6 Education and Training in Culturally Competent Care

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Guideline: *Nurses shall be educationally prepared to provide culturally congruent health care. Knowledge and skills necessary for assuring that nursing care is culturally congruent shall be included in global health care agendas that mandate formal education and clinical training, as well as required ongoing continuing education for all practicing nurses.*

Douglas et al. (2014: 110)

6.1 Introduction

In addition, to culture being incorporated into formal nursing programs, continuing education of nurses in culturally competent and congruent care is increasingly becoming a requirement for accreditation of healthcare organizations by agencies such as the Joint Commission (The Joint Commission 2010; The Joint Commission International 2011). Education for culturally competent care encompasses knowledge of the cultural values, beliefs, lifeways, and worldview of population groups as well as individuals (Papadopoulos 2006). Although Great Britain has encouraged culturally competent education in nursing and other healthcare professions, no official mandate has materialized (George et al. 2015). Whereas Australia and New Zealand has initiatives on cultural competence in education, a mandate for including cultural competence in nursing education could not be found. The same is true for other countries around the world.

6.2 Individualistic and Collectivistic Attributes as a Framework

A good starting point for staff at all levels is to gain an understanding of general principles of broad cultural groups and an understanding of individualistic and collectivistic cultures. All cultures that vary along a continuum of individualism and collectivism, subsets of broad worldviews, are somewhat context dependent.

Individualism versus collectivism scale									
Individualism									Collectivism
1	2	3	4	5	6	7	8	9	10

A degree of individualism and collectivism exists in every culture. Moreover, individualism and collectivism fall along a continuum, and some people from an individualistic culture will, to some degree, align themselves toward the collectivistic end of the scale. Some people from a collectivist culture will, to some degree, hold values along the individualistic end of the scale (see Table 6.1). The degree of acculturation and assimilation and the variant characteristics of culture (see Chap. 2) determine the degree of adherence to traditional individualistic and collectivist cultural values, beliefs, and practices (Hofstede and Hofstede 2005; Purnell 2013). They include orientation to self or group; decision-making; knowledge transmission;

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Table 6.1 General collectivistic versus individualistic values

Collectivistic cultures	Individualistic cultures
Communication	
• Implicit indirect communication is most common. People are more likely to tell the professional what they think the professional wants to hear • More formal greeting is required by using the surname with a title. This can be a first step in gaining trust. The professional should always ask by what name the person wants to be called • Present temporality is most common, although balance is sought. The person usually wants to know how the illness/condition will affect them on a short-term basis. Address the individual's and family's concern before moving on • Punctuality is not valued except when absolutely necessary such as making transportation connections. If punctuality is required, explain the importance and the repercussions for tardiness such as a not being seen or a charge is made for being late • Truth telling may not be valued in order to "save face" • "Yes" may mean I hear you or I understand, not necessarily agreement. Do not ask questions that can easily be answered with "yes" or "no." The answer is invariably "yes." Instead of asking if the individual takes the medicine as prescribed, ask "what time do you take the medicine?" "How many times have you missed taking your medicine this week/month?" • Direct eye contact may be avoided with people in hierarchical positions as a means of respect, especially among older more traditional people but is maintained with friends and intimates. Do not assume that lack of eye contact means that the person is being evasive or not telling the truth • Sharing intimate life details of self or family is discouraged because it may cause a stigma for the person and the family. Ask intimate questions after a modicum of trust has been developed • Spatial distancing with non-intimates may be closer than 18 inches. Do not take offense if the person stands closer to you than what you have been accustomed to • Touch is readily and usually accepted between same-sex individuals but not necessarily between people of the opposite sex. Always ask permission and explain the necessity of touch • A diagnosis of depression is usually not acceptable. Do not use this diagnosis until a modicum of trust has been established	• Explicit, direct, straightforward communication is the norm • More informal greeting frequently use the given name early in an encounter. Professionals should introduce themselves by the name they preferred to be addressed. Ask the individual by what name they want to be addressed • Futuristic temporality is the norm. The person usually wants to know how the disease/condition will affect them on a long-term basis • Punctuality is valued. People are usually on time or early for formal appointments • Truth telling is expected at all times. Individuals will usually answer the professional truthfully or evade the question completely if they do not want to answer it • Questions requiring "yes" or "no" are usually answered truthfully • Direct eye contact is expected and is a sign of truth, respect, and trust • Sharing intimate life details is encouraged, even with non-intimates, and does not carry a stigma for people or their family • Spatial distancing with non-intimates is 18–24 inches. Sexual harassment laws encourage a low touch culture. Explain the necessity and ask permission before touching • A diagnosis of depression does not carry a stigma and can be shared with individuals and their families (if necessary) without a stigma

Table 6.1 (continued)

Collectivistic cultures	Individualistic cultures
Family roles and organization	
• Decision-making is a responsibility of the male or the most respected family member. The male is usually the spokesperson for the family, even though he may not be the decision-maker • Individual autonomy is not usually the norm • Older people's opinions are sought but not necessarily followed • Young adults and children are not expected to have a high degree of dependence until they leave their parent's home • Children are not usually encouraged to express themselves; they are expected to be seen, not heard • A stigma may result when a family member is placed in long-term care. Home care with the extended family is the norm • Alternative lifestyles are not readily accepted and may be hidden from the public and even within the extended family. Do not disclose same-sex relationship to family or outsiders • Extended family living is common with collective input from all members • Beneficence a normative statement to act for others' benefit may mean that the healthcare professional should not reveal grave diagnoses or outcome directly because it may cause them to give up hope. Therefore, the professional should disclose this information to the family who makes the decision to disclose the diagnosis to the individual. An alternative is to tell a story about someone else who has the condition	• Egalitarian decision-making is the norm, although there are variations. Ask who is the primary decision-maker for health-related concerns • Individual autonomy is the norm • Younger people are expected to become responsible and independent at a young age. Determine responsibilities for children and teenagers. • Children are encouraged to express themselves. Allow children to have a voice in decision-making • Each person in a group has an equal right to express an opinion • No stigma is attached for placing a family member in long-term care or substance misuse rehab • Alternative lifestyles are gaining more acceptance than in the past. Ask about same-sex relationships after a modicum of trust has been established • Nuclear family living is the norm. However, the professional must still ask who else lives in the household and what are their responsibilities • Beneficence a normative statement to act for others' benefit requires the healthcare professional to reveal grave diagnoses or outcome directly to the individual in order to make informed decisions regarding the future
High-risk health behaviors	
• Accountability is a family affair or some hierarchal authority • High-risk health behaviors are less likely to be revealed to healthcare professionals. Do not disclose substance misuse to family members	• People are accountable for their own actions • High-risk health behaviors are revealed to healthcare professionals. However, it is still best to ask about substance misuse after a modicum of trust has been established

(continued)

Table 6.1 (continued)

Collectivistic cultures	Individualistic cultures
Healthcare practices	
• Traditional practices are common as a first line of defense for minor illnesses. Specifically ask about traditional practices, including herbs • Complementary and alternative therapies are frequently preferred over allopathic practices. Specifically ask about complementary and alternative practices • Preventive practices are stressed • Rehabilitation is frequently a family responsibility. Great stigma can occur by placing a family member in a long-term care or rehab facility • Self-medication is common and expends to prescription medicines that may be obtained from overseas pharmacies and friends. Specifically ask what medicines the person is taking • Pain may be seen as atonement for past sins. Take every opportunity to dispel this myth • Mental health issues may be hidden because they carry a stigma for the family. Disclose mental health and substance misuse only to professionals who "need to know" • Advance directives that convey how the individual wants medical decisions made in the future may not be acceptable to some because this is a family, not individual, responsibility	• Traditional practices are common as a first line of defense for minor illnesses. Ask about over-the-counter medications and herbs • Complementary and alternative therapies are gaining acceptance because they are less invasive. Specifically ask the individual about their complementary and alternative practices • Curative healthcare practices have been the norm, but preventive practices and healthy living are gaining acceptance • Rehabilitation is well-integrated into allopathic care • Liberal pain medication is expected although recent research is sometimes discouraging this • Mental health issues do not usually carry a stigma for the family. However, ask the person about disclosure of substance misuse and reveal it only to those who need to know • Advance directives that convey how the individual wants medical decisions made in the future are compatible with individualism
Healthcare practitioners	
• Allopathic professionals may be seen as a first resource for major health problems, although traditional healers may be seen simultaneously. Professionals should partner with traditional healers • Spiritual leaders frequently serve as alternative practitioners for emotional concerns and substance misuse • Age of the professional may be a concern. Ask the individual if they prefer an older professional • Opposite sex healthcare provider may not be acceptable with devout Jewish and Muslim individuals. Ask the individual if a same-sex professional is required for non-life-threatening conditions	• Age of professional healthcare providers is usually not a concern • Same-sex healthcare providers are usually not required except for traditional Muslims and orthodox Jews. Specifically ask if a same-sex professional is required for non-emergent conditions

A degree of individualism and collectivism exists in every culture. Some people from an individualistic culture will, to some degree, align themselves toward the collectivistic end of the scale. Some people from a collectivist culture will, to some degree, hold values along the individualistic end of the scale. Thus, the information in this table should be seen as a guide

individual choice and personal responsibility; the concept of progress, competitiveness, shame, and guilt; help-seeking; expression of identity; and interaction/communication styles (Hofstede 2001; Hofstede and Hofstede 2005; Rothstein-Fisch et al. 2001). One should not confuse individualism from individuality. Individuality is the sense that each person has a separate and equal place in the community and where individuals who are considered "eccentrics or local characters" are tolerated (Purnell 2010; Singelis 1998; Triandis 2001).

6.2.1 Individualism

Individualism is a moral, political, or social outlook that stresses independence (Bui and Turnbull 2003; Greenfield et al. 2003; Markus

and Kitayama 1991; Hofstede and Hofstede 2005; Purnell 2013; Triandis 2001). Consistent with individualism, individualistic cultures encourage self-expression. Adherents freely express personal opinions, share many personal issues, and ask personal questions of others to a degree that may be seen as offensive to those who come from a collectivistic culture. Direct, straightforward questioning with the expectation that answers will be direct is usually appreciated with individualism. Small talk before getting down to business is not always appreciated. However, the healthcare provider should take cues from the patient before this immediate, direct, and intrusive approach is initiated. Individualistic cultures usually tend to be more informal and frequently use first names. Ask the patient by what name she/he prefers to be called. Questions that require a "yes" or "no" answer are usually answered truthfully from the patient's perspective. In individualistic cultures with values on autonomy and productivity, one is expected to be a productive member of society (Purnell 2011, 2013; Singelis 1998). Some highly individualistic countries include Australia, Belgium, the United States, Great Britain, England, Canada, Finland, Germany, Ireland, Israel, Great Britain, Finland, Luxembourg, Norway, the Netherlands, postcommunist Poland, Slovakia, South Africa, Sweden, and Switzerland, to name a few (Darwish and Huber 2003).

Individualistic cultures expect all to follow the rules and hierarchical protocols, and each person is expected to do his/her own work and to work until the job is completed (Eshun and Hodge 2014). In addition, children are often expected to become responsible at a young age and have more independence and self-expression. However, in situations where the group makes decisions, each member has an equal right to express their opinions, and opinions can differ greatly, enhancing the chance the decision is better than what one person's decision would be. The expectation is that all will follow the decisions made (Eshun and Hodge 2014).

Individualistic cultures socialize (enculturate) their members to view themselves as independent, separate, distinct individuals, where the most important person in society is self. A person feels free to change alliances and is not bound by any particular group (shared identity). Although they are part of a group, they are still free to act independently within the group and less likely to engage in "groupthink."

6.2.2 Collectivism

Collectivism is a moral, political, or social outlook that stresses human interdependence—it is important to be part of a collective. The individual is defined in terms of a reference group—family, church, work, school, or some other group. Collectivism can stifle individuality and diversity leading to a common social identity (Bui and Turnbull 2003; Greenfield et al. 2003; Hofstede and Hofstede 2005; Markus and Kitayama 1991; Triandis 2001). Some collectivistic cultures include American Indian/Alaskan Native and most indigenous populations, Asian Indian, Chinese, Korean, Pakistani, Filipino, Japanese, Mexican, Spanish, and Taiwanese (Darwish and Huber 2003).

Most collectivist cultures are high context where implicit communication may be valued over explicit communication: the meaning is usually embedded in the information, and the listener must "read between the lines" (Keeskes 2016). Shame and guilt are strong, and the individual must not do anything to cause shame to self, the family, or the organization. Most believe in the hierarchal structure, and one should not stand out in the crowd (Greenfield et al. 2003; Hofstede and Hofstede 2005; Markus and Kitayama 1991; Purnell 2011). To interrupt another in a conversation is considered extremely rude. Sensitive issues that may cause a stigma to family or others are not revealed.

Time is more relaxed; punctuality is valued only in business and situations where it is essential such as in making transportation connections. Most value formality; therefore, always greet the patient and family members formally until told to do otherwise. In most traditional cultures, but not all, men have decision-making authority or are the spokesperson for the family, even if they are

not the primary decision-maker. Gender roles are usually less fluid than in individualistic cultures; however, expectations upon immigration may cause significant family discord (Purnell and Pontious 2014).

6.3 Knowledge of Specific Cultures Cared for in the Practice Setting

Whereas the individualistic and collectivistic framework is a good starting point for understanding culture and a broad assessment guide, providers need to obtain an understanding of the specific cultural and subcultural groups seen in their practice. Specific content of the groups should include the overview and heritage of the group, communication practices, family roles and organization, workforce issues, biocultural ecology, high-risk health behaviors, nutrition, pregnancy and the childbearing family, death rituals, spirituality and religion, healthcare practices, and healthcare practitioners. A brief description of these concepts follows (Purnell 2013; Purnell and Fenkl 2018).

1. Overview and Heritage: Includes concepts related to the country of origin and current residence and the effects of the topography of the country of origin and the current residence on health, economics, politics, reasons for migration, educational status, and occupations.
2. Communication: Includes concepts related to the dominant language, dialects, and the contextual use of the language; paralanguage variations such as voice volume, tone, intonations, inflections, and willingness to share thoughts and feelings; nonverbal communications such as eye contact, gesturing, facial expressions, use of touch, body language, spatial distancing practices, and acceptable greetings; temporality in terms of past, present, and future orientation of worldview; clock versus social time; and the amount of formality in use of names. Differences between the language spoken by the healthcare provider and the patient, educational level, and health literacy can add to communication difficulties. Effective communication is the first and probably the most important aspect of obtaining an accurate health assessment (see this chapter).
3. Family Roles and Organization: Includes concepts related to the head of the household, gender roles (a product of biology and culture), family goals and priorities, developmental tasks of children and adolescents, roles of the aged and extended family, individual and family social status in the community, and acceptance of alternative lifestyles such as single parenting, same-sex partnerships and marriage, childless marriages, and divorce.
4. Workforce Issues: Includes concepts related to autonomy, acculturation, assimilation, gender roles, ethnic communication styles, and healthcare practices of the country of origin.
5. Biocultural Ecology: Includes physical, biological, and physiological variations among ethnic and racial groups such as skin color (the most evident) and physical differences in body habitus; genetic, hereditary, endemic, and topographical diseases; psychological makeup of individuals; and the physiological differences that affect the way drugs are metabolized by the body. In general, most diseases and illnesses can be divided into three categories: lifestyle, environment, and genetics. Lifestyle causes include cultural practices and behaviors that can generally be controlled, for example, smoking, diet, and stress. Environment causes refer to the external environment (e.g., air and water pollution) and situations over which the individual has little or no control (e.g., the presence of malarial mosquitos, exposure to chemicals and pesticides, access to care, and associated diseases and illnesses). Genetic conditions are caused by genes.
6. High-Risk Health Behaviors: Includes substance use and misuse of tobacco, alcohol, and recreational drugs; lack of physical activity; increased calorie consumption; nonuse of safety measures such as seat belts,

helmets, and safe driving practices; and not taking safety measures to prevent contracting HIV and sexually transmitted infections.
7. Nutrition: Includes the meaning of food, common foods and rituals, nutritional deficiencies and food limitations, and the use of food for health promotion and wellness and illness and disease prevention. Multiple diseases and illnesses are a consequence of this major cultural component.
8. Pregnancy and Childbearing Practices: Includes culturally sanctioned and unsanctioned fertility practices, views on pregnancy, and prescriptive, restrictive, and taboo practices related to pregnancy, birthing, and the postpartum period.
9. Death Rituals: Includes how the individual and the society view death and euthanasia, rituals to prepare for death, burial practices, and bereavement behaviors. Death rituals are slow to change.
10. Spirituality: Includes formal religious beliefs related to faith and affiliation and the use of prayer, behavioral practices that give meaning to life, and individual sources of strength.
11. Healthcare Practices: Includes the focus of healthcare (acute versus preventive); traditional, magico-religious, and biomedical beliefs and practices; individual responsibility for health; self-medicating practices; views on mental illness, chronicity, and rehabilitation; acceptance of blood and blood products; and organ donation and transplantation.
12. Healthcare Practitioners: Includes the status, use, and perceptions of traditional, magico-religious, and biomedical healthcare providers and the gender of the healthcare provider.

6.4 Cultural Theories and Models for Patient Assessment

A number of cultural theories and models for patient assessment have been developed. Some are very extensive, while others are more general in nature without a specific framework. All of these theories and models should be included in formal education programs. In practice, each organization can select the model or theory that they deem fits their needs.

Although some of these simplistic techniques can be used for collecting initial interview data, they do not work well with all ethnic and cultural groups nor are they comprehensive. Two examples are acronymic approaches: LEARN and BATHE. The LEARN approach includes the following guidelines: *listen* to your patients from their perspectives; *explain* your concerns and your reasons for asking for personal information; *acknowledge* your patients' concerns; *recommend* a course of action; and *negotiate* a plan of care that considers cultural norms and personal lifestyles (Berlin and Fowkes 1983). The BATHE acronym stands for *background*, information, *affect* [sic] the problem has on the patient, *trouble* the problem causes for the patient, *handling* of the problem by the patient, and *empathy* conveyed by the healthcare provider (McCullough et al. 1998).

The limited space available here does not permit an exhaustive description of the numerous models and theories centered on culture. A brief description of the models most commonly used in practice, education, administration, and research follows.

The Campinha-Bacote Model is a practice model focusing on the process of cultural competence in the delivery of healthcare services. This model, which is currently referred to as a volcano model, is used primarily in practice and education; it does not have an accompanying organizational framework. According to Transcultural C.A.R.E. Associates (2015), individuals, as well as organizations and institutions, begin the journey to cultural competence by first demonstrating an intrinsic motivation to engage in the process of cultural competence. The five concepts in this model are cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire (Transcultural C.A.R.E. Associates 2015).

The Giger and Davidhizar Model focuses on assessment and intervention from a transcultural nursing perspective. The six areas of human diversity and variation include communication, space, social orientation, time, environmental

control, and biological variations (Giger and Davidhizar 2012).

The Papadopoulos, Tilki, and Taylor Model focuses on the process of cultural competence in the delivery of healthcare services and is used in education, practice, and administration. This model does not have an assessment guide or organizing framework. The four main components of this model are cultural awareness that includes an ethnohistory, cultural knowledge, cultural competence, and cultural sensitivity. The center of the model includes compassion (Papadopoulos 2006).

Leininger's Cultural Care: Diversity and Universality Theory and Sunrise Model promote understanding of both the universally held and common understandings of care among humans and the culture-specific caring beliefs and behaviors that define any particular caring context or interaction. This theory incorporates (a) care (caring); (b) generic, folk, or indigenous care knowledge and practices; (c) professional care knowledge and practices that vary transculturally; (d) worldview, language, philosophy, religion, and spirituality; and (e) kinship, social, political, legal, educational, economic, technological, ethnohistorical, and environmental contexts of cultures. Within a cultural care diversity and universality framework, nurses may take any or all of three culturally congruent action modes: (a) cultural preservation/maintenance, (b) cultural care accommodation/negotiation, and (c) cultural care repatterning/restructuring (McFarland and Wehbe-Alamah 2015).

Spector's HEALTH Traditions Model incorporates three main theories: Estes and Zitzow's heritage consistency theory, the HEALTH Traditions Model, and Giger and Davidhizar's theory about the cultural phenomena affecting health. The HEALTH Traditions Model is based on the concept of holistic health and explores what people do to maintain, protect, or restore health. This model emphasizes the interrelationship between physical, mental, and spiritual health with personal methods of maintaining, protecting, and restoring health. Spector also provides a heritage assessment tool to determine the degree to which people or families adhere to their traditions. A traditional person observes his or her cultural traditions more closely. A more acculturated individual's practice is less observant of traditional practices (Spector 2009).

The cultural safety model includes actions which recognize and respect the cultural identities of others and safely meet their needs, expectations, and rights. Strategies that enhance the ability to be culturally safe are (a) reflecting on one's own culture, attitudes, and beliefs about "others"; (b) having clear, value-free, open, and respectful communication; (c) developing trust; (d) recognizing and avoiding stereotypical barriers; (e) being prepared to engage with others in a two-way dialogue where knowledge is shared; (f) and understanding the influence of culture shock (Cultural Connections for Learning: Cultural Safety 2013).

Cultural humility has three processes: (a) lifelong commitment to self-evaluation and self-critique, (b) a desire to fix power imbalances, and (c) aspiring to develop partnerships with people and groups who advocate for others (American Psychological Association 2013).

The Purnell Model for Cultural Competence has been classified as a holographic and complexity theory because it includes a model and organizing framework that can be used by all health disciplines. The purposes of this model are to (a) provide a framework for all healthcare providers to learn concepts and characteristics of culture; (b) define circumstances that affect a person's cultural worldview in the context of historical perspectives; (c) provide a model that links the most central relationships of culture; (d) interrelate characteristics of culture to promote congruence and to facilitate the delivery of consciously sensitive and competent healthcare; (e) provide a framework that reflects human characteristics such as motivation, intentionality, and meaning and provide a structure for analyzing cultural data; and (f) view the individual, family, or group within their unique ethnocultural environment (Purnell and Fenkl 2018) (see Appendices 1 and 2).

6.5 Interdisciplinary Practice

Cultural competence is a requisite for all professionals who have direct or indirect contact with patients. Most cultural concepts, knowledge, and practice skills are shared by all health disciplines, making cultural competence a requirement for all. For example, cross-cultural communication principles do not change for direct care professionals, auxiliary staff, or administrative personnel. Workshops and conferences should include multidisciplinary professionals where personal cultural stories can be shared.

6.6 Recommendations

Recommendations for clinical practice, administration, education, and research follow.

6.6.1 Recommendations for Clinical Practice

Staff at all levels should attend continuing education classes, in-services, conferences, and other learning experiences to maintain cross-cultural skills. Upon admission, professional staff need to use a comprehensive cultural assessment tool that can be added to as time and circumstances permit (see this chapter). The assessment should include the patient's cultural and ethnic background as well as familiar genetic and hereditary health conditions. The assessment needs to include not just current work environment but previous work as well. In addition, the work history needs to be completed for patients who are retired. Environmental living arrangements are included in an assessment.

6.6.2 Recommendations for Administration

Organizational administration has the prime responsibility to assure that culturally competent care is delivered throughout the organization. The organization's mission and philosophy must be addressed at the department level as well as each unit within a department. Administrators and managers, whether in direct or indirect care, must role model cultural competence and work with national and community organizations to ensure that patients' needs are being met. They should also seek positions and be involved on community and national boards.

Staff should be provided with unit-written resources and partner with universities for online resources that all staff can access. In addition, administration can support and host workshops and conferences as effective approaches to culturally congruent nursing practice. Hosting community health fairs with ethnic community organizations that support vulnerable populations adds value to the organization's mission.

6.6.3 Recommendations for Education

In the academic setting, all the concepts included in Chap. 2, knowledge of cultures, should be included. The preference is to have a separate course on culture that includes both cultural general as well as cultural specific information in every course and include the use of complementary and alternative practices. What might be complementary and alternative in one culture may be mainstream health care in other cultures.

The curriculum must include content on vulnerable populations, socioeconomics, and cultural general information on the populations in clinical areas that also stress the importance of individual cultural values and beliefs. Culture needs to also be integrated throughout all courses such as pathophysiology, pharmacology, and simulation labs and clinical courses. If a specific cultural course is not feasible, maintain a system that assures cultural content is included in all courses so that cultural content is not lost.

In the service setting, cultural content needs to be addressed in orientation with annual in-service training in cultural competence for all levels of staff including management, other profession-

als, and auxiliary staff in any department with patient contact. Classes to increase staff's cultural knowledge about the ethnically diverse patients who receive health services in the facility should be conducted and reinforced in the organization's intranet with population health beliefs and values.

Educators should mentor staff for whom the dominant language is not the same as the patient's for sociopragmatic competence specific to the medical setting (Sedgwick and Garner 2017). A variety of modalities to teach cultural competency can include workshops, conferences, online training, films, and immersion experiences whether in diverse communities, in the home environment, or in other countries. Faculty should partner with transcultural experts to provide staff with continuing education courses, consultation, and practice skills for culturally competent care.

6.6.4 Recommendations for Research

Journal clubs can be established to review current scholarly evidence-based literature on the populations served by the organization and should be instituted and offered at times that clinical staff can attend. Consultants from local university and college faculty can be employed to facilitate implementation of evidence-based cross-cultural practice. Staff wanting to conduct research can partner with local faculty for expertise in the research process and study design.

An interdisciplinary team of researchers and educators can collaborate on quality improvement projects and to apply for funding. Initial research should be on ethnic/cultural groups common to the organization. Although it might not be possible to translate satisfaction surveys in all the patients' languages served by the organization, at least they should be translated into the most common languages of patients; otherwise, only part of the data is collected. The results of satisfaction served can be used in quality improvement projects or to conduct research.

Conclusion

Cultural competence has become one of the most important initiatives worldwide for a number of reasons. Diversity has increased in many countries due to wars, political strife, world socioeconomic conditions, and migration. In addition, the last few decades have demonstrated that culturally congruent care increases patient satisfaction, improves patient care, and reduces cost. The recognition of the social determinants of health with vulnerable populations (see Chap. 1) has been a focus to help alleviate heath disparities. Therefore, a requisite is to include culturally competent education in formal health-related programs and continue the process where the organization includes cultural competence during orientation and yearly thereafter. Cultural competence education and training are for all healthcare providers, including those who encounter diverse patients and families even though they may not be direct care providers.

Formal education must include content on the various models and approaches to learn culture and provide a stand-alone course on culture if possible and then integrate culture in every theory and clinical course. If a separate stand-alone course is not possible, the education organization needs to keep a tracking system to assure that culture is included in every course. Cultural competence is required for the organization and the individual provider. The American Association of Colleges of Nursing; the Office of Minority Health in the United States, Australia, and New Zealand; Royal College of Nursing; American Medical Association; National Medical Association; International Council of Nursing; and the American Nurses Association have all recognized the importance of culturally competent education.

Appendix 1: Recommended Content for Beginning Level Cultural Competency Education

Beginning level includes vocational or practical nursing programs, associate degree and diploma programs, and continuing education and in-service programs. The cultural content can be provided in a separate course as well as integrated into existing clinical curriculum. Modules of key concepts can be developed to provide for the greatest flexibility of presentation of this material. Key concepts that need to be integrated follow.

Overall Program Objectives Related to Culture

Develop cultural assessment skills of self and others (individuals and families):

1. Identify cultural similarities and differences and potential approaches to differences.
2. Use culture-related resources available for potential problems.
3. Recognize forms of discrimination in nursing care and take action to prevent or address them.

Content Related to Culture

1. Effective communication is essential for healthcare practice at all levels. A sample communication exercise is included (see Appendix 2 Chap. 14).
2. Culturally congruent care should be integrated as a component of every clinical course.
3. Social and material determinants of health should be included in theory courses and reinforced in clinical courses.
4. Cultural patterns and values of select cultural and ethnic or subcultural groups should be included in theory courses and reinforced in clinical courses.
5. Common cultural terms should be included in theory courses and reinforced in clinical courses. Some essential terms and concepts are collectivism, individualism, and individuality; cultural awareness, sensitivity, competence, and congruency; cultural imposition, relativism, and imperialism; cultural assimilation and accommodation, ethnocentrism, and stereotyping versus generalizing; individual and organizational cultural competence; interpretation versus translation; and ethnicity and subculture.
6. Biocultural variations should be incorporated into anatomy and physiology and pathophysiology and reinforced in clinical courses.
7. Genetic and hereditary diseases should be included in pathophysiology courses and reinforced in all clinical courses.
8. Common illnesses and diseases in cultural and ethnic groups should be included in pathophysiology and reinforced in clinical courses.
9. Dietary practices that include prescriptive, restrictive, and taboo practices of specific cultural and ethnic groups should be included in all clinical courses.
10. Health belief systems and complementary and alternative practices can be incorporated in pharmacology and/or assessment and reinforced in all clinical settings.

Appendix 2: Recommended Content for Advanced-Level Cultural Competency Education

Components of culture should be integrated into courses such as health assessment, pharmacology, anatomy and physiology, and all specialty clinical courses. Communication strategies beginning with assessing the client's preferred language and health literacy along with spatial distancing, eye contact, greetings, temporality, touch, and name format are essential. Interpretation and translation that include sign languages are also essential components of communication (see Chap. 14). In a pharmacology course, the racial/cultural difference in response to drugs should be included. In physiology and pathophysiology courses, the biocultural aspects of diseases should be included as

well as the biocultural variations in pain, height, weight, musculoskeletal variations, and physical appearances in general.

The following is a sample stand-alone course recommended for senior healthcare practitioners, nurse practitioners, and masters and doctoral level students. Cultural case studies should be included in all courses with content appropriate for the course. In addition, resources for teaching culture are included.

Course Description

Components of this course can be used in in-service and continuing education classes as deemed relevant or pertinent by the organization. A comprehensive course should include theories and models focused on culture, social and material determinants of health, health disparities, selected culturally specific groups commonly found in the catchment area of the school or organization, and common research methodologies used in cultural research. Evidence-based practice must be incorporated in discussions and formal scholarly papers (see Chap. 30). Students will critically reflect on their own cultural beliefs and values. Assignments should include group discussions on cultural and religious groups with an application to nursing practice. A formal team paper with four to six students is recommended because it increases learning knowledge. The team paper should be on a cultural or subcultural group different from anyone on the team.

Suggested Course Objectives

Upon completion of this course, the student will be able to:

1. Articulate the concepts that explain cultural diversity and their relevance for nursing practice
2. Examine cultural issues and trends in nursing practice
3. Analyze selected population group cultural patterns and behavioral manifestations of cultural values
4. Evaluate the socioeconomic impact of client's cultural needs upon levels of care: primary, secondary, and tertiary
5. Articulate theory, research methods, and advanced multicultural-sensitive nursing practice concepts
6. Formulate a model of care integrating culturally sensitive assessment, planning, intervention, and evaluation
7. Analyze impact of public and organizational policies on health of individuals and populations
8. Develop collaborative engagement with individuals and groups to mitigate health inequity
9. Promote engagement of individuals, groups, and organizations in health promotion for disadvantaged populations
10. Develop cross-cultural leadership to promote culturally competent care and retention of multicultural workforce

Possible Teaching Strategies

PowerPoint lectures

Live classroom or online discussions of cultural, ethnic, or subcultural groups

Required and recommended readings determined by the faculty teaching the course

Recommended Web sites

Topical Outline

A. Introduction to culture and related concepts
   1. Values and culture
   2. Vulnerability as a framework
   3. Expanding definitions of cultural groups and underserved populations
   4. Review of common cultural terms: collectivism, individualism and individuality; cultural awareness, sensitivity, competence and congruency; cultural imposition, relativism, and imperialism; cultural assimilation and accommodation, ethnocentrism, stereotyping, and generalizing; individual and organizational cultural competence; interpretation versus translation; and ethnicity and subculture.

B. Selected theoretical models for nursing practice
   1. Andrews and Boyle Assessment Guide
   2. Campinha-Bacote's Model The Process of Cultural Competence in the Delivery of Healthcare Services
   3. Giger and Davidhizar Transcultural Assessment Model
   4. Leininger's Culture Care Diversity and Universality Theory
   5. Jeffrey's Cultural Competence and Confidence (CCC) Model: Transcultural Self-Efficiency
   6. Papadopoulos, Tilki, and Taylor Model for Developing Culturally Competent and Compassionate Healthcare
   7. Purnell Model for Cultural Competence
   8. Schim, Dorenbos, Benkert, and Miller Dimensional Puzzle Model of Culturally Competent Care

C. Managing health disparities through culturally competent research
   1. Minorities, migrants, and refugees
   2. Health disparities in the catchment area where students do clinical

D. Cultural patterns and values of select cultural and ethnic, or subcultural groups: Hispanic/Latino, Arab/Muslim, Jewish, Haitian, Lesbian Gay Bisexual Transgender, Alcoholics Anonymous, and/or others. Some should come from the catchment area where the students practice and at least one that is not common among the community to give the course a global perspective.
   - Biocultural ecology
   - High-risk health behaviors
   - Nutrition and the meaning of food
   - Pregnancy and the childbearing family
   - Death and dying rituals
   - Spirituality and religion
   - Healthcare practices including complementary and alternative practices

2. In a team paper, each team should have no more than four to six members.
3. Most references should come from the last 6 years, although classic references are acceptable.
4. Most of the references should come from the research literature. Internet sources are acceptable as long as they come from governmental organizations, universities, or professional associations and organizations. Wikipedia is not an acceptable reference because content has not been refereed. Blogs and travel sites are not acceptable.
5. Once the literature review is completed, create a list of at least four recommendations for research based on gaps in the literature. The research questions must be something that a graduate student can accomplish. For each question, identify if the research is qualitative or quantitative research, the specific methodology (phenomenology, grounded theory, correlational, quasi-experimental, etc.), and a brief description of the methods to carry out this research.
6. Identify applications to *practice*. Be specific, not something general that would be the same for any cultural group.

Scholarly Formal Paper on a Specific Cultural, Ethnic, or Subcultural Group

1. Conduct a literature review on four domains of a cultural, ethnic, or subcultural group different from your own culture. The domains for the literature review can include:
   - Heritage overview (as the introduction)
   - Communication
   - Family roles and organization
   - Workforce issues

Resources for Advanced Courses in Cultural Competency Education

- American Association of Colleges of Nursing. (2017). Essentials of Baccalaureate and Graduate Education in Nursing. Available at http://www.aacnnursing.org/. [Accessed 7 December 2017].
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- McFarland, M and Wehbe-Alamah, HB. (eds). (2015). Leininger's culture care diversity and universality: a worldwide nursing theory, (3e). Burlington, ME: Jones & Bartlett Learning.
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- Sagar, P. (2014). Transcultural nursing education strategies. NY: Springer Publishing Company.
- Schim, Dorenbos, Benkert, & Miller, (2007). Dimensional Puzzle Model of Culturally Competent Care Available at http://europepmc.org/articles/PMC3074191. [Accessed 7 December 2017].
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- U.S. Department of Health and Human Services Office of Minority Health, (n.d.). National CLAS Standards. Available at https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53. [Accessed 7 December 2017].

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Cultural Connections for Learning: Cultural Safety (2013) http://www.intstudentsup.org/diversity/cultural_safety/. Accessed 29 July 2017

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