In our multicultural society, nurses and health care providers, educators and administrators, professional association leaders, and researchers must work toward achieving cultural competence. This new edition, along with the digital Cultural Competence Education Resource Toolkit, offers a unique and effective guide to do just that.

Newly updated and revised, this book presents ready-to-use materials for planning, implementing, and evaluating cultural competence strategies and programs. Users will learn to identify the needs of diverse constituents, evaluate outcomes, prevent multicultural-related workplace conflict, and much more. Complete with vignettes, case exemplars, illustrations, and assessment tools, this book is required reading for those working in academic settings, health care institutions, employee education, and nursing and health care organizations and associations.

Key Features:
- Offers a wide selection of educational activities and techniques for diverse learners
- Presents guidelines for helping educators, students, and professionals to maximize strengths, minimize weaknesses, and facilitate success
- Describes toolkit questionnaires for measuring and evaluating cultural learning and performance
- Provides guidelines for employee orientation programs to achieve cultural competence in the workplace

The Digital Cultural Competence Education Resource Toolkit:
Offering a wealth of hands-on, user-friendly tools, this kit provides specialized resources to measure cultural competence for all levels and settings—both academic and professional. This toolkit incorporates the 7 essential steps toward achieving cultural competence, and contains numerous evaluation and assessment tools, data sheets, and much more!
Teaching
Cultural Competence
in Nursing and Health Care
Dr. Marianne R. Jeffreys’ grant-funded research, consultations, publications, and professional presentations encompass the topics of cultural competence, nontraditional students, student retention and achievement, self-efficacy, teaching, curriculum, and psychometrics. The first edition of her book *Teaching Cultural Competence in Nursing and Health Care: Inquiry, Action, and Innovation* received the AJN Book of the Year Award; she is also author of *Nursing Student Retention: Understanding the Process and Making a Difference*, articles, book chapters, and videos. Her conceptual models and questionnaires have been requested worldwide and in various disciplines. She is currently a professor of nursing at the City University of New York (CUNY) Graduate College and at CUNY College of Staten Island.

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Teaching
Cultural Competence
in Nursing and Health Care
Inquiry, Action, and Innovation

2nd Edition

Marianne R. Jeffreys, EdD, RN
To my son, Daniel W. Edley
Contents

Contributors ix
Preface xv
Acknowledgments xxi

PART I. Getting Started
1. Overview of Key Issues and Concerns 3
2. Dynamics of Diversity: Becoming Better Health Care Providers through Cultural Competence 27
3. A Model to Guide Cultural Competence Education 45

PART II. Tools for Assessment and Evaluation
4. Transcultural Self-Efficacy Tool (TSET), Cultural Competence Clinical Evaluation Tool (CCET), and Clinical Setting Assessment Tool—Diversity and Disparity (CSAT-DD) 63
5. A Guide for Interpreting Learners’ Transcultural Self-Efficacy Perceptions, Identifying At-Risk Individuals, and Avoiding Pitfalls 95

PART III. Educational Activities for Easy Application
6. Academic Settings: General Overview, Inquiry, Action, and Innovation 117
## Contents

9. Faculty Advisement and Helpfulness: A Culturally Congruent Approach  
227
243
11. Case Exemplar: Linking Strategies—Spotlight on Employee Orientation Programs to Enhance Cultural Competence  
285
12. Case Exemplar: Linking Strategies—Spotlight on Employee Inservice Education to Enhance Cultural Competence  
303
13. Professional Associations  
325
14. New Priorities: Challenges and Future Directions  
347

References  
355
Index  
391
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Preface

Preparing nurses and other health professionals to provide quality health care in the increasingly multicultural and global society of the 21st century requires a comprehensive approach that emphasizes cultural competence education throughout professional education and professional life. Nurses and other health care providers, educators, administrators, professional association leaders, managers, and researchers are called upon to:

- Provide optimal care for the large number of culturally diverse patient populations
- Implement cultural competence education strategies in academic and hospital settings for diverse learners
- Evaluate outcomes of cultural competence education
- Prevent multicultural workplace conflict and promote multicultural workplace harmony
- Personally engage in lifelong cultural competence education

These tasks can seem daunting and overwhelming without appropriate resources. If you want to develop optimal cultural competence in yourself and others, *Teaching Cultural Competence in Nursing and Health Care, 2nd Edition*, and the *Cultural Competence Education Resource Toolkit* are the how-to resources for you. These hands-on, user-friendly resources reveal a systematic 7-step approach that takes nurses, educators, administrators, professional association leaders, managers, educators, students, and other health care providers from their own starting points toward the pinnacle—optimal cultural competence. Appropriate for all levels and settings (academic, health care institutions, employee education, professional associations, and continuing education), the book and toolkit end the struggle to find ready-to-use materials for planning,
implementing, and evaluating cultural competence education strategies and programs. Users of the book and toolkit will find the following:

- A model to guide cultural competence education
- Questionnaires for measuring and evaluating learning and performance
- A guide for identifying at-risk individuals and avoiding pitfalls
- A wide selection of educational activities
- Techniques for diverse learners
- Chapters detailing employee orientation, inservices, and continuing education
- Chapters detailing multidimensional strategies for undergraduates and graduates
- Vignettes, case examples, illustrations, tables, and assessment tools
- Abstracts and sample research reports from researchers evaluating strategies

Based on the results of several post-doctoral grant-funded studies, practical teaching experience with academically and culturally diverse learners across all levels, and multidisciplinary literature, the book and toolkit provide resources and a wealth of information for all user groups.

The book is divided into three parts: Part I, Getting Started; Part II, Tools for Assessment and Evaluation; and Part III, Educational Activities for Easy Application.

Part I is comprised of three chapters filled with resources to help educators begin teaching cultural competence. Essential background information about the multidimensional process of teaching cultural competence offers a valuable guide for educators at all levels who are planning, implementing, and evaluating cultural competence education.

Educators and researchers are continually challenged to measure outcomes following educational interventions. Part II addresses this challenge by introducing several quantitative questionnaires and assessment tools [to be found in the toolkit] and discussing implementation and data interpretation strategies in a detailed, user-friendly approach that is easily adapted by novice and advanced researchers. Questionnaires, assessment tools, a cultural competence documentation log, and a research report template are easily accessed in the accompanying Cultural Competence Education Resource Toolkit. (See details concerning toolkit access in the final section of the preface.)

Part III offers a wide selection of educational activities that can easily be applied by educators everywhere. Three chapters (6, 10, and 13) provide a general overview and a menu of activities and strategies for use in three areas: the academic setting, the health care institution, and
professional associations. Chapter discussions, supplementary diagrams, and descriptions of toolkit items explore the 7 steps essential for optimal cultural competence development:

- Self-assessment
- Active promotion
- Systematic inquiry
- Decisive action
- Innovation
- Measurement
- Evaluation

Five chapters (7, 8, 9, 11, and 12) in Part III creatively link strategies via detailed case exemplars that spotlight various populations and settings.

The book’s final chapter (Chapter 14) presents important implications for educators everywhere. Educators are challenged to commit to a focused and transformational change that will not only advance the science and art of cultural competence education, but will also result in culturally congruent care, ultimately benefiting health care consumers worldwide. The urgent expansion of educational research specifically focused on the teaching and learning of optimal cultural competence is emphasized, and areas for further inquiry and research, and future goals are proposed. Extensive references are provided at the end of the book.

Unquestionably, implementing creative, evidence-based educational activities that promote positive cultural competence learning outcomes for culturally diverse students and health care professionals continues to be a challenge. A new challenge is to reach beyond competence (a minimum expectation) toward optimal cultural competence. This new quest recognizes that all individuals, groups, and organizations have the potential for “more.” Optimal cultural competence embraces the diversity of diversity, requires ongoing active learning, fosters multicultural workplace harmony, and promotes the delivery of the highest level of culturally congruent patient care.

Why optimal cultural competence?

First, culture is a crucial factor in promoting wellness, preventing illness, restoring health, facilitating coping, and enhancing quality of life for all individuals, families, and communities. Unfortunately, the two main goals of the U.S. Department of Health and Human Services report *Healthy People 2010* have not been met. The first goal—to increase quality and years of healthy life for all—can only be achieved when an examination of “quality of life” and the meaning of “health and well-being” within a cultural context are put into service. The second goal was to eliminate health disparities among different segments of the population, which necessitated culture-specific and competent actions designed
Preface

to eliminate disparities; however, health disparities remain overwhelming. As such, customized health care that responds to a client’s cultural values, beliefs, and traditions (culturally congruent care) remains urgent (Giger et al., 2007; Leininger, 2002a, 2002b; Rosal & Bodenlos, 2009; Whitt-Glover et al., 2009). For health care professionals with some cultural competence skills, the challenge now is to go beyond mere cultural competence toward optimal cultural competence. It is also imperative that health professionals without cultural competence education actively begin their journey to develop optimal cultural competence.

Second, culturally congruent health care is a basic human right, not a privilege, and therefore every human is entitled to it. The International Council of Nurses (ICN) Code for Nurses (ICN, 1973), the American Nurses Association (ANA) Code of Ethics (ANA, 2001), and the National Standards for Culturally and Linguistically Appropriate Services in Health Care (Office of Minority Health, 2001) are important documents that serve as reminders. Criteria devised by accreditation and credentialing agencies such as the Joint Commission on Accreditation of Healthcare Organizations, the National Committee on Quality Assurance, the American Medical Association, and the National League for Nursing strive to ensure that culturally competent health care series and education are provided. The essential inclusion of cultural competence as viewed from an ethical and legal standpoint is addressed on varying levels within the disciplines of physical therapy, occupational therapy, speech-language pathology, dentistry, medicine, psychology, and social work (AAMC, 2005; ADA, 2005, 2007; APA, 1994; APTA, 2008; Lubinski & Matteliano, 2008; NASW, 2001, 2007, 2009; Nochajski & Matteliano, 2008; Panzarella & Matteliano, 2008). Not only are nurses, physicians, other health care providers, and institutions ethically and morally obligated to provide the best culturally congruent care possible (optimal cultural competence), they are also legally mandated to do so. Within the scope of professional practice, nurses and other health professionals are expected to actively seek out ways to promote culturally congruent care at optimal levels.

The AJN award-winning first edition of Teaching Cultural Competence in Nursing and Health Care introduced readers to easy-to-use teaching–learning strategies for cultural competence education. Positive comments about the first edition, along with a surge of requests for “more” from academic and employee educators, researchers, practicing health professionals, and students from around the world and in various disciplines, inspired the writing of the expanded second edition and the creation of the Cultural Competence Education Resource Toolkit. The ideas and suggestions presented here are not meant to be exhaustive, but are offered to stimulate new ideas and invite health professionals to explore new paths on the journey to developing cultural competence in
oneself and others. Readers are encouraged to pause, reflect, and question throughout the book in order to gain new insights and perspectives. Everyone is empowered to contribute to a transformational change in health care that prioritizes optimal cultural competence development and embraces diversity.

### About the Cultural Competence Education Resource Toolkit

As mentioned previously, this book includes a valuable and ready-to-use Cultural Competence Education Resource Toolkit. The Toolkit consists of three sets of tools and a total of 21 distinct tools. The three sets of tools are: Resources for Academic Settings; Resources for Health Care Institutions; and Resources for Professional Associations. Taken together, the tools provide a comprehensive set of materials for planning, implementing, and evaluating cultural competence education strategies and programs. These tools may be used alone or in conjunction with other tools and will be of use to a broad range of readers at all levels: nurses, educators, administrators, association leaders, managers, researchers, students, and other health care providers. The tools and this book will enable you to achieve optimal cultural competence.

All of these tools are to be found on a special website. The address of the website is springerpub.com/jeffreystoolkit. You can download and print the tools from this website and you can also distribute them electronically.

**An important note:** As a purchaser of this book you are entitled to employ these tools for individual use without extra charge. Any use of the toolkit or portions of the toolkit beyond individual, personal use (such as within an institutional setting and/or in a research study) will require a license from Springer Publishing Company and payment of a modest fee for a one year unlimited use license.

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PART I

Getting Started

Part I, Getting Started, contains three chapters filled with resources and tools to help educators begin teaching cultural competence. Essential background information about the multidimensional process of teaching cultural competence offers a valuable guide for educators at all levels when planning, implementing, and evaluating cultural competence education.

Chapter 1 overviews key issues, concerns, and new challenges facing health care consumers, professionals, and educators. Professional goals, societal needs, ethical considerations, legal issues, changing demographics, and learner characteristics are highlighted. Select cultural values and beliefs are vividly compared and contrasted in a supplementary table that enhances the text. The chapter concludes with a discussion of factors influencing cultural competence development among culturally diverse learners and proposes that confidence, or in the context of this book transcultural self-efficacy (TSE), is a major component in cultural competence development and a strong influencing factor in achieving culturally congruent care.

Creating environments that embrace diversity, meeting the culture-specific needs of patients, preventing multicultural workplace conflict, and promoting multicultural workplace harmony are portrayed in Chapter 2. These endeavors begin with diversity awareness of self and others, with each defined at the beginning of the chapter. Several poignant clinical and workplace examples illustrate the significance of actively weaving cultural competence throughout all aspects of health care settings. The acronym “COMPETENCE” assists health care professionals in remembering essential elements for optimal cultural competence development.

Chapter 3 introduces a model to guide cultural competence education—the Cultural Competence and Confidence (CCC) model. The underlying assumptions, principles, concepts, and terms associated with
the model’s development are concisely presented. A unique feature of the model (and the book) is that its major concepts, propositions, and constructs are supported by several quantitative studies using a questionnaire also discussed in this book and available in the Jeffreys Cultural Competence Education Resource Toolkit (Jeffreys, 2010). The visual illustration of the model enhances understanding of the text. A second illustration expands on the CCC model illustration by tracing the proposed influences of TSE (confidence) on a learner’s actions, performance, and persistence for learning associated with cultural competency development and culturally congruent care. The model has relevance to other disciplines recognizing the essential inclusion of cultural competence within clinical practice and in initial and/or ongoing educational preparation, such as physical therapy, occupational therapy, speech-language pathology, dentistry, medicine, psychology, and social work. The model is brought to life through a realistic “Educator-In-Action” vignette featuring cultural competence education in the health care institution (hospital setting).
Meeting the health care needs of culturally diverse clients has become even more challenging and complex. In addition to acknowledging the cultural evolution (growth and change) occurring in the United States (and other parts of the world), it is imperative that nursing and other health care professions appreciate and understand the impending cultural revolution. The term cultural revolution implies a “revolution of thinking” that seeks to embrace the evolution of a different, broader worldview (Jeffreys & Zoucha, 2001). Both cultural evolution and cultural revolution have the potential to bring about a different worldview regarding cultural care and caring by including key issues previously nonexistent, underrepresented, or invisible in the nursing and health care literature. This new vision challenges all health care professionals to embark upon a new journey in the quest for cultural competence and culturally congruent care for all clients (Jeffreys & Zoucha, 2001). This new journey also challenges health care professionals and organizations to go beyond the goal of achieving “competence” (minimum standard) toward the goal of achieving “optimal” cultural competence (standard of excellence). Educators everywhere are additionally challenged to learn how to lead the quest for culturally congruent health care by implementing creative, evidence-based educational activities that promote positive cultural competence learning outcomes for culturally diverse students and health care professionals, aiming to reach beyond minimal competence to the achievement of optimal cultural competence.
GETTING STARTED

This transformational journey begins by seeking to understand the key issues, concerns, and new challenges facing health care consumers and professionals today and in the future. This chapter evokes professional awareness, sparks interest, stimulates revolutionary thought, highlights vital information, and shares new ideas concerning the health care needs of culturally diverse clients and the development of cultural competence among culturally diverse health care professionals. Cultural competence has been described as a multidimensional process that aims to achieve culturally congruent health care (Andrews & Boyle, 2008; Campinha-Bacote, 2003; Leininger, 1991a; Purnell & Paulanka, 2008). Culturally congruent health care refers to health care that is customized to fit with the client’s cultural values, beliefs, traditions, practices, and lifestyle (Leininger, 1991a). It is beyond the scope of this chapter to provide a summary review of the existing literature concerning cultural competence and health care. Rather, this chapter emphasizes select points from the literature, identifies future complexities and challenges in health care, discusses factors influencing cultural competency development, and proposes a construct involved in the process of cultural competence development and education.

COMPLEXITIES, CHANGES, AND CHALLENGES IN HEALTH CARE

Rapid growth in worldwide migration, changes in demographic patterns, varying fertility rates, increased numbers of multiracial and multiethnic individuals, and advanced technology contribute to cultural evolution. For the purpose of this book, cultural evolution refers to the process of cultural growth and change within a society (Jeffreys & Zoucha, 2001). Within the nursing literature, cultural growth, change, and the need for culturally congruent nursing care have been frequently reported in various countries outside the United States including Australia, Canada, Israel, Sweden, South Africa, and the United Kingdom (Cowan & Norman, 2006; Davidson, Meleis, Daly, & Douglas, 2003 Douglas, 2000; Douglas et al., 2009; Glittenberg, 2004; Holtz, 2008). Although this book addresses cultural changes in the United States, readers should recognize that globalization is a worldwide phenomenon, with populations now moving more frequently than ever before. Because more people are migrating to several different places, the acculturation experience may include cultural values and beliefs (CVB) assimilated from more than one source, resulting in new ways of expressing traditional CVB and/or resulting in new cultural values and belief patterns. Consequently, health care professionals are challenged to meet the needs of changing societies in new and different ways.
Overview of Key Issues and Concerns

The United States Census (U.S. Census Bureau, 2002) and Healthy People 2010 (DHHS, 2000) provide valuable data about select population characteristics; however, they are limited in providing information about cultural values, beliefs, behaviors, and practices associated with the many diverse cultural groups existing within the United States. For example, it is helpful to know that minority populations are increasing more rapidly than white non-Hispanic, nonimmigrant populations (as determined by such variables as age and fertility rates), further justifying and demanding increased population-specific resource allocation (Kosoko-Lasaki, Cook, & O’Brien, 2009). It is also crucial to have identified health disparities, high priority areas, goals, and proposed strategies for improvement; however, nurses and other health care professionals must become actively aware of the diverse cultural groups comprising each designated minority category if Healthy People 2010 and 2020 goals are to be met (de Chesnay & Anderson, 2008). For example, the “Hispanic” category may include individuals whose heritage may be traced to Cuba, Nicaragua, Mexico, Puerto Rico, Peru, Spain, and/or other countries, each also representing much diversity within and between groups. Diversity may exist based on birthplace, citizenship status, reason for migration, migration history, food, religion, ethnicity, race, language, kinship and family networks, educational background and opportunities, employment skills and opportunities, lifestyle, gender, socioeconomic status (class), politics, past discrimination and bias experiences, health status and health risk, age, insurance coverage, and other variables that go well beyond the restrictive labels of a few ethnic and/or racial groups.

The projected increase of multiracial and multiethnic (multiple heritage) individuals in the United States (Glittenberg, 2004; Johnson, 1997; Lee & Fernandez, 1998; Perlmann, 1997; Sands & Schuh, 2004; Spickard & Fong, 1995) and throughout the world demonstrates a growing change in demographic patterns, adding to this new cultural evolution. Forced single category choices and/or the “other” category make the unique culture of the multiracial and multiethnic individual invisible (Jeffreys, 2005; Jeffreys & Zoucha, 2001). Although the 2000 U.S. Census permitted individuals to select more than one racial/ethnic category, the lateness of this option demonstrates the reluctance of society to acknowledge and appreciate the existence of mestizo (mixing) in the United States (Nash, 1995). The late repeal of the last laws against miscegenation (race mixing) in the 1970s attests not only to societal reluctance, but also to political resistance reflecting racial ideologies of some white Americans (Pascoe, 1996).

Inconsistent use of the data from individuals selecting more than one census category is confusing and typically favors the antiquated process of assigning individuals to one category only; usually the minority status or politically advantageous category is selected. For example, when
reporting the number of “minority” individuals within a public school system for the purpose of demonstrating integration within a predominantly white school, someone selecting “black” and “white” would be assigned as being “black.” In reality, it may be impossible for a multiracial individual to choose one ethnic or racial identity over the other (Hall, 1992; Pinderhughes, 1995). Multiple heritage identity can include membership within one select group, simultaneous membership with two or more distinct groups, synthesis (blending) of cultures, and/or fluid identities with different groups that change with time, circumstance, and setting (Daniel, 1992; Root, 1992; Spickard & Fong, 1995). Moreover, multiple heritage individuals often describe being “multiracial” or “multietnic” as a separate and unique culture (Root, 1997; Spickard, 1997). Culturally congruent health care for the 6,826,228 individuals who identified as being of more than one race in the 2000 Census (U.S. Census Bureau, 2002) must begin with openly acknowledging the uniqueness of multiple heritage individuals and seeking to learn about their lived experience. Multiple heritage individuals present unique concerns and challenges for transcultural nurses and other health care professionals because of the lack of research and published studies in nursing and health care (Jeffreys, 2005; Jeffreys & Zoucha, 2001).

Similarly, other underrepresented, invisible, unpopular, or new issues present complexities and challenges to health care professionals because of the lack of substantive research, resources, and expertise specifically targeting such topics related to culture and changing populations (cultural evolution). With the rapid changes and influx of new populations from around the world, nurses are, more than ever before, faced with the challenge of caring for many different cultural groups. Changes are occurring more rapidly in urban, suburban, and rural areas, often with cultural groups clustering together in ethnic neighborhoods. This means that there is less time for nurses to learn about and become accustomed to new cultural groups. Lack of nurses with transcultural nursing expertise presents a severe barrier in meeting the health care needs of diverse client populations (Leininger & McFarland, 2002).

Political changes throughout the world have resulted in large migration waves from former socialist, communist, monarchal, and dictatorship nations. Too many choices (in health care planning options) may overwhelm individuals who are not used to such freedoms (Miller, 1997). Mismatches in expectations between health care professional and client can cause poor health outcomes, stress, and dissatisfaction. Nurses unfamiliar with various political systems and the potential impact on clients’ perceptions may be unprepared to provide culturally congruent care for these clients. Understanding the ethnohistory, especially the influence of politics, economics, discrimination, intergroup and intragroup
conflicts, is an important cultural dimension that warrants further attention (Davidson, Meleis, Daly, & Douglas, 2003; Glittenberg, 2004; Leininger & McFarland, 2002, 2006; Miller, 1997). Despite the commonality of national origin, cultural experiences may be quite different for persons seeking asylum, refugees, and immigrants, and may vary at different points in history, necessitating an accurate and individualized appraisal.

Health care professionals are also challenged to differentiate between numerous minority groups around the world (who may have been victims of overt and/or covert stereotyping, prejudice, discrimination, and racism) and dominant groups. Within the United States, it has been well documented that discrimination, stereotyping, prejudice, and racism exist in nursing and health care (Abrums & Leppa, 2001; ANA, 1998b; Barbee & Gibson, 2001; Bolton, Giger, & Georges, 2004; Bosher & Pharris, 2009; Farella, 2002; Huff & Kline, 1999; Kosoko-Lasaki et al., 2009; Porter & Barbee, 2004; Wilson, 2007). This unpopular topic has not gained the sufficient attention and action necessary to actively dismantle stereotyping, prejudice, discrimination, and racism. Raising awareness is insufficient; taking appropriate and definitive action through well-planned positive innovative interventions followed by evaluation strategies will move beyond complacent “passive advocacy” to positive “active innovative advocacy.” Such innovative actions require development of cultural competence and sincere commitment on the part of health care professionals.

Groups identified as “subcultures” have been identified as “vulnerable populations”; such populations present complex scenarios to health care professionals today and will do so in the future (de Chesnay & Anderson, 2008; Giger et al., 2007; Kosoko-Lasaki et al., 2009). For example, illegal immigrants, migrant workers, tenant farmers, and the homeless often present unique health care challenges due to lack of health insurance, illiteracy, poverty, and fear. In addition, tenant farmers and migrant workers may be grouped together under the heading of “rural health”; thus, the truly unique culture(s) and needs within and between groups across various geographic regions may remain undiscovered. Because tenant farmers may receive food and housing as part of their wages, they may not be eligible for food stamps; Medicaid; Women, Infants, and Children; public assistance; or other social services. Employee benefits such as health insurance and dental insurance are usually nonexistent. Funds for clothing, soap, toothpaste, toothbrushes, and other toiletries may be scarce, making tenant farmers susceptible to preventable diseases. Geographic isolation and lack of transportation are barriers encountered within rural communities, thus presenting another barrier to health care access. Within the United States, health insurance diversity presents inconsistencies in health care, especially in health promotion and illness
GETTING STARTED

prevention. Consequently, primary care for treatment of acute and ad-
anced problems is not routinely accessible with delayed entry into the
health care system occurring.

The global economic crisis, rising unemployment rates, loss of health
insurance coverage, job and retirement uncertainty, increased housing
foreclosures, and general economic unrest present multifaceted problems
that political leaders, financial advisers, and the general public are poorly
equipped to address effectively and with which they are inexperienced.
Within a multicultural society, different CVB concerning economic stabil-
ity, lifestyle expectations, acceptance of charity, debt, and profit further
complicate these problems. Stress associated with periods of economic
uncertainty and doubt may present greater numbers of individuals seek-
ing and/or needing mental health services and/or other health services for
diseases often triggered or exacerbated by stress. Inability to pay for med-
ical services, drugs, housing, and food may aggravate health and social
problems as well as intensify personal debt, thereby broadening deficits in
the overall economy. The global economic crisis has spurred the forced,
rapid movement and lifestyle changes of individuals, families, and even
whole communities.

Rapidly moving populations bring unfamiliar diseases, new diseases,
treatments, and medicines, challenging health care professionals to be-
come quickly proficient in accurate diagnosis, treatment, and prevention.
For example, nurses unfamiliar with malaria may be suddenly faced with
several refugees from Africa who require treatment for malaria. Newer
diseases, such as severe acute respiratory syndrome (SARS) and swine flu,
can cause epidemics if not identified early and then properly controlled.
Medicines and treatments considered “alternative” or “complementary”
within the culture of Western medicine may actually be considered “rou-
tine” in other cultures. Medicines considered “routine” within the culture
of Western medicine may have varying and adverse effects with differ-
ent ethnic or racial groups due to health beliefs and/or due to genetic
differences in body processes (e. g., metabolism) and/or anatomical char-
acteristics (e. g., sun absorption based on skin color). The growing new
field of ethnopharmacology attests to the urgent need to investigate the
pharmacokinetics, pharmacodynamics, and overall pharmacological ef-
effects of drugs within specific cultural groups. Unfortunately, insurance
company approval for drug therapy regimen is often guided by drug stud-
ies among primarily homogeneous populations, rather than taking into
account new, however sparse empirical evidence provided by ethnophar-
macological studies.

Inconsistencies in the expected roles of the nurse may vary from cul-
ture to culture, therefore confounding the therapeutic nurse–client inter-
action, nurse–nurse interaction, nurse–physician interaction, and nurse–
family interaction. Differences in nursing practice throughout the world
Overview of Key Issues and Concerns

influence how the nurse views power, autonomy, collaboration, and clinical judgments (Sherman & Eggenberger, 2008; Zizzo & Xu, 2009). Whether the nurse is viewed as a well-educated professional, vocational service provider, paraprofessional, uneducated worker, or servant will impact greatly on the therapeutic and working relationship (Purnell, 2008). Furthermore, whether the nurse is viewed as an outsider, “stranger,” “trusted friend,” or insider will significantly influence the nurse–client relationship, the achievement of culturally congruent care, and optimal health outcomes (Leininger, 2002c). The mismatch between the diversity of registered nurses and U.S. populations presents one large barrier to meeting the needs of diverse populations. For example, white nurses of European-American heritage represent approximately 90% of all registered nurses (Barbee & Gibson, 2001; Bosher & Pharris, 2009; Kimball & O’Neill, 2002).

Expected roles and perceptions about other health care professionals will also vary from culture to culture, thus necessitating an accurate appraisal of clients’ baseline knowledge, beliefs, and expectations, if culturally congruent care is to be achievable by the multidisciplinary health care team. Gender roles and expectations about members of the health care team are variable. Within certain cultures, it may be unacceptable for women to become physicians and provide care for male patients; conversely, it may be unacceptable for men to become nurses and provide care for female patients (Purnell & Paulanka, 2008; St. Hill, Lipson, & Meleis, 2003). In some cultures there may not be a word or concept for “psychologist,” “psychiatrist,” “dietician,” “social worker,” “physical therapist,” “occupational therapist,” “respiratory therapist,” or “recreational therapist,” thus presenting new challenges for health care professionals in Western society. For example, there is no word in Korean for psychologist or psychiatrist; mental illness is highly stigmatized, with clients and families encountering great difficulties when mental illness occurs (Donnelly, 1992, 2005). In some countries, nurses may be trained to perform radiologic procedures and physical therapy interventions (Lattanzi & Purnell, 2006). This broad diversity calls for students, nurses, the nursing profession, and other health care professionals to become active participants (and partners) in the process of developing cultural competence and actively seek and embrace a broad (even revolutionary) worldview of diversity.

ETHICAL AND LEGAL ISSUES

Culturally congruent health care is a basic human right, not a privilege (ANA, 1985, 1998a, 2001; Cameron-Traub, 2002; Douglas et al., 2009; International Council of Nurses, 1973; Leininger, 1991a, 1991b; UN,
1948; WHO, 2002, 2006); therefore every human should be entitled to culturally congruent care (see Exhibit 1.1). In addition, empirical findings clearly document the strong link between culturally congruent care and the achievement of positive health outcomes. Increasing numbers of lawsuits with clients claiming that culturally appropriate care was not rendered by hospitals, physicians, nurses, and other health care providers attest to the complicated legal issues that may arise from culturally incongruent care. Furthermore, clients are often winning their cases in court (Leininger & McFarland, 2002). The ICN Code for Nurses (1973), the ANA Code of Ethics (1985, 2001), and the National Standards for Culturally and Linguistically Appropriate Services in Health Care (Office of Minority Health [OMH], 2001), are several important documents that serve as direct reminders and provide guidance to health professionals. Not only are nurses and other health care providers ethically and morally obligated to provide the best culturally congruent care possible but nurses and health care providers are legally mandated to do so. Within the scope of professional practice, nurses and other health professionals are expected to actively seek out ways to promote culturally congruent care as an essential part of professional practice. For example, the discipline of social work recognizes that the “shifts in the ethnic composition of American society in the coming 45 years (U.S. Census Bureau, 2004) and the realities of racism, discrimination, and oppression combine to make cultural competence essential to effective social work practice, and thus to social work education” (Krentzman & Townsend, 2008). The essential inclusion of cultural competence from an ethical and a legal standpoint is addressed on varying levels within the disciplines of physical therapy, occupational therapy, speech-language pathology, dentistry, medicine, psychology, and social work (AAMC, 2005; ADA, 2005, 2007; APA, 1994; APTA, 2008; Gerstein et al., 2009; Lubinski & Matteliano, 2008; NASW, 2001, 2007, 2009; Nochajski & Matteliano, 2008; Panzarella & Matteliano, 2008; Ponterotto et al., 2010; Suh, 2004).

Exhibit 1.1  Tracing the legal right to healthcare: International and U.S. law

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Sixty years ago the United States ratified the constitution of the World Health Organization (WHO), which recognized healthcare as a fundamental right.¹ Emerging from the end of World War II as the leader of the free
world, the United States was the driving force in drafting the constitution of the WHO, the United Nations Charter (UN Charter), and the Universal Declaration of Human Rights (UDHR). Each of these documents recognizes a legal right to healthcare and advocates the involvement of many sectors of society in removing barriers to healthcare access and treatment.²

Ratification of an international treaty is the only act under the American constitution that gives an international treaty legal status in the United States. The American constitution requires that the Senate ratify (give its advice and consent) an international treaty with a two-thirds vote.³ Once the Senate ratifies an international treaty, that treaty becomes national law in the United States, equivalent to a federal statute.⁴

The American Senate ratified the UN Charter in 1945⁵ (giving legal effect also to the UDHR and the WHO Constitution, both of which are authorized by the UN Charter), and the United States was one of the original countries to sign the UDHR and the WHO Constitution in 1948. In 1992, the American Senate also ratified the International Covenant on Civil and Political Rights (ICCPR), which establishes universal standards for the protection of basic civil and political liberties and a fundamental right to health care.⁶

Arguably, the UN Charter, the WHO constitution, and the UDHR have been the law in the United States since at least the 1940s, and the ICCPR has been law since 1992. Under the last in time rule, only a later enacted federal statute can supercede them.⁷ The last in time rule was established by the U.S. Supreme Court in the case of Ping v U.S. (1889). In 1858, the United States and China ratified a treaty addressing immigration between the two countries, granting reciprocal rights of unrestricted travel between them. In 1888, subsequent to the discovery of gold in California, the United States Congress enacted a federal statute severely limiting Chinese laborers from entering the United States, which violated the terms of the 1858 treaty.

In upholding the federal statute, the U.S. Supreme Court held that a federal statute could supercede a treaty if enacted after ratification of the treaty, and a treaty could supercede a federal statute if ratified after the enactment of a federal statute.⁸ There have been no later enacted federal statutes that repealed the U.S. Senate ratification of the United Nations Charter. Therefore, Americans have had a right to health care since 1948.

With the right to healthcare established as a fundamental right in 1948, healthcare delivery must comply with the American Constitution’s equal protection clause of the Fourteenth Amendment.⁹ Whether a private provider or a single payer public system provides health care, compliance with the Fourteenth Amendment’s equal protection clause would uniformly address the unfair, unjust, and avoidable causes of ill health.

A reconstituted Department of Health and Human Services could regulate oversight of the process. It would be able to address issues of health inequity in a way similar to how the U.S. International Trade Commission (ITC) monitors international and national compliance with American intellectual property law¹⁰ and the Equal Employment Opportunity Commission’s power to prohibit discrimination in both private and public employment.
The United States recognized a legal right to healthcare when it ratified the World Health Organization’s constitution, the United Nations’ Charter, and the Universal Declaration of Human Rights more than sixty years ago. The Obama administration must muster the political will necessary to implement healthcare as a fundamental right into the national policy of the United States.

To “assist, support, facilitate, or enhance” culturally competent care, Leininger (1991a) proposed three modes for guiding nursing decision and actions: (a) culture care preservation and/or maintenance; (b) culture care accommodation and/or negotiation; and (c) culture care repatterning and/or restructuring that also have multidisciplinary relevance. Because culturally congruent care can only occur when culture care values, expressions, or patterns are known and used appropriately (Leininger, 1995a), a systematic, thorough cultural assessment is a necessary precursor to planning and implementing care (AACN, 2008, 2009; AAMC, 2005; Andrews, 1992; Andrews & Boyle, 2008; APA, 1994; APTA, 2008; Campinha-Bacote, 2003; Giger & Davidhizar, 2008; JCAHO, 2008; Lattanzi & Purnell, 2006 Leininger, 2002a, 2002c; Lubinski & Matteliano, 2008; NASW, 2001, 2007, 2009; Nochajski & Matteliano, 2008; Panzarella & Matteliano, 2008; Purnell & Paulanka, 2008; Spector, 2009). Assessment, planning, implementing, and evaluating culturally congruent care requires active, ongoing learning based on theoretical support and empirical evidence. The goal of culturally congruent care can only be achieved through the process of developing (learning and teaching) cultural competence (Jeffreys, 2006).

**BARRIERS**

Professional goals, societal needs, ethical considerations, and legal issues all declare the need to prioritize cultural competence development,
Overview of Key Issues and Concerns

necessitating a conscious, committed, and transformational change in current nursing practice, education, and research (Jeffreys, 2002). Although nursing and other health care professions can be transformed through the teaching of transcultural nursing (Andrews, 1995; Leininger, 1995a, 1995b; Leininger & McFarland, 2002, 2006), two major barriers prevent a rapid effective transformation. One major barrier is the lack of faculty and advanced practice nurses formally prepared in transcultural nursing and in the teaching of transcultural nursing (AACN, 2008, 2009; Andrews, 1995; Jeffreys, 2002; Leininger, 1995b; Ryan, Carlton, & Ali, 2000). The second major barrier is the limited research evaluating the effectiveness of teaching interventions on the development of cultural competence (Jeffreys, 2002). These two barriers are further complicated by the (a) changing demographics of students and health care professionals and (b) severe shortage of nurses and nursing faculty. Other health professions have also acknowledged the lack of diversity within their respective fields as well as the lack of faculty prepared to incorporate substantive cultural competence education within professional education as severe barriers to effective transformation (AAMC, 2005; ADA, 2007; APA, 1994; APTA, 2008; Gerstein, et al., 2009; Kazdin, 2008a, 2008b; Lubinski & Matteliano, 2008; NASW, 2001, 2007; Nochajski & Matteliano, 2008; Panzarella & Matteliano, 2008; Ponterotto, et al., 2010; Rosenkoetter & Nardi, 2007). Several of these factors are highlighted in the following sections.

Parts II and III of this book present action strategies, innovations, and practical examples for cultural competence education and evaluation aimed at overcoming barriers and invigorating an effective transformation that reaches beyond competence to “optimal” cultural competence. The goal of optimal cultural competence recognizes that cultural competence is not an end product, but an ongoing developmental process; therefore individuals, groups, and organizations can continually “improve,” striving for “peak performance” outcomes or standards of excellence. Steps essential for optimal cultural competence development include: self-assessment, active promotion, systematic inquiry, decisive action, innovation, measurement, and evaluation.

CHANGING DEMOGRAPHICS OF STUDENTS AND HEALTH CARE PROFESSIONALS

The projected increase in immigration, globalization, and minority population growth has the potential to enrich the diversity of the nursing profession and to help meet the needs of an expanding culturally diverse society (Barbee & Gibson, 2001; Bessent, 1997; Bosher & Pharris, 2009, DHHS, 2000; Griffiths & Tagliareni, 1999; Grossman & Jorda,
GETTING STARTED

2008; Harvath, 2008; Schumacher, Risco, & Conway, 2008; Tagliareni, 2008; Tucker-Allen & Long, 1999; Villaruel, Canales, & Torres, 2001; Wilson, 2007; Yoder, 2001). What has actually occurred is that the dramatic shift in demographics, the restructured workforce, and a less academically prepared college applicant pool have created a more diverse nursing applicant pool (Bosher & Pharris, 2009; Grossman & Jorda, 2008; Harvath, 2008; Hegge & Hallman, 2008; Kelly, 1997; Schumacher et al., 2008; Tagliareni, 2008; Tayebi, Moore-Jazayeri, & Maynard, 1998). Nursing students today represent greater diversity in age, ethnicity and race, gender, primary language, prior educational experience, family’s educational background, prior work experience, and enrollment status than ever before (Jeffreys, 2004; Tagliareni, 2008).

Today’s student profile characteristics can be examined to predict the potential future impact on the nursing profession (see Table 1.1). For example, recent nursing enrollment trends suggest a steady increase among some minority groups, yet no increase has been noted among Hispanic groups (Antonio, 2001; Heller, Oros, & Durney-Crowley, 2000; Ramirez, 2009; Villaruel et al., 2001). As a result, the number of Hispanic nurses is grossly disproportionate to client populations, demanding urgent and innovative recruitment efforts. Recruitment of diverse, nontraditional student populations does not assure program completion, licensure, or entry into the professional workforce. In fact, attrition is higher among nontraditional student populations (Bosher & Pharris, 2009; Braxton, 2000; Jeffreys, 2004; Seidman, 2005, 2007). Therefore, intensive recruitment efforts must be partnered with concentrated efforts aimed at enhancing academic achievement, professional integration, satisfaction, retention, graduation, and entry into the nursing professional workforce.

Unfortunately, current employment trends in nursing indicate high turnover rates, with nurses moving from workplace to workplace. High attrition rates for new nurses leaving the nursing profession are also a major concern. The nursing shortage, high acuity of patient care, diminished resources, and an aging society emphasize the need to prioritize retention of nurses in the workplace. Alleviating the nursing shortage, optimizing opportunities for career advancement, offering incentives for educational advancement, and striving to promote professional (and workplace) satisfaction are broad objectives aimed at facilitating nurse retention.

The recruitment of foreign nurses has been one strategy implemented to alleviate the nursing shortage that has contributed to the changing profile characteristics of professional nurses. Foreign nurses are a heterogeneous group, representing much diversity in profile characteristics and in prior work experience as a registered nurse. The recruitment of foreign nurses must incorporate culturally congruent strategies to ease
Overview of Key Issues and Concerns

Table 1.1  Select Nursing Student Trends and Potential Future Impact on the Nursing Profession

<table>
<thead>
<tr>
<th>Variable</th>
<th>Select Nursing Student Trends</th>
<th>Potential Future Impact on the Nursing Profession</th>
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<tbody>
<tr>
<td>Age</td>
<td>Consistent with global and multidisciplinary trends, the enrollment of older students in nursing programs has increased over the last decade with projected increases to persist in the future.</td>
<td>Age at entry into the nursing profession will be older, resulting in decreased number of work years until retirement.</td>
</tr>
<tr>
<td>Ethnicity and Race</td>
<td><strong>Enrollment</strong>: Recent nursing enrollment trends suggest a steady increase among some minority groups, however, no increase has been noted among Hispanic groups. <strong>Retention</strong>: Minority groups incur higher attrition rates than nonminority groups.</td>
<td>Currently, white, non-Hispanic nurses of European-American heritage represent approximately 90% of all registered nurses in the United States. Mismatches between the cultural diversity in society and diversity within the nursing profession will persist into the future unless strategies for recruitment and retention are more successful.</td>
</tr>
<tr>
<td>Gender</td>
<td><strong>Men</strong>: Although the numbers of men in nursing are increasing, they remain an underrepresented minority (6%). <strong>Women</strong>: Support for women entering the workforce has shifted away from encouraging traditional female professions.</td>
<td>Men will continue to be disproportionately underrepresented in nursing. Many academically well-qualified male and female high school students with a potential interest in nursing may never enter the nursing profession.</td>
</tr>
<tr>
<td>Language</td>
<td><strong>Enrollment</strong>: Consistent with global and national trends in higher education, nursing programs in the United States and Canada have experienced an increase in ESL populations over the past decade. <strong>Retention</strong>: ESL student populations have unique learning needs and incur higher attrition rates.</td>
<td>Although individuals with personal lived experiences in other cultures and languages can potentially meet the needs of linguistically diverse and culturally diverse client populations, they will still be disproportionately represented within the nursing profession.</td>
</tr>
<tr>
<td>Variable</td>
<td>Select Nursing Student Trends</td>
<td>Potential Future Impact on the Nursing Profession</td>
</tr>
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<tr>
<td>Prior Educational Experience</td>
<td>Consistent with trends in higher education worldwide, prior educational experiences are increasingly diverse with an academically less prepared applicant pool. Increases in the number of second-degree individuals have been noted. <em>Retention:</em> Academically underprepared students incur higher attrition rates.</td>
<td>Nurses with degrees in other fields can enrich the nursing profession by blending multidisciplinary approaches into nursing. Nurses with academically diverse experiences may broaden the overall perspective, especially with socioeconomic and educationally diverse client populations.</td>
</tr>
<tr>
<td>Family’s Educational Background</td>
<td>Nursing programs have also seen an increase in first-generation college students, especially among student groups traditionally underrepresented in nursing. <em>Retention:</em> First-generation college students incur higher attrition rates.</td>
<td>First-generation college students who become nurses have the potential to enrich the diversity of the nursing profession and reach out to various socioeconomic and educationally diverse client populations.</td>
</tr>
<tr>
<td>Prior Work Experience</td>
<td>A restructured workforce, welfare-to-work initiatives, displaced homemakers, popularity of midlife career changes, and health care career ladder programs have expanded the nursing applicant pool, increasing its diversity in prior work experience. Many students work full- or part-time. <em>Retention:</em> Work–family–school conflicts may interfere with academic success and retention.</td>
<td>New graduate nurses may enter the nursing profession with a variety of prior work experiences that have the potential to enrich the nursing profession.</td>
</tr>
<tr>
<td>Enrollment Status</td>
<td>Almost half of all college students attend part-time. The number of part-time nursing students, especially those with multiple role responsibilities (work and family) has increased. <em>Retention:</em> Work–family–school conflicts may interfere with academic success and retention.</td>
<td>Part-time students will take longer to complete their education. Entry into practice will be delayed and total number of potential work years in nursing will be decreased.</td>
</tr>
</tbody>
</table>
the transition into the workplace setting, create multicultural workplace harmony, and promote professional satisfaction and opportunities for career advancement (Rosenkoetter & Nardi, 2007; Sherman & Eggenberger, 2008; Zizzo & Xu, 2009). Bridging the gaps between diverse groups of nurses is essential to preventing multicultural workplace conflict and promoting multicultural workplace harmony.

PREPARING CULTURALLY COMPETENT HEALTH CARE PROFESSIONALS

Goals of culturally congruent health care and multicultural workplace harmony can only be achieved by preparing health care professionals to actively engage in the process of cultural competence. Adequate preparation necessitates a diagnostic–prescriptive plan guided by a comprehensive understanding of the teaching–learning process of cultural competency development. Such a comprehensive plan must incorporate a detailed assessment and understanding of learner characteristics. Each learner characteristic provides vital information that is integral to determining special needs and strengths.

Meeting the needs of culturally diverse learners is a growing challenge in academia, the professional workplace, and within professional associations. Because all students, nurses, and other health professionals belong to one or more cultural groups before entering professional education, they bring their patterns of learned values, beliefs, and behaviors into the academic and professional setting. Values are standards that have eminent worth, meaning, and importance in one’s life; values guide behavior. These cultural values are the “powerful directive forces that give order and meaning to people’s thinking, decisions, and actions” (Leininger, 1995a). Cultural values guide thinking, decisions, and actions within the student and/or nurse role as well as other aspects of their lives. Students, nurses, and other health professionals also hold numerous beliefs (ideas, convictions, philosophical opinions, or tenets) that are accepted as true without requiring evidence or proof. Beliefs are often unconsciously accepted as truths (Purnell & Paulanka, 2008).

Cultural values and beliefs unconsciously and consciously guide thinking, decisions, and actions that ultimately affect the process of learning and the outcomes of learning. High levels of cultural congruence serve as a bridge to promote positive learning experiences and positive academic and/or psychological outcomes; high levels of cultural incongruence are proposed as inversely related to positive learning experiences and academic and/or psychological outcomes (Jeffreys, 2004). Cultural congruence refers to the degree of fit between the learner’s values and
beliefs and the values and beliefs of their surrounding environment (Constantine, Robinson, Wilton, & Caldwell, 2002; Constantine & Watt, 2002; Gloria & Kurpius, 1996). Here, the surrounding environment refers to the environment of nursing education within the nursing profession and the educational institution, workplace, or professional association setting.

Nursing is a unique culture that reflects its own cultural style. Cultural styles are the “recurring elements, expressions, and qualities that characterize a designated cultural group through their series of action-patterns, beliefs, and values” (Leininger, 1994a, p. 155). The dominant values and norms of a cultural group guide the development of cultural styles (Leininger, 1994a, p. 155). Currently (within the United States), the culture of nursing reflects many of the dominant societal values and beliefs held in the United States. Similarly, nursing education reflects many of the Western European value systems predominant in U.S. universities. Because nursing has its own set of CVB, students must become enculturated into nursing. Enculturation is a learning process whereby students learn to take on or live by the values, norms, and expectations of the nursing profession (Leininger, 2002a). Sufficient assistance during enculturation adjustment can minimize acculturation stress and enhance enculturation.

Another unique challenge facing nurse educators is to enculturate foreign-educated physicians and other second-career individuals who are entering nursing programs (Grossman & Jorda, 2008; Hegge & Hallman, 2008; Johnson & Johnson, 2008). Unfortunately, cultural competence as a priority professional value received delayed popularity among the nursing profession overall, with little emphasis or inclusion in nursing curricula, practice, research, theory, administration, and the literature. Consequently, today’s nurse educators may be inadequately prepared to enculturate students into the new era of the nursing profession that embraces cultural diversity and supports cultural competence development. Similarly, within other health disciplines, cultural competence as a priority or even as an essential professional value received delayed attention in professional practice settings and professional curricula, thereby contributing to a multidisciplinary health care culture poorly equipped to meet the culture-specific care needs of diverse patients in a multicultural workplace environment.

Although increases in culturally diverse students have been noted in higher education and in nursing, the values and beliefs underlying nursing education have been slow to change in accordance with changing student population needs. Ethnocentric tendencies and cultural blindness have been major obstacles to the needed changes in nursing education. Ethnocentric tendencies refer to the belief that the values and beliefs traditionally held within nursing education are supreme. Consequently,
Overview of Key Issues and Concerns

traditional teaching–learning practices are upheld. Too often, cultural blindness exists in nursing education. Within the context of nursing education, cultural blindness is the inability to recognize the different CVB that exist among diverse student populations. Because cultural blindness does not acknowledge that differences exist, cultural imposition of dominant nursing education values and beliefs undoubtedly occur. Cultural imposition can cause cultural shock, cultural clashes, cultural pain, and cultural assault among students whose CVB are incongruent with the dominant nursing CVB (Jeffreys, 2004).

Nurse educators are challenged to explore various CVB within nursing, nursing education, higher education, and student cultures and to make culturally sensitive and appropriate decisions, actions, and innovations. Table 1.2 selectively compares and contrasts CVB of nursing education, higher education, and four other cultural groups. Based on a review of the literature, traditional views within the identified cultures were included but are in no way meant to stereotype individuals within the cultures. Readers are cautioned about making stereotypes and are reminded to explore CVB of individual learners. It is beyond the scope of this book to provide in-depth explanations about each category, yet the importance of an in-depth understanding must be recognized. The selective approach is meant to spark interest, stimulate awareness, and encourage further exploration among educators before attempting the design of culturally relevant and congruent educational strategies. This approach is critical, because the need to understand, respect, maintain, and support the different CVB of culturally diverse learners is a precursor to culturally relevant and competent education (Abrums, 2001; Bosher & Pharris, 2009; Crow, 1993; Davidhizar, Dowd, & Giger, 1998; Labun, 2002; Manifold & Rambur, 2001; Rew, 1996; Sommer, 2001; Tucker-Allen & Long, 1999; Villaruel et al., 2001; Weaver, 2001; Williams & Calvillo, 2002; Yoder, 1996; Yoder & Saylor, 2002; Yurkovich, 2001).

The teaching–learning process of cultural competence must consider the various philosophies and approaches to learning. Whether the teacher is perceived to be an authority figure, partner, coach, mentor, professional, or member of a service occupation will influence the teaching–learning process (see Table 1.2). Preferred teaching–learning styles may be active (learner-centered) or passive (teacher-centered). Although student-centered learning has long been advocated, nursing curricula have been slow to embrace this philosophy and to address the needs of diverse learner styles (Bellack, 2008). Teaching–learning strategies perceived as fun and likable by some may be perceived as aggressive (debate), competitive (gaming), threatening (Web-based, role-playing, or small group activity), boring (rote memorization), and/or irrelevant by others. Learner goals and philosophies that emphasize the “process” of learning focus on
Table 1.2  Comparison of Select Cultural Values and Beliefs

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<tbody>
<tr>
<td>Orientation</td>
<td>Individual</td>
<td>Individual</td>
<td>Group</td>
<td>Group</td>
<td>Group</td>
<td>Individual</td>
</tr>
<tr>
<td>Punctuality valued</td>
<td>Punctuality valued</td>
<td>Punctuality valued</td>
<td>Traditionally, lateness for appointments is expected.</td>
<td>Punctuality less important</td>
<td>Punctuality valued</td>
<td>Flexible sense of time.</td>
</tr>
<tr>
<td>Verbal Communication</td>
<td>Direct, specific, and quick communication preferred.</td>
<td>Depending on discipline, may have more or less elaboration and speed may not be as much of a priority as in the fast-paced health care setting common to nursing.</td>
<td>Moderate to low tones preferred. Loud tone associated with anger. Answers &quot;yes&quot; when asked if something is understood. Reltuctant to talk about feelings and views.</td>
<td>Loud tones (in comparison to other cultures) are preferred. Views and feelings are shared openly with family and trusted friends. Personalt topics may be taboo.</td>
<td>Loud tones (in comparison to other cultures) are preferred. Loud tone associated with anger. Answers &quot;yes&quot; when asked if something is understood.</td>
<td>Low contextual language where meaning is explicit rather than implicit. Personal topics are private. Thoughts and feelings shared only with close family and friends.</td>
</tr>
<tr>
<td>Nonverbal Communication</td>
<td>Most often consistent with dominant societal values, such as direct eye contact, handshake, and spatial distances.</td>
<td>Same as nursing education.</td>
<td>Avoid direct eye contact, especially with persons of authority and highly respected individuals.</td>
<td>Direct eye contact is sometimes perceived as aggressive.</td>
<td>Avoid direct eye contact, especially with persons of authority and highly respected individuals.</td>
<td>Direct eye contact is maintained, indicating respect and trust.</td>
</tr>
<tr>
<td>Household Responsibilities</td>
<td>The &quot;traditional&quot; student did not have household or outside responsibilities. Student role is primary.</td>
<td>Same as nursing education.</td>
<td>Household responsibilities shared; however, specific roles may be based on gender. Male is head of family.</td>
<td>Household responsibilities may be divided between men and women and children. Woman is often head of family.</td>
<td>Household responsibilities mainly part of female role. Male dominance with male as head of family. Modesty.</td>
<td>Traditionally, household responsibilities part of female role; however, in recent years responsibilities shared between men and women.</td>
</tr>
<tr>
<td>Health</td>
<td>Professes &quot;holistic&quot; view of health but still strongly based on medical model with focus on symptom alleviation, use of technology, and Western medicine.</td>
<td>Health is not the major focus of institutions of higher education. In recent years, many colleges have eliminated or relaxed graduation requirements for courses in health, fitness, and/or physical education.</td>
<td>Balance between &quot;yin and yang.&quot;</td>
<td>&quot;Health is viewed as a harmony with nature.&quot;</td>
<td>Balance between &quot;hot and cold.&quot;</td>
<td>Determined by external forces.</td>
</tr>
<tr>
<td>Nurse</td>
<td>&quot;Professional&quot; seeking more respect from other health professions and society.</td>
<td>In comparison to other disciplines, nursing had a late start in higher education. May be viewed as a profession rather than profession.</td>
<td>Respected as authority figures after physicians. Nurses with advanced education are more highly respected than nurses with less education.</td>
<td>Respected member of the health care team, but less important than physicians.</td>
<td>Respected member of the health care team, however, often viewed as an outsider.</td>
<td>Nurses are respected as members of a service-oriented field or &quot;occupation.&quot;</td>
</tr>
</tbody>
</table>
Within the nursing culture, disputes surrounding minimal educational requirements still persist. Minimal education for tenure and promotion is the doctorate; although masters degree may be minimal at the community colleges. Highly valued, especially a college education. Education is valued, however, access to college education has been limited historically. Families often expect females to put family first.

Traditional pedagogy viewed teacher as "authority" who "transmits" learning to student. Never proponents of andragogy view teacher as partner or facilitator of learning who implements learner-centered approaches. Authority figure. True equality does not exist, there fore concept of "partner" in learning may be difficult to comprehend. High expectation within group to excel academically.

Rote learning and memorization predominates teaching role and load has greater emphasis at community colleges. Teaching role may be minimal at college education. Doctorate, although master's degree may be minimal at community colleges. Families often expect females to put family first. Traditionally valued. Respect professional. Teacher is viewed as a highly respected superior. Rote learning and memorization predominates in Mexico with little emphasis on practical application, analysis, and synthesis.

"Keeping busy" is less valued than high quality, scholarly productivity, especially at senior colleges and research institutions. Keeping busy is less valued than high quality, scholarly productivity, especially at senior colleges and research institutions. Speed at working is not a priority. Hard work is valued. Speed at working is not a priority. Hard work is valued. "Keeping busy" is valued. Work is secondary to family and other life activities. May be uncomfortable with authority persons checking work.

Competition with authority. Assertive. Autonomous decision-making within the scope of nursing practice expected. Competitive, assertive. Academic freedom highly valued. Democratic governance, faculty-developed curricula, and professional unions/organizations valued. Defers to person in authority, often seeking approval before making decisions. Avoids conflict and values harmony. Self-efficiency and autonomy encouraged within group. Past discrimination experiences may discourage autonomy. Females are often head of household and decision-makers. Defers to person in authority, often seeking approval before making decisions. Avoids conflict and values harmony. Self-efficiency and autonomy encouraged within group. Past discrimination experiences may discourage autonomy. Females are often head of household and decision-makers. Autonomy and independence outside the family is encouraged while family loyalty is still maintained.

Individual is expected to initiate help-seeking behaviors. Same. Stigma for seeking help for emotional disorders & stress. May be reluctant to approach for help by attempting to "save face". Stigma for seeking help for emotional disorders & stress. May be reluctant to approach for help by attempting to "save face". Stigma for seeking help for emotional disorders & stress. May be reluctant to approach for help by attempting to "save face". May delay seeking help. Denial of problems is a way of coping with physical and emotional problems.

Nursing is "hard work" Withdrawal from a nursing course is acceptable for academic and/or personal circumstances and should be decided by the individual. Among disciplines outside of nursing, nursing may not be perceived as "hard work" or academically rigorous/challenging work for academically strong students. Views on withdrawal similar to nursing education. Hard work is highly respected. Withdrawal decisions may be difficult, especially if families have sacrificed greatly to assist student with educational endeavors. Withdrawal decisions may be difficult, especially if families have sacrificed greatly to assist student with educational endeavors. Withdrawal decisions may be difficult, especially if families have sacrificed greatly to assist student with educational endeavors. Withdrawal decisions may be difficult, especially if families have sacrificed greatly to assist student with educational endeavors. Withdrawal decisions may be difficult because academic or personal problem must first be acknowledged.
the journey of “becoming” culturally competent through the integration of cognitive, practical, and affective learning. Process learners recognize that the journey itself is the “learning”; obstacles, mistakes, and hardships along the way are part of the expected developmental process that requires extra effort, sincere commitment, motivation, and persistence. Process learners realize that there is no final end product labeled “cultural competence,” rather cultural competence is dynamic and ongoing. In contrast, “product” learners are focused on obtaining an end product through the mastery of content. Memorizing a multitude of “facts” about a culture becomes important rather than comprehensively understanding, applying, and appreciating the cultural context or rationale behind the “fact.” There is less concern with how to learn to apply knowledge and develop skills, and even less concern with affective learning (values, attitudes, and beliefs). Product learners would be greatly disturbed, dissatisfied, and poorly motivated with an approach that views the end point for becoming culturally competent as infinite.

Perceived barriers to learning, mismatches in teacher–learner expectations, and poor learning experiences will hinder the learning process of cultural competence. For example, faculty beliefs that nonminority students are less confident in caring for culturally different clients than minority students is stereotypical and inaccurate (Jeffreys, 2000; Jeffreys & Smodlaka, 1998, 1999a, 1999b; Lim, Downie, & Nathan, 2004). Similarly, the belief that minority nurses are intrinsically equipped to care for culturally diverse clients is also inaccurate and negates the uniqueness of the many cultures that comprise the federally recognized “minority” group categories and disregards the many cultures that comprise nonminority groups. The danger is that minority students’ and nurses’ special educational needs with respect to providing culturally congruent care for many different groups of culturally different clients (different in culture from care provider) may be ignored. Expectations that are more, less, or different, based solely on ethnic or racial background, are grossly inadequate, because other diverse profile characteristics and their potential influence on learning must be objectively appraised.

Meeting the needs of learners representing diversity in age, ethnicity and race, gender, primary language, prior educational experience, family’s educational background, prior work experience, and/or enrollment means embracing a broader, inclusive worldview that appreciates various forms of diversity. Awareness of how each profile variable can potentially influence learning is a necessary first step in understanding the multidimensional process of cultural competence development. For example, the learning needs and expectations of foreign-educated learners may be very different from what educators initially perceive, creating an obstacle for learning, achievement, and satisfaction (Billings
Overview of Key Issues and Concerns

Acculturation stress, adaptation, assimilation, CVB toward education, experiences with second language, and expectations can impact greatly upon learning and achievement (Bosher & Pharris, 2009; Flege & Liu, 2001; Fuertes & Westbrook, 1996; Jalili-Grenier & Chase, 1997; Kataoka-Yahiro & Abriam-Yago, 1997; Kurz, 1993; Manifold & Ramdur, 2001; Olenchak & Hebert, 2002; Smart & Smart, 1995; Upton & Lee-Thompson, 2001). Other stressors that may affect specific subgroups in nursing include: perceived cultural incongruence (Constantine et al., 2002; Maville & Huerta, 1997), perceived (or fear of) discrimination and bias (Bosher & Pharris, 2009; Kirkland, 1998), student (learner) role incongruence (Chartrand, 1990), maternal role stress (Gigliotti, 1999, 2001), perceived multiple role stress (Courage & Godbey, 1992; Gigliotti, 1999; Gigliotti, 2001; Greenhaus & Beutell, 1985; Lambert & Nugent, 1994; Loerch, Russell, & Rush, 1989), and gender role identity stress (Baker, 2001; Constantine et al., 2002; Patterson & Morris, 2002; Streubert, 1994). In addition, students who work in the health care field as unlicensed personnel, licensed practical nurses, or health care paraprofessionals may have difficulty adjusting to a new role, new worldview, and critical thinking and decision making within a nursing perspective that is guided by the professional scope of nursing practice (Jeffreys, 2004; Sweet & Fusner, 2008). Second-career students entering nursing may also bring new visions; however, second-career nursing students and graduates in accelerated programs present new challenges for professional socialization and integration (Penprase & Koczara, 2009).

New graduate nurses may experience reality shock with their new professional role, workload, and responsibilities; experienced nurses may encounter burnout. Inactive nurses returning to the workforce after a gap in work experience benefit from refresher courses and other transitional strategies to ease them into the new workplace environment (Hammer & Craig, 2008). Recently, researchers have begun to realize the need to explore the relationships between psychological distress, effort–reward imbalance, and the nursing work environment among different generations: Baby boomers, Generation X, and Generation Y (Lavoie-Tremblay et al., 2008). The generation of the Millennials challenges educators to keep pace with the social and educational technologies that these learners expect (Bellack, 2009; Zalon, 2008). For example, the net generation (1980 to 2004) expects technology, participates actively in the learning process, wants immediate response to learning, multitasks, prefers group work, and enjoys being mentored by older generations. In contrast, Generation X (1960 to 1980) are self-directed learners who are less technology proficient, can delay gratification, and seek learning with practical application.
Baby boomers (1940 to 1960) are generally less technology proficient, because technology is viewed as a new approach rather than an expected approach, are more familiar with passive learning styles, and expect a caring and connected work environment (Billings & Kowalski, 2004).

The nursing profession has the challenging opportunity to meet the unique needs of various populations of nurses, improve nurse retention, decrease the nursing shortage, and promote cultural competence. Evidence-based transitional programs, specialized orientation programs, ongoing employee workshops, refresher courses that integrate the values, skills, and knowledge needed for cultural competence in the workplace have the potential to address these needs. Unfortunately, state and certifying boards/associations have varied continuing education (CE) and competency requirements for license renewal and reentry (Yoder-Wise, 2009) and none require documentation of CE programs in cultural competence. Among other health professionals, inconsistencies in licensure renewal, certification, CE, and practice requirements also exist. For example, physicians licensed in New Jersey are now required to complete CE in cultural competence, yet this is not a universal medical requirement throughout the United States. Professional inconsistencies (in any discipline) may translate into questioning the need for the requirement, decreased motivation, resentment, and lack of commitment on the part of the professional, thereby defeating the overall goal of actively engaging the health professional in lifelong commitment to cultural competence development.

**CULTURAL COMPETENCE AND CONFIDENCE**

Despite the numerous complexities, changes, and challenges faced by many nursing students and nurses today, some individuals are more actively engaged in cultural competence development whereas others are not. Some individuals are more motivated to pursue cultural competence development and are more committed to the goal of culturally congruent care than others. Therefore, the evaluation of factors that may influence motivation, persistence, and commitment for cultural competency development is a necessary precursor to any educational design strategy.

Confidence (self-efficacy) is one such factor that is emphasized in this book. According to Bandura (1986), the construct of self-efficacy is the individuals’ perceived confidence for learning or performing specific tasks or skills necessary to achieve a particular goal. Furthermore, self-efficacy is the belief that one can perform or succeed at learning a specific task, despite obstacles and hardships, and will expend whatever energy is necessary to accomplish the task (Bandura, 1986). Consequently, confidence is
inextricably linked as a major component in cultural competence development and an influencing factor in the achievement of culturally congruent care. Confidence is an integral component in the action-strategy acronym “COMPETENCE,” introduced and illustrated in the next chapter. The acronym may be used by the multidisciplinary health care team to: (a) guide clinical practice with culturally diverse patients and (b) promote multicultural workplace harmony and prevent multicultural workplace conflict among culturally diverse health care workers. Later, Chapter 3 proposes a new conceptual model to understand and guide cultural competence education, research, and practice.

KEY POINT SUMMARY

- Rapid growth in worldwide migration, changes in demographic patterns, varying fertility rates, increased numbers of multiracial and multiethnic individuals, and advanced technology contribute to cultural evolution.
- Culturally congruent health care refers to health care that is customized to fit with the client’s cultural values, beliefs, traditions, practices, and lifestyle.
- Health care professionals and organizations are challenged to go beyond the goal of achieving “competence” (minimum standard) toward the goal of achieving “optimal” cultural competence (standard of excellence).
- Educators everywhere are additionally challenged to learn how to lead the quest for culturally congruent health care by implementing creative, evidence-based educational activities that promote positive cultural competence learning outcomes for culturally diverse students and health care professionals aiming to reach beyond minimal competence to the achievement of optimal cultural competence.
- Two major barriers prevent a rapid effective transformation through transcultural education: (a) lack of faculty and advanced practice nurses formally prepared in transcultural nursing and in the teaching of transcultural nursing; and (b) limited research evaluating the effectiveness of teaching interventions on the development of cultural competence.
- Goals of culturally congruent health care and multicultural workplace harmony can only be achieved by preparing (teaching) health care professionals to actively engage in the (learning) process of cultural competence.
• Meeting the needs of learners representing diversity in age, ethnicity and race, gender, primary language, prior educational experience, family’s educational background, prior work experience, and/or enrollment means embracing a broader, inclusive worldview that appreciates various forms of diversity and must consider the various philosophies and approaches to learning.

• Confidence (self-efficacy) is an important factor that may influence motivation, persistence, and commitment for cultural competency development.