providing appropriate care.

5. Cultural Competence and Ethical Decision Making in Research

Cross-cultural and international research have become a hallmark of the health care professions. This development can be attributed to a multitude of diverse factors such as e.g., the development of evidence based practice; treatment outcomes research, disparity in access to health care services, international networking, the WHO Report on Disability, Cf. the Ref. [29], and the International Classification of Functioning, Disability and Health, Cf. the Ref. [27]. In spite of the proliferation of multicultural research in the health care professions, gaps in knowledge remain within and across countries regarding issues ranging from incidence of disability to treatment outcomes. It is commonly accepted that there is an ethical imperative to ensure cultural sensitivity in cross-cultural and international research. Despite this need, there is a lack of practical guidance based

on empirical results to conduct culturally sensitive research, Cf. the Ref. [30].

Research ethics and cultural competence are separate concepts yet interrelated as illustrated in Figure 1. M. Paasche-Orlow, Cf. the ref. [7], points out that the literature on cultural competency seldom discusses the role of ethics. It is suggested that the general ethical research principles namely, autonomy, beneficence, and justice be mapped on to the essential principles of cultural competence. According to M. Paasche-Orlow Cf. the ref. [7], the essential principles of cultural competence are acknowledgement of culture in people's lives, respect for cultural differences, and minimization of any negative consequences of cultural differences. Linking research ethics and cultural competence has major implications for teaching curricula and research conduct.

Curricula within the health care professions include education in ethics for practice, research ethics, and cultural competence. However cultural competence in research ethics does not appear to be well integrated in training curricula. Although cross-cultural and cross-linguistic research abounds in the different health care professions, cultural sensitivity is usually not addressed in research methods courses to any significant degree. This results in many student researchers either exploring the field independently as guided by their research mentor, or the majority of students lacking culturally sensitive research skills. Clinical practice in health care professions around the globe calls for cultural competent care which should be based on research evidence. Therefore, including cultural competence in research courses will ensure that researchers of the future are better equipped to conduct cross-cultural and cross-linguistic research.

It is imperative that research courses in health sciences address cultural competency as a focal point in the curricula. This can be done in a myriad of ways. Cultural competence needs to be integrated in both research ethics and research methods, as they become inseparable in conducting research. Challenges of and suggestions for conducting culturally sensitive research can be included as a topic in research course syllabi. Research ethical principles can be linked to the ethics of cultural competence and examples can be provided for example finding information about a specific community, how to source appropriate literature, setting inclusion and exclusion criteria, gaining informed consent, establishing partnerships and gaining the trust of the participants, Cf. the Ref.[31].

Unless researchers dedicate time and effort in planning research projects to address cultural issues, the use of research methods and techniques developed in one culture, then applied to another, can threaten the validity and generalizability of research results. Research methods such as ethnography, survey research by interview, and focus groups are especially appropriate to use with culturally diverse clients and families to elicit perceptions on opinions on health related and treatment topics when conducting culturally sensitive research, Cf. the Refs. [31] and [32]. The relevance of cross-cultural research can be pointed out in the

classroom when presenting the different types of research methods. According to M. B. Huer and T. I. Saenz, Cf. the Ref. [31], conducting culturally sensitive research, irrespective of the method used, is unique in that modification of procedures and additional strategies that need to be included into any given design in order to collect relevant and usable data. The authors, Cf. the Ref. [31], offer guidelines for preparing clinical research instruments, methods for data collection, data analysis, and interpretation of results when conducting cultural sensitive research. A criticism that is levelled against research in the health care professions in the minority world is that sampling is often not representative of the general population and does not include sufficient diversity. Issues and challenges need to be identified and possible solutions sought to better prepare future professionals for their role in ethically sound cross-cultural research.

Another important issue that needs to be addressed in both training and conducting cross-cultural and cross linguistic research in an ethical manner, is working with interpreters and translators. These individuals play a crucial role for imparting verbal and cultural understanding to participants. According to Y. Shimpuku and K. F. Norr, Cf. the Ref. [33], the interpreters' and translators' role and their influences on the findings are not always adequately described by researchers, and therefore the credibility of qualitative research study is weakened. It is generally recommended that interpreters and translators selected for a research project are both bilingual and bicultural in order to perform their role as cultural brokers. Interpreters and translators are to be valued as cultural brokers, who work with the participants on the one side and the researcher on the other, to ensure that both sides understand the research process according to their view of the world. A key element in working with interpreters and translators during research is to introduce and explain the research ethical principles of autonomy, beneficence, and justice. Interpreters and translators can be encouraged to follow, "A National Code of Ethics for Interpreters in Healthcare", Cf. the Ref. [11]. This code includes nine principles and could be adapted to a code of ethics for interpreters in Health Care Research. It is essential to inform interpreters of the purpose and aims of the research project and researchers are required to train interpreters regarding their required roles in the project.

It is important to be flexible when working with interpreters and translators in conducting research. Researchers need to be able to adapt the usual processes of translation/back-translation when appropriate to the cultural context and the specific situations of the translators. Such practices may also apply to the clinical context when health care professionals work with bilingual and bicultural interpreters and translators e.g. when communicating with persons who have limited literacy in their first language, are hearing impaired or non-verbal.

C. E. Burnette, S. Sanders, H. K. Butcher, and J. T. Rand, Cf. the Ref. [30], conducted a two part qualitative research study on cultural sensitivity in research. In Part 1, they

identified strategies for cultural sensitivity in research in a descriptive qualitative study. They then applied the strategies to a rigorous critical ethnography with indigenous communities in Part 2 of their study. Based on their results, the authors, Cf. the Ref. [30], describe a toolkit for ethical and culturally sensitive research. The themes from part one of their study inform the toolkit, which includes the impact of history, relational research, incorporating cultural sensitivity and strengths, demonstrating patience, and negotiating multiple perspectives. This toolkit can be used when teaching and /or conducting research with different communities and cultures.

Ethical decision making in research is guided by ethical codes and rules, but students require training, experiences (real or simulated), and examples of culturally sensitive research to learn how to act and make decisions should an ethical dilemma arise in a multi-cultural context. Responsible Conduct of Research (RCR) is defined as encompassing overlapping concepts related to the discovery and dissemination of new knowledge, research, responsible science, scientific integrity, and responsible researchers, Cf. the Ref. [34]. Only by including cultural competence in research courses can future health care professionals truly become responsible researchers.

Cultural competence enhances the quality and usefulness of research, which is better able to address the pressing problems experienced by some communities, Cf. the Ref. [30]. Increasing the amount of culturally sensitive research has the consequence of enabling health care professions to better serve their consumers, Cf. the Refs. [30] and [35], and will lead to improved health care of individuals from all cultures.

6. Cultural Competence and Ethical Decision Making in the Clinical Context

According to figure 1, the third context in which cultural competence and ethical decision making for health care professionals are integrated is the context of clinical practice itself. Evidence Based Practice (EBP) requires that health care professionals have the necessary knowledge, skills and attitude to provide competent care to clients/patients for a range of diverse cultures, Cf. the Ref. [36]. More recent developments in approaches to multicultural care such as ethnography and narratives, may facilitate the development of cultural competency.

Practicing from a culturally sensitive ethical perspective in a multicultural context is essential for good practice. Health care professionals need to understand that strict adherence to professional ethical codes may result in ethical dilemmas when providing services to individuals from a variety of cultures. This may lead to less optimal care of clients/patients from different backgrounds. Health care professionals need to be equipped with skills to resolve such ethical dilemmas. First and foremost they need to be able to communicate

effectively and to understand each client's/patient's unique background and beliefs, and make decisions that will meet each client's/patient's needs in a thoughtful, sensitive and effective manner. As discussed earlier, a common ethical dilemma arises when respect for autonomy and cultural sensitivity collide. For instance when a spouse makes an intervention decision for a client/patient which the health care professional may interpret as a bad decision. Reconciling the sense that the client/patient had not freely exercised his/her autonomy with the desire to be culturally sensitive by respecting the value of community in a culture, Cf. the Ref. [3]. Health care professionals may use a number of resources to address ethical dilemmas in multicultural contexts, such as the frameworks for ethical decision making proposed by e.g. Cf. the Refs. [10] and [37]. Ethical decision making frameworks typically begin with developing ethical sensitivity, which is the ability to recognize that an ethical issue exists.

A. M. Naudé, Cf. the Ref. [9], describes the key characteristics of ethical sensitivity as moral perception (identify client and situational needs), affectivity (putting self in place of clients to identify and weigh comparable reactions) and dividing loyalties (awareness of moral and ethical principles, their significance in the context, stakeholders' needs and interests). These attributes enable health care professionals to recognize, understand and evaluate ethical elements in clinical practice. The more skilled a health care professional is in terms of ethical sensitivity, the easier it is to use a framework for ethical decision making, Cf. the Ref. [9].

Various authors identify cultural awareness as the first step in developing cultural competence, Cf. the Refs. [5], [14] and [15]. A crucial skill in developing ethical sensitivity is controlling social bias. This involves understanding, recognizing and opposing prejudice. Mastering these skills results in an appropriate response to diversity, Cf. the Ref. [9]. It is generally accepted the health care professionals should approach clinical situations with caution and a sense of cultural incompetence in order to actively be open to strive to address that feeling in the process of developing cultural competence. Understanding cultural differences and how those can lead to conflict and misinterpretation, will empower health care professionals and positively impact on their relationships with clients/patients. Cultural competence and ethical decision making are inseparable in clinical practice.

Another framework which health care professionals can apply to facilitate both culturally competent services and ethical decision making is the International Classification of Functioning, Disability and Health (ICF), Cf. the Refs. [9] and [27]. The ICF and ICF-CY, Cf. the Refs. [12] and [24], provide a framework for the holistic assessment and intervention of clients/patients. They are based on the biopsychosocial model and are divided into two parts, which encompass four components. Part 1 consists of Functioning and Disability, with the components Body Functions and Structures, and Activities and Participation. Part 2 consists of Contextual Factors, including the components Environmental

Factors and Personal Factors, Cf. the Ref. [27]. This framework respects client/patient autonomy and emphasises the importance of a health care professional's ability to recognize not only how physiological factors influence the client's/patient's perceptions, expectations and behavior, but also how psychological, social and environmental factors affect the manner in which a client/patient perceives his/her ability to function as a member of society. Using this framework health care professionals can adapt their assessments and interventions in accordance with the values and needs of clients/patients from various socioeconomic, ethnic, racial, religious backgrounds and a range of gender and sexual identities, Cf. the Ref.[9]. Positive cultural experiences increase confidence, engage interest and result in a desire to become culturally competent, thus enabling health care professionals to provide culturally responsive services across settings.

7. Conclusion

In conclusion cultural competence and ethical decision making are both based on respect for and understanding of the different values that clients/patients and health care professionals give to various moral domains. It is clear that ethical sensitivity, the crucial first step in making ethical decisions, is interwoven with cultural competence. This necessitates that health care professionals need to be trained in both cultural competence and ethical decision making in an integrated manner, both pre-professionally and during continuing education.

Educating future health care professionals has become a formidable task due to the expanding knowledge fields of the disciplines. Training programs need to ensure that the curriculum is balanced and that appropriate pedagogical training and clinical experiences in cultural competence and professional ethical issues are provided. Such training will empower health care professionals to consistently and effectively deal with ethical decision making which will present during their future professional careers. Cultural competence and ethical decision making need to be viewed as interrelated within the broader contexts of higher education and research to ensure that health care professionals are able to function efficiently in clinical practice in both situational and global contexts. Health care professionals need to balance their professional ethics with cultural competence to provide services that are responsive to the cultural and linguistic needs of individual clients/patients so as to ensure the best intervention outcomes.

References

- [1] American Speech-Language-Hearing Association, Scope of practice in speech-language pathology [Scope of practice]. www.asha.org/policy (2007).
- [2] P. R. Rose, "Cultural Competency for the Health Professional". Jones & Bartlett Publishers (2013).
- [3] H. Minkoff, "Teaching Ethics: When Respect for Autonomy and Cultural Sensitivity Collide". *American Journal of Obstetrics and Gynecology*, 210, vol. 4, 298-301 (2014).
- [4] D. E. Battle, "Communication Disorders in Multicultural and International Populations". 4th ed. Elsevier: St. Louis, Missouri, USA (2012).
- [5] E. W. Lynch, and M. J. Hanson, "Developing Cross-Cultural Competence a Guide for Working with Children and Their Families". 4th ed., Paul H. Brookes Pub, Baltimore, USA (2011).
- [6] E. Donate-Bartfield, and L. Lausten, "Why Practice Culturally Sensitive Care? Integrating Ethics and Behavioral Science". *Journal of Dental Education*, 66, 1006-1011 (2002).
- [7] M. Paasche-Orlow, "The Ethics of Cultural Competence." <http://gateway.tx.ovid.com/sp-3.17.0a/ovidweb.cgi> *Academic Medicine*, 79, vol. 4, 347-350 (2004).
- [8] A. M, Naudé, and J. Bornman, "A Systematic Review of Ethics Knowledge in Audiology." *American Journal of Audiology*, 23, vol. 2, 151-157 (2014).
- [9] A. M, Naudé, "Exploring ethical sensitivity in the SA context: developing and implementing a measure in the therapeutic sciences". Unpublished doctoral thesis, University of Pretoria, South Africa (2015).
- [10] D. Irwin, M. Panbacker, T. W. Powell and G. T. Vekovius, "Ethics for Speech-Language Pathologists and Audiologists. An Illustrated Casebook". Thomson Dellmar learning: Clifton Park, NY, USA (2007).
- [11] H. W. Langdon, T. I. Saenz, "Working with interpreters and translators: A guide for speech-language pathologists and audiologists". Plural Publishing, (2015).
- [12] A. L. Williams, B. Louw, N. J. Scherer, K. M. Bleile, M. Keske-Soares, and I. Trindade, "Academic and clinical preparation in speech-language pathology and audiology: A global training consortium for US-Brazil students". *Contemporary Issues in Communication Sciences and Disorders*, 40, pp. 40-49 (2013).
- [13] B. Leask, "Internationalizing the Curriculum". Routledge: New York, NY, USA. (2015)
- [14] J. Campinha-Bacote, "The process of cultural competence in the delivery model of healthcare services: A model of care". *Journal of Transcultural Nursing*, 13, 181-184 (2002).
- [15] J. Campinha-Bacote, "Coming to know cultural competence: an evolutionary process". *International Journal of Caring*, 15, 3, 42-48 (2011).
- [16] M. J. Bennett, "Becoming Interculturally Competent". In J. S. Wurzel (Ed). *Toward multiculturalism: A reader in multicultural education*. Intercultural Resource Cooperation: Newton, MA, USA (2004).
- [17] R. Lubinski and M. A. Matteliano, "A Guide to Cultural Competence in the Curriculum: Speech Language Pathology". Center for International Rehabilitation Research Information and Exchange, 1-68 (2008).
- [18] D. Murdoch-Eaton, A. Redmond, and N. Bax, "Training Healthcare Professionals for the Future: Internationalism and Effective Inclusion of Global Health Training". *Medical Teacher*, 33, 562-569 (2011).

- [19] P. S. Seibert, P. Stridh-Igo and C. G. Zimmerman, "A Checklist to Facilitate Cultural Awareness and Sensitivity". *Journal of Medical Ethics*, 28, 143-146 (2002).
- [20] M. R. Hammer, "The Intercultural Development Inventory Manual (v. 3)". IDI, LLC: Ocean Pines, MD, USA (2007).
- [21] L. E. Rumbley, P. G. Altbach and L. Reisberg, "Internationalization within the higher education context". in. D. K. Deardorff, H. De Wit, J. D. Heyl and T. Adams, *The SAGE Handbook of International Higher Education*. SAGE: Thousand Oaks CA, USA (2012).
- [22] J. Knight, "Concepts, rationales and interpretive framework in the internationalization of higher education". in. D. K. Deardorff, H. De Wit, J. D. Heyl and T. Adams, *The SAGE Handbook of International Higher Education*. SAGE: Thousand Oaks CA, USA (2012).
- [23] J. K. Hudzik, "Comprehensive Internationalization". *Institutional Pathways to Success*. Routledge: New York, NY, USA (2015).
- [24] A. L. Williams, B. Louw, M. Keske-Soares, K. Bleile, I. Trindade, T. Kessler, L. Maximino, and A. P. Fukushiro, "Nexus of Research-Cultural Competence: A Twist on Study Abroad". Poster presented to the American Speech-Language-Hearing Association Annual Convention, Orlando, USA, November 19-21 (2014).
- [25] E. Plante, "Establishing a lab environment for the responsible conduct of research: research, participants, scenarios and challenges in identifying vulnerabilities and creating a plan to mitigate risks". *CREd Library* 3.1 (2014).
- [26] U. Bronfenbrenner, S. J. Ceci, "Nature-nurture reconceptualized in developmental perspective: A bioecological model". *Psychological review* 101, 568 (1994).
- [27] World Health Organization "International Classification of Functioning, Disability and Health". World Health organization: Geneva, (2007).
- [28] J. D. Heyl and J. Tullbane, "Leadership in International Higher Education". *The SAGE Handbook of International Higher Education*, 113 (2012).
- [29] World Health Organization and the World Bank, "World Report on Disability". Geneva: World Health Organization, (2011).
- [30] C. E. Burnette, S. Sanders, H. K. Butcher, and J. T. Rand, "A toolkit for ethical and culturally sensitive research: An application with indigenous communities". *Ethics and Social Welfare*, 8, 364-382 (2014).
- [31] M. B. Huer and T. I. Saenz, "Challenges and strategies for conducting survey and focus group research with culturally diverse groups". *American Journal of Speech Language Pathology*, 12, 209-220 (2003).
- [32] G. M. A. Higginbottom and L. Serrant-Green, "Developing culturally sensitive skills in health and social care with a focus on conducting research with African Caribbean communities in England". *The Qualitative Report*, 10, 4, 662-686 (2005).
- [33] Y. Shimpuku, and K. F. Norr, "Working with Interpreters in Cross-Cultural Qualitative Research in the Context of a Developing Country: Systematic Literature Review". *Journal of advanced nursing*, 68, vol. 8, 1692-1706 (2012).
- [34] J. Horner and F. D. Minife, "Research Ethics I: responsible conduct of research (RCR)-historical and contemporary issues pertaining to human and animal experimentation". *Journal of Speech, Language and Hearing Research*, 54, S303-S329 (2011).
- [35] C. Qualls, "Multicultural and International Research on Communication Disorders: Past, Present, and Future". In D. Battle, *Communication Disorders in Multicultural and International Populations*. 4th ed. Elsevier, St. Louis, USA, (2012).
- [36] G. Roysircar, "Evidence-Based Practice and Its Implications for Culturally Sensitive Treatment". *Journal of Multicultural Counseling and Development*, 37, 66-82 (2009).
- [37] Z. Weber, "Working Towards Culturally Sensitive Ethical Practice in a Multicultural Society". *The Journal of Practice Teaching and Learning*, 40-54 (2003).