Perspectives on Transcultural Care

Dana Bjarnason, PhD, RN, NE-BC[a,*], JoAnn Mick, PhD, RN, AOCN, NEA-BC[b], Julia A. Thompson, PhD, RN, CIP[c], Elizabeth Cloyd, MBA, RN, NEA-BC, FACHE[d]

KEYWORDS

• Transcultural • Caring • Diversity • Culture
• Moral and ethical reasoning

Culture has been defined as the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.[1] An ideal culture suggests attributes that are most desired or preferred or the wished for desires of a group. A culture of nursing refers to the learned and transmitted lifeways, values, symbols, patterns, and normative practices of members of the nursing profession of a particular society.[2] In the culture of health care, these norms refer to the way information is received, rights and protections are exercised, and even what is considered to be a health problem.[1] Clearly, health care is a cultural construct, central to the effective delivery of health care services. In nursing, respect for persons has continuously been maintained as a core ethical principal of professional practice. To serve the unique and diverse needs of patients in the United States, it is imperative that nurses understand the importance of cultural differences by valuing, incorporating, and examining their own health-related values and beliefs and those of their health care organizations, for only then can they support the principle of respect for persons and the ideal of transcultural care.

TRANSCULTURAL NURSING

More than 5 decades ago, nurse theorist Madeleine Leininger began exploring culture concepts from the field of anthropology and care concepts from nursing, forming the construct of culture care.[3] Leininger defined transcultural nursing as a humanistic and scientific area of formal study and practice in nursing focused on differences and similarities among cultures with respect to human care, health, and illness and is based on

[a] Ben Taub General Hospital, Quentin Mease Community Hospital, 1504 Taub Loop, Houston, TX 77030, USA
[b] Nursing Research & Clinical Outcomes, Harris County Hospital District, 2525 Holly Hall, Houston, TX 77054, USA
[c] Research & Sponsored Programs, Harris County Hospital District, 2525 Holly Hall, Houston, TX 77054, USA
[d] Harris County Hospital District, 2525 Holly Hall, Houston, TX 77054, USA
* Corresponding author.
E-mail address: dana_bjarnason@hchd.tmc.edu (D. Bjarnason).

Nurs Clin N Am 44 (2009) 495–503
doi:10.1016/j.cnur.2009.07.009 **nursing.theclinics.com**
0029-6465/09/$ – see front matter

cultural values, beliefs, and practices.[4] Culture in American hospitals has been shaped by nursing, and Leininger discussed several major reasons for examining this phenomenon. Of particular relevance to the idea of the culture of nursing is Leininger's postulation that nurses need to understand and appreciate inherent differences and similarities not only locally but also regionally, nationally, and worldwide.

Although it is clear that values, norms, and standards differ in nursing globally, the moral commitment that nurses make to patients includes upholding cherished human virtues, such as sympathy, compassion, faithfulness, and truth telling. There is a connection between Leininger's postulation that caring is the central and unifying domain for nursing knowledge and practice and her belief that professional nursing care embodies scientific and humanistic models of helping or enabling patients to maintain a healthy condition for life or death.[5]

CULTURAL DIVERSITY AND THE NURSING WORKFORCE

Understanding and responding to diversity in health care is especially challenging in the United States because of America's increasingly multicultural society and the different ethnic, religious, and personal values not only of patients but also of health care providers. Globalization, immigration, and nursing shortages have created complex issues related to patient care delivery and the nursing workforce. Globalization is reflected in the increasing interaction and integration among people and governments and is driven by international trade, investment, and commerce.[6] Immigration has significantly affected and radically changed the composition of the population and the workforce in the United States. In the midst of these changes, nursing shortages that began in the middle of the last century have led to the employment of increasing numbers of foreign-born and foreign-educated registered nurses (RNs), which now represent a considerable segment of the practicing US nurse workforce. The growing US nursing workforce dependence on foreign-born RNs is evidenced by statistics that indicate that 37% of total RN employment growth is attributed to the rapid growth of employment of foreign-born nurses.[7]

Although the problem of minority underrepresentation in nursing is particularly acute (the percentage of nurses from racial and ethnic minorities grew only from 7% in 1980 to 12% in 2000), this lags significantly behind the proportion of minorities in the general population, which is approximately 30%.[8] Complicating this finding is the fact that although 15%[7] of nursing full-time equivalent positions in the United States are foreign-born minorities, they do not necessarily represent the face of America.

Racial and ethnic population statistics from the 2000 national census estimated that whites comprised 75.1% of the US population, whereas 12.3% were black or African American and 3.6% were Asian. Of the total population, 12.5% represented Hispanics or Latinos of any race.[9] In contrast to national population statistics, the racial/ethnic makeup of the RN workforce practicing in the United States is 84.9% white, 3.2% black or African American, 1.7% Asian, and 1.2% Hispanic, with the remaining 9.6% comprised of all other races/ethnicities.[10] Gender and age/generational diversity further complicate factors related to cultural diversity in the nursing workforce. Although 49.1% of the US population is male compared with 50.9% female,[9] 93.8% of nurses employed in nursing are women, compared with 6.1% who are men.[10] Demographic trends and low recruitment during health care workforce restructuring in the 1990s have resulted in a nursing workforce that represents 4 generations and is more skewed toward older workers than the general workforce.[11–13]

NURSING'S EVOLVING POSITION ON DIVERSITY

Nursing's voice in valuing diversity is evidenced in the evolution of the American Nurses Association ''Code of Ethics for Nurses.'' Since the Code's inception in 1893, the profession of nursing's ethical stance has reflected a value in people and relationships. At that time, nurses pledged to ''devote myself to the welfare of those committed to my care.''[14] By 1940, nurses provided public statements that ''honesty, understanding, gentleness, and patience should characterize all acts of the nurse'' and that ''the nurse has a basic concern for people as human beings… [and] respect for [the] religious beliefs of others.''[15] In 1950, nursing first introduced language that substantially addressed the issue of justice in the health care setting, proclaiming that ''the need for nursing is universal …[and that] professional nursing service is…unrestricted by considerations of nationality, race, creed, or color.''[15]

Nurses' commitments were strengthened in the 1976 revision of the code when the connection between people, relationships, and diversity were first introduced in ethical statements describing perspectives of human dignity and respect for persons. The new provision recognized the uniqueness of each individual, requiring the nurse to provide care ''with respect for human dignity…unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.''[15] Further changes to the code in 1985 clarified, redirected, and sometimes altered the nuance of the original provisions, demonstrating a shift from the character virtues of nurses to the rights of patients and principles of professional nursing conduct. Although in 1976, the code mandated quality nursing care as a right of all citizens, in 1985 citizenship was irrelevant to any consideration of access to or distribution of nursing health care services.[16]

The most recent revisions to ''The Code of Ethics for Nursing'' occurred in 2001. The value of diversity continues to be a strong assertion, as evidenced by the first provision, which states that ''the nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.''[17] In addition to the code of ethics, the American Nurses Association bolstered nursing's position relative to the moral and ethical treatment of patients and the importance of understanding the relationship between nurses and patients when it published a position statement that was released in October 1991 entitled ''Cultural Diversity in Nursing Practice.'' This document offers guidance regarding the need to understand—among other things—the influence of the cultural background of the nurse on care delivery, with particular emphasis on the need to understand that the nurse-patient relationship is influenced by three distinct interactions: the culture of the nurse, the culture of the patient, and the culture of the setting.[18]

NURSING'S SOCIAL POLICY STATEMENT AND DIVERSITY

Nursing's social policies offer another strong example of the commitment that US nurses make to honoring diversity. Last updated in 2003, ''Nursing's Social Policy Statement'' is a fundamental document that describes the articulation of nursing and its social framework and obligations. Simply, it is the expression of the social contract between the public and the nursing profession in the United States.[19] The current document was derived from the 1980 landmark document ''Nursing: A Social Policy Statement'' and the 1995 document ''Nursing's Social Policy Statement.'' The social policy statement provides a framework for nursing's understanding of the profession's relationship with society and the obligation to the recipients of nursing care.

The statement articulates values and assumptions that characterize the value of diversity, including that human experience is contextually and culturally defined and that the interaction between the nurse and the patient occurs within the context of the values and beliefs of both.[19]

NURSING'S PROFESSIONAL REGULATION AND DIVERSITY

In addition to the code of ethics and the social policy statement, nursing has defined its professional regulation (as opposed to legal regulation) in a 2004 document entitled ''Nursing Scope and Standard of Practice,'' which outlines 6 standards of practice that describe a competent level of nursing care. Themes that consistently arise and are integral to the practice of professional nursing include providing culturally and ethnically sensitive care and communicating effectively.[20] Although these themes represent just a fraction of the actions required of RNs, their connection to the need to understand and value diversity—not only of their patients, but within the profession—is clear. The standards reflect nursing's values and priorities and are the authoritative statements for which nurses are accountable.[20]

US WORKFORCE RESPONSE TO DIVERSITY

Visible differences in the workforce related to age, languages, religions, race, ethnicity, sexual orientation, abilities, disabilities, levels of education, skills, and experiences have increasingly appeared as demographics have continued to shift in the United States.[21] Although diversity in the workplace has brought many benefits to organizations, it also has created many challenges.[22] As technology, growth, globalization, and socioeconomic advances continued to effectively connect diverse cultures, industries and professions began to initiate efforts to manage increasingly diverse workforces by implementing management strategies such as cultural awareness, sensitivity, diversity training, and cultural competencies.[23] In health care, diversity training has helped to increase awareness of differences and promoted sensitivity and attentiveness to interactions between faculty and staff. Health care providers began to focus on understanding how and why different belief systems, cultural biases, ethnic origins, family structures, and other culturally determined factors influenced the illness experience, treatment decision making, adherence to medical advice, and response to treatment and how these factors led to differences in care outcomes.[24] Cultural competencies were developed to assure required knowledge, skills, attitudes, and behaviors to provide optimal health care services to persons from a wide range of cultural and ethnic backgrounds.

As organizations were attempting to address diversity with training, however, management researchers began to identify that rapid and significant increases in work force diversity would result in communication problems, potential for increased organizational conflict, and a high degree of value incongruence among members of the work force immigrating to the United States from a variety of culturally diverse countries.[25] Researchers proactively identified that without learning and understanding how to work together, the productivity of new recruits and existing employees would be less than optimal. Failure to address cultural aspects of teamwork could lead to low morale, ineffective communication, and interpersonal conflict. Initially, assimilation was the predominant management strategy used to integrate foreign recruits into the existing workforce. Expectations for newly hired employees to forgo prior knowledge and experiences often suppressed their ability to express themselves genuinely in the workplace setting, thus denying significant parts of their lives in a social context and causing increasing frustration.[26] Assimilation into the

dominant organizational culture began to show negative consequences for individuals and organizations. A greater focus emerged on management of workplace conflict, including addressing the topic of horizontal violence. Employers began to provide educational opportunities for workers to acquire skills to more effectively deal with interpersonal conflict.

To better address employee dissatisfaction and interpersonal conflict in the workforce, the current frame of reference has begun to change from an ethnocentric view of adoption of "our way is the best way" to a more culturally relative perspective of using the best of a variety of practices.[27] Assuring opportunities for all employees to openly contribute their ideas and passion to accomplish an organization's mission can support goal achievement and improved business outcomes. Beyond the acknowledgment of diversity by culture, an organization can achieve increasing respect for the range of knowledge and experiences offered by employees with diverse backgrounds.

CULTURAL COMPETENCE AND THE VALUE OF DIVERSITY

The first step in the evolution toward organizational cultural competence is to align objectives of the initiative with the organization's mission, vision, and values and with applicable regulations, guidelines, and accreditation requirements. The mission/vision, values, and philosophy of a health care organization must establish a high regard for diversity by embracing the provision of culturally sensitive care as a consistent platform for operations, including that every individual has the right to be treated with dignity and respect. In health care organizations, nurses bring their personal cultural heritage and the cultural and philosophic views of their education into the organizational setting. The literature consistently suggests that cultural competence begins with individual self assessment.[28] To understand that there are multiple equally justifiable culturally determined values, systems, and behaviors, nurses must first be aware of and understand their own set of values.[29] Cultural competence must become an inherent part of the organizational culture.

> *"…the customary way of thinking and behaving that is shared by all members of the organization and must be learned and adopted by newcomers before they can be accepted into the agency…a combination of assumptions, values, symbols, language, and behaviors that manifest the organization's norms and values."*[30]

In 2002, the Commonwealth Report defined cultural competence in health care as "the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs."[31] Cultural competence is one of the key elements thought to reduce disparities in health care, and it must be achieved at the organizational, systemic, and provider levels. A competency program can assist an organization to establish effective communication systems between different cultures. Examination of the cultural variations that make a difference in health care can generate opportunities to transition a culturally diverse environment into a collaborative workforce. To be successful, a cultural competency program requires a strong commitment at the organizational level and should identify manageable and concrete goals, outline operational plans to meet those goals, and establish management accountability and oversight mechanisms.

The assessment of cultural competence in nursing may be accomplished through the use of various tools. For example, the National Center for Cultural Competence at Georgetown University captures a wide range of information in its "Cultural Competence Health Practitioner Assessment," which includes 6 subscales: (1) values and belief systems, (2) cultural aspects of epidemiology, (3) clinical decision making,

(4) life cycle events, (5) cross-cultural communication, and (6) empowerment/health management.[32] The American College of Healthcare Executives, the American Hospital Association, the National Center for Leadership, and the Institute for Diversity in Health Management combined efforts to develop a research-based diversity and cultural competence tool that can be used for a baseline evaluation of a health care organization's diversity management performance. The tool "Strategies for Leadership: Does Your Hospital Reflect the Community It Serves?"[33] can be used to evaluate the diversity and cultural proficiency of an organization and identify existing activities and practices and those that may need to be implemented.

Employee satisfaction surveys offer 1 approach to evaluate the outcomes of a cultural competence program. Other methods include maintenance of records of appeals, complaints, grievances, and lawsuits, differentiated by the ethnicity of the complainant and guaranteeing "whistle-blower" immunity to employees who draw attention to practices, actions, or policies that are not culturally competent.

CULTURALLY COMPETENT CARE

The Commonwealth Report also identified many barriers to the delivery of culturally competent care that are relevant to a community, including lack of diversity in health care leadership and workforce, systems of care poorly designed for diverse patient populations, and poor cross-cultural communication between providers and patients.[31] The inability of a provider to understand socioeconomic differences may lead to patient noncompliance, which can affect health outcomes. Health care leaders can take action to deal with these disparities, including development of patient assessment tools that explore cultural values, alternative medicine, and family roles in illness. At the organizational level, interventions to address these barriers include fostering the hiring and promotion of a diverse work force and working to understand the needs of the community. At the systemic level, evaluating the structure of the entire health care delivery system to include culturally appropriate programs, disease management programs, and educational materials is imperative. At the clinical competence level, health care providers must be equipped with knowledge of health beliefs of different cultures.

In order for optimum patient care to occur, patients must trust their providers. Effective communication is critical to building trust in the patient/provider relationship and in team relationships. Trust comes from the ability to communicate, understand, and be understood. Ideally, staff communicate effectively in the language of the patient. The availability and deployment of on-site, in person, or telephonic interpreters is critical. Written materials also should be available at appropriate reading levels and in the language that the patient and family can understand.

In health care, challenges to effective communication may be exacerbated by culturally distinctive dialect, speech patterns, or colloquialisms of patients and/or providers. Providing elocution classes to the workforce is one strategy for managing employee communication concerns. Actions that can assist providers to effectively communicate with patients include providing access to a medically trained translator when the provider does not speak the patient's language, assessing patients' baseline understanding when communicating by encouraging patients to ask questions, and using plain language without medical jargon. Highlighting 1 to 3 important points the patient needs to remember, providing important instructions in written format in the patients' preferred language, and providing educational materials, pictures, and drawings whenever possible also promote effective communication and enhance understanding.[34]

National standards on culturally and linguistically appropriate services are available from the Office of Minority Health.[1] There are 14 culturally and linguistically appropriate services standards that focus on language to improve understanding between patient, family, and providers and address culturally appropriate care. The instruments used to gather information from patients must be broad enough to capture information that encompasses culturally specific beliefs about health and illness (eg, use of herbal remedies and family roles in illness). Knowledge of these basic tenets allows for care planning that embraces a patient's belief system in the treatment plan.

TOWARD A TRANSCULTURAL IDEAL

In view of the increasing range of diversity within the care-receiving and care-providing segments of society in the United States, it is more important than ever to focus on understanding and addressing the impact of diversity and its relationship to patient care. Now more than ever, health care leaders are charged with understanding and managing diversity to maintain a healthy, productive, and respectful work environment. By aligning organizational objectives to appreciate the diverse nature of health care providers and patients, the work and care environments are enriched. By addressing cultural diversity in health care, employers can keep employees engaged and motivated, thereby maximizing patient safety and productivity.

Although multiple generations and cultures are working together, further increasing the diversity of the nursing workforce is necessary to successfully expand health care access for underserved populations.[35] The development of a diverse nursing workforce will help to expand health care access for the underserved, foster research for neglected societal needs, and enrich the pool of managers and policymakers to meet the needs of an increasingly diverse US population.[36,37] To build a diverse workforce that meets the needs of a diverse population, nurse leaders need to continue to assess their existing workforce culture and systems to identify barriers and strategies to effectively attract and retain culturally diverse employees, enhance recruitment/hiring processes, and create positive work environments. Focusing on diversity and the culture of nursing in formal programs has inherent benefits. It assists newcomers in understanding dominant, recurrent, and patterned features of nursing, serves as a valuable historical guide to past, current, and future change,[2] and reinforces the moral commitment that nurses make to patients, which mandates the need to understand nursing care practices and appreciate the differences and similarities among all nursing cultures.

REFERENCES

1. US Department of Health and Human Services. 2001. National standards for culturally and linguistically appropriate services in health care. Available at: http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf. Accessed June 4, 2009.
2. Leininger M. The tribes of nursing in the USA culture of nursing. J Transcult Nurs 1994;6:18–22.
3. Murphy SC. Mapping the literature of transcultural nursing. J Med Libr Assoc 2005;94:143–51.
4. Leininger M. Transcultural nursing: the study and practice field. Imprint 1991;38: 55–66.

5. Leininger M. Reflections on Nightingale with a focus on human care theory and leadership. Commemorative edition. In: Carroll DP, editor. Notes on nursing. Philadelphia: J.B. Lippincott; 1992. p. 28–38.
6. Carnegie Endowment for International Peace. What is globalization. Available at: http://www.globalization101.org/What_is_Globalization.html. Accessed May 19, 2009.
7. Buerhaus PI, Staiger DO, Auerbach DI. The future of the nursing workforce in the United States: data, trends and implications. Sudbury (MA): Jones and Bartlett Publishers; 2008.
8. US Department of Health and Human Services. 2000. The registered nurse population: findings from the national sample survey. Available at: ftp://ftp.hrsa.gov/bhpr/rnsurvey2000/rnsurvey00.pdf. Accessed May 19, 2009.
9. US Census Bureau. Census 2000 data for the United States. In United States census 2000. Available at: http://www.census.gov/census2000/states/us.html. 2003;. Accessed May 19, 2009.
10. US Department of Health and Human Services. The registered nurse population: findings from the 2004 national sample. Available at: http://bhpr.hrsa.gov/healthworkforce/rnsurvey04/appendixa.htm. Accessed June 25, 2007.
11. Buerhaus PI, Saiger DO, Auerbach DI. Why are shortages of hospital RNs concentrated in specialty care units? Nurs Econ 2000;18:111–6.
12. Cordonez JA. Recruitment, retention and management of generation X: a focus on nursing professionals. J Healthc Manag 2002;47:237–49.
13. Kupperschmidt BR. Understanding generation X employees. J Nurs Adm 1998; 28:3–43.
14. "The Florence Nightingale Pledge." Available at: http://www.nursingworld.org/FunctionalMenuCategories/AboutANA/WhereWeComeFrom_1/FlorenceNightingalePledge.aspx. Accessed June 7, 2009.
15. American Nurses Association. Guide to the code of ethics for nurses. Washington, DC: American Nurses Publishing; 2008.
16. Fowler M. A chronicle of the evolution of the code for nurses. In: White GB, editor. Ethical dilemmas in contemporary nursing practice. Washington, DC: American Nurses Publishing; 2001. p. 149–54.
17. American Nurses Association. Code of ethics for nurses with interpretive statements. Washington, DC: American Nurses Publishing; 2001.
18. American Nurses Association. Cultural diversity in nursing practice. Available at: http://nursingworld.org/readroom/position/ethicsetcldv.htm. Accessed March 19, 2006.
19. American Nurses Association. Nursing's social policy statement. Washington, DC: American Nurses Publishing; 2003.
20. American Nurses Association. Nursing scope and standards of practice. Washington, DC: American Nurses Publishing; 2004.
21. Stokes L. Ten ways to operationalize your diversity process Available at: www.prisminternational.com. Accessed May 8, 2009.
22. Burke RJ, Ng E. The changing nature of work and organizations: implications for human resource management. Hum Resource Manag Rev 2006;16:86–94.
23. Heller BR, Oros MT, Durney-Crowley J. The future of nursing education: ten trends to watch. Available at: http://www.nln.org/nlnjournal/infotrends.htm. Accessed May 8, 2009.
24. Crawford C, Harrington C, Estes CL. Health policy: crisis and reform in the U.S. health care delivery system. San Francisco: Jossey-Bass; 2004.
25. Hopkins WE, Sterkel-Powell K, Hopkins SA. Training priorities for a diverse work force. Public Pers Manage 1994;23:429–36.

26. Fine MG. Cultural diversity in the workplace: the state of the field. J Bus Com 1996;33:485–502.
27. Seymen OA. The cultural diversity phenomenon in organizations and different approaches for effective cultural diversity management: a literary review. Int J Cross Cult Manag 2006;13:296–315.
28. Swanson JW. Diversity: creating an environment of inclusiveness. Nurs Adm Q 2004;28:207–11.
29. Leininger M. Founder's focus: transcultural nursing is discovery of self and the world of others. J Transcult Nurs 2000;11:312–3.
30. Marriner-Tomey A. Guide to nursing management and leadership. 8th edition. St. Louis (MO): Mosby Elsevier; 2009.
31. Betancourt JR, Green AR, Carrillo JE. Cultural competence in health care: emerging frameworks and practical approaches. New York: Commonwealth Fund, Quality of Care for Underserved Populations; 2002. Available at: http://www.cmwf.org/usr_doc/betancourt_culturalcompetence_576.pdf. Accessed June 7, 2009.
32. Georgetown University Center for Child and Human Development, National Center for Cultural Competence. Cultural competence health practitioner assessment. Available at: http://www11.georgetown.edu/research/gucchd/nccc/foundations/need.html. Accessed May 3, 2009.
33. American College of Healthcare Executives, the American Hospital Association, the National Center for Leadership, and the Institute for Diversity in Health Management. Strategies for leadership: does your hospital reflect the community it serves?. Available at: www.aha.org/aha/key_issues/disparity/content/DiversityTool.pdf. Accessed May 3, 2009.
34. Kripalani S, Weiss B. Teaching about health literacy and clear communication. J Gen Intern Med 2006;21:888–90.
35. Institute of Medicine. In the nation's compelling interest: ensuring diversity in the health care workforce. Washington, DC: National Academy Press; 2004.
36. Cohen JJ, Gabriel BA, Terrell C. The case for diversity in the health care workforce. Health Aff 2002;21:90–102.
37. US Department of Health and Human Services. The rationale for diversity in the health professions: a review of the evidence. Available at: ftp://ftp.hrsa.gov/bhpr/workforce/diversity.pdf. Accessed May 8, 2009.