

# **Nursing Education and Practice: What Cultural Competency Can Teach Us**

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## **Abstract**

*This manuscript begins with an overview of terminology and assumptions underpinning culture and cultural competence. Cultural competence education is explored from the perspectives of the recent growth of teaching-learning tools and identification of curricula grounded in the language of culture and cultural competence. Stereotyping, prejudice and discrimination are identified as contrary to the values and behaviors of culturally competent care. The transcultural nursing theories of Campinha-Bacote, Leininger, and Purnell, are detailed in relationship to nursing assessment, interventions and outcomes. Research evidence on the outcomes of cultural competency is identified, as are next steps in the process of improving nursing competence, expanding our knowledge of patient and family outcomes, and ensuring sustainability of this important determinant of health.*

**Key words:** *competence; culture; ethnicity; transcultural nursing*

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## **1. Introduction**

Throughout human history, cultural differences have led to misunderstanding, lack of respect and conflicts between countries, communities and individuals. As communication, travel, and businesses rapidly expand worldwide, understanding culture and differences in life-experiences by different groups becomes more and more important. In healthcare, culture is widely considered to be an important but often overlooked determinant of health.

Culture has been defined in a number of ways. It is generally described as the learned and shared beliefs, values, and behaviors of a community of interacting human beings. While we

frequently think of culture as being synonymous with ethnicity, culture also applies to other human communities such individuals with chronic illness or disabilities, generational groups, gender orientation groups, and even gangs. Culture determines what people think causes health and illness, what healers are sought to prevent and treat disease, and what treatments are used. It also defines sick role behaviors, how long a person is sick, and when he or she has recovered.

This paper identifies fundamental assumptions about culture and addresses cultural competence from the perspectives of how it is learned and how it is practiced. Examples of culturally competent assessment and interventions across the lifespan are explored. Information grounded in transcultural nursing\* theory is applied to nursing practice. In conclusion, research evidence demonstrating the impact of cultural competence on health outcomes is identified.

## **2. The Environment of Cultural Competence**

### **2.1 *Assumptions of cultural competence***

An understanding of the assumptions underpinning culturally competent care creates a framework for teaching, learning, and practicing cultural competence. Learning to be culturally competent is an ongoing process that develops in a variety of ways, but primarily through cultural encounters. Cultural competence begins with self- and other awareness, an increased consciousness of the value of cultural diversity, and a willingness to learn about and provide culturally appropriate care.<sup>[4]</sup>

There are core similarities shared by all cultures as well as differences within, between, and among cultures. Cultural competence assumes one culture is not better than another. While there is more variability in culturally-based beliefs, values, and behaviors within ethnic groups than across ethnic groups, each individual has the right to be respected for his or her uniqueness and cultural heritage. Caregivers need both culturally general and culturally specific information in order to provide culturally competent care.

### **2.2 *Cultural Competence Education (CCE)***

Beach et al. authored a systematic literature review focusing on teaching cultural competence under the sponsorship of the Johns Hopkins Evidence-Based Practice Center and the Agency for Healthcare Research and Quality. Their review reported the following: (a) Programs and tools for CCE were appearing with increasing frequency in the literature; (b) CCE programs were gaining the attention of not only educators, but healthcare administrators as well;

\*Transcultural nursing is a substantive area of study and practice focused on comparative cultural care (caring) values, beliefs, and practices of individuals or groups of similar or different cultures with the goal of providing culture-specific and universal nursing care practices in promoting health or well-being or to help people to face unfavorable human conditions, illness, or death in culturally meaningful ways.<sup>[14] [16]</sup>

(c) many different curricular methods and content areas had been evaluated; and (d) there was good-to-excellent evidence that cultural competence training impacts intermediate outcomes such as the knowledge, attitudes, and skills of health professionals.<sup>[3]</sup> CCE programs and tools have continued to grow, populating scholarly literature and internet sites.

CCE program content ranges from anecdotes about international cultural immersion programs to rigorous Cochrane Collaboration reviews and updates.<sup>[5] [12] [20]</sup> Tools are available for specific healthcare populations,<sup>[2] [6]</sup> as well as for mid- and late-career health professionals.<sup>[9]</sup>

The American Association of Colleges of Nursing has identified culture competencies as a priority and developed CCE in the form of baccalaureate and graduate nursing tool kits for nurse educators to use.<sup>[1]</sup> The University of Washington (UW) School of Medicine developed a detailed CCE curriculum organized around four core competencies quite similar to those of Campinha-Bacote.<sup>[2] [4]</sup> *Cultural Competency – Awareness* is expressed as sensitivity to one's own cultural heritage and respect of differences; ability to reflect on how one's own values and biases affect others; and comfort with differences of race, gender, sexual orientation, ability, spirituality/religion, and other socio-demographic variables. *Cultural Competency – Knowledge* includes having specific knowledge and information about the particular identity groups one is currently working with, including knowing how to obtain evidence-based information and data regarding social and behavioral determinants facing patients; and understanding the impact these have on decision-making and delivery of care for individual patients and their families. *Cultural Competency – Skills* signify effective verbal and non-verbal communication skills, appropriate cross-cultural conflict resolution and negotiation skills, and skills to assess patient literacy level. *Cultural Competency – Advocacy* focuses on the students' capacity to advocate for their patients in decision-making and to function as change agents.

### **2.3 Stereotyping, Prejudice, and Discrimination**

A discussion about cultural competence would be incomplete without mentioning contradictory behaviors such as stereotyping, prejudice, and discrimination. Biases come in many forms, including race, age, gender, and ethnicity and can be universal or location specific. While stereotyping, prejudice, and discrimination are somewhat similar, they are also quite different. Each form of bias is carried out by one individual or group judging another, prior to obtaining factual knowledge of the individual or group. A stereotype is a widely held, oversimplified idea of a particular individual or group based on experience or hearsay. Stereotypes emerge from collective and/or individual experiences with different groups. Individuals behave in a prejudicial manner when they have an emotional reaction to another individual or group based on preconceived ideas about the individual or group. Discrimination is

the denial of equal rights based on prejudices and stereotypes.<sup>[7]</sup> Prejudice and discrimination, whether manifested as racism, genderism or ageism, run counter to cultural competence.

### **3. Transcultural Nursing Theories: Applications in Practice**

#### **3.1 *Campinha-Bacote's Model of Cultural Competence***

The language of cultural competence is filled with a number of terms, which different authors and providers use differently. Campinha-Bacote identified a set of inter-related terms that incorporate cultural competence into assessment of patients' condition and needs.<sup>[4]</sup> *Cultural awareness* is the self-examination and in-depth exploration of one's own cultural and professional background. Without awareness of one's own beliefs, sensations, thoughts, and environment, the nurse risks *cultural imposition*, a term that describes the tendency of individuals to impose their own beliefs, values and patterns of behavior on another culture.<sup>[13]</sup> *Cultural knowledge* is the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups. *Cultural skill* is the ability to collect relevant cultural data regarding the patient's presenting problem as well as accurately performing a culturally-based health assessment. *Cultural encounter* is the process that motivates healthcare providers to engage in cross-cultural interactions directly with clients\*\* from culturally diverse backgrounds. This theory largely framed the UW curriculum described above.

#### **3.2 *Purnell's Model of Cultural Competence***

Purnell's Model of Cultural Competence provides twelve overlapping cultural domains that guide nursing assessment of relevant cultural data.<sup>[17]</sup> These domains begin with *Overview/Heritage*, which includes concepts related to country of origin, current residence, the effects of the topography of the country of origin and current residence, educational status and occupation, as well as economics, politics, and reasons for emigration. This concept also includes an understanding of the degree to which the patient and family adhere to a given cultural community's beliefs, values and practices about health and illness that are consistent with the values and behaviors of the dominant culture.

*Communication* plays an important role in culturally competent care. Key concepts include those related to the dominant language and dialects; contextual use of language such as use of names, voice volume, tone, and intonation; and willingness to share thoughts and feelings. Language differences, whether culturally specific or related to the language of medicine, require

\*\* Patients and their families need culturally competent nursing care. Therefore, the term *client(s)* is used to include both patient and family.

the attention of the nurse. Medical terms and “lingo” often need to be explained by carefully selecting words and experiences that are familiar to the client. When the patient and family speak a language that is not known to the nurse, use of a trained interpreter is the preferred approach. This is not always possible and using nonverbal ways of communicating is of great value.

Nonverbal communication includes eye contact, facial expression, body language, special distancing practices, and acceptable greetings. Two important nonverbal means of communicating for nurses include temporality and touch. Temporality refers to the notion of “clock time” versus “social time” as well as whether the group has a past, present, or future worldview orientation. Touch can enhance both information exchange and comfort care. Holding a hand or gently squeezing or patting it can communicate comfort. Hands can say “stop” or they can ask, “may I go ahead with what I am doing for you?” Some cultures have norms about touch. Generally these are gender related (women may touch women and men may touch men), but can also relate to social status. Asking permission to touch is an especially important culturally competent behavior.

*Family roles and organization* include beliefs, values and behaviors related to family roles. Such roles include the head of household and who makes family decisions, gender roles, roles of aged family members and those of extended family members. Also included are matters of family and community relations, developmental tasks of children and adolescents, and child-rearing practices. Social status and views toward alternative lifestyles such as single parenting, sexual orientation, child-less marriages, and divorce are also included.

*Workforce issues* relate to autonomy, gender roles, ethnic communication styles, individualism, and health care practices of the country of origin. Workforce issues also include education, literacy, how knowledge is valued, and how information is accessed and by whom. The concepts of acculturation and assimilation are often linked to workforce issues.\*\*\*

*Bio-cultural ecology* includes variation in ethnic and racial origins such as skin coloration and physical differences in body stature, genetics, and heredity, and endemic and topographical diseases. Bio-cultural ecology also includes how the body metabolizes drugs. It includes access to technologies ranging from high-level diagnostic equipment to roads, cars, and airplanes, as well as books, cell phones, television, clean water and the internet. Bio-cultural ecology also includes the many diseases that pose different risks to different ethnic groups. For example,

\*\*\*The term *assimilation* describes the process by which immigrants give up their culture of origin for the sake of adopting the mainstream language and culture of their adopted country. The term *acculturation* describes the process of bi-directional change that occurs when two ethno-cultural groups come into sustained contact with each other.<sup>[18]</sup>

Sickle cell disease is most common among people whose ancestors come from Africa, Mediterranean countries, the Arabian Peninsula, India, and Spanish-speaking regions in Central and South America. Beta thalassemia occurs most frequently in people from Mediterranean countries, North Africa, the Middle East, India, Central Asia, and Southeast Asia. Multiple sclerosis is more common in regions that are farther away from the equator, and lactose intolerance in adulthood is most prevalent in people of East Asian descent.<sup>[8]</sup>

*High-risk behaviors* manifest themselves in both active and passive behaviors. The use of tobacco, alcohol, recreational drugs, and high-risk sexual practices are examples of active high-risk behaviors. Lack of physical activity and non-use of road safety measure such as seatbelts and helmets are considered to be passive high-risk behaviors.

*Nutrition* includes having adequate food, the meaning of food, and food choices. Nutrition also includes food related rituals and taboos, and how food and food substances are used during illness, pregnancy, and for health promotion.

*Pregnancy and childbearing* includes fertility practices, methods of birth control, and views towards pregnancy. Prescriptive, restrictive, and taboo practices related to pregnancy, birthing, and postpartum treatment are also included.

*Death rituals* refer to how the individual and the culture view death, rituals and behaviors to prepare for death, care of the body, and burial practices. There may be bathing rituals, taboos against touch, or expectations about the opening or closing of windows. Bereavement behaviors are also included in this domain.

*Spirituality* includes religious beliefs and practices including belief in witchcraft, belief in a God who heals, or belief in a God who punishes. This domain also includes worship practices, rituals and holy items, holy days, religious activities, food restrictions, fasting, and care provided by a religious community. The use of prayer, behaviors that give meaning to life, and individual sources of strength are also included.

*Health care practices* include the focus of health care such as acute or preventive; traditional, magico-religious, and biomedical beliefs; individual responsibility for health; self-medication practices; and views towards mental illness, chronicity, and organ donation and transplantation. Barriers to health care and one's response to pain, and the sick role, are included in this domain.

*Health care practitioner* concepts include the status, use, and perceptions of traditional, magico-religious, and allopathic biomedical health care providers. In addition, the gender of the health care provider may have significance.

### 3.3 *Leininger's Culture Care Diversity and Universality Theory*

Madeleine Leininger is considered to be the “mother” of transcultural nursing. Her work as an anthropologist in the 1950s led the way to our understanding of the relationship between culture and health.<sup>[14]</sup> Leininger's *Culture Care Diversity and Universality Theory* identifies a set of factors designed to help members of the healthcare team assess the relevant cultural and social structures that support culturally congruent healthcare in a given situation. Leininger's seven factors include technological factors, religious and philosophical factors, kinship and social factors, cultural values and lifeways, political and legal factors, economic factors, and educational factors.

Leininger's theory goes beyond assessment, to problem identification and intervention. Leininger places the nurse in a very central role in which she or he ensures that traditional (folk health) systems and professional (biomedical) systems are communicating with each other.<sup>[14]</sup> To this end, Leininger identifies three categories of nursing interventions:

*Preservation and/or maintenance* refer to those decisions that maintain, protect and save desirable and helpful values and beliefs. Examples include (a) encouraging direct care such as bathing, feeding, and other activities of daily living be performed by family members who wish to directly participate in the patient's care, and (b) encouraging the family to bring in foods they believe have healing properties that also fit with the patient's dietary restrictions related to medical diagnoses such as congestive heart failure or renal failure.

*Accommodation and/or negotiation* include helpful strategies when providing care that fit with the culture of the individual, family, or group. An example might be allowing clients to engage in religious practices while ensuring that the behaviors do not interfere with other patients' comfort or safety.

*Repatterning and/or restructuring* involve strategies the nurse employs through mutual decision-making with the patient to change or modify the plan of care in order to achieve better health outcomes. Examples include (a) the importance of avoiding homeopathic remedies known to be associated with harmful outcomes for vulnerable populations such as rubbing petrol or kerosene on children's scalps for the treatment of head lice or (b) putting butter or oil on a burn.

## 4. **Research Evidence on Outcomes of Cultural Competency**

Since the review by Beach et al., a collection of valid measures for examining the quality of research studies has emerged.<sup>[3]</sup> Horvat et al. published a Cochrane review on cultural competence education (CCE) for health professionals.<sup>[12]</sup> Healthcare providers demonstrated an increase in knowledge about culture, and client perceptions of health professional were

significantly higher in the intervention groups. To assess effectiveness and consistency of educational programs, the team developed a conceptual framework for describing interventions. The framework was comprised of (a) educational content, (b) pedagogical approach, (c) structure of the intervention, and (d) participant characteristics.

The review included 337 healthcare professionals and 8400 patients, of which 41% were from culturally and linguistically diverse (CALD) backgrounds. Evaluation of patient-related outcomes following CCE for health professionals revealed low-quality evidence of improvements in the involvement of CALD patients. Conclusions focusing on future research asserted that measures of patient outcomes including treatment outcomes, health behaviors, involvement in care and evaluation of care were needed targets for future research. They also highlighted the role of cultural competence in addressing health inequities.<sup>[12]</sup>

Truong et al. also published a systematic review examining interventions to improve cultural competency in health care, supported by the Australian National Health and Medical Research Council.<sup>[20]</sup> Inclusion criteria for the review required the participation of healthcare providers, health administrators, support staff and health service users (clients); and evaluation of CCE interventions and outcome measures at the individual level (surveys), organizational level (programs), and/or systems level (policy).

The search yielded 6,830 titles, of which 19 met overall inclusion criteria. Some studies examined outcomes of CCE for health providers and found some evidence of improvement in provider knowledge, skills and attitudes. Others looked at specific clients populations. Hawthorne et al., Sumlin and Garcia, and Whittemore developed culturally appropriate diabetes health education programs and found short-term effects (up to one year) for glycemic control and knowledge of diabetes and healthy lifestyles.<sup>[11] [19] [20]</sup> Whittemore studied only Hispanic populations; findings included significant improvements of selected clinical and behavioral outcomes and diabetes-related knowledge in the majority of studies.<sup>[21]</sup> Lu et al. and Harun et al. found mixed results in their reviews measuring patient/client satisfaction and hence were unable to generalize conclusions for patient participation in cancer screening.<sup>[15] [10]</sup>

Three aggregate reviews studied cost-effectiveness of interventions. It was noted in one review that fewer than 10% of the studies examined included costs of cultural competence, and in another that only rough estimates of costs were identified.<sup>[3] [11] [20]</sup> The conclusion by Truong et al. stated the majority of reviews found moderate evidence of improvement in provider outcomes and health care access and utilization outcomes, but weaker evidence for improvements in patient/client outcomes.<sup>[20]</sup>



This paper identified ways nursing can improve patient outcomes related to culture and culture care. Nurse educators, practitioners, and administrators are challenged to promote cultural competence through teaching, research, and practice.

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