

Culturally Competent Nursing Care A Challenge for the 21st Century

Deborah L. Flowers, RN, PhD

Throughout the centuries, nursing has been a dynamic, continuously evolving entity, changing and adapting in response to a wide range of stimuli. Changes in societal norms and expectations, discoveries of new medical treatments, developments in highly sophisticated technical systems, and breakthroughs in pharmaceutical treatments have helped shape contemporary nursing practice. Another recent trend that has influenced nursing considerably is the consumer mandate for culturally competent care in an increasingly diverse, multicultural society.

The ability to provide culturally competent care is especially important for critical care nurses, who function in high-acuity, high-stress healthcare environments. Critical care nurses must develop cultural competency to be effective in estab-

lishing rapport with patients, and to accurately assess, develop, and implement nursing interventions designed to meet patients' needs. As patients' advocates, critical care nurses are required to support decisions made by patients or patients' families that may reflect a cultural perspective that conflicts with mainstream healthcare practices. In today's society, culturally competent care cannot be offered to all patients unless nurses have a clear understanding of diverse cultural backgrounds.

In this article, I describe current population trends in North America, discuss the need for critical care nurses to develop cultural competence, present a model for development of cultural competence, and describe common pitfalls in the delivery of culturally competent care.

Changing Demographics

Demographic changes in many countries reflect an increasingly diverse population. For example, in Sweden, a society that once reflected only a single or perhaps a few ethnic groups now comprises more than 100 different ethnic groups. On the basis of their society's changing demographics, healthcare professionals in Sweden have begun to address the need for "establishing a commitment and a way of working to facilitate the development of cultural competence" in various healthcare situations.¹ To this end, the executive committee of the Public Health and Medical Services in Sweden has begun to assess the need for culturally competent care and to develop training programs for healthcare workers that are designed to address this need.¹

The United States also has experienced a change in demographics stimulated by an influx of persons from diverse ethnic and cultural groups. If current population trends continue, it is projected that by the year 2080, the white population will become a minority group, constituting 48.9% of the total population of the United States.² Data from the censuses of 1980 and 2000 (Table 1) illustrate a marked change in ethnic population trends among 4 ethnic groups: white, African American, Hispanic, and Native American.³

Culturally Competent Nursing Care

The increasingly multicultural profile of the US population requires that nurses provide culturally competent nursing care.

Author

Deborah L. Flowers is an associate professor with East Central Oklahoma Department of Nursing, Ada, Okla. She is program coordinator for the distance education nursing program, ECU @ Southeastern Department of Nursing, Durant, Okla.

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Table 1 Ethnic population trends in the United States³

Group	1980	2000	% Increase
White	188 372 000	211 460 626	12.3
African American	26 495 000	34 658 190	30.8
Hispanic	14 609 000	35 305 818	141.7
Native American	1 420 000	2 475 956	74.4

Cultural competence is defined as “developing an awareness of one’s own existence, sensations, thoughts, and environment without letting it have an undue influence on those from other backgrounds; demonstrating knowledge and understanding of the client’s culture; accepting and respecting cultural differences; adapting care to be congruent with the client’s culture.”⁴

The American Nurses Association recognized the need to provide culturally competent care and stated in the association’s code that nurses, in all professional relationships, should “practice with compassion and respect for the inherent dignity, worth, and uniqueness of every individual.”⁵ The tragedy of the attack on the World Trade Center in New York City, which necessitated emergency and critical care for many persons from diverse, multicultural backgrounds, underscored the need for nurses to provide culturally competent care. Provision of such care requires that nurses recognize and understand the differences that exist among patients’ cultural backgrounds.⁶

Hospitalized patients and their families are subjected to numerous stresses. This reality is especially true in critical care units, where patients with life-threatening illnesses are treated. In these situations, the need for culturally competent care is strikingly evident, as the following anecdote illustrates.

As an emergency room nurse in a small rural hospital, I was present when an elderly Native American man was brought to the emergency room by his wife, sons, and daughters. He had a history of 2 previous myocardial infarctions, and his current clinical findings suggested he was having another. During the patient’s assessment, he calmly informed the emergency room staff and physician that, other than coming to the hospital, he was following the “old ways” of dying. He had “made peace with God and was ready to die” and “wanted his family with him.”

The emergency room physician ordered intravenous fluids, a dopamine infusion, a Foley catheter, and transfer to the intensive care unit of a regional hospital 3 hours away. The patient died 2 weeks and 2 code blues later, and was intubated and receiving mechanical ventilation for most of that time. No family members were present when he died except for his wife. The rest of his family members were unable to afford the cost of traveling to a healthcare facility that far from home. This man’s cultural values and preferences in relation to dying were disregarded.

Lack of cultural awareness and failure to provide culturally competent care can greatly increase the stresses experienced by critically ill patients and can result in inadequate care provided by healthcare professionals. Shi and Shu-Hsun⁷ compared American-Chinese and

Taiwanese patients’ perceptions of dyspnea and related nursing actions during the patients’ admissions to the intensive care unit after cardiac surgery. Chinese patients in the study believed that physical energy was depleted during a dyspnea episode and that uninterrupted rest, sleep, and nutritional support allowed the body to recharge afterward. Lack of awareness of these concerns among the intensive care nurses resulted in several comments offered by one Chinese patient. “I wrote down ‘eating, wife.’ I meant I wanted my wife to prepare my favorite food for me. But American nurse didn’t understand me, she suggested me to relax and sleep again. But, how can I relax? I needed the homemade food which was cooked with herbs, and only my wife knew how to make it. I didn’t request it again since I was afraid they might think I was odd, and look down on me.”⁷ This patient’s level of stress could have been markedly decreased if awareness of his cultural beliefs had been incorporated into his care.

Galanti⁸ illustrates the importance of culturally competent care with an example of a newborn Vietnamese boy too ill to be discharged home with his mother. Nursing staff were concerned because the mother appeared unable to bond with her new infant. She provided basic care for him, such as feeding and changing his diapers, but refused to cuddle him or show any outward signs of maternal-infant bonding. Although the baby remained in the hospital nursery several days after the mother’s discharge, neither parent visited the baby. By consulting a nurse who specialized in transcultural nursing care, the staff learned that many

persons from rural Vietnam believe that spirits are attracted to newborns and are likely to harm the infants. Consequently, parents do everything they can to avoid attracting attention to their new infants. The seeming lack of concern and bonding in this case reflected an intense love for the infant, rather than a lack of bonding.⁸

Model for Cultural Competence

Campinha-Bacote and Munoz⁹ offered a 5-component model for developing cultural competence (Table 2). Five components of cultural competence were proposed:

1. cultural awareness,
2. cultural knowledge,
3. cultural skill,
4. cultural encounter, and
5. cultural desire.

The first component, *cultural awareness*, involves self-examination and in-depth exploration of one's own cultural and professional background.⁹ Cultural awareness should begin with

insight into one's own cultural healthcare beliefs and values. Catalano² states that "merely learning about another person's culture does not guarantee the nurse will have cultural awareness; nurses must first understand their own cultural background and explore the origins of their own prejudiced and biased views of others." The Cultural Awareness Assessment Tool (Table 3) could be used to assess a person's level of cultural awareness.² The questions in this tool should be answered honestly; the score obtained offers insight into understanding one's own cultural healthcare beliefs and values.

The second component, *cultural knowledge*, involves the process of seeking and obtaining an information base on different cultural and ethnic groups.⁹ Nurses can develop and expand their cultural knowledge base by accessing information offered through a variety of sources, including journal articles, textbooks, seminars,

workshop presentations, Internet resources, and university courses. Table 4 summarizes resources for obtaining information about various cultural and ethnic groups.

The third component, *cultural skill*, involves the ability of the nurse to collect relevant cultural data regarding the client's presenting problem and accurately perform a culturally specific physical assessment.⁹ The Giger and Davidhizar model¹⁰ described in Table 5 contains a framework for assessing cultural, racial, and ethnic differences between patients. This model provides a systematic method for assessing culturally and ethnically diverse persons. The elements of this model are communication, space, social organization, time, environmental control, and biological variations.¹⁰

The fourth component, *cultural encounter*, is defined as the process that encourages nurses to directly engage in cross-cultural interactions with patients from culturally diverse backgrounds.⁹ Directly interacting with patients from different cultural backgrounds helps nurses increase their cultural competence. Development of cultural competence is an ongoing process that continues throughout a nurse's career and cannot be mastered.²

The last component, *cultural desire*, refers to the motivation to become culturally aware and to seek cultural encounters.⁹ Inherent in cultural desire is the willingness to be open to others, to accept and respect cultural differences, and to be willing to learn from others.

Common Pitfalls

One common pitfall to avoid in becoming culturally competent is unintentionally stereotyping a patient

Table 2 Components of model for cultural competence⁹

Component	Definition
Cultural awareness	Self-examination and in-depth exploration of one's own cultural and professional background; identification of biases and possible prejudices when working with specific groups of clients
Cultural knowledge	The process of seeking and obtaining an information base on different cultural and ethnic groups, as well as understanding the groups' world views, which will explain how members of a group interpret their illness and how being a member guides their thinking, doing, and being
Cultural skill	Ability to collect relevant cultural data about patients' immediate problem and accurately perform culturally specific assessments; involves how to perform cultural assessments and culturally based physical assessments
Cultural encounter	The process that encourages nurses to engage directly in cross-cultural interactions with patients from culturally diverse backgrounds; directly interacting with such patients will refine or modify existing beliefs about a cultural group and prevent possible stereotyping that may have occurred
Cultural desire	Motivation to want to engage in the process of becoming culturally aware, knowledgeable, and skillful and to seek cultural encounters, as opposed to being required to seek such encounters; includes a genuine passion to be open to others, accept and respect differences, and be willing to learn from others as cultural informants

Table 3 Cultural awareness assessment tool²

Directions: Circle the number that best reflects your honest response to the statement. When you are finished, add up the total number of points and compare them to the Cultural Awareness Scale below.

Statement	Always	Sometimes	Never
I feel comfortable when discussing alternative lifestyles with clients.	3	2	1
I support the use of traditional cultural healing practices for hospitalized clients.	3	2	1
I know the limits of my communications skills with clients from different cultures.	3	2	1
Outside the work setting, I make an effort to be involved with people from different cultures.	3	2	1
When assessing clients, I recognize the biologic variations of different ethnic groups.	3	2	1
I accept that there is a strong relationship between culture and health.	3	2	1
I consider the race, sex, and age of my clients when administering medications.	3	2	1
When caring for clients from different cultures, I consider the specific diseases common among their group.	3	2	1
I openly acknowledge my own prejudices and biases when working with clients from different cultures.	3	2	1
I seek out and attend in-service classes that deal with cultural and ethnic diversity.	3	2	1
I remain calm when my healthcare values or beliefs clash with those of a client.	3	2	1
I practice culturally competent nursing when dealing with all clients, not only those from different ethnic groups.	3	2	1
When assessing clients initially, I consider their geographic origins, religious affiliation, and occupation as important elements of the care plan.	3	2	1
I have a high level of knowledge about the beliefs and customs of at least two different cultures.	3	2	1
I use a standardized cultural assessment tool when performing admission assessments on clients from different cultures.	3	2	1
I take into consideration the policies of my institution that serve as barriers for the effective provision of culturally competent care.	3	2	1
I recognize the cultural differences between the members of the same culture.	3	2	1

Cultural Awareness Scale

- 40 to 51 points = High degree of cultural awareness
- 30 to 39 points = Average degree of cultural awareness
- 17 to 29 points = Low degree of cultural awareness

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into a particular culture or ethnic group on the basis of characteristics such as outward appearance, race, country of origin, or stated religious preference. Stereotyping is defined as an oversimplified conception, opinion, or belief about some aspect of an individual or group of people.⁴ Nurses should be aware that many subcul-

tures and variations may exist within a cultural or an ethnic group. For example, the label Asian American is inclusive of cultures such as Chinese, Japanese, Taiwanese, Filipino, Korean, and Vietnamese. Within each of these cultures are many subcultures based on variations, including geographic region, religion, language, socioeco-

nomie level, gender, family structure, parenthood, educational level, and degree of adherence to folk medicine.

Healthcare professionals should also be careful about labeling patients. For example, citizens in the United States tend to refer to themselves as Americans. This term could also apply to persons from Central and South America, so a more accurate way of referring to a person from the United States would be “US citizen.”

The degree of acculturation or assimilation of the client into US society also must be determined. Acculturation is the “modification of one’s culture as a result of contact with another culture.”⁴ Assimilation refers to the “gradual adoption and incorporation of the characteristics of the prevailing culture.”⁴ Traditionally, the United States has been considered a melting pot of world cultures, with the majority of immigrants eager to assimilate and/or acculturate into US society so they could “fit in” to their new homeland. However, since the early 1970s, the trend has been for immigrants to maintain their own unique cultural practices and traditions.² Because of this trend, the United States now seems more of a “salad bowl” than a melting pot, with modern immigrants retaining their own unique flavors and textures.² To provide culturally competent care, nurses working in critical care areas must determine the extent to which persons belonging to cultural or ethnic groups have assimilated or acculturated into US society.

Conclusion

The increasingly diverse, multicultural population in the United States is offering new challenges in the provision of culturally compe-

Table 4 Resources for cultural diversity

Internet links

Ethnomed	www.ethnomed.org
Foundation of Nursing Studies	www.fons.org
Cross-cultural healthcare	www.diversityrx.org
Transcultural/multicultural health links	www.lib.iun.indiana.edu/trannurs.htm
Transcultural Nursing Society	www.tcns.org
Multicultural links	www.worlded.org/us/health/does/culture/materials/websites_015.html
Nursing specialties	www.allnurses.com

Journal resources

- International Journal of Nursing Studies*
- International Nursing Review*
- Journal of Cultural Diversity*
- Journal of Multicultural Nursing*
- Journal of Transcultural Nursing*
- Minority Nurse*
- Western Journal of Medicine: Cross Cultural Issues*

Table 5 Components of the Giger and Davidhizar assessment model¹⁰

Component	Definition/Comments
Communication	Communication of all types is the primary matrix through which culture is transmitted. Essential elements of communication that must be considered in assessing individuals from minority groups include dialect, style (language and social situations), volume (silence), use of touch, context of speech (emotional tone), and kinesics (gestures, stance, and eye behavior). What are the differences in communication? Do persons from this culture engage in chanting, crying, stoicism, or expressive gesturing?
Space	Space refers to the distance needed in personal relationships and intimacy techniques used in relating verbally or nonverbally to others. How close should you stand to a person when talking to him or her? Is touching a member of another sex by a nurse acceptable behavior in this culture?
Social organization	For many cultural groups, the family is the most important social organization. Who is the head of the family? Is the family nuclear or extended? Who makes the primary decisions within the family?
Time	Time orientation is past, present, or future. Past-oriented persons tend to focus on maintaining tradition and have little interest in future goals. A present-oriented person focuses on the present and has little appreciation for the past or for planning for the future. A future-oriented person is more focused on achieving future goals. A culture's time orientation often helps answer questions such as how much time is observed between death and burial or how longevity is viewed.
Environmental control	Environmental control refers to the ability of a person from a particular cultural group to plan activities that control nature and to the person's perception of ability to direct factors in the environment. How much control does a person have over what is happening to him or her? Do things happen by fate or by God's will? Or do a person's actions have a direct action on what is happening to the person?
Biological variations	Persons differ biologically according to race; health professionals should be aware of these differences in order to plan appropriate treatment and intervention. What health conditions and diseases tend to be more prevalent in a patient's culture?

tent care by critical care nurses. A direct relationship exists between a patient's culture and his or her health; of the many variables known to influence health beliefs and practices, culture is one of the most influential.⁹ If the provision of the best possible care for all patients is the goal, critical care nurses must have expertise and skill in the delivery of culturally appropriate and culturally competent nursing care. Each critical care nurse must take an active role in obtaining an information base upon which to develop a cultural competency. The ability to deliver nursing care that will allow effective interactions and the development of appropriate responses to persons from diverse cultures, races, and ethnic backgrounds is truly a challenge for nurses in the 21st century.

References

1. Ekblad S, Marttila A, Emilsson M. Cultural challenges in end-of-life care: reflections from focus groups' interviews with hospice staff in Stockholm. *J Adv Nurs*. 2000; 31:623-630.
2. Catalano J. *Nursing Now: Today's Issues, Tomorrow's Trends*. 3rd ed. Philadelphia, Pa: FA Davis; 2003:393-411.
3. United States Bureau of Census, 2000. Available at: <http://www.census.gov/population/www/cen2000/briefs.html>. Accessed August 2003.
4. Purnell LD, Paulanka BJ. *Transcultural Health Care: A Culturally Competent Approach*. Philadelphia, Pa: FA Davis; 1998:1-7.
5. American Nurses Association. *Code for Nurses*. Washington, DC: ANA Publishing; 2001.
6. Erlen JA. Culture, ethics, and respect: the bottom line is understanding. *Orthop Nurs*. November/December 1998;17:79-82.
7. Shi F, Shu-Hsun C. Comparisons of American-Chinese and Taiwanese patients' perceptions of dyspnea and helpful nursing actions during the intensive care unit transition from cardiac surgery. *Heart Lung*. 1999;28:41-54.
8. Galanti G. *Caring for Patients From Different Cultures: Case Studies From American Hospitals*. 2nd ed. Philadelphia, Pa: University of Pennsylvania Press; 1997.
9. Campinha-Bacote J, Munoz C. A guiding framework for delivering culturally competent services in case management. *Case Manager*. March-April 2001;12:48-52.
10. Dowd SB, Poole VL, Davidhizar R, Giger JN. Death, dying and grief in a transcultural context: application of the Giger and Davidhizar assessment model. *Hosp J*. April 1998;13:33-45.