

CHAPTER 5

Cultural Sensitivity and Global Health

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► Introduction

One of the most noted fundamental teachings in many of the world's religions is commonly referred to as the Golden Rule. The Golden Rule, "Do unto others as you would have them do unto you," is likely the most familiar moral value in Western culture (Stanglin, 2005). The rule has a strong connection to many religions including Christianity, Buddhism, Judaism, and Islam. Despite the origin, the tenet of the Golden Rule guides us to treat others as we would like to be treated. Its foundation is the reciprocity of kindness and human giving. The Golden Rule must be used with caution; it is when our best intentions to treat others with the compassion, respect, and care while following the fundamental underpinnings of the Golden Rule that we may have unintended outcomes (Corazzini et al., 2006). The general principles that often drive the day-to-day decisions and actions of nurse practitioners (NPs) need reconsideration for the diverse and unique populations in their care.

There is an assumption that people who resemble us or speak our language are the same and should be treated as we would like to be treated. As the providers of direct care to individuals and populations, NPs must consider how those they provide care for want to be treated. This consideration differs from the Golden Rule, in which we treat others in a manner that is acceptable to our standards and beliefs without consideration of the individual's preferences. Stepping away from viewing circumstances from our own perspective to the patient's perspective is a critical step in the care of others in a diverse world. Putting aside an imperialistic attitude of thinking one knows what is best for others, and taking the time to know what is significant to individuals and communities, is an important step in developing a successful patient–NP relationship (Ott & Olson, 2011).

As the United States is becoming more diverse, healthcare providers are caring for individuals and groups who have varied perspectives; many are distinct from the mainstream healthcare system. Many healthcare providers, including NPs, do not identify themselves with any one particular culture; however, they often do view their patients and families to have cultural traits (Matteliano & Street, 2012). The notion that our own cultural and societal norms can be applied to the general population can create obstacles and barriers in caring for patients. These beliefs are a result of personal, professional, and educational socialization. Ethnocentrism impedes the delivery of culturally competent nursing care (Dayer-Berenson, 2014). Not understanding others, or having limited information about another group, can lead primary care providers to make false assumptions that could potentially be harmful, hurtful, and destructive. Believing that the culture one is most familiar with is the cultural standard does not afford providers the opportunity to comprehend and appreciate the needs of others. Critical to understanding the perspective of others is the willingness of NPs to acknowledge their own beliefs and recognize that other individuals' values are cogent despite being different from their own (Dayer-Berenson, 2014). Considering the viewpoint of others is the first step to comprehending the ideals from the eyes of others and the avoidance of unfounded assumptions and biases.

► Global Diversity

The world is becoming increasingly more diverse. Globalization brings diversity and affects societies as cultures, values, and traditions transcend into new territory. The U.S. population is becoming increasingly more ethnically and socioculturally varied. In the United States between 2000 and 2010, a large increase in the Hispanic population accounted for more than half of the growth in the total U.S. population, while growth of the Asian population grew more rapidly than any other main race group (Census Bureau, 2011). The data highlight the changes in population and increasing diversity of the United States. Considering the United States as a “melting pot” or the blending together of various cultures to form one, is not considering the unique qualities of the various cultures of the population. Instead, looking at the U.S. society as a “tossed salad,” where the diversity of the culture is valued for what it contributes to the whole, embraces a more culturally aware viewpoint. As advanced practice nurses, NPs are challenged to respond to this “tossed salad” culture by providing care for the health and wellness needs of the population. In 2009, a study commissioned by the Joint Center for Political and Economic Studies indicated the estimated combined cost of health disparities and subsequent deaths due to inadequate and/or inequitable care at \$1.24 trillion (LaVeist, Gaskin, & Richard, 2009). Clearly, this is unacceptable, and healthcare providers and organizations need to work on reducing health disparities.

Leininger's theory on diversity and universality implies that for a caregiver's work to be meaningful and relevant, transcultural knowledge and competencies are imperative to guiding decisions and actions for effective and successful outcomes (Tomey & Alligood, 2002). Leininger's theory is suitable for application to the care of diverse populations. Her theory states that the provision of care needs to be harmonious with an individual's or group's cultural beliefs, practices, and ideals (Sitzman & Eichelberger, 2004). With the impact of globalization, primary care providers must possess sensitivity, compassion, and competence to care for individuals and communities from diverse cultural backgrounds. To effect positive health promotion activities and influence positive healthcare outcomes of individuals and communities, healthcare

providers must understand and appreciate the importance of culturally competent care (Sitzman & Eichelberger, 2004). NPs are charged with integrating cultural care into practice through a comprehensive clinical approach, role modeling, policy development, performance, evaluation, and use of the advanced nursing process (McFarlane & Eipperle, 2008). The advanced practice NP has an obligation to develop the skills necessary to be a culturally competent practitioner.

► Cultural Competency and Clinical Education

Cultural competency is an essential component to be infused into professional practice. Professional nursing organizations recognize the need for nurses, at all levels, to respond to the diversity in the population. The American Association of Colleges of Nursing (AACN), in the *Essentials of Baccalaureate Education for Professional Nursing Practice*, states, “The professional nurse practices in a multicultural environment and must possess the skills to provide culturally appropriate care” (2008, p. 6). The *Essentials of Master’s Education of Advanced Practice Nurses* includes cultural competence as an essential component of the advanced practice nurse’s educational preparedness (AACN, 1994). Cultural sensitivity and awareness are concepts guiding the practice of the Doctorate of Nursing Practice prepared nurse (AACN, 2006). Cultural competency is an essential component of the educational preparedness of nurses; and the inclusion of cultural sensitivity and awareness into the curriculum will promote cultural competency within the profession of nursing.

Medical and nursing academics are infusing cultural competence preparation into their educational curricula. Over 90% of medical schools’ curricula in the United States include cultural competence training (Boutin-Foster, Foster, & Konopasek, 2008). The AACN essentials outline the required curriculum requirements and student learning outcomes, which include cultural competency. Nursing and medical faculty are charged to develop teaching strategies to achieve the set standards over the curriculum recognizing that cultural competence is a developmental process. In an effort to design the graduate nursing curriculum to meet these expectations, faculty have collaborated with community leaders to develop recommendations for the development of competencies for graduate nursing curricula (Axtell, Avery, & Westra, 2010). Five student themes emerged: (1) self-awareness, (2) basic knowledge of culture and identity, (3) attitudes that promote intercultural communication, (4) cross-cultural clinical skills, and (5) advocacy skills. The inclusion of the community to assist in the development of the graduate nurse was viewed as a positive strategy in the development and projected outcomes of the identified objectives (Axtell et al., 2010). Caring for individuals necessitates understanding the influence of culture on their healthcare situation. Approach the individual without preconceived assumptions to avoid treating persons with common backgrounds the same. Each individual should have input into their healthcare choices, incorporating their cultural preferences.

“Assume every encounter is a cross-cultural encounter. This refers to the fact that even when a care provider and care recipient may appear to have a common background, they most likely do not view health care situations in the same way, so it is important to ask questions, discuss relevant issues, and avoid making assumptions in all clinical encounters.” (Axtell, S., Avery, M., & Westra, B., *Journal of Transcultural Nursing* 21(2), p. 187, copyright © 2010 by SAGE Publications. Reprinted by Permission of SAGE Publications.)
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The NP must be aware of the secondary elements of diversity in these situations that are not typically considered to be a cultural encounter. Loden and Rosener (1991) first developed the “dimensions of diversity” model to incorporate elements of diversity such as religion, sexual orientation, education, gender, age, and socioeconomic class, among others. Asking questions that incorporate the broader elements of diversity will make the patient encounter and healthcare outcomes more successful.

► Cultural Awareness

“We don’t see the world the way it is. We see the world the way we are.”

—Anais Nin

Cultural awareness is being knowledgeable about one’s own thoughts, feelings, and sensations, as well as the ability to reflect on how these can affect one’s interactions with others (Giger et al., 2007). One’s perceptions of “what is” are connected to our interpretation of the world, our experiences, values, and beliefs. To deliver care that is culturally sensitive the NP needs to have an appreciation of the culturally relevant facts about a client and the provision of care. Giger and Davidhizar’s “transcultural assessment model” includes six cultural phenomena that influence healthcare delivery (Giger, 2017).

Communication

Language or communication patterns are a significant part of how information is transferred in the healthcare setting. Communication, however, extends beyond linguistics and includes the process of communication. “Nurses need to have not only a working knowledge of communication with clients of the same culture, but also a thorough awareness of racial, cultural, and social factors that may affect communication with persons from other cultures” (Giger, 2017, p. 20).

Space

Personal space is the area that surrounds an individual and his or her level of comfort, which may vary from one individual to another. Space should consider sensory aspects including olfactory, sensory, auditory and visual, all of which can have cultural implications.

After discussing the pathology report, the NP reached out and embraced the young female patient. The NP, feeling her embrace was not welcomed, later reflected on the gesture. The gesture, intended to be a measure of comfort, was not positively received by the client. The client, from a culture where touch is limited, felt that the NP was intrusive, especially when distressing news was recently discussed.

Social Organization

Social organizations are structured groups that have a pattern of behaviors and set norms, beliefs, and values that influence the persons within the group. Examples

include family, religious groups, communities, and organizations. Race and ethnicity may also be considered a social organization.

Time

The concept of time can have different implications based on a person's cultural view. Culture can impact one's relationship to time—past, future, or present orientation. Future orientation considers the future in present-day terms, past orientation has a connection to the past. New changes are based on what was considered in the past. Present orientation is focused on the current time. Understanding a client's orientation to time can be helpful in determining possible reasons for motivation, compliance, and participation.

The toddler came into the office with several layers of clothing. The day was warm and comfortable. The mother stated, "My baby has a cold." Believing that the source of the cold was from the cool evening air that the infant was exposed to was a literal belief that the mother held from her past; the "chill was caught."

Environmental Control

The relationship between a person, the environment, and health and wellness determines the person's environmental control. Considerations of environmental control include the locus of control. *The client verbalized that the illness was in God's hands and they did not have any control.* Alternative therapies are more frequently considered in Western medicine. In 2007, approximately 38% of adults and approximately 12% of children were using some form of complementary and alternative medicine (CAM) (National Center for Complementary and Integrative Health [NCCIH] and the National Center for Health Statistics, 2008).

The scent of lavender was present in the hospital room. The patient applied the essential oil to her temples to relieve the tension headache she was experiencing.

Biological Variations

Biological variations exist among different racial groups and should be considered when caring for individuals and groups. A person's shape, size, and skin color are variable and have genetic and ethnic connections. Genetics (the study of heredity) and genomics (the study of genes and their functions) are part of the NP's practice. Some genetic conditions are more likely to occur in a particular group; however, one cannot assume that a biological variation exists based on an individual's culture or ethnicity. For example, in the United States, sickle cell anemia is most prevalent in the African-American population.

A young African-American mother brought her toddler in for a physical exam. She reported her daughter was pale and she expressed concern that her daughter might have sickle cell disease, like her brother. She was told as a young child their family had "bad cells" and her fear of her daughter

having the disease was frightening. Upon further examination of the child, it was determined she had iron deficiency anemia, a condition common in toddlers who consume excessive amounts of cow's milk, and not sickle cell disease caused by a genetic mutation.

Hofstede's Cultural Dimensions Theory

Geert Hofstede developed a framework for cross-cultural communication that describes the effects of a society's culture on the values of its members. Understanding the culture's values can provide a clearer understanding of how to relate to the culture. Although Hofstede's work focused on the influence of culture on the values in the workplace, the information obtained can be applied to other settings. Applying Hofstede's model on national culture to the healthcare industry equips the provider with insight about culture and fosters opportunities to recognize the uniqueness of another culture through a comparison perspective. (Hofstede's model on national culture can be found at <https://geert-hofstede.com/national-culture.html>.)

► Cultural Humility

Culture has many different components that shape who we are and how we interact with the world. It is dynamic and multifaceted. Each of us has our own personal culture evolving from not only our own ethnic background but also our gender, age, socioeconomic status, life experiences, and so on (California Health Advocates, 2007; Office of Minority Health [OMH], 2011b; Tervalon & Murray-Garcia, 1998). Reading and learning about other cultures is a worthwhile endeavor; however, it is unlikely that one can become competent in every culture. Being aware of this limitation, the concept of “cultural humility” is perhaps a better term to assist the NP in improving meaningful relationships with patients, coworkers, and others.

In the *Handbook of Humility: Theory, Research, and Applications* (2016), Mosher and colleagues describe cultural humility as placing a priority on “developing mutual respect and partnership with others” (p. 91). This requires self-awareness and reflection as a lifelong process to develop a respectful relationship with patients. It also requires the provider to be flexible and humble in order to be open to the cultural dimensions of each patient encounter. Values associated with cultural humility include openness, appreciation, and acceptance, in addition to flexibility (Luluquisen, Schaff, & Galvez, n.d.).

Further, it is important for the NP to focus on both interpersonal and intrapersonal components of cultural humility—realizing one's own limitations in understanding cultural backgrounds and being open to the “other” (Mosher et al., 2016). One needs to be acutely aware of the potential power imbalances that can occur in the healthcare expert–patient interaction. By continually working to be open, flexible, appreciative, and accepting of their patients, in addition to striving to avoid any imbalance of power, NPs can create meaningful partnerships with patients and communities to develop treatment plans, and individual and community goals to improve health. Practicing lifelong self-awareness and reflection will assist the NP to be a culturally sensitive healthcare provider.

In an effort to educate healthcare providers (NPs, physicians, PAs) about delivering culturally sensitive care, *A Physician's Guide to Culturally Competent Care*

was developed by the U.S. Department of Health and Human Services, Office of Minority Health (OMH, n.d.b). It contains nine Cultural Competency Curriculum Modules (CCCMs), including Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS standards), which are available for free at <https://cccm.thinkculturalhealth.hhs.gov/>. CME credits can be earned.

The objectives for this educational program are for NPs, PAs, and physicians to:

- Define issues related to cultural competency in medical practice.
- Identify strategies to promote self-awareness about attitudes, beliefs, biases, and behaviors that may influence the clinical care.
- Devise strategies to enhance skills toward the provision of care in a culturally competent clinical practice.
- Demonstrate the advantages of the adoption of the CLAS standards in clinical practice.

In many of the modules are patient cases and scenarios that require the health-care provider to reflect upon what is being presented by the case, as well as how the reader feels about the situation. The fictional practice setting includes a profile of the community and the patients that are seen at the setting. The vast majority of the populations are white, non-Hispanic, who have at least a high school education; however, there are many migrant farm workers who use the practice, as well as Native Americans. The providers and support staff come from a variety of ethnic backgrounds and take different approaches to their practice. The practice setting is in need of much improvement, to work more efficiently and to provide culturally competent care to their patients. Through the learning modules, the healthcare provider is encouraged to consider what the patient's perspective is, to be more sensitive to one's own attitudes, including biases and the behaviors they may have displayed that affect patient care. **BOX 5-1** represents eight essential elements to consider in developing a culturally competent healthcare provider.

BOX 5-1 Eight Elements of Cultural Competence for Primary Healthcare Providers

1. Examine your values, behaviors, beliefs, and assumptions.
2. Recognize racism and the institutions or behaviors that breed racism.
3. Engage in activities that help you to reframe your thinking, allowing you to hear and understand other worldviews and perspectives.
4. Familiarize yourself with core cultural elements of the communities you serve.
5. Engage clients and patients to share how their reality is similar to, or different from, what you have learned about their core cultural elements.
6. Learn, and engage your clients to share, how they define, name, and understand disease and treatment.
7. Develop a relationship of trust with clients and co-workers by interacting with openness, understanding, and a willingness to hear different perceptions.
8. Create a welcoming environment that reflects the diverse communities you serve.

► Cultural Competence and the Clinician

Nurse practitioners are poised to lead initiatives to implement the strategies to meet the challenge of fulfilling national standards of cultural competence in health care. Since there are hundreds of ethnic groups in our society with diverse needs, there is no one specific intervention for each health issue. To improve the health and well-being of individuals and communities, there are some general principles that can be practiced when delivering care to clients with a different culture than our own (Bomar, 2004). Reflecting on one's own culture, seeking knowledge about local cultures, understanding political issues of culturally diverse groups, and using culturally sensitive and linguistically appropriate resources are among the few (Bomar, 2004). Schools of nursing and organizations recognize the need to promote cultural awareness and sensitivity and provide opportunities for enhancing the practice of nursing (AACN, 2009). The American Association of Colleges of Nursing (2009) calls for the need for cultural competence education in graduate nursing to address the diverse needs of patients and minimize disparities in health. Once healthcare providers identify their own need for cultural growth, they can engage themselves in a variety of actions to increase their cultural competence on an individual level. This engagement calls for self-reflection and acknowledgement that their own beliefs, values, and attitudes may affect the care they provide to others. The NP can take a "cultural approach," being cognizant of "cultural variations" that will be advantageous to the patient as a management plan is developed for the individual. Each encounter should be approached as unique. Clustering values, beliefs, and behaviors from a cultural group and applying them to all persons of that culture does not consider the multiple variables that may influence an individual's cultural uniqueness. The following example demonstrates misinterpretation of communication style.

Elsu, a 76-year-old Native American male, arrived to the clinic for reevaluation of hypertension. The nurse assessing the patient felt that Elsu was "not truthful." The nurse expressed the concerns to the practitioner in charge of his care. Upon entering the room, the practitioner noticed that Elsu avoided eye contact and participated minimally in conversation. The nurse who initially encountered the patient viewed his behaviors as untrusting. Elsu, being a Native American, is quiet and reserved when meeting new people. Eye contact, for the Native American, is considered a sign of disrespect and hence is avoided. The nurse assumed that Elsu's communication style had a different and undesirable meaning.

Patterns of culturally incompetent care from providers affects patient care outcomes and may widen the healthcare disparities gap (Doorenbos, Schim, Benkert, & Borse, 2005). Health disparities are linked to social, economic, and environmental disadvantages causing a difference in one's well-being (Office of Disease Prevention and Health Promotion, 2010). *Healthy People 2020* identifies populations who experience barriers to health care at higher rates than the general population; these groups include Hispanics, African-Americans, those with low levels of education, and the poor. The American College of Physicians (2010) in a position paper, *Racial and Ethnic Disparities in Health Care*, discuss the disparities and poor health care that exist among racial and ethnic groups. The American College of Physicians

(2010) makes several recommendations to reduce the disparities that affect health and wellness. Culturally competent care providers can influence the health of the population by reducing the barriers that negatively impact health. Cultural sensitivity and awareness are important steps to understanding the complex issue of racial and ethnic health disparities.

Culture Awareness and Cultural Sensitivity

According to the American Nurses Association (ANA, 2012), “diversity awareness” can be defined as the acknowledgement and appreciation of the existence of differences in attitudes, beliefs, thoughts, and priorities in the health-seeking behaviors of different patient populations. Cultural awareness is having the knowledge or information about what is unique or the same among various cultures. In contrast, cultural sensitivity is the individual’s attitude about themselves or others and their desire to learn about the cultural aspects of others (Schim, Doorenbos, Benkert, & Miller, 2007). In an effort to meet the needs of communities and populations, we need to be open to learning about the unique characteristics they possess. Being aware and sensitive will allow us the ability to see beyond what is the accepted norm within our society. Cultural sensitivity is when we are able to appreciate the situation from another’s perspective and value the viewpoint of others, despite it being different from our own.

What Determines Cultural Competence?

Many theoretical and methodological models exist that attempt to determine cultural competence. Schim, Doorenbos, Miller, and Benkert (2003) describe a theoretical model of cultural competence with three components: the circumstance in which the clinician incorporates the cultural diversity experience; the clinician’s awareness of his or her reactions to people who are different; and lastly, examining attitudes and cultural bias toward other sociocultural groups. Based on this description and the cultural competence model developed by Schim and Miller (as cited in Schim et al., 2003), the Cultural Competence Assessment (CCA) was developed. The CCA tool is a method of measuring cultural competence behaviors (CCB) and cultural awareness and sensitivity (CAS).

In contrast, the *Purnell Model for Cultural Competence* (Purnell, 2002) uses a methodological approach to determine cultural competence. The basic assumptions of the model derive from multidisciplinary theories including organizational, administrative, communication, and family development as well as anthropology, sociology, psychology, and several others. The model has evolved to include 12 domains in a framework that assist the NP in developing cultural competence abilities.

TABLES 5-1 and **5-2** feature other theoretical and methodological models. None of the models are without limitation. Constraints vary from lack of measurement of healthcare outcomes to the abstract nature, making the models difficult to put into practice. One model that lies outside of the healthcare realm describes a more concrete approach to cultural competence.

International education scholar Darla Deardorff developed the Pyramid Model of Intercultural Competence (2006, 2009) which includes requisite attitudes necessary to develop cultural competence. These attitudes include respect, openness, and curiosity and discovery. Respect includes valuing other cultures and cultural diversity; openness

TABLE 5-1 Theoretical Models of Cultural Competence

Authors year	Model Name	Components of Constructs or Domains	Sources	Assessment Instrument Linkage	Validation
Campinha-Bacote, 2002b	Culturally competent model of care	Five constructs within the cultural content of individual, family, and community (cultural awareness, knowledge, skill, encounters and desire [cultural desire added in 1998])	Lelinger's (1991) transcultural nursing theory; Pedersen's (1998) multicultural development theory (as cited in Campinha-Bacote, 2002b)	Inventory for assessing the process of cultural competence among healthcare professionals, revised (IAPCC-R)	Yes
Papadopoulos et al.,	Model for the development of culturally competent health practitioners	Four components (cultural awareness, cultural knowledge, cultural sensitivity, cultural competence)		Cultural competence assessment tool (CCA Tool), 2004 (40 items) based on Papadopoulos et al's 1998 model	Yes
Kim-Godwin, et al., 2001	Culturally competence community care model	Three constructs (cultural competence, health care system, and health outcomes) with four dimensions (caring, cultural sensitivity, cultural knowledge, and cultural skills)	Concept analysis	Cultural competence scale to test the 3 dimensions of cultural sensitivity, knowledge, and skills	Yes

TABLE 5-1 Theoretical Models of Cultural Competence*(continued)*

Authors year	Model Name	Components of Constructs or Domains	Sources	Assessment Instrument Linkage	Validation
Jeffrey's, 2010a	Cultural competence and confidence model	Transcultural nursing skills in cognitive, practical, and affective dimensions, transcultural self-efficacy, and culturally congruence care	Lelninger's transcultural nursing theory; Bandura's (1986) self-efficacy theory in psychology	Transcultural self-efficacy coal (TEST)	Yes
Schism & Doorknobs, 2010; Schism Doarenbes, Bunkers, & Miller, 2007; Schism, Doorenbes, Miller & Bunker, 2003	3-D model of culturally congruent care	Three dimensions of provider level (cultural diversity, cultural awareness, cultural sensitivity, and cultural competence behaviors), client level (patient, family, and community beliefs, and behaviors) and culturally congruent care as outcome layer (when provider and client levels for well together)	Lelninger's transcultural nursing theory	Cultural competence assessment (CCA)	Yes
Campinha-Bacote, 2005	Biblically based cultural competence model	Eighteen intellectual and moral virtues (love, caring, humility, love of truth, teachableness, intellectual honesty, inquisitiveness, wisdom, discernment, judgment, prudence, attentiveness, studiousness, practical and compassion) ingraced into the five constructs (cultural awareness, cultural knowledge, cultural desire, cultural skill and cultural encounters)		Inventory for assessing a biblical worldview of cultural competence (ABWCC) among healthcare professionals	

(continues)

TABLE 5-1 Theoretical Models of Cultural Competence*(continued)*

Authors year	Model Name	Components of Constructs or Domains	Sources	Assessment Instrument Linkage	Validation
Pepadopoulos & Lees, 2008	Model for the development of culturally competent researchers	Four components (cultural awareness, cultural knowledge, cultural sensitivity, cultural competence) with culture-generic and cultures-specific competence as the two layers of cultural competence			
Wills, 1999	Framework for cultural competence	Seven-step progression (knowledge of one's own culture, knowledge of others culture, cultural interaction, cultural tolerance, cultural induction, cultural appreciation acceptance, cultural competence)			
Wills, 2000	Cultural development model (for individual and institutional cultural competence development)	A continuation of six stages in two phases (cultural incompetence, cultural knowledge, and cultural awareness as the cognitive phase; cultural sensitivity, cultural competences, and cultural proficiency as the affective phase)	Cross et al. 1989 Orinda 1992		

TABLE 5-1 Theoretical Models of Cultural Competence*(continued)*

Authors year	Model Name	Components of Constructs or Domains	Sources	Assessment Instrument Linkage	Validation
Burchum, 2002	Model for cultural competence	Six attributes (cultural awareness, knowledge, understanding, sensitivity, interaction, and skill) a nonlinear, expensive process of becoming culturally competent	Concept analysis		
Pacqutao, 2012	Culturally competent model of ethical decisions	Three competence cultural context compassions advocacy for social justice and human rights protection for culturally congruent healthcare for wearable populations and culturally competent healthcare by real station of cultural patterning	Lelinger's transcultural nursing theory and principles of culturally congruent healthcare as a basic human right		
Suh, 2004	Model of cultural competence	Four domains as antecedence cognitive (cultural awareness, knowledge), effective (sensitivity), behavior (skills) and environmental (encounters); three attributes of cultural competence (ability, openness, flexibility); and three variables (receiver-based, provider-based, and health outcomes)	Concept analysis		

Reproduced from Shen, Z. (2015). Cultural competence models and cultural competence assessment instruments in nursing: A literature review. *Journal of Transcultural Nursing*, 26(3), 308–321.

TABLE 5-2 Methodological Models of Cultural Competence

Authors	Model Name	Components/Constructs/Domains	Sources	Assessment Instrument Linkage	Validation
Giger & Davidhizar, 2004, 2008	Transcultural assessment model	Six cultural phenomena (communication, space, social organization, time, environment control, and biological variations)	Leininger (1991); Spector (1996); Orque, Bloch, & Monroy (1983); as cited in Giger & Davidhizar (2004, 2008)	Tested Smith (1998b) with three scales CAS by Bonaparte [1997, 1979]; CSES by Bernal & Froman [1987, 1993]; and Rooda's [1990, 1992] knowledge-based questions on cultural competence); also as cited in Giger & Davidhizar, 2002	yes
Spector, 2004s, 2009	Health traditions model	Five respects of heritage consistency (culture, ethnicity, religion, [acculturation and socialization, 2009]) interrelated with six cultural phenomena (communication, space, social organization, time, environmental control, and biological variation) to maintain, process, and restore the health of the body, mind, and spirit.	Giger & Davidhizar's (1999, 2002, 2004, 2008) model; Ester & Ziow's theory (as cited in Spector, 2013)	Heritage assessment tool with 29 questions, Spector (2004b)	
Orque, 1983	Ethnief cultural system framework	Eight components applicable to nurses and clients (diet, family life processes, healing beliefs and practices, language and communication process, social groups' interactive patterns, value orientations, religion, art land history) along with two models (intercultural communication model and model of biological, sociological and psychological systems)	Nursing, sociology	Bloch's (1983) assessment guide for ethniefcultural variations	

TABLE 5-2 Methodological Models of Cultural Competence*(continued)*

Authors	Model Name	Components/Constructs/Domains	Sources	Assessment Instrument Linkage	Validation
Leininger, 1991	Sunrise model	Six domains (culture values and lifeways; religion, philosophical, and spiritual beliefs; economic factors; educational factors; technological factors; kinship and social ties; and political and legal factors) and three modalities (cultural care preservation and maintenance; cultural care accommodation and negotiation; and cultural care repatterning and restructuring)	Nursing, anthropology		
Purcell, 2003, 2008	Purcell model for cultural competitions	Twelve cultural domains (overview, inhabited localities, and Logography, communication, family roles and organization, work influence issues; bicultural ecology; high-risk health behavior nutritious pregnancy and childbearing practices; death rituals spiritually; and healthcare practices and healthcare practitioners)	Organizational administrative, communication, and family development theories		
Andrews & Boyish 2008	Transactional nursing assessment guide for individuals and families	Twelves categories of cultural knowledge (cultural affiliations, values concentration, communication, health rebuild beliefs and practice, nutrition, social economic considerations, organizations providing cultural supports education, religion, cultural aspects of disease incidence biocultural variations, and developmental considerations across the life aspan p. 35)	Feininger's transcendental nursing theory		

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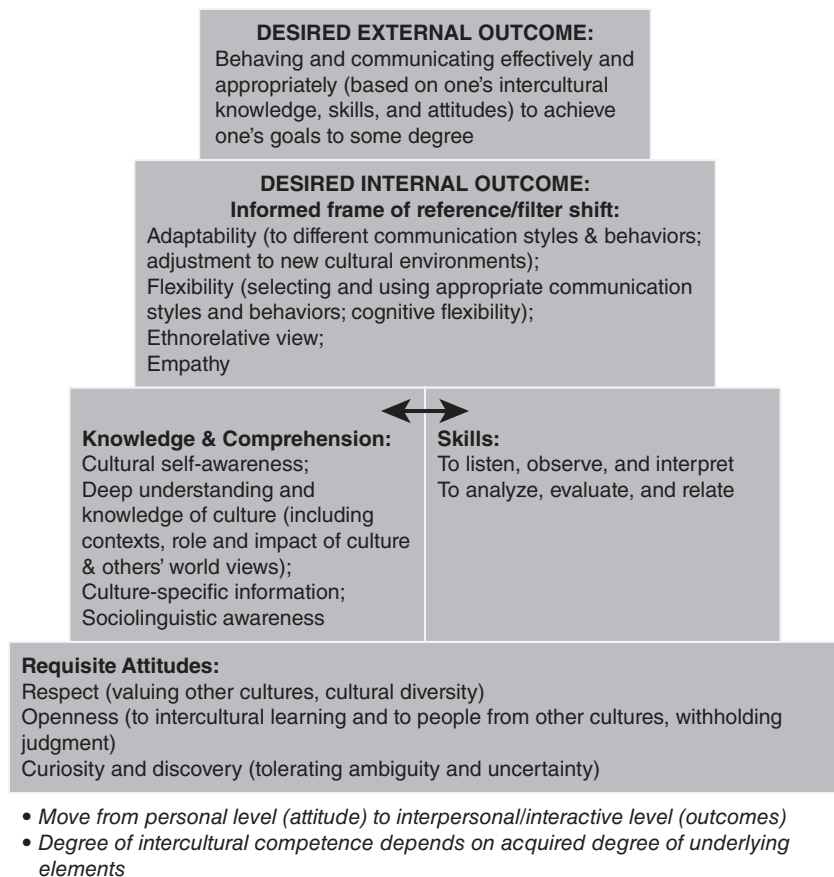


FIGURE 5-1 Pyramid Model of Intercultural Competence

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is a measure of withholding judgment of other cultures and diversity; curiosity and discovery allow for tolerating ambiguity and uncertainty. See **FIGURE 5-1**.

Measuring our cultural competency aids in our understanding and responsiveness to the components of care crucial for meeting the needs of the diverse populations that NPs serve. Using a tool such as the CCA will enable educators, mentors, and primary care providers the opportunity to evaluate their progress or journey of cultural competency.

A personal self-assessment tool for the primary healthcare provider can provide insight into the cultural competence of the care provider (see **BOX 5-2**). This quantitative tool requires the clinician to reflect on various areas of the cultural provision of care. Although there are no right or wrong answers, responding that “I rarely or never do” may suggest limitations in the ability to “demonstrate beliefs, attitudes, values, and practices that promote cultural competence within healthcare delivery programs” (Nova Scotia Department of Health, 2005, p. 19).

BOX 5-2 Promoting Cultural Competence in Primary Health Care

- I. Physical Environment, Materials, and Resources
 - A. I ensure the printed and posted information in my work environment reflects the diversity and literacy of individuals or families to whom I provide service.
- II. Communication Styles
 - A. When interacting with individuals and families who do not have spoken English proficiency, I always keep in mind that:
 1. Spoken English proficiency does not reflect literate English proficiency or language of origin proficiency or literacy.
 2. Limited ability to speak the language of the dominant culture has no bearing on ability to communicate effectively in one's mother tongue.
 3. Limitations in English proficiency do not reflect mental ability.
 - B. I use bilingual and/or bicultural staff trained in medical interpretation when required or requested.
 - C. For individuals and families who speak languages other than English, I attempt to learn and use key words in their language so I am better able to communicate with them during assessment, treatment, or other interventions.
 - D. I understand the cultural context for naming disease and try to be respectful of this in my interactions. (In some cultures, there is stigma associated with terminal disease, sexually transmitted disease, and/or communicable diseases. In some cultures, this stigma is avoided by naming the disease by its attributes, rather than its medical name (e.g., AIDS is sometimes named "the sleeping sickness").
 - E. I can provide alternatives to written communication if required or preferred.
- III. Social Interaction
 - A. I understand and accept that family is defined in a variety of different ways by different cultures (e.g., extended family members, kin, godparents).
 - B. Even though my professional or moral point of view may differ, I accept individuals and families as the ultimate decision makers for services and supports affecting their lives.
 - C. I understand that age, sex, and life-cycle factors need to be considered in interactions with individuals and families. For instance, a high value may be placed on the decisions of elders, the role of eldest male or female in families, or roles and expectations of children within the family.
 - D. I accept and respect that male–female gender roles may vary among different cultures and ethnic groups (e.g., which family member makes major decisions for the family).
- IV. Health, Illness, and End-of-Life Issues
 - A. I understand that the perceptions of health, wellness, and preventive health services have different meanings to different cultural or ethnic groups.
 - B. I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors that are not culturally competent.
 - C. I screen resources for cultural, ethnic, or racial stereotypes and/or inclusion before sharing them with individuals and families served by my program or agency.

(continues)

BOX 5-2 Promoting Cultural Competence in Primary Health Care*(continued)*

- D. I am aware of the socioeconomic and environmental risk factors that contribute to the major health problems of culturally, ethnically, and racially diverse populations served by my program or agency.
- E. I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, ethnically, racially, and linguistically diverse groups.
- F. I advocate for the review of my program or agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

Reproduced from Nova Scotia Department of Health. (2005). *A cultural competence guide for primary health care professionals in Nova Scotia*. Halifax, Nova Scotia: Author.

► Cultural Immersion Experiences

Cultural competency, infused into the skill set of all NPs, is a starting point for the reduction of disparities that exist within our healthcare system. Increasing cultural competence among providers will facilitate the goal of decreasing the healthcare disparities gap (Doorenbos et al., 2005). Cultural immersion experiences have been cited as a method to increasing cultural awareness and sensitivity (Green, Comer, Elliott, & Nuebrander, 2011; Johns & Thompson, 2010; Jones, Ivanov, Wallace, & VonCannon, 2010; Larson, Ott, & Miles, 2010). When individuals interact with various culturally diverse groups, their own beliefs regarding a cultural group will be affected and thus prevent stereotyping (Campinha-Bacote, 2003). A substantial portion of the literature on cultural immersion experiences affecting cultural awareness and sensitivity relates to students within the educational setting. Inclusion of service learning activities that increase the cultural sensitivity and awareness of students is a means to addressing the needs of our society. Students are likely to gain global attitudes and perspectives when schools of nursing include global experiences in their curriculum (Riner, 2011). This preparation will develop a sensitivity to and appreciation of cultures in an effort to provide high-quality care across various settings. The following is a reflection of a graduate student who participated in a clinical immersion experience in Central America:

One of the things that really affected me while we were in Guatemala was seeing the number of children that were unable to go to school because they had to work to help support their families. Growing up in the United States, our culture prides itself on education for all children. However, going to Guatemala and speaking with children who actually cannot go to school because they have to work really struck a chord with me. It is so easy for Americans to live in their little bubble because many have no idea what it is like to not have that option. In other words, we can complain about school because there is little risk that school won't be there for us. We see it as our inherent "right." Then there are the kids in Guatemala that are longing to go to school who are denied because their family needs them to help put food on the table. Kids who are 6, 7, and 8 years old, who, in America, would be

doing homework, are instead out on the street selling bracelets at 10 pm at night in order to help their families. Talk about perspective! It really helps me to appreciate all the educational opportunities I have been and still am being given. (Regina, graduate student)

Cultural awareness and sensitivity improvements can be directed toward practicing providers within the healthcare setting. Communication and cultural awareness education can infuse a healthcare provider's communication skills with empathy, a nonjudgmental approach to patients, enhanced awareness of self, and awareness of his or her own nonverbal communication (Thomas & Cohn, 2006). To care for the population in a culturally competent manner, NPs should see themselves on a journey growing and cultivating distinctive experiences, which will lead toward achieving cultural competence (Campinha-Bacote, 2003). This journey provides the opportunity to learn and appreciate the uniqueness of culture. In the following excerpt a nurse educator speaks about her journey to develop cultural competency:

As an educator I prided myself in having knowledge to share with others. Reflecting on years of direct patient care, caring for individuals and groups of various cultural and ethnic backgrounds, I was humbled by what I still did not know. It is when I examined my cultural competence that I began to realize that I will not “achieve” cultural competence but will be on a journey forever to reach competency. Each interaction I have with others will increase my understanding, my sensitivity, and my awareness. I will approach others with openness and nonjudgment as I persist in my efforts along the journey. (Carolina, nurse faculty)

► Demystifying the Cultural Competence Puzzle

Cultural awareness training may be helpful in increasing cultural awareness, yet it is not an easy fix to improving outcomes for disparate populations. Sequist and colleagues (2010) in a randomized control study noted that primary care clinicians had increased awareness of racial disparities after an intensive 12-month program consisting of cultural competency training and race-stratified performance feedback. This training did not improve important aspects of disease control for black diabetic patients in the program, suggesting a need for further interventions (Sequist et al., 2010). Awareness of cultural aspects of a particular group can be insightful, aiding in increased understanding, but it is not until the provider recognizes the influence of culture on a person's existence that it is significant. A partnership between a NP and client could assist in developing a greater understanding and appreciation of the culturally specific needs of the client in the context of his or her population. As expressed by the graduate student below, having one piece of the cultural competence puzzle is not enough:

We talked about various cultures in the cultural nursing course, but it had little meaning to me. I am a NP student who has not encountered much diversity in my life. As a future NP, I know I need cultural skills to be effective in my role. But is having the knowledge I learned in class enough?

In a 2010 qualitative study, Erwin et al. (2010) examined the barriers and opportunities of Latino women to obtain health screenings and interventions. The study found that country of origin and their current geographical location affected their experiences with healthcare systems and access to services. Several cultural themes emerged including the influence of “machismo” and putting the family before themselves. The effects of these culturally based influences can present as barriers to women obtaining healthcare services (Erwin et al., 2010). Cultural influences, such as the (American/U.S.) approach where women are encouraged to care for themselves and seek health promotion services, may be regarded as a method of empowerment in one culture, yet perceived as a barrier in other cultures.

For the Latino woman who depends on the input of her husband to receive care, it is in the best interest of the woman to involve her husband in the decision-making process regarding care decisions. By considering the Latino family’s views as the preferred approach to health care, the healthcare team may have greater success in meeting the family’s healthcare needs.

The following case study is representative, in that it involves a Guatemalan male in the implementation of care for his infant child:

Ana, a mother who walked 90 minutes to the clinic in a developing country, brought her 3-month-old baby, Alessandra, to the clinic our team sponsored. The mother reported she was told to bring her baby home to die; the doctors in her country could not help her. When Alessandra arrived at the clinic she was just over 3 pounds, nearly 2 pounds less than her birth weight. The team, after assessing the baby, determined that she was drinking cow’s milk and had severe gastrointestinal and cutaneous symptoms. The team developed a feeding plan utilizing soy-based formula. When the team discussed the plan with the mother, it was apparent that the father of the baby needed to consent to the outlined plan. Ana was not able to make the decision for her baby. A community leader, who served as the liaison between team and family, facilitated the communication of the plan to the father, who consented. It was through the use of the community leader and a nonjudgmental approach, incorporating cultural considerations into the plan, that a successful plan was created for Alessandra. (Ellen, public health nurse)

In a article describing the fasting practices of women during pregnancy and breastfeeding, the differences between some practicing Muslim women and U.S. standards were discussed (Kridli, 2011). In a culture where pregnant women are encouraged to “eat for two,” caregivers may find that the practice of fasting during pregnancy or breastfeeding is strange or wrong. It is important for the NP to take the time to understand the significance of fasting in the spiritual life of the Muslim woman. It is when healthcare providers can accept and appreciate the cultural uniqueness of an individual that they can then adapt the provision of care to meet the needs of the patient. The following case scenario is an example of how the nurse practitioner helped the patient with strong religious beliefs navigate his care in a complex health system:

As a nurse practitioner I often need to reassess my own ability to reframe the ability to accept my patients’ beliefs regarding healthcare treatments as well as their spirituality. It is sometimes difficult when we feel strongly that current practices are the only viable option for patients to choose, particularly when their choice is almost always one that will significantly alter the

ability to survive. Religious beliefs can stir up much passionate argument for insisting patients do things “our” way. I will touch upon this in my short story.

George was a middle-aged gentleman who came in yearly for his physical examination. He was doing very well in keeping his cholesterol in check with diet and a low dose statin, and was up to date with immunizations. Until one recent visit, there were no other significant healthcare-related issues. At that visit George described feeling so fatigued he could hardly get through his workday as a manager for a large home goods store. He said he was bruising easily, and was very concerned, as was I. I knew that George was a Jehovah’s Witness, and we had in his file his official document regarding no blood transfusions. I have some members of my family who are also Jehovah’s Witnesses, so I was well aware of all the details and scriptural support for this belief. Unfortunately, his blood work returned showing a severe pancytopenia. I convinced him to go for the consultation with the hematologist we worked closely with, assuring him I would be his advocate for him to be the main director of his own healthcare treatment plan once he was fully assessed and treatment options were discussed. Being an advocate, I also had to speak with the hematologist before George went there so he could understand what issues could cause tension within their patient–physician relationship during this time of turmoil. Unfortunately, it did appear that George had aplastic anemia.

We are working to find the cause, and he has opted to use complementary and alternative therapies instead of blood transfusions. The hematologist made George sign a document that released him from liability regarding George’s decisions; however, he is still working with us for the time being. George is well aware of the possibility of dying without getting transfused, and he strongly holds to his belief system. As his primary care provider, I try to be supportive, as well as honest, when discussing his current status and his options. I have found that I am often being an advocate for George among the staff and other providers, using opportunities to correct inaccurate understanding regarding Jehovah’s Witnesses.

Incorporating a cultural assessment or the collection of relevant cultural data relating to a patient’s diagnosis or health concern is vital in the care of diverse populations (Campinha-Bacote, 2003). It is important to consider the biological, physical, and physiological cultural variations that may influence the physician’s ability to conduct an appropriate and correct physical evaluation (Purnell, 1998, as cited in Campinha-Bacote, 2003). Significant cultural data should be gathered, adapted prior to and during the evaluation, and used in the planning and implementation of care. Goldbach, Thompson, and Hollaren Steiker (2011) discuss the importance of cultural consideration in the care of Latinos with substance abuse. The Latino culture values family orientation, *familismo*, and respect, *respeto*, in their lives. The inclusion of culturally specific aspects of care, along with acculturation, were identified as considerations when treating adolescents with substance abuse (Goldbach et al., 2011). Current strategies or approaches that do not include culturally specific strategies may be ineffective in meeting the unique needs of a specified population. To care for the adolescents, the practitioner must care for the family, use respect, and understand the psychosocial adjustment to the society in which the adolescent lives.

To understand health, it must be examined from the viewpoint of the individual or family. Health must not be gauged by others; the information must come directly

from the person or community and be related to their specific circumstances (Kagan, 2008). To be effective practitioners caring for individuals, communities, and populations of need it is important to use awareness and sensitivity, authentic listening, trust, partnerships, and commitment. It is when we strive for cultural competence that we are able to improve the lives of others.

► Language and Communication

The Institute of Medicine (IOM, 2003) report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, illustrates the importance of cross-cultural communication. Effective culturally sensitive communication will lead to patient satisfaction, leading to adherence, and thus favorable patient outcomes, as seen in **FIGURE 5-2**. Faulty communication and a lack of consideration of the sociocultural factors will lead to poor patient outcomes and racial and ethnic disparities in care (IOM, 2003). To be an effective communicator, the NP must possess curiosity, empathy, respect, and humility (IOM, 2003) during interactions with individuals and communities. It is when providers ask questions and listen to the response that assumptions can be avoided.

The Office of Minority Health (OMH) was established in 1986 in response to the increased awareness regarding poor health outcomes in racial and ethnic minority populations in the United States (OMH, 2011a). CLAS standards were developed by the OMH for healthcare systems to use in order to provide the best care possible for the diverse patient populations seeking care in the United States. These standards were recently enhanced, and the goals are to (1) advance health equity, (2) improve quality, and (3) help eliminate healthcare disparities. Providing services that are adapted to an individual's cultural and language preference can aid in positive patient outcomes. The 14 CLAS standards guide the NP and other healthcare providers to the recommended language and communication processes in healthcare settings that will enhance patient care outcomes (OMH, n.d.a). For example, the NP should know the qualifications of the interpreter, interpreters must be trained in their role, and the clinician should speak directly to the patient and not the interpreter. The Think Cultural Health initiative contains educational resources to aid in the development of healthcare providers and organizations (<https://www.thinkculturalhealth.hhs.gov/index.asp>).

Listening

An important element of communication must not be overlooked: listening. Listening is an important yet underused skill. Patients express a desire to be listened to by their



FIGURE 5-2 Communication Model

healthcare providers more than anything else (Berman & Chutka, 2016). Listening is an essential part of the appreciation and awareness of the viewpoints and feelings of others and is inherently connected to quality of life (Kagan, 2008). It is especially beneficial to employ therapeutic listening when working with individuals or groups from other cultures.

One study illustrated the benefit of listening and gaining insight into the lives of immigrant women (Belknap & VandeVusse, 2010). Using active listening, the researchers were able to identify emerging themes related to the lived experience of the women. Interventions and support related to the themes can be developed based on the knowledge obtained from listening sessions. The NP must become familiar with culturally competent organizations in the community to assist families. Partnering with the community and listening to their needs can assist the NP with the assessment, development, and implementation of interventions for the specified community. The listener, by providing a safe environment, allows the individual or group to feel secure to voice their expression. It is essential for the listener to be nonjudgmental, accepting, and negate all preconceived ideas, prejudices, and negative attitudes (Shiple, 2010). It is through active listening that the provider is receptive to discovering the needs and desires of others. NPs are often seen as the care providers that hear the patient; NPs often have the ability to truly listen to the patient's voice, and this has significant implications in the cultural considerations of care.

The ETHNIC mnemonic represented in **BOX 5-3** has been identified as a tool to assist the primary care provider in obtaining a history that encourages the inclusion of the patient's cultural perspective.

Trust

There is mistrust of the healthcare system by minority patients. Their mistrust is connected to treatment refusal for a variety of reasons including discontentment with the patient-provider relationship (Baldwin, 2003). As part of the most trusted profession (ANA, 2016), NPs are in a position to establish trusting and meaningful relationships with individuals, groups, and communities. Many of the skills necessary to build cultural awareness and sensitivity are instrumental in establishing trust: empathy, respect, listening, and a nonjudgmental approach. Taking time to build a rapport will aid in the development of trust and build relationships between the provider and the patient community. The following below displays examples of a trusting relationship between an NP and a high-risk patient:

Jana is an African-American mother of a 2-year-old, recently paralyzed child. The child suffered the injuries during a motor vehicle accident in which her maternal grandmother was under the influence of an illegal substance. Jana herself is a recovering drug addict and prostitute who is starting to make great strides in her life. She is working and independently living in a small apartment with her daughter. As the NP overseeing her care in the hospital setting, I have the tremendous responsibility of working with the mother with the mutual goal of discharging the daughter home.

The initial discharge was complex. There were many considerations: ventilator, G-tube feedings, wheelchair, and nursing, to highlight several. As I discussed the plan with the discharge coordinator, we were encountering obstacle after obstacle to meeting our goal. Was the home accessible? Was it safe? Did the mother have adequate support? We updated the mother frequently with the progress (or lack of progress). One morning the mother was angry

BOX 5-3 The ETHNIC Mnemonic**E: Explanation**

What do you think may be the reason you have these symptoms? What do friends, family, or others say about these symptoms? Do you know anyone else who has had or who has this kind of problem? Have you heard about/read/seen it on TV/radio/newspaper? (If patient is unable to offer an explanation, ask patient what is most concerning about the problem.)

T: Treatment

What kinds of medicines, home remedies, or other treatments have you tried for this illness? Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy? Tell me about it. What kind of treatment are you seeking from me?

H: Healers

Have you sought any advice from alternative/traditional or folk healers, friends, or other people (nondoctors) for help with your problems? Tell me about it.

N: Negotiate

Negotiate options that will be mutually acceptable to you and your patient and that do not contradict, but rather incorporate, your patient's beliefs.

I: Intervention

Determine an intervention with your patient. This may include incorporation of alternative treatments, spirituality, and healers, as well as other cultural practices (e.g., foods eaten or avoided both in general and when sick).

C: Collaboration

Collaborate with the patient, family members, other healthcare team members, healers, and community resources.

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and started to voice her concerns in a loud and disruptive manner; she said she “had it” with “all of you.” After calming her and listening to her concerns it was apparent that she did not trust that we were truly trying to discharge her daughter to home. She felt the obstacles were hiding what she felt we considered the “true” issue: that she was unfit, due to her past history, to provide care to her daughter. Despite displaying the skills and behaviors that could support her daughter's needs, Jana felt that the staff saw her as an unfit parent. I was shocked. I thought we had a professional relationship that fostered trust, but what I did not understand was how Jana's life events affected her ability to trust us and voice her concerns. I learned, after caring for Jana and her daughter, that experiences can affect a person's perception and reaction. As an NP, I need to ensure that patients and their families are able to trust me as their care provider. I need to find ways to better understand them and their experiences.

Trust and privacy were major themes that emerged in a 2012 study examining the provision of health-related services to bisexual men (Dodge et al., 2012). Perception of others, confidentiality, and trusting relationships influenced their likelihood of seeking healthcare services. Fearing that their privacy and trust will be violated, many marginal groups may distance themselves from the healthcare services they

require. This separation leads to continued disparities in the provision of care and negatively affects their health and well-being.

Global and race-based medical mistrust were high among black women who have sex with black women in a recent study (Brenick, Romano, Kegler, & Eaton, 2017). Individuals with mistrust have less engagement in health care, which is of concern for the health and well-being of this identified population. Stigma from race or sexual orientation, although low in the study, should be considered to reduce disparities and promote engagement in health care.

Trust can influence health. Another study examining the relationship of trust between patients with type 2 diabetes and their physicians demonstrated that trust was related to patient outcomes. The authors concluded that “trust in physicians could contribute to improvements in patient outcomes over time” (Lee & Lin, 2011, p. 411). When caring for populations, trust is essential to building a caring relationship, and having trust in a relationship is an important aspect of care that can improve health outcomes. If a provider is culturally competent, it will positively impact the treatment adherence of the patient and the quality of care (Davey, Waite, Nuñez, Niño, & Kissil, 2014).

Nurse practitioners are viewed as being skillful in developing trusting relationships with patients. The trust is developed by learning about the patient’s family, culture, and socioeconomic needs; developing and using cultural tools; and incorporating nursing tenets from professional training.

► Community Partnerships

When providing care to marginalized or culturally based populations, establishing a relationship with the community is essential. Partnership, defined as two or more individuals or groups working together for a shared goal, is a key element to community engagement. Meade, Meanard, Therival, and Riveria (2009) discuss the importance of community partnerships in the development and adaptation of sustainable breast education and outreach programs for Haitian women. The partnership worked on the unique needs of the community and included cultural, educational, and literacy considerations. The development of a partnership affords the ability to determine factors that affect health and to develop approaches to maximize health and wellness. Partnerships with community leaders and community gatekeepers are essential features to the success of outreach initiatives (Meade et al., 2009).

An example of a lack of partnerships within the healthcare setting was presented in a 2009 study examining the use of CAM in the treatment of autism spectrum disorder (ASD) in the United States and China. An interesting finding from this study revealed that only 22.4% of respondents informed their doctors about CAM use to treat ASD. The study suggests that the participants did not inform their physician of the CAM use because they felt that the Western physician would not allow CAM nor believe its effectiveness (Wong, 2009). Lack of trusting partnerships can lead to continued healthcare disparities.

In a study exploring the influence of NPs on the delivery of culturally competent care, NPs stated that collaborating with other members of the healthcare team, as well as patients, was effective in the delivery of culturally competent care. Working with patients to meet their identified needs was a priority for the NP, as well as for the patient. Addressing other impending concerns was completed by negotiation and partnering.

In a 2011 study of Native American men and HIV, barriers to HIV/AIDS care were presented. Many of the barriers were related to and contributed to the disparity in the provision of care to Native American men. The participants in this study identified that using indigenous outreach workers would be an effective approach to the prevention and intervention efforts (Burks, Robbins, & Durtschi, 2011). They also expressed the importance of inclusion of traditional healing practices into the provision of HIV/AIDS services. Establishing partnerships with community leaders and outreach workers could improve the health of the community by addressing their needs with a culturally focused approach.

In addition, Saha and colleagues (2013) found that minority HIV patients who had a provider who scored toward the middle or high ranges of cultural competence were more likely to be on antiretrovirals than patients who had a provider who scored low in cultural competence. Again, this study shows that the cultural competence of the healthcare provider is connected to healthcare quality and outcomes of patients.

► Pulling It All Together

Caring for patients and addressing and adapting care to meet the cultural needs of patients takes a holistic approach. When care is provided in a culturally sensitive manner, it extends beyond the medical concerns presented. The inclusion of social, spiritual, lifestyle, societal, and familial aspects of the individual is imperative to determining and responding to the patient's needs. Having a holistic approach is to look at the patient's complete life, not solely focusing on illness.

The LIAASE, a general cultural competence tool, is a helpful structure to guide the provider in providing care that is sensitive to the individual's culture and preferences (see **BOX 5-4**).

In the following case scenario, the NP uses components of the LIAASE tool as she develops a culturally competent plan of care for the patient.

Using the LIAASE Tool to Provide Culturally Sensitive Care

While working in a busy OB/GYN clinic as a new FNP, I was quickly moving my novice skill level to advanced due in part to the resident physicians' avoidance of the clinic. It was also a wonderful place to provide culturally sensitive care. We had a large number of patients from Haiti and Guatemala, in addition to almost every other country. One day I went into an examination room and found a pleasant young couple waiting for a new OB examination. The woman was covered in a very colorful sari and was smiling, but quiet and deferential to her equally pleasant husband.

He very nicely told me that since I was the only female provider in the clinic that day that they had requested I do her initial intake and examination. I loved doing the new OB visits, so that was not the challenge—the challenge was in trying to do a pelvic exam and get a PAP smear and ultrasound with all that clothing. Saris can be worn in different colors to represent different meanings; for instance, yellow can typically be worn for the first 7 days postpartum, and paisley can be worn as a symbol of fertility. The couple was pleased that I managed to get all the necessary portions of the examination done while maintaining the woman's privacy. We developed a mutually understanding and respectful partnership during a time of joy for this newly pregnant couple in what could have been disastrous if the provider who attended to them was not culturally sensitive.

BOX 5-4 The LIAASE: A General Cultural Competence Tool

Learn

Read literature from other cultures.
Identify your own biases and stereotypes.

Avoid Polarization

Solicit other options or points of view.
Ask what perspective a person from a different background would have.

Inquire

Ask questions to clarify and understand information.
Dig deeper to find reasons for behaviors or attitudes.
Frame inquiries as searches for answers, showing a willingness to learn.
Do not judge or interpret actions or speech; verify that what you understand is correct.
Speak clearly; avoid slang, colloquial expressions, and large, complex words.

Avoid Arguing and Defending

Curb the impulse to defend your point of view or opinion.
Agree to disagree on differences in values.

Show Empathy

Listen not just to the words, but to the feelings behind the words.
Acknowledge and validate powerful emotions when expressed.

State Your Needs and Expectations

It is important to set a respectful tone for the interaction. Let people know what you want and what you consider unacceptable behavior. In this way assumptions, conflict, and/or resentment can be avoided.

Reproduced from Nova Scotia Department of Health and Wellness. (2005). A cultural competence guide for primary health care professionals in Nova Scotia. Retrieved from http://www.healthteamnovascotia.ca/cultural_competence/Cultural_Competence_guide_for_Primary_Health_Care_Professionals.pdf. Used by permission of Nova Scotia Department of Health and Wellness.

► Evaluation

When working with individuals or groups, there is a need to evaluate the outcomes of the interventions, including the evaluation of those we partner with. Outcome evaluations should be culturally sensitive; they should use wording and terms that the community or individual would understand within the context of their culture. It is important to receive feedback from the community or individual on whom the intervention focused. Do they perceive the intervention as useful or beneficial? After using focus groups to determine the best interventions to use in a community-based intervention program for Mexican American women, Ingram et al. (2012) used a participatory evaluation process to adapt to the needs of the women in the community. The authors, using the women's responses, were able to understand the behavioral and knowledge changes as a result of the program's interventions. Their responses revealed why they adapted their behaviors and the barriers they encountered when following the intervention recommendations (Ingram et al., 2012). Their input was valuable to gaining their perspective on the

significance of the interventions as well as their perceived barriers, thus contributing an important aspect of program evaluation. When examining the outcomes of a program or intervention, cultural influences must be considered when applying meaning to the results (Issel, 2009).

Evaluation is the ability to reflect on our care as NPs in an effort to gain greater clarity on the provision of culturally competent care. It serves as a time to ask if the care was what the patient needed or desired. In our role, this feedback ensures that we are evaluating not only the care provided but also ourselves as care providers. In summary, nurse practitioners must respond to the unique and distinct needs of the diverse and ever-changing society. Attention to cultural variations as well as societal factors influencing health must be considered to care for an increasingly diverse population. Cultural awareness and sensitivity are critical to the achievement of culturally competent care.

► Seminar Discussion Questions

1. Identify your own cultural beliefs and values.
2. Discuss the variety of cultures in your professional practice.
3. Reflect on your cultural journey. What do you consider as obstacles to achieving cultural competence? What strategies can be employed to overcome the barriers?
4. Describe a situation or circumstance when cultural factors influenced the care of an individual or family. Were culturally sensitive interventions/approaches implemented? If yes, please describe. If interventions/approaches were not based on the individual's or family's cultural preferences, how could the encounter have been adapted to meet the unique cultural needs?
5. What method or strategy could be implemented to evaluate the integration of cultural strategies during a patient encounter?

References

- American Association of Colleges of Nursing (AACN). (1994). *The essentials of master's education for advanced practice nursing*. Retrieved from <http://www.aacn.nche.edu/education-resources/MasEssentials96.pdf>
- American Association of Colleges of Nursing (AACN). (2006). *The essentials of doctoral education for advanced nursing practice*. Retrieved from <http://www.aacn.nche.edu/publications/position/DNPEssentials.pdf>
- American Association of Colleges of Nursing (AACN). (2008). *The essentials of baccalaureate education for professional nursing practice*. Retrieved from <http://www.aacn.nche.edu/education-resources/BaccEssentials08.pdf>
- American College of Physicians. (2010). *Racial and ethnic disparities in health care* (Policy paper). Philadelphia, PA: Author.
- American Nurses Association (ANA). (2012). *Diversity awareness mission statement*. Retrieved from <http://nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/Improving-Your-Practice/Diversity-Awareness/Mission-Statement.html>
- American Nurses Association (ANA). (2016). *Nurses rank #1 most trusted profession for 15th year in a row*. Retrieved from <http://www.nursingworld.org/FunctionalMenuCategories/MediaResources/PressReleases/Nurses-Rank-1-Most-Trusted-Profession-2.pdf>
- Axtell, S. A., Avery, M., & Westra, B. (2010). Incorporating cultural competence content into graduate nursing curricula through community-university collaboration. *Journal of Transcultural Nursing, 21*, 183–191. doi:10.1177/1043659609357633

- Baldwin, D. M. (2003). Disparities in health and health care: Focusing efforts to eliminate unequal burdens. *Online Journal of Issues in Nursing*, 8(1). Retrieved from <http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume82003/No1Jan2003/DisparitiesinHealthandHealthCare.aspx>
- Belknap, R. A., & VandeVusse, L. (2010). Listening sessions with Latinas: Documenting life contexts and creating connections. *Public Health Nursing*, 27, 337–346. doi:10.1111/j.1525-1446.2010.00864.x
- Betancourt, J. R., Green, A. R., Carrillo, J. E., & Anaeh-Firempong II, O. (2003, July–August). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, 118, 293–302.
- Bomar, P. (2004). *Promoting health in families: Applying family research and theory to nursing practice*. Philadelphia, PA: Saunders.
- Boutin-Foster, C., Foster, J., & Konopasek, L. (2008). Viewpoint: Physician, know thyself: The professional culture of medicine as a framework for teaching cultural competence. *Academic Medicine*, 83, 106–111. doi:10.1097/ACM.0b013e31815c6753
- Brenick, A., Romano, K., Kegler, C., & Eaton, L. A. (2017). *Understanding the influence of stigma and medical mistrust on engagement in routine healthcare among black women Who have sex with women*. *LGTB*, 4(1). doi:10.1089/lgbt.2016.0083
- Burks, D. J., Robbins, R., & Durtschi, J. P. (2011). American Indian gay, bisexual, and two-spirit men: A rapid assessment of HIV/AIDS risk factors, barriers to prevention, and culturally sensitive intervention. *Culture, Health & Sexuality*, 13(3), 283–298.
- California Health Advocates. (2007). *Are you practicing cultural humility? The key to success in cultural competence*. Retrieved from <http://www.cahealthadvocates.org/news/disparities/2007/are-you.html>
- Campinha-Bacote, J. (2003). Many faces: Addressing diversity in health care. *Online Journal of Issues in Nursing*, 8. Retrieved from <http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume82003/No1Jan2003/AddressingDiversityinHealthCare.aspx>
- Census Bureau. (2011). *Overview of race and Hispanic origin: 2010*. Retrieved from <http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf>
- Corazzini, K. N., Lekan-Rutledge, D., Utley-Smith, Q., Piven, M. L., Colon-Emeric, C. S., Bailey, D., . . . Anderson, R. A. (2006, November 15). *The golden rule: Only a starting point for quality care*. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1636677>
- Davey, M. P., Waite, R., Nuñez, A., Niño, A., & Kissil, K. (2014). A snapshot of patients' perceptions of oncology providers' cultural competence. *Journal of Cancer Education*, 29(4), 657–664.
- Dayer-Berenson, L. (2014). *Cultural competencies for nurses: Impact on health and illness* (2nd ed.). Burlington, MA: Jones & Bartlett.
- Dodge, B., Schnarvs, P. W., Gonclaves, G., Majebranche, D., Martinez, O., Reece, M., & Fortenberry, J. D. (2012, June 1). The significance of privacy and trust in providing health-related services to behaviorally bisexual men in the United States. *AIDS Education and Prevention*, 24, 242–256.
- Doorenbos, A. Z., Schim, S. M., Benkert, R., & Borse, N. N. (2005). Psychometric evaluation of the cultural competence assessment instrument among healthcare providers. *Nursing Research*, 54(5), 324–331.
- Erwin, D. O., Trevino, M., Saag-Harfouche, S. G., Rodriguez, E. M., Gage, E., & Jandorf, L. (2010). Contextualizing diversity and culture within cancer control interventions for Latinas: Changing interventions, not cultures. *Social Science & Medicine*, 71, 693–701. Retrieved from <http://ac.elsa-cdn.com.silk.library.umass.edu>
- Giger, J. N. (2017). *Transcultural nursing: Assessment and intervention* (7th ed.). Retrieved from <https://pageburstls.elsevier.com/#/books/9780323399920/>
- Giger, J., Davidhizar, R., Purnell, L., Harden, J., Phillips, J., & Strickland, O. (2007). American Academy of Nursing Expert Panel Report: Developing cultural competence to eliminate health disparities in ethnic minorities and other vulnerable populations. *Journal of Transcultural Nursing*, 18(2), 95–102.
- Goldbach, J. T., Thompson, S. J., & Hollaren Steiker, L. K. (2011). Special considerations for substance abuse intervention with Latino youth. *Prevention Researcher*, 18(2), 8–11.
- Green, S. S., Comer, L., Elliott, L., & Neubrander, J. (2011). Exploring the value of an international service-learning experience in Honduras. *Nursing Education Perspectives*, 12, 302–307.

- Ingram, M., Piper, R., Kunz, S., Navarro, C., Sander, A., & Gastelum, S. (2012). Salud sí: A case study for the use of participatory evaluation in creating effective and sustainable community-based health promotion. *Family & Community Health, 35*, 130–138. doi:10.1097/FCH.0b013e31824650ed
- Institute of Medicine (IOM). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academy Press. Retrieved from http://www.nap.edu/openbook.php?record_id=12875&page=200
- Issel, L. M. (2009). *Health program planning and evaluation* (2nd ed.). Sudbury, MA: Jones and Bartlett.
- Johns, A., & Thompson, C. W. (2010). Developing cultural sensitivity through study abroad. *Home Health Care Management Practice, 22*, 344–348. doi:10.1177/1084822309353153
- Jones, E. D., Ivanov, L. L., Wallace, D., & VonCannon, L. (2010, August). Global service learning project influences culturally sensitive care. *Home Health Care Management Practice, 22*, 464–469. doi:10.1177/1084822310368657
- Kagan, P. N. (2008). Feeling listened to: A lived experience of human becoming. *Nursing Science Quarterly, 21*(1), 59–67. doi:10.1177/0894318407310779
- Kridli, S. (2011). Health beliefs and practices of Muslim women during Ramadan. *MCN, the American Journal of Maternal Child Nursing, 36*, 216–221. doi:10.1097/NMC.0b013e3182177177
- Larson, K. L., Ott, M., & Miles, J. M. (2010). International cultural immersion en vivo reflections in cultural competence. *Journal of Cultural Diversity, 2*, 44–50.
- LaVeist, T., Gaskin, D., & Richard, P. (2009). *The economic burden of health inequalities in the United States*. Washington, DC: Joint Center for Political and Economic Studies. Retrieved from http://www.jointcenter.org/hpi/sites/all/files/Burden_Of_Health_FINAL_0.pdf
- Lee, Y., & Lin, J. L. (2011). How much does trust really matter? A study of the longitudinal effects of trust and decision-making preferences on diabetic patient outcomes. *Patient Education and Counseling, 85*, 406–412. doi:10.1016/j.pec.2010.12.005
- Levin, S. J., Like, R. C., & Gottlieb, J. E. (2000). Appendix: Useful clinical interviewing mnemonics. *Patient Care: The Practical Journal for Primary Care Physicians*. Special Issue: Caring for Diverse Populations: Breaking Down Barriers, 34(9), 189.
- Luluquisen, M., Schaff, K., & Galvez, S. (n.d.). Alameda County Public Health Department Community Assessment Planning & Education Unit. Cultural competence and cultural humility [PowerPoint presentation]. Retrieved from http://www.acphd.org/media/133120/modii_slides_cultural_competency.pdf
- Matteliano, M. A., & Street, D. (2012). Nurse practitioners' contributions to cultural competence in primary care settings. *Journal of American Academy of Nurse Practitioners, 24*, 425–435.
- McFarlane, M. M., & Eipperle, M. K. (2008). Culture care theory: A proposed practice theory guide for nurse practitioners in primary care settings. *Contemporary Nurse, 28*(1/2), 46–63.
- Meade, C. D., Meanard, J., Therival, C., & Riveria, M. (2009). Addressing cancer disparities through community engagement: Improving breast health among Haitian women. *Oncology Nursing Forum, 36*, 716–723. doi:10.1188/09.ONF.716-722
- Nova Scotia Department of Health. (2005). *A cultural competence guide for primary health care professionals in Nova Scotia*. Halifax, Nova Scotia: Author.
- Office of Disease Prevention and Health Promotion. (2010). *Healthy People 2020*. Retrieved from <http://healthypeople.gov/2020/about/DisparitiesAbout.aspx>
- Office of Minority Health (OMH). (2011a). *About OMH*. Retrieved from <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=1&lvlID=7>
- Office of Minority Health (OMH). (2011b). *What is cultural competency?* Retrieved from <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11>
- Office of Minority Health (OMH). (n.d.). *National CLAS standards*. Retrieved from https://www.thinkculturalhealth.hhs.gov/Content/clas.asp#clas_standards
- Office of Minority Health (OMH). (n.d.). *A physician's practical guide to culturally competent care*. Retrieved from <https://cccm.thinkculturalhealth.hhs.gov>
- Ott, B. B., & Olson, R. M. (2011). Ethical issues of medical missions: The clinicians' view. *HEC Forum, 23*(2), 105–113. doi:10.1007/s10730-011-9154-9
- Riner, M. E. (2011). Globally engaged nursing education: An academic program framework. *Nursing Outlook, 59*, 308–317. doi:10.1016/j.outlook.2011.04.005

- Saha, S., Korhuis, P. T., Cohn, J. A., Sharp, V. L., Moore, R. D., & Beach, M. C. (2013). Primary care provider cultural competence and racial disparities in HIV care and outcomes. *JGIM: Journal of General Internal Medicine*, 28(5), 622–629.
- Schim, S. M., Doorenbos, A., Benkert, R., & Miller, J. (2007). Culturally congruent care: Putting the puzzle together. *Journal of Transcultural Nursing*, 18, 103–110. doi:10.1177/1043659606298613
- Schim, S. M., Doorenbos, A. Z., Miller, J., & Benkert, R. (2003). Development of a cultural competence assessment instrument. *Journal of Nursing Measurement*, 11(3), 29–40.
- Sequist, T. D., Fitzmaurice, G. M., Marshall, R., Shaykevich, S., Marston, A., Safran, D. G., & Ayanlan, J. Z. (2010). Cultural competency training and performance reports to improve diabetes care for black patients. *Annals of Internal Medicine*, 152(4), 40–46. Retrieved from <http://web.ebscohost.com.silk.library.umass.edu/ehost/pdf>
- Shipley, S. D. (2010). Listening: A concept analysis. *Nursing Forum*, 45(2), 125–134.
- Sitzman, K., & Eichelberger, L. W. (Eds.). (2004). *Understanding the work of nurse theorists*. Sudbury, MA: Jones and Bartlett.
- Stanglin, K. D. (2005). The historical connection between the Golden Rule and the second greatest love command. *Journal of Religious Ethics*, 33(2), 357–371.
- Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, 9(2), 117–125.
- Thomas, V. J., & Cohn, T. (2006). Communication skills and cultural awareness courses for healthcare professionals who care for patients with sickle cell disease. *Issues and Innovations in Nursing Education*, 53, 480–488.
- Tomey, A. M., & Alligood, M. R. (2002). *Nursing theorists and their work* (5th ed.). St Louis, MO: Mosby.
- Wong, V. C. (2009). Use of complementary and alternative medicine (CAM) in autism spectrum disorder (ASD): Comparison of Chinese and Western culture. *Journal of Autism & Developmental Disorders*, 39(3), 454–463. doi:10.1007/s10803-008-0644-9

