Cultural Competence Models in Nursing

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KEYWORDS

- Cultural competence • Cultural competency models
- Diversity • Health care delivery • Theory of change
- Theoretic frameworks

> *Of all the forms of inequality, injustice in health care is the most shocking and inhumane.*
>
> *Dr. Martin Luther King, Jr.*

According to the American Organization of Nurse Executives' 2007 Position Statement and Guiding Principles for Diversity in Health Care Organizations, globalization, new technology, war, threats of bioterrorism, and ecosystem imbalances represent only the beginning of America's heightened awareness of movement between cultures and countries and the pervasive effects this has unleashed.[1,2] Even with the acknowledgment of these inconvenient truths, there is undeniable evidence that highlights continued acts of denial, resistance, and other desperate human actions to control that which is uncontrollable. Of all the issues, those related to demographic changes and the voices of difference seem to present the most struggle. Modern America is home to millions of immigrants. Today's workforce is a reflection of the considerable mix of cultures, ages, new family configurations, religions, and races. Diversity in its many forms will be a part of the future and requires new social interactions, societal expectations, and mandates. Accordingly, it is time to get serious about diversity.

Historically for the United States, the education of health care providers has focused on the demographic majority that is European-American. Despite growing evidence of the significant effect of psychosocial and behavioral factors in the onset, presentation, and prognosis of many illnesses,[3] a biomedical model remains dominant in medical practice. In a country with growing population diversity, care nevertheless has been increasingly standardized (and not necessarily in compliance with practice guidelines) rather than customized to individual patient and family needs or preferences. The current health care workforce has not been adequately prepared or educated to care or work with persons of the nonmajority culture in anything other than in a dominating, overseer type role. Such approaches have added insult to injury (often referred to as "microaggressions") and rendered the provider or the care environment countereffective in providing optimum care. Calls have been issued on providing culturally appropriate care and understanding the context for its provision. Moreover, compelling arguments and policy development to hold providers of care accountable and to train the workforce have been called for by the US Department of Health and Human Services Office of Minority Health's Culturally and Linguistically Appropriate Standards, the Joint Commission on Accreditation of Healthcare Organizations, and such landmark reports as The Sullivan Report: Missing in Action in 2006 and the Institute of Medicine's Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare in 2002.[4–7] The link between cultural competency and patient safety caused by the dimensionality in presentation of patient's symptoms and the need for providers to be familiar with such dimensionality (if they are to intervene and respond in a timely manner) is also getting greater attention.

Growth of traditionally underrepresented ethnic minority groups and the aging of the population pose a dilemma for the country and its systems. Official definitions of the social system call for equality, whereas many of the informal features of this system demonstrate inequality. The pursuit

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of happiness, justice, and liberty continues to be available to some and withheld from others at the expense of all. Statutory reality in the United States has not caught up with constitutional morality and racial apartheid exists in state statutes. Efforts to build "a more perfect union" have not been perfect and they continue to plague this country. Nowhere is that more evident than when looking closely at the issues of providing cultural and linguistically appropriate health care services.

This article provides heuristic interpretation on cultural competency frameworks that can be used in clinical practice to deliver the care needed for today's culturally diverse patient population. Two frameworks are presented: the American Organization of Nurse Executives Guiding Principles for Diversity in Healthcare Organizations, and the adapted shifting perspectives model (**Fig. 1**).

MIRROR, MIRROR ON THE WALL

Culture, like genetics, not only has a group definition, but also an individual expression. Culture is an individual concept, a group phenomenon, and an organizational reality. It is shared, learned, dynamic, and evolutionary. The construct of culture also implies a dynamic, nested systems perspective that goes beyond discussions of race and ethnicity to include diverse subcultures. Subcultures include communities of interest (ie, religious denominations, fraternities, sororities, the elderly, persons with disabilities, breast cancer survivors). Each individual, family, and community represents a unique blend of overlapping and intersecting cultural elements in which the whole is greater than the sum of the parts. Understanding complexities of culture from the perspective of providers and recipients of care is critical because culture pervades all aspects of health care and all aspects of life. To say that this is not an easy task is an understatement, because "culture hides much more than it reveals, and strangely enough, what it hides, it hides most effectively from its own participants."[8] Culture does this silently at an unconscious but powerful level as evidenced by the following musings:

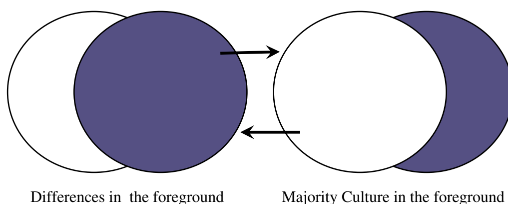

Fig. 1. The shifting perspectives model of chronic illness. (*Adapted from* Paterson BL. The shifting perspectives model of chronic illness. J Nurs Scholarsh 2001;33:23; with permission.)

- Racial bias and racism exist and function at all levels. No institution, system, or person is exempt. It threatens personal identity. Whether maligned, benign, or just plain misguided, it hurts all Americans, male and female; rich and poor; white, black, or Native American.
- There are two Americas and two systems of health care. According to former Surgeon General Dr. David Satcher, "if you want high quality health care it's good to speak English, be white and rich." (Dr. David Satcher, workshop, 2006)
- White privilege gives white students, white patients, and white colleagues in the workforce an edge over those who are nonwhite. Research reveals that whites fast track early to executive levels, whereas the nonmajority stays much longer in middle management. The reason for such outcomes is the lack of mentoring candidates of color receive.[8]
- Difference is seen and labeled as a problem. Teamwork and conformity are considered to be synonymous terms and are often used interchangeably. The aversion to differences is the result and the environments of care, education, and work are viewed as unwelcoming by those who are different from the majority.
- A commercial ethos exists in a social system.
- Abuse of power is growing in prevalence and practice, destroying the self-esteem of demographic populations that will be available and needed in the future.

Shaping the preferred future requires models or frameworks, leadership, political will, resilience, common sense, uncommon courage, and courageous dialog. Individuals and organizations can only change how they act if they are aware of their beliefs and assumptions. Examining assumptions about what is civil and any characteristics that hold people hostage to circumstances and situations over which they have no control is time well spent. In doing so, the level of self-awareness is raised, and in self-awareness begins the cultural competence journey. All encounters are cultural encounters and at the point of patient provider interaction three cultural encounters (the patient's, the provider's, and the organization's) occur simultaneously. This basic understanding is essential to producing the changes in thinking that

are necessary for respecting the culture of those under care.

UNDERSTANDING BY DESIGN

For the kind of understanding that makes for transformation at the human level, there must be a change in the "heart" and the "psychologic skin" of the environment. One of the most effective strategies for managing complexity, change, and establishing accountability is for system stakeholders to develop a clear link between their ideas and the strategies they intend to put into place.[9] The result of an idea is never separate from its source. Furthermore, thoughts always reveal themselves in behavior.

The theory of change articulates the underlying beliefs and assumptions that guide and are believed to be critical for producing the desired change or enable a person to meet the needs being addressed. A theory of change establishes clear links or connections between a system's mission and goals and actual outcomes. It is an approach that provides a way to make the de facto system visible and subject to thoughtful examination.[9]

According to Hernandez and Hodges,[10] there are three types of theories of change: (1) recorded theory (conceptualization); (2) expressed theory (operationalization); and (3) active theory (implementation). The first two are future oriented and the third is present oriented. Cultural competency encompasses all three. Edge[11] further elucidates that competency is "the ability to function effectively and to appreciate the gifts of those who look different, who were raised differently than we were." The core elements of the theory (the population context, the strategies to be used, and the goals or desired outcomes) are laid out so that the relationships between the three can be understood and conveyed. When this theory of change is applied to cultural competence, for example, a clear picture is outlined for the stakeholders such that cultural competence is easily recognizable wherever and whenever it is in use. Developing cultural competence happens by design and intention, not by default.

CULTURAL COMPETENCE: KNOWING IT WHEN SEEING IT

Some see cultural competence as a process, others as an outcome, and then there are those who see it as the skill that enables one to embrace diversity.[12] Anyone who desires to engage in such deliberate learning finds that reflection, critical thinking, and active participation in their learning is required. Without a doubt, cultural competencies are specific cognitive, affective, and psychomotor skills that are necessary for the facilitation of cultural congruence between provider and patient. Cultural competence is not an end point; an intention of eventual mastery is not possible. Approaches to cultural competence acquisition can be categorized as fact-centered or attitude- and skill-centered.[13] The attitude- and skill-centered approach represents a universal approach to cultural competence that enhances communication skills and emphasizes the particular sociocultural context of individuals. Like cultural competence training approaches, cross-cultural health programs and initiatives at the organizational level often fall into one of two categories: programs that focus on specific population groups, or health conditions and programs that address overall organizational cultural competence. The fact that it does not neatly fit into one of the types gives a plausible explanation for why there are so many frameworks in existence. Nine cultural, theoretic frameworks,[14–23] one meta-analysis,[14] and various evolving frameworks[24–27] are referenced in the literature.

Recognizing that both nursing care and culturally competent care are patient-centered care, the American Organization of Nurse Executives developed guiding principles for diversity in health care organizations in 2005 and updated these in 2007 (**Box 1**). These strategic and salient principles not only teach and raise the level of awareness for cultural competence; they also provide a means for evaluating the achievement of inclusive initiatives.

MODELS: SIX DEGREES OF INSPIRATION

The purpose of any model is to guide or inspire the user toward the preferred future as viewed by the model's creator. To provide greater clarity about the use of models, an acronym has been created that operationalizes what models do to enhance the user's understanding (**Box 2**).

In chronic illness, a helpful framework known as the "shifting perspectives model" is used. It was derived from a metasynthesis of 292 qualitative research studies on the perspectives of chronic illness.[13] The model shows living with chronic illness as an ongoing, continually shifting process in which people experience a complex dialectic between themselves and their "world." The shifting perspective model not only has application for chronic illness, but it also has value in cultural competence.

The chronic illness experience is depicted in the shifting perspective model as ever changing

Box 1
American Organization of Nurse Executives Guiding Principles for Diversity in Health Care Organizations

The following principles are intended to guide the nurse leader in achieving a diverse workforce by becoming an advocate for resources to implement and support a diversity program, encouraging a commitment to education, and leading diversity research initiatives that are based on performance improvement outcomes.

Guiding principle 1: Health care organizations will strive to develop internal and external resources to meet the needs of the diverse patient and workforce populations served

- Designate fiscal resources to develop programs and policies to meet the needs of diverse patient populations served.
- Establish system processes to ensure the needs of all patient populations are met.
- Include members from the local community with diverse backgrounds in organizational planning processes.
- Educate the community on the importance of collecting data, including patient and workforce race, ethnicity, and primary language spoken, for use in improving patient safety and quality.
- Develop processes and policies to ensure that non-English speaking and limited English proficiency patients will be assured of access to interpretive services and written translated patient education materials and documents.
- Implement processes to promote both the consistency of quality of care across various patient populations, and a balance in demographics between the patient and the workforce populations.
- Execute employment recruitment plans and strategies to attract a workforce that is reflective of the populations served.
- Train staff members in the importance of understanding the diversity of the patient population served and provision of culturally competent care.
- Support staff members in obtaining training and education in health care interpretation.

Guiding principle 2: Health care organizations will aim to establish a healthful practice/work environment that is reflective of diversity through a commitment to inclusivity, tolerance, and governance structures

- Encourage the employment of diverse groups of health care professionals.
- Actively involve all people in a shared decision-making process, when appropriate.
- Aim to establish a diverse healthful practice/work environment at all levels, including leadership and governance teams.
- Celebrate the diversity of talent as a source of strength, pride, and team spirit throughout the organization.
- Emphasize the promotion, recognition, and acceptance of diversity by all staff members in a nonbiased and sensitive manner.
- Facilitate the creation of a work environment that is conducive to open communication, flexibility, and acceptance of differences.
- Lead staff members without stereotypes or assumptions and with sensitivity to their gender, race/ethnicity, knowledge, skills, cultural backgrounds, values, and beliefs.
- Establish metrics to monitor targeted diversity benchmarks.

Guiding principle 3: Health care organizations will partner with universities, schools of nursing, and other organizations that train health care workers to support development and implementation of policies, procedures, programs, and learning environments that foster recruitment and retention of a student population that reflects the diversity of the United States

- Encourage use of admission criteria that focus on both qualitative and quantitative data.
- Recognize and appreciate the social and cultural barriers to college attendance that may exist for students from diverse population groups.
- Enter into collaborative agreements between education and practice that offer nursing staff from diverse groups the opportunity to serve as student mentors, guest lecturers, participants in school-based health centers, and/or clinical faculty.
- Encourage and support graduate education for nurses from diverse populations to build a more diverse pool of nurse leaders including nursing faculty.
- Develop and implement career plans for potential candidates for nursing careers from current employees with an emphasis on those from non-majority groups.
- Create and support community outreach programs such as shadow a nurse day, health care career fairs, and high school tutoring programs for targeted cultural groups in collaboration with members of the local community.

- Create a clinical rotation environment that supports a diverse nursing student body and learning styles.

Guiding principle 4: Health care organizations will collect and disseminate diversity related resources and information

- Use technology to heighten awareness and share information and resources related to diversity.
- Collect data (including, but not limited to, race and primary language spoken) as a part of routine patient registration processes and human resources management programs to better document and reflect the components of the patient and workforce populations. Establish formal policies and procedures to reflect these data collections.
- Support health care information technology (IT) systems that enhance the collection of diverse patient and workforce demographic data.
- Provide education to all staff regarding the relevance and value of collecting patient and workforce data including race, ethnicity and primary language spoken. Train staff on effective strategies and appropriate mechanisms for obtaining these data elements.
- Inform communities why it is necessary for health care organizations to collect patient and workforce race, ethnicity and primary language data.
- Routinely review quality and use data by race, ethnicity and primary language of patients to eliminate potential inconsistency in quality of care across various patient populations and to balance patient population demographics and the workforce population.
- Use data to develop action plans toward improving the state of diversity in the workplace.
- Conduct research to measure the effectiveness of improvement plans.
- Review evidence-based practice, related to diversity, and incorporate "best practices" into the organizations' own settings.

From the American Organization of Nurse Executives (AONE). Available at: www.aone.org. Accessed May 28, 2008; with permission.

perspectives about the disease that enable people to make sense of their experience. People with chronic illness live in "the dual kingdoms of the well and the sick" bouncing back and forth. The major factors identified as fostering exchange of prominences in the foreground is the perception of a threat to control and the recognition that the shift or bounce has occurred and a need to return to the closest state of wellness possible.[28] The measure of wellness is determined by comparing the experience with what is known and understood about illness and vice versa. According to the shifting perspectives model, the perspectives are not right or wrong but rather "reflect people's needs and situations." The basis of the model is also true in today's rapidly changing demographic interactions. It is even more so for individuals who are not of the majority. The many frameworks are in a way the shifting perspectives as captured by the model's developer. Applying this model to the cultural competency dilemma as an overarching framework shows promise as a way of conceptualizing the concepts, constructs, and relationships that form the complex and dynamic realm of culturally congruent health care and furthers the understanding of the many cultural competence frameworks in general.

Box 2
The purpose of MODELS

Makes sense of the relationships of the parts

Opens the mindset of the user

Develops individuals and organizations

Eliminates barriers to the desired outcome

Leads the user in the direction of the preferred state

Self-examination through questioning; ask questions…then ask more questions

Schematically, the shifting perspectives model looks like an eclipse where the majority culture is the sun and difference is the moon. Each perspective is depicted by overlapping circles in which either the majority culture or difference takes precedence. As the reality of the individual's experience and the personal and social context changes, the individual's perspectives shift in the degree to which difference is in the foreground or background of their "world." Past experiences also play a role in when difference shifts into the foreground for an individual. A person's past experiences, such as confronting racism, are always lurking in the shadows and can be pulled to the forefront based on the situation faced. Ignoring past experiences does not erase them or the residual effects they leave.

The perception of reality, not the reality itself, is the essence of how people interpret and respond

to their experiences. One's perspectives form and shape their realities. Gone are the days of failing to consider or outright ignoring the views, feelings, and interpretations of others. Multiple realities can and do inhabit the same space simultaneously. Because this country believes in individual rights, it is expected and extolled that personal reality receives consideration and respect. The sheer existence of these multiple perspectives is at the heart of the complexities and challenges of cultural competence. All of the cultural competence frameworks capture this phenomenon. Considering and using the knowledge and mandates of the patient's culture provides the ability to operationalize culturally competent care within the nursing process. To do so requires learning the "how tos," which includes asking questions, holding in abeyance assumptions and ethnocentricism, and learning more about different worldviews and that which is unfamiliar and sometimes taboo. Each emphasizes the need to learn about one's self and about other cultures, a proposition that is nonending and requires continuous learning.

SUMMARY

Culture: individuals possess it, organizations have it too, countries flaunt it with pride, professions and religious denominations are forms of it. Because every customer encounter (whether patient or a coworker) is a cultural encounter, using creative ways to approach content of this nature is always welcomed. Culture is the lens through which the world is viewed and approached. It influences decisions made, actions taken, and personal relations. One cannot operate for any length of time in a way that is inconsistent with one's own thinking. Culture is everywhere and exists in a variety of forms that often collide with each other, creating at times horrendous moments and at others quite humorous, but always instructional occasions. Because all knowledge is about the past and all decisions are about the future, mental models suggest that the quest to be the best requires continuous learning. When one puts culture and competence together (cultural competence), the result is both a process (series of events) and an outcome (a synthesis of different perspectives). Mastering the skill set of cultural competence is a win-win for all involved. In health care, this understanding is what is needed for the demands of today's unique patient and workforce.

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