

Analysis of cultural competency



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In this multicultural society, becoming a culturally competent health care professional is an essential and challenging prerequisite. The United States is quickly developing into a multicultural, pluralistic civilization of various peoples. According the U. S. Census (2000), more than 30 percent of the total population is composed of diverse ethnic minorities other than non-Hispanic Whites. As America is becoming increasingly diverse, cultural competence is taking on an increasing importance. With this focus on cultural competency in nursing and the significance surrounding the concept, it is important to understand its meaning and implication on our continuously evolving and diversifying healthcare system. According to Walker and Avant (2005), “ concept analysis examines the make-up and role of a concept.” Furthermore, concept analysis seeks to analyze and explain a particular concept (Walker & Avant, 2005, p. 64). This concept analysis of cultural competence provides conceptual clarity and examination of the attributes and history of cultural competence as well as the philosophical and theoretical application and relation of cultural competence to the nurse-patient relationship.

Defining Attributes of Cultural Competency

According to the McGraw-Hill Concise Dictionary of Modern Medicine (2002), cultural competence is “ the ability to understand, appreciate, and interact with persons from cultures and/or belief systems other than one’s own, based on various factors.” Walker and Avant (2005) identified defining attributes as “ the cluster of attributes that are the most frequent associated with the concept and that allow the analyst the broadest insight into the concept” (p. 68). Cultural competence is best described as a process that

can be categorized into three dimensions: awareness, attitudes, and behaviors. After review of the literature, cultural competence is best described as a process categorized into three dimensions: awareness, attitudes, and behaviors (Dudas, 2012). The defining attributes of cultural competency were identified as ability, openness, and flexibility (Suh, 2004).

Awareness, the first dimension established in cultural competence, can be described as knowledge cultural resemblances and variations. One must consider one's own tendencies, biases, thoughts, and ideas. When ethnocentrism is engaged, prejudice can intervene with accomplishing cultural competence. Bias may also include racial discrimination, generalizations, and stereotyping, all of which have the potential to intervene with achieving cultural competence. Further, awareness includes an understanding of oneself and a person's own culture; to comprehend the needs of another, one must comprehend oneself (Dudas, 2012).

Attitude is the second dimension and incorporates the culturally proficient healthcare provider showing sensitivity toward those of differing cultures than their own. Openness is an essential value when considering attitudes. Preventing the propensity to be judgmental of others and not supposing that all beliefs are the same is also seen as important. Recognizing, accepting, and respecting social variations and being comfortable with difference cultures are necessary attitudes to have in the achievement of culture competence; along with the desire and willingness to evolve to other's needs. Some claim that these attitudes are a ethical and moral responsibility of all medical staff (Dudas, 2012).

The third dimension, behavior, represents the actions the healthcare professional shows when adapting and adjusting care to be culturally congruent. This requires information of the culture, attitudes, habits, heritage, and behaviors of those in the healthcare providers care and calls for creativeness in the use of that information. Behaviors will be unique as healthcare providers interact within, among, and between groups, understanding and appreciating the differences encountered (Dudas, 2012).

Ability is the first attribute of cultural competence. It is described as the healthcare provider's ability to proficiently and effectively provide care to communities and people of diverse ethnicities. Cultural competency is about the healthcare provider's extensive ability to recognize and remove cultural difference and disparity between patients and medical professionals. Most of the current explanations of cultural competence include the word "ability" (Suh, 2004).

The second and third attributes are openness and flexibility. Openness mostly includes healthcare providers' being respectful, accepting, and having an open mind. It largely includes having an objective outlook and a nonjudgmental attitude to cultural attributes. Flexibility generally means an ability to evolve and adapt oneself to different circumstances and situations. Flexibility related specifically to cultural competence means embracing ethnically relativistic perspective, appreciation of and dedication to other cultures, and intersubjectivity (Suh, 2004).

History of the Concept

Recent research in the health sciences arena has just begun to discover connections between culture and research design, analysis, and evaluation and their necessity. In contrast to its use in the context of healthcare providers in health care settings, the notion of cultural competence in the framework of research has been restricted. “ Cultural competence in research is the ability of researchers and research staff to provide high quality research that takes into account the culture and diversity of a population when developing research ideas, conducting research, and exploring applicability of research findings.” In order to better understand the potential role of cultural differences among population groups, researchers must acknowledge the continuing demographic shifts taking place in our society. An understanding of how such changes may impact their research study design, analysis and interpretation, and as a result how best to engage diverse populations in research is profound. The majority of researchers do not appreciate or have not received training that allows them to incorporate the angle of minority populations into their work. This leads to the cultural perspective of the majority being the only perspective in the conduct of their work. Cultural competence is vital for researchers to ensure: (1) valuable communication and interface between study participants and researchers; (2) sufficient analysis and explanation of results as they pertain to the patient/population impact; and (3) suitable engagement in study design and execution for community/population based research. Cultural competence could help to advance participation of minority populations in research studies, ensuring that various subgroups in the population are equally represented (Atim & Cantu, 2010).

Since research became a facet of the nursing profession, there has been a need for educational researchers, medical staff, and various cultural communities to come together to enhance and increase understanding of illnesses, diseases, and conditions that affect people of varying racial, cultural, and ethnic backgrounds. It is common to find that performing analysis on wellness problems in cultural communities is often restricted by lack of available information. Thus, it is vital to pair cultural communities to design culturally appropriate research studies and gather information that can be integrated in clinical decision making and policy. There is also a need to assess culturally unique treatment methods and folk medicines to direct and inform clinical decision making. Analyzing how illnesses and diseases manifest in varying cultures, evaluating culturally specific treatment methods, and discovering how belief systems influence the “ illness experience” are significant health issues require further inquiry (Victor, 2009).

Including cultural competence in nursing curricula is an important beginning step to prepare healthcare providers for culturally diverse practice environments. It is also essential to provide continuing educational opportunities to healthcare providers to augment their understanding of different cultural beliefs regarding health and sickness, culturally specific treatment methods, and folk medicine. Welcoming leaders from a variety of cultural communities to educate healthcare providers on their beliefs and practices is a valuable way to enhance awareness and understanding. There is growing evidence in nursing literature to support the education of healthcare providers regarding cultural competence (Victor, 2009).

Oposing views of the term most appropriate to use for the concept of cultural competence are widely discussed in the nursing literature. These terms include cultural proficiency, cultural skill, cultural sensitivity, cultural understanding, cultural awareness, and cultural knowledge (Burchum, 2002). Cultural proficiency is evidence of a commitment to change and to gain new knowledge through conducting research, developing new culturally sensitive approaches, and by delivering the information to others (Burchum, 2002). Cultural skill is the ability to obtain pertinent cultural data and information about patient's immediate conditions and perform a culturally sensitive and specific assessment (Flowers, 2004). Cultural sensitivity is appreciating and valuing diversity. It means respecting a patient's beliefs and values thought it differs from one's own (Burchum, 2002). Cultural understanding is realizing that culture shapes one's beliefs, values, and behaviors as it relates to health issues and is understanding that marginalization influences patterns of seeking care (Burchum, 2002). Cultural awareness refers to self examination and in-depth discovery of one's own cultural and professional background and possible biases and prejudices (Flowers, 2004). Cultural knowledge is the seeking and acquiring of an information base on difference cultural and ethnic groups. It is familiarity with conceptual and theoretical frameworks that will explain how members of a particular culture interpret illness (Flowers, 2004). Although, there has been a propensity by some to use terms such as cultural sensitive to indicate a conceptual equivalence to cultural competence, this and alike terms are in fact components of cultural competence (Burchum, 2002).

Philosophical and Theoretical Application

Florence Nightingale's work with soldiers during the Crimean War and her work with the Australian aboriginal people leads her to being coined as the first transcultural nurse in modern history (Zander, 2007). However, the proposal to create and institute a new field of transcultural nursing that incorporated the concept of cultural competence began with Madeleine Leininger in the late 1950s and her Culture Care Diversity and Universality theory (also called Culture Care Theory). In 1965, Leininger introduced the first transcultural nursing program at the University of Colorado (Zander, 2007). The Transcultural Nursing Society was established in 1974 and the first Transcultural nursing book in 1978. The Journal of Transcultural Nursing began in 1989 (culturally competent care: invisible and visible). In the late 1990s, several models were developed to include patient's cultural factors in nursing practice such as the Sunrise Model (Suh, 2004).

Theories and philosophy are used by a discipline to distinguish it from other disciplines. Leininger's theory was built around the concept of cultural competence and was first published in 1988. The Culture Care Theory guides the nurse to perform a cultural assessment and to develop a care plan sensitive to the patient's cultural background. This theory encompasses cultural competence by focusing on understanding both similarities and differences in patient groups and culture care universality versus cultural care diversity. Using the theory allows the healthcare provider to better assess and provide resources and support that are respectful and most beneficial for that specific patient in his or her culture. Cultural competence and the Culture Care Diversity and Universality theory require education of

other cultures, including religions, ethics, and social structures to make healthcare providers more sensitive to patients with all types of backgrounds (Leininger,).

Nurses today are confronted by a world in which they are required to use transculturally-based nursing theories and practices in order to care for people of assorted cultures (Leininger, 1996). The main objective of the theory of the Culture Care Diversity and Universality is to discover and explain different, worldwide culturally based care factors influencing sickness, death of individuals or groups, and health. Using research results to provide culturally competent, safe, and meaningful care to patient's of different or similar cultures is the purpose and goal of Leininger's theory (Leininger, 2002). Leininger (2002) believed that " substantive theory-based research knowledge was greatly needed with a global and comparative focus to care for people of diverse cultures" (pg. 189). Leininger laid claim to the construct of culturally congruent care, which is the central goal of the theory. Today, the Culture Care theory has been well established today and is used by many nurses worldwide. The theory is known for its broad, holistic yet culture-specific focus to discover meaningful care to diverse cultures (Leininger, 2002). Culturally congruent, responsible, and sensitive care and the concept of cultural competence can no longer be omitted in human health services and new health care reforms as healthcare services are more popularly being rendered to immigrants, refugees, and other culturally diverse people (Leininger, 1994).

There are five major, unique, and contributing features related to the Culture Care Theory. The first is that having been launched in the mid-1950s, the <https://assignbuster.com/analysis-of-cultural-competency/>

theory is one of the oldest theories in nursing. Second, it is the only theory solely concentrated on interrelationships of culture and care on well-being, disease, and death. The third feature of the Culture Care Theory is that it is the most complete and multidimensional theory to ascertain specific and comprehensive culturally based care practice and meanings. Fourth, it is the first nursing focused on exploring international cultural care variations and care commonalities. Being the first nursing theory with a distinctively designed research method (ethnonursing) to match the theory is the fifth unique feature. Fifth, it is the first theory focused on social organization factors, data related to global view, various environmental contexts in ethnohistory, and generic (emic) and professional (etic) culture care (Leininger, 2002).

Out of the Culture Care theory grew the Sunrise Model. The sunrise model is a conceptual guide depicting the major interrelated dimensions of the theory that need to be discovered in order to generate culture care knowledge. The model presents different factors that need to be considered to arrive at a holistic picture of individuals, families, groups, cultures, communities, or institutions related to culture care patterns and needs. Currently, the theory and the sunrise model are being used to do culturological health care assessments for primary care and to develop culture-specific nursing care practices. Data obtained from the dimensions of the sunrise model lead to a comprehensive holistic way of knowing and understanding people. Using the theory with the sunrise model helps the nurse to think holistically to discover a patient's meaningful lifeways that relate to their health, illness, or dying process. The theory and model are major forces in moving nurses from

the traditional medical model of nursing to a new nursing paradigm for the 21st century (Leininger, 1996).

Cultural Competence in the Nurse-Patient Relationship

Cultural competence begins with the acknowledgment that every individual is born, reared, and dwelling in educational, social, and organizational cultures. These cultures shape assumptions, beliefs, values and behaviors (New South Wales Health Department, 2010). The American Nurses Association (2001) recognized the need to provide culturally competent care and stated in the association's code that " The nurses, 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." When healthcare providers interact with patients, the similarities and differences between cultural expectations often make the interaction both more interesting, and more challenging. In a health setting, these challenges must be met if equitable, appropriate and accessible services to all patients are to be provided (New South Wales Health Department, 2010). Interpersonal communication is key in the ability of a provider to bridge cultural differences to build an effective relationship with a patient. The healthcare provider must build rapport and trust, convey unconditional positive regard, be aware of health disparities and discrimination affecting a particular patient's minority group, and effectively use interpreter services when needed (Beach, Cooper, & Saha, 2006).

An individual who is culturally competent can communicate considerately and efficiently with patients who have multiple and varying ages, genders,

cultures, religions, sexualities, disabilities, languages and ethnicities.

Culturally competent health care providers make every effort to afford services that are consistent with the patients' needs and ethics first of all by acknowledging them, and secondly by, responding to them appropriately wherever possible (New South Wales Health Department, 2010). It is necessary for healthcare practitioners to develop a wide range of perspectives, knowledge, skills, attitudes, and practices which can be used to improve their cultural competence and guide their relationships with patients and coworkers (New South Wales Health Department, 2010). However, it is important that providers do not unintentionally stereotype or label a patient (Flowers, 2004).

Lack of cultural competent care impacts both patients and healthcare providers. People with rural backgrounds are used to dealing through family and kinship networks, in contrast to those with urban backgrounds. Health care institutions often represent loss of personal choice in the sense that the patient does not “ know” the providers. Eliminating this feeling of loss is a vital part of provider-patient interactions and providing culturally competent nursing care (Marlie & Putsch, 1990). It has also been found that failure to provide culturally congruent care can greatly increase the stresses experienced by critically ill patients (Flowers, 2004). It is hard for patients to build a sense of trust in a healthcare provider or a service if they feel they have been dismissed or disregarded, their concerns have not been understood, or they have not received the best services because of their cultural background or ethnicity or language (New South Wales Health Department, 2010). Culturally competent health care providers establish

respect and trust with patients which in return increase patient satisfaction. Health outcomes also improve such as a more efficient use of the staff and patients' time, more accurate information, and more helpful and satisfactory outcomes for staff and patients (New South Wales Health Department, 2010).

Advantages of incorporating the concept of cultural competence are the specific applicability to daily nursing care and nurse-patient relationships and the quality of nursing care through provision of culturally congruent care is greatly improved. Disadvantages to the nurse-patient relationship in acute care settings may be that an interview and observation in a patient's own environment is not possible, a patient with altered mental status may not be able to effectively cooperate during the assessment, and application of cultural competence may be time consuming (Mannion & Scott, 2002). It is believed that the intersubjective relationship between the nurse and patient is prerequisite to quality nursing care is. This relationship is characterized by receptive and caring attitudes toward patients and their health care needs and is without conjecture or judgments. Knowledge of patients' cultural attributes and recognition of and responsiveness to cultural differences allows for this type of nurse-patient relationship to take place (Frederickson, Kleiman, & Lundy, 2004).

Example of Cultural Competence as Related to Nursing Practice

According to Walker and Avant (2005), a model case “ is an example of the use of the concept that demonstrates all defining attributes of the concept”

(p. 69). The following case demonstrates the defining attributes of the concept of cultural competence.