

Exploring Cultural Competence – The Emerging Picture

By

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## ABSTRACT

**TITLE:** Exploring Cultural Competence: The Emerging Picture

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This study was centrally concerned with two concepts: culture and cultural competence as they relate to the education of healthcare professionals. The goal of this study was to examine the current state of cultural competence and contribute to its conceptual development in order to guide curricula in healthcare education. To accomplish this, a critical examination of the central tenets of cultural competence was made with recommendations for integration of cultural competence into healthcare education.

Findings from this study contend that conceptualizing, teaching, and learning cultural competence as a finite body of knowledge is both superficial and inadequate for the sweeping social and demographic changes occurring today. Furthermore, a focus on cultural "traits" obscures the interlocking systems and oppressive relations that establish and maintain systems of imbalanced power and therefore health disparities between and among groups within the U.S. and worldwide.

This study explored cultural competence through interviews with 20 multidisciplinary cultural and cultural competence experts from the U.S. and

abroad. Multidisciplinary data were thought to yield richer findings than any one discipline alone and therefore could generate a more comprehensive and innovative approach to integrating cultural competence in healthcare education in the future.

Awareness, engagement, and application were central themes that applied, albeit differently, across four domains of cultural competence: intrapersonal, interpersonal, system/organization, and global. Awareness in all domains stressed understanding context (of self, others, and systems) as a key element in developing cultural competence. Engagement highlighted development of intellectual, attitudinal, and behavioral flexibility, skillful communication, empathy, and building high-quality relationships. Application emphasized building personal capacity, whole body communication, conflict negotiation, and responsiveness to client, family, and community needs and priorities.

Recommendations for integrating cultural competence into healthcare education included faculty development, spiraling curriculum with an iterative revisiting and deepening of the complexity of the cultural competence content, experiential learning paired with facilitated reflection, and building a critical mass of cultural competence within a healthcare education setting through the support of leadership and infrastructure.

## Table of Contents

Chapter One	Page
Introduction .....	1
Significance to Nursing .....	3
Health Disparities .....	4
Purpose of Study .....	6
Aims of Study .....	7
Chapter Two	
Context of Inquiry and Review of the Literature .....	8
Search Strategy .....	9
Evolution of Culture as a Critical Concept in Healthcare .....	12
Transcultural Nursing .....	12
Cultural Competence .....	14
Culture .....	21
Essentialist View .....	24
Consequences of an Essentialist View .....	25
Constructivist View .....	30
Consequences of a Constructivist View .....	31
Contextual Cultures .....	32
U.S. Culture .....	32
Biomedicine .....	34
Healthcare Education .....	36

## Table of Contents (cont.)

Chapter Two (cont.)	Page
Cultural Competence Education Interventions and Evaluation .....	38
Competence .....	48
Ways of Knowing and Embodiment .....	49
Cultural Competence Critique .....	56
Summary .....	59
Chapter Three	
Study Design .....	62
Methodological Perspective .....	63
Sample .....	65
Methods .....	68
Recruitment .....	68
Data Collection .....	68
Setting .....	71
Data Management .....	72
Protection of Confidentiality .....	72
Data Analysis .....	73
Thematic Analysis .....	74
Memos .....	76
Criteria for Evaluation of the Findings .....	77
Credibility .....	78



## Table of Contents (cont.)

Chapter Three (cont.)	Page
Dependability .....	80
Transferability .....	80
Confirmability .....	81
Protection of Human Subjects .....	82
Summary .....	83
Chapter Four	
Results .....	84
Description of Cultural Competence Themes .....	87
Awareness .....	87
Engagement .....	87
Application .....	88
Description of Cultural Competence Domains .....	90
Intrapersonal Domain.....	90
Interpersonal Domain.....	91
System/Organization Domain .....	91
Global Domain .....	92
Themes and Domains of Cultural Competence .....	92
Awareness .....	94
Intrapersonal Awareness .....	94
Reflection .....	96

## Table of Contents (cont.)

Chapter Four (cont.)	Page
Contextual Setting .....	97
Privilege .....	98
Behavioral Approach to Self-Awareness .....	100
Interpersonal Awareness .....	101
Acceptance .....	102
Context .....	103
Humility .....	104
Arrogance .....	105
System/Organization Awareness .....	107
Role of System/Organization Cultural Competence .....	107
The U.S. and Biomedicine .....	109
Engagement .....	111
Intrapersonal Engagement .....	111
Interpersonal Engagement .....	112
Communication .....	112
Listening to Understand .....	113
Asking Questions .....	117
Developing Empathy .....	118
Relationship Building .....	119
System/Organization Engagement .....	121

## Table of Contents (cont.)

Chapter Four (cont.)	Page
Intra-Organizational Standards .....	121
Building Effective Partnerships .....	122
Application .....	123
Intrapersonal Application .....	123
Building Capacity.....	123
Whole Person Wellbeing .....	124
Interpersonal Application .....	125
Whole Body Communication .....	125
Noticing .....	126
Mirroring .....	126
Conflict Negotiation .....	127
System/Organization Application .....	128
Infrastructure .....	128
Client Centered Care .....	129
Responsive to Community and Partner Needs .....	131
Research .....	131
Healthcare Education .....	132
Context of Healthcare Education .....	133
Complexity .....	133
Hard and Soft Science .....	135

## Table of Contents (cont.)

Chapter Four (cont.)	Page
Meaning and Application of Cultural Competence .....	138
Healthcare Education Recommendations .....	141
Content .....	143
Health and Healthcare Disparities .....	143
U.S. Healthcare Context .....	144
Intrapersonal Context .....	144
Interpersonal Context .....	145
Communication .....	146
Conflict Negotiation .....	147
Client Centered Care .....	147
Strategies .....	148
Spiral Curriculum.....	148
Integration versus Stand Alone Course .....	149
Experiential Learning .....	151
Immersion Experiences .....	153
Reflection .....	154
Application of Cultural Competence.....	155
Faculty and Infrastructure.....	156
Transdisciplinary Faculty .....	156
Faculty Development .....	158

## Table of Contents (cont.)

Chapter Four (cont.)	Page
Critical Mass .....	158
Evaluation .....	159
Standards .....	160
Research .....	161
Summary of Findings .....	162
Chapter Five	
Summary of Key Findings .....	166
Discussion .....	166
Themes and Domains .....	166
Relational Nature of Cultural Competence .....	167
System/Organization Cultural Competence .....	169
Limitations .....	170
Implications for Further Study .....	173
Faculty Development .....	174
Spiraling Cultural Competence Content .....	176
Privilege and Power .....	177
Relational Skill Development .....	178
Role of the body .....	179
Global Competencies .....	180
Conclusion.....	181

## List of Tables

Table 1. Databases and subject headings searched .....	10
Table 2. Conceptualizations of culture in healthcare literature .....	24
Table 3. Educational approaches and evaluation strategies .....	38
Table 4. Summary findings of cultural competence themes and domains .....	93
Table 5. Key findings of cultural competence education recommendations ...	142

## List of Figures

Figure 1. Number of articles published on cultural competence 1986-2008 .....	10
Figure 2. Depiction of culture specific and client-centered information .....	18
Figure 3. Cultural Competence Themes and Domains .....	86
Figure 4. Relationship of awareness, engagement, and application .....	89
Figure 5. Awareness Continuum.....	111

## Chapter One: Introduction

Although interactions among population groups and nations are not new, beginning in the 20<sup>th</sup> century, political and economic crises have resulted in a marked increase in the migration of people across international borders throughout the world. This has increased contact among groups of people with widely varying backgrounds and worldviews. For example, today, 160 million people live outside their country of origin (Partida, 2007). In the U.S. alone, at the end of 2005, more than 35 million foreign-born persons accounted for 12% of the total population, including 8 million who had relocated since 2000 in the highest recorded five-year immigration in U.S. history (Koehn & Swick, 2006).

Because different cultural groups prioritize values differently, foundational mismatches in understanding may result from not appreciating basic cultural differences such as gender roles and positions of authority, sense of self and space, communication, relationship to time, relationship to others, learning styles, and spiritual practice. Within the healthcare system, these differences exhibit themselves in how health and illness are perceived and manifested; what is thought of as cause; how, when, and where communication occurs; the roles of health professional, client, family, and community; and how treatment is negotiated, implemented, and evaluated.

Research and clinical practice have led to increased awareness of the complexity brought to the healthcare system as a result of *globalization*, defined as the worldwide movement toward integration and interconnection of the

world's people, functioning together economically, politically, technologically, and socio-culturally (Merriam-Webster, 2008). Health professionals are now being called upon to alter traditional ways of working with clients, families, and communities and to begin thinking differently and "being" differently as they encounter new relationships across cultures both domestically and internationally.

In an effort to address the increased complexity of providing healthcare to widely varying cultures, the cultural competence movement was born. Although there are many definitions, *cultural competence* is generally thought of as the knowledge, skills, and attitudes that enable a health professional or system to provide meaningful, supportive, and beneficial healthcare that preserves a client and community's human rights and dignity (American Academy of Nursing [AAN], 1992; Betancourt, Green, & Carillo, 2000, 2002; Burchum, 2002; Cross, Bazron, Dennis, & Isaacs, 1989; Meleis, 1996; Paasche-Orlow, 2004; Pacquiao, 1995, 2007). Cultural competence emerged in part from a recognition that the continuation of a singular way of thinking or acting based on a singular set of cultural norms was not only unethical, it was also unprofitable (Bennett, 1993; Betancourt et al., 2000, 2002; Brannigan, 2008; Carter & Klugman, 2001; Harper, 2006; Klopf, 2001; Paasche-Orlow, 2004). Thinking and acting from a singular set of cultural norms is considered unethical because it does not provide accommodation for unique beliefs, values, or traditions. It is considered unprofitable because clients and communities seek out alternatives to healthcare



providers who are not aligned with their wishes and do not understand them (Bentancourt et al., 2000, 2002; Brannigan, 2008; Carter & Klugman, 2001; de Vries, 2004; Paasche-Orlow, 2004).

### **Significance to Nursing**

In the 21<sup>st</sup> century where people live in an increasingly multicultural society, many professional organizations now consider health to be a shared global responsibility, involving equitable access to essential care for all individuals. Statements by the International Council of Nurses (ICN) (2003), the American Nurses Association (ANA) (2007), and the World Health Organization (2008), among others, clearly entitle all people of the world equally to civil, economic, social, and cultural rights, including the right to health. Indeed, all human rights are best thought of as inseparable because, for example, poor health can have a harmful effect on other basic human rights such as education and full participation in society (Canales, 2000; Drevdahl, Canales, & Dorcy, 2008; Ornelas, 2008; Paez, Allen, Carson, & Cooper, 2008).

Over the past 20 years, nursing has played a leading role in addressing strategies to improve cultural healthcare provisions and healthcare outcomes, as reflected in the burgeoning literature on cultural competence that has been widely adopted in healthcare education, practice, and research (AAN, 1992; Institute of Medicine (IOM), 1994, 2002; Pew Health Professions Commission, 1995; US Department of Health and Human Services (USDHHS), 2000). However, personal experiences, both domestic and international, focused study

on alternate ways of perceiving, long-term musings, and a comprehensive review of the literature have led this researcher to question the adequacy of the mainstream approach of cultural competence in working with cultural differences. A critical assessment of the underpinnings of cultural competence is needed in order to help guide future educational, research, and practice directions.

### **Health Disparities**

Cultural competence is considered a primary strategy for reducing health disparities (Betancourt et al., 2000; Betancourt, Green, Carrillo, & Aneneh-Firempong, 2003; Betancourt, Green, Carrillo, & Park, 2005; Brach & Fraser, 2000, 2002; Demasio, 2003; Drevdahl, et al., 2008; Ganao, Bussey-Jones, Brady, Branch, & Corbie-Smith, 2003; Giger et al., 2007; Gonzalez, Gooden, & Porter, 2000; Hart, Hall, & Henwood, 2003; Horner et al., 2004; Kaplan & Greenfield, 2004; Koehn & Swick, 2006; Ornelas, 2008; Taylor & Lurie, 2004; Tervalon, 2003a, 2003b; Theil de Bocanegra & Gany, 2004). Health disparities are defined as "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the U.S." (Giger et al., 2007, p. 97). While concerns about health disparities have long preoccupied communities, the landmark report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (IOM, 2002) presented compelling evidence of inequalities in access to care, healthcare received, and healthcare outcomes in the health of the nation's most disadvantaged groups

(Drevdahl et al., 2008; Giger et al., 2007; Johnstone & Kanitsaki, 2007; Kai et al., 2007; Ornelas, 2008; Paez et al., 2008). Disparities also exist in the training of the healthcare professionals who provide the needed services to these vulnerable populations (Kosoko-Lasaki, Cook, & O'Brien, 2009). Fueled by the IOM's report, health disparities are a high priority for the national healthcare agenda as evidenced by its being ranked third among the top priorities of the Institute of Medicine (2006). Further, health disparities are an important component of Healthy People 2010 (Drevdahl et al., 2008; Office of Disease Prevention and Health Promotion (ODPHP), 2008; Silver, 2006).

While health disparities are often associated with ethnic minority groups, a growing body of literature reveals that health disparities are not limited to ethnic minorities alone. In fact, health disparities are determined not only by inequities in health status and healthcare, but they are also associated with unfair systemic social disadvantage for certain individuals and communities based on factors such as gender, socioeconomic status, disability, geographic location, sexual orientation, and spiritual practice (Johnson & Smith, 2002; Scharff et al., 2002). These underlying social factors, referred to as *social determinants of health*, include the interconnected social, economic, and political resources and structures that collectively influence health outcomes of both individuals and populations (Campesino, 2008; Dreahslin, 2007, 2008; Drevdahl et al., 2008; Johnson & Smith, 2002; Kumas-Tan, Beagan, Loppie, MacLeod, & Frank, 2007; Ornelas, 2008; Scharff et al., 2002).

Despite the health profession's commitment to high-quality care, health disparities remain daunting in the U.S. and worldwide. While the link between cultural competence and eliminating health disparities is made persistently in the healthcare literature, limited evidence is available that directly links cultural competence with reduced health disparities or improved health outcomes (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007; Carpenter-Song, Schwallie, & Longhofer, 2007; Drevdahl et al., 2008; IOM, 2002; Kai et al., 2007; Ornelas, 2008; Siantz & Meleis, 2007). Given this paucity of data, research is needed to further explore the concept of cultural competence and its implications for health and healthcare delivery.

### **Purpose of Study**

This study is centrally concerned with two concepts, culture and cultural competence, as they relate to the education of health professionals. Despite the current popularity of the concept of cultural competence, limited empiric knowledge exists regarding what cultural competence means, or what its essential components, underlying assumptions, and philosophical underpinnings are. In the face of rapidly changing healthcare needs, there is now, more than ever, an acute need for new understandings to guide the development of the concept of cultural competence. The goal of this study is to contribute to the conceptual development of cultural competence as a framework to guide knowledge development in healthcare education by critically examining the central tenets of the concept of cultural competence. The purpose of this study is

to explore how the term *cultural competence* has been used and the implications of the findings for the education of health professionals.

### **Aims of Study**

The specific aims of this study are as follows:

Aim 1: Describe how the term *cultural competence* has been used.

Aim 2: Identify the strengths, limitations, and underlying assumptions of cultural competence.

Aim 3: Generate recommendations for future integration of cultural competence in healthcare education.

## **Chapter Two: Context of Inquiry and Review of the Literature**

This chapter provides an overview of the background significance of the proposed investigation to explore the concept of cultural competence and its relationship to healthcare education. Relevant literature was culled from healthcare disciplines, primarily nursing and medicine, in response to the current education movement away from traditional curricula toward learning environments that are transdisciplinary in nature (Giddens, 2008; Giger & Mood, 1997; Hallin, Kiessling, Waldner, & Henrikson, 2009; Macfarlane et al., 2008; Christie, Smith & Bednarzyk, 2007). Therefore, literature on culture and cultural competence in healthcare was reviewed, the findings summarized, and significant gaps in knowledge about this phenomenon identified. The exploration of these broad topics was not exhaustive but established a foundation for the proposed investigation.

### **Introduction**

Cultural competence is a relatively new concept, yet it has already become an integral part of clinical practice in nursing, medicine, allied health, social work, clinical psychology, and education. The concept has also been used in the business and marketing aspects of the healthcare arena. Cultural competence has risen in its perceived importance in the past 20 years and has been adopted as a formal curricular goal across healthcare disciplines. The impetus for the burgeoning literature on cultural competence is complex and includes (a) the rapidly shifting demographics of the U.S. to a more ethnically, racially, and

linguistically diverse population; (b) recognition of the important role culture plays in healthcare; (c) an increased evidence base substantiating long-standing health disparities; and (d) mandates from professional organizations and accreditation bodies requiring cultural competence training for healthcare professionals and healthcare education. Growing interest in the concept and practice of cultural competence is also rooted in institutional efforts to meet legislative and regulatory mandates, the desire to gain a competitive edge in the healthcare market, interest in improving intercultural communication, transitioning of healthcare from institutions to communities, and consumer preferences and demands for holistic care (AAN, 1992; American Academy of Pediatrics (AAP), 2004; American College of Emergency Physicians (ACEP) 2002; American Public Health Association (APHA), 2002; IOM, 2002; National Center for Cultural Competence (NCCC), 2002).

## **Review of the Literature**

### **Search Strategy**

A systematic review of the literature from 1986-2008 was completed using two electronic search strategies in three databases: CINAHL, MEDLINE, and PsycINFO. First, the initial sampling produced over 3,800 articles using the key word cultural competence in the three databases (Figure 1). Second, search strategies were designed using subject headings specific to each database in order to maximize sensitivity in locating relevant literature (Table 1).

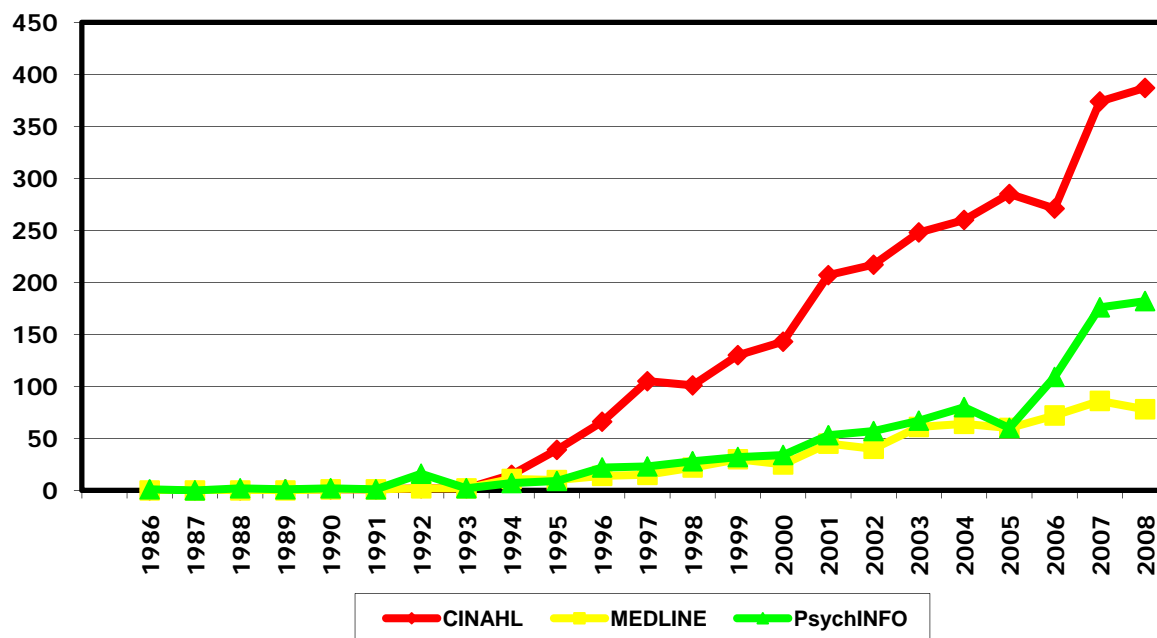


Figure 1. Number of articles published on cultural competence from 1986-2008.

Table 1. *Databases and subject headings searched*

Database	Subject Headings	Year Indexed
CINAHL	Cultural competence	1996
	Cultural sensitivity	1994
	Transcultural care	1993
	International nursing	1986
MEDLINE	Cultural competence	2008
	Cultural diversity	1996
	Transcultural nursing	1992
	Culture	1975
PsychINFO	Multiculturalism	1997
	Cultural sensitivity	1994
	Culture change	1967
	Culture (anthropological)	1967



In addition to electronic searching, hand searches were completed of key articles, dissertation abstracts, and books frequently cited and/or recommended by specialty organizations, such as the Transcultural Nursing Society and the Society of Intercultural Education, Training, and Research (SIETAR). Using the combined search strategies, titles and abstracts were compiled and reviewed for eligibility. Publications were included for review if they pertained to (a) the conceptualization of culture and/or cultural competence, and (b) cultural competence in healthcare professional education including curricula, educational interventions, and evaluation. Publications were excluded that were not available in English, were meeting or conference abstracts only (no full article for review), or articles that did not apply directly to the areas of focus noted above.

Of the 3,842 publications initially identified, 446 articles were selected for further scrutiny on the basis of screening the abstract and titles, after which 80 were excluded after full article review. In the end, 366 publications, 53 books, five monographs, and six websites were included in the review of the literature.

Most of the literature published on cultural competence has appeared since 2001. Indeed, the term *cultural competence* as a medical subject heading (MeSH) was indexed by MEDLINE in 2008. While nursing led in the early adoption of the term *cultural competence* and number of articles published, perhaps more importantly, the increase in cultural competence literature across disciplines indicates that cultural competence has become a robust movement in today's healthcare environment.

## **Evolution of Culture as a Critical Concept in Healthcare**

The need for healthcare professionals who are well equipped to treat clients, families, and populations of diverse social and cultural backgrounds has a well-established legacy in nursing. Harmer, in *The Principles and Practice of Nursing* (1928), described the essentials of nursing as including "a democratic spirit which leaves class and race prejudice behind. It is the aim...to give the same kind of care to men, women, and children, to all colors and creeds, rich and poor, enemies and friends" (p. 8). More recently during the 1960s and 1970s, emphasis on unique differences came into the social and political forefront in the U.S. through the civil rights and women's rights movements. During this time, healthcare providers and researchers gained a new awareness of unique cultural issues and the significance that these differences held for education, employment practices, and healthcare. Building on this understanding of unique differences over time has increased awareness of the impact of disparate worldviews, values, customs, and lived experiences of health, illness, and healthcare delivery. Consequently, two separate but interrelated movements emerged: transcultural nursing and cultural competence.

### **Transcultural Nursing**

Early efforts in the 1950s by Leininger, a nurse anthropologist, resulted in the well-known nursing approach to cultural care she called *transcultural nursing*, now considered both a nursing specialty and a general practice area (Andrews & Boyle, 1997, 2002, 2003; Leininger, 1985, 1988, 1991, 1995, 1997; Murphy,

2006). The unique focus of Leininger's approach was her belief that *care* is ultimately interconnected with *culture*. In her classic work, *Nursing and Anthropology: Two Worlds to Blend*, Leininger advocated that nursing and anthropology work hand in hand, stating that each would benefit from the contribution of the other by generating new ways of thinking and research (1970). Therefore, transcultural nursing is generally thought of as the interface between anthropology and nursing, translating anthropology concepts into nursing practice in order to guide culturally informed nursing practice (De Santis, 1994; McCance, McKenna, & Boore, 1999). Leininger (1997) defined transcultural nursing as "A formal area of study, research, and practice, focused on culturally based care beliefs, values, and practices to help cultures or subcultures maintain or retain their health (well-being) and face disabilities or death in culturally congruent and beneficial caring ways" (p. 9).

While Leininger conceptualized transcultural nursing in the mid 1950s, transcultural nursing courses and programs of study did not appear until the 1970s and 1980s. Consequently, preparation of a group of nurses specialized in transcultural nursing took until almost 1990 in the U.S. and other places around the world (Leininger, 1997).

Since the inception of the field of transcultural nursing, Leininger has been instrumental in developing concepts, definitions, standards, and a theoretical and research base for the development of transcultural nursing (Leuning, Swiggum, Weigert, & McCullough-Zander, 2002). In addition, she has been one of the most

prolific contributors to the nursing literature regarding the importance of cultural care in nursing practice. Leininger's pioneering work has spawned a worldwide movement of specialized nursing knowledge.

### **Cultural Competence**

Concurrent with transcultural nursing being generally recognized as a specialty field, the impact of culture on healthcare and healthcare delivery has been acknowledged as integral to quality care across a range of other healthcare disciplines. The earliest use of the term *cultural competence* was by Taft (1986), an Australian psychologist who worked with immigrants. The term in its original context referred to the adaptation of immigrants and their self-perceived sense of mastery in their new host culture. In the healthcare field, the seminal monograph by Cross et al. (1989) offered a definition that has become foundational to the study of cultural competence, although the definition has been widely adapted and modified. Cultural competence, according to Cross et al. (1989), was a "set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals to work effectively in cross-cultural situations" (p. 7).

Two significant shifts took place between the work of Taft (1986) and Cross et al. (1989) that altered the ensuing work on cultural competence. First, while Taft perceived cultural competence as an outcome or *consequence*, Cross et al. perceived cultural competence as an *antecedent*. Second, while Taft regarded cultural competence as an achievement of the care-receiver, Cross et

al. envisioned cultural competence as an achievement of the healthcare provider, system, or organization. These two central shifts have dominated the knowledge development of cultural competence in the healthcare fields over the past 20 years. Interestingly, Cross et al. (1989) considered cultural competence as the fifth in a six-point developmental process with cultural proficiency as the sixth or highest level of development.

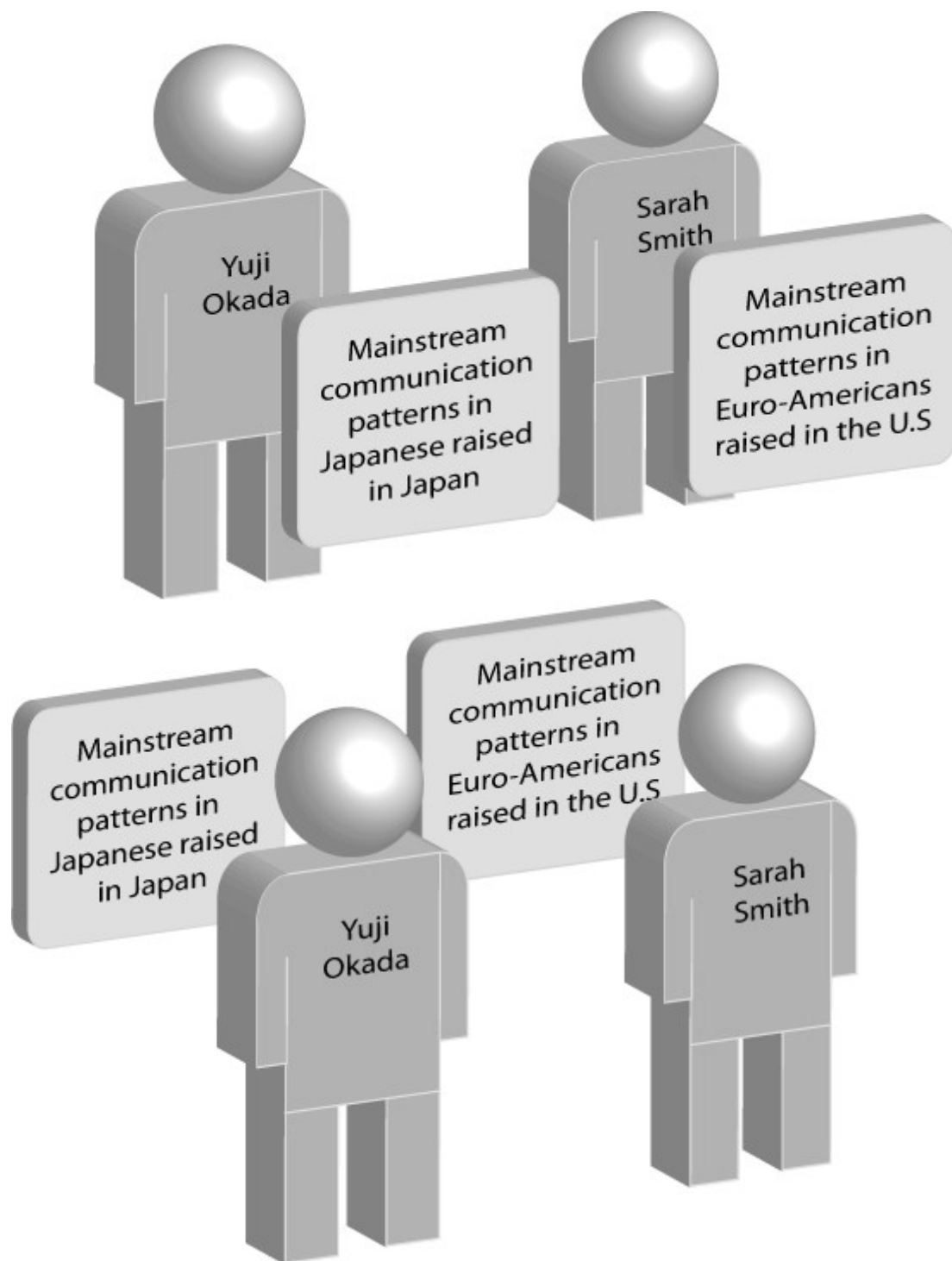
Over the past 20 years, an extensive body of literature on cultural competence has been generated to support the need for understanding, planning, implementing, evaluating, and refining cultural care in the health professions. Because cultural competence is a complex concept, it has been difficult to define and describe as evidenced in the multiple and varied definitions that have emerged from various disciplines. Cultural competence has been identified as *congruent behaviors, attitudes, and policies* (Cross et al., 1989); a *defined set of values* (NCCC, 1998); an *ability* (Betancourt et al., 2002); a *capacity* (OMH, 2001); *demonstrating knowledge and understanding* (Purnell & Paulanka, 1998); *a process of development* (Burcham, 2002); *application of cultural knowledge* (National Medical Association, 2004); and *providing acceptable cultural care* (Giger et al., 2007).

For the purposes of this study, the definition of *cultural competence* from the American Academy of Nursing Expert Panel on Cultural Competence (2007) has been used:

Having the knowledge, understanding, and skills about a diverse cultural group that allows the healthcare provider to provide acceptable cultural care. Cultural competence is an ongoing process that involves accepting and respecting differences and not letting one's personal beliefs have an undue influence on those whose worldview is different from one's own. Cultural competence includes having cultural general as well as cultural specific information so the healthcare provider knows what questions to ask. (Giger et al., 2007, p. 100)

To clarify, *culture general* and *culture specific* are two levels of understanding culture. Culture general can be considered an *etic*, or outside perspective, while culture specific can be considered an *emic*, or inside perspective (Bezanson & James, 2007). Culture-general approaches, as the name implies, focus on key issues that every culture expresses, albeit uniquely, such as relationship to time, relationship to authority, personal space, systems of social organization, and styles and patterns of communication, among others. Understanding from a culture-general approach (the etic view) can help individuals from a variety of cultures appreciate the broad continuum of appropriate but widely different behaviors, values, and beliefs between and among individuals, families, and communities. In contrast, culture-specific approaches emphasize the necessity of gaining a deep understanding of the unique traits, behaviors, and beliefs (the emic view) of specific groups or populations in order to provide effective care. For example, membership in a

group, or commonalities shared that constitute a group, may include a wide variety of factors including ethnicity, gender, addiction, sexual orientation, spiritual practice, or any other aspect that binds a specific group together. Increased attention to cultural-specific aspects of care is thought to decrease the possibility of inappropriate personal interactions and/or misunderstandings (Benzanson & James, 2007). It is important to emphasize that culture-specific information is best used as background, not foreground, so as not to stereotype individuals, families, and communities (Betancourt et al., 2002; Boyle, 2007; Gray & Thomas, 2005, 2006). Figure 2 illustrates the difference in emphasis between culture-specific and client-centered information.



*Figure 2.* Depiction of culture specific and client-centered information.



Cultural competence, the prominent cultural paradigm in U.S. healthcare today, has gained national attention and has been identified by policymakers, managed care administrators, academicians, and healthcare professionals as a possible solution to (a) eliminating health disparities, (b) decreasing cultural conflicts, and (c) promoting successful adaptation of services to meet unique needs in partnership with individuals and communities regardless of race, ethnicity, values, customs, or language proficiency (AAN, 1992; AACN, 2008; APHA, 2002; Betancourt, 2004; Betancourt et al., 2002; Boutin-Foster, Foster, & Konopasek, 2008; Burchum, 2002; Campesino, 2008; Cross et al., 1989; DeSantis, 1994, 1997; DeSantis & Lipson, 2007; Drevdahl, et al., 2008; Giger et al., 2007; IOM, 2002; Lancellotti, 2008; Meleis, 1996; NCCC, 2002; Ornelas, 2008; Paasche-Orlow, 2004). In addition, culturally competent care now serves as a criterion for healthcare quality and is regarded by professional organizations and accreditation bodies as an essential component of educational and practice reform (AAN, 1992; AAP, 2004; ACEP, 2002; APHA, 2002; IOM, 2002; ICN, 2003; NCCC, 2002; OMH, 2007a, 2007b).

While Harmer's (1928) *democratic spirit* may at first seem idyllic, examination of current trends in cultural competence question two main assumptions about culture and healthcare. First, that individuals of different gender, age, ethnicity, socioeconomic status, and worldviews would be best served by *the same kind of care*, and second, that healthcare providers and/or systems can readily *leave class and race prejudice behind* (Anderson,

Schimshaw, Fullilove, Fielding, & Normand, 2003; Brach & Fraser, 2000; Capell, Dean, & Veenstra, 2008).

In contrast to Harmer's (1928) recommendation for the *same kind of care*, current trends in cultural competence emphasize the unique needs of individuals and populations, calling for high quality but varied responses from healthcare providers and systems, including a broad scope of available healthcare options to serve the wide-ranging and distinctive needs of clients, families, and populations (Betancourt, 2004; Cuellar, Brennan, Vito, & Siantz, 2008; Hasnain-Wynia, 2006).

Current trends in cultural competence also diverge from Harmer's (1928) suggestion that healthcare professionals *leave class and race prejudice behind*. Rather, healthcare professionals are now called upon to gain greater insight into the social and historical context in which they have been raised and educated in order to have appreciation for the vital influence they have had on the development of values, beliefs, and biases. Specifically, healthcare professionals are encouraged to explore their own places of privilege that can both enhance and inhibit optimal health and healthcare for clients, families, and communities. The resulting insight can lead healthcare providers to a greater understanding of social and contextual factors that influence health and wellbeing. From both healthcare provider and systems perspectives, it is now thought that understanding and working from a variety of cultural perspectives is ethical, acceptable to consumers, and also profitable (AAN, 1992; Bennett, 1993;

Howard, Andrade, & Byrd, 2001; Klopf, 2001; Siantz & Meleis, 2007; Wright, Cohen, & Caroselli, 1997).

### **Culture**

A discussion of cultural competence requires an initial explication of the meaning of *culture*. This section begins with an orientation to healthcare's conceptualization of culture and its relationship to health and healthcare. For the purposes of this study, the definition of *culture* from the American Academy of Nursing Expert Panel on Cultural Competence (2007) is used.

A learned, patterned behavioral response acquired over time and includes explicit and implicit beliefs, attitudes, values, customs, norms, taboos, arts, habits, and life ways accepted by a community of individuals. Culture is primarily learned and transmitted within the family and other social organizations, is shared by the majority of the group, comprises an individualized worldview, guides decision making, and facilitates self-worth and self-esteem. (Giger et al., 2007, p. 100)

Culture is complex. It is an individual concept, a group phenomenon, and an organizational reality. Each individual, family, and community represents a unique blend of dynamic, overlapping, and nested cultures that influence perception, attitudes, and behavior related to factors such as gender roles, positions of authority, sense of self and space, communication, relationship to time, relationship to others, learning styles, and spiritual practice among others. Culture, therefore, helps determine what is important, valued, worthwhile, and

worth striving for (Barna, 1998; Engebretson, 2003; Horton, Tschudin, & Forget, 2007; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Johnston & Herzig, 2006; Klopf, 2001; Schim, Doorenbos, Benkertm & Miller, 2007). In the healthcare system specifically, culture influences how health and illness are perceived, how healthcare decisions are made, who has the authority to make these decisions; what is thought of as cause; how, when, and where communication occurs; what treatments are deemed appropriate; and how treatment is negotiated, implemented, and evaluated (Kleinman, 1983, 1988; Kleinman, Eisenberg, & Good, 1978). Consequently, culture and its effect on health and healthcare are now being acknowledged as complex, interconnected, nonlinear, and holistic (Chang, 2007; Daaleman, 2004; Heron & Reason, 1997; Kairys et al., 2002).

In *The Interpretation of Cultures*, Geertz (1973), an anthropologist, stated that humans are suspended in webs of significance that they themselves have spun, by which he meant that culture constitutes those webs that are simultaneously created by, and constraining of, human beliefs and actions. A serious approach to culture recognizes that culture, its meanings, and practices shape individuals and communities in profound ways. Nursing and medicine's conceptualizations of culture, influenced by anthropology, are interested in the effect culture has on the interpretive meaning that individuals and communities have, particularly in relation to health and illness.

The ambiguous use of the term *culture* in the healthcare literature has been identified as a significant limitation in the development of the concept of cultural competence (Carpenter-Song, Schwallie, & Longhofer, 2007; Chang, 2007; Fowers & Davidov, 2006, 2007; Grey & Thomas, 2005). While the vast majority of scholars writing about culture address its ubiquitous influence in human life, Paley (2002) disagreed:

What kind of thing is this ontologically independent culture? And for that matter, where is it?...It conjures up the image of a mysterious entity, or perhaps an equally mysterious medium, like ether—which sort of hangs around infecting people with meaning. It is like...a cloud hovering over Cincinnati. I don't really like the idea of abstract clouds—undetectable to the senses, but having a pervasive effect on the things I can see and hear...It is rather hard to see how something nonphysical can have physical consequences. Abstract entities cannot have concrete effects. (p. 571)

In healthcare education, generations of textbooks have made tacit reference to culture by including discussions of how national origin, spirituality, family, and community beliefs and values influence client behavior and responses to health and illness. Broadly speaking, two predominant perspectives on culture, essentialist and constructivist, are represented in the healthcare literature (Table 2).

Table 2. *Conceptualizations of culture in healthcare literature*

Essentialist	Constructivist
Simplistic	Complex
Static	Dynamic
Known	Unknowable
Single culture (ethnic) identity	Multiple cultural identities
Resides in client, family, community	Influences all individuals
Predictable response to health and illness	Unique responses to health and illness
Mindlessness (unconscious)	Mindfulness (conscious)

### **Essentialist View**

Scholars have noted that common notions of culture in healthcare literature seem to reflect an essentialist view wherein culture is portrayed as a static and timeless set of traits generally associated with an ethnic minority group (Carpenter-Song et al., 2007; Fowers & Davidov, 2006, 2007; Gray & Thomas, 2005; Kao, Hsu, & Clark, 2004). This approach represents culture as a decontextualized set of traits that provide a template for the perceptions, beliefs, and behaviors of its group members, and it can be recognized in the many authors who use the terms *culture* and *ethnicity* interchangeably. While on one hand, being raised within a particular culturally defined group may create a set of values, attitudes, or behaviors that can be understood in the context of that particular group, on the other hand, culturally defined groups tend to be

stereotyped, meaning that an oversimplified image is applied to all members of a particular group (Bennett, 1993). Scholars have noted that cultural competence trainings and professional books on caring for the *cultural* client frequently rely on this type of reductionist discussion of the needs, behaviors, and expectations of ethnic minorities in order to give information to health professionals about health beliefs and practices of diverse groups entering, or already in, the healthcare system (Barnes, Craig, & Chambers, 2000; Bond, Kardong-Edgren, & Jones, 2001; Carpenter-Song et al., 2007; Dimou, 1995; Engebretson, 2003; Gregg & Saha, 2006, 2007; Hudelson, 2006; Hughes & Hood, 2007; Jacobson, Chu, Pascucci, & Gaskins, 2005; Kleinman, 1983, 1988; Kleinman, Eisenberg, & Good, 1978; Taylor, 2003). Admittedly, over time this work has been fruitful, resulting in expanded and improved resources of many kinds including educational trainings, interpreter services, informative websites, and a greater awareness of the impact of culture on health and illness in the healthcare community.

**Consequences of an essentialist view.** Although an essentialist view of culture predominates in the healthcare literature today, there is growing concern about the unexamined assumptions underlying the concept of culture and therefore the concept of cultural competence (Campesino, 2008; Carpenter-Song et al., 2007; Doutrich & Storey, 2004; Gray & Thomas, 2005; Gregg & Saha, 2006, 2007; Kagawa-Singer & Kassim-Lakha, 2003; Nuland, 1997; Taylor, 2003; Tervalon & Murray-Garcia, 1998). Scholars have criticized the narrow and

limiting view of what constitutes culture, arguing that distilling and thus distorting cultural information unwittingly creates an artificial “package” that minimizes the complexities present in all cultures, which Gregg & Saha (2006) claimed “obscure more about people, their lives, and their motivations than they clarify” (p. 543). Failing to address the diversity that exists within cultural groups results in ethnic groups being considered as homogeneous when, in fact, the variations within the group may be greater than the differences between cultural groups (Carpenter-Song et al., 2007; Gregg & Saha, 2006, 2007; Kumas-Tan, et al., 2007; Meleis, 1996, 2008). The paradoxical result of this superficial understanding and approach to culture is that instead of engendering respect as originally intended, it promotes stereotyping of the client, family, and community.

Another consequence of an essentialist view of culture is evident in the recurrent appeal to health professionals to be sensitive to the cultural context, beliefs, values, and behaviors of clients, family, and community (AAN, 1992; Betancourt et al., 2002; Carpenter-Song et al., 2007; Campinha-Bacote, 1999; Dunn, 2002; Kumas-Tan et al., 2007; Purnell & Paulanka, 1998; OMH, 2001). In fact, this sensitivity to the culture of the client is considered a cornerstone in contemporary professional, culturally competent practice. This call for sensitivity may seem intuitively correct, yet implicitly it denotes culture as a feature residing outside of the healthcare professional and healthcare system. Embedded in the essentialist view is a dichotomizing of *us* and *them*, where what is labeled *them*



is considered diverse while *us* is considered the norm or culturally neutral. Specifically, *diverse*, in the context of dominant U.S. culture, is generally thought of as non-white, non-Western, non-heterosexual, non-English-speaking, and non-Christian (Carpenter-Song et al., 2007; Campesino, 2008; Kumas-Tan et al., 2007). Consequently, when the focus of cultural knowledge is outward, toward the client, the implied corollary belief is that biomedicine, healthcare education, and the U.S. culture in general, where most of the cultural competence literature has emerged, are culture-neutral. Scholars have argued that this failure to concomitantly identify the beliefs, behaviors, and customs in the culture of biomedicine, health professional education, and the U.S. is a major flaw in the cultural competence literature, stating that each of these cultures warrants careful examination as they are not neutral backgrounds against which other cultures can be measured (Campesino, 2008; Fox, 2005; Gray & Thomas, 2005, 2006; Gustafson, 2005; Hassouneh, 2006). It is generally thought that all individuals are influenced by culture, yet Yan and Wong (2005) noted a dichotomy in the cultural competence literature where health professionals are able to transcend the limits of cultural influence in order to help clients in culturally appropriate and specific ways. In this subject-object framework, health professionals are represented as *active* human subjects, learning from the clients' culture and experience as they are helping *passive* clients who can be understood and helped. This biased underlying assumption has been found to reinforce the power differential already present in a health professional/client

encounter (Carpenter-Song, et al., 2007; Campesino, 2008; Gregg & Saha, 2006; Yan & Wong, 2005).

Language can be considered both a manifestation of internal beliefs as well as a powerful influence on external perception (Bennett, 1993; Klopff, 2001; Mindell, 1992). Therefore, it is vital to acknowledge the subtle yet powerfully influential language surrounding culture and cultural competence that both implicitly and explicitly address culture as problematic. Culture is often framed as a risk factor rather than an asset and a source of strength and resilience. Phrases such as *managing diversity*, *evolving challenge*, *confronting culture*, *clash of cultures*, *when cultures collide*, or even *tolerance* carry a sub-text that there is something wrong, negative, or conflictual about beliefs and values that lie outside of the mainstream or are different from our own. And even though we perceive these characteristics as undesirable, out of fairness we should allow, or tolerate, them. Scholars have noted that implicitly the literature on cultural competence seeks to reduce negatives rather than build on the positive strengths of diversity (Cortis, 2003; Williams-Gray, 2001). When culture is thought of and dealt with as if it were a problem, what is neglected is the growing body of evidence demonstrating that serious engagement in issues of cultural diversity has been found to have positive outcomes. Positive outcomes have been noted by scholars including (a) attitudes, (b) opportunities to interact in deeper ways with those who are different, (c) cognitive development, and

(d) overall satisfaction and involvement with institutions of higher education (Hung, et al., 2007; Smith & Associates, 1997; Upvall & Bost, 2007).

Scholars have also noted that ethnic, spiritual, sexual, and other dimensions of difference are *not* problems in and of themselves (Chang, 2007; Clark & Thornam, 2002; Cortis, 2003; Dean, 2001; Dreachslin, 2008; Hassouneh-Phillips & Beckett, 2003; Hunt, 2001; Price & Cortis, 2000; Taylor, 2003). They are simply differences. However, prejudice, discrimination, and cultural conflict *are* problems. When these underlying biases are not understood and appreciated for the impact that they have on the delivery of healthcare, healthcare providers may inadvertently contribute to disparities by playing a dual role in attempting to reduce health disparities at the same time they are unwittingly maintaining them (Dreachslin, 2008; Kai et al., 2007).

Finally, when healthcare focuses narrowly on an essentialist view of *culture* by limiting its focus to the beliefs, customs, and traditions of immigrant, refugee, or ethnic minority groups, it can obscure the interlocking systems and oppressive relations that establish and maintain systems of imbalanced power in which certain groups are systematically privileged and certain groups are systematically devalued (Drevdahl, et al., 2008; Gray & Thomas, 2005, 2006; Hassouneh, 2006; Kai, et al., 2007). These scholars advocate that healthcare professionals individually and collectively must become centrally concerned with the underlying systems that maintain power imbalances and that keep structural disparities in place. Healthcare and the cultural competence movement have

been criticized for not recognizing and systematically analyzing these operations that they state remain “undetected and unscrutinized, and therefore impossible to change” (Gray & Thomas, 2005, p. 257).

### **Constructivist View**

While the term *culture* is frequently associated with ethnicity and ethnic groups, current anthropological understandings of culture broadly incorporate additional dimensions of difference including age, gender, appearance, sexual orientation, spiritual practice, socioeconomic status, educational level, abilities, or any other characteristic that sets a person or group apart from the dominant majority in which they live (Carpenter-Song, et al., 2007). Furthermore, constructivist views recognize culture as a dynamic process, evolving and changing over time as individuals and communities move in and out of various and multiple cultures throughout their lives (Baker, 1997; Carpenter-Song, et al., 2007; Cortis, 2008; Fowers & Davidov, 2006, 2007; Hall, 1976; Howard, Andrade & Byrd, 2001).

A critical understanding of culture focuses on the more fluid, dynamic, emergent, and relational aspects of how individuals make use of their cultural resources in creative and sometimes surprising ways. Critical here does not refer to negativity, but rather to discernment of underlying or implicit assumptions and underpinnings. From a constructivist view, the concept of culture itself can be understood as socially constructed (Carpenter-Song, et al., 2007; Gray & Thomas; 2005, 2006; Rhodes, 2003). For example, the notion of culture, as we

use the word today, arose in the 19<sup>th</sup> century and was used to explain difference in terms of deviation from the norm. Because the norm in the U.S. then, and now, is considered Euro-American, Gray & Thomas (2005) asked the provocative question: "What are the intended and unintended political, social, and economic consequences of the ways in which the construct of culture has been created?" (p. 254). The constructivist view that provides for this fundamentally more complex way of examining culture is under-represented in the healthcare literature (Carpenter-Song, et al., 2007; Hassouneh, 2006).

**Consequences of a constructivist view.** A constructivist view emphasizes the complexity and dynamic nature of culture as well as the recognition that individuals belong to multiple cultures simultaneously, thus generating unique and individual cultural mosaics (Cortis, 2003; Doutrich & Storey, 2004; Gregg & Saha, 2006; Hunt, 2001; Price & Cortis, 2000). It is important to become aware of the larger contextual and historical influences on the lives and health of clients. These include the dynamic interplay between ethnicity, gender, socioeconomic status, social rank, and power position, technological idea sharing across continents, as well as the degree of discrimination or persecution they have experienced. With this awareness, there are possibilities for transformation that are absent within an essentialist perspective (Gray & Thomas, 2005, 2006; Gregg & Saha, 2006; Koehn & Swick, 2006; Peters, 2000). For example, from a constructivist perspective healthcare providers not only address issues related to physical and mental health, but

examine experiences related to dislocation and adaptation to unfamiliar circumstances and settings. A constructivist view consistently directs attention to social and political factors in addition to individual ones acknowledging the multidimensional nature of human experience that varies considerably within any given group (Koehn & Swick, 2006). Consequently, from a constructivist view, a health professional does not have to be an expert in cultural minutia but rather can focus on resource-sharing, alliance-building, collaborative cross-disciplinary research, and the individuality and uniqueness of each client and his or her life-story. It can also mean recognizing the limits of our knowledge before the mystical nature of health and illness, and the expertise of the accumulated wisdom and resilience of clients and their communities (de Vries, 2004; Lebacqz, 1992). Scholars have suggested that it is time to redirect our focus and efforts from the *culture* of clients and instead actively address the social structures of our hospitals, clinics, and professional schools (Bishop & Glynn, 1992; Dreher & MacNaughton, 2002; Gregg & Saha, 2006).

## **Contextual Cultures**

### **U.S. Culture**

In studying the larger context in which the cultural competence movement has evolved, it is vital to address the intersecting cultures of the U.S. where most of the cultural competence literature has emerged, biomedicine, and healthcare education. U.S. scholars (Andrews & Boyle, 1997; Bhawuk & Brislin, 1992; Gustafson, 2005; Horton, Tschudin, & Forget, 2007; Kagawa-Singer &

Kassim-Lakha, 2003; Kitayama, 2002; Stewart & Bennett, 1991) have emphasized the importance of addressing the shared understanding of individualism that is so pervasive, revered, and so deeply ingrained in the U.S. that it is seldom recognized, let alone questioned. Individualism, rooted in a belief in the separation and autonomy of individuals, recognizes the individual, and not the group, as the basic unit of survival. Heron and Reason (1997), Ray and Anderson (2000), and Vincent (1999) noted that with such an emphasis on individualism, what remains silent is how individualism undermines community and the interdependence of individuals.

In contrast, Andrews and Boyle (1997), Bhawuk and Brislin (1992), and Klopf (2001) noted that many clients residing in the U.S. come from cultures that value a collectivist viewpoint. Collectivists perceive themselves as intrinsically part of a group and emphasize interdependence over independence, affiliation over confrontation, and cooperation over competition. Collectivism recognizes the group, and not the individual, as the basic unit of survival. Both individualism and collectivism have equal, albeit different, merits. However, of salient importance here is the understanding that each standpoint relies on different mechanisms and values in decision-making.

The exploration of individualism and collectivism was also addressed from quite a different tradition. The German philosopher, Martin Buber, (1958) made an important distinction in his classic work *I and Thou* as he explored the relationship of subject and object that is relevant in the conceptualization of

cultural competence today. He wrote about two primary worlds, the I-It and I-Thou. Buber differentiated between these worlds, claiming that the I-It world interacts on the basis of subject-object, representing separation and disconnection between the two. This perspective is representative of an individualist's view of the world. Buber believed that thinking and behaving from this standpoint fragments both the self and the surrounding world. In contrast, the I-Thou world interacts on the basis of being in relationship with others and the surrounding world. This standpoint of interdependence is representative of a collectivist view of the world.

### **Biomedicine**

The belief system that drives healthcare in the U.S. today is a relative newcomer to the healing professions and is commonly referred to as Western medicine, modern medicine, allopathic medicine, and/or biomedicine. This system, based on a belief in the power of science and technology, of personal autonomy, and of the capacity to overcome disease has been effective in generating public health measures that have resulted in improvements in health and life expectancy for many and eradicated a number of major worldwide diseases (Beiser, 2003; Betancourt & Maina, 2004; Carrillo, Green, & Betancourt, 1999; Duffy, 2006; Fox, 2005; Gregg & Saha, 2006; Lavizzo-Mourey & MacKenzie, 1995; Lebacqz, 1992; Numrich, Plotnikoff, Yang, Wu, & Xiong, 2002; Taylor, 2003; Thorne, 1993). In the world of biomedicine, the more ancient healing traditions are collectively referred to as complementary and/or



alternative medicine (CAM) and the frameworks underlying these modalities are viewed as intrinsically holistic (Kreitzer & Sierpina, 2008; Kreitzer, Sierpina, Maiers et al., 2008; Nedrow, et al., 2007). In the past, these more traditional modalities have been thought of as non-rational and superstitious, thus reducing them to appendages of the main body of "real" or modern medicine. However, recent National Institute of Health (NIH) funding trends point to a greater integration between biomedicine and CAM modalities in order to cull and blend the best from both traditions (Gregg & Saha, 2006; Kagawa-Singer & Kassim-Lakha, 2003; Lavizzo-Mourey & MacKinzie, 1995; Taylor, 2003; Thorne, 1993).

For much of the world, however, biomedicine is the alternative model, as it stands alone in conceptualizing health as belonging to the individual separated from the social fabric in which she or he is interwoven. Scholars have noted that this separation dissects the physical, mental, and spiritual aspects of a person, and the person from the family and community in which he or she is embedded (Carpenter-Song et al., 2007; Kagawa-Singer & Kassim-Lakha; 2003; Taylor, 2003). In addition, the values that underlie biomedicine may conflict with more traditional models by distrusting any *real* value in the mystical and metaphorical, aspects that are highly revered in many cultures of the world. For example, clients' choices to use complementary and alternative healing practices, spiritual healers, and community-based support mechanisms as primary sources for health maintenance or healing can be at odds with the beliefs and practices of

many U.S. providers whose explanations and approaches to health and illness differ markedly.

As discussed earlier, when culture is perceived as residing in the client, family, and community, what emerges is biomedicine imagining itself not as a culture but rather as fact, reality, or truth. Taylor (2003) identified this conceptualization of biomedicine as perceiving itself to be a "culture of no culture" (p. 557). This lack of understanding of biomedicine as a culture unto itself is thought to maintain power imbalances that may be endemic to client healthcare provider interactions (Carpenter-Song, et al., 2007). Tripp-Reimer, and colleagues (2001) took a novel approach to cultural competence; rather than using the standard approach that the clients' culture is a problem to be managed, they viewed the predominant barriers as arising from the culture of biomedicine itself. From this broader constructivist viewpoint, vulnerabilities most often attributed to cultures other than the dominant or mainstream can be thought of as the creation, and therefore the responsibility, of the biomedical system.

### **Healthcare Education**

Since the late 1980s, professional organizations have actively promoted cultural and cultural competence content in the education of health professionals (AAN, 1992; AAP, 2004; ACEP, 2002; APHA, 2002; IOM, 2002; ICN, 2003; NCCC, 2002; OMH, 2007a, 2007b). Since that time, there has been a growing dialogue among healthcare scholars and educators regarding content, methods,

implementation, evaluation, and application of cultural competence in healthcare education.

Scholars have discussed ways in which educators can evaluate and create instructional materials that broaden the conceptualization of culture and include diverse groups in health professional education (Anderson, Calvillo, & Fongwa, 2007; Byrne, 2001; Byrne, Weddle, Davis, & McGinnis, 2003; Campinha-Bacote, 1995; Graham & Richardson, 2008; Gustafson, 2005; Tanner, 1996). Of particular interest are recommendations that faculty identify and reduce Eurocentric bias in the curriculum (Byrne 2001; Byrne, et al., 2003; Hassouneh, 2006, 2008). This is particularly important in light of the interdependence and cross-pollination of text-based knowledge that routinely cites and cross-references other texts as a way of demonstrating reliability, validity, and therefore credibility.

Healthcare education has focused on curricular strategies to promote cultural competence, devoting substantial effort to generating and reporting information about specific ethnic groups. To reiterate, these strategies, with few exceptions, focus on developing the knowledge, attitudes, and skills of the health professional. Table 3 summarizes these educational approaches and strategies used in their evaluation.

Table 3. *Educational approaches and evaluation strategies*

<b>Educational Approach</b>	<b>Evaluation Strategy</b>
<b>Knowledge</b> (Social and historical context, patterns of immigration, disease incidences, etc.)	Pretest-posttest Clinical case studies Structured clinical interview and exam
<b>Attitudes</b> (Empathy, curiosity, respect, humility, sensitivity, etc.)	Surveying Structured interviewing Self-awareness assessment Clinical case studies Structured clinical interview and exam Videotaped / audio-taped encounter
<b>Skills</b> (Interviewing, communication, ability to recognize, elicit, negotiate, etc.)	Clinical case studies Structured clinical interview and exam

### **Cultural Competence Education Interventions and Evaluation**

Cultural competence education is being reported with increased frequency in the literature, and researchers have begun evaluating the results of interventions designed to increase the cultural competence of health professionals. This has proven difficult as there continues to be an ongoing dispute about the core meaning and components of cultural competence, which

has subsequently led investigators to question the constructs underlying the evaluative measures of cultural competence (Campesino, 2008; Davis, 2007; Dolhun, Muñoz, & Grumbach, 2003; Kumas-Tan, et al., 2007).

Efforts to evaluate the efficacy of cultural competence interventions are plagued by methodologic as well as conceptual concerns. Between 2005 and 2007, four systematic reviews evaluated (a) cultural competence interventions in healthcare education, (b) methodological rigor of studies evaluating cultural competence training in healthcare professionals and healthcare students, and (c) self-administered instruments to measure cultural competence of healthcare professionals and healthcare students. Researchers from the Johns Hopkins Evidence-Based Practice Center published three of the reviews (Beach, et al., 2005; Gozu, et al., 2007; Price, et al., 2005). A fourth systematic review (Kumas-Tan, et al., 2007), conducted by researchers from the U.S., Canada, and Australia, also focused on measures of cultural competence, examining underlying assumptions embedded within those measures.

In the first review, evaluating the *interventions to improve the cultural competence of health professionals*, investigators (Beach, et al., 2005) synthesized findings from 34 studies in order to determine (a) what strategies have been shown to improve the cultural competence of healthcare providers and (b) the associated costs of those interventions. A four-category grading system (A through D) was devised based on quality, quantity, and consistency of the studies reviewed. Results of this synthesis revealed excellent evidence that

cultural competence trainings improved the knowledge of health professionals (grade A), good evidence that attitudes and skills of health professional and client satisfaction are affected (grade B), and poor evidence that cultural competence trainings affect patient adherence or improve health outcomes (grade D). This low grade linking cultural competence trainings with improved health outcomes reflects too few studies in this area in order to judge consistency of results. The heterogeneity of curricular content, teaching methods, and evaluation strategies made it difficult to determine the impact of training on outcomes. Furthermore, while one of the two primary aims of this study was to determine cost of cultural competence interventions, there was insufficient evidence to support a cost estimate.

In a second study, the same group of investigators completed a systematic review to examine the *methodological rigor* of 64 studies evaluating educational interventions of health professionals (Price, et al., 2005). Five quality domains were used for evaluation: (a) representativeness of targeted providers, (b) complete description of intervention, (c) potential for bias and confounding, (d) outcome assessment, and (e) reporting analytic approach. In a summary appraisal of the 64 educational research articles, the authors concluded that the quality of the evidence from interventions to improve cultural competence of health professionals is generally poor, as most studies do not meet criteria for high study quality based on published guidelines for assessing the evidence of educational practices (Green, 2003; Harden, Grant, Buckley, & Hart, 1999; Kern,

Thomas, Howard, & Bass, 1998; Morrison, Sullivan, Murray, & Jolly, 1999). The findings indicated that most studies measured changes in provider knowledge and attitude as opposed to provider behavior or client outcomes. This conclusion may reflect that most studies targeted nursing and medical students in an educational setting rather than practicing clinicians. However, of particular concern, the researchers noted that the quality of the literature does not appear to be consistently improving over time.

A third systematic review, again by the same research team, evaluated *self-administered instruments to measure cultural competence* of health professionals (Gozu, et al., 2007). Of the 45 identified evaluation tools, approximately half of the instruments were available for review (n=23). In general, the instruments reviewed measured knowledge, attitudes, skill, and behavior of healthcare professional. The authors reported that most of the instruments have not been rigorously evaluated, with only one third having reported reliability or validity information.

Finally, the fourth systematic review (Kumas-Tan, et al., 2007) examined cultural competence measures and the hidden assumptions embedded within those measures. Not unlike the previous review, this study also raised questions about the reliability of currently used measures of cultural competence, adding that most of them were developed (a) without client input, (b) normed on predominantly white, middle-class, highly educated populations, and (c) that reliance on self-ratings make findings susceptible to social-desirability effects.

Taken one step further, this study identified six highly problematic assumptions implicit in the cultural competence measures reviewed: (a) culture is a matter of ethnicity and race, (b) culture is possessed by the Other; the Other is/has the problem, (c) cultural incompetence lies in practitioner's lack of familiarity with the Other, (d) cultural incompetence manifests in discriminatory attitudes by healthcare provider, (e) assumption of Caucasian practitioner working with ethnic minority group, and (f) cultural competence is about being confident in oneself and comfortable with others.

Taken collectively, these studies indicate that (a) there is little uniformity in the methods used to develop measures of cultural competence; (b) the available tools have not been comprehensively described or critiqued; that (c) existing measures "embed highly problematic assumptions about what constitutes cultural competence" (Kumas-Tan, et al., 2007, p. 548); and (d) the widespread use of self-report is highly subjective and therefore the results are misleading (Kitayama, 2002; Gozu, et al., 2007; Grant & Letzring, 2003; Kumas-Tan, et al., 2007). Despite the limitations identified by scholars in measures of cultural competence, these measures are still frequently promoted in the literature (Drevdahl, et al., 2008).

Scholars have suggested that there is a disconnection between the intention of cultural competence educational offerings and the resulting impact that often stereotypes ethnic minority groups (Dreher & MacNaughton, 2002; Gray & Thomas, 2005, 2006; Gregg & Saha, 2006). Until recently, most cultural



competence education focused on ethnic group affiliation as the predominant cultural variation. Wear (2003) specifically recommended that instead of focusing predominantly on the culture of client, experiences in healthcare education should be designed to help students perceive themselves as situated in a specific social and economic location in order to appreciate the influence that this positionality has on interactions with clients. Wear also noted that this level of accurate and reflective self-scrutiny flies in the face of the objectivity that many students believe they possess, no matter what the client looks like, how she or he acts, how she or he believes, or what she or he wants.

In fact, investigators found that many students did not perceive cultural and cultural competence content as essential or related to *real*/clinical practice; and that many students failed to recognize, and even denied, the effects of race, class, gender, culture, sexual orientation, and spiritual practice on a healthcare encounter (Beagan, 2003; Underwood, 2006). Furthermore, even when those social differences were acknowledged, the concomitant privileges enjoyed by their own social group went unrecognized. Scholars have noted that when there is a lack of acknowledgement of one's own place of privilege, it generates situations of oppression for others and maintains rather than transforms the power differential inherent in a provider/client encounter (Abrums & Leppa, 2001; Friere, 1973; Gustafson, 2005; Hassouneh, 2006; Hassouneh-Phillips & Beckett, 2003).

Many scholars and organizations assert that building a health professional workforce that mirrors current shifting demographics in the U.S. will build a culturally competent system (AAP, 2000; ACEP, 2002; Bola, Driggers, Dunlap, & Ebersole, 2003; Brown, 2001; Brush, Sochalski, & Berger, 2004; Cowan & Norman, 2006; Frusti, Neisen & Campion, 2003; Gerrish, 2004; Hassouneh, 2006; Hassouneh-Phillips & Beckett, 2003; IOM, 1994, 2004; Jones, Bond, & Mancini, 1998; Kosowski, Grams, & Wilson, 1997; Phillips & Weeks, 2002; Price, et al., 2005; Purnell, 1996; Robinson, 2000; Saha, Komaromy, Koepsell, & Bindman, 1999; Smith & Associates, 1997; Usher, Miller, Turale & Goold, 2005; Yoder, 2001). Recent reports, however, indicate that there has been limited gain in recruiting, relating to, and retaining this degree of diversity (Price, et al., 2005; Sullivan Commission Report, 2005). For example, while minority groups in the U.S. are rapidly approaching 33% of the nation's population, only 12% of today's nursing students are ethnic minorities, and only 5% are men (AACN, 2001; Sullivan Commission Report, 2005).

Other scholars however, (Anderson, et al., 2003; Geron, 2002), have argued that commonly used assessments of cultural competence in academic institutions can be problematic because they rely on easily observable indicators such as degree of workforce diversity, mission statements, and written support for diversity and cultural competency. Although these scholars acknowledged that specific indicators might be somewhat useful, these measures do not ensure that cultural competence is carried out in day-to-day practice or is embraced by

all health professionals or staff in an institution. Instead, they noted that these measures are more likely to capture the *possibility* that culturally appropriate and responsive care is provided, but these measures are at best proxies and not real evidence that culturally competent care is or is not being provided.

Authors have begun to address healthcare education as an essential culture itself worthy of careful examination (Benkert, Tanner, Guthrie, Oakley, & Pohl, 2005; Carillo-Zuniga, Dadig, Guion, & Rice, 2008; Carter, & Xu, 2007, Gaffney, 2000; Gray & Thomas, 2005, 2006; Hafferty, 1998; Hassouneh, 2006; Hassouneh-Phillips & Beckett, 2003; Johnston, 1991; Price, et al., 2005; Taylor, 2003). These scholars discussed the potentially problematic academic environment that may be reproducing existing social practices, values, and belief systems that further the political, social, and economic agendas of that same culture. *Institutionalized racism* is the term used to describe the invisible but presumed neutrality of Eurocentric values or “whiteness” (Puzan, 2003, p. 193) whose authority defines knowledge, membership and language within healthcare education. Furthermore, this authority has power to define values and beliefs often at the expense of marginalized groups within the same system. A system where whiteness is thus privileged creates political, economic, and institutional suffering for non-dominant members of the same community (Georges, 2004; Kleinman, Das, & Lock, 1997; Puzan, 2003). For example, Price, et al., (2005) found that *visible* dimensions of diversity, unable to be easily changed or disguised, such as race/ethnicity, gender, and foreign-born status, were more

subject to bias and stereotypes than *invisible* dimensions of diversity such as spirituality and sexual orientation. While prejudice is thought to dehumanize people by denying them individuality, racism is considered prejudice combined with the social power to dominate and control (Abrums, 2004; Capell, et al., 2008; Evans, 2008a, 2008b; Georges, 2004; Hassouneh, 2006, 2008; Lancellotti, 2008; McGrath & Puzan, 2004; Puzan, 2003). It has been argued that cultural competence in healthcare education focuses on the prejudice of individual students but does not squarely address the larger issues of institutionalized racism embedded in healthcare education which critical theorists have cited as a vital social issue that has gone largely undetected and unexamined (Benkert, et al., 2005; Capell, et al., 2008; Evans, 2008a, 2008b; Gray & Thomas, 2005, 2006; Hafferty, 1998; Hassouneh, 2006, 2008; Hassouneh-Phillips & Beckett, 2003; Johnston, 1991; Lancellotti, 2008; Price, et al., 2005; Taylor, 2003).

Furthermore, healthcare education, as it currently exists, may have little understanding of the sociopolitical and cultural backgrounds of students from diverse backgrounds. These students may be from environments that did not provide exposure to higher education, educational guidance, and the support needed to excel academically. Therefore, for these students, the “starting points are not the same” as those from the dominant culture (Boateng & Thomas, 2009). Without minority role models or mentors the academic environment can feel foreign and unwelcoming to many students. For example, Native American students have reported that they do not believe faculty will understand their

need to go home to participate in tribal ceremonies and are therefore reluctant to commit to health professional academic programs (Westberg, 2000). In another study, ethnically diverse nursing students recommended study groups, mentoring, and faculty role models in order to facilitate their success in nursing programs (Amaro, Abriam-Yago, & Yoder, 2006). Even within the dominant Euro-American culture, male students have expressed the experience that in female-dominated nursing schools they must “leave their masculinity at the door” in order to fit into the culture of nursing education (Oregon Health & Science University; Men in Nursing Forum, 2002). Furthermore, men face the challenge of not being considered *real* nurses and potentially deal with questions about their masculinity and/or sexuality (Brady, & Sherrod, 2003; Smith, 2006).

Scholars argue that students are finely attuned to hidden curricular, faculty, and institutional agendas within healthcare education (Hafferty & Franks, 1994; hooks, 1994; Johnston, 1991; Murray-Garcia & Garcia, 2008; Patterson, Osborne, & Gregory, 2004). In this context, students may not feel safe in being different, or may feel silenced when expressing differing viewpoints in the culture of health professional education. In fact, they may learn that divergent thinking is not rewarded. These disenfranchised or *unsuccessful* students may be blamed for their lack of ability or commitment to the rigorous work instead of calling for an examination of the educational system itself and how it may inhibit the contribution of *differently knowing* students. Brookfield (2000) addressed this concept in *The Skillful Teacher*:

The readiness to engage in imagining alternatives may not be apparent in many adults; indeed there may often be a dogged determination to cling to ways of thinking and living that provide a comforting psychological and social familiarity. Taking a critical look at the assumptions by which we live is not an easy task, either cognitively or emotionally. (p. 112)

### **Competence**

The term *competence* is a familiar one; in fact, it is one of the most common terms in the health professions today. In the context of healthcare education, cultural competence, a subset of competence, is most frequently addressed as the knowledge, attitudes, and skills of the health professional (Betancourt, 2003; Carberry, 1998; Epstein & Hundert, 2002; Flaskerud, 2007, 2008; Fuller, 1995; Leach, 2002, 2004, 2005; Tervalon & Murray-Garcia, 1998). Dean (2001) and Yan and Wong (2005) noted that this predominant focus on knowledge, attitudes, and skills suggests that cultural competence is a performance-centered (versus person centered) approach and conceived as a cognitively based technical solution to cross-cultural challenges. Today, because of the emphasis in favor of the mind, we may think of cultural competence as an intellectual activity centered on the pursuit of knowledge and skills. However, scholars observed that healthcare education and professional systems that primarily emphasize competence vis-à-vis empiric and cognitive understanding can generate a climate of arrogance and exclusivity, with the unintended consequences of a false security in *knowing*, which can inherently be a state of

closure. Consequently, new inquiry and discovery can be blocked as can the capacity to understand and accept the worldview of another (Langer, 1989a, 1989b, 1992, 2001; Ludwig & Kabat-Zinn, 2008; Munhall, 1993; Murray-Garcia & Garcia, 2008).

### **Ways of Knowing and Embodiment**

Importantly, when one of the primary foci in the cultural competence literature is cognitive knowing, implicitly the body, including sensations and visceral responses, are excluded as another important way of knowing. Bennett and Castiglioni (2004) stated that this exclusion of the body has led to a cognitive-based observation of cultural experience rather than to the experience itself, which alienates us from the rich complexity of our physical experience (Bennett & Castiglioni; 2004; Brookfield, 2000; Cherniss, 2002; Csikzentmihalyi, 1993; Dyche & Zayas, 2001; Horn & Wilburn, 2005; Lakoff, 1987; Langer, 2001; Ludwig & Kabat-Zinn, 2008; Maturana & Varela, 1988; Matus, 2004; Munhall, 1993; Purnell & Palunka, 2003; Reason, 1993). Kim & Flaskerud (2007) contrasted the knowledge and skills of health professionals this way:

This new journey as a patient opened my senses and increased my level of sensitivity, especially in encounters with health professionals...each person contributed to my recovery according to their particular levels of knowledge and skills. However there were subtle differences: Some individuals made me feel connected and understood without demonstrating particularly extraordinary skills, while others were clearly

clinical experts in their field yet their efficiency felt strangely insufficient.  
(p. 931)

Scholars have argued that cultural knowledge alone is insufficient for successful engagement with others and that it is also necessary to become sensitive to the *feeling* of appropriateness (multisensory awareness) that accompanies cultural knowledge in order to build interpersonal relatedness (Bennett, 1979; Browne, 1997; Dyche & Zayas, 2001; Kunyk & Olson, 2001; Langer, 1989a, 1989b, 1992, 2001; Langer & Piper, 1987; Langer & Moldoveanu, 2000; Ludwig & Kabat-Zinn, 2008; Sutherland, 2002; Wiseman, 1996). This ability to physically experience one's own and another's experience is termed *embodiment*.

Bennett and Castiglioni (2004) addressed embodiment, noting that in one's own culture, things simply *feel right*. This *feeling right* can be considered the physical manifestation of ethnocentrism that perceives our own culture as central to reality. Furthermore, without a similar sense or *feeling* for another culture, we are thought to be limited in our depth of understanding and ability to adapt and build rapport with others (Bennett & Castiglioni, 2004; Chang, 2007; Kim & Flaskerud, 2007). Moreover, our bodily experience of *feeling right* also includes the energetic field around us where we are particularly sensitive to the presence of others (McCraty, Atkinson, Tomasino, & Tiller, 1998). Lakoff and Johnson (1999) addressed the physical aspects of culture in *Philosophy in the Flesh*:



There exists no...person...for whom thought has been extruded from the body. That is, there is no real person whose embodiment plays no role in meaning, whose meaning is purely objective and defined by the external world, and whose language can fit the external world with no significant role played by mind, brain, or body. Because our conceptual systems grow out of our bodies, meaning is grounded in and through our bodies. (p. 6)

Although empiric and cognitive views still predominate in healthcare literature, alternate ways of knowing are being addressed with increased frequency (Allen, 1995; Belenky, Clinchy, Goldberger, & Tarule, 1986; Gardner, 1985; Goleman, 1995; Ludwig & Kabat-Zinn, 2008). For example, psychologist and educator Howard Gardner (1985) recognized multiple definitions of what is traditionally considered intelligence. In addition to verbal and computational intelligence, he identified spatial, kinesthetic, musical, intrapersonal, interpersonal, and naturalist ways of knowing as important ways of knowing. Goleman's theory (1995) built on the work of Gardner, coined the term *emotional intelligence*, which he described as the capacity for recognizing and managing feelings within ourselves and in our relationships with others (Silver, 2006). Furthermore, scholars (Langer 1989a, 1989b, 1992, 2001; Langer & Moldoveanu, 2000; Langer & Park, 1990; Langer & Piper, 1987; Ludwig & Kabat-Zinn, 2008) have advocated for *mindfulness* by which they mean attending to relevant aspects of experience in a detached and nonjudgmental manner, which they propose fosters clear thinking and openheartedness.

Broadly speaking, in order to be culturally competent, it is thought that individuals must be interested in other cultures, be sensitive enough to notice cultural differences, and then also be willing to modify their attitudes and behavior as an indication of respect for the people of other cultures (Bhawuk & Brislin, 1992; Campihna-Bacote, 2002a, 2002b, 2006; Curle, Kim & Flaskerud, 2007; Tervalon & Murray-Garcia, 1998). However, this can prove very challenging, particularly for health professionals who have been rewarded for their competence in professions with values and practices that differ sharply from those of many clients (Leonard & Plotnikoff, 2000). Scholars have noted that inviting and integrating a foreign perspective is fundamentally unnatural, and discomfort, resistance and chaos are the more likely responses to significant cultural difference.

In a recent qualitative study health professionals described their experience and perceptions of work with diverse clients (Kai, et al., 2007). Findings included discomfort, apprehension, and fear of being perceived as either discriminatory or giving preferential treatment. Given the innate link between mind and body, anxiety, which is often present in the face of significant cultural difference, is consistently accompanied by physical tension. Physiologically, this stricture of mind and body can lead to limited thinking and a skewing of perceptions, which may include withdrawal, defense, and/or hostility (Barna, 1998; Bennett & Castiglioni, 2004; Chang, 2007; Klopff, 2001; McCraty et al., 1998). Chang (2007) noted that these personal, often negative emotional

reactions could either become catalysts or act as blocks to the competence process. Moreover, although negative feelings are often treated as problems to be solved or cured in the healthcare literature, these negative emotions are thought to have the possibility of adding a complementary dimension of insight to the development of cultural competence not currently found in the cultural competence literature (Chang, 2007; Gao & Gudykunst 1990).

Where cultural competence is thought to reside differs, depending on the literature reviewed. Some scholars perceive cultural competence as a receiver-based variable and, therefore, the ability to evaluate whether someone or something is culturally competent is held by the client (Beisecker, 1990; Johnson, et al., 2004; Kagawa-Singer & Kassim-Lakha, 2003; Kumas-Tan, et al., 2007; Ruben, 1989; Switzer, Scholle, Johnson, & Kelleher, 1998; Tucker, et al., 2003). However, overwhelmingly, the term cultural competence is used as a sender-based variable referring to the healthcare professional, system, or organization. It may therefore be argued that the cultural competence literature conceptualizes cultural competence in a unidirectional flow, from healthcare professional to client, in a cause-and-effect or sequential manner that can be measured quantitatively (Gustafson, 2005; Tervalon & Murray-Garcia, 1998). Consequently, if a health professional, system, or organization, is deemed *culturally competent*, an association is made presuming a concomitant change in the health outcomes of client, family, and/or community. This thinking may have merit because if a health professional has knowledge about and experience with

a specific group, he or she may be able to build rapport, elicit information, and negotiate a plan of care more effectively. Although this seems intuitively reasonable, there is currently no literature or other published evidence that directly links cultural competence with reduction of health disparities and improved health outcomes (Anderson, et al., 2003; Beach, et al., 2005; Betancourt, 2003; Gregg & Saha, 2006; Jones, Bond, & Mancini, 1998; Paquiao, 1995).

In healthcare education, students are strongly encouraged to understand the genesis of their own values, beliefs, and bias. This self-awareness is actually considered the cornerstone of a culturally competent encounter and an effective cross-cultural relationship (Glen, 1999; Yan & Wong, 2005). Why this sensitivity is important is addressed repeatedly in the literature. How specifically this self-awareness is developed, identified, or assessed has begun to appear in the professional literature, yet remains underdeveloped (Rew, 2000; Tervalon & Murray-Garcia, 1998; Triandis, 1994; Yan & Wong, 2005). Moreover, health professional competence, within the reality of healthcare today, often includes what Ludwig & Kabat-Zinn (2008) refer to as "continuous partial attention" (p. 1350), derived in part from economic pressures that demand ever-increasing productivity paired with technology such as electronic charting, e-mail, cell phones, and beepers, all competing for our attention simultaneously. The combination of intellectual knowledge and continuous partial attention can masquerade as competence, however, have a detrimental effect on the client -

healthcare provider relationship which is considered the foundation of client-centered care (Bennett, 1979; Brookfield, 2000; Dean, 2001; Gardenswartz & Rowe, 1998; Goleman, 1995; Hunt, 2001; Johnston, 1991; Ludwig, & Kabat-Zinn, 2008; Paasche-Orlow, 2004; Palmer, 1998).

In healthcare education cultural competence is taught alongside the concept of professionalism. Some scholars, such as Lebacqz (1992), have suggested that topics such as spirituality and humility, not often discussed in professional circles, are not simply overlooked but are perceived as antithetical to competence, professionalism, and professional practice. This division inevitably creates a gap between the values of professionalism and the values of the community within which a professional functions. Because many health professionals are educated to think in these terms, they may be quick to misunderstand or reject teachings that offer an unrecognized worldview or alternate set of truths (Doukas, 2004; Fitzgerald, Williamson, Russell, & Manor, 2005; Guskin, 1991; Juarez et al., 2006; Lakoff, 1987; Lakoff & Johnson, 1999; Luckmann, 1999; Ludwig & Kabat-Zinn, 2008; Nuland, 1997; Reagan, 2005; Stewart & Bennett, 1991; Tisdell, 2003). Moreover, building partnerships where health professionals respect the expertise of the client and family in their own healthcare decisions runs contrary to how professionalism is taught and role modeled in our schools and professions today (Fuller, 1995; Kumas-Tan, et al., 2007; Leach, 2002, 2004, 2005; Twohig, 2004; Wessel, 2004; Wurm-Schaar & Fato, 2004).

## Cultural Competence Critique

Because the concept of cultural competence was conceived and born from a specific standpoint, deeply influenced by the cultures of biomedicine, academics, and the U.S., it is based on a particular set of assumptions and structures about how the world is viewed and interpreted. Like any standpoint, cultural competence focuses on certain things while obscuring others.

Historically, it has been nursing and medical leaders and educators, operating from predominantly Euro-American philosophies and theories that have initiated, promoted, and researched cultural competence. Scholars have observed that this has led to a deep bias in favor of mainstream or dominant culture (Carpenter-Song, et al., 2007; Cortis, 2003; Dreher & MacNaughton, 2002; Gray & Thomas, 2005, 2006; Gregg & Saha, 2006; Guftason, 2005; Hassouneh, 2006; Koehn & Swick, 2006; Taylor, 2003). Furthermore, these scholars argue that the logic of the cultural competence movement is inadequate and flawed because it emerges from a standpoint that perpetuates the values and beliefs of mainstream culture rather than transforms the relationship between health professional, system, client, family and community by concomitantly recognizing the underlying values that drive healthcare and healthcare education.

In addition to numerous definitions, the application of cultural competence refers to (a) community care, (b) public health, (c) the research process, (d) elimination of health disparities and healthcare disparities, (e) clinical assessment, and (f) numerous clinical specialties. Finally, the term cultural

competence is used when speaking of (a) an individual's awareness of their own cultural bias, (b) the interface between healthcare provider and client, family and/or community, (c) a healthcare system's relationship with the surrounding community, and (d) global relations among others. With a different standpoint and focus in each of these levels and domains, it is difficult to presume that cultural competence means the same thing in these widely varied contexts and circumstances (Campesino, 2008; Carpenter-Song, et al., 2007; Geron, 2002; Morse, 1995).

While cultural competence is currently the most frequently addressed cultural paradigm in U.S. healthcare, it is not the only one. Concurrently, a plethora of cultural concepts (e.g. cultural sensitivity, cultural awareness, cultural efficacy, cultural safety, cultural humility, cultural proficiency, transnational competence, cultural empathy, cultural relevance, etc.) have emerged in the healthcare literature, creating confusion, as most of the concepts are not clearly defined, described, conceptualized, or discussed in relation to each other (Duncan, Cloutier, & Bailey, 2007; Finfgeld-Connett, 2006; Morse, 1995). While there is still much that is unknown regarding cultural competence, there is even less known about how cultural competence may be interrelated to these other concepts, the degree to which each is distinct or overlaps others, and what the relationship is between and among these concepts. This is a significant gap in the cultural competence literature and more research is needed in order to clarify these concepts individually and collectively.

As the concept of cultural competence has evolved, it has moved from rather simplistic attempts to educate health professionals about minority groups, their cultural norms, and cultural peculiarities regarding health and healthcare into something that has become more akin to client-centered care (Betancourt, 2004; Hasnain-Wynia, 2006). However, even given today's more complex understanding of cultural competence, there remains a lack of clarity regarding definitions, conceptual development, approaches to teaching and evaluation, and evidence linking cultural competence with reduced health disparities, healthcare disparities, and improved health outcomes.

Koehn and Swick (2006) joined Gustafson (2005), Wear (2003), Tervalon and Murray-Garcia (1998), and Hassouneh (2006) in advocating for a more comprehensive look at systemic ethnocultural and sociopolitical influences when considering cultural competence. For example, cultural competence education that is primarily intended to teach mastery of specific domestic two-culture interactions is of little value in today's dynamic, diverse, and complex healthcare environment. Furthermore, the effects of war, dislocation, and migration, both unidirectional (emigration/immigration) and circular (return and repeat migration), must be addressed, as these are defining elements of our current world.

In the body of literature on cultural competence, there is a dichotomy between the claims that cultural competence is an ongoing process and the implication that it is attainable. Incongruence thus exists when some of the



literature describes attempts to measure cultural competence while other researchers assert that it is a lifelong process and an ultimately unattainable goal (Allison, Echemendia, Crawford, & Robinson, 1996; Altshuler, Sussman & Kachur, 2003; Bonder, Martin & Miracle, 2001; Douglas, 2002; Dunn, 2002; Lister, 1999; Narayan, 2001; Shapiro, Hollingshead, & Morrison, 2003; Sinclair, 2000).

Johnston (1991) in *Necessary Wisdom* noted that cultural competence is rooted in an understanding that health professionals mediate between the healthcare system and the *cultural* client. In order to get optimal care, health professionals support clients in making changes in their attitudes and behaviors. However, the client is expected to change, while the role of the health professional and role of the system remains unchanged or at best undergoes minor adjustments. Unwittingly, these goals and strategies reinforce rather than transform the social practices and power differentials that are embedded in healthcare education and practice as it exists today.

### **Summary**

Cultural competence has been widely adopted as a major curricular element in healthcare education. As the field of cultural competence has evolved, it has moved from rather simplistic attempts to educate health professionals about ethnic minority groups' cultural norms and practices, related to health and healthcare into something that has become more akin to client-centered care (Betancourt, 2004; Hasnain-Wynia, 2006). Furthermore, culture and its effect on health and healthcare have begun to be perceived as complex, interconnected,

nonlinear, and holistic (Daaleman, 2004; Heron & Reason, 1997; Kairys, et al., 2002). However, even given today's more complex understanding of cultural competence, there remains a lack of clarity regarding definitions, conceptual development, approaches to teaching and evaluation, and evidence linking cultural competence with reduced health disparities, healthcare disparities, or improved health outcomes.

Because U.S. health professionals live in a multiethnic, multiclass society, working with clients, families, and communities from every subgroup and identity imaginable, it is not possible to become competent in the many permutations of *culture* that exist in individuals and communities. Despite the prominence of cultural competence in the literature, scholars have noted that because clear definitions are lacking and there is insufficient conceptualization, the central tenets of cultural competence often remain implicit, poorly stated, overly simple, ambiguous, biased, inconsistent, and unrealistic (Canales & Bowers, 2001; Cunningham, et al., 2002; Dean, 2001; Gustafson, 2005; Hixon, 2003; Hunt & de Voogd, 2005; Koehn & Swick, 2006; Powers, 2003; Taylor, 2003; Thorne, 1993; Wear, 2003). Furthermore, because cultural competence, its relevance, and its application to healthcare are exceedingly complex, scholars have noted that it requires more thorough thought and analysis than is evident in much of the literature (Betancourt, 2004; Cortis, 2003; Culley, 1996; Cunningham, et al., 2002; Dean, 2001; Dreher, & MacNaughton, 2002; Green, Betancourt & Carillo,

2002; Gustafson, 2005; Hixon, 2003; Hunt & Voogd, 2005; Koehn & Swick, 2006; Powers, 2003; Taylor, 2003; Thorne, 1993; Wear, 2003; Wells, 2000).

The very real challenges of the intersection of culture and healthcare, and the limitations noted in the existing cultural competence literature establish the vital need for further research at this time. Therefore, this study proposes to describe the ways cultural competence has been used, identifying strengths, limitations, and underlying assumptions. This will be accomplished by interviewing multidisciplinary cultural and cultural competence experts in order to guide knowledge development and the integration of cultural competence into healthcare education.

### **Chapter Three: Research Design and Methods**

The purpose of this study was to contribute to the conceptual development of cultural competence as a framework to guide knowledge development in healthcare education. This was accomplished by critically examining the central tenets of the concept of cultural competence from a multidisciplinary perspective. The specific aims were to:

Aim 1: Describe how the term cultural competence has been used.

Aim 2: Identify the strengths, limitations, and underlying assumptions of cultural competence.

Aim 3: Generate recommendations for future integration of cultural competence in healthcare education.

#### **Study Design**

This study used a qualitative descriptive design to explore the current status of cultural competence by interviewing multidisciplinary cultural and cultural competence experts from the U.S. and abroad. Because cultural competence is a concept used frequently across many disciplines, multidisciplinary experts were explicitly chosen for this study in order to investigate the concept of cultural competence most broadly. It was anticipated that multidisciplinary data would yield richer findings than data collected from any one discipline alone and therefore generate a more comprehensive and innovative approach to integrating cultural competence in healthcare education in the future. According to Sandelowski, (2000) the goal of qualitative description

is to provide a comprehensive understanding of a phenomenon by transforming a person's experience into language that describes their experience and its meaning. Exploring the perceptions of multidisciplinary experts was the first step in a program of research examining cultural competence and its relationship to healthcare education. Experts on culture and cultural competence were chosen for this initial study because they are easily identifiable, relatively accessible, and in a position to influence healthcare education initiatives through their writings and presentations. Their unique multidisciplinary perspectives on culture and cultural competence helped identify themes that can then help direct future studies.

### **Methodological Perspective**

Qualitative methods were chosen because they are particularly suitable to illuminate human experience by discovering underlying context, values, and background meaning, and then providing an in-depth description regarding a specific phenomenon (Ayres, Kavanaugh, & Knafel, 2003; Creswell, 1998; Munhall, 2007, Norwood, 2000; Press, 2005; Rubin & Rubin, 1995; Sandelowski, 2000). Although qualitative descriptive studies are thought to be the least "theoretical" on the spectrum of qualitative approaches, they are also the least encumbered by pre-existing theoretical and philosophical constraints. This approach was particularly useful when examining a concept such as cultural competence that has multiple aspects and perspectives to consider, is used across many disciplines, and has thus far been incompletely and inconsistently

conceptualized and evaluated (Denzin & Lincoln, 2000; Lopez & Willis, 2004; Munhall, 2007; Sandelowski, 2000; Strauss & Corbin, 1998).

Qualitative description is a research approach based on a social constructivist worldview that emphasizes the importance of individual situatedness or vantage point within a world and social context. This inquiry method assumes the relativism of various perspectives and relies on the co-creation of knowledge and experience between researcher and participant, participant and data, and researcher and data (Sandelowski, 2000). Meaning is then constructed based on individual, historical, and social contexts that in turn influence the interpretation and creation of knowledge (Creswell, 1998; Denzin & Lincoln, 2000; Lopez & Willis, 2004; Rew, Bechtel, & Sapp, 1993; Sandelowski, 1994, 2000; Strauss & Corbin, 1998). Consequently, there is an underlying recognition of multiple, equally valid realities or truths that may, in fact, contradict each other (Creswell, 1998; Crotty, 1998; Lincoln & Guba, 1985; Munhall, 2007; Sparkes, 2001; Whitemore, Chase, & Mandle, 2001).

People approach situations with beliefs and pre-understandings (Gadamer, 1975; Heidegger, 1962). Gadamer (1975) referred to these pre-understandings as *horizons* that he defined as "the range of vision that includes everything that can be seen from a particular vantage point" (p.269). These pre-understandings are thought to influence not only what is studied but also how the study is interpreted. For example, when interaction takes place between investigator and participants, there is communication that is simultaneously physical (e.g. degree

of eye contact, intonation, and gesturing), intellectual, emotional, cultural, and historical. In reporting these interactions there are overlapping meanings resulting from shared human history and cultures (Bennett & Castiglioni, 2004; Heidegger, 1962). Smith (1993) noted that individual horizons or vantage points are not closed and shut off from the horizons or vantage points of others as these perspectives can and do change. Furthermore, he notes that one does not have to abandon their own standpoint in order to grasp the standpoint of another, which he refers to as a "fusion of horizons" (p. 137). Therefore, in order to gain a true understanding of human meaning of experiences, research must take into account the significance of the existing world and its meanings for both the investigator and the participants being studied. In the end, because all inquiry entails description, and all description entails interpretation, description is always influenced by the perceptions, inclinations, sensitivities, and sensibilities of the researcher (Morse, 1999; Sandelowski, 2000). Consequently, situating the principal investigator and research advisors within their background beliefs and histories as explicitly as possible is important when doing interpretive work. Therefore the investigator and research advisors must remain as self-aware as possible of beliefs and values brought from previous experience, educational preparation, and cultural background (Benner, 2000; Finlay, 2002).

### **Sample**

Three specific types of sampling were used in this study: (a) purposive, (b) maximum variation, and (c) network. Purposive sampling involved selecting

participants whose unique abilities, experience, and articulation of their ideas would contribute to maximum discovery by providing information-rich data about the phenomena under investigation (Denzin & Lincoln, 2000; Morse, 2000; Patton, 2002). In this case, the investigator and research advisors generated a list of potential participants. The list identified individuals who have conducted and published research on culture or cultural competence, whose primary work relates to culture and cultural competence in the U.S. and abroad, and who speak English. These people are considered experts by virtue of their formal education and professional roles.

Maximum variation sampling, including participants with a broad range of disciplinary and practice backgrounds, was used with the goal of identifying and describing a wide range of experiences and beliefs that enhanced the breadth of knowledge development (Denzin & Lincoln, 2000; Morse, 2000; Patton, 2002; Whittemore, et al., 2001). Maximum variation sampling facilitated the critical and broad study of cultural competence from multiple perspectives in order to generate a novel and more holistic understanding of cultural competence than any one discipline alone might represent. Because the findings from this study were intended to be used to inform the integration of cultural competence in healthcare education, the goal was to have approximately one half of the participants from healthcare (e.g. nursing and medicine) with the remaining participants from other disciplines including anthropology, intercultural communication, psychology, sociology, health policy, etc.



The third sampling technique used in this study is referred to as network, snowball, or referral sampling (Norwood, 1999). After participants were recruited and interviewed, each one was asked to recommend colleagues whom they identified as experts on the topic as possible additional participants. Because many of these experts, particularly in the healthcare fields, were familiar with each other, had worked and published together previously, it was not uncommon for them to recommend each other. Therefore in the end, while participants did make recommendations, none of the network or snowball recommendations were used as additional participants.

**Sample size.** An in-depth qualitative method is intended to study a phenomenon, in this case cultural competence, intensively rather than extensively, and therefore sample sizes are often much smaller than in quantitative studies (Norwood, 1999; Polit & Hungler, 1999). Generally, there is an inverse relationship between the amount of quality data obtained from each participant and the number of participants that are required. Therefore, what might be lost in sample size will be gained in depth of information (Morse, 1989, 1994, 2000; Patton, 2002; Press, 2005; Strauss & Corbin, 1998). When considering sample size in qualitative research, a number of factors need to be considered including the purpose of the study, the resources available, feasibility, and methods of data collection (Morse, 1991, 2000; Patton, 2002).

Because the participants in this study are considered content experts and, by virtue of their educational and professional backgrounds likely to be highly

articulate, the sample size was 20 participants. However, data were gathered until informational redundancy was evident (Benner, 2000; Munhall, 2007; Norwood, 1999; Polit & Hungler, 1999).

## **Methods**

### **Recruitment**

An e-mail of introduction, purpose, and study description was sent to each prospective participant inviting their participation in the study (Appendix A). Because the participants were practicing professionals, contact information was gathered via the Internet, published articles, and/or professional colleagues. In the introduction e-mail, the study was identified as a doctoral dissertation entitled *Exploring Cultural Competence – The Emerging Picture*. The stated purpose was to explore the current status of cultural competence from a multidisciplinary perspective and to evaluate its strengths and limitations in order to guide future integration into healthcare education. A brief description of participation was provided: the investigator would conduct one 30-60 minute interview that would ask for personal opinions, perspectives, and experiences related to cultural competence. Participants were given a choice to either (a) do nothing, which prompted a phone call to schedule an interview, or (b) notify the investigator if they did not want to, or were unable to participate.

### **Data Collection**

Three types of data were collected: (a) text data from interviews, (b) text data from publications to confirm, challenge, and/or elaborate interview themes,

and (c) demographic data describing the participants. Consent procedures involved requesting verbal consent for participation at the beginning of the audio-taped interview for record keeping (Appendix B). The interview guide was designed to gather the thoughts and experiences of the participants on the ways cultural competence has been used, its strengths and limitations, their lived experiences, and recommendations for integrating cultural competence into healthcare education (Appendix C). All questions on the interview guide were asked of each participant in order to capture as broad a range of perceptions and experiences as possible. Acknowledging the expertise of the participants, the investigator remained open to additional lines of dialogue related to culture and cultural competence as context and interaction dictated (Benner, Tanner, & Chesla, 1996). Additionally, an inquiry was made at the end of each interview "What else should I have asked?" This allowed the investigator to address what was important to individual participants beyond their responses to questions in the interview guide. The interviews were audio-taped and lasted between 30 and 60 minutes.

Documents published by the participants were located through electronic databases. The publications were used as confirmatory and/or elaborating resources in relation to the interview data. The use of multiple data sources to illuminate various aspects of a subject is known as triangulation, and was intended to increase the investigator's understanding of the phenomena being discussed by the participants (Barbour, 2001; Farmer, Robinson, Elliott, & Eyles,

2006; Jones & Bugge, 2006; Lietz, Langer, & Furman, 2006; Nolan & Behi, 1995; Wray, Markovic, & Manderson, 2007). These materials provided additional data regarding each participant's views about culture and cultural competence.

Because this study focused on the current status of cultural competence, database searches were limited to between 2005 and 2008. Documents were eligible as data for analysis when the participant was listed as primary or co-author, including papers, abstracts, chapters, and monographs. Up to three papers for each participant were selected for review. Only papers published in English were included because the investigator does not speak or read other languages. Priority criteria for selecting papers included (a) the topic focus of conceptualization of culture or cultural competence or culture or cultural competence in healthcare education and (b) participant is first author on the paper. When a participant had published more than three papers between 2005-2008, the three that were considered the strongest fit with the inclusion criteria were selected for analysis. For one participant, three publications met inclusion criteria and were reviewed. For two participants, two publications each met inclusion criteria and were reviewed. For another five participants, one article each was reviewed, and for 12 participants, there were no publications available. The articles that were reviewed are listed in Appendix D.

Demographic data were gathered for the purpose of describing the sample of participants. These data included gender, discipline, ethnicity, and professional role.

Two types of triangulation were used in the data collection phase of this study: interdisciplinary and data. First, interdisciplinary triangulation was used in order to bring a range of perspectives to bear on the understanding of the concepts of culture and cultural competence. Second, triangulation of data sources included two data sources: (a) an audio-taped, in-depth interview lasting 30-60 minutes using a semi-structured interview guide with open-ended questions, and, when available, (b) participants' published writings on culture and/or cultural competence (Appendix D).

### **Setting**

Because cultural competence is a paradigm most widely accepted in the U.S., participants were drawn primarily from the U. S. However two participants resided and worked one each in Cuzco, Peru and Oslo, Norway. All interviews were conducted at a time and in a private place of convenience identified by the participant. Eight interviews were conducted face-to-face and 12 by telephone. While face-to-face interviews may have been ideal so non-verbal nuances such as physical expressions and gestures could be observed and noted, telephone interviews increased feasibility and allowed access to additional experts. Relevant observations, determined by the type of interview (face-to-face or telephone) were described in researcher memos as soon as possible after each interview, enhancing the contextual meaningfulness of the narrative texts.

## **Data Management**

A professional transcriptionist transcribed all audio-taped data verbatim. The transcriptionist signed a confidentiality statement that acknowledged the potential sensitive nature of the work. The transcripts were then checked for accuracy against the audiotapes by the investigator. Written materials (e.g. published papers) were electronically accessed for digital management. Data were then entered into Atlas.ti v5.2, a qualitative software program used for organizing data, coding, analysis, and synthesis. The use of Atlas.ti permitted identification and organization of data by participant, by data source, analytical codes, and by other categories such as demographic information (e.g. participants' disciplinary backgrounds).

## **Protection of Confidentiality**

Because the participants in this study were professionals, they were not considered vulnerable in the traditional sense. While anonymity was offered to each participant at the beginning of the interview, all the participants permitted their names, disciplines, and places of employment to be listed in an alphabetically ordered table of participants as an appendix to the final report (Appendix E). The audio-taped interviews were stored in a locked office, accessible only to the investigator. Transcripts de-identified the participants, and randomly assigned participant numbers were used to organize the interview data. In order to respect privacy and focus on themes rather than on any

particular participant, participant numbers were used during analysis and for data exemplars used in the discussion of findings.

### **Data Analysis**

In interpretive studies, the investigator serves as the instrument of both data collection and analysis. It is the role of the investigator to decide what ideas are similar and represent a pattern, what constitutes a theme, what to name and define as a code, and the meaning of coded ideas, patterns, and themes within the context of the study (Patton, 2002). Qualitative description uses language as a vehicle of communication and provides a narrative summary based on text data that are systematically collected and analyzed simultaneously in an ongoing and iterative process. Therefore, the relationships and interactions among investigator, participant, and data are critical for the interpretive analysis in qualitative description (Creswell, 1998; Denzin & Lincoln, 2000; Munhall, 2007; Patton, 2002; Sandelowski, 2000).

Data analysis followed the procedures of (a) within-case analysis, and (b) across-case analysis (Ayres, et al., 2003; Patton, 2002). Each participant account included two data sources when publications were available and met the selection criterion. Interview data, or interview data and published material together constituted each case. For within case analyses, interview data were analyzed prior to review of published materials. Published materials were used as supportive and confirmatory to the interview data identifying common themes and unique variations. Subsequently, individual cases were analyzed in

relationship to each other (across-case analysis). Common or recurring themes and unique variations in ideas were identified during the across-cases analyses.

The analytic process involved first reading and rereading individual transcripts in order to arrive at a sense of the participants' ideas as a whole (Patton, 2002). A summary synopsis of key ideas discussed in the interview was created. The text data were then coded line by line for relevant words, phrases, stories, or context that represented key elements describing culture or cultural competence. Coding took into account the three aims of this study: (a) the way in which cultural competence is used, (b) strengths, limitations, and underlying assumptions of cultural competence, and (c) recommendations for integrating cultural competence into healthcare education. An electronic codebook was kept to document the cumulative list of code names and definitions beginning with the first interview data and moving to the publications of the same participant. Constant comparison across the data identified recurrent themes and elaborations on ideas mentioned in the interviews, ideas not mentioned, or ideas that seemed contradictory.

### **Thematic Analysis**

As an idea was found to occur repeatedly the idea was considered a theme. Themes consisted of patterns, perspectives, or concerns of like meaning that were identified both within and across cases. Themes reflected a higher level of conceptual abstraction than smaller units of data such as words or phrases and captured the essence of the meaning in such a way that the



meaning was additionally recognized in other situations or contexts (Ayres, et al., 2003; Benner, 2000; Morse, 1994; Patton, 2002).

Identification of codes and themes resulted in a distilled data set using key words and phrases placed into a matrix format. This matrix listed names of individual participants down the left column and identified codes across the top, serving as a visual enhancement of the data. The interpretive task of the researcher was both a deliberate and emergent one requiring movement back and forth between small portions of the text and the larger whole. This process helped to clarify differences, similarities, inconsistencies and even incoherent aspects of the text (Ayres, et al., 2003; Benner, 2000).

As data were analyzed over time, the investigator was able to distinguish repeated themes that were embedded within individual stories as well as those that crossed the experience of specific groups of participants or all participants.

Across-case analysis followed within-case analysis discerning how codes and themes between and among participants were the same, slightly different, or related with the need to add or alter codes, themes or categories for increased clarity (Farmer, et al., 2006; Patton, 2002). As additional accounts were reviewed, ideas found in previous accounts sensitized the investigator and dissertation committee to similar information as it occurred in multiple contexts (Ayres, et al., 2003; Lincoln & Guba, 1985).

## **Memos**

Summary, questions, and reflexivity memos were recorded for each participant case. The summary memo had two parts, one for each of the two data sources: interview and publications. Summaries recorded the investigator's thinking about key items such as repeated themes, focus, congruence, and context. The summary memo included a description of the interview itself including location and any interruptions, technical difficulty, or other unique factors that might have influenced the interview process. The second memo contained questions that were generated during data analysis such as gaps or possibly relationships between and among ideas.

Finally, the reflexivity memo addressed three aspects of investigator awareness and voice: (a) self-reflexivity, (b) reflexivity about the participants, and (c) reflexivity regarding audience. Each of these perspectives involved a different set of questions. For example, self-reflexivity considered questions such as what has shaped my perspectives? How have my perceptions and background affected the data I have collected and its analysis? What do I already know? Self-reflexivity also focused on the thoughts, feelings, and sensory responses of the investigator to all aspects of the research process. Secondly, reflexivity about the participants pondered questions such as how do the participants know what they know? What has shaped their current worldview? How do they perceive me as the investigator? Finally, reflexivity about the potential audience contemplated questions such as how will those who receive my findings make sense of them?

How might they perceive me? How do I perceive them? How might these perceptions affect what I report and how I report? This triangulated reflexive inquiry provided a framework for becoming aware and sorting through these important aspects during data analysis and reporting of findings (Patton, 2002).

When the investigator and research advisors reviewed these documents insights were gained into investigator patterns of potential judgment and bias and facilitated a holistic perspective of the data and ultimate findings. While this process promoted personal insight, it also caused discomfort when less than ideal responses, techniques, judgments, or interpretations of the research data or process were noted and documented. In order to use the reflexivity process most effectively, open inquiry, critical analysis, and transparency were required to assure that the explanations offered, relationships identified, conclusions drawn, and final interpretation were valid and grounded within the data (Finlay, 2002; Patton, 2002; Whitemore, et al., 2001).

### **Criteria for Evaluation of the Findings**

Qualitative research is challenging because of the need to balance scientific integrity and rigor with artfulness and sensitivity to interpretations of meaning within context (Sandelowski, 1986, 1993, 1994, 1998, 2000, 2002; Sparkes, 2001; Whitemore, et al., 2001). While scientific rigor is needed for quality research, systematic adherence to specific procedures does not necessarily produce sound data or credible interpretations. On the other hand, too much emphasis on artfulness and creativity that support the discovery of the

yet unknown, and challenge current thinking can also create unsubstantiated findings that are reflective only of investigator bias (Whittemore, et al., 2001). Therefore criteria for evaluating the integrity and validity of this qualitative study must reflect both the systematic and interpretive elements of qualitative research.

Qualitative research, often defined by uncertainty, fluidity, and emergent learning, requires flexibility and good judgment in the application of qualitative standards of validity. These standards include “the need to demonstrate the truth value of multiple perspectives, the dependability of findings amid variability, the application of findings to broader contexts, and freedom from bias in the research process” (Whittemore, et al., 2001, p. 524). Lincoln & Guba (1985) address these components collectively as trustworthiness, comprised of (a) credibility, (b) dependability, (c) transferability, and (d) confirmability. These criteria were used to evaluate the rigor and validity of the study findings.

### **Credibility**

*Credibility* refers to the degree to which the investigator establishes confidence or believability in an accurate interpretation of the meaning of the data (Lincoln & Guba, 1985; Whittemore, et al., 2001). In qualitative studies, credibility is the counterpart to internal validity in quantitative studies in ensuring truth-value or authenticity of the findings. Qualitative descriptive studies rely on an assumption of multiple perspectives from which many truths are shaped.

Lincoln and Guba (1985) outline ways investigators can increase the essence of credibility by generating faithful descriptions and interpretations.

According to Sandelowski (1986) the major threat to credibility is enmeshment or “going native” which may lead the investigator to believe that they understand the world of another more than they actually do. Therefore, the closeness between participant and investigator is a fine balance that can either enhance or detract from the credibility of a study. In order to maintain the separate positions of investigator and participant in this study, three procedures were employed. First, a qualitative seminar composed of doctoral students and an Oregon Health & Science University faculty experienced in qualitative methodology reviewed transcripts and interpretations in order to verify findings and reduce investigator bias. Second, weekly meetings between investigator and a doctoral student colleague were used to review transcripts and interpretations together. Finally, research advisors including the dissertation chairperson and committee members regularly reviewed data and interpretations to verify findings.

Credibility was further sought in this study through (a) an understanding of the historical and social context in which cultural competence has emerged, (b) building rapport and trust between investigator and participants during the interview, (c) asking “What else should we have talked about”, and (d) negative case analysis, to revise conceptualizations of the data when new data

contradicted or could not be explained by earlier analytic interpretations (Lincoln & Guba, 1985).

### **Dependability**

*Dependability* refers to consistency or stability of the findings and is the qualitative equivalent of reliability in quantitative studies (Guba & Lincoln, 1981; Sandelowski, 1986; Whittemore, et al., 2001). A study is thought to have dependability when there is evidence that substantiates the investigators' interpretations. Another investigator who comes to similar findings or conclusions by following the decision trail generated by the primary investigator can confirm this evidence. The decision trail came in the form of theoretical memos written throughout the research process that were used to identify what may be happening, emerging ideas, and key decision points and reasoning. During meetings, the research advisors reviewed and discussed theoretical memos with the investigator.

### **Transferability**

*Transferability* (Lincoln & Guba, 1985) or fittingness (Sandelowski, 1986) is the parallel in interpretive criteria to external validity or generalizability in the quantitative method. It refers to how the findings may "fit" or apply to contexts outside the original study situation. Because the purpose of interpretive work is meaning and understanding, one way to demonstrate transferability is to be sure the data reflects thick description with artfulness, imagination, and clarity (Geertz, 1973; Lincoln & Guba, 1985; Whittemore, et al., 2001). In this case,

presentation of rich data contributed to the ability to highlight significant themes that represented the essence of the phenomenon being studied in order to determine if the findings may be appropriate to different contexts and/or situations (Lincoln & Guba, 1985).

### **Confirmability**

*Confirmability* and meaningfulness are central tenets of qualitative research, reflecting an underlying constructivist paradigm where objectivity is not thought possible. Instead, qualitative studies acknowledge potential bias, and identify and account for potential biases that influence investigator data collection and the interpretive process. Qualitative research acknowledges subjectivity in interpretation of the data, and acknowledges that all research is value-laden, with objectivity impossible (Lincoln & Guba, 1985; Sandelowski, 1986). From this perspective *confirmability* is achieved when dependability, transferability, and credibility have been established. The confirmability of this study was judged by (a) examining the audit trail for documentation of activities and decisions related to study processes, (b) using publication data to confirm, challenge, and/or elaborate on themes from the interview data, and (c) evaluating whether the findings and discussion were represented in the data.

In addition to the four evaluation criteria established by Lincoln and Guba (1985), reflexivity was used as an additional strategy to assure quality findings. Finlay (2002) defines reflexivity as thoughtful, conscious self-awareness and includes an investigator engaging in explicit self-awareness analysis

throughout the research process. This active acknowledgement of how the investigator's actions and decisions inevitably impact the meaning and the context of the research is necessary in order to ponder the ways in which they both assist and hinder the process of co-constructing meanings (Lietz, Langer, & Furman, 2006). Reflexivity was demonstrated in this study by keeping a reflexivity document on each participant that included three sections: (a) self-reflexivity, (b) participant reflexivity, and (c) audience reflexivity. These three different points of view were examined for each participant interview in order to gain clarity and identify potential bias and underlying assumptions in the data interpretation.

### **Protection of Human Subjects**

The research participants in this study were professional experts and therefore not considered vulnerable in the traditional sense of needing protection from a safety risk as a result of their participation. Verbal consent for participation was requested at the beginning of the audio-taped interview for record keeping. The participants were asked to give permission to list their names, disciplines, and contribution to their fields within the body of the dissertation. None declined. The potential risk of the interview process itself was minimal. However, the participants were reminded that their participation was voluntary, that they could refuse to answer any question, they could stop the interview at any time, and could choose to withdraw from the study at any time. The potential benefits from participating in the study included the sense of



contribution, providing professional expertise, and rethinking cultural competence. Before data collection, the Internal Review Board (IRB) from Oregon Health & Science University approved this study.

### **Summary**

This qualitative descriptive study was designed to develop knowledge regarding the concept of cultural competence and its relationship to healthcare education. This was accomplished by interviewing 20 multidisciplinary experts on culture and cultural competence from the U.S. and abroad. Two data sources were collected and analyzed: interview text and publications. Analysis was conducted using within-case and across-case comparisons. Criteria for trustworthiness were the primary basis for ensuring that the findings were reliable and valid. Care was taken to protect human subjects, organize and manage the data, and document analytical processes in developing the key ideas represented in the findings.

## Chapter Four: Results

### Introduction

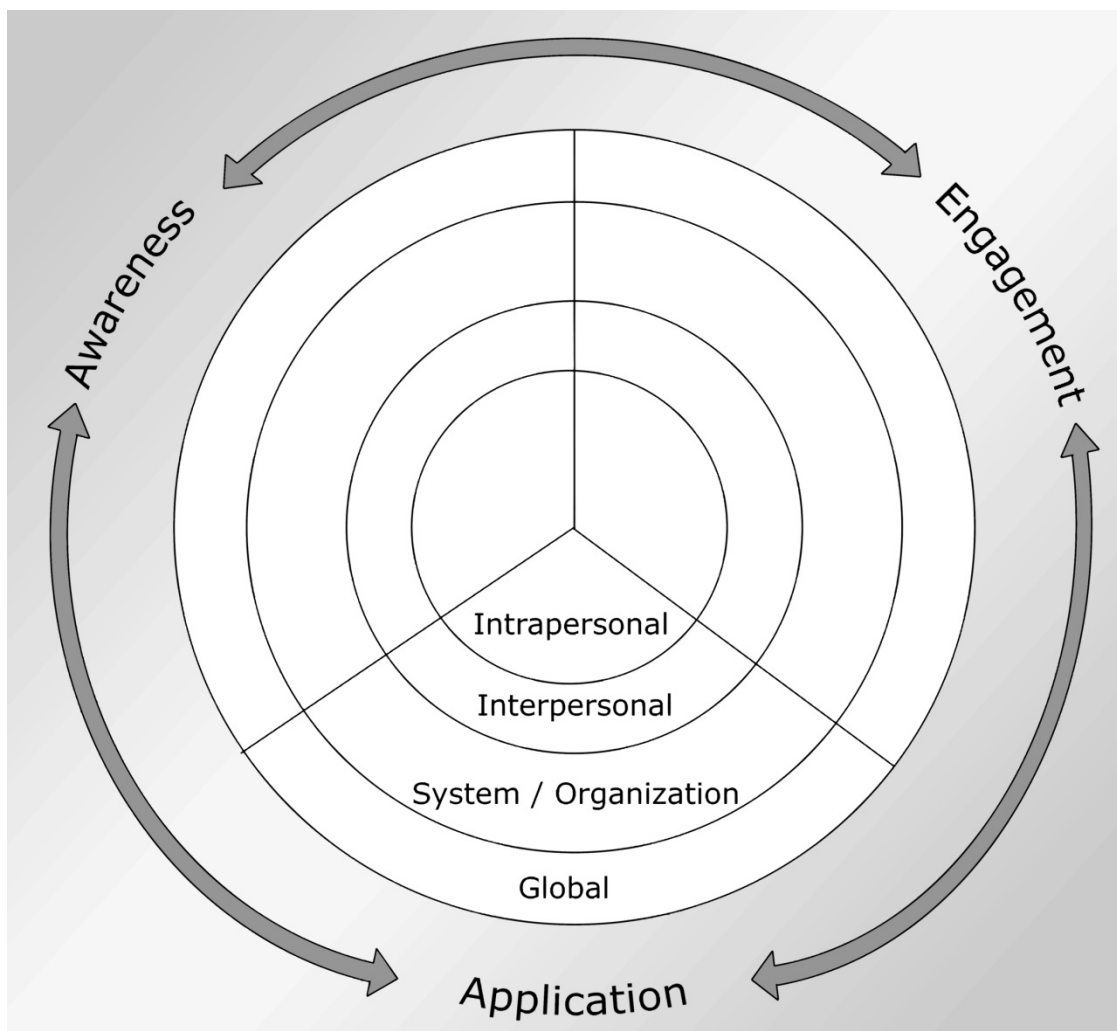
The purpose of this study was to explore the concept of cultural competence by (a) describing how the term has been used; (b) examining perceptions of its strengths, limitations, and underlying assumptions; and (c) developing recommendations for integrating cultural competence into healthcare education. Qualitative descriptive methods were used to analyze data from 20 multidisciplinary participant interviews. The participants were selected for their expertise in culture and cultural competence and were from the U.S., Peru, and Norway. The participants answered the questions from their own understandings of cultural competence.

The selected data excerpts identify common themes and shared meanings, provide evidence for the interpretation, and aid in understanding the phenomenon being discussed. Exemplars represent contrasting ideas and alternate explanations. Source participants are identified by number after the data quote. To protect anonymity each participant was assigned a number not associated with the list of participants in Appendix E.

The findings are presented here in two ways. The first representation provides a framework of three themes and four domains that are core elements of cultural competence: (a) awareness, (b) engagement, and (c) application. These themes were found to apply, albeit differently, across four domains of cultural competence: (a) intrapersonal, (b) interpersonal, (c)

system/organization, and (d) global. Although I define and describe the themes and domains independently, they are ultimately interdependent with reciprocal influence. Secondly, recommendations for the integration of cultural competence into healthcare education are organized in four categories: (a) content, (b) educational strategies, (c) faculty and infrastructure, and (d) evaluation and research. Finally, there is a summary of the study findings at the end of this chapter.

Figure 3 shows the model that forms the framework for the first portion of the findings. This model represents the three themes identified in the data analysis: (a) awareness, (b) engagement, and (c) application and their relationship to each other and to the four domains of cultural competence: (a) intrapersonal, (b) interpersonal, (c) system/organization, and (d) global. The data suggest that cultural competence is centrally concerned with self-awareness and moves steadily outward from the intrapersonal, to the interpersonal, to the system/organization, and finally to the global domain. The nested circles in Figure 3 represent this finding.



*Figure 3.* Cultural competence themes and domains.

The following section begins with broad descriptions of themes and domains in order to familiarize the reader with the foundational concepts of the findings. Next, a systematic in-depth examination of each of the themes occurs as they relate to the domains (Table 4).

The distribution of the data within this framework varied widely. Within the themes, the majority of the data emphasized awareness, then engagement, and lastly application. Within the domains, the majority of the data emphasized the interpersonal domain, then system/organization, next intrapersonal, and

finally the global domain. In fact, while a few participants addressed cultural competence in the global domain, there was a paucity of data in that area. I describe the global domain; however, discussion of the global domain occurs in Chapter Five in the context of future directions of cultural competence.

### **Description of Cultural Competence Themes**

The data analysis identified three distinct but interconnected themes: (a) awareness, (b) engagement, and (c) application. These will be described in the following section.

#### **Awareness**

Awareness represents a continuum of conscious knowledge and simultaneous discernment of self and others including the larger context in which individuals live and interpret their worlds. This continuum of awareness ranged from a lack of awareness (mindlessness, reactivity, interference or impediment of a specific mindset and "entrenchment") on one end to self-awareness (mindfulness, open to new information, ability to imagine from multiple perspectives) on the other.

#### **Engagement**

Engagement represents thoughtful consideration and active involvement occurring in synchrony and has three phases: (a) intention, (b) process, and (c) outcome. The intention, or willingness to engage, is both a precursor and consequence of successful engagement and is similar to Campihna-Bacote's (2003) concept of "cultural desire," which she defined as "motivation to 'want' to

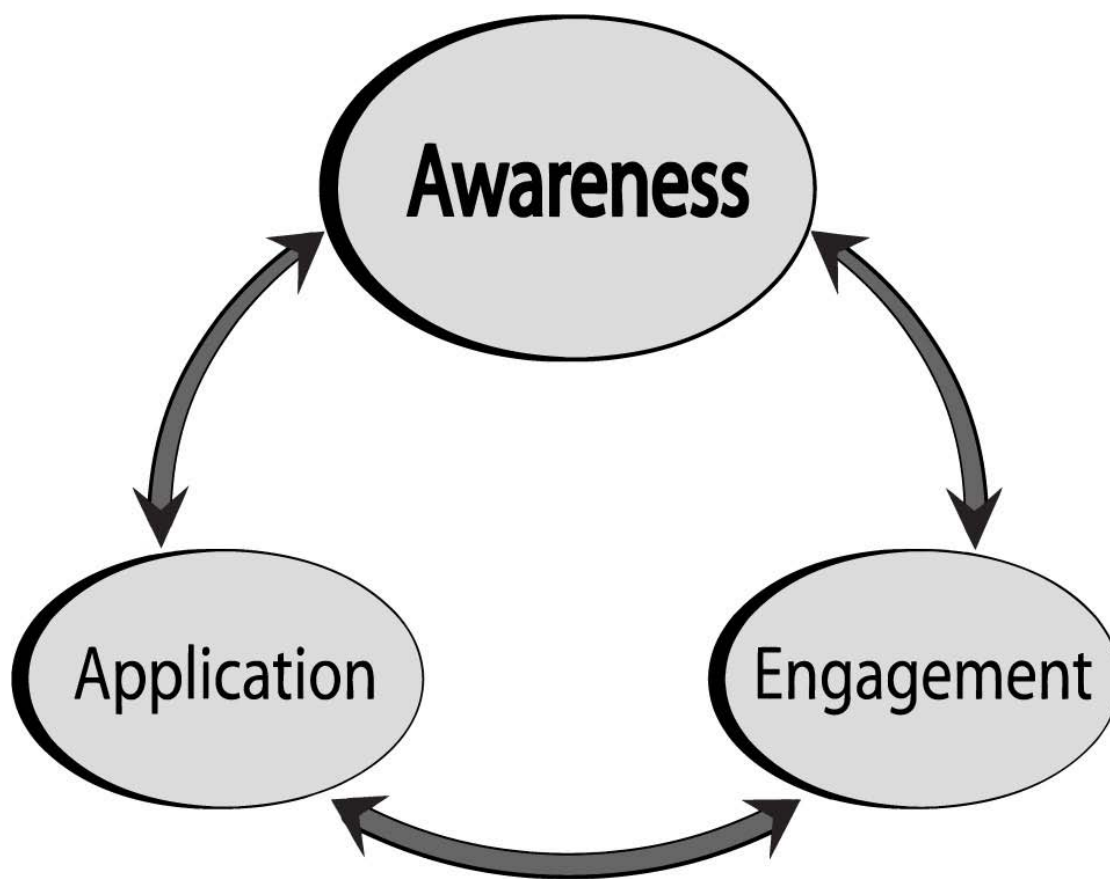
engage in the process of becoming culturally aware, culturally knowledgeable, and culturally skillful, and seeking cultural encounters" (p. 239).

The intention to engage can be fruitfully thought of as fueling the second phase, or process of engagement, which was found to include "getting to know the people, space, relationships, power structures and a willingness to say okay we can work" (Participant 10). Participants described outcomes of engagement as "empathy," "connectivity," (Participant 3) and "high quality relationships" (Participant 1).

### **Application**

Application represents the process by which principles of cultural competence (including attitudes, knowledge, and skills) are used as guides toward a specific purpose or goal; requiring different thinking at different levels. Application denotes moving beyond "cultural knowledge" into an "action" sphere such as "intervention," (Participant 18) "demonstration of competence," (Participant 3) or "operationalization" (Participant 9). Application was implicitly found to spiral back to awareness, engagement, and additional reflection, thus allowing for meaningful change. Importantly, application was the theme least addressed in the interview data and was most often noted to be an underdeveloped area of cultural competence.

While awareness, engagement, and application were entwined and interrelated, participants viewed awareness as a precursor to both engagement and application across all domains (Figure 4).



*Figure 4.* Relationship of awareness, engagement, and application.

The discovery of awareness as a first step toward cultural competence is congruent with the findings of Jirwe, Gerrish, and Emami (2006), who performed a qualitative content analysis of nine theoretical frameworks of cultural competence developed across three continents.

All the theoretical frameworks suggested that nurses [providers] must become aware ...in order to deliver culturally competent care. Two dimensions of awareness were identified, awareness of oneself and an awareness of the other. Awareness of oneself is the first step in developing cultural competence. In order to care for patients from

different cultural backgrounds, nurses [providers] must first become aware that everyone has a cultural background. Nurses [providers] must begin by understanding that they have their own cultural values, attitudes, and belief systems, which include prejudices and stereotypical attitudes. (p. 10)

Participant 8 stated this regarding the primacy of self-awareness:

I think that commitment to self-reflection is one that every individual has to make...and I try to be conscious about how I have been influenced. The emphasis is on being introspective and self-aware and why you're motivated to relate this way, and the kind of questions that you ask or don't ask, and what your own background causes you to see and not see or to be sensitive to or not sensitive to.

Each of these three themes, although presented in a linear format, are not linear processes but iterative, and will be discussed later in this section.

### **Description of Cultural Competence Domains**

The data presented four distinct but interrelated domains of cultural competence: (a) intrapersonal, (b) interpersonal, (c) system/organization, and (d) global. These domains will be described in the following section.

#### **The Intrapersonal Domain**

*Intrapersonal* refers to the aspects of cultural competence that relate to understanding ourselves as unique cultural beings. This includes our distinctive



blend of attitudes, beliefs, values, and stereotypes, and the larger context of socio-historical and personal experiences from which they have been shaped.

### **The Interpersonal Domain**

*Interpersonal* refers to how cultural competence is manifested between and among individuals. While most commonly spoken about in the context of a provider/client encounter, it is also applicable to a wide range of other relationships within the healthcare setting. This domain encompassed understanding the context of another as a parallel process to understanding context of self, and examination of similarities and differences between worldviews.

### **The System/Organization Domain**

The *system/organization* domain of cultural competence refers to institutions of healthcare delivery including healthcare education. This domain was sub-divided into two distinct areas: intra-organizational and extra-organizational. Intra-organizational cultural competence referred to system-organizational internal processes such as mission statements, strategic plans, policies and procedures, hiring practices, employee behavior expectations, and performance appraisals. Extra-organizational cultural competence included a system/organization's relationship to the surrounding community, the willingness and ability to build effective partnerships and coalitions, and incorporation of cultural practices relevant to the populations being served.

## **The Global Domain**

Finally, a few participants discussed cultural competence in the *global* domain through ideas such as global citizenship, global competencies for healthcare professionals, and local and international diversity. Because there was little global-domain data text, that area is discussed in Chapter Five in the context of future directions of cultural competence.

### **Themes and Domains of Cultural Competence**

This section discusses awareness, engagement, and application as they relate to the domains: (a) intrapersonal, (b) interpersonal, and (c) system/organization. Table 4 summarizes the findings as they will be presented in the following section.

Table 4. *Summary findings of cultural competence themes and domains*

Domain	Awareness	Engagement	Application
Intrapersonal	Awareness of context in which personal beliefs, attitudes, and biases emerge	Developing intellectual, attitudinal, and behavioral flexibility	Building capacity Whole person wellbeing
Interpersonal	Awareness of context of another in relationship to context of self	Communication Developing empathy Relationship building	Whole body communication Conflict negotiation
System/ Organization	Awareness of context of U.S. healthcare system	Intra-organizational: Standards Extra-organizational: Building effective partnerships	Intra-organizational: Infrastructure Client-centered care Extra-organizational: Responsive to community and partner needs Research

Participants naturally emphasized topics that were of particular interest to them, their discipline, or their personal research regarding culture and cultural competence. Therefore, while all participant views are represented in this data analysis, specific participants' views dominate within certain themes and domains.

## Awareness

Awareness was one of three central themes that traverse the *intrapersonal, interpersonal, and system/organization* domains of cultural competence. The majority of the awareness data emphasized the interpersonal aspect of awareness, particularly becoming aware of the values, beliefs, worldview, and context of “others.” While development of intrapersonal or self-awareness was present in the data, the process by which it was acquired was not well developed. (In Chapter 5, future directions of cultural competence are discussed in more detail.)

### Intrapersonal Awareness

*Context* was the main topic in the text related to intrapersonal awareness. Developing intrapersonal awareness included four components: (a) reflection, (b) contextual setting, (c) privilege, and (d) behavioral approach. In addition, participants conceptualized context in two different ways. First, explicitly, context referred to the larger socio-historical background, social position, and unique personal experience in which an individual’s attitudes, beliefs, values, and biases develop. Second, implicitly, context represented the local setting or situation in which self-awareness was thought to increase and develop under some conditions and diminish or be suppressed under others.

The majority of participants noted the significance of self-awareness in developing cultural competence. Most often they addressed self-awareness as identifying one’s values, beliefs, and biases signifying a personal or inward

transformation thought to inevitably produce external changes in attitudes, behaviors, and skills.

The first step in developing self-awareness was found to be *noticing* and accepting “what is,” without the need to change.

I’ve gotten to the point where it has gotten much more important to me for people to be aware and curious about where they are, and to be compassionate about where they are, and not even need to change; not to approach it from the way you are is a problem, but to start with okay, just notice where you are...and say okay, this has gotten you some place. You’ve gotten as far as you’ve gotten in the world with this way of being...so let’s just honor and notice that. (Participant 8)

Participants noted that the development of self-awareness required a “safe” context, including self-compassion, in order to “open up one’s mind to go to the next level” (Participant 12). In contrast, an environment of judgment or oppression, whether local and/or systemic, was noted to be a context in which self-awareness could not flourish.

A few participants acknowledged that becoming aware of one’s own beliefs and biases can “be painful to get in touch with” (Participant 6) as it most likely brings up attitudes and feelings that are considered politically and/or socially incorrect. Participant 8 noted two frequent consequences of developing self-awareness: (a) being “unwilling to admit” one’s own bias and (b) “guilt” over the bias one discovers is present. Pain, discomfort, and guilt can generate

resistance and dissuade individuals from moving toward deeper self-awareness. The cultural competence literature rarely addresses painful or tender parts of developing self-awareness. One exception, Chang (2007), observed that negative emotional responses to significant differences are natural, and rather than being suppressed, have the potential to become valuable learning tools in the cultural competence process.

**Reflection.** Several participants noted that building self-awareness relied on ongoing and deepening reflection requiring “personal commitment” (Participant 8). This process was thought to bring awareness of (a) the questions that we ask or don’t ask, (b) what our own background causes us to see and not see, and (c) underlying motivation. Furthermore, participants recommended examination of underlying assumptions as a means to self-awareness:

Take a step back and question some basic assumptions about who you are, who the “they” are, who the “them” and the “us” are, and how you understand them, and how you think you understand them. It will make you reflect on the process in a deeper way than if you didn’t question your assumptions at all. (Participant 14)

Stevens and Cooper (2009) defined reflection as a “complex and intentional intellectual activity that generates learning from experience” (p. 19). Participants saw reflection as a continuous and cumulative process; Participant 15 described it as leading to “wisdom.” This participant went on to describe reflection as both a process and paradox:

You've got to figure out how you reach that other level. And it only can be learned through...deep reflection on experience...And I say to people that you have to go beyond your own experience...And how do you get people to go beyond their own experience? It's paradoxical because we are a product of our own experience, so you are now asking people to be more than their own experience. How is that possible? And it's possible only...through deep reflection on the experience, which then transforms the experience into thinking of it in new ways and trying to be open to new ways of doing things.

Craft (2005) noted that a process of "personalizing and reflecting on experiences" is needed in order to develop what she termed "hidden knowledge" (p. 54). In addition, Tanner (2006) noted that clinical judgments are often influenced to a greater extent by what an individual brings to the situation, such as preconceptions, beliefs, values, and worldview, than the data at hand. Therefore, it is essential that faculty members are skillful in their ability to support and facilitate personal reflection, first in themselves, and then in their students.

**Contextual setting.** Importantly, participants emphasized the need to examine the development of particular biases and assumptions as developing from within a larger context than is usually considered including socio-historical setting, social position, and personal experience. Taking this broader view shifts the responsibility for attitudes, biases, and prejudices from individual choice to

“naturally” occurring, given the larger context in which they develop. Gray (2006) described the shift in paradigm from individual responsibility to a shared responsibility this way:

From an essentialist perspective, the focus is on identifying particular prejudices and biases and eliminating, managing, or denying them. An essentialist perspective fails to provide a broader context for understanding the evolution of prejudices and biases; thus, the individual process of developing this conscious awareness of one’s cultural perspectives is often difficult. A constructivist perspective [addresses] the processes by which prejudices develop as a larger societal practice. Prejudices are viewed as something that innocent people are likely to acquire as a result of living in a particular culture, thus removing some of the personal negativity associated with the exploration of prejudices. (p. 79)

Using this broader perspective to examine the development of prejudice and bias can be useful in helping individuals move beyond the guilt often associated with politically undesirable attitudes, to a deeper understanding of the societal influences that initiate and reinforce those ways of thinking.

**Privilege.** Many participants identified privilege as an important and influential aspect of intrapersonal context. Johnson (2001) described privilege as a unique advantage that an individual or group has over, and often at the expense of, other individuals or groups. Therefore, membership in specific



groups, thought of as more valuable, brings privilege and therefore power, whereas conversely, membership in other groups brings less privilege and therefore less power. The process of how groups are defined as valuable and not valuable (explicitly and implicitly) is enacted through the values of the mainstream or dominant group that is defining value and, therefore, not-value. Privilege, a result of being in the valued groups, has many dimensions and can include age, appearance, ethnicity, gender, nationality, physical ability, socio-economic status, educational level, sexual orientation, professional status, and spiritual practice among others.

Participants reflected that for those who experience privilege, it is often outside conscious awareness. One participant advocated for individuals becoming aware of their unique areas of privilege in order for them to help and ally with those less privileged. She described her own privilege this way:

I've got access to financial resources, so I have financial privilege. Maybe I'm white so I have skin color privilege. Maybe I'm male so I have male privilege. Maybe I'm, I don't know, Christian heterosexual so I have those kinds of privileges. And how people look at and work with their own privilege has a lot to do with people's ability to listen to other people work with their privilege or lack of privilege...I see people either being unwilling to admit that privilege has any influence on people...or I see people feeling guilty about the privilege that they have and not want to acknowledge it. So it's sort of either unconsciousness or guilt about it, or,

in the most optimal situations, recognizing that I have in certain areas privilege and other areas lack privilege. I don't have gender privilege, for example, in this culture. And it's like that's okay, I don't have that, but I can pay attention to the privilege that I have and use those privileges in a way that I can and be conscious about the way that I am using that privilege to help other people and to be allies of other people. (Participant 8)

While it can be difficult for members of privileged groups or systems (e.g. healthcare providers) to recognize their privilege and realize the distance privilege places between themselves and less privileged groups, denial or minimizing the effect of privilege is a significant barrier to becoming self aware and therefore to the development of cultural competence.

**Behavioral approach to self-awareness.** While the majority of participants agreed that self-awareness developed via an internal change that manifested externally, two participants disagreed. They criticized the internal-to-external approach, arguing that cultural competence “information” and trainings did not inevitably lead to behavioral change. Instead, they emphasized the external-to-internal approach of developing intrapersonal cultural competence.

I think one of the things we often believe is [that] if I give you the information, you will change...I don't think that works. I think what works is working with behaviors. This is what you are going to do, this is what you are going to look for, this is how you're going to value that client... I

don't think you can retain the negative imagery if you begin to do things in a culturally competent way in the workplace...Control the mind and the body will follow. That's one way of thinking. Another way, control the body and the mind will follow. That's where I'm coming from...I think the way we've done it is that I am going to teach you something, not the behaviors, but I'm going to teach you a thought process, and you are going to discover the behaviors on your own...I think that's the way I grew up believing. And right now...this is how you're going to value that client, this is how you are going to respect them. (Participant 16)

These participants argued that an external-to-internal approach, linking the intrapersonal and systems domains of cultural competence, could offer consistent reinforcement of basic cultural competence practices by holding individuals accountable for behaviors. Behaviors were then thought to be the catalyst for possible, but not assured, internal change. Consequently, the findings supported self-awareness as developing in two distinct, but contrasting ways, internal to external and external to internal. This finding regarding the bidirectional nature of self-awareness development has implications for systems/organizations as well healthcare education and is addressed more fully in the final section of this chapter.

### **Interpersonal Awareness**

Interpersonal awareness was one of the dominant aspects of cultural competence that the participants addressed, and in that way, it mirrored the

professional literature. Context was again identified as a central theme. While they referred to interpersonal awareness most often in relation to the healthcare provider/client dyad, participants also included relationships between healthcare providers, between healthcare providers and other employees within a system/organization, and between healthcare providers and community members. Developing interpersonal awareness was found to include three components: (a) acceptance, (b) context, and (c) humility.

**Acceptance.** Several participants noted the importance of accepting differences as equally valid as a vital aspect of developing interpersonal awareness. One participant addressed the process of working effectively with others this way:

It's a combination of accepting difference and withholding evaluation of that difference. We have a tendency to judge and to critically evaluate rather than to suspend that and just be in accepting mode. In other words, this is who I am and this is who they are. It is about interacting in a non-judgmental way with people who have different ways of looking at things and therefore asking questions rather than giving answers...The key in dealing with others is what I like to think of as a sense of humility... and a respect for difference; that difference is legitimate and people who have different ways of expressing themselves are just as valued as my own. (Participant 15)

Respecting different viewpoints as equally valid was found to serve healthcare providers in revealing where their viewpoints may be incomplete or limited. Understanding these limitations was found to enhance a healthcare provider's ability to open up to worldviews other than their own, a key skill in the development of trust and empathy.

**Context.** The role of understanding context in developing interpersonal awareness was not unlike the process described in the data text on developing intrapersonal or self-awareness. Participants believed that appreciation of the context of another would enhance the ability to understand how their values, attitudes, and behaviors have been influenced and developed through socio-historical events, social position, and personal experience. From within this broader understanding, one participant noted "Whatever I'm seeing, when I see it in context, everything makes sense" (Participant 19). Another participant described a similar response this way:

Well...I think it's being able to understand an individual and their context, and it's the...context piece that I think requires some nimbleness and flexibility and some expertise because you don't get the context without being able to solicit it, usually. And so with different individuals from different backgrounds, how that happens is different, and if you don't understand the context of the person, it's really hard to have healthcare that is going to be acceptable or that is going to make sense. So, it's

understanding anybody in their context...When you can get the context, you can drop the judgment. (Participant 12)

A broad understanding of the influence of context in identifying the development of one's own "situatedness" was thought to be a precursor to allowing the healthcare provider to also view the client as "situated." This framework of understanding, beginning first with the self and then moving outward toward others, which the majority of participants supported, was thought to enhance the healthcare provider's capacity to distinguish a "more complex system of relationships that influence client behavior and health choices than is normally considered by healthcare providers" (Chrisman, 2007, p. 68S).

**Humility.** Many participants identified the need for healthcare providers to become cognizant of their own place of privilege and power that exist as a result of socio-economic status, specialized knowledge, professional and social status, and national citizenship. Participants consistently identified the disparity in power between providers and clients, families, and communities as blocks to the development and practice of cultural competence. I address these power differentials in both the interpersonal domain and in the system/organization domain later in this chapter.

In order to redress power imbalances, half of the participants specifically identified the need for humility in order to work skillfully with others. Humility was described by Tangney (2000) as a "rich, multifaceted construct that entails an accurate assessment of one's characteristics, an ability to acknowledge

limitations, and a forgetting of the self" (p. 70). Benner and Sutphen (2007) described humility as allowing providers to "stay curious or be willing to be corrected" (p. 107). Taken collectively, participants noted that interacting from a starting point of humility rather than professional expertise generated a different type of healthcare encounter. One participant defined humility this way:

Humility is the capacity to recognize you're a limited creature. You are able to be stupid and stubborn, and all this is human arrogance. Look at your stubbornness, your stupidity, your limitation and so on, so you can really cultivate humility. Humility is a part of the real act of knowing how to receive. To receive well, you need to know you need something.

(Participant 4)

A participant described the need for humility in the healthcare encounter this way:

I think that is what the humility is all about in the healthcare encounter, because we basically see people at their worst. If we can't greet them with all the power and grace they are deserving of as we desire to see them beyond their circumstances, then shame on us. (Participant 5)

The professional literature has also discussed the attribute of humility, albeit rarely (de Vries, 2004; Guskin, 1991; Hunt, 2001; Lebacqz, 1992; Tangney, 2000; Tervelon & Murray-Garcia, 1998).

**Arrogance.** Because humility was identified as influencing a healthcare encounter, understanding the role of arrogance was also helpful in illuminating

the concept of humility. Arrogance can be thought of as exaggerating our own importance. Participants described this concept in a variety of ways including “(students) just filling the room too much with themselves,” (Participant 19), “diminishing the values of others,” “believing you are better than others,” (Participant 4), “dismissing practices outside your own,” “a tendency common to most if not all human societies,” (Participant 6), “ethnocentrism,” and “every prejudice is arrogance” (Participant 1). Arrogance was found to narrow the understanding of the healthcare provider and to generate distance between healthcare provider and client, making it difficult if not impossible to negotiate a collaborative plan of care.

While acceptance, context, and humility were identified in the data as the ideals of cultural competence, two participants were doubtful of that reality coming to fruition without radical transformation within our healthcare systems and education. One participant described the difficulty this way:

So...it's basically being non-ethnocentric and being open to the idea that other cultures may have value...Which I think is a hard sell...Getting to the point of being equals with a patient and not exerting your power and understand[ing] that you can learn as much from the patient as the patient can learn from you. I will tell you, doing that will require major cultural shifts in our institutions...and our society that basically puts doctors and nurses at the top of the mountain. It's easy to see ourselves there. I don't think many people go into an office visit and...really consider



the patient. They may say it, but they don't behave in a way that makes the patient an equal partner. We have the knowledge, they don't.

(Participant 3)

Interpersonal awareness resulted from recognizing self in relation to another, acceptance of alternate viewpoints as equally valid, and humility in interactions with others.

### **System/Organization Awareness**

Context, again, emerged as a central theme in awareness in the system/organization domain including awareness of (a) the role of cultural competence at the systems level, and (b) the influence of the U.S. and biomedicine.

**Role of system/organization cultural competence.** Many participants discussed the role that cultural competence now plays in healthcare's agenda to eliminate health disparities. Furthermore, healthcare's traditional focus on interpersonal cultural competence has obscured the more influential aspects of health disparities including social, economic, political, and environmental variables. Chrisman has written extensively on system/organization cultural competence. He situated system/organization cultural competence within a broader context this way:

It is popular for writers and researchers in the health sciences to argue that culturally competent clinicians and organizations...will have a significant effect to improve the health of our nation and, in particular, to reduce the

disparities across population groups in the United States. Most information shows that medical care (including nursing and the other health professions) accounts for less than 20% of the nation's health status (Frank 1995). More than 80% is because of other influences. In essence, the factors that underlie our health as a nation are the social determinants of health, such as income disparity, racism, poverty, lack of education, and environmental threats. Our work on cultural competence must be seen in the light of these larger and much more politically sensitive aspects.

(Chrisman, 2007 p. 8S)

Participants advocated for an increased awareness of the role system/organization cultural competence plays within this larger context, emphasizing the importance for healthcare systems to work in collaboration with other systems to combat the complex issues that create and sustain health disparities. In addition, participants noted the dual role played by providers in sustaining health disparities by focusing on attaining compliance with healthcare system values, rather than examining ways in which the system can be transformed in order to better meet the unique needs of clients, families and communities. Gray (2005) stated this:

One cultural manifestation of power and privilege...is the development and establishment of class systems. Inadequate financial resources and their implications for health are addressed in the emerging literature on so-called "health disparities," but a critical analysis of the complex

cultural processes that serve to create and sustain those disparities is lacking in the nursing literature. Also absent is a critique of the ways in which the profession of nursing serves a dual cultural role to both maintain and reduce those disparities. (p. 257)

Not unlike intrapersonal and interpersonal awareness, participants noted that system/organization awareness called for both internal and external examination. Internal, or intra-organizational, and external, or extra-organizational, were considered two distinct parts of a larger whole and were deemed equally important aspects of system/organization cultural competence.

**The U.S. and biomedicine.** A few participants discussed the extensive influence that science, computers, information, and technology currently play in the U.S. in general, and in healthcare specifically. They noted that when clients, families, and communities also come from this particular understanding and value set, rapport, client satisfaction, and strong ties between system/organization and community can be built. Yet many participants noted that significant demographic changes in the U.S. have brought widely varying worldviews into the healthcare system. These participants described the incongruence between the skill sets required for technology proficiency and working across cultural differences. One participant stated it this way:

I think as Americans across the board, we are taught to classify, to put people into categories, and, I believe, to think linearly as things become worse with computers...and so it's very hard, with that type of thinking, to

then go into the cultural dimension where there's so much variation.

(Participant 5)

Participants noted that the lack of examination of the underlying assumptions of the healthcare system itself was a hindrance to developing system/organization awareness, and therefore cultural competence. They agreed that this was no longer acceptable, and they strongly advocated for system/organization examination as a primary force in the cultural competence movement. Finally, one participant noted that cultural competence would be best served by including alternate perspectives from outside of the U.S.:

[Cultural competence] still tends to be predominantly based...from the U.S. And I know there's work done on what other cultures are doing, but not enough. So if there is a limitation or an opportunity, I think it would be great to have genuinely other perspectives from outside where people have already probably used it [cultural competence] and live it [cultural competence] to figure out how we can assess cultural competence and how people interact with each other. (Participant 1)

Participants advocated that the development of cultural competence awareness move beyond an interpersonal focus to a system/organization focus. Understanding the role of cultural competence at the system/organization level was thought to be more comprehensive viewpoint and therefore more effective in eliminating health and healthcare disparities. Figure 5 summarizes an

awareness continuum that is applicable in the intrapersonal, interpersonal, and system/organization domains.

<b>Lack of Awareness</b> .....	<b>Awareness</b>
Mindlessness.....	Mindfulness
Automatic or unconscious responses .....	Conscious responses
Lack of discernment.....	Discernment
Entrenchment .....	Flexibility

Figure 5. Awareness continuum.

## Engagement

### Intrapersonal Engagement

Flexibility was the central theme in intrapersonal engagement. Many participants implicitly identified the need for flexibility in order to move into understanding both self and another. Flexibility included being open and available in order to (a) learn, (b) conceive of alternate sets of values, (c) appreciate how mind-sets develop, and (d) understand that all behaviors make sense in context. Taken broadly, flexibility included intellectual, attitudinal, and behavioral flexibility on the part of the healthcare provider in order to move toward cultural competence. Inevitably, participants noted that individuals brought up in widely varying contexts and backgrounds lived in widely different realities or “truths.” They described flexibility as imagining oneself in the perceptual world of another and understanding the world through her or his specific viewpoint and life experience. Almost all participants identified these skills as foundational in developing cultural competence.

In contrast, a lack of flexibility, what Palmer (2004) described as the “arrogance of absolutism” (p. 126) and what one participant termed “entrenchment” (Participant 11), represented a fixed set of values, singular mindset, or set of actions. This was identified as a block to the development of cultural competence, and therefore to the ability to effectively work with others.

### **Interpersonal Engagement**

Interpersonal engagement comprised three topics: (a) communication, (b) developing empathy, and (c) relationship building. These topics are described and illustrated in the following section.

**Communication.** Participants discussed communication in a variety of ways taking into account communication beyond simple conversations to examine a combination of verbal and non-verbal communication, including how we present ourselves to others. Aspects of verbal communication frequently addressed language spoken; however, most often, communication referred to something more subtle and intangible such as style of communication, tone, underlying meaning, explanatory models, and mutual understanding. Almost all participants addressed effective communication as a vital aspect of working effectively with others. One participant made this link between cultural competence and communication:

I think cultural competence is about communication....My other job is [as] a clinician at the VA and I work at the intensive care unit. And every day when I go in to see a family, it's a cultural experience. And my job is to

learn their language in terms of how they see life, how they see death, and how they see value in life as quickly as I can...because what's important is that I can communicate with them...to help them deal with what are often very stressful clinical circumstances. In the same vein or by analogy, I see cultural competence as an ability to communicate important information in a language the other person can understand; not the first language that the individual has as a healthcare provider, but in the language that the patient has. (Participant 17)

Consistently, participants noted that it is the responsibility of the provider to (a) notice client and/or family communication and (b) adjust to that style in order to ensure mutual understanding.

Participants identified two specific strategies to effectively communicate with clients and families: (a) listening to understand and (b) asking questions. These strategies are described and discussed in the following paragraphs.

***Listening to understand.*** Many participants acknowledged the importance of listening deeply in order to understand the perspectives and life worlds of others. One participant noted the similarity between psychology and medicine in that each relies on allowing the client to speak in order to gain clues to his or her underlying concerns. In coming to deeply know her own research participants, another participant described the role of listening this way:

It is only through talking and listening that you can develop a profound understanding for the way that they [clients] manage their health

problems. My teachers were primarily my research participants...hours and hours and hours talking to them, raising a lot of questions about their life, their beliefs, their values. (Participant 18)

A third participant described listening as more of a solitary act, and another participant described it as "bearing witness" (Participant 13). Listening to understand the experience of trauma and torture of refugee clients was described this way:

It is important to just accept that this has happened and let them tell their story without trying to change it. And that's what they really long for...is to be able to tell all the horrible things that they experienced. They share their stories and don't want me to mess with it. I don't need to do anything with it but have appropriate emotional responses. (Participant 19)

The idea of listening to understand without competing agendas such as attempting to inform, fix, or advise supports and acknowledges the client as the expert in his or her own life, and therefore a collaborative partner in his or her own healing process. Palmer (2004) described listening as an "inward and invisible act" (p. 120), yet deep listening can also help generate concrete results such as planning care along with clients and families. Participants noted that using a listening-to-understand approach to communication blends the roles of expert and learner and helps reduce the power differential that is nearly always



present between healthcare provider and client, which itself blocks effective communication.

A few participants gave personal examples of not being listened to by healthcare providers and acknowledged that clients and families frequently have similar experiences. One participant described a situation where a woman in a focus group reported that when she described her symptoms to her physician, he corrected her:

In the focus group we ask them [clients] if you could say one thing to your doctor, what would it be and one woman's quote captured it perfectly. She said I would tell him that I have been in this body for 40 years and I think I know what's going on with it. (Participant 3)

Listening to understand is a strategy that represents respecting the client as an individual, gaining clarity on client priorities and concerns, and creating an environment that encourages collaboration in negotiating a plan of care.

Participants also described ways in which they became aware that communication was not going well. These included the client's reflexive non-verbal responses, (Participant 17), incongruence between verbal and non-verbal cues (Participant 1), and an underlying difference in core values (Participant 19). One participant described her experience with a Kurdish woman this way:

It's almost always the communication issue in which I sense a lack of emotional connection...I find that my theories of change aren't working... We are not connected on the goal of why she is coming to talk with me.

That's quite an explicit difference. I can say to a Kurdish woman, 'Maybe you need to put in a reward system for your son so that he'll behave better,' and she will look at me and say 'I would prefer that he just respect me,' which is a strong message for me that I am off-track. [Using] Western reward systems for a culture where the relationships are built on another level...and I immediately recognize that I have a problem and we continue to think about it. (Participant 19)

Importantly, listening to understand was found to engage senses beyond the auditory alone including noting visual cues, sensing or intuiting, "presencing" self, and mirroring the client in order to build rapport. One participant described a personal experience using this skill set in order to diffuse a potentially dangerous situation:

The man did not know where his daughter was. And there was good reason for his daughter to be gone. He was furious. He was fierce. His eye contact is intense and he is very, very loud. He is angry and he is scary and he is going on and on. And I looked at the three of us there, sitting with our bodies closed up, our legs crossed, arms across our chests, leaning back under this onslaught. So I leaned forward and I looked him right in the eye and said "We hear that you are really concerned and if we hear anything we will let you know." And he just looked at me and he smiled and he said thank you. It was our nonverbal stuff he was

responding to, and he didn't think we were listening to him. Showing him that we heard him made all the difference. (Participant 20)

***Asking questions.*** A few participants addressed the role of asking questions as an important way to come to understand others. These participants cautioned that the questions traditionally asked in a healthcare encounter are rooted in a specific value set, which might work well for some groups; however, they might not be appropriate for others. One participant emphasized the need to ask different types of questions in order to generate different kinds of conversations with clients and families:

We need questions that create different kinds of conversations with patients than the things that we are asking now, and it takes a lot of courage to do this. I think we have learned to be nice and we avoid conversations that would make other people or ourselves uncomfortable. [For example] "Have you had experiences where you have been treated poorly as a result of the fact that you have dark skin color or look Hispanic? Is that something that you're afraid of happening here? And if so, what do we need to do to help with that?" My ability to ask the question conveys something important to people that says I recognize that in the body that they are in, you [sic] may have had experiences that have been difficult and painful for you and that you may be worried that you're going to have those experiences here...You may have had those experiences here the last time you were here and you may still be upset. I

am willing to listen and work with you to create a situation where it is less likely that will happen again. And if it does, creating the possibility that you will have an ally with you to address it, or at least to listen to you.

(Participant 8)

Asking deeper questions and generating deeper dialogue with clients and families was thought to enhance the development of empathy—another important aspect of interpersonal engagement identified by participants.

**Developing empathy.** Empathy is defined by Sichel (2004) as:

The capacity for and action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another without necessarily communicating those feelings, thoughts, and experiences in an explicit manner. (p. 167)

Empathy is denoted as a virtue that is demonstrated in how we act toward and treat people more than something to be explained. While words have a role in expressing empathy, ultimately and more importantly, participants described empathy as the ability to be receptive to others and effectively enter into the perceptual experience of another, including intellectual, attitudinal, and behavioral aspects. Webster (2010) notes that “empathy builds trust, and individuals ...who perceive nurses as empathetic feel accepted and valued” (p. 88). In contrast, (Webster, 2010) notes that healthcare providers with low levels of empathy are “unable to interpret what the client is feeling or even disregard the client’s feelings altogether” (p. 88).

A number of participants addressed the concept of empathy and described it as “entering the patient’s world and seeing the illness through their eyes” (Participant 3), “walking in the patient’s shoes” (Participant 14), and “trying to look at the world through another’s perspective” (Participant 15).

**Relationship building.** Skillful communication and empathy lead to the ability to build high quality relationships between and among individuals.

Participants noted that these relationships benefited not only the client and family, but they also benefited the healthcare provider as well by creating greater work satisfaction. One participant described the mutuality and joy in relationship when reflecting on his ongoing relationship with a community in Zimbabwe:

It feels very good to me to have a stake with this community since my first visit in '94. I have been back every year since then. And when you ask about cultural competence, for me, it means getting to know the people, getting to know the space, getting to know relationships between men and women and between neighbors and each other, getting to understand some of the power structure in the community and how that works. What it feels like is engagement, awareness, sensitivity, a degree of humility, and the willingness to say okay, we can work. (Participant 10)

Finally, a participant made this link between cultural competence and relationship building:

For me, ultimately I think for cultural competence to work there has to be—I don't know how best to call it—maybe connectivity is the best word that comes to mind in terms of forming relationships that are significant and important...Edward G. Hall talked about making a friend in the culture that you know the least about because if you don't have a genuine sense of humanity and the need to connect with other people, it's very, very difficult, I think, for all the things that we talk about in intercultural communication and cultural competence to work. And so I would like to see more work [on] how that can happen, how to do it, especially in the context of healthcare where we know the challenges of time. How do we find ways to make it happen so that there are genuine connections and connectivity between people? (Participant 1)

In contrast, many participants described the numerous competing agendas within the complex healthcare system that vie for a healthcare provider's attention other than relationship building, including time constraints, technology, and the quality improvement movement. One participant described the consequences of our current system this way:

Look at the number of people...who are exiting Western medicine and going to the naturopaths and going to acupuncturists and going to these integrated clinics, and people are doing it because doctors don't give them what they want any more. They don't give them time and nurturing and relationship. And part of that is [that] the quality movement sometimes

mechanizes care in a way that is sort of antithetical to relationships. I think we are going through growing pains because I think it's clear that people still want relationships. It's clear that you have to sort of do this quality stuff, but right now we are invading the relationship with all of this check-box medicine. At some point I think we will take the check boxes out so that the doctors and nurses can still have relationships...So I think relationship-centered care has got to be re-established because I think it was all that we had, right, 100 years ago? (Participant 3)

Successful interpersonal engagement requires a combination of skillful communication, development of empathy, and a willingness and capacity to build high quality relationships with clients and families.

### **System/Organization Engagement**

Two themes were identified in the data text related to system/organization engagement: (a) intra-organizational standards and (b) building effective partnerships. These topics are described in the following section.

**Intra-organizational standards.** In order to create an environment where culturally competent behavior is the expected norm, participants recommended a systems approach to developing institutional standards. Participants identified "dispiriting circumstances" as (a) "unevenly dispersed" attention to cultural competence across caregivers, (b) discrepancy in expectations between disciplines, particularly nursing and medicine, and (c)

undermining of cultural competence efforts by leadership whether administration, physicians, or other providers. One participant, a nurse researcher, expressed this concern:

Plus...I'm annoyed and irritated. The docs have discovered this [cultural competence] now, so it's going somewhere and it's getting funded and it's getting recognized...Nurses have been doing this for so long, it's just like we didn't get recognized. We didn't have the money and the recognition and the status to really push it through, whereas the physicians now who have gotten on this bandwagon much more recently, they do...Some of the stuff that's coming out now, yeah, it's fine, it's good, but it has been said before. They just don't realize. They don't read the literature that we have produced. (Participant 20)

A systems approach was thought to increase the likelihood that all healthcare providers would aim at the same goals of high quality care regardless of their status in the healthcare system.

**Building effective partnerships.** Many participants described the mistrust that exists as a result of academic centers' historical misuse of power in relationship to communities, particularly minority communities. Partnerships, a new paradigm in healthcare's relationship with communities, were found to require a balancing of power, eliciting and working from the priorities identified by the community, and valuing diverse types of expertise. One participant made an important distinction between service and partnership:



And so partnership means equal, equality. I mean, to be partners with somebody is, while you may not be the same, you both together are working toward a common goal, where service, as you know, means one can serve another. It's valuable, but it's a very different hierarchal situation. (Participant 15)

Implicit in the concept of service is the group who serves and the group that receives. In every act of "service" to others is an underlying statement, intended or not, of one group's ability to give and the other's inability to get along without the gift. Johnson (2001) notes that in a "society that counts independence, autonomy, and self-sufficiency among its highest cultural values, it's impossible to avoid the negative judgment attached to those on the receiving end and the status enhancing judgments conferred on those who give" (p. 78). System/organization engagement requires both an intra-organizational and extra-organizational vision including the capacity to build strong egalitarian partnerships across differences.

## **Application**

### **Intrapersonal Application**

Intrapersonal application was comprised of two themes: a) building capacity and b) whole person wellbeing. These themes are described and illustrated in the following section.

**Building capacity.** Intrapersonal application was implicitly described as a process to build capacity to work effectively with others. Capacity can be

described as an aptitude, a capability, and/or facility. Underlying these descriptors is the idea that capacity is flexible, and therefore susceptible to influence such as learning and experience. The data represents intrapersonal capacity as developing an “openness” (Participant 1), or “space within yourself” (Participant 6), in order to respond effectively toward others. Capacity was found to represent both intellectual and emotional capacity.

Two participants addressed specific tools to increase intrapersonal capacity toward cultural competence. Interestingly, while they were raised and living on different continents and trained in different disciplines, their recommendations were very similar and included “meditation”, “practicing relaxation and imagery exercises”, and “working with energy work” (Participants 4 and 13).

**Whole person wellbeing.** Importantly, context was identified as an essential precursor to building capacity. Context, which has been described and discussed earlier in the findings, relates in this case to the overall wellbeing of an individual before they can move successfully into building capacity. One participant stated this:

Recently I was asked to review a piece where a couple of our colleagues from the Summer Institute [Intercultural Communication] are trying to find or explore dimensions of being bicultural or multicultural and how that actually gets enacted on a day-to-day basis. There are some very nice dimensions, but one of the things I talked with them about was

there's an assumption here that we are always culturally competent and there's an assumption here that we are always in good health, emotionally or physically or spiritually or economically or any of those things, and I said cultural competence is very challenging to practice...when we are going through our own interpersonal issues and challenges and battles and life changes. (Participant 1)

This participant implicitly referred to the need for underlying holistic health and wellbeing before capacity could be developed. While only one participant discussed this aspect of cultural competence, it has strong implications for healthcare education and will be discussed later in this chapter.

### **Interpersonal application**

Two themes related to interpersonal application of cultural competence were whole body communication and conflict negotiation. These themes are discussed in the following section.

**Whole body communication.** Whole body communication describes communication that uses the senses, including vision, hearing, and intuiting simultaneously to build rapport with others. Participant 1 stated this:

So there is research to support this. Clearly, when we meet somebody we have a sense of a synchrony of energies or a dissonance of energies...I find that if that [cultural competence] skill set or behavior does not come with a certain level of authenticity...the client...in the encounter...gets a

sense of how this doesn't seem right, this doesn't seem real, and most people tend to pick up on that pretty quickly.

Whole body communication was found to be an essential skill needed by healthcare providers given the close link between “communication, trust, and health outcomes” (Participant 9). Two aspects of whole body communication were identified: (a) noticing, and (b) mirroring.

***Noticing.*** Interpersonal noticing requires conscious attention and is bi-directional. First, noticing is directed outward toward how client and/or family communicate including style, tone, pace, use of language (e.g. specific terms), and non-verbal cues such as gesturing, body posture, personal space, and degree of eye contact. Second, noticing is also directed inward to one's own style, tone, pace, use of terms, and non-verbal cues. Participants noted that flexibility was needed on the part of the healthcare provider to match the style of the client and/or family in order to build rapport.

I believe that healthcare providers are responsible for noticing how the patient or family communicates and noticing if our style is different and trying to adjust it to be more similar to the family's way. (Participant 17)

***Mirroring.*** Mirroring and noticing were closely related and when skilled communication was occurring, they occurred in synchrony. Mirroring is best thought of as subtly reflecting both verbal and non-verbal communication of another, including behaviors, actions, and body language. One participant described her practice of mirroring this way:

I used to do this with my...students all the time. I would watch...I would put my chair in a certain place when one of them would be in my office and watch them. If their eyes were going everywhere but mine, my eyes just checked in briefly and then went elsewhere. If they were leaning forward, I would move my chair a little bit forward. If they looked like they were leaning back, I thought oh, okay, my distance is a little too close. I would lean back a little bit or move my chair a little bit back. I basically tried to adjust my own and checking in, well, what am I doing? What is my face doing? What is my body doing? What is it that could be getting in the way here and what would make this more comfortable? And it takes a lot of practice and it takes a lot of skill to do that, but just noticing a little bit and learning from it is really a good process.

(Participant 20)

Whole body communication comprises multiple sensory pathways at work simultaneously. Noticing self and another, and mirroring aspects of whole body communication were recommended to build rapport.

**Conflict negotiation.** Conflict was noted as a natural outcome of working with others, particularly when working across significant differences. Despite the inevitability of conflict, participants noted the lack of conflict negotiation skills taught in healthcare education. One participant spoke about her research with nursing leaders:

Well, it was really interesting about what they [nurse leaders] shared with us was how much of nursing leadership is really around conflict resolution and how you help people who come from really different backgrounds get along. And, I mean, people had story after story after story of how one needs to be able to embrace differences and to have respectful, safe places for difference to be and how that can be healthy and how you do that. And that they never learned how to do that in any of their nursing programs. (Participant 12)

Given the context of increasing complexity in the healthcare system, difficult decisions are required, and conflict is inevitable. Healthcare providers with creative conflict negotiation skills will be more able to resolve tensions that arise than those who avoid and or “give in” to conflict.

### **System/Organization Application**

Four central themes were related to application in the system/organization domain: (a) infrastructure, (b) client centered care, (c) responsive to community and partner needs, and (d) research. These themes will be addressed in the following sections.

**Infrastructure.** Participants noted the importance of leadership in setting a tone for integrating cultural competence throughout a system/organization. Strong leadership was found to be essential as it can help elevate the priority of cultural competence within the organization, drive systematic efforts, and inspire staff support. Cultural competence was found to

be an important aspect of client care, as well as for building strong relations among workforce that often includes large rank and class differences.

Furthermore, participants noted the need for infrastructure to link standards, behaviors, and performance appraisals in order to give rise to “institutional accountability” for culturally competent practice. (Participant 12)

Chrisman (2007) described the role of system leadership this way:

There is broad agreement among those who toil in the cultural vineyard that this is a lonely, difficult, and sometimes thankless position. Champions within organizations should be identified and supported. This is a leadership decision related to the institutional commitment to cultural competence. (p. 8S)

Generating a critical mass of cultural competence within a system/organization was thought to reinforce the use of culturally competent care. In this type of environment, colleagues could find support from a workforce comfortable in dealing with a variety of cultural backgrounds, creating a norm of “culturally appropriate care for all.” (Participant 11)

**Client centered care.** Several participants noted that client centeredness in the system/organization domain is a significant paradigm shift which refocuses the healthcare provider role from “cultural broker in service to the healthcare system” and “bringing clients into the ways of the system” (Participant 8) to organizing system resources and personnel around clients rather than around “specialized departments” (Participant 3). This shift

transferred the responsibility for change to the system rather than leaving it with clients and families. One participant noted that this paradigm shift requires different skill sets from providers and systems:

In clinical rotations we teach biomedicine. We don't teach communication, we don't teach understanding the patient's perspective, we don't teach compassion and humanity. And all those are pretty basic things. So from that perspective...I think the patient-centered care movement is pushing that agenda. We need to teach people to be compassionate. We need to teach doctors to understand their own biases and we need to pay attention to things like health literacy. (Participant 3)

At the same time, several participants raised concerns regarding the rush to incorporate cultural competence that they stated led to premature and simplistic solutions to very complex issues. One participant stated it this way:

I think that the cultural competence movement is going too fast. It's going too fast in the sense that people...want something now, so there's a mandate, so people say do something and people are grabbing whatever they can. I get requests from people do you have any Web-based stuff Can you do something...because then we can check the box." (Participant 3)

When quick solutions are sought for issues related to the complex, multidimensional nature of cultural competence, the result is short-term at best. Short-term thinking, however, makes the goal of cultural competence difficult if



not impossible, because effecting transformative change requires a long-term commitment. Leaders in healthcare and healthcare education must hold a vision for the long-term benefits of cultural competence in order to sustain them through the long journey from centrally fulfilling the needs of the system, toward a system that prioritizes client-centered care.

**Responsive to community and partner needs.** Participants discussed the importance of accommodating needs of specific populations and building effective partnerships with communities noting that there is no “one size fits all” solution, and that cultural competence is unique for each system/organization in relationship with the communities they are engaged with. Understanding the unique needs of specific communities was thought to contribute to providing safe, quality care, decrease health disparities, and engage community in sharing information and resources.

**Research.** Many participants contended that the argument for integrating cultural competence into systems/organizations has been weakened because of the lack of research that (a) demonstrates positive or negative consequences of a culturally competence system/organization and workforce, (b) expands our understanding of how to be culturally competent, and (c) examines cultural competence from the perspective of clients and families. Betancourt (2006) stated:

Much of the literature on disparities to date has focused on defining areas where they exist, but much less has been done to identify the multiple factors

that contribute to those disparities, and very little has been done to develop and evaluate interventions to address them. There is clearly a need for a research agenda that identifies promising practices and disparities solutions.

Academic medicine can be at the cutting edge of this agenda. (p. 6)

Participants agreed that more quality research is required in order to determine the essential components of cultural competence, how it is enacted in the intrapersonal, interpersonal, and systems domains, and its relationship to health and healthcare disparities. Furthermore, examining the collective voices of clients, families, and communities can help healthcare providers and systems to understand how to provide skillful culturally competent care for all.

### **Healthcare Education**

Data on healthcare education were voluminous, contained diverse thoughts and opinions, and were embedded within the larger context of the strengths and challenges that face the healthcare system and healthcare education today.

Participant recommendations were rooted in many aspects of higher education and healthcare education including discipline, undergraduate and graduate programs, traditional and non-traditional students, healthcare institutions across wide geographic sites throughout the U.S., and international study abroad programs. While each participant tended to emphasize a specific topical area over others, several themes consistently surfaced within the larger context of healthcare and healthcare education today. In the following section, the context

of current healthcare education will be addressed, followed by recommendations for integrating cultural competence into healthcare education.

### **Context of Healthcare Education**

Three themes described the context of healthcare education today: (a) complexity, (b) hard and soft science, and (c) meaning and application of cultural competence. These themes are discussed in the following paragraphs.

**Complexity.** The majority of participants spoke repeatedly about the complexity that faces the current healthcare system including healthcare education. One participant stated succinctly that we are facing a “future that looks very different than our past...the future is basically permanent white water...no still water” (Participant 15).

Participants consistently discussed specific factors that impinge on, and add complexity to, healthcare education including (a) a growing knowledge base across disciplines (Participants 3, 8, and 9), (b) contemporary technology to understand and master (Participants 5, 17, and 18), (c) competing priorities with other essential subject matter (Participants 7, 8, 9, 11, 18), (d) shortage of healthcare providers, (Participants 3, 5, 8, 9, 11, 18, and 20), and (e) accelerated education programs designed for students with previous academic degrees (Participants 3, 8, 9, and 20). In describing the significant complexity of healthcare education, one participant stated the need to understand the disparate priorities:

I think we as a community also need to understand that there are many, many competing interests for medical students, nursing students, and others, many things they need to learn, so we can't drive an 18-wheeler into a curriculum. We need to really think about how this [cultural competence] fits, where it's integrated, and we can't always think that our issue is the most important issue ever. I mean, we really need to balance this with the fact that there's a lot of important issues and a lot of people advocating for more teaching in genetics, more teaching in end-of-life care, more teaching in geriatric care, and everybody has a case for why teaching in their area is important, and so I think we need to think about how that [cultural competence] fits in with what else is done. (Participant 9)

Participants also expressed concern that providers in the current healthcare climate may become discouraged and unable to sustain their individual efforts toward cultural competence, becoming burned out in the process. Betancourt (2007) addressed the reality of current healthcare practice, and emphasized the importance of cultural competence this way:

It is really important that among the set of stresses that we face-the 15-minute clinical encounter, nursing shortages and needing to care for 25 patients in an afternoon-we make people understand that, in fact, cultural competence isn't a marginal skill. That this is really central to the work we do. And we need to empower doctors with a set of tools and skills that let

them fit that into the work-not just care about the patient band or computer-order entry as we see in patient safety. (p. 27S)

Clearly, participants were aware that cultural competence is one of many critical areas that compete for attention in both curricula and practice. Participants also believed that cultural competence could facilitate the work of clinicians who have multiple demands on their time.

**Hard and soft science.** Several participants expressed concern that despite compelling evidence of health and healthcare disparities in the U.S., and the espoused role of cultural competence to help eliminate disparities, that cultural competence is still viewed as a “soft science”, and therefore devalued by many healthcare systems, administrators, and educators. This devaluing was said to take place both in the formal curriculum where there is a paucity of cultural and cultural competence content and also reflected in what one participant referred to as the “the second curriculum” or informal curriculum (Participant 7). Betancourt (2007) described the perceived role of cultural competence this way:

Nevertheless, among administrators and leaders, it (cultural competence) is still seen as a soft science. It is often optional. Sometimes these courses are offered from 4:00-6:00 p.m. on a Friday afternoon, with no evaluation. This sends very powerful messages to learners about where this fits in your set of professional tools and skills and where it fits in your toolbox. (p. 27S)

Several participants discussed that healthcare education has shifted away from building relationships with clients over the past 50 years as biomedicine, technology, and quality improvement have moved to the forefront. As a result, a divide has developed between “hard science” and “soft science” with “hard science” being more highly valued. To clarify, “hard science” and “soft science” are terms often used when comparing fields of research or scholarship with hard being perceived as empirically based, and more rigorous, accurate, and objective. Within the context of healthcare education, topics such as pathophysiology and pharmacology are thought of as “hard science”, while therapeutic communication and cultural competence are thought of as “soft science”, implying less rigor, and therefore not scientific. Participants recommended an integrated blend of “hard” and “soft” science incorporating “skills beyond knowing the best treatments for diabetes to include the ability to communicate with and engage patients across cultures...and truly being responsive to all patients we see” (Participant 9). One participant addressed “hard” and “soft” science this way:

I think it's time that doctors become anthropologists. We have become scientists. It's very clear that being an ethnographer or being a good interviewer, even, is so much more valuable a skill than knowing the Krebs's cycle, right? We teach so much crap that is irrelevant and we don't teach how to get a patient on board. (Participant 3)

Participants identified the primary goals of cultural competence in healthcare education as (a) improving the provider's ability to understand, communicate with, and care for clients from diverse backgrounds, (b) enhancing provider's awareness of sociocultural influences on clients' health beliefs and behaviors, and (c) providing the skills for healthcare providers to understand and negotiate these factors in collaboration with client, family, and/or community.

Most of the participants who are also healthcare providers reflected on the disconnection between their own healthcare training and the goals emphasized from a cultural competence perspective. Participant 7 described his medical education experience this way:

I went to...medical school. And I was at that time very much involved in innovation in education. And when I got into medical school I was immediately shocked because I had not had much contact with the medical world before I got into medical school and I had just sort of thought about medicine as something that provides leadership...And I walked into the first week of medical school, here I had been involved with innovative education, and it was obviously a coercive, test-driven environment, which is great for learning certain things, but is really lousy for teaching leadership or innovation or anything beyond the most sort of brutal, cognitive learning...So I have some pretty strong feelings about what medical education could be. And I think it's one of the main reasons

I've had very little to do with academia over my life is because I don't see academia as a place where major innovation is happening.

Participants noted that students are inadequately prepared for practice in the future when educated in a system based primarily on “hard” science with minimal or no incorporation of “soft” science. Further, when participants noted that recent healthcare students have more global savvy than their cohorts of 50 years ago, at the same time, findings in a recent national survey (Betancourt, 2006) revealed that more than one in five resident physicians felt unprepared to deal with cross-cultural issues including (a) religious beliefs that may affect treatment, (b) clients who use complimentary modalities and treatments, (c) clients with health beliefs at odds with Western medicine, (d) clients with mistrust of the healthcare system, and (e) new immigrants and refugees. Given the dramatic shift in demographics in the U.S., this finding demonstrates an alarming disconnection between healthcare education as it exists today, and the dynamic changes needed in order to prepare healthcare providers of the future. Participant 9 asked the provocative question “Would we accept this low level of preparation for other key components of healthcare delivery?”

**Meaning and application of cultural competence.** Many participants discussed the continuing concern that the meaning of cultural competence remains unclear, that cultural competence means different things and manifests differently depending on the domain being addressed, and is interpreted, implemented, and evaluated in a wide variety of ways. Participants stated: “we



don't really have widespread agreement of what cultural competence is and what it means and what its components are" (Participant 3), the term is "thrown around too loosely" (Participant 2), and "implies more than is actually possible" (Participant 5). According to participant 9, this ongoing confusion has reaped the consequences of "negative visceral responses from a lot of different people".

The participants acknowledged the challenge in developing cultural competence content for healthcare education because of the variations in definitions and general lack of agreement on what cultural competence is, what its components are, and how to best teach, learn, implement, and evaluate it.

Though many participants acknowledged ongoing difficulties, two particular recommendations were made to help bring clarity to the field of cultural competence: (a) standards and evaluation, and (b) a national organization of cultural competence educators.

I think we as a community of leaders in this field need to be more flexible and understanding with each other and not afraid to come to some agreements on what our key principles in the field. I think evaluation is something that's a hot topic that people talk about a lot, which is how do you evaluate cultural competence, how do you evaluate whether somebody is proficient in this area, and I think people have struggled a lot with it. They have tried to use very universal tools to evaluate this. And again, it's tough to develop a tool if there isn't a consensus in the field, right? But the bottom line is, for the national movement to really take

root, we need to do more to come to some consensus on what are the key teaching objectives, learning goals, and then evaluate accordingly.

(Participant 9)

Five participants specifically described the important role the California Endowment, a private, statewide health foundation, has played in the development of cultural competence in healthcare education. Despite this support, participants stated that a formal group of cultural competence educators that is “able to meet every year and refine, review, and publicize principles would be a great advance” (Participant 9).

Finally, in order to be responsive to healthcare’s future, participant 3 described the need for radical transformation in healthcare education this way:

So we have created this culture, and everybody knows this...We make it an us-against-them kind of world...That's the culture. We take these students who are very altruistic, very highly motivated, and we turn them into these completely vile, medical thinking, dehumanizing people. So, before we can start talking about cultural competence, we have to fix that. Cultural competence is always going to be marginalized until we get past the notion that the best way to function is to be this automaton who basically gets all the work done really fast and loves procedures and can't wait to do their next central line. I think to change and go where we want to go, it has to be a pretty radical transformation. And it seems like an

unmanageable task, but there needs to be a culture shift rather than a curriculum shift.

Furthermore, one participant reflected on a different type of healthcare student needed in the future of healthcare education:

Traditionally, being a physician has much more to do with being a plumber and electrician than it does asking philosophical questions...and the detail with which we have to think about the plumbing and the electrical stuff gets more complicated every day. But I think if we realize the larger questions that healthcare also needs to be about and the kind of human skills that are required in connection to one's own body that's really required to be a healer, then we would select somewhat different people to go into medical school and into nursing leadership, and it would be a more demanding and complex personal and cultural kind of training process than it would be otherwise. (Participant 7)

Participants repeatedly acknowledged the complexity of healthcare education, yet emphasized the essential nature of cultural competence training for contemporary professional practice. Moving cultural competence from a marginalized to mainstream position in healthcare education was recommended in order to provide skillful cultural care to all clients.

### **Healthcare Education Recommendations**

Recommendations for integrating cultural competence into healthcare education came explicitly and implicitly through data analysis and coalesced

around four primary topical areas; (a) cultural competence content, (b) strategies, (c) role of faculty and infrastructure, and (d) evaluation and research. The majority of recommendations focused on cultural competence content, secondarily on strategies, and finally on faculty/infrastructure and evaluation/research. While there were much less data regarding faculty, infrastructure, evaluation and research, the text was nevertheless significant, and several participants identified these as essential foci for the future of cultural competence in healthcare education. Table 5 summarizes the key findings related to healthcare education recommendations.

Table 5. *Key findings of cultural competence education recommendations*

Content	Health disparities / healthcare disparities Context U.S. healthcare Intrapersonal Interpersonal Communication Conflict negotiation Client-centered care
Strategies	Spiral curriculum – 101, 201, 301, 401 Experiential learning Immersion – domestic and international Reflection Application of cultural competence to practice
Faculty / Infrastructure	Transdisciplinary faculty Faculty development Critical mass
Evaluation	Standards Research

## Content

Data analysis identified seven topical areas recommended for healthcare education content: (a) health and healthcare disparities, (b) U.S. healthcare context, (c) intrapersonal context, (d) interpersonal context, (e) communication, (f) conflict negotiation, and (g) client centered care. These topics will be described and illustrated in the following section.

**Health and healthcare disparities.** Participants noted a dichotomy between compelling evidence of health disparities and healthcare disparities and a recent survey of over 2,600 physicians giving direct patient care who were not aware of either the extent or the severity of racial and ethnic disparities in U.S. healthcare (Betancourt, 2006). Many participants emphasized the role and responsibility of academic centers to inform and educate future healthcare providers in order to eliminate health and healthcare disparities in the U.S. and worldwide.

If you measure this stuff and show that there's a problem, well, then, that's the fastest way to get people on board for a solution...so...whatever curriculum is out there, it has to start with looking at what the disparities in care are. It has to start with that because otherwise people are going to be like "this is fluff". Well, if you show them it's not fluff, show them the data, show them that there's evidence that we treat people in biased ways, well-thinking, well-meaning, altruistic professionals, treat people in different ways based on their race, their gender, their class...If you look at

population data and say look, it's happening everywhere, you can say it doesn't happen in my backyard, but you know what? It happens in your backyard, too. (Participant 3)

**U.S. healthcare context.** Several participants argued that healthcare education curricula should include critical examination of dominant U.S. culture so students can understand the U.S. and specifically U.S. healthcare as situated within a specific context with unique worldviews, values, and beliefs. Participants suggested elements include (a) geopolitic, and the role U.S. citizens play in ongoing domination of people throughout the world (Participants 7, 8, and 12), (b) exploration of privilege and power (Participants 6, 7, 8, 9, 11, 12, and 16), (c) national migration and diaspora (Participants 5, 9, 12, and 20), and (d) the underlying values of biomedicine (Participants 2, 3, 8, 9, and 12). Furthermore, participants advocated that healthcare providers become social activists, using intentional action to bring about social, political, economic and environmental change in order to challenge cultural operations that sustain health disparities and healthcare disparities in the U.S. and throughout the world (Participants 1, 8, 12).

**Intrapersonal context.** Participants advocated that healthcare education include "anti-bias, anti-discrimination, and anti-racism awareness" (Participant 16) in order to (a) help individuals understand the roots of personal values and beliefs, and (b) decrease healthcare disparities in the future.

Specifically, Participant 16 explained their approach to this topic in healthcare education:

One of the ways I...start is just making them aware...that they have biases and they shouldn't run from those or be ashamed. They are not endemic to the species, but it's part of our social learning, part of our formal learning, part of the imagery that we are exposed to. We know who should be flying the plane and we know who should be serving the drinks, right? We know who should be making the incision and we know who should be bringing the bedpan, right? That's such a big part of our upbringing.

One participant noted that stereotypes are more likely to come to the forefront when healthcare providers are "stressed, multitasking, and under time pressure" - all hallmarks of a clinical encounter in today's healthcare system (Participant 9).

**Interpersonal context.** Participants recommended exploration of "cultural filters" (Participant 3), "distinction between disease and illness", (Participant 9), "how a client understands their illness and the illness experience" (Participant 16), in order to appreciate the complex ways that culture shapes interpretations. Understanding another from within a specific context was thought to develop empathy in healthcare providers, and enable them to work with others from a place of understanding and compassion rather than judgment. Furthermore, Gray (2006) advocated a constructivist approach in

examining the processes whereby some groups are defined as different, marginalized or vulnerable. This approach was intended to bring about the possibility of individuals relating to each other with conscious awareness of the identity constructions that shape our understandings; constructions that to a large extent, determine the nature of our relationships with each other.

**Communication.** Achieving effective communication skills was found to be a vital component of cultural competence training, and was emphasized numerous times throughout the data. One bicultural healthcare provider stated this:

Some of my personal experiences made it obvious, but then embarking on medical training and getting into the culture of medicine where really the emphasis for students and trainees is much more on the biomedical and knowing the 5 best medicines to treat hypertension, whereas very little emphasis is placed on important communication and even less on the importance of cross-cultural communication despite the fact that in real practice you realize very quickly that you can know all this medical knowledge, but if you can't communicate with a patient, you can't get them to buy into a treatment plan or buy into what you have to offer from the medical standpoint, all is worth nothing. (Participant 9)

The majority of participants emphasized the need for healthcare providers to develop proficiency in communication, including whole body communication, in order to effectively demonstrate cultural competence in the healthcare arena.



**Conflict negotiation.** Participants recommended that conflict negotiation be a required topic in cultural competence curriculum, noting that cross-cultural interactions are complex and can generate conflict between individuals with widely different worldviews and behaviors. This skill set was described as benefiting relationships between healthcare provider and client/family, as well as relationships of all types within a healthcare setting (Participants 3, 8, 9, 10, 11, 12, 16 and 17).

**Client centered care.** As healthcare provision is moving from a paradigm of medical authority to a more responsive paradigm of client centered care, participants noted that major shifts will be needed in our healthcare education systems. While traditionally the role of healthcare provider was to help the “patient cope with the existing system” (Participant 8), and “get the patient on board” (Participant 9), the focus from a client centered perspective is to become an ally, and create systems that are responsive to a variety of needs, including “negotiating culturally sensitive and mutually acceptable interventions” (Participant 20).

Participants note that this shift will take major cultural changes in the healthcare education system, what Benner, Stuphen, Leonard and Day (2009) term “radical transformation”. This transformation is needed in order to identify incongruities between what currently exists and a vision for the future of cultural competence. These changes may not be well-liked by some, and will require an awareness of the existence and impact of power and privilege in the existing

system, and a letting go of the status quo in order to allow for innovative change. This transformation will likely bring discomfort and fear, and therefore will need to be approached with sensitivity.

### **Strategies**

Four particular strategies, approaches, or learning tools were discussed by participants to support and enhance cultural competence learning in the healthcare education environment: (a) spiral curriculum, (b) experiential learning, (c) reflection, (d) application of cultural competence to practice. The following section will provide an overview of these strategies and their anticipated use in healthcare education.

**Spiral curriculum.** Many participants advocated for a systematic spiraling of cultural and cultural competence content throughout the healthcare education curricula. A spiral curriculum, according to Harden and Stamper (1999) includes reinforcing content by revisiting a theme at ever deepening and complex levels over time. One participant expressed this concern:

For cultural understanding...you take one class and that's it...you don't get the full depth and breadth of how one needs to remain open to a more dynamic systematic progression of learning and you leave it to the accountability of the individual and there's very little accountability on the institution to retain the integrity of a developmental process. Instead it's you take this course and you satisfy some criteria. (Participant 6)

Another participant reflected a similar sentiment:

I've never seen it [done] well, this is cultural competence 101. You're a nurse, you're a doctor, you're at this institution, we are going to do this, and then we are going to do 201 and 301. We are going to keep going on it. It seems like it's always kind of a one-shot deal or repetition of the same thing rather than a deepening of the concept. (Participant 14)

When successive encounters with culture and cultural competence in the healthcare curriculum build on previous knowledge and experience, mastery at one stage can be carried to a new level of complexity with the next encounter. This intentional design can help ensure that healthcare students are prepared for professional practice with a sophisticated understanding of, and experience with, culture and cultural competence.

***Integration versus stand alone course.*** How a systematic deepening of cultural and cultural competence content could be best implemented varied depending on the participant. However there was agreement that the strategies used must be respectful of the many challenges that healthcare education faces such as time limitations, competition with other important content areas, accelerated education programs, and faculty shortages.

Participants who advocated for an integrated approach, or weaving “cultural threads throughout each course and level” (Participant 20) stated that this approach was efficient and effective in times of faculty shortage. Limitations to this approach included faculty members in subsequent courses adhering to covering cultural content, and more specifically having the knowledge and skill to

adequately address cultural content. Furthermore, integration and revisiting the content with increasingly complexity was thought to enhance the standing of cultural competence as an important topic and not be seen as separated or an add-on to more traditional content. One participant advocated for a short-term plan until faculty can be hired or trained in this specialty area, and culture and cultural competence could be fully integrated throughout healthcare education curriculum. He stated:

In the interim, though, I think there is a role for stand-alone curricula as long as they are done right. But I think there is a stronger role for integration. (Participant 3)

Advocates of separate or stand-alone cultural courses felt that integration of cultural and cultural competence throughout a curriculum diluted the content.

One participant expressed discouragement over watching this take place:

You might say I'm becoming somewhat disillusioned with the whole aspect of teaching culture in nursing. And I see it deemphasized as a specific content area. What I see happening in it is it's being integrated, and, as you well know, when you integrate something, it's the first step to losing it. So I guess the question I ask myself is has all of these years that you have put into it made a difference? And I honest to God can't tell you if it has. (Participant 20)

The debate of integration versus stand-alone courses is currently being addressed in many aspects of healthcare education including cultural

competence. This ongoing dialogue may reflect a growing uneasiness throughout healthcare education at the complexity of the current system and an awareness of the multiple critical skills required for contemporary professional practice.

**Experiential learning.** All of the participants who addressed effective education strategies agreed that experiential learning helped to embed cultural competence learning more effectively than didactic information alone. One participant stated this:

So therefore the question is how do you train people to be culturally competent? And my answer is you cannot do it intellectually. It's not an intellectual activity, it's an experiential activity which then has intellectual components, and so you have to be in a situation in which you are not in control of the events and therefore you have to learn how to survive by doing things differently than you normally do it and changing your cues.  
(Participant 15)

While one participant boldly suggested "every student should have to live on a hospital ward for three days" (Participant 3), most participants recommended other types of experiential learning such as simulation to enhance the ability to understand the client's perspective including aspects of economic, political, and system contexts that affect a client's ability and/or willingness to carry through with treatment recommendations or maintain cultural beliefs and practices. Building these skills was thought to be foundational in moving from a paradigm of biomedicine to one of client-centered care.

That's really the way to teach empathy. You can teach how to behave empathetically, but to actually create the attitude of empathy...you have to use approaches that actually let you imagine yourself in this person's shoes, which, it turns out, does work...Actual workshops where people work with students and say try to imagine you're in the other person's shoes and then you have a discussion about what it is like to be in that person's shoes. There's research to show that those people do become more empathetic, they actually take on more affective empathy. So you can change attitude, even through discussion, but I think if you actually put someone in someone's shoes, and that's why I think the idea of becoming a patient is so powerful because you don't have to imagine what it is like to be in that person's shoes, you know what it is like because you have been there. And it's silly, really, that we don't do that.

(Participant 3)

Experiential learning was found to enhance the development of empathy, which involves not only understanding another's feelings, but also a level of self-awareness that enables an individual to demonstrate this understanding to another. Furthermore, experiential learning can lead to what Myrick & Tamlyn (2007) refer to as "connected knowing" which builds on the notion that the most trustworthy knowledge is derived from personal experience.

***Immersion experiences.*** Several participants also recommended immersion experiences, both domestic and international, as an important aspect of experiential learning. Immersions were thought to give students the lived experience of being an “outsider” within an experience of a host community, that could “actually make people see what it is like to live in a minority community or a disadvantaged community and sort of see what the health system looks like from their perspective” (Participant 3).

It seems to me that when we have immersion experiences, especially abroad, (students) have to think on their feet...those experiences make a lasting impression. And sometimes we don't see that immediately, but you hear about it later on through alumni surveys, or students will write and say they really now understand the importance of culture when they are heading up their own areas, or after they come back from immersion experiences. I think once you start an immersion experience and you strip them of all their own cultural crutches, they can't leave and come back to their own places at night and experience their own culture, I would just love to see more of that. (Participant 5)

While immersions were highly recommended as a learning opportunity for healthcare education students, one participant cautioned that going abroad did not in itself constitute a valuable cross-cultural experience. He stated:

One of the reasons I think we send people overseas is to get a cross-cultural experience...Just to study overseas and travel overseas usually

doesn't lead to developing any kind of cross-cultural-cultural competence. And it seems as if it does, but it doesn't. They (students) tend to live with other Americans and they speak English all the time. They study in special programs for Americans and they travel as tourists...But they have an experience, which is looking at buildings and things of that nature and looking at places, which is interesting, but they are not developing cross-cultural competence. (Participant 15)

Both domestic and international immersions, when designed, implemented, and evaluated thoughtfully, were found to meaningfully enhance the development of cultural competence.

**Reflection.** Participants recommended reflection, both individual and collective, in order to gain insight and discernment into experiences and deepen understanding of the experience from alternate perspectives. One participant described this process as a “second order change” or a transformational change in a way of understanding (Participant 1). Another participant stated this:

Experience by itself is not necessarily learning. It's only the reflection of the experience so it becomes integrated within one's own conception of reality. That's where the learning really is significant. And so it's a constant pushing people to reflect deeply on the experience. And I would say that what we don't do well in higher education is that we don't bring people who can help the students reflect from that culture in to work with us in the educational environment. (Participant 15)



Lasater and Nielsen (2009) noted that faculty guidance can enhance the development of reflective skills in students until they are comfortable with the process on their own. Importantly, participants also noted that reflection took time and that taking such contemplative time was countercultural in our fast paced, multi-tasking, production focused healthcare environment.

**Application of cultural competence.** Most healthcare educators, particularly nurses, recommended that healthcare education begin shifting cultural and cultural competence content from primarily didactic information to including measurable objectives for clinical application.

We just teach a 2-hour course, one semester, and it doesn't have a clinical component to it. And while our students are very bright and they are very good, I don't believe they can always make that application just by sitting in class and listening to a lecture about culture...If you look at most of our clinical objectives, in most baccalaureate programs across the country there are not specific objectives for cultural competency in our expectations of students in clinical practice. The link simply is not there.

(Participant 18)

Linking didactic learning with clinical application can help in the formation of healthcare professionals by developing increased proficiency in cultural competence through practical experience.

## Faculty and Infrastructure

Participants made three particular recommendations regarding faculty and infrastructure: (a) transdisciplinary faculty, (b) faculty development, and (c) critical mass. These recommendations will be discussed and illustrated in the following section.

**Transdisciplinary faculty.** Participants noted that schools vary in the amount and quality of cultural content in curriculum based on faculty expertise. Several nursing educators noted concern that “nursing xenophobia” (Participant 11) or the current trend to require PhD’s in nursing limits innovation in healthcare education brought about by transdisciplinary expertise.

Transdisciplinary can be thought of as multiple disciplines converging to address a single topic, such as cultural competence. Using a transdisciplinary approach can bring about a more holistic view than any single discipline alone.

Participants noted a disconnection between faculty who teach using the ways they were taught, unwittingly training students to adapt to the status quo, and the new skill sets required by healthcare providers in contemporary practice. One participant recommended partnering with social scientists and anthropologists to improve the client centeredness and cultural competence of healthcare educators and students. He stated:

So we say you have to have a Ph.D. and you have to have this number of years of experience in publications and then you can be a real faculty member, right? Whereas, in terms of learning cross-cultural competence,

you need the intellectual kind of capabilities of a faculty member, but you also need the real cultural knowledge that can only exist in the educated people from these communities, who can work with the faculty...The problems with the faculty member is they themselves may not be able to understand what's going on. So it's a joint working together with, say, a relatively well-educated Somali person or a Chinese person with the faculty member together getting the students to reflect in a group setting, which would be the most powerful way of educating. (Participant 15)

Finally, another participant gave an example of learning from a cultural expert, a gay, HIV positive, physician during her medical training early in the AIDS epidemic.

He taught sexual history and demonstrated how he asks gay male patients about their sexual history and practices...He leaned back and said "all right, you slut, tell me what you do"...And without being explicitly about cultural competence, it was totally about cultural competence...that combination of somebody who was himself a representative of a particular culture...that was an incredible privilege to be able to watch that.

(Participant 14)

Participants recommended using transdisciplinary faculty teams, including educated community members, to enhance innovation and generate a more holistic approach in the educational endeavor toward cultural competence.

**Faculty development.** Participants advocated for faculty development in cultural competence including developing programs for mentorship and role models within healthcare education. Participants acknowledged again that healthcare and healthcare education has moved toward biomedicine and technology as the most necessary skill sets in healthcare, often at the expense of other essential content such as communication skills. Bentencourt (2007) observed:

The importance of the person in clinical care...we've lost a lot of that in medicine, and probably in nursing as well, as biomedicine has become the sexy issue and is seen as the necessary skill, and the rest-such as communication-is just soft science. (p. 27S)

Faculty development was found to be an essential first step in generating a critical mass of cultural competence and thus creating a genuine and lasting change in healthcare education systems. Such changes, according to Myrick and Tamlyn (2007) are thought to "foster a spirit of inquiry, an independence of thought, an ability to question prevailing assumptions, and a confidence with which to meet the complexities of a dynamic healthcare system" (p. 301).

**Critical mass.** In order to develop a critical mass of cultural competence in healthcare education, leadership must actively engage in the process and lend their power to shape organizational culture and set examples that will inspire others and bring them along. Faculty development and personal change combined with institutional standards and accountability for cultural competence

were thought to lead to a critical mass of cultural competence within a larger healthcare or healthcare education system. This critical mass was thought to shift cultural competence from a marginalized to mainstream topic in the curriculum and develop a set of expected behaviors to be enacted by individuals at all levels of the system/organization. Chrisman (2007) observed that a critical mass of cultural competence could “promote greater unity of purpose and action” and:

Increase opportunities for formal and informal reinforcement of appropriate professional behavior. Experience by one or a few will reinforce the behavior of others. When the majority of clinicians on a unit feel relatively comfortable with patients from different cultural backgrounds, the norm is culturally appropriate care of all. The [provider] who is uncomfortable with such a patient will have a lot more support from colleagues to work with the person and to grow at the same time (p. 2S).

While factors such as budget and leadership change can slow and even reverse the progress of developing a critical mass of cultural competence, efforts must continually engage dominant groups in an ongoing dialogue to address promising practices in developing an environment prepared to incorporate cultural competence principles throughout all aspects of a system.

### **Evaluation**

Because U.S. healthcare is a measurement culture, many participants advocated for evaluation of cultural competence as an essential next step.

Evaluation was expected to facilitate the national cultural competence movement to “take root”, moving from a marginalized to mainstream position in healthcare education and practice. One participant stated:

When the healthcare policy makers in the U.S. say how do we know cultural competence works, to actually be able to show studies with multiple indicators to say that it does make a difference and here is how it makes a difference. (Participant 1)

Rigorous, systematic, longitudinal studies are needed in order to study the many aspects of cultural competence that influence healthcare systems and healthcare delivery.

**Standards.** While some participants advocated for clear cultural competence standards similar to what is available for medical outcome measures, others felt that cultural competence was a much more diffuse type of knowledge, and at best, difficult to measure. One participant stated this:

I think it's difficult to measure and determine what is a culturally competent person and what is a culturally competent environment. There is no one standardized model...it's appreciating that programs and people are processes that are always in development...they are constantly dynamic and changing by generation, by migration, by legislation...I think it (cultural competence) doesn't address some of the impediments that have been historical in our society, that remain, the institutional, interpersonal, and internalized aspects of racism, discrimination,

stereotyping, bias, many of the things that the Institute of Medicine's report highlighted around our healthcare system. (Participant 6)

One participant recommended coming to consensus as a first step toward developing cultural competence standards. He stated:

“We need to do more to come to some consensus on what are the key teaching objectives, learning goals, and then evaluate accordingly”

(Participant 9).

Finally, another participant described the need for clinical objectives in order to move cultural competence from the realm of cultural information into clinical practice. She stated:

I really believe we are past the point where we need to stop talking about cultural competence and begin to see if we can measure it now.

We can write objectives for clinical practice that we can then evaluate students against. And I think as an educator I look at measuring it that way, but I think also we could begin to think about how we might measure it in groups of patients. (Participant 18)

Responses regarding the implementation of standards were mixed. On one hand, participants advocated for standards; on the other hand, cultural competence was perceived a dynamic multidimensional process, and therefore difficult to encapsulate in a single set of standards.

**Research.** While the literature on cultural competence has increased exponentially in the past 20 years, participants noted that the lack of quality

research evaluating the effectiveness of cultural competence in healthcare education diminishes the credibility of cultural competence in the current healthcare climate. One participant stated:

Undoubtedly, this lack of evaluation sends a clear message to students and residents about the level of importance of cultural competence—if it is not evaluated, it must not be important. (Participant 9)

Participants recommended that research include systematic interventions and longitudinal studies in order to evaluate the long term effects of cultural competence education and to establish “a common base of understanding...that could help give us a macro understanding of [cultural competence]”.

Finally, Chrisman (2007) recommends research on activities of teaching, or pedagogical research:

More pedagogical research is needed...Just as culturally competent practice diverges from traditional practice that did not take culture into account, so our pedagogical approaches need to be more innovative and flexible to move our students toward new practice directions. (p. 75)

Participants emphasized the need for development of educational interventions, evaluation tools, and pedagogical research in order to move toward practical application of cultural competence in healthcare education.

### **Summary of Findings**

Awareness, engagement, and application were central themes that applied, albeit differently, across four domains of cultural competence: intrapersonal,



interpersonal, system/organization, and global. While the themes are interconnected, awareness was seen as a precursor to the other two themes of engagement and application.

Awareness, characterized as conscious knowledge and discernment, appears to rely on reflection and includes examination of central influences including context, situatedness, and underlying assumptions (e.g. who constitutes "us" and who constitutes "them"). This process was germane across all domains of cultural competence.

Engagement appears to rely on receptivity and manifests in three phases: intention, process, and outcomes. Engagement consists of thoughtful consideration in combination with action. The intention or desire to engage is a precursor and consequence to the process of engagement. Desired outcomes of engagement included empathy, connectivity, and high-quality relationships.

Application appears to rely on responsiveness and to require different thinking at different levels; using attitudes, knowledge, and skills toward the "operationalization" of cultural competence. Application was implicitly found to spiral back to awareness and engagement, thus allowing for refinement and meaningful change.

Healthcare education recommendations addressed four main areas: (a) cultural competence content, (b) educational strategies, (c) the role of faculty and infrastructure, and (d) evaluation. These topics will be summarized in the following paragraphs.

Understanding the complexity of the current healthcare system including an expanding knowledge base, mastering technology, competing priorities with other educational content, provider shortages, and accelerated programs were all identified as challenging in the reality of our current healthcare and healthcare education systems. Nevertheless, cultural competence was identified as an essential skill for care provision in contemporary practice.

Recommended cultural competence content included presentation of health disparities and healthcare disparities as identified in the IOM's 2002 report *Unequal Treatment*, including an examination of the context of U.S. healthcare including underlying values, beliefs, privilege, and power. In addition, critical examination of the intrapersonal and interpersonal contexts in which attitudes, values, and beliefs develop was recommended in order to bring about an understanding of the underlying yet often unconscious and therefore unexamined ways in which bias and prejudice develop. Other essential content included effective communication and conflict negotiation in order to enhance client-centered care.

Recommended strategies included a spiraling of cultural competence content throughout the curriculum. Spiraling included deepening the content when revisiting the topic, with each successive encounter building on the previous one. In addition, experiential learning in combination with facilitated reflection, along with domestic and international immersions were recommended

in order to move cultural content from an intellectual “knowing about” culture into an experiential or embodied understanding.

Participants recommended that cultural competence content be co-facilitated by transdisciplinary faculty as well as by educated community experts. It was this combination of expertise that would bring about greater breadth and depth in content area than healthcare educators alone, who have widely varying experience and commitment to this content area. Further, faculty need to have the skills to guide students in exploring their experiential and reflective learning experiences – for making sense of seemingly disparate perceptions and views. In addition, the role of a supportive administration and infrastructure were noted as essential for developing faculty expertise through faculty development, for elevating the importance of this content area, and for developing a critical mass of cultural competence in the healthcare education system.

Finally, participants recommended the establishment of a national organization of cultural competence educators in order to come to consensus on key teaching objectives and learning goals of cultural competence in healthcare education. This essential first step would help the profession move toward effective measurement, evaluation, and research of cultural competence and cultural competence outcomes in the future.

## **CHAPTER FIVE: DISCUSSION**

### **Summary of Key Findings**

Participants in this study viewed cultural competence as primarily relational in nature and requiring certain proficiencies, which include (a) attitudinal, behavioral, and intellectual flexibility; (b) skillful communication; (c) understanding context and situatedness; and (d) conflict negotiation. They found these relational skills to be at odds with, and undervalued by, traditional healthcare education and healthcare systems.

### **Discussion**

Several findings from this study have been reported in the literature while some themes represent new ideas. Three possible explanations for the overlap between study findings and the current literature come to mind. First, several prominent authors in the culture and cultural competence field were participants in this study. Subsequently, a portion of the interview data echoed previously published literature as discussed in Chapter Two. Second, the field of cultural competence has matured over the past 20 years, and the growing body of literature and the thinking of professionals in the field have, to some extent, coalesced. Third, the lack of international cross-pollination may have contributed to similar ways of conceptualizing and considering cultural competence.

### **Themes and Domains**

Although each theme and domain has been addressed to varying degrees in the literature (e.g. Lenburg, et al., 1995; Meleis, Isenberg, Koerner, Lacy, &

Stern, 1995; Stetler & Dienemann, 1997), the data from this study are unique in combining and expanding these themes and domains into one dialogue, emphasizing their interconnectedness.

Cultural competence is a fluid, dynamic process progressing from themes of awareness to engagement and application and back again at ever-deepening levels across four domains. The emphasis on awareness of context in the intrapersonal, interpersonal, and system/organization domains, addressed in the last chapter, adds a critical and multidimensional component to the development of situatedness of individuals, systems, not often found in the current cultural competence literature. While there was a paucity of data in the global, or fourth domain, it was identified as an area for further exploration.

### **Relational Nature of Cultural Competence**

The traditional ways of conceptualizing, teaching, and learning cultural competence as a finite body of knowledge are both superficial and inadequate for the sweeping social and demographic changes occurring today. The findings affirm others' ideas regarding knowledge in and of itself as insufficient for genuine understanding. Munhall (1993) considered knowledge alone to bring about a false sense of security, a state of closure that blocks new discovery and relationship with others, and Reason (1993) referred to cognitive knowledge as the "barrenness of the isolated intellect" (p. 6). Healthcare education's focus on the biomedical aspects of science and technical procedures over the past 50 years, while essential, is insufficient and limiting for healthcare professionals who

work with clients, families, and communities, and ineffective in supporting the development of cultural competence.

The findings identify that a central aspect of cultural competence is the ability to build high-quality relationships across all domains. This more complex and dynamic understanding of cultural competence includes the integration of the cognitive, relational, emotional, practical, aesthetic, and spiritual aspects of human experience. Scholars (e.g. Beddoe & Murphy, 2004) have repeatedly found that relational aspects of care such as compassion and empathy are far more related to affect than to cognition. This framework is consistent with the study findings, which emphasized intellectual, attitudinal, and behavioral flexibility, skillful communication, and conflict negotiation skills as more important than culturally specific information.

While the intrapersonal domain of cultural competence is acknowledged in the literature as important and relevant (e.g., Bennett & Castiglioni, 2004; Davis, 2001; Hassouneh-Phillips & Beckett, 2003; Kleinman, 2006; Yan & Wong, 2005), there remains a lack of consensus in several areas: the instructional context in which self-awareness is best supported; strategies for achieving self-awareness; and the varying capacity, propensity, and/or desire of individuals to develop self-awareness. Further, consensus is lacking regarding application of self-awareness in the clinical encounter, observable behaviors that demonstrate self-awareness and subsequent evaluation methods for studying the impact of self-awareness on cultural competence in specific clinical encounters. This study added new

knowledge to the intrapersonal aspect of cultural competence by identifying two divergent avenues for developing intrapersonal cultural competence: (a) internal transformation manifesting in behavioral change and (b) external or behavioral actions which lead to the possibility of transforming the internal experience of difference. Further research is needed on how these two divergent yet complementary approaches may lead to cultural competence.

### **System/Organization Cultural Competence**

System/organization cultural competence has a broader range of influence and possibility for bringing about significant change (e.g. elimination of health disparities and healthcare disparities) than cultural competence at the interpersonal level alone. This expanded perspective brings about a new vision of cultural competence wherein diverse healthcare providers work effectively with diverse clients, families, and communities sharing knowledge while learning from and with clients. In addition, recognizing, acknowledging, and challenging the many forms of oppression present in society at large and specifically within the healthcare system is necessary to eliminate injustice, health disparities, and, therefore, unnecessary human suffering. Starting from the 'top down' (e.g. administration), linking organizational policies, procedures, behaviors, and performance appraisals sets the "tone" of an organization and is required to meet the needs of diverse clients, families, and communities, in settings where cultural competence is the expected norm. At the same time, developing a "critical mass" of employees who demonstrate and expect cultural competence in

self and co-workers provides a framework of support in developing a skilled workforce that is effective with diverse groups. These 'top down' and 'bottom up' expectations can also support building high-quality relationships between healthcare centers and surrounding communities.

The study finding emphasizing system/organization cultural competence mirrors the current professional literature, which over the past 20 years has moved from a primary focus on the interpersonal aspects of cultural competence to a more systemic perspective recognizing health disparities, healthcare disparities, and social determinants of health as associated with how clients are viewed and treatment processes and decisions made (cf. Betancourt, 2004; Cortis, 2003; de Ruiter & Saphiere, 2001; Dean, 2001; Dreher & MacNaughton, 2002; Gustafson, 2005; Hixon, 2003; Hunt & Voogd, 2005; Koehn & Swick, 2006; Wear, 2003).

### **Limitations**

When weighing the value of the results of this study, several limitations are noted. Of greatest impact is the limited method for data collection. Participants were interviewed once. Additional interviews could have strengthened the quality of the data by providing opportunities for the investigator and participants to more fully explore ideas from the original interview data. While analysis of participants' recent publications provided an opportunity to confirm and elaborate on ideas from the interview data, additional



interviews may have expanded on and added to the trustworthiness of the findings.

Additional limitations exist. First, several of the participants are colleagues to one another. They see each other at meetings and conferences and have published together. Some of the ideas relevant in the findings and professional literature have most likely been discussed among the participant network previously. Although this does not negate the importance of the findings, it may have skewed the findings.

Another limitation results from the fact that cultural competence is a complex and multidimensional area of study. Because of this complexity, there are no simple strategies for its development, implementation, and/or evaluation. Therefore recommendations for promising practices may have limited efficacy depending on the context in which they are applied. Each system, including healthcare and healthcare education systems, must identify the unique needs of the populations it serves and assess how well it is meeting these needs through the current systems via a multidisciplinary team with expertise in culture and cultural competence.

Another limitation concerns the fact that approximately half of the participants were raised and formally educated in the U.S. giving them a specific context from which they created individual meaning regarding cultural competence. Interviews with five non-native U.S. participants helped to counter the bias of U.S. educated scholars. Another limitation has to do with language

and culture, as two participants had limited English proficiency (LEP) and lived and worked outside the U.S. Using a non-native language can be difficult when trying to express precise details and nuances of meaning. Furthermore, different cultures implicitly ban specific topics that may be important in the development of cultural competence.

Efforts to ameliorate the limitations included analysis of participant publications as a strategy to confirm and elaborate on findings from single interviews, purposeful inclusion of non-native U.S. residents as participants, and investigator efforts to summarize and seek feedback on ideas expressed by participants with limited English proficiency.

Despite the above-mentioned limitations, the findings of this study are significant and contribute to the growing body of knowledge related to the development of cultural competence in the intrapersonal, interpersonal, system/organization and global domains. Particularly significant are the following ideas: the primacy or centrality of developing awareness of context of self, other, and systems; the relational nature of cultural competence; and the need for transformational changes in healthcare education to prepare culturally practitioners, and healthcare systems that value and expect cultural competence in healthcare professionals.

Recommendations related to integrating cultural competence into healthcare education reflect recent trends toward transdisciplinary education, constructivist pedagogy, and transformation of the academic educational

environments (Giddens, 2008; Hallin, Kiessling, Waldner, & Henrikson, 2009; Hassouneh, 2006, 2008; Hassouneh-Phillips & Beckett, 2003; Hunter & Krantz, 2010; Macfarlane et al., 2008; Christie et al., 2007). In addition, curricular modifications are based on disciplinary concerns related to preparing future clinicians for contemporary practice in a globalized world (IOM, 2002; Koehn & Swick, 2006).

### **Implications for Further Study**

There is no longer a question whether cultural competence should be integrated into healthcare education. Instead, it is more crucial to healthcare delivery than ever before. At the same time clinicians also struggle to achieve competency in other essential areas including genetics, chronic illness management, and gerontology, while, technological advances, workforce shortages, and economic factors create pressures on both healthcare education and delivery. Educators, both administrators and faculty, are exploring ways to best integrate cultural competence into curriculum in order to prepare students for contemporary professional practice and leadership roles in our globalized society.

There are no simple solutions to the challenges inherent in the complexity of culture and cultural competence, including how they are conceptualized, taught, learned, applied to clinical practice, and measured including their impact on health and healthcare disparities and health outcomes. However, four areas for research are recommended: (a) faculty development, (b) spiraling of cultural

competence content, (c) relational skill development, and (d) development of global competencies.

### **Faculty Development**

The data on the benefits of a diverse workforce are compelling and indisputable. Diversity is thought to generate intellectual, cultural, and civic development as well as enhance team creativity, problem solving, and innovation. However, despite decades of targeted programs, minorities of all types are still vastly underrepresented among healthcare faculty of all ranks (Sullivan & Mittman, 2010). The literature reports that an inhospitable academic climate, institutional racism and discrimination, a limited view of professionalism and scholarship, inadequate mentoring, isolation of minority faculty, and low salaries have resulted in healthcare education's bleak record in recruiting, relating to, and retaining diverse faculty (Hunter & Krantz, 2010).

In order to reverse this detrimental pattern, developing an organizational climate of inclusion, understanding, and appreciation of a broad range of human experience can enhance an environment and make it welcoming to widely varying dimensions of difference. Supported by leadership, policies, and the resources of an academic institution, faculty development in cultural competence can bring about a change in the healthcare educational environment and provide a more accepting and respectful atmosphere for difference. Healthcare education students are best served by a group of faculty proficient in enhancing cultural competence. Creating a critical mass of healthcare education faculty who can

develop, support, and sustain cultural competence attitudes, skills, and behaviors can in turn create a critical increase in healthcare education's capacity to work effectively with diverse faculty, students, clients, families, and communities.

Myrick & Tamlyn (2007) note that although the trend in healthcare education involves the promotion of critical thinking and reflective ability, rarely has attention been focused on the ability of healthcare educators to be critically reflective of their own teaching. Faculty must examine their own taken-for-granted assumptions about culture, cultural competence, and the teaching-learning process. In challenging traditional assumptions, they can also challenge their usual ways of thinking about the world. This idea reinforces the need to build on intrapersonal cultural competence in order to develop interpersonal and system/organization cultural competence.

Both practical and philosophical reasons support a concerted effort toward faculty development in cultural competence. The practical reason is that health disparities, healthcare disparities, and social determinants of health are part of everyday healthcare practice, yet often go unexamined. Philosophically, we cannot expect our students to be what we ourselves are not willing to become. A group of skilled, diverse, transdisciplinary healthcare faculty with a complex understanding of culture and cultural competence will be better prepared to lead students into contemporary professional practice and leadership roles. Research is needed to develop reliable and valid measures of cultural competence, effective strategies to connect conceptualization, theory, teaching, and learning,

and to develop the skills of self-discovery in faculty in order to challenge and change the status quo and lead the way to transformative healthcare education.

### **Spiraling Cultural Competence Content**

This study's findings were unambiguous regarding the need to develop more refined curricula that address culture and cultural competence at progressively more complex levels. This multidimensional approach to culture and cultural competence in healthcare education calls for moving away from a superficial focus on non-dominant groups to an examination of how individual values and beliefs create "situatedness" and how unequal distribution of privilege and power, individually and collectively, generate and sustain health and healthcare disparities. This shift in the central focus of cultural competence can also bring about further shifts such as examination of ethnocentrism in dominant culture and healthcare culture, racism, and other forms of oppression as a set of social conditions that impact the health of individuals and populations.

The unique challenges of teaching and learning about culture and cultural competence warrant the use of experiential learning activities such as simulation, reflection, and engagement in diverse communities. A critical examination of the background cultures of healthcare including the educational climate of healthcare education, biomedicine, and the U.S. as dominant paradigms is needed in order to more deeply understand their influence on the philosophical underpinnings of cultural competence and its application to clinical practice. Finally, development of educational standards by a national organization of cultural competence

educators is recommended to help the cultural competence movement “take root,” redress the power imbalances inherent in much healthcare provision, and move into a mainstream position in healthcare education.

These three action recommendations, exploration of dominant culture, an experiential approach, and development of educational standards, confront the challenges in healthcare education of an expanding knowledge base, mastery of new technology, shortened education programs, and traditional hierarchical relationships within the healthcare education environment. At the same time, there has been considerable progress away from traditional models of education to a more emancipatory approach to healthcare education. This includes student-centered pedagogies, development of new partnerships in the educational endeavor, the reforming of classroom teaching, clinical redesign, and innovations in preparing healthcare students for contemporary professional practice. Research is needed in order to evaluate promising practices to nurture, reassess, and reshape cultural competence in healthcare education.

### **Privilege and Power**

Privilege and power that allow for acceptance, inclusion, and respect in the world were strong sub-texts woven throughout the study findings. The ease of not being aware of privilege is an aspect of privilege itself, and what Johnson (2001) calls “the luxury of obliviousness” (p. 24). Privilege of some groups at the expense of others was seen as causing disparities in income, dignity, safety, and general quality of life and thus contributing to a deep divide in health outcomes

among varying populations. Furthermore, these conditions are perceived as promoting fear, suspicion, and discrimination. Denying the privilege that exists in the healthcare system and healthcare education is a serious barrier to change. Furthermore, when privilege and power are associated with individuals, the central role played by dominant groups in oppression is obscured. Deepening awareness of the presence of privilege, and a concomitant examination of how privilege operates, and affects individuals and healthcare systems may help dispel the myth of objectivity in the healthcare system and contribute to the elimination of health and healthcare disparities.

### **Relational Skill Development**

In order to cultivate the relational nature of cultural competence, essential aspects such as understanding the context of our own and the client's perspective, building attitudinal, behavioral, and intellectual flexibility, skillful communication, and conflict negotiation must be brought to the foreground of cultural content, while culture-specific information regarding ethnic groups and their cultural traits must be placed in the background. Although the substance of healthcare education has evolved with emerging knowledge of health and illness through the biomedical sciences, and technology advances, relational aspects of care have not evolved to fully accommodate cultural competence. This is not meant as criticism but rather as an acknowledgement of the many critical and conflicting challenges faced in healthcare education today. Although many participants recommended sweeping educational reform, there was



acknowledgement from participants as well as other scholars of the delicate balance inherent in our fragile healthcare system. Participants cautioned that educational integrity in other areas should not be undermined through efforts to address inadequacies in the teaching and learning of cultural competence (e.g. Barnes et al. 2000; Dimou, 1995; Engebretson, 2003; Jacobson et al., 2005; Kleinman, 1983, 1988; Kleinman et al., 1978; Taylor, 2003).

**Role of the body.** The data from this study suggest a distinction between cognitive and embodied knowing; shifting cultural competence from a traditional external knowing “about” culture to an internal experiencing “of” culture. The division between mind and body—cognition and behavior—reinforces the current division in Western healthcare between the cognitive, affective, and behavioral aspects of experience. Yet it has long been known that values create a context that influences sensory perceptions, and that our bodies can be instruments to effectively gather information about culture (Bennett & Catsiglioni, 2004; Damasio, 1999; Langer, 1989). An exclusive emphasis on the cognitive aspects of cultural competence can mask the deeper phenomenon of the embodiment of culture and theoretically simplify and fragment the development of cultural competence. Because healthcare providers are in a practice that relies on developing perceptual acuities in order to see, hear, feel, and notice events and signs that they could not recognize before their education, understanding the physical nature of cultural competence can enhance perceptual abilities, discernment of patterns and distinctions, and nuances

including empathy. While not generally found in the healthcare literature, more research is needed on the enhancement of physical discernment skills as a possible additional dimension in the development of cultural competence.

### **Global Competencies**

Global health, as a field of study, places a priority on improving health and achieving health equity for all people worldwide, where the heaviest burden of disease falls on the developing world (Caffrey, Neander, Markle, & Stewart, 2005; Crampton, Dowell, Parkin, & Thompson, 2003; Crigger, Brannigan, & Baird, 2006; Dupre & Goodgold, 2007; Gokah, 2007; Jones & Bond, 1996; Yamada, 2008). Global competencies are in their infancy in healthcare, and they need further development toward implementation and evaluation in order to ensure that healthcare providers of the future are prepared to practice in a globalized world. In order for healthcare providers to see themselves in this broader role of advocacy, it is vital that they first perceive themselves as global citizens and acquire global health skill sets. This exponential shift will require letting go of familiar ways in order to embrace new thinking, and encouraging collaborative innovation across disciplines and nations. Academic centers can play a major role in enhancing partnerships that will be crucial to eliminating the enormous health disparities that are present locally and worldwide. Global competencies used to guide curricula should include but not be limited to global health disparities, healthcare disparities, donor/recipient nations, migration and diaspora, population health, conflict negotiation, and the role of power and

privilege in the provision and receipt of healthcare. Participant 16 noted this: "So do I think cultural competence has a nuance outside of health and human service? It absolutely does...It matters in how we govern...it matters in how we run the world."

### **Conclusion**

Recent dramatic social and demographic changes in the U.S. have led to addressing cultural competence in the context of major challenges in healthcare education in order to serve individuals and communities locally and worldwide in the 21<sup>st</sup> century. This study examined cultural competence from a composite interdisciplinary approach with a specific focus on recommendations for healthcare education. While the findings reflected concepts that have been expressed in the professional literature, it added new knowledge and presents an opportunity to reexamine and perhaps change the paradigm for conceptualizing, educating, and evaluating cultural competence in healthcare education. This study contributes an understanding of cultural competence as both relational and interconnected, as individuals and systems are connected to each other through a dynamic relationship. Spiraling cultural competence education can provide an essential skill set for preparing healthcare providers for contemporary practice and leadership roles, and to create a vision of care delivery that redresses some of the issues pervasive within today's healthcare system.

This exploration of cultural competence in healthcare and healthcare education is a small step toward the achievement of a more complex understanding of culture

and cultural competence that moves away from superficial approaches toward a recognition of the interplay of the many economic, political, geographic, and social conditions that provide a context for health disparities and healthcare disparities. Negotiating a common understanding of the components of cultural competence, practical application, and effective evaluation methods can help to reduce the burden of human suffering. In summary, this study describes core aspects of cultural competence that disciplinary scholars consider critical to contemporary healthcare delivery, and areas requiring additional exploration to better understand and develop cultural competence in healthcare and healthcare education in the future.

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## Appendices

Appendix A: Recruitment Letter

Appendix B: Phone Consent Script

Appendix C: Interview Guide

Appendix D: Publications Reviewed

Appendix E: Table of Participants

Appendix F: Questions to Generate Effective Inquiry and Continued Dialogue

## Appendix A

**IRB Approved #3113****Invitation to Participate in a Doctoral Dissertation Study on:  
Exploring Cultural Competence – The Emerging Picture**

Dear Dr.

Because of your expertise in culture and cultural competence you are being invited to participate in a qualitative study exploring cultural competence.

**The purpose of the study:** To explore the current status of cultural competence from the perspective of experts in nursing, medicine, anthropology, education, and intercultural communication. The intention of this broad and varied view of cultural competence is to evaluate its strengths and limitations in order to help guide future education, research, and practice.

**What is involved in being in the study?** Participation will involve an interview of 30 minutes to one hour during which you will be asked a variety of questions related to your professional experience with cultural competence. You will have the opportunity to express personal opinions, perspectives, and experiences as well as recommend a professional colleague for participation in this study. I plan to interview approximately 25 experts from around the country and abroad. You will be asked if you are comfortable revealing the most basic demographic information (name, discipline, professional expertise) for publication in a table of participants. If not, your data will be assigned a code number and your anonymity protected.

**If you are interested in participating:** You need do nothing. Within approximately two weeks, I will contact you in order to arrange a convenient time for the interview.

**If you do NOT wish to participate:** Please call (503) 494-1473 or send an e-mail to [soulei@ohsu.edu](mailto:soulei@ohsu.edu).

I am looking forward to this rich learning. Thank you in advance for considering contributing to this study.

Respectfully,

Isabelle Soulé, RN, PhD Candidate  
Assistant Professor  
Oregon Health & Science University, School of Nursing  
Portland, Oregon, USA

## Appendix B



**IRB Approved # 3113**

Exploring Cultural Competence – The Emerging Picture

Nancy Press, PhD, PI

Isabelle Soulé, RN, PhD Candidate

**Phone Consent Script:**

This interview is part of a study I am doing as a doctoral student in the OHSU School of Nursing. The purpose of the research is to explore the current status of cultural competence from the perspectives of experts in nursing, medicine, education, anthropology, and intercultural communication. You are being invited to take part in this study because you are an expert in one of these areas. The interview will consist of questions within your area of professional expertise. I anticipate that it will take 45-60 minutes. You are, of course, free to not answer any questions and to end the interview at any point. Does this sound alright?

I would like to tape record the interview, primarily so that I can give my complete attention to our interaction, rather than to taking notes. Do I have your permission to tape our interview exchange? Thank you.

If and when they consent, I will ask them to state their name and give their verbal permission again at the beginning of the audiotape.

Appendix C

**IRB Approved #3113**

## Interview Questions: Exploring Cultural Competence – The Emerging Picture

## Theme One: Strengths of Cultural Competence

1. What are the most important elements of cultural competence?
2. What are the strengths of cultural competence/cultural competence movement?
3. What difference has your involvement in cultural competence made in your work?
  - a. What example(s) best demonstrate its impact?

## Theme Two: Limitations of Cultural Competence

1. What are the limitations or gaps of cultural competence/cultural competence movement?
2. How can cultural competence address these limits or gaps?
3. Is cultural competence accomplishing what it set out to do?

## Theme Three: Next Steps

1. What do you think is needed now?
2. Recommendations for next steps.
3. What else should I have asked?

## Snowballing:

1. Who else would you recommend I talk to about this?

## Demographics:

1. Discipline, profession, and primary functional role
2. Gender
3. Ethnicity

Appendix D

### Participant Publications Used as Secondary Data Sources

- Betancourt, J. R. (2006). Cultural competence and medical education: Many names, many perspectives, one goal. *Academic Medicine, 81*(6), 499-501.
- Betancourt, J. R. (2006). Eliminating racial and ethnic disparities in healthcare: What is the role of academic medicine? *Academic Medicine, 81*(9), 788-792.
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Appendix E

Table of Participants

Name	Role/Location	Professional Expertise
Richard Adams, PhD	Professor Emeritus, Lewis and Clark College, Portland, OR; Executive Director, Zimbabwean Artist Project (ZAP)	Sociology, gender and social change. Founder, Lewis and Clark overseas study program in Zimbabwe
Joseph Betancourt, MD, MPH	Assistant Professor, Harvard School of Medicine, Boston, MA; Director, The Disparities Solutions Center; senior scientist, Institute for Health Policy	Multicultural education; cross-cultural medicine; minority recruitment into health professions; minority health and health policy research
Joyceen Boyle, PhD, RN, FAAN	Professor and Associate Dean for Academic Affairs, University of Arizona, Tucson, AZ	Cultural responses to illness. Author <i>Transcultural Concepts in Nursing Care</i>
Noel Chrisman, PhD	Professor, Community Health, University of Washington School of Nursing, Seattle, WA	Anthropology; cross-cultural nursing; cultural competence training
Lydia DeSantis, PhD, RN, MPH	Professor, University of Miami School of Nursing, Miami, FL. Director, Institute for the Study of Culture and Nursing	Transcultural nursing; international health; community health
Dawn Doutrich, PhD, RN	Associate Professor, Washington State University, Vancouver, WA	Cultural competence in nursing; workforce diversity; values differentiation in cross-cultural nursing ethics
Barbara Dossey, PhD, RN, HNC, FAAN	Director, Holistic Nursing Consultants, Santa Fe, NM	Holistic nursing; Nightingale global initiative. Seven-time recipient American Journal of Nursing book of the year award
Brian Gibbs, PhD	Director, Program to Eliminate Health Disparities, Harvard University, School of Public Health, Boston, MA	Minority health; intersection of poverty, race, and health; social justice



Barbara "Bobbie" Gottlieb, MD	Associate Professor of Medicine, Harvard Medical School, Boston, MA. Former Medical Director Brookside Community Health Center	Lives and works in a Latino and Caribbean community where she has worked with three generations of clients
D. Patricia Gray, PhD, RN	Associate Professor and Chair Dept of Adult Health, Virginia Commonwealth University School of Nursing, Richmond, VA	Development and application of critical qualitative approaches to inquiry, critical analysis of culture in nursing
Alan Guskin, PhD	Professor Emeritus, Antioch University, Seattle, WA. Director, doctoral program in leadership and change. Director and senior scholar, Project on the Future of Higher Education	Role of leadership, power, conflict and change in universities; cultural humility
Charles Johnston, MD	Psychiatrist and futurist; Clinical Director, Institute for Creative Development, Seattle, WA	Originator of Creative Systems Theory; advanced leadership training, author <i>The Creative Imperative</i> (1986) <i>Necessary Wisdom</i> (1991), and <i>Hope and the Future</i> (in press).
Juliene Lipson, PhD, RN, FAAN	Professor Emeritus, University of California San Francisco School of Nursing, San Francisco, CA	Health and adjustment of immigrants and refugees to U.S.; member of council on nursing and anthropology
James Mason, PhD	Director Office of Multicultural Health, Oregon Department of Human Services	Intersection of culture and health policy, senior project consultant at National Center for Cultural Competence, Georgetown University, Washington, DC
Swapna Mukhopadhyay, PhD	Assistant Professor, Department of Education, Portland State University, Portland, OR	Curriculum development and instruction in higher education, developed course in ethnomathematics

Juan Nunez Prado, PhD	Professor of Anthropology, National University of San Antonio Abad, Cuzco, Peru	Medical Anthropology, Shamanism
Molly Osborne, MD, PhD	Associate Dean for Student Affairs, Oregon Health & Science University, Portland, OR	Medical education, global health, facilitator, Healer's Art curriculum, OHSU School of Medicine
Nagesh Rao, PhD	Associate Professor, Zayed University, Abu Dhabi, and Ohio State University, Columbus, OH	Faculty Summer Institute of Intercultural Communication (SIIC); healthcare across cultures, client /physician relationships
Somnath Saha, MD, MPH	Associate Professor of Medicine and Public Health, VA Medical Center, Portland, OR	Influence of race and ethnicity in client/physician relationships
Judith Van der Weele, PhD	Director, Alternatives to Violence, Oslo, Norway	Refugee health, forced migration, reduction of social impact of violence and traumatic stress

Appendix F

## **Questions to Generate Effective Inquiry and Continued Dialogue**

The following questions, prompted by ideas in the data, are designed to generate effective inquiry and continued dialogue in considering how to best move forward in educating healthcare providers toward cultural competence.

### **Context of Healthcare System and Healthcare Education**

- What are the current beliefs and values in healthcare, healthcare education, biomedicine, and the U.S. that may enhance and/or inhibit the development of cultural competence? What would remain and what would need to change in order for beliefs and values to be in alignment with key cultural competence principles?
- How might we best design an organization of individuals who would participate in ongoing deep dialogue locally, regionally, nationally, and internationally regarding the intersection of cultural competence and healthcare education to develop recommendations and promising practices?

### **Healthcare Education**

- Given what we know and the probable future demographic, technological, faculty, and economic resources, how would we design a healthcare curriculum to enhance cultural competence while at the same time respecting other aspects essential to healthcare education? Who are the prominent stakeholders, educational partners, and recipients of this future

healthcare curriculum? Are there existing models inside and/or outside the U.S. that could help inform this design?

- In what ways is our current healthcare curriculum congruent with the key cultural competence principles of deep-rooted self-awareness, flexibility, communication, and understanding context? In what ways is that current curriculum incongruent?

### **Teaching and Learning**

- What is the best way to conceptualize and implement an increasingly sophisticated program of cultural competence, moving from a superficial cognitive focus to an experiential one, throughout the healthcare curriculum? Who are the diverse experts who can contribute to our thinking about this?
- Are there alternate pedagogies such as complementary medicine, traditional wisdom, and Eastern thought that could help inform how cultural competence is approached in healthcare education?
- How might the concept of cultural safety, used in educational programs around the world, help inform how we design and teach about cultural competence in the U.S.?
- How can teaching strategies such as experiential learning, role-play, literature, film, the visual arts, and body awareness be used to promote cultural competence? Who would we engage to help us in this endeavor?

- What strategies, experiences, or opportunities can we offer students that will enhance their ability to understand themselves and others as unique cultural beings and their experience of being global citizens?
- How can technology, including simulation, be best used to enhance student learning in moving toward cultural competence?

### **Faculty**

- How can colleges and universities best support the personal and professional development of faculty in moving toward cultural competence supporting the development of self-awareness, flexibility, and skillful communication? What resources are available? What resources are needed?
- How might a diverse and interdisciplinary faculty including educated community members influence healthcare education?

### **System/Organization**

- How can we best build individual and institutional capacity and accountability to recruit, relate to, support, and retain diverse faculty and students? How can we best learn to build effective partnerships with colleagues, communities and diverse populations?

### **Healthcare Education Research**

- Given the diffuse nature of culture and cultural competence, how can we begin to design and measure the effectiveness of programming and

application to clinical practice in meaningful and relevant ways? What are the next steps? Who can be our partners in this endeavor?

- How can this essential area of research be supported? How can we enroll healthcare educators and emerging researchers in order to move this field of knowledge forward?