Nursing in a Multicultural Setting

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2013/2014
At the end of this section, the participant will be able to:

- Define cultural competence.
- Explore several tools for cultural self-assessment.
- Assess and evaluate own level of personal competence.
- Describe how cultural influences shape individual health behavior.
- Discuss how explanations of disease etiology can differ among diverse patients.
- Differentiate between a cultural generalization and a cultural stereotype.
- Identify barriers that inhibit the provision of culturally competent nursing care.
The United States population is increasingly more racially and ethnically diverse.

Research has shown that culture shapes a person's attitudes, beliefs, and practices toward health and disease; culture influences the patient-caregiver relationships; and cultural differences contribute to the health disparities in society.

Research has also shown that successful patient-provider communication is associated with patient satisfaction, adherence to healthcare instructions, and positive health outcomes.

Nurses should become well versed in patient-centered care and cultural competence in order to improve quality of care and help eliminate cultural disparities in health care (Betancourt, Green & Carrillo et al, 2005).
As a nurse educated outside of the United States, you will encounter several different cultures here. You may also be treated differently by the people you meet.

You may also feel different being in the minority in your neighborhood or workplace.

You will also encounter different ways of nursing practice.

Do not be afraid to ask questions and learn as much as possible about the people you meet and their way of life.

Learn about the acceptable means of communication verbal and non verbal. Share with others your cultural experiences to get them to better understand you.
**Patient-Centered Care:** The Nurse of the Future will provide holistic care that recognizes an individual’s preferences, values, and needs and respects the patient or designee as a full partner in providing compassionate, coordinated, age and culturally appropriate, safe and effective care.

**KNOWLEDGE:**
- **K4:** Describes how diverse cultural, ethnic, spiritual and socioeconomic backgrounds function as sources of patient, family, and community values.

**ATTITUDES/BEHAVIORS**
- **A4a:** Values opportunities to learn about all aspects of human diversity
- **A4b:** Recognizes impact of personal attitudes, values and beliefs regarding delivery of care to diverse clients
- **A4c:** Supports patient-centered care for individuals and groups whose values differ from their own
SKILLS

- S4a: Provides patient-centered care with sensitivity and respect for the diversity of human experience.

- S4b: Implements nursing care to meet holistic needs of patient on socioeconomic, cultural, ethnic, and spiritual values and beliefs influencing health care and nursing practice.

- S4c: Demonstrates caring behaviors toward patient, significant others, and groups of people receiving care.
KNOWLEDGE:
- K6: Demonstrates understanding of the diversity of the human condition

ATTITUDES/BEHAVIORS
- A6: Values the inherent worth and uniqueness of individuals and populations

Skills
- S6a: Understands how human behavior is affected by socioeconomics, culture, race, spiritual beliefs, gender, lifestyle, and age
- S6b: Provides holistic care that addresses the needs of diverse populations across the life span
- S6c: Works collaboratively with health care providers from diverse backgrounds
- S6d: Understands the effects of health and social policies

The preceding two slides are not the NOF core competencies in its entirety.

Sources:

You can read more about the nurse of the future core competencies the knowledge, behavior and skills required for the entry level nurse by visiting
  - http://www.mass.edu/currentinit/NiNofCompetencies.asp
  - http://www.mass.edu/currentinit/currentinitNursingNurseFutureComp.asp
  - http://www.mainenursepartners.com/competencies.html
The ANA issued a position statement on cultural diversity in nursing practice:

- "Nurses need to understand how cultural groups understand life processes, how cultural groups define health and illness, what cultural groups do to maintain wellness, what cultural groups believe to be the cause of illness, how healers cure and care for members of cultural groups, and how the cultural background of nurses influences the way in which care is delivered" (American Nurses Association, 1991).
In health care settings, culture and language differences may result in
- misunderstanding,
- lack of compliance, or
- other factors that can negatively influence clinical situations

Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care
- Minorities receive lower quality of health care even when socioeconomic and access related factors were controlled.
- Bias, stereotyping, prejudice, and clinical uncertainty may contribute to racial and ethnic disparities in health care. (IOM, 2002)
Diversity
Ethnocentrism
Cultural values
Discrimination
Diversity
Health disparity
Attitude
Stereotype
Value
Communication style
Translator vs. interpreter
Bias
Race
Culture has many definitions.

One of the definitions is that culture is the shared beliefs, values and practices that are learned and transmitted throughout a society, and influence the way that a group of people live and make decisions and interact.

Culture has been described as the learned and shared patterns of information that a group uses to generate meaning among its members. (Diversity.org 2001).
Culture: The learned, shared, and transmitted, values, beliefs, norms and lifeway practices of a particular group that guides thinking, decisions and actions in a patterned way.

Culture is dynamic. It changes from generation to generations. But certain things remain the same and is passed on from generation to generation.

Cultural variations also play a role in perceptions of health and illness, diet and nutrition, life cycle events such as birth and death, gender and family roles, and pain perceptions.
**Culture** is akin to being the person observed through a one-way mirror; everything we see is from our own perspective.

It is only when we join the observed on the other side that it is possible to see ourselves and others clearly – but getting to the other side of the glass presents many challenges.

(Lynch & Hanson 1992 Developing Cross Cultural Competence)

Slide Source: National Center for Cultural Competence, 2007
A local geographic or global human population distinguished as a more or less distinct group by genetically transmitted physical characteristics. A group of people united or classified together on the basis of common history, nationality, or geographic distribution (Office of Minority Health, 2001).

Ethnic Group: An ethnic group is a group of people whose members have different experiences and backgrounds from the dominant culture by status, background, residence, religion, education, or other factors that functionally unify the group and act collectively on each other (Giger et al., 2007, p. 100).
Looks different, tastes different, may feel different but still an apple
There are several definitions for diversity.

In broad terms, diversity is any dimension that can be used to differentiate groups and people from one another.

Diversity refers to the variety of experiences and perspectives which arise from differences in race, culture, religion, mental or physical abilities, heritage, age, gender, sexual orientation, and other characteristics (University of California, San Francisco (UCSF), 2006).

- It means respect for and appreciation of differences in ethnicity, gender, age, national origin, disability, sexual orientation, education, and religion. However diversity is more than the above definition.
Cultural Diversity: Refers to diversity in race, color, ethnicity, national origin, religion, age, gender, sexual orientation, ability/disability, social and economic status or class, education, occupation, religious orientation, marital and parental status, and other related attributes of groups of people in society (Giger et al., 2007, p. 100).
Cultural competency: “adaptation of care” to be in harmony with the client’s culture (Purnell, 2002).

Cultural competence is having the knowledge, understanding, and skills about a diverse cultural group that allows the health care provider to provide acceptable cultural care (Giger, Davidhizar, & Purnell et al., 2007, p. 100).

Campinha-Bacote defines cultural competence as "the process in which the healthcare professional continually strives to achieve the ability and availability to effectively work within the cultural context of a client" (family, individual or community).

- To become culturally competent, the nurse must take into account issues related to diversity, marginalization, and vulnerability due to culture, race, gender, sexual orientation etc.
Cultural competence includes:

- Awareness of one's own identity, beliefs, values, social position, life experiences and so on and their implications for the provision of care.

- "Knowledge about diversity in beliefs, practices, values and world views both within and between groups and communities, thus recognition of similarities and differences across individuals and groups and of the dynamic and complex nature of social identities.

- Recognition of social, economic and political inequality and discrimination and how this shapes healthcare experiences and outcomes for minority groups.

- Effective communication with appropriate provision and effective use of resources for cross-lingual and cross-cultural communication.

- Resourcefulness and creativity to resolve issues arising during the provision of care across difference (Higginbottom et al., 2011).
Communicating effectively and appropriately across language, religious or cultural difference can be challenging with many possibilities for misunderstanding, perceived offence and disempowerment.

Inter-cultural communication competence has therefore been identified as an important element in cultural competence.

Achieving intercultural communication competence requires more than speaking the same language, or making provision for interpretation.

It requires detailed understanding of and sensitivity to the patient's social and cultural context, attention to power dynamics, awareness of non-verbal cues, and provision of appropriate physical surroundings, empathy and patience (Higginbottom et al., 2011).
Values: Ideas held by human individuals or groups about what is desirable, proper, good or bad.

- Differing values represent key aspects of variations in human culture. What individuals value is strongly influenced by the specific culture in which they happen to live.
- Values are the things we hold as important. Just as each individual holds certain values, each culture promotes different ones.

**Cultural values:** Cultural values give an individual a sense of direction as well as meaning to life with a culture.

- There are many additional cultural value dimensions that make up the complex ways that our culture helps us make sense of the world.
Learning these invisible aspects of culture is challenging and sometimes frustrating if members of the “host” culture don’t necessarily know how to talk about them.

They are just “the way things are done”.

When you are part of a culture, you can act and respond automatically; knowing what the boundaries of acceptable behavior are.

It is not uncommon for people in a new culture to shut down or hold back until they figure out the rules or become comfortable with the risks and consequences.

This can sometimes be misinterpreted as lacking in confidence, shyness.
“A predisposition or a tendency to respond positively or negatively towards a certain idea, object, person, or situation. Attitude influences an individual's choice of action, and responses to challenges, incentives, and rewards (together called stimuli”).

Four major components of attitude are

- (1) Affective: emotions or feelings.
- (2) Cognitive: belief or opinions held consciously.
- (3) Conative: inclination for action.
- (4) Evaluative: positive or negative response to stimuli.

Source: http://www.businessdictionary.com/definition/attitude.html
Communication style is how individuals interact with one another and the messages they send, intentionally or not, through their behaviors.

The Four Basic Styles of Communication
- Assertive Communication
- Passive Communication
- Passive-aggressive communication
- Aggressive Communication

To read more about communication styles, check the power points titled Assertiveness.
Racism

Racism: Racism refers to feelings of prejudice against persons of another race or group of people. Racist practices lead to interpersonal tension, isolation, discrimination, and covert anger (Giger et al., 2007, p. 100).

Cultural Imposition: Intrusively applies the majority cultural view to individuals and families (Giger et al., 2007, p. 100).
  - Prescribing a special diet without regard to the client’s culture and limiting visitors to immediate family borders on cultural imposition.

Ethnocentrism: Ethnocentrism is a universal tendency to believe that one’s own worldview or culture is superior to another’s (Giger et al., 2007, p. 100).
  - It is often experienced in the health care arena, in particular when the health care provider considers his or her own culture or ethnic group superior to that of the client.
Discrimination: Bias or prejudice resulting in denial of opportunity, or unfair treatment regarding selection, promotion, or transfer. Discrimination is practiced commonly on the grounds of age, disability, ethnicity, origin, political belief, race, religion, sex, etc. factors which are irrelevant to a person's competence or suitability.

Stigma: A characteristic or trait that causes a stain or reproach on a group's or individual’s reputation or being (Giger et al., 2007, p. 100).

Bias: An inclination of temperament or outlook; especially a personal and sometimes unreasoned judgment.

Prejudice: A negative feeling toward a group based on a faulty generalization. Irrational, preconceived opinion that leads to preferential treatment to some people and unfavorable bias or hostility against others, due to ignorance (or in direct contradiction) of facts. Prejudice literally means, pre-judgment.
Cultural sensitivity is experienced when neutral language, both verbal and nonverbal, is used in a way that reflects sensitivity and appreciation for the diversity of another (Giger et al., 2007, p. 100).

Ability to empathize, show respect and engender trust in others.

- Cultural sensitivity is conveyed when words, phrases, categorizations, and so on are intentionally avoided, especially when referring to any individual who may interpret it as impolite or offensive.

- It is important to understand that cultural differences as well as similarities exist, without assigning values, i.e., better or worse, right or wrong, to those cultural differences.
Health Disparity: Health disparity is defined as differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States (Giger et al., 2007, p. 100).

Health Care Disparity: A health care disparity exists when persons of different races, ethnic groups, and cultures do not receive equal health care, and illness occurs disproportionately from one group to the other (Giger et al., 2007, p. 100).
Microaggressions is defined as “Brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial, gender, sexual orientation, and religious slights and insults to the target person or group.” (Sue, 2010, p5).

See Dr. Sue speak to microaggression on YouTube at http://www.youtube.com/watch?v=xAlFGBIEsbQ
Stereotype

- Stereotype includes having a simplified and standardized conception, image, opinion, or belief about a person or group (Giger et al., 2007, p. 100).

  - Overall impressions based on the assumption that all members of a group possess similar attributes.
  - Stereotypes are the cognitive precursors of prejudice and discrimination
    - A health care provider who fails to recognize individuality within a group is jumping to conclusions and therefore stereotyping.
  - Example: “People from Country X are lazy”
“The danger in considering cultural differences is that of stereotyping people” (Galanti, 2000, p. 335)

Every individual is unique.

The following statements is both foolish and possibly dangerous
- “Russians do this”
- “Vietnamese believe that”
- “Spanish people think that” or
- “African American are this”
Stereotyping

"I've seen your type before."

Everything covered but her eyes, what a cruel male-dominated culture!

Nothing covered but her eyes, what a cruel male-dominated culture!
Generalizations begin with assumptions about the individual or family within an ethnocultural group but lead to further information seeking about the individual or family (Giger et al., 2007, p. 100).

A generalization is a statement about common trends within a group, but with the recognition that further information is needed to ascertain whether the generalization applies to a particular individual/person.
Information about cultural patterns represents generalizations, which should not be mistaken for stereotypes.

Cultural generalizations will not fit every patient, but awareness of broad patterns can give practitioners a starting point from which to provide appropriate care (Galanti, 2000).

It is important to distinguish between stereotypes and generalizations.

They may appear similar, but they function differently (see next slide).
For example, if I meet a Mexican woman named Maria and assume that she has a large family, I am stereotyping her.

But if I say to myself, “Mexicans tend to have large families; I wonder if Maria does,” then I am generalizing.

A stereotype is an ending point, and no effort is then made to ascertain whether it is appropriate to apply it to the person in question or the current situation.
“Knowledge of cultural customs can help avoid misunderstanding and enable practitioners to provide better care” (Galanti, 1997).

Because differences always exist between individuals, stemming from a variety of factors, such as, in the case of immigrants, the length of time they have spent in the United States and their degree of assimilation, even generalizations may be inaccurate when applied to specific persons.

Cultural generalizations will not fit every patient whom the nurse see, but knowledge of broad patterns of behavior and belief can give nurses and other health professionals a starting point from which to provide the most appropriate care possible.
Many health professionals think that if they just treat each patient with respect, they will avert most cultural problems. But that is not always the case.

Some knowledge of cultural customs can help avoid misunderstandings and enable practitioners to provide better care.
Cultural Generalization

- The tendency of a majority of people in a cultural group to hold certain values and beliefs, and to engage in certain patterns of behavior.

Cultural Stereotype

- The application of a generalization to every person in a cultural group; or, generalizing based on only a few people in a group.

Source: Building Cultural Knowledge
http://volunteeralberta.ab.ca/intersections/staff/building-cultural-knowledge/stereotypes-generalizations
Characteristics of Stereotype

- Often lie below the level of consciousness
- A way of categorizing
- The mental organization of your experience of others
- Simplistic
- Learned from parents, relatives, and friends
- Learned from limited exposure or experience
- Learned through the media
- Can evolve out of fear
- Are problematic when we put people into the “wrong category”

Cultural Generalization

- Broad characterizations
- Useful as a general guide to anticipating and discussing cultural reactions, attitudes, and behaviors in a neutral way
- Helpful in analyzing cultural patterns
- Will never apply to everyone in a culture because individual personalities and backgrounds always play a role in how people think and act
- Used as a shorthand way to make nonjudgmental cross-cultural comparisons, not to oversimplify or deny the complexity of social interaction
- Flexible and open to new information
Benefits of cultural competence in healthcare

- Improves communication with patients
- Helps with negotiating differences
- Promotes disclosure of patient information
- Makes more effective use of time with patients
- Promotes patient adherence to treatment
- Decreases health worker and patient stress
- Builds trust in a relationship
- Increases patient and provider satisfaction
- Meets increasingly stringent government regulations and standards
- Positively affects clinical outcomes
Specific reasons why cultural competence must be developed in healthcare include;

- Improving quality of services and outcomes;
- Meeting legislative, regulatory, and accreditation mandates;
- Gaining a competitive edge in the marketplace; and
- Decreasing the likelihood of liability and malpractice claims.
Diversity – refers to a range of human perspectives, backgrounds, and experiences as reflected in characteristics such as age, class, ethnic origin, gender, nationality, physical and learning ability, race, religion, sexual orientation, and veteran’s status.

Other dimensions of diversity include, but are not limited to, education, marital status, employment and geographic background, as well as cultural values, beliefs, and practices. (Retrieved from http://www.worldlearning.org/ as cited in NCCC)
Diversity

Visible
- Gender
- Race
- Education
- Work/Life Experience
- Disabilities
- Religion
- Personal Truths
- Physical Attributes
- Socio-Economic Status
- Political Views

Invisible
- Character or Personality
- Sexual Orientation
- Work Style
- Marital or Partnership Status
- Parental Status
- Dress
- Religionism

Core
Factors that Make Our Area Diverse.

Internal factors that influence diversity among individuals and groups in the community or geographic locale:

- Age
- Gender and sexuality
- Cultural, racial and ethnic identify
- Tribal affiliation/clan
- Nationality
- Socioeconomic status/class
- Education
- Language
- Family constellation
- Social history
- Sexual orientation and identity
- Religion and spiritual views
- Political orientation and affiliation
- Acculturation/assimilation (NCCC)
Factors that Make Our Area Diverse.

- **External factors that influence diversity in the community or geographic locale:**
  - Experiences with racism and discrimination
  - Experiences of bias with organizations and agencies related to health/mental health
  - Community economics
  - Community history
  - Inter-group relations
  - Natural networks of support
  - Group and community resiliency
  - Political climate
  - Migratory patterns (NCCC).
One of the challenges many workplaces struggle with is how to acknowledge difference.

Some workplaces want to act like there are no differences—that everyone is the same. This is simply not true.

Differences are unavoidable in the workplace and they usually make workplaces stronger.

Acknowledging differences doesn’t lead to perpetuating bias. Recognizing that Kechi is black is fine. However, assuming characteristics about her because she is black is not.

Knowing that English is Alicia’s second language is fine; basing our assessment of her abilities on that is not.

Difference is an essential part of recognizing the individual, but when difference is used to generalize individuals based on what we think of that group, it becomes a bias.
Reflect. Spend time reflecting on the biases that you might have, almost everyone holds some form of bias.
  
  - Think through how those biases might have been formed and if there is any sound logic or reason to them.

Confront. Consider why you might be holding onto a bias.

  - Is it because of fear—a preventative measure based on a bad experience?
  - Is it because of security—a crutch that helps you feel better about yourself?
  - Is it avoidance—a way to dodge difficult situations with groups you don’t understand or that make you uncomfortable?
Steps to Changing Bias

★ Engage. One of the best ways to eliminate a bias is to prove it wrong through personal experience and engagement. We’re all professionals and we can draw on each other to help improve our workplace.
  - Engage in a conversation with someone different from yourself. Get to know them as an individual and take note of how they dispel the biases you might hold.

★ Commit. Commit to experiencing individuals, not groups. Remember that everyone is a unique individual, not a stereotype of a group.
  - Make your relationships about the individual, not about group membership.

★ Maintain. Keep making connections with individuals—embrace each opportunity to meet and experience a new person and appreciate the differences and unique elements that make that person who they are.

★ Discuss. Talk about your experiences with bias and with overcoming biases. Encourage others to talk about their experiences. Use discussion to help point out lingering blind spots and to continue building a bias-free workplace (American Library Association (ALA), nd.).
More efficient use of staff time by reducing communication delays between patients and providers. Simply by addressing language issues, providers, provider office staff and patients enjoy reduced delays and a more efficient health care interaction.
OMH issued the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care in December 2000 as a means to correct the existing inequities in health services.

The Standards were developed through a rigorous research and review process that drew upon the input of hundreds of national experts and stakeholders.

The CLAS Standards provide consistent and comprehensive guidance to health care organizations and providers to ensure cultural and linguistic competence in health care.
CLAS stands for Culturally and Linguistically Appropriate Services.

The standards are guidelines for accreditation and credentialing agencies:
- to assess and compare providers who say they provide culturally competent services, and
- to assure quality for diverse populations. (Please refer to CLAS recommended reading pages 7-12).

The 14 standards are organized by themes:
- Standards 1-3: Culturally competent care
- Standards 4-7: Linguistic competency or Language Access Services
- Standards 8-14: Organizational supports for cultural competency. (UMCC, 2005 and Culturally Competent Nursing Modules (CCNM), )
Several laws and regulations have been passed which serve as a foundation for some of the CLAS Standards. For example:

- Title VI of the Civil Rights Act of 1964 states that "no person in the United States shall, on the grounds of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination" under any federally supported program (Civil Rights Act of 1964, 1964). DHHS's Office for Civil Rights (OCR) extends this protection to language, viewing inadequate interpretation as a form of discrimination.

- The Americans with Disabilities Act of 1990 extends language accommodations to individuals who are deaf or hard of hearing when they seek and access health care.
The Process of Cultural Competence in the Delivery of Healthcare Services, assumes cultural competence is a process. Dr. Campinha-Bacote identified several fundamental assumptions that serve as guidelines for implementing her model:

- Cultural competence is a process, not an event; a journey, not a destination; dynamic, not static; and involves the paradox of knowing.

- The process of cultural competence consists of 5 interrelated constructs: cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters; the key — pivotal construct is cultural desire.

- Cultural competence is an essential component in providing effective and culturally responsive nursing care to all clients.

- All encounters are cultural encounters.
The Process of Cultural Competence in the delivery of healthcare services, assumes cultural competence is a process.

As seen in the above figure the model is portrayed as a volcano called cultural desire that erupts the process of cultural competence.

The “eruption” of cultural competence contains cultural awareness, cultural skill, cultural knowledge, and cultural encounters.
Cultural desire, a spiritual component of the model involves:
- the nurse’s motivation, caring and willingness to sacrifice prejudice'
- Humility, respect for diversity,
- willing commitment to identify similarities as a foundation for the relationship, and
- eagerness to learn from the client are all integral to this construct. (Campinha-Bacote, 2003).

Cultural desire is seen as the source of cultural competence.

Cultural desire encompasses the “commitment to be open and flexible with others, and to respect differences but build on similarities,” (Campinha-Bacote, 2003, p. 21)
Cultural awareness is a consciousness to one’s own attitudes and assumptions toward diverse others, including racism, bias, and stereotyping.

Cultural knowledge is the cognitive awareness of health conditions associated with specific races and ethnic groups as well as their response to treatment and the client’s beliefs and values about health care.

Cultural skill is the ability to assess the client in a culturally appropriate manner.

Cultural encounters involve interactions with culturally diverse individuals and includes linguistic needs.
• The continuous process of interacting with patients from culturally diverse backgrounds in order to validate, refine or modify existing values, beliefs, and practices about a cultural group and to develop cultural desire, cultural awareness, cultural skill, and cultural knowledge.

Cultural awareness
• The deliberate self-examination and in-depth exploration of one's biases, stereotypes, prejudices, assumptions and "isms" that one holds about individuals and groups who are different from them.

Cultural knowledge
• The process of seeking and obtaining a sound educational base about culturally and ethnically diverse groups.

Cultural skill
• The ability to collect culturally relevant data regarding the patient's presenting problem, as well as accurately performing a culturally-based physical assessment in a culturally sensitive manner.

Cultural desire
• The motivation of the healthcare professional to "want to" engage in the process of becoming culturally competent; not the "have to."
Culture Advantage: Papadopoulos, Tilki and Taylor Model

**Cultural Awareness**
- Self-awareness
- Cultural identity
- Heritage adherence
- Ethnocentrism

**Cultural Competence**
- Assessment skills
- Diagnostic skills
- Clinical Skills
- Challenging and addressing prejudice, discrimination and inequalities

**Cultural Knowledge**
- Health beliefs and behaviours
- Barriers to cultural sensitivity
- Stereotyping
- Ethnohistory
- Sociological understanding
- Similarities and variations

**Cultural Sensitivity**
- Empathy
- Interpersonal/communications skills
- Trust
- Acceptance
- Appropriateness
- Respect
Cultural awareness

Cultural awareness’ stage is an essential first stage in the process of achieving cultural competence.

It begins with an examination of one’s personal value base and beliefs.

This self awareness crucially contributes to one’s understanding of the nature and construction of their cultural identity.

At the same time a person becomes more aware that his/her cultural background is a major factor in shaping one’s values and beliefs which in turn influences one’s health beliefs and practices.
Cultural knowledge can be gained in a number of ways.

Meaningful contact with people from different cultural groups can enhance knowledge about health beliefs and behaviors and raise understanding of the problems they face.

This knowledge is required in order to understand the similarities and differences of cultural groups as well as the inequalities in health within and between groups, which may be the result of structural forces in society, such as the power of health care professionals, and the role of medicine in social control.
Cultural sensitivity

How do you as a nurse view people in your care?

Patients should be viewed as partners. Partnership demands that power relationships be challenged and that real choices are offered.

To form a partnership with patients, nurses have to act as facilitators, advocates and negotiators.

This can only be achieved on a foundation of trust, respect and empathy.

To this the nurse need to learn to communicate effectively with patients across cultures.
Cultural competence is merely a process rather than a specific skill.” (Papadopoulos 2006:11). It is an ongoing process.

Cultural competence requires the synthesis and application of previously gained awareness, knowledge and sensitivity.

An important component of this stage of development, is the ability to recognize and challenge racism and other forms of discrimination and oppressive practices.
Important Links

Culture Advantage: Free course: Cultural Awareness: Online Continuing Education (Est. 1 to 1.25 Contact Hours*)
Published March 22, 2006 from

http://www.culture-advantage.com/awarenesspage1.html

Or www.culture-advantage.com/awarenesspage1.html
Davidhizar and Giger also present a transcultural assessment model to assist health care professionals in assessing patients from diverse cultures that focuses on six factors.

According to Davidhizar and Giger, health care professionals should receive training on how to use these factors to assess the health beliefs and practices that may have a significant impact on how an individual responds to treatment and patient education.

Using this assessment model will assist the nurse in providing care that is sensitive and tailored to the needs of culturally diverse individuals.
This nursing assessment and intervention model helps raise nurses' awareness of the differences between people from different cultural backgrounds and consider each individual’s unique cultural identity.

The model takes into account six interrelated cultural phenomena:

- 1. Communication,
- 2. Space,
- 3. Time,
- 4. Social organization,
- 5. Environmental control, and
- 6. Biological variations.

(Giger & Davidhizar, 2002).
# Giger and Davidhizar Transcultural Assessment Model

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<td>Use of silence Use of nonverbal communication</td>
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<td></td>
<td>Pronunciation</td>
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<td>Space</td>
<td>Degree of comfort observed</td>
<td>Body movement Perception of space</td>
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<td>(conversation)</td>
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<td>Proximity to others</td>
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<td>Other physical dimensions</td>
<td>Psychological characteristics and coping and social support</td>
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<tr>
<td>Verbal Communication</td>
<td>Non-Verbal Communication</td>
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<tr>
<td>Voice volume</td>
<td>Touch</td>
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<td>Voice quality</td>
<td>Facial expressions</td>
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<td>Voice tone</td>
<td>Eye contact</td>
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<td>Voice intonation</td>
<td>Sounds</td>
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<td>Voice rhythm</td>
<td>Gestures</td>
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<td>Voice speed</td>
<td>Posture</td>
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<tr>
<td>Reflections</td>
<td>Body movement</td>
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<td>Vocabulary</td>
<td>Reflexes</td>
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<tr>
<td>Pronunciation</td>
<td>Silence</td>
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<tr>
<td>Grammatical structure</td>
<td>Use of space (personal and social)</td>
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<tr>
<td>Informal and formal language</td>
<td>Appearance</td>
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<tr>
<td>Dialect</td>
<td>Cultural artifacts</td>
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<tr>
<td>Therapeutic Communication Techniques</td>
<td>Non-Therapeutic Communication Techniques</td>
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<tr>
<td>Listening</td>
<td>Changing the subject inappropriately</td>
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<td>Broad Openings</td>
<td>Expressing unnecessary approval or disapproval</td>
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<td>Restating</td>
<td>Giving an opinion or advice</td>
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<td>Clarification</td>
<td>Defensiveness</td>
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<tr>
<td>Informing</td>
<td>Offering false reassurance</td>
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<tr>
<td>Accepting</td>
<td>Stereotyping</td>
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<tr>
<td>Purposeful Questioning</td>
<td>Probing and challenging</td>
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Table 3. Strategies for improving culturally sensitive patient-provider communication.\textsuperscript{3,4}

- Do not rush through the discussion.
- When communication difficulties exist, the tendency is to speak louder. Avoid this propensity and speak in moderate tones.
- Repeat instructions more than once and summarize the content throughout the discussion.
- Speak in brief, easy-to-understand sentences.
- Translate the treatment plan into the patient’s native language.
- Use well-known terminology, such as cavity as opposed to caries.
- Act out instructions using gestures and pantomiming.
- Ask the patient to repeat the instructions or act out the treatment so it is clear that he or she has fully understood.
Cultural competence is a developmental process and evolves over an extended period.

Individuals are at various levels of awareness, knowledge and skills along the cultural competence continuum.

The capacity to engage in self-assessment helps individuals to:

- gauge the degree to which they are effectively addressing the needs of culturally and linguistically diverse groups;
- determine their strengths and areas for growth; and
- strategically plan for the systematic incorporation of culturally and linguistically competent policy, structures and practices (Goode, 2001).
Self Assessment

- Complete the Cultural Competence Health Practitioner Assessment (CCHPA) at http://nccc.georgetown.edu/resources/assessments.html

- Harvard University’s Project Implicit http://www.projectimplicit.net/index.html

Click the link below to access the site for nurse competency training. If the link does not work, copy and paste on your Google search bar and the site should come up. You need to provide your information for the credit.


- https://ccnm.thinkculturalhealth.hhs.gov/Content/Course1/Course1_Intro.asp

The Culturally Competent Nursing Modules are based on the CLAS standards.
CCNM provides in-depth information including:

1. Models and approaches for delivering culturally competent nursing care including knowledge and skill-centered approaches to promote effective patient-nurse interaction,

2. Effective communication techniques and tools for delivering language access services, and

3. Tools and resources to support and advocate culturally competent nursing organizations.

Each module is designed for participants to integrate awareness, knowledge, and skills.
Course 1: Delivering Culturally Competent Nursing Care.

This curriculum is founded in the CLAS Standards and is intended to support nurses in the delivery of culturally competent care and the implementation of the CLAS Standards in their organizations. Course 1 is focused on Standards 1–3:

- **Standard 1**: Health care organizations should ensure that patients receive from staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

- **Standard 2**: Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

- **Standard 3**: Health care organizations should ensure that staff receive ongoing education and training in culturally and linguistically appropriate service delivery.
This Course encompasses six modules:

- Module 1 provides nurses with an overview of culturally competent care;

- Modules 2 and 3 assist nurses in understanding the importance of self-awareness in providing culturally competent care;

- Modules 4, 5, and 6 present information for nurses to understand more about their patient’s health-related experiences; discuss patient-centeredness and learn how to balance knowledge and skill-centered approaches in delivering culturally competent care.

There are Pre-test and Post test for each module and you get a certificate.
Course II discusses the importance of language in cross-cultural health care, legal requirements and obligations for health care providers in ensuring language access services (LAS) for their patients, and business and practice issues in providing LAS. Providing LAS is not only good nursing practice, but is also a legal requirement for recipients of federal financial assistance. LAS helps to ensure mutual understanding of illness and treatment, increases patient satisfaction, and improves the quality of health care for limited English proficiency patients.
The framework of this Course is based on the following four CLAS Standards to provide LAS:

- Standard 4: Health care organizations must offer and provide language assistance services including bilingual staff and interpreter services, at no cost to the patient with limited English proficiency at all points of contact.

- Standard 5: Health care organizations must provide to patients in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

- Standard 6: Health care organizations must assure the competence of language assistance provided to limited English proficient patients by interpreters and bilingual staff.

- Standard 7: Health care organizations must make available easily understood patient-related materials and post signage in the languages of the encountered groups in the service area.
This Course encompasses six modules:

- Module 1 provides nurses with an overview of effective communication with patients.

- Modules 2 and 3 provide nurses with the tools needed for effective communication and explain the role of health literacy in effective communication.

- Modules 4, 5, and 6 present information on interpreter and language access services, articulate the roles of an interpreter, and discuss effective communication tools to use with LEP patients.

- Modules 1-6 will support nurses in adopting CLAS Standards 4-7, Language Access Services (LAS).
Course III: Supporting and Advocating for Culturally Competent Health Care Organizations

Course III discusses the importance of cultural competence in organizations, ways nurses can support cultural competence in their organizations, organizational assessments, strategic planning, and the importance of partnerships. This curriculum is founded in the CLAS Standards and is intended to support nurses in the delivery of culturally competent care and the implementation of the CLAS Standards in their organizations. The framework of this Course is based on the following seven CLAS Standards on organizational supports:
This Course will help nurses develop specific strategies to improve upon their current clinical environment to better serve patients in their community. The Course encompasses six modules:

- Module 1 provides nurses with an overview of culturally competent organizations;

- Modules 2 and 3 assist nurses in understanding how to advocate for cultural competence and the importance of strategic planning and data collection; and

- Modules 4, 5, and 6 present information for nurses to assess their organizations; learn about cultural competence training; and develop partnerships to support cultural competence in their organizations.
To complete the course modules visit the links below. You will have to create a user name and password to sign in and a get certificates.

https://ccnm.thinkculturalhealth.hhs.gov/Content/Introduction/Introduction1.asp

https://ccnm.thinkculturalhealth.hhs.gov/Content/Course1/Course1_Intro.asp

https://ccnm.thinkculturalhealth.hhs.gov/Content/Course2/Course2_Intro.asp

https://ccnm.thinkculturalhealth.hhs.gov/Content/Course3/Course3_Intro.asp
Ms. L. has a Hispanic surname and speaks with an accent. She is often upset when she calls a health care provider’s office or goes in for a visit, and staff assume she does not speak or understand English. Sometimes this assumption leads staff to speak slowly and loudly. Other times they will have a Spanish-speaking staff person interact with her. Although she is pleased that some health care providers make an effort to have Spanish speakers on staff for families who require this level of language assistance, she wishes they would ask about her specific needs.
Caring for Patients From Different Cultures

- Family composition or structure
- Decision making and spokespersons
- Gender issues
- Caring role
- Expectations of and for children
- Strong emphasis on education
- Expectations of and for elders
- Expectations of adults in caring for children and elders
- Expectation of visitors
Cultural assessment models and tools are vehicles that enable nurses to deliver effective transcultural nursing care.

Narayanasamy (1999) ACCESS model was developed to offer nurses and other healthcare professionals a framework to bridge the cultural gap and provide acceptable transcultural care:

- The ACCESS model delineates communication as the crux of cultural care.

- Nurses are required to make efforts to become aware of others' cultures by negotiation and compromise, while establishing respect and rapport and showing sensitivity to all aspects of patients' needs.
The ACCESS tool/model focuses on

Narayanasamy (2002, p. 645)

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Communication</th>
<th>Cultural negotiation and compromise</th>
<th>Establishing respect and rapport</th>
<th>Sensitivity deliver diverse cultural sensitive care to culturally diverse groups</th>
<th>Safety -- enable clients to derive a sense of cultural safety</th>
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<tr>
<td>- Assessme&lt;br&gt;nt of cultural aspects of clients' lifestyle, health beliefs and health practices</td>
<td>- Taking note of variations in verbal and non-verbal responses</td>
<td>- become aware of aspects of other people's culture and understanding clients' views and explaining their problems</td>
<td>- A therapeutic relation that portrays genuine respect for clients' beliefs and values is required</td>
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The most important tools for health care professionals in multicultural encounters are professional knowledge, understanding, sensitivity and interaction skills. Respecting both the patient and the patient’s values are intertwined in the encounters. When discussing about different care options with the patients, the primary starting point is the respect for the patient’s cultural beliefs, customs, life, values and following the patient’s own will. Even though the decisions in health care are often made together with the family of the patient, it is still important to stress that the patient’s own will and wishes will be heard. (Etene 2004:10).
Obtaining culture specific knowledge is challenging, however it is never too late to begin the process.

The cultural identity of each patient should not be overlooked or disregarded, but rather preserved and respected.

All individuals have their own expectations, backgrounds, values, and preferences that may affect the way they interact with health care professionals.

Nurses who are sensitive to cultural differences are on the right track to increasing patient satisfaction, improving processes and outcomes of care, and minimizing conflict between nursing care practices and diverse patient cultures.
Remember that every encounter is a cross-cultural encounter in health care.

Never make the assumption that patients who look like you share your beliefs and practices.

Principles of patient-centered care should be applied to all patients to encourage individuals to become an active partner in their own health care.

As a nurse educated outside of the United States transitioning into practice. It is imperative to familiarize yourself with the cultural care models, so you can practice nursing care more efficiently and effectively.
Stereotyping can have intense negative effects.

As you interact with others of different cultures, there is no good substitute for receptiveness to interpersonal feedback, good observation skills, effective questions, and common sense.

There is much to be gained by observing how people of the same culture interact with each other.

Don't be afraid to ask questions as most people respond very positively to inquiries about their culture.

Ask a variety of people so you can get a balanced view.
Resources


- Building Cultural Knowledge: Cultural Values http://volunteeralberta.ab.ca/intersections/staff/building-cultural-knowledge/cultural-values

- Cultural diversity in health care: http://www.ggalanti.org/books.html

References

- HRSA, (Health Resources and Services Administration Study On Measuring Cultural Competence in Health Care Delivery Settings
- Images obtained from google image.
References


http://rwjms.rutgers.edu/departments_institutes/family_medicine/chfcd/grants_projects/aetna.html


