UNIT 1

Overview of Cultural Foundations, Cultural Competency, and Transcultural Nursing/ Health Care

This textbook is intended to be a resource for practicing nurses, and for all types of nursing students (diploma, Associate's degree [AA], Bachelor of Science in Nursing [BSN], Master of Science in Nursing [MSN] and Doctor of Nursing Practice [DNP]) on cultural competency and its impact on health and illness. There has been an explosion in the allied health and nursing literature on cultural competency in the last few years, and a textbook of this kind is necessary to help the nurse, at all levels, navigate through the obstacles that culture can place on the patient experience. The textbook will provide a "one-stop shop" so the nurse can find the history and theory behind cultural competency in nursing as well as a resource for "pearls" regarding health beliefs and the impact of culture on health and illness.

This textbook is intended to serve as a resource and reference to be used by all nurses when they need to learn more about cultural competency and the health/illness beliefs of patients. Although providing information is an extremely important consideration, ideally, education is not just about information—it is also about knowledge. In order for information to become knowledge, it requires added context and interactivity. It is the intent that this textbook will transcend just being

an information source to provide a framework and structure that permits the acquisition of knowledge by the reader. It is for this reason that this textbook will have the following pedagogic features: at the beginning of each chapter, objectives will be provided; inside each chapter that describes a particular racial/ethnic or cultural group there will be case studies that reinforce and highlight the essential facts regarding each group; key terms will be noted and definitions provided at the beginning of some chapters; pertinent research studies will be highlighted (this will be done for important or landmark research studies or findings); in addition, review questions of the key concepts will be provided at the end of each chapter. Unit One will provide the cultural foundation, with an overview of the important models of cultural competence included. The history and development of the transcultural nursing movement will be described. Unit One is entitled, "Overview of Cultural Foundations, Cultural Competency, and Transcultural Nursing/Health Care" and will consist of four chapters. The outline for each of the four chapters is as follows:

Chapter 1—Birth of Transcultural Nursing to Current Theories and Conceptual Models for Cultural Diversity

Theory of Culture Care Diversity and Universality (Sunrise Model) (Dr. Madeline Leininger—founder of the field of transcultural Nursing in the mid-1960s); Dr. Leininger's Sunrise Model was developed to help nurses manage when caring for diverse groups of patients in response to changing demographics in the United States, and due to the fact that the leadership in healthcare delivery in the United States led many people from other countries come to America for medical care. As a result, US nurses are often called upon to assess clinically, in a short period of time, individuals who, in many cases, are very different culturally, racially, and ethnically from themselves. *Culture Care Diversity and Universality* has been studied, praised, and criticized since it was first published in 1970.

Giger and Davidhizar's Transcultural Assessment Model (2008, 1988)

Purnell Model for Cultural Competence (2013, 1998)

Chapter 2—Culture

Appropriate terms defined: culture, ethnicity, acculturation, assimilation, health, health belief model, illness, sick role, healing, ethnocentrism, cultural diversity, cultural awareness, cultural sensitivity, cultural competency, stereotyping, generalizations

Chapter 3—Global Diversity

Multicultural populations

Census data

Cultural groupings/health disparities

Chapter 4—Organization of Healthcare Delivery in the 21st Century

Interdisciplinary healthcare delivery

Standards of Care: Institute of Medicine reports on unequal treatment

National Standards for Culturally and Linguistically Appropriate Services in Health Care, The Joint Commission

Shift from medical model (Western medicine) to health belief model

Barriers (communication issues, lack of access to preventive care, history of discrimination and abuse in some cultures, distrust of healthcare providers, noncompliance and/or refusal to enter the healthcare system at all).

Impact on Provision of Primary Care by nurse practitioners—The integration of cultural competency into primary care practice has been clarified in the National Organization of Nurse Practitioner Faculties document on cultural competency. It states that the nurse practitioner demonstrates cultural competence when she/he shows respect for the inherent dignity of every human being, whatever their age, gender, religion, socioeconomic class, sexual orientation, and ethnic or cultural group; accepts the rights of individuals to choose their care provider, participate in care, and refuse care; acknowledges personal biases and prevents these from interfering with the delivery of quality care to persons of other cultures; recognizes cultural issues and interacts with clients from other cultures in culturally sensitive ways and incorporates cultural preferences, health beliefs, and behaviors and traditional practices into the management plan; develops client-appropriate educational materials that address the language and cultural beliefs of the client and accesses culturally appropriate resources to deliver care to clients from other cultures; and assists clients to access quality care within a dominant culture.

Certification opportunities—Cultural Competence Certification for Clinicians is offered by the Center for Professional Development at the School of Nursing, University of Pennsylvania.

Unit Two will consist of chapters for different ethnic groups with an emphasis of the impact of health and illness on each group.

I do realize that it would be unreasonable to expect that any single textbook could satisfy all of the needs of a student/learner and that the same needs exist in all students/learners. This would dispute the importance of individuality which lies at the heart of the cultural competency movement. While writing this textbook, an attempt was made to consider the many different reasons, aims, and needs a student/learner has that led them on the journey of acquiring knowledge about cultural competency while also recognizing that different people with the same learning goal have different needs in this learning process. Each of us has individual learning styles, habits, abilities, and life and work circumstances. As a framing reference, this textbook will attempt to introduce cultural competency as a theoretical foundation; to explain the *why* and *how* when caring for patients from cultures that differ from our own; to teach the nurse how to use, implement, and utilize this new knowledge; to verify that this new knowledge has been acquired; and finally, to assist the nurse with the everyday application of this newly gained knowledge. To provide safe and effective nursing care in the 21st century, the nurse must not only have knowledge about our diverse society and the science of nursing, but also focus on the art of nursing care. This requires a global focus from the nurse, given the extensive cultural diversity that exists in the United States.

UNIT ONE OBJECTIVES

1. Differentiate among the various theories of cultural competency to select the model that will best support your nursing care delivery in the 21st century.
2. Know the history of the transcultural nursing movement from its birth (Dr. Madeline Leininger) to its present.
3. Distinguish among various ethnic/cultural groups as well as the primary and secondary characteristics of culture.
4. Describe the impact of global diversity on healthcare delivery in the United States.
5. Develop proficiency in cultural concepts and race categories and provide definitions for essential terminology.
6. Commit to providing culturally competent care to all patients.

Unit One provides the nurse with the theoretical foundation of the cultural competency movement. Various important cultural competency theories are

described as well as the impact of diversity on cross-cultural exchanges and the impact that the Western biomedical model has on healthcare delivery in the United States. The Western Biomedical Model—with its emphasis on patient autonomy—often is in conflict with the health beliefs of many different racial and ethnic groups who enter the healthcare system and who require nursing care. In order to provide culturally aware nursing care, the nurse must not only understand where he/she comes from but also needs at a minimum a basic working understanding of the cultures of the patients for whom he or she delivers nursing care. This requires the nurse to be able to answer two questions: what is my culture, and what do I know/understand about my patient's culture? The overriding goal is for the nurse to develop a respect for cultural differences that will allow the nurse to demonstrate a genuine appreciation of different cultural values and views wherever they are encountered. Often, what we do not understand is viewed negatively. Cultural assessment is integral to understanding the meaning of patient behaviors so this does not occur. Nurses need to consider that each patient experience is likely to vary in many ways beyond just its medical presentation. The nurse needs to ask questions to determine the likely response, so that the appropriate interventions can be offered. For example, the nurse needs to consider if this is a patient who would respond positively to touch. Also, how should physical assessment be adjusted to provide for modesty, or to determine oxygen status of the tissues in a dark-skinned patient? The questions are many, but the answers are more likely to be determined when the nurse possesses a foundation of cultural awareness and has demonstrated a willingness to learn about, recognize, and most importantly, appreciate the individual differences of each and every patient in our care.

Unit Two provides cultural information on selected population groups in detail, with a focus on traditional health and illness beliefs, so that the nurse can determine if these beliefs are impacting the current healthcare issues. It is not possible to fully define or describe a cultural group, but the information provided can serve as a foundation to inform and sensitize the nurse as to the needs and beliefs of various cultural groups. The material is presented in a sensitive manner and is not intended to be viewed as stereotypical but to serve as a starting point for the nurse to seek clarification from the patient so that individual variation can be taken into account, and truly individualized patient care can be provided.

The journey begins by knowing ourselves and accepting our values; we possess the framework to accept the existence of values that differ from our own. This realization, and ultimately the acceptance of these differing values and needs, will permit the nurse to work collaboratively with patients in the provision of safe professional nursing care.

The book will also provide tips for effective cross-cultural communication as well as specific information to increase the chance that a cross-cultural patient encounter will be viewed as successful by both the patient and the nurse. Strategies on how to effectively use interpreters for communicating with patients with limited or no English speaking ability, and for integrating every patient's cultural beliefs and traditional health practices (whenever possible, considering safety) into the treatment plan will also be included.

DISCLAIMER

Membership in a particular culture does not mean that the person will necessarily reflect all of the customs, traditions, and beliefs that are associated with the culture. There are many other variables that impact all of us and contribute to who we are as people. These factors, including our place of birth, family background, socioeconomic status, educational level, urban versus rural geography, and level of acculturation attained, will also impact the degree to which we subscribe to the health and illness beliefs associated with that culture and our approach and preferences for health care. The material provided is meant as a guide; it is not a rule book. It provides information that the nurse can refer to and consider when providing individualized patient care and evaluating its response. The labels used in the book to classify or categorize various cultural groups are broad; it is important to remember that each group is comprised of different cultures, nationalities, histories, and heritages, and that the nurse must remember that individuals are unique and not all of the material will be pertinent to every person. Every effort was made to be as culturally sensitive in writing this book, but I do recognize that the information (based on an extensive review of the literature) may be interpreted differently from my intent, and offense may be taken by readers who are members of the cultural groups described in this book. Please know that the intent was to present factual information that is evidence-based, and stems from a true desire to improve nursing care delivery in the 21st century to be the best that it can be. Our patients do better when their needs are met and beliefs are understood.

Knowing about our patients' cultures and individual beliefs is as important as knowing about their physical problems, functional limitations, and response to illness in providing safe, competent, and comprehensive nursing care. Given the increasing diversity of patients and nurses, as well as other members of the healthcare team, cultural competence is an absolute necessity. It is hoped that this book will assist the nurse and nurse practitioner to provide the best nursing care possible and to confidently practice when in a cross-cultural patient encounter.

CHAPTER 1

Birth of Transcultural Nursing to Current Theories and Conceptual Models for Cultural Diversity

CHAPTER OBJECTIVES

Upon completion of this chapter, the nurse will be able to:

- Provide working definitions for transcultural nursing, cultural competence, and diversity.
- Identify various areas of diversity that the nurse should assess for and be aware of in order to provide culturally appropriate care.
- Describe three nursing theories that promote the delivery of competent nursing care to culturally diverse patients.
- Select a theoretical model of cultural competency that is complementary to the reader's nursing philosophy of patient care.

KEY TERMS

Cultural competency

Diversity

Giger and Davidhizar's Transcultural Assessment Model

Leininger's Culture Care, Diversity, and Universality Theory

Purnell Model for Cultural Competence

INTRODUCTION

Whether a nursing student in the clinical setting, a seasoned nurse, or nurse practitioner, you observe diversity within your patient population on a daily basis. Our patients come from many different races and ethnic groups, which means they often do not look, feel, or respond like we do. These differences result in a cultural mismatch. Helping you to develop a plan for proceeding in the face of a cultural mismatch is the guiding force behind this textbook. The Office of Minority Health in 2001 published recommendations for 14 national standards for culturally and linguistically appropriate services in health care to provide the knowledge necessary for nurses to work respectfully and effectively with patients and each other in a culturally diverse work environment. These standards are called CLAS for short and were revised in 2012. CLAS will be described and discussed in more detail in Chapter 4 of this book.

How have we come to this point where the federal government has provided mandates, guidelines, and recommendations? It would appear that all members of the healthcare team need to do a better job. The CLAS standards were developed with input from national leaders (including the American Nurses Association [ANA]) and are based on an analysis of current standards in use that are deemed essential and appropriate.

The members of the expert panel on cultural competence of the American Academy of Nursing (AAN) have developed recommendations (**Box 1–1**) to ensure that measurable outcomes be achieved to reduce or eliminate health disparities commonly found among racial, ethnic, uninsured, underserved, and/or underrepresented populations residing throughout the United States.

Achieving cultural competence suggests possession of the ability to respond effectively to the cultural needs of our patients. This view would be too narrow, however. We must recognize that diversity exists among patients but also within the members of the healthcare team (nurses, physicians, and other allied health professionals). As we continue to struggle with a nursing shortage, one ongoing

Box 1–1 Twelve Recommendations of the Expert Panel on Cultural Competence of the American Academy of Nursing

1. The AAN, through its publications, mission statements, and yearly conferences, must make an explicit commitment to quality, culturally competent care that is equitable and accessible by targeting four groups: healthcare customers, healthcare providers, healthcare systems, and communities.
2. The AAN will collaborate with other organizations and communities in developing guidelines.
3. The AAN shall develop mechanisms to synthesize existing theoretical and research knowledge concerning nursing care of ethnic/minorities and other vulnerable populations.
4. The AAN, through its expert panels and commissions, must create an interdisciplinary knowledge base that reflects healthcare practices within various cultural groups, along with human communication strategies that transcend interdisciplinary boundaries to provide a foundation for education, research, and action.
5. The AAN, through its expert panels and commissions, must identify, describe, and examine methods, theories, and frameworks appropriate for utilization in the development of knowledge related to health care of minority, stigmatized, and vulnerable populations.
6. The AAN shall seek resources to develop and sponsor studies to describe and identify principles used by organization magnets that provide an environment that enhances knowledge development related to cross-cultural, ethnic minority/stigmatized populations, and attract and retain minority and other vulnerable students, faculty, and clinicians.
7. The AAN, through its various structures, must identify healthcare system delivery models that are the most effective in the delivery of culturally competent care to vulnerable populations and develop mechanisms to promote the necessary changes in the United States healthcare delivery system toward the identified models.
8. The AAN must collaborate with other organizations in establishing ways to teach and guide faculty and nursing students to provide culturally competent nursing care practices to clients in diverse clinical settings in local, regional, national, and international settings.
9. The AAN must collaborate with racial/ethnic nursing organizations to develop models of recruitment, education, and retention of nurses from racial/ethnic minority groups.
10. The AAN will collaborate with other organizations in promoting the development of a document to support the regulation of content reflecting diversity in nursing curricula. In addressing regulations, specific attention needs to be given to the National Council Licensure Examinations, continuing education, and undergraduate curricula.
11. The AAN must take the lead in promulgating support of research funding for investigation with emphasis on interventions aimed at eliminating health disparities in culturally and racially diverse groups and other vulnerable

(*Continues*)

Box 1–1 *Continued*

populations in an effort to improve health outcomes. The AAN must take a more proactive stance to encourage policy makers to create policies that address the elimination of health disparities and ultimately improve health outcomes.

12. The AAN must encourage funding agencies' requests to solicit proposals focusing on culturally competent interventions designed to eliminate health disparities.

Source: Giger, J., Davidhizar, R. E., Purnell, L., Harden, J. T., 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.

solution has been for large numbers of immigrant nurses to enter and work within the American healthcare system. Not only will the immigrant nurses have the challenge of adapting to our healthcare delivery system, but often their ethnocultural background may be different than that of the dominant culture and of the patients to whom they are to deliver nursing care. Since the 1960s, the Philippines has been the number one source of foreign-trained nurses in the United States; this trend is continuing in the 21st century (Marquand, 2006). Cultural differences will not only impact the nursing care that is provided, but it also may negatively affect the ability of the immigrant nurse to assimilate effectively as an essential member of the healthcare team. The growing diversity that has been seen and that continues to widen in the U.S. population has not been seen within the population of healthcare professionals. This lack of parallel growth in diversity among healthcare professionals impacts healthcare delivery and suggests that many patients are receiving culturally discordant care. Culturally discordant care arises from unaddressed cultural differences between healthcare providers and patients. Research has shown that significant disparities exist in health status, treatment, and medical outcomes between groups of patients who differ on the basis of gender, race, or ethnicity. A provider's unconscious bias about a particular race, ethnicity, or culture, or his or her lack of effective cross-cultural communication skills, may contribute to discordant medical care and health disparities. This suggests that all healthcare providers should know how to interact effectively with and provide care for patients whose ethnic or cultural background differs from their own, and highlights the need for this text.

The population growth in the United States between 2000 and 2012 was almost entirely minority driven with more than one in three U.S. residents being a

member of a minority group (U.S. Census Bureau, 2012). According to the most recent census, our country continues toward diversity, as demonstrated by significant increases in the numbers and proportion of populations such as Hispanics, Asians, and Pacific Islanders (U.S. Census Bureau, 2012). Data from the 2010 census released in 2011 reveals the Caucasian population (White or European American) of the United States is 223.5 million (72.4% of total population), 38.0 million Blacks (12.6% of total population), 14.6 million Asians (4.8%), and 50.5 million Latinos (16.4% of total population) (U.S. Census Bureau, 2010).

BICULTURAL/MULTICULTURAL

Another important consideration is that in contemporary U.S. society many individuals are bicultural (McGrath, 1998). Membership in more than one culture, being bicultural, is not the same as being biracial or multiracial. A bicultural person identifies with core elements of their culture of origin as well as those of the dominant culture. They self-identify with more than one cultural group, and the bicultural person sees both sides and can function in both worlds. The degree of biculturalism and acculturation that has occurred can influence intergenerational differences in health beliefs and behaviors for certain U.S. ethnic groups (English & Le, 1999). Bicultural individuals successfully integrate into and participate in important aspects of the values and belief systems of both cultures.

In today's increasingly diverse and mobile world, growing numbers of individuals have internalized more than one culture and can be described as bicultural or multicultural. In fact, 12.5% of U.S. residents are immigrants and have presumably internalized more than one culture (Battalova & Terrazas, 2010). We must also consider that U.S. born ethnic and cultural minorities (descendants of immigrants) identify with their ethnic culture and the mainstream culture of the United States. It is a process for the bicultural or multicultural person to navigate between these different cultural identities.

Biculturalism can be associated with feelings of pride, uniqueness, and a rich sense of community and history, while also bringing to mind identity confusion, dual expectations, and value clashes (Benet-Martínez & Haritatos, 2005).

ACCULTURATION

Acculturating immigrants and ethnic minorities have to deal with two central issues. The first issue is the extent to which they are motivated or permitted to

retain their identification with their culture of origin (their ethnic culture), and the second is the extent to which they are motivated or are permitted to identify with the dominant mainstream American culture. The dominant mainstream American culture is usually defined as having a Northern European cultural tradition while utilizing the English language. As the immigrant wrestles and negotiates with this, he or she can end up in one of four identified acculturation positions. According to Berry (1990), the four distinct acculturation positions are assimilation (identification mostly with the dominant culture), integration (high identification with both cultures), separation (identification largely with the ethnic culture), or marginalization (low identification with both cultures). Acculturation is not a linear process—one does not move forward in a direct line from one position to the next. This is why individuals can simultaneously hold two or even more cultural orientations. People who are bicultural can move easily between their two cultural identities by engaging in cultural frame switching (Hong, Morris, Chiu, & Benet-Martínez, 2000). Cultural frame switching occurs in response to cultural cues. The important point is the individual response. There will be individual variation in the way the bicultural identity is negotiated and organized. Some bicultural individuals will find both cultural identities are compatible, integrated, and easy to negotiate. Others may struggle if they find the two cultures are oppositional or difficult to integrate or negotiate. Various terms for the acculturation process of biculturals have been developed by different theorists. Some examples of these terms are "fusion" (Chuang, 1999), "blendedness" (Padilla, 1994), and "alternating biculturalism" (Phinney & Devich-Navarro, 1997).

OTHER AREAS OF DIVERSITY

Although racial diversity is becoming more known, it is not the only potential area of diversity encountered by healthcare providers. Diversity can be categorized as dimensions of human diversity, dimensions of cultural diversity, or systems diversity dimensions. Examples of human diversity are race, gender, physical ability, marital status, family status, ethnicity, and age. A person's dimensions of cultural diversity are characterized by their beliefs, attitudes, values, personal characteristics, lifestyle, communication, and religion. There are also systems diversity dimensions, such as teamwork, empowerment, education, and strategic alliances (Guillory, 2001).

Healthcare providers increasingly **have to** care for and communicate with patients of varying backgrounds, preferences, and cultures. Diversity may even

have an impact on treatment response. Some researchers suggest that there may be subtle differences in the way that members of different racial and ethnic groups respond to treatment, particularly with regard to some pharmaceutical interventions, suggesting that variations in some forms of treatment may be justified on the basis of patient race or ethnicity. Diversity may also impact rejection of treatment recommendations by patients. As an example, it was cited in the Institute of Medicine report (IOM, 2003) that a number of studies concluded that Black Americans are slightly more likely to reject medical recommendations for some treatments, but these differences in refusal rates are generally small (Black Americans are only 3 to 6% more likely to reject recommended treatments, according to these studies). The IOM report recommends that more research is needed to fully understand the reasons for the refusal of treatment, as this may lead to the development of different strategies to help patients make informed treatment decisions. The IOM report hypothesizes that stereotypes, bias, and clinical uncertainty may influence clinicians' diagnostic and treatment decisions; education may be one of the most important tools as part of an overall strategy to eliminate healthcare disparities. Clearly, there is much to consider, and we have much more that we need to learn.

OVERVIEW OF CONCEPTUAL MODELS FOR CULTURAL DIVERSITY

For more than five decades, nurses have recognized cultural diversity as an important variable and have attempted to provide culturally specific and appropriate care to a population that is continuing to become even more racially and ethnically diverse. This desire to provide appropriate care was based on the knowledge that people belonging to different cultures have different kinds of demands and needs in terms of health and illness. People having different cultural values should be respected, and the health care offered and provided should be inclusive of the patient's cultural values whenever possible. Transcultural nursing models provide the nurse with the foundation to become knowledgeable about the various cultures seen in their practice setting. Nurse scholars continue to develop and refine a vast number of cultural theories, models, and assessment guides that are used internationally. Dr. Madeline Leininger has provided the basic foundation for cultural competency in nursing practice. Today, arguably the most well-known and commonly used nursing cultural competency models are by Leininger (1991), Purnell (Purnell, 2013; Purnell & Paulanka, 1998) and Giger and Davidhizar (Giger, 2013; Giger et al., 2007). After the passing of Ruth

Davidhizar, Joyce Giger published the 6th edition of the textbook, *Transcultural Nursing: Assessment and Intervention* in 2013 (Giger, 2013). Each of these theories/models will be discussed in greater detail in this chapter because it is essential for the nurse to utilize the knowledge gained from these models to deliver culturally appropriate care. In today's diverse world, our nursing care must be grounded in the knowledge and science of transcultural nursing. Through these theories, nursing has made an important contribution to the provision of all health care by all types of practitioners.

Because of our global relationships and the leadership in the area of healthcare delivery in the United States, many people from other countries come to America for medical care. As a result, U.S. nurses are often called upon to assess clinically, in a short period of time, individuals who, in many cases, are very different culturally, racially, and ethnically from themselves. An area of formal study and practice developed in response to this fact; the knowledge and understanding of different cultures is called transcultural nursing (Leininger, 1995). Transcultural nursing is a learned branch of nursing that focuses on the comparative study and analysis of cultures as they apply to nursing and health/illness practices, beliefs, and values. Transcultural nursing was developed in the mid-1960s by Madeline Leininger, a nurse anthropologist. In the 1960s, the field received financial support for nurses who wished to obtain doctoral degrees and become nurse anthropologists. These nursing pioneers were convinced that an understanding of cultural diversity relative to health and illness was an essential component of nursing knowledge. The essential foundation of transcultural nursing is that cultures exhibit both diversity and universality.

The first course in transcultural nursing was offered by Dr. Leininger in 1966 at the University of Colorado (one year after she earned her PhD in anthropology from the University of Seattle). Dr. Leininger stated that transcultural nursing developed in response to nurses having increased exposure to diverse groups of patients. This increase was because of the changing demographics in the United States as well as the leadership of the United States in healthcare delivery, resulting in many people from other countries coming to America for medical care. Dr. Leininger and other transcultural nursing scholars refer to care as a universal phenomenon that transcends cultural boundaries. Because we provide direct patient care, it is critical for nurses to understand how to work effectively within a diverse cultural atmosphere.

Transcultural nursing, as defined by Leininger (1984), is a humanistic and scientific area of formal study and practice in nursing that is focused on the comparative study of cultures. Focusing on differences and similarities in care, health,

and illness patterns based on cultural values, beliefs, and practices of different cultures in the world, transcultural nursing uses knowledge to provide culturally specific and universal nursing care to people. The goal of transcultural nursing is to provide care that is congruent with cultural values, beliefs, and practices—culturally specific care (Leininger, 1984). Today, transcultural nursing concepts are found in the curricula for nursing programs in the United States and Canada. This theory has provided the basic foundation for transcultural nursing practice.

The Transcultural Nursing Society was founded in 1974. It publishes a monthly journal (*The Journal of Transcultural Nursing*) and provides a certification process for transcultural nursing for nurses in the United States and Canada.

Although the importance of the work done by Dr. Leininger cannot be denied, there have been some problems identified in her transcultural nursing framework by nurse scholars. The major flaw, according to Tripp-Reimer and Fox (1990), is that it was based on the anthropological theory of functionalism. Dr. Leininger did, after all, receive her doctorate in anthropology. Functionalism in anthropology stresses understanding culture by emphasizing specific customs, folkways, and patterns such as diet preferences, religious practices, communication styles, and health beliefs and practices (Tripp-Reimer & Fox, 1990). Critics (Brink, 1990; Browning & Woods, 1993; Sprott, 1993; Tripp-Reimer & Fox, 1990) feel that this "narrow view" of people results in stereotyping. This is by no means a small concern. The fear of stereotyping is often cited as the major criticism of the cultural competency movement. It is important that this process of identifying the characteristics that may be associated with certain cultural groups be done with an extremely open mind, and for the nurse to realize that, just like in anything, exceptions can be found. It is important that we do not proceed with blinders on as the nurse must continually assess for affirmation or for exceptions.

Although the concern about stereotyping is an important one, there are other nurse scholars who argue that a reliance on generalizations about race, ethnicity, and culture are necessary to expand a nurse's knowledge about a particular patient population (Giger, 2013; McGoldrick, 1993; Valente, 1989). Looking at the situation from both sides, it is clear that it is important for the nurse to be cautious and to use these generalizations as a flexible guide that permits individualization of patient care at all times. We must strive to avoid stereotyping and oversimplification of the impact of culture (Betancourt, 2003) and the nurse must attempt to possess cultural humility, openness, and inquisitiveness toward each individual patient (Tervalon & Murray-Garcia, 1998).

In the 21st century, with the emergence of evidence-based medicine (EBM), a new challenge of integration with cultural competence has risen. There is some

concern in the literature that cultural competence and evidence-based medicine can be contradictory goals. This is because the overriding goal of EBM is to provide quality health care through standardization of care, not individualized care. The overriding goal of cultural competence is the delivery of individualized health care that acknowledges and understands cultural diversity, with respect for individual health beliefs, values, and behaviors. Combining these approaches can result in optimal patient-centered care. Future research needs to focus on determining the best way to integrate EBM and cultural competence to ensure demonstrably improved patient outcomes. Nurses need to assess for a patient's explanatory model of the patient's health status (how they understand their illness) to avoid stereotyping and oversimplification of the impact of culture.

All of nursing's largest professional organizations—the ANA in 1991, the National League for Nursing in 1993, and the American Association of Colleges of Nursing in 1998—have cited the need for nurses to practice cultural competence.

The ANA established the American Academy of Nursing in 1973. Its purpose is to advance health policy and practice and it is often referred to as the think tank of nursing. The AAN has a number of expert panels including the Expert Panel on Cultural Competence. From 1991 to 1992, the Expert Panel on Cultural Competence proposed 10 recommendations in an attempt to address health disparities. This panel developed its most recent position paper in 2007 to help serve as a catalyst for substantive nursing action to promote outcomes that reduce or eliminate health disparities commonly found among racial, ethnic, uninsured, underserved, and underrepresented populations residing throughout the United States (Giger et al., 2007). Membership on any of the expert panels within the AAN are by invitation only to fellows of the AAN. Fellowship in the AAN is considered one of the highest honors a nurse can achieve. The members consist of major nursing theorists and scholars.

The Expert Panel on Cultural Competence developed a comprehensive list of 12 recommendations (Box 1–1) that can serve as a starting point for all health professionals who seek to address the problem of health disparities in the United States through cultural competency with the hope that measurable outcomes be achieved to reduce or eliminate health disparities commonly found among the minority and vulnerable populations in the United States (Giger et al., 2007).

Based on the work of the Expert Panel on Cultural Competence, a set of universally applicable standards of practice for culturally competent care were developed that nurses can use when providing care. The 12 standards were developed based on the social justice framework, which is the belief that each and every person

is entitled to fair and equal rights and participation in healthcare opportunities (Douglas et al., 2009). The standards (**Box 1–2**) were collaboratively developed

Box 1–2 Standards of Practice for Culturally Competent Nursing Care

Standard	Description
1. Social Justice	Professional nurses shall promote social justice for all. The applied principles of social justice guide nurses' decisions related to the patient, family, community, and other healthcare professionals. Nurses will develop leadership skills to advocate for socially just policies.
2. Critical Reflection	Nurses shall engage in critical reflection of their own values, beliefs, and cultural heritage in order to have an awareness of how these qualities and issues can impact culturally congruent nursing care.
3. Transcultural Nursing Knowledge	Nurses shall gain an understanding of the perspectives, traditions, values, practices, and family systems of the culturally diverse individuals, families, communities and populations they care for, as well as a knowledge of the complex variables that affect the achievement of health and well-being.
4. Cross-Cultural Practice	Nurses shall utilize cross-cultural knowledge and culturally sensitive skills in implementing culturally congruent nursing care.
5. Healthcare Systems and Organizations	Healthcare organizations should provide the structure and resources necessary to evaluate and meet the cultural and language needs of their diverse clients.
6. Patient Advocacy and Empowerment	Nurses shall recognize the effect of healthcare policies, delivery systems, and resources on their patient populations, and shall empower and advocate for their patients as indicated. Nurses shall advocate for the inclusion of their patient's cultural beliefs and practices in all dimensions of their health care.
7. Multicultural Workforce	Nurses shall be activists in the global effort to ensure a more multicultural workforce in healthcare settings.
8. Education and Training	Nurses shall be educationally prepared to promote and provide culturally congruent health care. Knowledge and skills necessary for ensuring that nursing care is culturally congruent shall be included in global heathcare agendas that mandate formal education and clinical training, and ongoing, continuing education for all practicing nurses will be required.

(*Continues*)

Box 1–2 *Continued*

9.	Cross-Cultural Communication	Nurses shall use effective, culturally competent communication with clients that takes into consideration the client's verbal and nonverbal language, cultural values and context, and unique healthcare needs and perceptions.
10.	Cross-Cultural Leadership	Nurses shall have the ability to influence individuals, groups and systems to achieve outcomes of culturally competent care for diverse populations.
11.	Policy Development	Nurses shall have the knowledge and skills to work with public and private organizations, professional associations, and communities to establish policies and standards for comprehensive implementation and evaluation of culturally competent care.
12.	Evidence-Based Practice and Research	Nurses shall base their practice on interventions that have been systematically tested and shown to be the most effective for the culturally diverse populations that they serve. In areas where there is a lack of evidence of efficacy, nurse researchers shall investigate and test interventions that may be the most effective in reducing the racial and ethnic inequalities in health outcomes.

Adapted from: Douglas, M. K., Pierce, J. U., Rosenkoetter, M., Callister, L. C., Hattar-Pollara, M., Lauderdale, J., . . . Pacquiao, D. (2009). Standards of practice for culturally competent nursing care: A request for comments. *Journal of Transcultural Nursing, 20*(3), 257–269.

by Douglas et al. (2009), with participation from members of the Expert Panel on Cultural Competence, among others.

Nurses are ideally suited to strive toward cultural competence. When nurses consider the race, ethnicity, culture, and cultural heritage of their patients, they become more sensitive to each patient's individual needs. This is by no means an easy feat, as evidenced by the vast number of cultures and subcultures that exist on our planet (estimated to be more than 2,500 by Leininger), but a highly complex issue that requires a lifelong commitment (McGee, 2001).

It is important to learn from our mistakes, as each cultural gaffe provides the opportunity to learn, improve, and grow professionally. We must also realize that the practice of nursing should never be done by using a "cookbook approach." There is as much variation within certain races, cultures, or ethnic groups as there is across cultural groups. The informed nurse is being asked to consider the significance of culture to ensure that patients are then approached and cared for from a more informed perspective—this is the crux of transcultural nursing care delivery.

NONNURSING MODELS FOR CULTURAL ASSESSMENT

There are both nonnursing and nursing models for cultural assessment from which to choose. Arguably, the two most well-known nonnursing models are the *Outline of Cultural Materials* by Murdock (1971) and Brownlee's (1978) *Community, Culture and Care: A Cross-Cultural Guide for Health Workers*. The Murdock tool was designed for use by anthropologists and as such does not utilize the nursing process. The Brownlee tool is considered difficult by some and also is not a nursing tool. This lack of nursing focus has been a driving point behind the development of nursing-specific cultural assessment models.

SELECTED NURSING MODELS FOR CULTURAL ASSESSMENT

Culture Care, Diversity, and Universality: A Theory of Nursing

The first nursing cultural assessment model was developed by Dr. Madeline Leininger. She developed her theory—Culture Care, Diversity, and Universality—from both anthropology and nursing principles. She first published her theory in *Nursing Science Quarterly* in 1985. In 1988, the theory was further described in the same journal, and in 1991, she published her textbook, *Culture Care Diversity and Universality: A Theory of Nursing*. The theory states that nurses must take into account the cultural beliefs, caring behaviors, and values of individuals, families, and groups to provide effective, satisfying, and culturally congruent nursing care (Leininger, 1991). The central purpose of the theory is to discover and explain diverse and universal culturally based care factors influencing the health, well-being, illness, or death of individuals or groups. The goal is to identify ways to provide culturally congruent nursing care to people of diverse or similar cultures (Leininger, 2002). The foundation of the theory is that cultures exhibit both diversity and universality. Leininger (1985) defined diversity as perceiving, knowing, and practicing care in different ways, and defined universality as commonalities of care.

To fully understand any nursing theory or nursing care model, one must understand the operational definitions for key terms. Traditionally nursing has four metaparadigms: the concepts of person, environment, health, and nursing. Leininger feels that the paradigm of nursing is too limited in its definition, so that construct was replaced by caring. Caring, according to Leininger, has a better ability to explain

nursing. She feels that the concept of *person* is too limiting and culture-bound to explain nursing, because the concept of *person* does not exist in every culture. The term *person* is often used globally to refer to families, groups, and communities. Leininger also views the paradigm of health as belonging to many other healthcare disciplines and as such it is not unique to nursing. The fourth paradigm is environment, which Leininger has replaced with environmental context. Environmental context includes events with meanings and interpretations given to them in particular physical, ecological, sociopolitical, and/or cultural settings (Leininger, 1995).

Leininger (1985) defines culture as a group's values, beliefs, norms, and life practices that are learned, shared, and handed down. Culture guides thinking, decision making, and our actions in specific ways. Culture is the framework people use to solve human problems. In that sense, culture is universal yet also diverse. Cultural values are usually long-term and are very stable. Caring is defined by Leininger (1985) as assisting, supporting, or enabling behaviors that ease or improve a patient's condition. Leininger (1985) states that the essence of nursing is caring; caring is unique to nursing. It is essential to life, survival, and human development. It is through caring that people can deal with life's events. Caring is the verb counterpart to the noun *care* and is a feeling of compassion, interest, and concern for people. Caring has different meanings in different cultures. Individual cultural definitions of caring can be discovered by examining the cultural group's view of the world, social structure, and language (Leininger, 1985). Culture care refers to the values and beliefs that assist, support, or enable another person or group to maintain well-being, improve personal condition, or face death or disability. Culture care, according to Leininger (1985), is universal, but the actions, expressions, patterns, lifestyles, and meanings of care may be different. A nurse cannot provide appropriate cultural care without having a knowledge and understanding of cultural diversity. Worldview is defined as the outlook a group or person has, based on their view of the world or universe. Worldview consists of both a social structure and environmental context. The social structure provides organization to a culture, and it can come from religion, education, or economics. The environmental context is any event or situation that gives meaning to human expressions. Folk health, or well-being systems, are care practices that have a special meaning within the culture. These practices are used to heal or assist people in their homes or within the community at large. Folk or well-being systems have the potential to supplement traditional healthcare delivery systems. Person is defined as a human being that is capable of being concerned about others. A key construct of all nursing theory is environment. Leininger did not specifically define environment in her theory other than providing an operational definition

for environmental context. Health is viewed as a state of well-being. Most importantly though, health is culturally defined, valued, and practiced. Health is viewed as a universal concept across all cultures, but is defined differently by each to reflect its specific values and beliefs. Nursing is defined as a learned humanistic art and science that focuses on personalized behaviors, functions, and processes to promote and maintain health or recovery from illness. According to Leininger (1985), nursing uses three modes of action to deliver care: culture care preservation or maintenance, culture care accommodation or negotiation, and culture care restructuring or repatterning.

Leininger's Sunrise Model (1991) illustrates the major components and interrelationships of the culture care, diversity, and universality. Nurses can use the Sunrise Model when caring for patients to ensure that nursing actions are culture specific. It requires that the nurse understand the values, beliefs, and practices of the patient's culture. The Sunrise Model symbolizes the rising of the sun (the sun represents care). The model depicts a full sun with four foci. Within the circle in the upper portion of the model are components of the social structure and worldview factors that influence care and health.

When applying Leininger's model, it is important for the nurse to consider if there is a cultural mismatch present. A cultural mismatch is what occurs when people violate each other's cultural expectations. The healthcare provider needs to develop awareness into his or her personal style of interaction, because he or she may have a personal style of interaction that does not match the patient's. An example of a cultural mismatch would be the healthcare provider, attempting to keep to a tight schedule, interrupting the prayer session of a devoutly Muslim patient (Leininger, 1995). This interruption would definitely result in a cultural mismatch, but it could also result in causing cultural pain to the Muslim patient, which is a much more serious situation. Leininger (1997) states cultural pain occurs when hurtful, offensive, or inappropriate words are spoken to an individual or group. These spoken words are experienced by the receiver as being insulting, discomforting, or stressful. Cultural pain occurs because of a lack of awareness, sensitivity, and understanding by the offender of differences in the cultural values, beliefs, and meanings of the offended persons. When these types of events occur during a patient–provider encounter, they can result in significant consequences. It is essential that if a cultural mismatch or the infliction of cultural pain does occur, it be recognized, or we risk the development of consequences, one of which would be the inability to establish a therapeutic alliance with the patient. If a cultural mismatch or mistake is made, it is best for the healthcare provider to attempt to recover quickly from the mistake and to avoid becoming defensive. If

the provider suspects that the mismatch has been serious enough to have caused cultural pain (as evidenced by seeing a sudden negative change in attitude), the health professional must act on this feeling and ask if they did or said anything offensive. Cultural pain occurs if the clinician inadvertently ignores an important cultural obligation or violates a cultural taboo. Making this type of adjustment requires cultural flexibility—this is only possible in those healthcare providers who have taken the time to develop self-awareness and who have examined their own cultural background and biases.

Leininger (2002) identified eight unique features of her model. The eight features include (1) the fact that it is one of the oldest nursing theories (1950s), (2) its focus is on the interrelationships of culture on health and illness, (3) its focus on comparative cultures, (4) it is holistic and multidimensional, (5) it was designed to discover global diversities (both differences and similarities), (6) it has its own associated research method (ethnonursing), (7) it consists of both abstract and practical modes for delivering culturally congruent care, and (8) it has a focus on ethnohistory for use in diverse environmental contexts (Leininger, 2002).

Leininger (2002) advocates the concurrent use of her theory and the Sunrise Model in order to discover factors that may impact the patient's response, such as cultural stresses and pain, and to reduce the incidence of anger and noncompliance.

The importance of Leininger's theory and Sunrise Model is substantial and invaluable as it has served as the prototype for the development of other culturally specific nursing models and tools.

Giger and Davidhizar's Transcultural Assessment Model

Giger and Davidhizar's model provides a framework for assessment that focuses on the six cultural phenomena that they believe shape care: communication, space, social organization, time, environmental control, and biologic variations (Giger, 2013). They also systematically explore the variations that exist in caregivers' responses and recipients' perspectives relative to the cultural diversity that is present in the United States. The model serves as a resource for healthcare professionals when they are called upon to provide culturally discordant care. The authors advocate that the model can and should be used in a variety of clinical settings (primary, secondary and tertiary) (Giger, 2013). The model was first developed in 1988 to help undergraduate nursing students assess and provide care for patients that were culturally diverse. Giger and Davidhizar state that although all cultures are not the same, they share the same basic organizational factors (Giger, 2013). In its present form, the model provides a framework to systemati-

cally assess the role of culture on health and illness and has been used extensively in a variety of settings and by diverse disciplines. In 1993, Spector combined this model with the Cultural Heritage Model, which appears in *Potter and Perry Fundamentals of Nursing*. Spector (1993) used the model's six phenomena, but placed them in a different hierarchical arrangement and then used this hierarchy as a guide for cultural assessment of people from a variety of racial and cultural groups. The model has been utilized in other healthcare disciplines such as medical imaging, dentistry, education, and administration. The model has also been the theoretical framework for dissertations and other research studies.

Giger (2013) provides the following definition of culture:

> Culture is a patterned behavioral response that develops over time as a result of imprinting the mind through social and religious structures and intellectual and artistic manifestations. Culture is also the result of acquired mechanisms that may have innate influences but are primarily affected by internal and external environmental stimuli. Culture is shaped by values, beliefs, norms and practices that are shared by members of the same ethnic group. Culture guides our thinking, doing and being and becomes patterned expressions of who we are. These patterned expressions are passed down from one generation to the next.... [Cultural values are] unique expressions of a particular culture that have been accepted as appropriate over time. (p. 2)

The model postulates that every individual is culturally unique and requires culturally competent care. Culturally competent care is defined by Giger (2013) as

> A dynamic, fluid, continuous process whereby an individual, system, or healthcare agency finds meaningful and useful care delivery strategies based on knowledge of the cultural heritage, beliefs, attitudes, and behaviors of those to whom they render care. Cultural competence connotes a higher, more sophisticated level of refinement of cognitive skills and psychomotor skills, attitudes, and personal beliefs. To develop cultural competency, it is essential for the healthcare professional to use knowledge gained from conceptual and theoretical models of culturally appropriate care. Attainment of cultural competence can assist the astute nurse in devising meaningful interventions to promote optimal health among individuals regardless of race, ethnicity, gender identity, sexual identity, or cultural heritage. (p. 8)

Patients should be assessed according to the six cultural phenomena. It is important to emphasize that the model does not presuppose that every person within an ethnic or cultural group will act or behave in a similar manner. In fact, Giger (2013) informs us that a culturally appropriate model must recognize differences in groups while also avoiding stereotypical approaches to client care. In addition, the six cultural phenomena described are not mutually exclusive but are related and often interacting. Whereas the phenomena vary with application across cultural groups, the six concepts of the model are evident in every cultural group. The six cultural phenomena will be discussed individually.

The Phenomena

Communication

The first phenomenon is communication. Communication embraces the entire world of human interaction and behavior and it is how we relate or connect to others. Communication is the way by which culture is transmitted and preserved. It is a continuous and complex process as it can be transmitted through written or oral language and nonverbal behaviors, such as gestures, facial expressions, body language, or the use of space. While the factors that influence communication are universal, they vary among culture-specific groups in terms of language spoken, voice quality, pronunciation, use of silence, and use of nonverbal communication (Giger, 2013). Effective communication is essential for effective healthcare delivery because it motivates both the patient and the nurse to work together to manage the patient's health because the patient is better informed and empowered to participate more fully. Motivating our patients to take action on behalf of their own health is one of the tenets of Healthy People 2020.

Communication can present a barrier between the nurse and the patient, as well as the patient's family, especially when the nurse and the patient are from different cultural backgrounds. This feeling of alienation or powerlessness can occur if the language spoken is the same or if it is different. Impaired communication can result in a poor outcome. There are many different types of communication differences that the nurse may experience. Even when the language is shared between patient and nurse, misunderstandings can occur because of cultural orientation. Even though people may speak the same language, word meanings may differ between the sender and the receiver. This is because vocabulary words have both a connotative and denotative meaning. A denotative meaning is the meaning that is used by most people who share that common language,

but the connotative meaning comes from the person's personal experience. Differences in the meaning of words can cause numerous conflicts among various cultural groups. Overcoming language differences is probably the most difficult hurdle when attempting to provide cross-cultural health care. Clear and effective communication is essential. Nurses often become frustrated and find it difficult when faced with a language difference between patient and nurse. All parts of the nursing process are impacted negatively when we are unable to speak with our patients. When verbal communication is not possible, then we must rely instead on interpretation of the patient's nonverbal language. When patients are unable to communicate with us, they may withdraw or become hostile or uncooperative.

Both verbal and nonverbal communication is learned within one's culture. Communication and culture are intertwined. Our culture determines how our feelings are expressed and what is and is not appropriate. It is felt that cultural patterns of communication are firmly a part of us as early as age 5. Communication is essential to human interaction—it discloses information or provides a message. Through communication, we become aware of how another is feeling. Often, communication issues cause the most significant problems when working with people from a different culture. One of the most common barriers to communication is overcoming ethnocentrism (viewing one's culture as superior to another), particularly when assessing patients. An example of how to ensure that a patient's communication needs for patient education are met would be to provide oral instructions if the patient feels less comfortable with written materials. In contrast, when educating the Asian population, it is helpful to know that the majority of Asians prefer written materials over oral instructions.

Language differences need to be overcome with the use of competent interpreters. When caring for a patient who does not speak the dominant language, an interpreter is a must. In 1998, the National Council on Interpreting in Health Care was founded with the goal of promoting culturally competent healthcare interpretation. The Office of Minority Health recommends against the use of a patient's friends or family members as interpreters. One reason for this is that the patient may not be comfortable disclosing certain symptoms or behaviors to their friends or family. Other important considerations for the effective use of interpreters will appear later in the text.

Differences between patient and provider influence communication and clinical decision making. There is strong evidence that provider–patient communication is directly linked to patient satisfaction. When these differences are not acknowledged or explored, they result in poor patient satisfaction, poor adherence, and most alarmingly, a poor outcome (Betancourt, Green, Carrillo, &

Ananeh-Firempong, 2003). Failure to recognize the uniqueness of all of our patients can result in stereotyping and biased and discriminatory treatment.

Space

The second of the six phenomena is space. Space refers to the distance between people when they interact. Personal space is the area that surrounds the body. All communication occurs within the context of space. Rules concerning personal distance vary from culture to culture; therefore, views of appropriate spatial distance will vary between persons of different cultures. Discomfort occurs when one feels their personal space has been violated (Giger, 2013). Personal space is perceived through our biological senses, and the degree of comfort one feels in proximity to others, in body movement and perception of personal, intimate, and public space, is culturally based (Giger, 2013). European North Americans are aware of zones associated with personal space: the intimate zone, personal distance, social distance, and public distance. Other cultures may not be aware of these distinctions. Humans are similar to felines in that we wish to establish territoriality and we become uncomfortable when our territory is encroached upon. How large our territorial space is depends on individual and cultural preferences. Encroachment into one's intimate zone by another can cause many different types of reactions. One possible outcome is embarrassment and modesty. Modesty may pose a significant barrier that may be difficult to overcome when it is time to examine the patient.

Giger and Davidhizar identified four aspects of behavior patterns related to space that must be assessed to promote a healthy interaction: (1) proximity to others, (2) attachment with objects in the environment, (3) body posture, and (4) movement in the setting (Giger, 2013). These four concepts are particularly important during periods when family members are experiencing emotional chaos, such as during the grieving process. Although the desired degree of physical proximity between the client and provider is based on the degree of intimacy and the trust that has been mutually established, as a general rule, Hispanics and Asians tend to stand closer to each other than do Euro-Americans.

Social Organization

The third phenomenon is social organization. Cultural behavior, or how one acts in certain situations, is socially acquired, not genetically inherited. Patterns of cultural behavior are learned through a process called enculturation (also referred to as socialization), which involves acquiring knowledge and internalizing values (Giger, 2013). Most people achieve competence in their own culture through

enculturation/socialization. Social organization refers to the manner in which a cultural group organizes itself around the family group. Family structure and organization, religious values and beliefs, and role assignments all relate to ethnicity and culture. Where we grow up and choose to live in adulthood plays an essential role in our socialization process. There is a strong need among many cultural groups to maintain social congruency. This need can negatively impact health care. Access to healthcare providers does not necessarily translate into positive lifestyle behaviors or risk-reduction activities as prescribed by the dominant society. People from some cultures may verbally agree with a treatment plan out of respect to the provider but then defer to folk remedies or alternative health practices upon discharge. Social organization consists of the family unit and the social organizations in which one may have membership. Social organizations are structured in a variety of groups, including family, religious, ethnic, racial, and special interest groupings. Membership in groups, except for ethnic or racial groups, is voluntary. Social barriers also exist and can impact access to health care as was pointed out in the IOM (2003) report. These social barriers include unemployment, socioeconomic status, and lack of health insurance.

Time

The fourth phenomenon of the Giger and Davidhizar model is time (Giger, 2013). Time has two meanings. The first is duration (interval of time) and the second is specified instances or points in time (Giger, 2013). Due to these two distinct meanings, time is very culture-bound, as it is perceived, measured, and valued differently across cultures (Giger, 2013). In essence, time is conceptualized in reference to our chronologic age, its perception in relation to events, and as an external entity that is outside of our control (Giger, 2013).

While it may not be readily apparent on the surface, time is an important aspect of interpersonal communication. The concept of time is not only based on clock hours and social influences (e.g., meals and holidays) but is culturally perceived. Clock time is frequently more highly valued by the majority of Western cultures, where appointments tend to be kept at the prescribed time. In a culture in which places and persons are more important than social time, activities start when a previous social event has been completed, and to be dominated by adherence to clock time is often considered rude. Persons in different cultures may have a time orientation that focuses on either the past, present, or future. This can impact tremendously on preventative health care because a patient must have at least a small degree of future time orientation to be motivated by a future-situated reward (improved health down the road, or a longer life). People who are future oriented

are more likely to embrace preventive health measures as they are concerned about the onset of illness in the future. People who are present oriented are often late for medical appointments or may skip them entirely. Recognizing the patient's time orientation has value for the nurse. Considering the time orientation can provide a bridge to increase compliance with a medication regimen or with recommended health screenings.

Environmental Control

The fifth phenomenon is the environment and locus of control and refers to the ability of the person to control nature and to plan and direct factors in the environment that may affect them. Many Americans believe they have internal control over nature, which impacts the decision to seek out health care. If the patient comes from a culture in which there is less belief in internal control and more in external control, there may be a fatalistic view in which seeking health care is viewed as useless. Human attempts to control nature and the environment are as old as recorded history. At its most basic level, locus of control is a significant variable in how people react within the American healthcare system. In general, the willingness to accept responsibility for one's health is considered an internal locus of control. Persons who have an external locus of control believe the healthcare delivery system exists to provide essential care and can become especially frustrated with the complexities of health care in America and the myriad of options available.

The environment also encompasses a person's health and illness beliefs and whether they expand health delivery from that provided only from Western medicine with those of complementary or alternative practitioners. Understanding the patient's perspective on alternative therapies is essential when developing an optimal plan of care for our patients.

Biological Variations

The last of the six phenomena is biologic variations (Giger, 2013). Biologic differences, especially genetic variations, exist between individuals in different ethnic groups. Although there is as much difference within cultural and ethnic groups as there is across and among cultural and racial groups, knowledge of general baseline data relative to the specific cultural group is an excellent starting point to provide culturally appropriate care. This is also an important area when it comes to racial differences in how pharmaceuticals are metabolized and utilized (ethnopharmacology).

Ethnopharmacologic research has revealed that ethnicity significantly affects drug response. Genetic or cultural factors, or both, may influence a given drug's pharmacokinetics (its absorption, metabolism, distribution, and elimination) and pharmacodynamics (its mechanism of action and effects at the target site), as well as patient adherence and education. In addition, the tremendous variation within each of the broader racial and ethnic categories defined by the U.S. Census Bureau (categories often used by researchers) must be considered. For example, some researchers use the terms *race*, *ethnicity*, and *culture* synonymously, even though they each have distinct and unique definitions. Improper labeling can result in inaccuracies with data collection and the nurse should consider that when critically evaluating ethnopharmacologic research findings. In addition, most clinical drug trials are conducted on adult White males, with the results then generalized to all patients who might be prescribed and administered the drugs. Despite the growing evidence that ethnicity influences drug response, many nurses and healthcare providers still remain largely unaware of this. Research has shown that genetic variations in certain enzymes may cause differing drug responses (although the precise mechanisms are unknown); also, certain ethnic groups have more of these variations than others do. Individual factors, such as diet and alcohol and tobacco usage, can also influence gene expression, and therefore drug metabolism (Muñoz & Hilgenberg, 2005).

Nurses need to become knowledgeable about drugs that are likely to elicit varied responses in people with different ethnic backgrounds, as well as the potential for adverse effects. The existing ethnopharmacologic research focuses primarily on psychotropic and antihypertensive agents (Muñoz & Hilgenberg, 2005). The nurse should utilize caution and consider the possibility of biologic variations when administering antihypertensives and/or psychotropic drugs to culturally diverse patients. Some patients will have a therapeutic response at a lower dose than those typically recommended for a particular agent. The nurse must carefully monitor the patient to help prevent unnecessary increases in dosage, which will increase the likelihood of adverse events.

The nurse must also be on guard in the event a therapeutic substitution is required. Sometimes this is done to contain costs or because a drug is not on an institution's formulary. Drugs may vary in how they are metabolized, and substitution may be more clinically risky for patients from non-White racial and ethnic groups. While individual differences exist and should be considered, the nurse would be wise to be extra vigilant when drug substitutions occur in their non-White patients.

Healthcare providers must understand the biologic differences and susceptibility that exist in persons from different cultures. For example, Black Americans have a higher prevalence of cardiovascular disease, cancer, and diabetes than others. Cultural differences can also contribute to either noncompliance or poor compliance with therapy. Unfortunately, in many cases, lack of knowledge limits the ability of healthcare professionals to differentiate environmental, familial, and genetic predisposition to disease states. Although research is being conducted on biologic differences relating to ethnic groups, it lags behind the knowledge available regarding other cultural phenomena. An important example of this is that the development of pain measurement instruments remains culturally centered, even though significant differences exist among members of different cultural groups in their perception and response to pain management.

There are several ways that people from one cultural group differ biologically from members of other cultural groups. These differences are called biologic variants. They can include stature or size, skin color, genetic differences, disease susceptibility, and nutritional variants. Asians traditionally are smaller in stature than other racial or ethnic groups. Skin color differences among races also impacts hair and nail texture. Genetic differences can result in enzyme deficiencies such as a lack of lactase, causing lactose intolerance. Certain ethnic groups, such as Hispanics and Black Americans, have higher morbidity rates than other groups because of differences in disease susceptibility. Even the diets that are followed by our patients can be culture-bound, such as a Jewish patient's kosher diet or balancing hot and cold foods, as is common in many Hispanic homes.

Another area that is under intense study is biocultural differences. This area of study is also known as biocultural ecology, and focuses on human adaptation and homeostasis (Giger, 2013). Biocultural ecology may help to lessen the fragmentation that has occurred in the past where culture, biology, ecology, and the environment have been looked at separately or in isolation.

Clinical Application of the Model

It is essential for all healthcare professionals to be aware that not all patients with the same medical diagnosis are likely to have the same experience. Following this model permits the patient to be an equal partner with the nurse. A cultural assessment can be obtained by utilizing the questions posed by Giger and Davidhizar, which will provide a better understanding of patient behaviors that might, if not understood within the context of ethnic values, be regarded as puzzling or even negative (Giger, 2013). This approach is not meant to be stereotypical. If care-

fully listening and observing, and questioning appropriately, the nurse should be able to discover the health traditions or beliefs that belong to that individual patient. The recognition of the importance of providing culturally appropriate clinical approaches has developed in response to the easily discernible fact that the United States is rapidly becoming a multicultural, heterogeneous, pluralistic society. As the demographics of the population of the United States continues to expand, and especially when the demographics of the healthcare professional and the patient do not match, it is essential that the healthcare professional embark on a journey to develop sensitivity and cultural competence in order to provide safe and effective care. This can be achieved by performing cultural assessment according to the guidelines established by any transcultural nursing model.

See **Box 1–3** for examples of cultural gaffes that can occur within each aspect of the Giger and Davidhizar's Transcultural Assessment Model.

Purnell Model for Cultural Competence

One of the unique components of the Purnell (Purnell & Paulanka, 1998) Model for Cultural Competence is, as a holographic theory, it has applicability and can be used by all disciplines and healthcare team members. Nurses who are members of interdisciplinary teams may wish to use this model for this reason. Not only can this model be used by all team members, but it is also unique in that it includes the recognition of biocultural ecology and workforce issues and the impact of this on the culturally diverse patient. Often, team members can be from various cultures and this model can be helpful when trying to forge a greater understanding of what is similar and different among the various cultures that make up the healthcare team. Purnell (2013) identifies many benefits to the use of his model. First, the model provides a framework for all healthcare providers to utilize when learning about the inherent concepts and characteristics of new cultures.

The Purnell Model for Cultural Competence consists of a circle. The outermost rim represents the global society, the second rim represents community, and the third rim represents the family. The innermost rim represents the person. The interior of the circle is divided into 12 pie-shaped wedges. Each wedge depicts one of the 12 cultural domains. The dark center of the circle represents all unknown phenomena. There is a jagged line at the bottom that represents the concept of cultural consciousness, which is nonlinear (Purnell, 2013).

The model provides a link between historical perspectives and their impact on one's cultural worldview. It also provides a link for the central relationships of culture so that congruence can occur and to facilitate the delivery of consciously competent care.

Box 1–3 Six Phenomena of the Giger and Davidhizar Model and Examples of Cultural Gaffes

Phenomenon	Event	Response
Time	Visiting hours are not being respected.	Explain institution's time expectations.
Space	Poor eye contact on the part of your patient.	Make sure you are aware of the customs regarding contact, such as eye contact and touch, for many different cultural groups (optimally, all that you will come in contact with in practice). Poor eye contact is a sign of respect in some cultures (Vietnamese Americans, American Indian, Appalachians); excessive eye contact may be perceived as rude by Chinese Americans.
Communication	Family member is using a lot of hand gesturing when communicating.	Gestures do not have universal meaning; what is acceptable to one group may be taboo to another.
Social Organization	Prayer sessions in a hospital room by patient and family members.	Be aware of the expected rituals and how religious services are conducted for many different groups.
Biologic Variations	Family members repeatedly bring home-prepared meals for the patient with foods that are in violation of the prescribed diet plan.	Look for foods that are not in violation of the prescribed diet and encourage the family to only bring in foods from the approved list.
Environmental Control	Family members wish to bring in a folk medicine healer as a member of the healthcare team.	Advocate for the patient for inclusion of the complementary provider as a member of the team.

Adapted from: Giger, J. N. (2013). *Transcultural nursing: Assessment and intervention* (6th ed.). Philadelphia, PA: Elsevier.

Consciously competent care is an important concept because when we are conscious of the care we provide, we ensure that it is culturally competent and we can replicate that care delivery for this patient and for other patients in the future. The model also provides a framework that allows the nurse to reflect on and consider

each patient's unique human characteristics such as motivation, intentionality, and meaning when planning for and providing patient care. The model provides a structure for analyzing cultural data, and it permits the nurse to view the individual, family, or group within its own unique and ethnocultural environment. The model encourages the nurse to consider communication strategies to overcome identified barriers. Effective communication depends not only on verbal language skills that include the dominant language, dialects, and the contextual use of the language, but also other important factors such as the paralanguage variations of voice volume, tone, intonations, reflections, as well as the openness of the patient (willingness to share their thoughts and feelings). Another important component is nonverbal communication. The varied and numerous components of nonverbal communication must also be considered. For example, the nurse must know whether to engage in the use of eye contact or to avoid it, depending on the cultural norms of the patient. This consideration must also be given to the type of facial expressions to utilize, as not all facial expressions will be acceptable to all patients. If or when to touch a patient is also culturally dependent, as is our use of and interpretation of the patient's body language. Even how close we are to our patients communicates information about us. Nurses must become aware of the spatial distancing practices and acceptable greetings associated with the various cultural groups who come under their care. The nurse's worldview in terms of whether the nurse or the patient utilizes a past, present, or future orientation must be considered and planned for. Does the patient place a focus on clock time (as is the case with the Western Biomedical Model) or is the focus on social time? Even consideration must be given on how to address our patient. Miscalculating the degree of formality in the use of names can result in breaking trust or blocking the establishment of a therapeutic alliance between nurse and patient. Communication styles may vary between insiders (family and close friends) and outsiders (strangers and unknown healthcare providers). Purnell (2013) reminds us that in regard to verbal and nonverbal communication, there is indeed much to consider.

The Purnell (2013) model has an organizing framework of 12 universal domains:

- Overview, inhabited localities, and topography
- Communication
- Family roles and organization
- Workforce issues
- Biocultural ecology

- High-risk health behaviors
- Nutrition
- Pregnancy and childbearing practices
- Death rituals
- Spirituality
- Healthcare practices
- Healthcare practitioners

An important consideration for the nurse to keep in mind is the higher level of regard or esteem that nurses are given in the United States compared to what is given to nurses in other parts of the world. This higher regard may be due to the amount of educational preparation required and the need to pass a licensing examination to become a nurse in the United States. In some ethnic or cultural groups, however, folk healers or other nonlicensed healthcare providers (e.g., shamans, medicine men, lay midwives) are held in higher regard than nurses who are educationally prepared and who practice within the Western Biomedical Model. When providing care to patients from a culture where this may be an issue, the nurse should spend time establishing a good interpersonal relationship in order to bridge the cultural gap and to improve the patient's outcome and the overall healthcare experience of the patient.

SUMMARY

By now, it should be clear that it is impossible to practice high-quality nursing to our culturally diverse patient population unless we gain knowledge in transcultural health care and cultural competency models. See **Table 1–1** for more information on cultural factors and **Table 1–2** for a process to follow to develop cultural competence. It is not enough to just gain this knowledge, however. In order to deliver high-quality culturally diverse nursing care, nurses need to utilize this unique nursing knowledge; it is not enough just to know, but we must also attempt to do. Utilizing any of the described nursing models allows the nurse to gain knowledge and to deliver culturally appropriate care. The use of transcultural models is beneficial for nurses to become knowledgeable about and for evaluating society in terms of culture, to find the cultural data in a more systematic and standardized way, and to improve the field of transcultural nursing. Having a greater knowledge of the cultures served by the nurse will play an important role in improving the quality of health care. It is well known that the meaning of health and illness is different for various cultural groups. Nurses who utilize

Table 1–1 Cultural Factors

Family structure and characteristics
Education levels
Family assets
Family in the community
Communication style
Health beliefs and practice
Help-seeking style
View of professional and family roles
View of early intervention
Knowledge of health and education system
Time orientation
Socioeconomic status

transcultural theories are in an ideal position to demonstrate how the provision of culturally competent care will shape health care in the future. These and other models provide a starting point for assessment of patients who are culturally diverse. The nurse just needs to select the one that fits him or her best. The key is to remember that patients' cultural behaviors are relevant to health assessment and should be considered when planning care for all patients. Nurses can be guided in this process by selecting and following one of the available nursing models. A description of three of these models was provided in this chapter—Leininger's Culture Care, Diversity and Universality Theory and the Sunrise Model; Giger and Davidhizar's Transcultural Assessment Model; and Purnell's Model for Cultural Competence—to help you select the model that is best for you. You are now ready to begin to develop your transcultural nursing practice.

Table 1–2 Process for Attaining Cultural Competence

Develop awareness of own cultural biases
Understand facets of culture
Acknowledge and honor range of diversity in families' values and beliefs
Develop cultural sensitivity
Develop collaborative partnerships with families
Develop methods of cross-cultural communication
Learn to collaborate with interpreters
Minimize cultural bias in assessments
Identify and address barriers to assessment and intervention

PERTINENT RESEARCH STUDIES OF SELECTED MEDICAL DISORDERS AND CULTURAL COMPETENCY

TUBERCULOSIS: Many studies have found that patients who stopped treatment worldwide for tuberculosis (TB) did so because they felt better, their symptoms abated, or they thought that they were cured. In addition, patient beliefs about TB may differ from the medical model, such as believing that the disease has a mystical, superstitious, or religious origin. Compliance can also be a factor, especially if a patient was a refugee, as the patient may perceive the healthcare worker as a government representative or as an oppressor. Various rumors have also spread among different cultures that TB is caused by smoking, pollution, or even hard labor.

VIETNAMESE PATIENTS

Hoa, N. P., Thorson, A. E. K., Long, N. H., & Diwan, V. K. (2003). Knowledge of tuberculosis and associated health-seeking behaviour among rural Vietnamese adults with a cough for at least three weeks. *Scandinavian Journal of Public Health, 31*(Suppl. 62), 59–65.

Houston, H. R., Herada, N., & Makinodan, T. (2002). Development of a culturally sensitive educational intervention program to reduce the high incidence of tuberculosis among foreign-born Vietnamese. *Ethnicity and Health, 7*(4), 255–265.

Johannson, E., Long, N. H., Diwan, V. K., & Winkvist, A. (1999). Attitudes to compliance with tuberculosis treatment among women and men in Vietnam. *International Journal Tuberculosis and Lung Disease, 3*(10), 862–868.

ASIAN INDIAN PATIENTS

Asghar, R. J., Pratt, R. H., Kammerer, J. S., Navin, T. R. (2008). Tuberculosis in South Asians living in the United States, 1993–2004. *Archives of Internal Medicine, 168*(9), 936–942.

Singh, V., Jaiswal, A., Porter, J. D., Ogden, J. A., Sarin, R., Sharma, P. P.,… Jain, R. C. (2002). TB control, poverty and vulnerability in Delhi, India. *Tropical Medicine & International Health, 7*(8), 693–700.

GAMBIA PATIENTS

Harper, M., Ahmadu, F. A., Ogden, J. A., McAdam, K. P., & Lienhardt, C. (2003). Identifying the determinants of tuberculosis control in resource poor

countries: Insights from a qualitative study in The Gambia. *Transactions of the Royal Society of Tropical Medicine and Hygiene, 97*(5), 506–510.

DIABETES PATIENTS: According to the Centers for Disease Control and Prevention (CDC), there are 900,000 new cases of diabetes mellitus (DM) annually, which translates to more than 2,600 new cases each and every day. The worst-case scenario results when a strong genetic predisposition is combined with a poor lifestyle. When this occurs repeatedly, it results in escalating rates of type 2 diabetes. It is believed that this is one of the primary reasons why minority populations are experiencing such a high type 2 diabetes incidence. This is a worldwide problem because the burden of diabetes is growing even more rapidly in other countries than it is growing in the United States. This will result in a huge economic burden to some countries that are not in a financial position to handle it. Type 2 diabetes is becoming epidemic in areas with higher proportions of at-risk ethnic groups. In these areas, a child as young as 12 years old is more likely to have type 2 diabetes than type 1 diabetes (sometimes still referred to as juvenile diabetes).

Recognition that poor diabetes outcomes may be related to inadequate cultural competency could result in a reduction or elimination of poor outcomes in these high-risk ethnic groups. These poor outcomes can be eliminated or reduced by enhanced awareness and improved skills in cross-cultural encounters. This understanding needs to extend to the complications that can be associated with DM in minorities as well. The following contributing factors have been identified to explain the high incidence of long-term complications of diabetes in ethnic minorities: high prevalence rate of DM, earlier age of onset that results in a longer duration of diabetes, poor glycemic control, delayed diagnosis, limited access to health care, less intense or comprehensive healthcare encounters, and a genetic susceptibility to complications (IOM, 2001).

Type 2 diabetes affects different populations in different ways. The prevalence is significantly higher in minority groups in comparison to the White population. This important disparity is beginning to be shared with the public through public service announcements. The American Diabetes Association has used the public service campaign of "Diabetes Favors Minorities." These facts were included in that public service announcement: diabetes strikes 1 out of 3 Native Americans, 1 out of 7 Hispanics, and 1 out of 14 Blacks.

The Translating Research Into Action for Diabetes (TRIAD) study was published in *Medical Care* in December 2006 by Duru et al. TRIAD's overall goal is to understand and influence the quality of care (both processes and outcomes of care) for patients with diabetes in managed care settings. TRIAD is a 10-year

project funded by the Centers for Disease Control and Prevention and the National Institute of Diabetes and Digestive and Kidney Diseases, and is a 6-center prospective study of managed care and diabetes quality of care, costs, and outcomes in the United States.

The goal of this study was to determine if the utilization of clinical care strategies in managed care (diabetes registry, physician feedback, and physician reminders) is associated with attenuation of known racial/ethnic disparities in diabetic care. The study found that for the most part, high-intensity implementation of a diabetes registry, physician feedback, or physician reminders—three clinical care strategies similar to those strategies that are used in many healthcare settings—are *not* associated with an attenuation of known disparities of diabetes care in managed care. The authors also reported that disparities in care do exist, particularly among the Black American population.

REVIEW QUESTIONS

1. Differentiate the terms *culture*, *cultural assessment*, and *cultural competency*.
2. List the six cultural phenomena of the Giger and Davidhizar model.
3. Purnell identifies the 12 domains of culture in his model. What are the similarities and differences between those 12 domains and the 6 cultural phenomena that are in the Giger and Davidhizar model?
4. Provide two nursing implications for a nurse administering antihypertensives or psychotropics to the non-White patient (ethnopharmacology principles).
5. What was the theoretical framework used to develop the 12 standards of culturally competent nursing care practice that were published in the *Journal of Transcultural Nursing* in 2009?
6. Describe the process to attain cultural competency.
7. Which nursing theorist gave birth to the transcultural nursing movement?
8. Identify and describe three potential areas of diversity.
9. Describe the potential consequences of culturally discordant care.
10. What can the nurse do to decease the likelihood of committing a cultural gaffe?

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