2.4: Cultural Competency

Description

Cultural competency is a concept that arises from the seminal work of Madeleine Leininger, who was trained as a nurse and an anthropologist. Leininger first saw the importance of culture in nursing care delivery. Leininger’s theory of cultural care diversity and universality (1995) is based on the fundamental assumption that culture affects people’s health and illness experiences as well as nursing care delivery. Leininger (1995) postulates that “culture is an integral and essential aspect of being human, and the culture care aspects cannot be overlooked or neglected” (p. 4). Culture represents “the learned, shared, and transmitted knowledge of values, beliefs, norms, and lifeways of a particular group that guides an individual or group in their thinking, decisions, and actions in patterned ways” (Leininger, 1995, p. 60). Religion, gender, and socialization influence cultural patterns and create a diversity of needs when applied to nursing and health care. Nurses need to possess cultural competency when navigating culturally diverse clienteles and multicultural workplaces.

Cultural competency is both an individual and an organizational process (Andrews & Boyle, 2012). Purnell (2013) defines cultural competence in health care as “having the knowledge, abilities, and skills to deliver care congruent with the patient’s cultural beliefs and practices” (p. 7). Jeffreys (2010) refers to cultural competence as “a multidimensional learning process that integrates transcultural nursing skills in all three dimensions (cognitive, practical, and affective), involves transcultural self-efficacy (confidence), and aims to achieve culturally competent nursing care” (p. 36). Campinha-Bacote (2002) defines cultural competency as an “ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client [individual, family, community]” (p. 181). Campinha-Bacote’s Process of Cultural Competency and Model of Care (2002) builds on the assumption that cultural competency is an ongoing process of being and becoming. Campinha-Bacote (2002) points out that to be effective, this model “requires health care providers to see themselves as becoming culturally competent rather than already being culturally competent” (p. 181). This ongoing process means that nurses are immersed in a
continual process of education where there is no end point to learning about cultural differences.

In her article, Bourque Bearskin (2011) points out that “culture is everything about people: the way they live, the way they view things, the way they communicate” (p. 4). It is through encounters with peoples from different ethnocultural backgrounds that nurses start their journey of becoming culturally competent. Cultural competency cannot happen if there is no exposure to cultural diversity. Similarly, Campinha-Bacote underlines that encountering cultural diversity is a prerequisite or an antecedent for the development of cultural competency. In her model, Campinha-Bacote describes five interrelated concepts: (1) cultural awareness, (2) cultural knowledge, (3) cultural skill, (4) cultural encounters, and (5) cultural desire.

## Cultural Assessment

**Cultural awareness** involves assessing one’s cultural and racial biases as a means to identify how one’s cultural stereotypes may affect the delivery of nursing care to cultural or linguistic minority groups. **Cultural knowledge** refers to knowledge about cultural groups and how their cultural beliefs and norms may impact on perceptions and experiences of health and illness, and influence access to health care and relationships with nurses and other health care professionals. It is important to know how ethnicity and race may affect pharmacotherapeutics or how culture shapes lifestyle and other health-related behaviours.

Campinha-Bacote (2002) argues that the acknowledgement of culture implies that nurses must develop knowledge and **cultural skills** to conduct a cultural assessment of each client. A **cultural assessment** is defined as “a systematic appraisal or examination of individuals, groups, and communities as to their cultural beliefs, values, and practices to determine explicit needs and intervention practices” within the context of the health encounters (Leininger, 1995, p. 122). Other theories can be used to conduct cultural assessments using Giger and Davidhizar’s *Transcultural Assessment Model* (2002), Leininger’s *Cultural Care Diversity and Universality Theory* (2002), Purnell’s *Model for Cultural Competence* (2013), or Spector’s *Model of Cultural Diversity in Health and Illness* (2009). For instance, Giger and Davidhizar’s *Transcultural Assessment Model* (2002) explores six cultural phenomena, believed to be culturally unique among persons, that become the object of cultural assessment. These variables are: (1) communication, (2) space, (3) social organization, (4) time, (5) environmental control, and (6) biological variations (Giger & Davidhizar, 2002, p. 185). Similarly, Purnell’s *Model for Cultural Competence* (2013) assesses 12 domains of culture. The domains of culture are:

1. overview, inhabited localities, and topography
2. communication
3. family roles and organization
4. workforce issues
5. biocultural ecology
6. high-risk behaviours
7. nutrition
8. pregnancy and childbearing practices
9. death rituals
10. spirituality
11. health care practiced
12. health care provider (Purnell, 2013, p. 18)

**Cultural encounters** focus on cross-cultural interactions. Cross-cultural interactions enable nurses to engage with culturally diverse clients or groups to change or challenge ethnic and racial biases. Communication and language are important factors to facilitate access to clients’ lived experiences of health and illness. In cases of a lack of linguistic fluency, nurses may use interpreters or cultural brokers to access clients’ knowledge of their illness or conditions.

**Cultural skill** represents the ability to perform the cultural assessment when meeting with clients or families.
Desire refers to the motivation and the genuine desire for cultural understanding, as opposed to the obligation of encountering cultural diversity. Campinha-Bacote suggests that caring is an antecedent of cultural desire in the fact that the nurse cares about those from different cultures. Cultural desire can be manifested through openness to cultural diversity and a willingness to learn from others. Campinha-Bacote explains that becoming culturally competent is an interactive and transformational endeavour.

**Professional Nursing Guidelines for Culturally Competent Care**

The delivery of culturally competent care is embodied in standards and codes of ethics set by international, national, and provincial nursing regulatory bodies, including the Canadian Nurses Association. The International Council of Nurses (2012) mentions that “in providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family, and community are respected” (p. 2). The Canadian Nurses Association supports the view of social justice that is inherent to the delivery of culturally competent nursing care. The Canadian Nurses Association (2010) defines cultural competency as “a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable them to work effectively in cross-cultural situations” (p. 1). In a document entitled “Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nations, Inuit and Métis Nursing,” the Aboriginal Nurses Association of Canada (now the Canadian Indigenous Nurses Association), the Canadian Association of Schools of Nursing, and the Canadian Nurses Association stipulate that Canadian nurses must know the impact of colonialism on Indigenous health issues to avoid the pitfalls of ethnocentrism and cultural imposition. Nurses need to learn how to communicate and respect Indigenous ways of knowing. While cultural competency encompasses attributes like cultural awareness, sensitivity, and humility, the ultimate goal of developing and applying core cultural competencies is to advocate and protect the dignity of individuals and groups (Douglas et al., 2014).

Similarly, in the United States, the Office of Minority Health (OMH), part of the US Department of Health and Human Services, requires that US citizens have access to “culturally and linguistically appropriate services, are respectful of and responsive to the health beliefs, practices and needs of multicultural and diverse patients” (OMH, 2017). Cultural competency is therefore not only a nurse’s individual and ethical duty, but also an organization’s responsibility—a responsibility to enable and facilitate the establishment of rules and policies that will promote cultural competency within work relations in nursing workplaces.

Finally, the Saskatchewan Registered Nurses’ Association (SRNA) stipulates that the development of cultural safety is a core competency that must be addressed in nursing curricula. Cultural competency is reflected in Standard II.2 (44): “Negotiates priorities of care and desired outcomes with clients while demonstrating an awareness of cultural safety and the influence of existing positional power relationships” (SRNA, 2013, p. 13). We now examine the characteristics of culturally competent organizations.