



CULTURAL COMPETENCE IN CLINICAL PRACTICE

By Marianne Jeffreys

Culturally congruent care is care that is customized to fit with the patient's own values, beliefs, traditions, practices, and lifestyle. Culturally different patients are patients whose racial, ethnic, gender, socioeconomic, and/or religious backgrounds or identities are different from those of the nurse or nursing student. The rapid growth in worldwide migration, changes in demographic patterns, varying fertility rates, increased numbers of multiracial and multiethnic individuals, and advanced technology contribute to changes in cultural diversity, necessitating a conscious, committed, and transformational change in nursing.

Today's nursing students need to become active participants in this transformational change. The goal of culturally congruent care can only be achieved through the process of learning cultural competence; therefore, you must become empowered, active learners in this process, integrating it into all aspects of practice.

Confidence (self-efficacy) is one factor that may influence motivation, persistence, and commitment to cultural competency. The following clinical case scenario, illustrates how important cultural competence and confidence are in meeting the needs of culturally diverse patients.*

Clinical Case Scenario

Students in a medical-surgical nursing course are eager to begin their new rotation on a cardiac unit. During the pre-clinical conference, Professor Hart mentions that several students will administer digoxin orally to their patients. Professor Hart asks them about the nursing implications associated with digoxin administration.

All of the students agree that they must evaluate the patient and ensure that pulse rate and serum digoxin levels are within the ranges indicated in the handbook.

Martine mentions that it is also important to plan ahead

for discharge and begin patient teaching right away. She notes that information about the specific cardiac problem and digoxin should also be accompanied by demonstration and return demonstration of pulse-taking techniques. Professor Hart reminds the students to incorporate culture into all aspects of nursing care, including patient teaching. She comments: "A thorough health assessment must incorporate a systematic assessment of cultural values and beliefs. Please incorporate your previously learned skills about cultural assessment into your plan each week with your patients. I will be available to assist you if needed. The clinical nurse specialist (CNS) is also a good resource person in case I am busy with another student."

After pre-clinical conference, Dawn says quietly to Steven, "I don't know why Professor Hart emphasizes culture so much. Most parts of nursing care can just be done as described in our medical-surgical procedure book. Besides, how many ways can you give an oral medication?"

Steven replies, "I agree. The patients on this unit are all here for heart problems. Hearts don't have cultural values and beliefs. We should spend more time looking at rhythm strips, cardiac enzyme results, and stress test results instead of spending time with cultural assessments."

The following are excerpts from their post-clinical conference:

Steven

My patient was a 64 year-old woman who was a religious Muslim from Egypt. When I told her that it was important to listen to her heart before giving her the heart medication, she said she did not want to take her pill and became upset. I noticed that her heart monitor showed tachycardia and arrhythmia, especially when I started to approach her with my stethoscope. Janice, who was assigned to the other patient in the room, overheard what was going on and asked my patient if she would prefer a female nursing student to listen to her heart. My patient was agreeable. After a few minutes, Janice assessed the apical rate and administered the medication with Professor Hart observing.

Janice

I also learned that it was important to use my right hand to place the digoxin in her mouth and offer her water using my right hand. She needed my help because she had bilateral arm casts. I knew that cultural considerations were important to assess, but I was not confident that I would know how to accommodate drug administration procedures to her cultural beliefs. However, I was somewhat confident that I could find out by asking her. Before I gave her the medicine, I asked her if she had any special preferences on how I should give her the medication. She told me that she appreciated that I cared enough to ask.

Dawn

My patient was a 75 year-old recent immigrant from China who spoke some English. Her heart rate was 72 and regular. When I brought her the digoxin to take with a cold glass of water, she did not want to take the pill. At that moment, Maria, the clinical nurse specialist entered the room. She explained that consistent with traditional Chinese beliefs, the patient preferred warm beverages. When I brought some hot decaffeinated green tea, she readily took her digoxin. I guess I was overly

confident about how easy it would be to administer medications without realizing cultural beliefs and customs could really make a difference. I also appreciate the importance of collaborating with other nurses, especially the CNS who had some background knowledge about Chinese culture and my patient.

Maria also explained that although there were several nurses, pharmacists, and physicians in the hospital who spoke Chinese, only one nurse (Ming) spoke the dialect understood by my patient. I had the opportunity to speak with Ming about my patient's discharge teaching plan. She explained that while it was important to preserve and accommodate some of the patient's traditional values and health practices within the care plan, there were others that necessitated repatterning. My patient often used herbal teas at home containing ginseng, which can result in digoxin toxicity. Before today, I didn't think that detailed questions concerning herbal and dietary practices were important. I don't think I recognized the need to individualize this to my patient's cultural values, beliefs and practices. I guess I needed repatterning about my views concerning culture and safe, high quality nursing care.

Juanita

My patient also had digoxin ordered. He did not want to take anything by mouth because it is a religious fasting day. He became distressed and said he didn't want to be labeled a "difficult" patient by the staff and be ignored. Early this morning, his rhythm strips showed normal sinus rhythm with rates ranging between 74 and 86. Distressed about his medication, he became flushed and his pulse rate increased to 132. With the patient's permission, I contacted the hospital priest to speak with him. Afterwards the patient was happy because he was able to take Communion. The priest explained that it was fine to take medication orally, even on a religious fast day. The patient's pulse rate returned back to his baseline.

Martine

My patient was started on digoxin yesterday. The staff nurse asked me to reinforce patient teaching started yesterday concerning medication. I had no problem with assessing his apical pulse or getting him to take his digoxin which took less than two minutes. I tried to look him right in the eye and then I asked him to speak up if he had any questions about the medication. He turned his head away and didn't answer me so I left the room. I wondered what I was going to do for the rest of the day since I had finished everything in less than three minutes.

However, the staff nurse sent me back to talk with the patient about discharge planning, follow-up visits, lab tests, daily self-assessment of pulse, and medication side effects. After five minutes of trying to talk with him, I considered several nursing diagnoses: 'impaired verbal communication,' 'noncompliance,' 'knowledge deficit,' 'ineffective coping,' and 'anger' for my patient.

I didn't think he had any interest in complying with his medication regimen at home. He never looked me in the eye when I spoke to him, he used very few words to respond to me, and he kept looking at the floor during his long periods of silence. When I tried to talk to him about follow-up visits to the hospital's cardiac clinic, he finally said that he would most likely go to the clinic on the reservation when discharged. He said he only came to this hospital because he collapsed and had a heart attack right in front of the building. I didn't even consider that he might live on an Indian reservation because he didn't look like an "Indian." At that point, I realized I had probably made many mistakes, although I really didn't understand what they were. Because I didn't have any confidence in asking questions about cultural values and beliefs, I avoided the process. I successfully completed all my tasks in three minutes. I realized that I hadn't met my patient's needs; I had met my own. I told the patient I would be back soon. Then I

went to find Professor Hart.

Professor Hart and I returned to speak with my patient. This discussion revealed that he perceived the hospital environment to be threatening and uncaring. No one had asked him about his cultural background, identity, values, beliefs, or practices. He said this “lack of caring wouldn’t have occurred in the Reservation’s Clinic.” I realized that these culturally insensitive incidents had adversely affected my patient’s well-being and health outcomes. For example, his elevated heart rates and hypertension during hospitalization may have been influenced by stress caused by cultural pain. At this point, I felt totally incompetent and questioned if I could ever become a good nurse. What should I do next?

After expressing regret and sincere concern over the factors that had stressed the patient, Professor Hart assured him that every effort would be made to provide culturally specific and congruent care. Next, she performed a detailed and systematic cultural assessment that provided valuable information for designing his care plan. In addition to the obvious mistakes I had made, I learned about several other barriers to achieving positive outcomes with my patient. One was my misinterpretation of my patient’s periods of silence in conversation and avoidance of eye contact as indicating lack of interest. Among many traditional Native American groups, silence is expected to enhance understanding and exemplifies respect for the other person. Avoidance of eye contact also indicates respect and that the person is paying close attention to what is being said. I realized the importance of conducting a thorough cultural assessment on all patients – it must not be avoided.

Achieving Culturally Congruent Care

According to Leininger (1991a), culturally congruent nursing care refers to “those cognitively based assistive, sup-

portive, facilitative, or enabling acts or decisions that are tailor-made to fit with an individual’s, group’s, or institution’s cultural values, beliefs, and lifestyles in order to provide meaningful, beneficial, and satisfying health care, or well-being services (p.49). To “assist, support, facilitate, or enhance” culturally congruent care, Leininger proposed three modes for guiding nursing decision and actions: (1) cultural care preservation and/or maintenance; (2) culture care accommodation and/or negotiation; and (3) culture care repatterning and/or restructuring. Because culturally congruent care can only occur when cultural values, expressions, or patterns are known and used appropriately (Leininger, 1995), a systematic, thorough cultural assessment is a necessary precursor to planning and implementing care (Andrews & Boyle, 2002; Campinha-Bacote, 2003; Giger & Davidhizar, 1999; Leininger, 2002; Purnell & Paulanka, 2003; Spector, 2004). Assessment, planning, implementing, and evaluating culturally congruent care requires active, ongoing learning based on theoretical support and research evidence. The goal of culturally congruent care can only be achieved through the process of developing cultural competence.

The acronym of “COMPETENCE” can assist you in remembering several essential elements for developing cultural competence and achieving culturally congruent care. COMPETENCE refers to Caring, Ongoing, Multidimensional, Proactive, Ethics, Trust, Education, Networks, Confidence, and Evaluation. Each will be briefly described below:

Caring: Demonstrate caring

The essence of nursing is caring. Caring refers to actions and activities directed toward assisting, supporting, or enabling others with actual or potential needs to alleviate or improve a human condition or face death (Leininger, 1991a). Caring is essential for curing but curing is not essential for caring (Leininger, 1991a). Caring can only occur within the patient’s cultural

CARING

ONGOING

MULTIDIMENSIONAL

PROACTIVE

ETHICS

TRUST

EDUCATION

NETWORKS

CONFIDENCE

EVALUATION

context. Patients who perceive nurses as non-caring may perceive that they have not received “care” at all. Perceptions of caring (or non-caring) can positively or negatively affect patient outcomes.

Ongoing: Engage in ongoing cultural competence

Cultural competence development is ongoing. Lifelong, ongoing cultural competence development is an essential professional expectation presently and in the future. Cultural competence is not an end-point or product of learning. Cultural competence is an ongoing process in which one is always attempting to “become” more culturally competent (Campinha-Bacote, 2003; Leininger & McFarland, 2002; Purnell & Paulanka, 2003). Additionally, culturally congruent care must be individually appraised, applied, and modified, in an ongoing fashion throughout all aspects of patient care. Effectively weaving culturally specific care interventions throughout the care plan requires ongoing commitment and energy but will result in high quality, cultural congruent care.

Multidimensional: Develop transcultural nursing skills in all three dimensions: cognitive, practical, and affective

The cognitive learning dimension focuses on knowledge outcomes, intellectual abilities, and skills. Within the context of transcultural learning, cognitive learning skills include understanding ways in which cultural factors may influence professional nursing care among patients of different backgrounds and throughout various phases of the lifecycle.

The practical learning dimension focuses on motor skills or practical application of skills. Within the context of transcultural learning, practical learning skills refer to communication skills (verbal and nonverbal) needed to interview patients of different cultural backgrounds about their values and beliefs.

The affective learning dimension is concerned with attitudes, values, and beliefs and is considered to be the most important in developing professional values and attitudes. Affective learning includes self-awareness, awareness of cultural differences, acceptance, appreciation, recognition, and advocacy (Jeffreys, 2000; Jeffreys & Smodlaka, 1998). All components are essential for the development of cultural competence.

Proactive: Conduct cultural assessments proactively on all patients upon initial encounter

Systematic cultural assessments and culture-specific care plans should be routinely initiated at the first patient contact and regularly re-appraised and modified throughout interactions with patients, families, and communities. Such a proactive approach actively anticipates patient needs and is preferred to a reactive approach that passively waits for patient-initiated requests, problems, misunderstandings, and cultural clashes.

Ethics: Apply ethical principles in all patient encounters.

Culturally congruent health care is a basic human right, not a privilege (ANA, 2001; 2003; 2004; Cameron-Traub, 2002; ICN, 1973; Leininger, 1991a; Leininger, 1991b), and every human being is entitled to it. The International Council of Nurses Code for Nurses (1973), the ANA Code of Ethics (2001), and the National Standards for Culturally and Linguistically Appropriate Services in Health Care (OMH, 2001), are among the important documents that provide guidance to health professionals. Not only are nurses and other health care providers ethically and morally obligated to provide the best culturally congruent care possible but they are legally mandated to do so. Increasing numbers of lawsuits with patients claiming that such care was not rendered by hospitals, physicians, nurses, and other health care providers attest to the complicated legal issues that may arise. Furthermore, patients are often winning their cases in court (Leininger & McFarland, 2002).

Trust: Establish mutual trust

Gaining a patient's trust is a necessary first step before patients willingly share their cultural values, beliefs, behaviors, and practices. Until the nurse (or nursing student) has gained the patient's trust, shared information may not be entirely credible or true. Leininger (2002) advocates "moving from a mainly distrusted stranger to a trusted friend in order to obtain authentic, credible, and dependable" information (p. 91).

Education: Participate in ongoing cultural competence education

All students and nurses (regardless of age, ethnicity, gender, sexual orientation, lifestyle, religion, socioeconomic status, geographic location, or race) require formalized educational experiences to meet culture care needs of diverse individuals (Andrews, 1995; Jeffreys, 2000; Jeffreys, 2002; Leininger, 1995). At the undergraduate level,

examples of formalized education to enhance cultural competence include taking a course or series of courses in transcultural nursing or attending a transcultural nursing conference/workshop taught by qualified individuals.

Networks: Create collaborative networks

Collaboration and networking with other nurses, health professionals, and organizations permits the shared pooling of resources, skills, and knowledge. Within health care institutions, advanced practice nurses with educational background in general transcultural nursing skills provide onsite resources and referral. Advanced practice nurses with specialized education about particular cultures have additional expertise. The Transcultural Nursing Society provides numerous local and global opportunities for collaboration and networking through its website (www.tcns.org), its network of certified transcultural nurses, its journal (*Journal of Transcultural Nursing*) and newsletter, local chapter meetings and events, and annual conference. The internet has made networking and dialogue with transcultural nurse experts easier than ever before.

Confidence: Develop confidence to actively learn and perform transcultural nursing skills. Avoid overly high or low confidence

Individuals with low confidence for transcultural nursing skills are at risk for decreased motivation, lack of commitment, and avoidance of cultural considerations when planning and implementing nursing care. Overly confident individuals are at risk for inadequate preparation in learning the transcultural nursing skills necessary. Students with strong, resilient, and realistic confidence will persist despite obstacles and hardships, and will expend whatever energy is necessary (Jeffreys, 2000).

Evaluation: Use evaluation results to improve nursing practice

Realistic, frequent self-appraisal of strengths, weaknesses, gaps, and barriers in the journey to develop cultural competence provides new direction for future growth and learning. Patient outcome evaluation, especially of satisfaction and perception of culturally

relevant care provide valuable information to guide learning and nursing care decisions and actions.

Professional goals, societal needs, ethical considerations, and legal issues all declare the need to prioritize cultural competence development (Jeffreys, 2002). Overcoming skepticism, challenging the status quo, and creating a new vision for professional nursing that

actively advocates culturally congruent care for all patients requires strong commitment, energy, and motivation. As nursing students, you should network with others to develop new, innovative strategies that maximize cultural competence, embrace cultural diversity, implement culturally congruent care, and optimize health. ☉

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footnote

* The scenarios described are an expanded version of a vignette from Jeffreys, M. R., *Teaching Cultural Competence in Nursing and Health Care* (to be published by Springer Publishing Company in late 2006).

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