Care CEUs

Continuing Education for Nursing Home Administrators

Cultural Competence in Healthcare

Section 1: Introduction

The history of the United States of America is one of increasing diversity. It has been known as the “melting pot” or, more accurately, the “salad bowl” because people from many cultures and backgrounds settled in the United States over hundreds of years, though rather than losing their cultural identities, many have been able to maintain their cultural identity while also becoming a valued and contributing member of American society (Bauer & Baum, 2022). The United States is also challenged with health equity issues, many of which stem from systemic racism, cultural differences, and lack of cultural competence in healthcare. Access to health differs by race and ethnicity. Language barriers can contribute to poor outcomes. Racial minorities are disproportionately affected by chronic illnesses. By fostering a more culturally competent healthcare workforce, we can be part of the solution to cultural health inequity (Ihara).

The racial and language diversity of the people living in the United States is rapidly changing. It is expected that by the early 2040s, minority racial groups will make up the majority of the US population (NASEM, 2023). As of 2022, 12.1% of the population was Black or African American (non-Hispanic), 5.7% Asian and 12.64% Hispanic. Currently, over 21% of households in the United States report speaking a non-English language as the typical household language. The most common is Spanish, followed by Chinese (including Mandarin and Cantonese) and Tagalog (DATAUSA).

Religious diversity in the United States is also changing. The US population that identifies as white Christian has declined by 21% since 1996. This group does still account for the majority religion in the United States, with 44% of the population declaring themselves white Christians. Twenty-five percent of the population identifies as Christians of color. The distinction between white Christians and Christians of color is made because research has shown that the most cultural and

political divides exist between these two groups. Non-Christian religious groups comprise about 4.5% of the population, including Jewish, Muslim, Buddhist, Hindu, and other non-Christian groups. Six percent of the population identifies as agnostic or atheist, while 17% claim no religious affiliation (PRRI, 2021).

Global migration has increased in the last few decades, with over 280 million people living in countries other than the ones they were born in. Fifty million of those migrants reside in the United States (United Nations Department of Economic and Social Affairs, 2020). As a result of migration, countless ethnicities, religions, and geographical origins are represented by the current US population (United Nations Department of Economic and Social Affairs, 2020). Diversity continues to grow and change as our country continues to grow and change as well, creating a true “salad bowl”. This diversity is well-represented among the patients seeking medical care across all healthcare settings. As nurses and healthcare workers seek to provide individualized care, it is necessary to understand the importance of providing culturally competent care to each patient.

Providing culturally competent care is a skill, like assessments and interventions, that each clinician must learn. Nurses are not expected to be inherently knowledgeable about the intricate nuances of every ethnic, religious, and geographical culture represented by each patient. However, nurses are skilled at creating individualized approaches to care and can learn to provide culturally competent care to each client as a method to facilitate patient-centered care. Cultural competence aims to improve healthcare quality and positively affect patient outcomes.

Section 2: What is Cultural Competence?

Culture is defined as “the customary beliefs, social forms, and material traits of a racial, religious, or social group” (Merriam-Webster, n.d.). The Centers for Disease

Control (CDC) defines cultural competence as “Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations” (CDC, 2024). Cultural competence is an aspect of patient-centered care that describes the ability of an individual or an organization to consider the diverse cultural factors impacting a patient’s care experience and integrate those differences into the delivery of care, with the benefit of improved outcomes. Cultural competence is not the same as awareness or sensitivity. While these include acknowledging the different customs and beliefs of others, cultural competence requires incorporating these considerations into the patient’s care plan. A culturally competent nurse can work cross-culturally without judgment or discrimination, recognizing that the norms and customs of the patient they are caring for may differ from their own, and can integrate these considerations into multiple aspects of their work, including bedside care delivery, patient education, and patient advocacy. Culturally competent nurses value the diversity of the patients they care for and recognize that culturally competent care can positively impact the quality of healthcare their patient receives.

Culture describes how people live their lives, including what they eat, how and what they celebrate, specific values, behavioral customs, and more. What may be considered rude behavior in one culture, such as making eye contact, may be seen as a sign of respect in another culture. These differences can lead to unintended miscommunication but also can lead to health disparities. When cultural differences are ignored, it can lead to barriers to patient education, treatments, at-home care, and overall outcomes (Green, 2019).

The approach by healthcare professionals to culture and healthcare has a varied past. Before the last half of the 20th century, psychological healthcare and social services focused on immigrant assimilation to American culture. By the 1960s, it was recognized that this approach was ineffective and that treatments based on

Western ideals for individuals from other backgrounds were not universally applicable. Cultural Awareness in the Human Services, published in 1982 by anthropologist James Green, provided approaches to culturally aware services (Wilson, 2021). This has given rise to the concept of cultural competence.

Cultural competence was first mentioned in the literature in 1989 by Terry L. Cross, founder of the National Indian Child Welfare Association and a member of the Seneca Nation (Wilson, 2021), regarding improving the mental health service delivery for minority pediatric patients. It was explored as a construct for "systems, agencies, and practitioners" to "respond to the unique needs of populations whose cultures are different from that which might be called 'dominant' or 'mainstream.'" (Cross & al., 1989). Since this time, assimilation has decreased as the focus of care for minorities. At the turn of the 21st century, cultural competence began to play a more significant role in the healthcare world as clinicians began to recognize it was not only important to acknowledge cultural differences but also to adjust their approach to integrate those differences in the delivery of care (Wilson, 2021).

While cultural competence has moved to the forefront of healthcare, there is room for improvement. Personal and professional growth are required. Healthcare workers can begin to understand cultural competence by considering four aspects.

Four Aspects of Cultural Competence

1. **Awareness**: Nurses must be able to identify their own biases and how they perceive individuals from backgrounds other than their own. For example, a nurse may realize they think of people who are not English speaking as having less ability to understand discharge instructions, developing awareness of their bias.

2. **Attitude**: Once a nurse understands their own bias, they can reflect on their personally held traditions and belief systems. They can explore how their own background affects the way they interact with patients and how they can improve their approach to provide better care.

3. **Knowledge**: The nurse must be willing to learn about their patient's culture. They must also seek to continue to learn about various cultures and how their beliefs may affect their healthcare, especially those cultures represented in their community. For example, nurses working in a community that has recently welcomed refugees must educate themselves on how culture impacts healthcare. Understanding the healthcare system of a patient's country of origin may also help the clinician understand the patient's expectations for care.

4. **Skills:** Nurses can integrate cultural competence into their care by integrating awareness, attitude, and knowledge into their interactions with patients. They can include these understandings in their physical assessment approach, patient education, and identifying discharge needs, among other things. Nurses working in a community health setting can integrate what they have learned as they are immersed in their client's culture, learning how to interact appropriately and respectfully.

   (Deering, 2024) (Wilson, 2021)

Before we can become culturally competent, we must understand bias. Bias impacts the care provided throughout the healthcare system. Bias is one's outlook (Merriam-Webster, n.d.). There are different types of bias. Explicit bias is known and consciously held by the individual. The person is aware that they have positive or negative views of a particular group. Racist comments are an example of explicit bias (USDJ, 2021).

Implicit bias is subconscious. The individual is unaware of their feelings and stereotypes, but this still affects their actions toward different people groups. Though unintended, the person may be less trusting of others from a different race than their own (USDJ, 2021). Implicit bias continues to contribute to healthcare disparities. The way nurses communicate with their patients, deliver care, and provide education is impacted by their implicit bias (Vela et al., 2022). A well-known example of implicit bias in healthcare is the assumption by patients that the male healthcare worker is their doctor rather than their nurse, and vice versa for female care providers. Implicit bias can cause unfavorable outcomes and healthcare disparities (Gopal et al., 2021). Once we recognize what bias is and that it exists for everyone, we can become more culturally competent.

Cultural competence contributes to more favorable outcomes. In the primary care setting, care that is accessible, effective, and cost-efficient must take into consideration the culture of the patient. Cultural competence also increases effective communication between healthcare workers and patients, which decreases health malpractice claims. Cultural competence fosters increased health literacy for patients, which, in turn, empowers individuals to make more informed decisions regarding their health (NCCC).

Section 2 Case Study

Janet is a Latina emergency room nurse. She reports to the oncoming nurse, Debbie, that Mr. Lewis, the elderly Native American man she has been caring for, has not experienced any pain during her shift. Debbie performs her initial assessment and finds Mr. Lewis watching TV quietly, though his heart rate and blood pressure have increased. He appears to be breathing shallowly and winces when Debbie auscultates his abdomen. Debbie asks Mr. Lewis if he is experiencing pain. He states that he has been for much of the day, and when she offers to

administer PRN pain medication, he agrees. What could be the problem in this scenario? What type of bias likely occurred and why? What could have prevented this?

Janet and Mr. Lewis are from differing ethnic cultures. Janet may have assumed that since Mr. Lewis was not complaining of pain, he was not experiencing pain. This is an example of implicit bias. While Janet did not intend to withhold pain medication, she was unable to see that Mr. Lewis was in pain. This bias likely occurred because, in Janet's culture, people are more expressive regarding pain, while in Mr. Lewis's culture, people tend to be more stoic. Further cultural competence education and self-assessment could help Janet to be more aware of her own background and potential biases she may experience.

Section 2 Personal Reflection

What is your background? How might that contribute to your interactions with different populations? How might it affect your delivery of care? Reflect on incidences of explicit bias and implicit bias you have observed or experienced.

Section 2 Key Words

Background - the combination of a person's experiences, knowledge, and education

Bias - an outlook which favors one's own perspective

Community - a group of people with common characteristics, interests, beliefs, or shared history living in a larger society

Cultural Competence - the ability of an individual or an organization to consider the diverse cultural factors impacting a patient's care experience and integrate those differences into the delivery of care

Diversity - the inclusion of people of different races in a group or organization

Explicit Bias - when the outlook or opinion is known to the person

Implicit Bias - when the outlook or opinion is unknown to the person

Patient-Centered Care - care focused on the individual needs of the patient

Racism - a belief that race is a determinant of human capacity and that those differences make a particular race superior to others

Discrimination - prejudiced behavior or treatment towards a particular group

(Merriam-Webster, n.d.)

Section 3: How Does Culture Impact Healthcare?

Culture impacts patient lives in every aspect and similarly impacts healthcare. From learning styles to dietary needs to discharge planning and preventative care, culture affects each piece of the patient experience. Healthcare workers must understand how each patient's culture impacts healthcare. It would be impossible to define every culture a healthcare worker might interact with; however, recognizing how culture may affect care may help the healthcare worker think about how different aspects of a patient's culture affect their care. Beliefs about health in general can impact care. For some people, it is felt that acknowledging illness and discussing it could lead to that illness occurring. Family plays a variable role in healthcare in different cultures. Some cultures prefer more privacy, while others rely on family members to be an integral part of the healthcare decision-making, possibly even deferring all decisions to a particular family member.

Eastern and Western medicine preferences may also depend on family culture. There are differences between religious groups regarding acceptable medical treatment options, such as receiving organ donations or therapeutic blood products. Dietary customs can be an essential difference that must be acknowledged, not only for how a client will eat in the inpatient setting but also may affect specific prescribed diets. A low-sodium diet will be difficult for a person whose cultural foods are generally high in sodium. Interpersonal customs can be more subtle but just as crucial to the delivery of care. As mentioned earlier in this course, eye contact in different cultures may signify respect or disrespect. Physical touch may signal care or offense (AHRQ, 2024).

The healthcare delivery setting can affect how the patient's culture impacts their care. In the inpatient setting, clients may feel detached from the norms of their usual daily life. The absence of particular routines and rituals, foods, family members, and community involvement can contribute to decreased engagement in their health. In the home health care setting, the nurse must consider the culture of the home they are entering and incorporate that culture into their care while also maintaining standards of nursing. In the primary care setting, the nurse may only have a brief time to determine if there may be issues with understanding or adherence to medical advice due to cultural differences. In the hospice setting, the nurse must consider the cultural aspects of death and dying, recognizing what may be necessary for their patient and their family to have a peaceful experience.

CRITICAL NOTE: It cannot be assumed that every person of a similar racial, ethnic, geographical, language, or religious background shares the same cultural beliefs regarding healthcare. Subcultures of certain groups can affect beliefs and practices. A younger person in a spiritual community may be more or less committed to cultural traditions than their older counterparts. A person of a particular ethnicity may identify with the cultural beliefs of that group, or they may not. It is essential to be aware of stereotyping based on race, ethnicity, origin,

religion, gender, and language backgrounds. This can lead to bias and racism in care, which can contribute to health disparities rather than improve health equity (CDC, 2024).

By integrating cultural competence into healthcare delivery, health outcomes can be improved. A study published in 2020 explored the impact of a culturally appropriate diabetes education program for Mexican American residents living along the US/Mexico border. Participants were recruited into an educational program that considered the effect of this community's culture on their health and utilized culturally appropriate interventions to improve health. The education program was bilingual, sensitive to cultural issues, and addressed misconceptions about diabetes held within the cultural community. Clinical lab measures and self-care practices significantly improved after participating in the culturally competent education program. Cultural barriers to care were also identified, such as lack of health literacy and transportation challenges. By focusing on cultural competence as a method for improving health in minority groups, researchers were able to help participants significantly improve their health status (Flores-Luevano et al., 2020).

Section 3 Personal Reflection

How have you experienced cultural differences as a healthcare worker? How did those impact the care your patient received? Recall incidences where the patient's culture was considered and integrated into the delivery of care. Was this successful? Why do you think it was or was not significant for your patient?

Section 4: Health Disparities in the United States

The US ranks at the top of the list for health disparities among high-income nations (MacKinnon et al., 2023). As of 2021, non-white adult patients were less likely to receive needed mental health services or a flu vaccine. The infant mortality rate of black infants was more than double that of white infants (Hill et al., 2023). LGBTQ+ teens have significantly higher incidences of poor mental health and suicidal ideation compared to their heterosexual peers (CDC, 2023). Racial and ethnic minorities were less likely to receive a COVID-19 vaccination during the 2020 pandemic (CDC, 2022). People living in rural areas had higher incidences of chronic illness and high-risk health behavior while also experiencing less available access to care (MacKinnon et al., 2023). Culture plays a significant role in contributing to these health disparities.

Different aspects of culture can contribute to health disparities or affect how care is delivered at the bedside. They include ethnic, belief, and subculture differences. Ethnic differences refer to differences based on race and geographic origins. Belief differences may be religious, but they also could be political or value based. Subculture diversity may be the most difficult to identify and address for many healthcare workers because it can be more subtle. For example, it is well known that there are health disparities between rural and urban populations of the same region, though these individuals may share race, ethnicity, beliefs, and values (MacKinnon et al., 2023).

Culture has an impact on health literacy. Health literacy is “the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions.” This definition has been expanded in recent years to also include the responsibility of society to make things more easily accessible and understood (Parker & Ratzan, 2019). Culture impacts health literacy because communication is crucial to ensuring adequate

care. Communication is impaired when language differences are not addressed. People of some cultures may have a lower education or socioeconomic status. Still, even when these are equitable, cultural differences among populations may affect what people consider a health problem, when to seek care, and how they adhere to medical guidance. By practicing cultural competence, nurses can have a positive impact on improving health literacy and reducing health disparities (Bryant, 2021).

The COVID-19 pandemic revealed the depth and effect of health disparities in the United States and had a significant effect on the ability of healthcare workers to provide culturally competent care. In many healthcare systems, non-essential jobs were eliminated, even if temporarily. This often included chaplains and in-person language interpreters. People who practice minority faiths became disadvantaged because clergy of these faiths were often volunteers in the healthcare system rather than employees. Strict visitation guidelines, while necessary to slow the spread of COVID-19, also prohibited family members and those of the patient's cultural community from visiting the patient and advocating for their cultural needs and preferences. A disparity was discovered during this time between those patients who had access to technology, such as mobile phones and tablets, that would allow them to communicate with family, friends, and clergy and those who did not have this access. Patients who could remain in contact were more likely to have their cultural needs met. Sociocultural aspects of health also contributed to vaccine hesitancy once the COVID-19 vaccine was made widely available. Mistrust of authorities and misinformation also affected some cultural groups more than others. The COVID-19 pandemic caused healthcare workers to reflect on how cultural differences affect healthcare and how those differences may have contributed to patient outcomes. In the future, the disparities of the COVID-19 pandemic concerning the ability to administer culturally competent care can be considered to assist healthcare workers in anticipating, minimizing, and

eliminating the barriers that contributed to the lack of culturally competent care in many settings (Papadopoulos, 2022).

Health disparities exist among the LGBTQ+ population as well. The LGBTQ+ community is a very diverse group with many subcultures. Overall, this population experiences higher rates of suicide, cigarette smoking, alcohol and drug abuse, mental health challenges, and HIV/AIDS and may avoid seeking medical care when it is needed. Inequalities in cancer screening have been observed within this community. Transgender patients are challenged with identifying healthcare providers and nurses who are knowledgeable about their unique needs. There is disagreement on whether gender identity should affect medical care, which can also contribute to health disparities. There continues to be a knowledge gap among healthcare workers on what medical needs are present for members of the LGBTQ+ community. Curriculum for healthcare workers continues to lack education on transgender health, mental health, sexual health, and the health of aging members of this community. Because of insufficient education, healthcare workers may struggle to find resources to learn more about the healthcare needs of this population. Learning more about providing culturally competent care to the LGBTQ+ community can increase confidence in providing quality care to these individuals while also making the patients feel valued and their needs met (Lee et al., 2021).

Health disparities can contribute to lack of cultural competence themselves. In the Asian American community, the rate of obesity is much lower than other ethnic minority groups living in the United States. Asians experience obesity at a rate of 42%, while 76% of African Americans and 80% of Hispanic Americans are categorized as obese. There are many subcultures within the Asian minority group, including Filipinos, who experience obesity at a rate of 16.8%, and Japanese, who experience obesity at a rate of only 15.3%. Because the rate of obesity in the Asian American community is much lower than the rate of other

ethnic groups in the US, there is a lack of research regarding how to improve the health status of Asian Americans who are experiencing obesity. Body Mass Index (BMI) has become an outdated measure for obesity, especially in this population, where body frames tend to be smaller, and people generally have a higher percentage of body fat. Since there is little research on this condition in the Asian American community, there is consequently little information about how culture impacts obesity rates in this group, which makes developing culturally competent interventions difficult. It has been found that generational status does affect health habits in this people group. Those who are further removed from first-generation immigrants tend to adhere to a more Western lifestyle, which is more prone to contributing to obesity. Another barrier for this group is the model minority myth. During the civil rights movement of the 1960s, Asian Americans were stereotyped as the model minority with high education achievement, strong work ethic, emphasis on family connections, and increased wages. This broad categorization is damaging because it contributes to the minimization of health issues affecting this population. Studies found that Asian Americans experiencing obesity struggle to improve their health because there has been too little research into incorporating culturally competent strategies for this condition because the health disparity makes it appear that obesity is not a significant concern for this community (Carlos & Doll, 2023).

Healthy People 2030, the initiative created by the Office of Disease Prevention and Health Promotion, focuses on eliminating health disparities and improving health equity among populations in several key areas. A method used to accomplish this is focusing on social determinants of health, which are often dependent on culture (ODPHP, 2022). Some of the focuses include decreasing the rate of preterm births, which is significantly higher in the African American community, decreasing the rate of blindness and visual impairment in children under 17 years old, which is much higher for children living in the United States who were born in

another country, and lowering the rate of lung cancer deaths in rural communities, which is 30% higher than those who live in metropolitan areas (ODPHP, 2024).

Cultural competence in the healthcare setting can improve patient outcomes by improving communication, increasing health literacy, decreasing the risk of errors, and cultivating patient engagement. Showing respect for differences and adjusting treatments to meet patient needs can also improve the patient care experience. Cultural competence has become part of initial and ongoing healthcare education because it is vital to providing quality care to patients of diverse cultures (Tulane, 2021).

Section 4 Case Study

Mrs. Winters, 89 years old, visited her primary care doctor to follow up on lab results from recent testing. Her doctor stated that she had concerns regarding some of the lab work and that further testing would be needed. Mrs. Winters is instructed to contact a hematology clinic to make an appointment for follow-up testing. Mrs. Winters is seen in the primary care clinic three months later with new onset symptoms. She is unaware that her previous lab results may relate to the symptoms she is currently experiencing. The nurse asks Mrs. Winters if she has been seen in the hematology clinic, as instructed at the last appointment. Mrs. Winters stated she could not remember the name of the doctor she was supposed to see and figured she would ask the doctor at her next primary care appointment. She had not felt ill, so she figured it was not urgent.

What could have been done differently for Mrs. Winters?

Mrs. Winters should have been counseled on the urgency of receiving follow-up testing, even if she felt okay. The physician or nurse could have inquired about

Mrs. Winters's comfort with contacting the hematology clinic or if she would like them to make the appointment for her.

What may have caused this delay in receiving appropriate care?

Mrs. Winters may have a deficit in health literacy. She may not have understood the significance of the lab values in the initial lab results or had access to technology to educate herself regarding these results. Poor communication may have led to this issue. Regardless of Mrs. Winters's cultural background, health literacy affects many different populations. Language barriers, lack of education, or noticeable cultural differences can alert healthcare workers to ensure the patient understands the communicated instructions and has the ability to follow through with making appropriate healthcare decisions, but less obvious cultural differences may make it not as apparent that the healthcare worker should assess health literacy.

Section 4 Personal Reflection

What health disparities have you observed in your practice? What may have contributed to that disparity? How do you see culture affect your patient's health literacy?

Section 4 Key Terms

Health Disparity - a health difference that is related to socioeconomic status or environmental disadvantage, particularly for groups that have systemically faced challenges with systemic discrimination

Healthy Equity - when all individuals can achieve their highest level of health, focusing on equality and eliminating avoidable differences among people groups

Health Literacy - “the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions.” (Parker & Ratzan, 2019)

Healthy People 2030 - An initiative created by the Department of Health and Human Services to identify and seek to remediate systemic gaps in the health of the American population

Section 5: Cultural Competence Self-Assessment

While it is necessary to respect the diversity of patients, it is also essential for each healthcare worker to recognize their own unique background and assess their personal levels of cultural competence (NCCC, 2024b). It can be challenging for a healthcare worker to evaluate their own levels of bias; after all, implicit bias is part of unconscious thought. While there is improvement among healthcare workers in their ability to recognize and respect cultural differences, there is still work to be done. Self-evaluation can help identify personal areas of bias and provide areas to focus on for self-education (NCCC, 2024b).

The National Center for Cultural Competence (NCCC) at Georgetown University has created and aggregated tools for self-assessment. Cultural competence can be assessed at a personal or organizational level. By evaluating each individual’s learning needs, areas for personal growth can be identified. When healthcare organizations assess the level of cultural competence among their staff, education gaps can be remediated to improve competency. Multiple assessment tools based on different specialty areas can be found at www.nccc.georgetown.edu (NCCC, 2024b).

A specific tool created by the NCCC is the Cultural and Linguistic Competence Health Practitioner Assessment (CLCHPA). This tool was developed to address

health and healthcare disparities by allowing practitioners to enhance their knowledge and skills in the area of cultural competency. After completing the tool, the user is provided with feedback on their understanding of diverse populations, how they adapt to diverse patient populations, and how they can promote health among those populations. This tool has been adapted to various settings and can be found on the NCCC website at https://www.clchpa.org (NCCC, 2024a).

The American Speech-Language-Hearing Association (ASHA) developed multiple self-check-in tools based on an earlier tool created by the National Center for Culture Competence. These tools help develop cultural humility or recognize that everyone has opportunities for growth, which is part of improving cultural competence. The ASHA website also includes the next steps for learning. The check-in tools can be found at www.asha.org/practice/multicultural/self/ (ASHA, 2021).

The Self-Assessment Inclusion Scale (SAIS) was developed to help people understand their knowledge of themselves and others regarding diversity and inclusion. While not explicitly developed for healthcare workers, it can still be a valuable tool to help individuals gauge their strengths and weaknesses regarding cultural competence. This tool acknowledges that the practice of inclusion in the presence of diverse groups is a continuous growth process. The SAIS allows participants to rate themselves on a scale using statements that reflect the four aspects of cultural care, which are awareness, knowledge, skills, and attitudes. A point value is assigned to each response and combined to create a score that can be interpreted. The user can interpret their score and provide context to what level of cultural competence and inclusion are. In the study of the validity of this tool, adults may object to the presence of standardized testing, but most had some level of understanding of their own bias. The use of the tool increased self-awareness and reflection regarding cultural differences (Argyriadis et al., 2023).

A scale to determine knowledge of the culture of the LGBTQ+ community was created called the Lesbian, Gay, and Bisexual Knowledge and Attitudes Scale for Heterosexuals (LGB-KASH) to assess the knowledge and attitudes held regarding this culture. THE LGB-KASH encompasses five key domains: hate, knowledge, civil rights, religious conflict, and affirmativeness. Another scale used is the Riddle scale, which has participants score themselves based on a range of feelings, from repulsion to nurturance of GLBT people. As a result of improving the cultural competence of care provided to those in the LGBTQ+ community, patients have reported better quality of care and increased confidence in their healthcare team. More research needs to be conducted to determine how gender and sexuality affect healthcare. Role-playing scenarios effectively educate healthcare workers on how to care for patients in the LGBTQ+ community. Utilizing either of these scales can help healthcare workers identify knowledge gaps and improve cultural competence (Lee et al., 2021).

A study published in 2023 by Sara Noori Farsangi et al. found that a mobile app-based education module for cultural competence self-assessment significantly improved cultural humility and the capacity to understand the healthcare needs of other cultures (Farsangi et al., 2023). Mobile app programs are often found through organizational education materials or employee development programs.

There are many books related to cultural competence self-assessment. Some books focus on evaluating personal bias that may inhibit providing culturally competent care. Other publications help healthcare workers identify their knowledge regarding specific populations. Books are available that are written specifically for healthcare workers, while others may be more appropriate for business settings, though they also provide valuable information.

Selecting a method for cultural competence self-assessment depends on the healthcare worker's learning style. Online tools are a great resource as they are

easily accessible and generally free. Self-assessment is a starting place for becoming more culturally competent. Once personal cultural competency is assessed, the healthcare worker can identify areas for growth and seek opportunities to learn. Periodic reassessment using updated tools is also helpful as the populations each healthcare worker interacts with can change.

A result of cultural competence self-assessment can be cultural humility. This describes the ability of a healthcare worker to understand that their personal culture is not superior to others and that becoming culturally competent is a lifelong process. Cultural humility is seen as the result of increasing awareness, knowledge, and skills in the area of cultural competence. Cultural humility is divided into subscales. Cultural desire is a subscale of cultural humility that addresses the attitude of the healthcare worker. When the healthcare worker desires to provide culturally competent care, they have an attitude of willingness to engage and improve their practice. Another subscale of cultural humility is cultural sensitivity. A culturally sensitive nurse respects their patient's culture and is aware of actions or verbal interactions that could offend their patient. Cultural sensitivity continues to improve as the healthcare worker increases their knowledge. Cultural empathy is a subscale of cultural humility that refers to the willingness of the healthcare worker to consider the impact a patient’s culture may have on their mental well-being. This requires compassion and understanding. When the nurse considers the patient's perspective, a deeper appreciation is developed for the patient’s circumstances. Cultural caring is the subscale that acknowledges that quality healthcare depends on care delivered from a place of cultural acknowledgment. Cultural compassion is the final subscale of cultural humility and is essential to the heart of nursing care. Cultural compassion occurs when the healthcare worker understands the patient's suffering and seeks to improve the patient’s quality of life in a way that respects and integrates the patient’s cultural background (Abualhaija, 2021).

Section 5 Learning Activity

Take time to access one or more of the self-reflection activities listed above. Was there anything that surprised you about the results? How do you feel this information will help you develop greater cultural competence?

Section 5 Key Terms

Self-Assessment - the process of analyzing one's actions or beliefs

Self-Education - the process of educating oneself through independent study of a topic

Humility - freedom from pride; in this context, acknowledging one likely has more opportunities for learning and growth.

Section 6: Integrating Cultural Competence into Patient Care

Becoming more culturally competent is an ongoing journey that first incorporates self-discovery, which was discussed in the previous section, and then intentional self-education. Learning about different cultures, especially those of patients you care for, helps to increase knowledge. Interacting with diverse groups in clinical and nonclinical settings helps to improve understanding of different cultures. Attending local cultural events is another way to enhance a diverse experience (Clay, 2010).

Identifying the presence of diverse cultures in one's community is a starting point for self-education. Suppose a substantial population of a specific ethnicity, religious group, or other cultural group exists in your community. In that case, learning about that culture can help healthcare workers incorporate cultural

competence in the care of patients in their local community. For example, if a regional hospital system serves many members of the rural community, it would be essential to learn what health disparities may exist within that community and how its culture may contribute to those disparities.

Cultural assessment allows nurses to adapt to their patients' needs. While conducting the cultural assessment is critical to creating an effective care plan for the patient, nurses must be careful not to generalize and stereotype based on their patients' responses. A basic cultural assessment will include asking about ethnicity, preferred language, religious affiliation, food preferences, eating patterns, and health practices.

A brief cultural assessment can include the 4C's of Culture approach. Drs. Stuart Slavin, Alice Kuo, and Geri-Ann Galanti created this mnemonic tool to help healthcare workers remember what to ask their patients during a basic cultural assessment interview.

The 4C's of Culture

1. What do you **CALL** your problem?

   While the nurse would not literally ask the patient what they call the problem, this is a reminder to ask them what they think is the problem. The meaning of the symptoms may differ among cultures. For example, in Hmong culture, a seizure is known as "the spirit catches you, and you fall down." Because this can have positive cultural connotations for the patient, the patient may be less motivated to treat the seizures. The conversation with the healthcare worker and patient may differ when this context is understood.

2. What do you think **CAUSED** your problem?

The believed cause of illness varies among cultures. Some cultures may feel it is not germs that caused the disease but rather a spiritual imbalance or consequences of violating a taboo. Understanding what the patient thinks caused the illness can help the healthcare worker incorporate culturally appropriate interventions so that the patient feels their health is indeed restored. For example, if a patient believes their illness results from God's punishment for a transgression, it may be appropriate to have clergy come pray with the patient.

3. How do you **COPE** with your illness?

   This reminds the healthcare worker to ask what treatments they have tried to alleviate symptoms and how the condition affects the patient's daily routine. Alternative therapies may have been attempted, but the patient may be nervous to discuss them for fear of judgment. Approaching this conversation non-judgmentally makes the patient more comfortable in sharing vital information. Alternative treatments and home remedies may be safe and effective, or they may cause drug interactions that could be potentially dangerous. This can also reveal any difficulties the patient may have in coping with their illness.

4. What **CONCERNS** do you have regarding your condition?

   This question reminds the healthcare worker to ask important questions like "What lifestyle changes have you had to make due to your diagnosis?" and "How serious do you feel your diagnosis is?" The healthcare worker can correct misunderstandings and answer questions about the condition by asking about concerns. The healthcare worker can also inquire about concerns regarding treatments, especially those treatments that may conflict with cultural norms for that patient (Slavin et al., 2021).

A relational approach to the culture assessment will be most effective. This includes building trust, active listening, and respect. Asking questions in a nonjudgmental way can clarify the beliefs of the patient. For example, “What do you think may be causing you to feel this way?” (Roberts et al., 2024). Conversational interest in the patient’s history will contribute to a trusting relationship. If a client mentions they recently moved to the city, ask where they moved from. This can reveal potential culture changes the patient may have recently experienced. In the hospice setting, assessing what cultural rituals are essential to the patient and their family for end-of-life care is necessary. Asking if the patient’s culture is known for unique customs (foods, holidays, etc.) can also help create a more personalized approach to care. Inquiring about what pronouns a patient prefers can facilitate trust and a sense of safety for the patient. Asking meaningful questions and listening respectfully to the patient’s answers is beneficial for both the patient and the healthcare worker.

Preferred language is a crucial piece of culturally competent care. Due to a language barrier, health literacy can be impaired if the patient does not understand their diagnosis, medications, care instructions, or follow-up expectations. Professionally trained interpreters are preferred instead of family interpreters, as the trained interpreters are knowledgeable about communicating information more accurately while being culturally appropriate. Sometimes, a family interpreter may leave out important information when communicating it to the patient or caregiver. Many interpreters may have insights into the patient’s culture that can also be helpful to the healthcare worker caring for the patient, especially if the interpreter and patient have a shared or similar background. An in-person interpreter is preferred rather than a virtual or telephone interpreter, as cultural nuances may affect the accuracy of communication due to non-verbal communication. Bilingual staff members may also be effective interpreters,

though adhering to organizational policy regarding this practice must also be considered (Bauer & Baum, 2022).

When using a language interpreter, the healthcare worker must consider multiple factors to ensure that culturally competent care is delivered. The healthcare worker should first ask the patient for permission to utilize the interpreter. It is easy to assume the patient would want to communicate using an interpreter if English is not their primary language. However, gaining permission first allows the patient to exercise autonomy in the healthcare setting. The healthcare worker must understand that using a language interpreter will lengthen the encounter with the patient since each interaction must be translated for the nurse or patient. It will be necessary to allow extra time when planning these encounters. It may be helpful to the interpreter to briefly explain to them the purpose of the communication and the intended goals. Body posture is an important consideration when using a language interpreter. The healthcare worker should face the patient and speak directly to them rather than the interpreter. Using concise sentence structure and avoiding medical jargon can facilitate more accurate translation. An effective way to evaluate the success of the language interpretation is to ask the patient to repeat essential information back when the conversation has concluded. Documentation of the interpreter's name in the patient record is essential, as there may be questions regarding the clarity of the patient's answers in the future (Bauer & Baum, 2022).

The refugee community presents unique challenges to the delivery of culturally competent care. When arriving in the United States after fleeing their home country, there are language and cultural differences to consider, as well as the specific cultural needs of refugee communities. In addition to the often overwhelming cultural differences, refugees are immediately tasked with navigating literacy challenges, meeting transportation needs, navigating financial considerations, seeking employment, enrolling children in school, acclimating to a

potentially different landscape and climate, and navigating an unfamiliar healthcare system. The usual aspects of providing culturally competent care need to be implemented, but the state of crisis must also be considered. Patients may be unfamiliar with what care options are available, how to access that care, or how to navigate the American healthcare routines, like needing to pick up a prescription medication at the pharmacy that the physician electronically sent. Collaboration between healthcare workers and refugees can help identify needs and knowledge gaps, as well as identify aspects of the patient's culture that should be incorporated into their care (Dave, 2019).

One way healthcare workers can improve their cultural competence is to experience different cultural groups in a personal way. International travel has been shown to improve the cultural competence of nursing students in various studies, though this is often impractical and inequitable for most students and healthcare workers. Creativity can help glean the benefits of international experiences without international travel's logistical and cost challenges. By interacting online with peers of different nationalities and cultures, it was found that cultural competence could be improved. Structured online peer exchanges can benefit those seeking to improve their ability to provide culturally competent care. Access to these programs may be limited but can also be created by partnerships between organizations and informal discussions with healthcare workers of differing cultures through social media (Wu et al., 2021).

Managing cultural transitions can be difficult for anyone, but this stress is compounded when the individual is also tasked with navigating an unfamiliar healthcare system. Healthcare workers can help patients manage cultural transitions by using The Four Key Components of Transition Planning as introduced by Kate Berardo. The first step in this framework is to recognize WHAT transition stress is. Moving to a new culture has many stressful aspects. The ability to cope with this stress varies as people move to new cultural settings for different

reasons, such as education, business, or to seek asylum. "Culture shock" is a term that may be often heard, but it does not adequately represent the concept of transition stress. Transition stress occurs due to the emotions and feelings experienced when the individual experiences the differences in the new cultural setting. Healthcare workers can improve their ability to understand transition stress by reflecting on their own reactions to change and trying to visualize what it may be like to transition to a new culture. Next, it is essential to understand WHY transition stress occurs. This requires some reflection to understand why the source of the transition stress is difficult for the patient to cope with. When cultural differences are more pronounced, they can often be a source of more significant stress because they require more effort to understand and adjust to, as well as produce heightened levels of emotions. The source of transition stress will vary according to each circumstance but may include leaving behind family and friends, inability to understand behaviors present in the new culture, dual excitement and anxiety of new experiences, questioning values and routines that are different from the culture of origin, and fear of being judged or stereotyped. Healthcare workers can ask insightful questions, which may reveal underlying causes of transition stress. The next component of transition planning is to personalize the HOW. Healthcare workers must understand that different individuals will respond differently to transition stress. Some patients may be more withdrawn, some may gain or lose weight, while others may try to avoid acknowledging their feelings. When a healthcare worker can help a patient understand how they respond to transition stress, they can help identify potential issues that affect their health.

Reviewing how patients have handled transitions in the past may be helpful. The last aspect of the framework is to apply the WHAT NOW. This is the point where coping strategies can be discussed with the patient. Planning to develop more social support and creating strategies to stay in touch with friends and family may

be helpful for a social person feeling withdrawn due to separation. Creating actionable steps can give the patient a sense of purpose. Committing to small tasks is less overwhelming and more practical for individuals experiencing transition stress. Transition stress can affect health and healthcare workers who are prepared to help their patients navigate these challenges. This can provide a different aspect of culturally competent care and positively affect patient outcomes (Berardo, 2023).

Section 6 Learning Activity

Mr. Kovalenko, a 54-year-old man, arrives at the emergency room complaining of abdominal pain, weight loss, and fatigue. His nurse, Sarah, completes the orders given by the physician, who reveals that while the vital signs are elevated, Mr. Kovalenko does not have any physical causes that they can determine are the source of his symptoms. While Sarah is conversing with Mr. Kovalenko, she asks if he has experienced any recent sources of stress. Mr. Kovalenko tells Sarah that he recently immigrated to the United States as a political refugee due to the crisis in his home country of Ukraine. Apply the four key components of transition planning to help Mr. Kovalenko cope with transition stress and improve his health status.

Section 6 Case Studies

1. Mason is providing discharge teaching for Mr. Sanchez before he returns home after a lengthy hospital stay. Mr. Sanchez speaks Spanish but understands some conversational English and can communicate his basic needs without a language interpreter. Mason and Mr. Sanchez have developed a rapport over the last few weeks, and Mason feels comfortable communicating the discharge instructions to Mr. Sanchez. Mason reviews

the medication changes ordered by the physician and provides the standard patient handout for post-operative wound care. Mason concludes the teaching session by asking Mr. Sanchez if he understands the instructions. Mr. Sanchez verbalizes that he does understand. Six days later, Mr. Sanchez is readmitted to the inpatient unit with a surgical wound infection. It was also discovered that changes in his medications were not adhered to at home.

What may have happened?

Mr. Sanchez felt that he understood what was communicated in the discharge teaching but did not actually grasp the details of some of the instructions. The standard wound care handout was given in English, so when Mr. Sanchez needed to refer to it at home, he could not remember exactly what Mason had told him or what was shown to him regarding wound care. Mr. Sanchez misunderstood Mason when he explained the medication changes and continued the same doses he had been taking before the hospital admission. Mr. Sanchez liked Mason and did not want to bother him by asking too many questions during the teaching session.

What could Mason have done differently to possibly avoid this situation?

While Mr. Sanchez is competent in basic English, instructions for care after hospitalization usually require more than a very basic knowledge of the language used to communicate. Mason could have asked Mr. Sanchez if it was ok to utilize the language interpreter to ensure the instructions were understood. Then, using the interpreter, Mason could have used a more effective teaching technique and had Mr. Sanchez teach back the instructions to ensure understanding. Most patient teaching materials used in hospitals are available in multiple languages. A copy translated into Spanish would have been more appropriate for Mr. Sanchez since that is his

primary language. If Mr. Sanchez had received the discharge education in his preferred language, the readmission may have been avoided.

2. Meredith is a home health nurse who arrives at the home of her new pediatric client. The client's father welcomes Meredith in and requests that she remove her shoes, as this is a cultural practice of their home and community. Meredith knows that it violates her company's policy and workplace safety standards to work without shoes on, especially around the heavy equipment necessary for her patient's care. What should she do?

   Meredith tells the parent that she cannot remove her shoes due to the safety rules of her agency. She asks if it would be okay to wear shoe covers over her shoes so she does not track dirt and germs into the home. The patient's father understands and agrees that having the nurse wear shoe covers would be a good compromise. Meredith contacts her clinical supervisor and requests that shoe covers be provided to the home and that new nurses on the case understand the expectation that they should wear shoe covers in the house. Incorporating cultural competence does not mean abandoning evidence-based care but considering alternatives that allow quality care to be provided in a respectful way.

3. The following case study is not about a healthcare scenario but is a real-life example of why competent language interpretation is necessary for effective communication. While some aspects of this miscommunication may be humorous, it is a memorable way to remember that it is not only interpreting the vocabulary of a different language that is important but also the common phrases and colloquialisms. Cultural competence relies on the delivery of information and the reception and understanding of the intent of the communication.

In the 1990s, the California Milk Processor Board hired an advertising agency in San Francisco to create a campaign to help increase milk sales figures. The “Got Milk?” campaign was created and was immediately successful. It was utilized for over twenty years before being discontinued in 2014. When the ad campaign was initially implemented, a Spanish translation was made available as “¿Tiene Leche?”. The literal translation of this phrase is, “Do you have milk?” which may seem appropriate. However, the actual cultural interpretation of this phrase is “Are you lactating?” This was certainly not the intended message of the advertising campaign. In addition to the unintended misinterpretation, the cultural suggestion did not translate. In a culture where ensuring the family is well-fed is a way many Latinx mothers and grandmothers express their affection, the implication that the target audience for the campaign, the adult female members of the family, may not be providing adequate nutrition for the household was offensive. The cultural disconnection was identified very early in the campaign, and the materials for the Spanish-speaking community were adjusted to say “Familia, Amor y Leche,” which translates to “Family, Love and Milk.” Not only was this phrase more successful at communicating the intended message, but also it considered the cultural environment. Milk was closely associated with family and love, a much more effective marketing strategy for this community (Raine, 2001) (Cattlesite, 2008).

In addition to correct language interpretation, the cultural context must also be considered in communication. By utilizing effective language interpreters and seeking to understand the cultural context, healthcare workers can improve their cultural competence and avoid miscommunication with their patients.

Section 6 Reflection Scenario

Caroline is a new graduate nurse working on a Med-Surg unit. She encounters a patient from a different ethnic and religious background than her own. As her preceptor, what can you share with Caroline that will help her become a more culturally competent nurse? What resources can you encourage her to review?

Section 6 Key Terms

Cultural assessment - A series of questions the healthcare worker utilizes to determine what cultural considerations may affect the patient's healthcare.

Relational approach - Utilizing conversation and rapport building to gain trust and facilitate understanding with the patient

Preferred language - The language the patient feels most comfortable and confident with for conversing, reading, and understanding instructions

Section 7: Cultural Considerations

It is impossible to learn every nuance about every culture. In fact, this is discouraged because it can lead to stereotyping. It is important, however, to learn about the cultures of the population in the area in which you work and of individual patients you may care for. Generalizations about different cultures can help the healthcare worker be aware of potential cultural concerns or accommodations that should be made. However, this knowledge does not replace the need for discussion with the individual patient and their family (Galanti, 2019).

The following cultural considerations are just a few generalizations gathered from various ethnic backgrounds and compiled by Dr. Geri-Ann Galanti for "Understanding Cultural Diversity in Healthcare." These generalizations will not

apply to every patient of the following ethnic backgrounds, but they give some examples of cultural considerations that may affect healthcare.

African Americans - Due to a long history of racism, abuse, and medical experimentation, there may be less trust of healthcare systems by African Americans. Religion is often significant, and privacy in which to pray may be needed. In the South, the terms “high blood” and “low blood” may be confused with medical diagnoses, such as high blood pressure or low blood count, when it refers more to perceived dietary imbalance. Families may be reluctant to remove life support due to the belief that miracles are always possible. Family structure may be nuclear, extended, or matriarchal. The use of herbal remedies is common.

Anglo Americans - A high value is placed on privacy. Direct eye contact is expected, though prolonged eye contact is considered rude. Independence and self-care are valued. Family size is generally small, and families are often spread out geographically. In the LGBTQ+ community, friends may take the place of family. Husbands and wives typically have equal authority regarding decision-making for a pediatric patient. Some upper-middle-class parents may believe vaccines can be harmful and refuse them. Hospice care is becoming more common, though it may be delayed until the last few days of life. Patients generally prefer an aggressive approach to treatment.

Asians - Respect is a significant part of many Asian cultures. Therefore, the patient and their family may agree to instructions as an act of respect but not follow through with implementing them. Patient education should include the importance of adherence to instructions. Direct eye contact may be avoided as a sign of respect. Patients, even those of adult age, will often defer to their elders for medical decision-making. Patients may initially refuse offers of comfort measures to be polite, but when asked again, may say yes. Anticipate healthcare needs, as the patient may feel it is inappropriate to distract the healthcare worker

from other tasks to attend to their personal needs. Stoicism is highly valued; thus, pain may be more challenging to assess. Fevers may be treated with warm environments and warm liquids. Traditional treatments, such as coining and cupping, may be used.

Hispanic/Latinx - Present time orientation is common, which may make preventative care and planning for follow-up care more difficult. Personal relationships are valued, and asking about family is seen as a sign of respect. Patients are often more expressive when in pain. Extended families may be more intimately involved in the patient's life compared to other cultures. Family members may want to withhold a fatal diagnosis from the patient. Families may resist hospice care as it may be viewed as "giving up hope." Hot/cold balance in the body may be considered a cause of illness. Certain foods and drinks may be avoided due to this. Increased body weight may be viewed as a sign of "health," and nutritional counseling may be necessary for adherence to specific medical diets.

Middle Eastern - Healthcare workers may be expected to take a personal interest in their patients. Direct eye contact with the opposite sex may be seen as a sign of sexual interest, especially for female patients. "Thumbs up" is considered a rude gesture for some nationalities. Islam is the primary religion and cultural influence. Patients may have a fatalistic view of their health condition. Family is seen as more important than the individual. Personal problems are generally addressed within the family, and the patient may resist outside counseling. Same-sex caregivers may be very important to the patient. Prenatal care may be delayed, as pregnancy is seen as a routine condition.

Native Americans - This population often uses stories to relay information. Long pauses may mean the patient is considering the question. It is important to allow time for this and not rush the patient to answer. Direct eye contact is often

avoided. Due to a history of misuse of signed documents, some may be hesitant to sign informed consent or advanced directives. The newborn and mother frequently stay indoors until the umbilical cord stump falls off. The stump is then usually kept as it may be considered to have spiritual significance. Some may leave a window open at death for the soul to depart, while others may wish to orient the patient's body to a specific cardinal direction before death. Tobacco may be seen as sacred and have ceremonial uses.

South Asians - Feelings may not be expressed openly. Direct eye contact may be considered disrespectful. Women are often very modest. Medical decisions may be deferred to the father or eldest son. Autopsy is generally not allowed unless absolutely necessary.

(Galanti, 2019)

Religious cultural differences can also impact aspects of healthcare and may require accommodation by the healthcare team. Dietary guidelines, spiritual practices, and beliefs may affect healthcare decisions. In some regions of the world, ethnic, geographical, and religious cultures are very closely linked. In the United States, however, it is very common to encounter people of an ethnic culture who do not practice the traditional religion of that ethnicity and people who practice a faith not tied to their ethnic background. The healthcare worker can advocate for the patient by discussing preferences, respecting differences, and communicating needs to the healthcare team. Creating solutions for barriers to care is an integral part of cultural competence. The following descriptions are a small collection of religious culture differences a healthcare worker may experience:

Christianity - There are many different divisions of Christianity, including Christian Science, Eastern Orthodox, Jehovah's Witness, Mormonism, Protestantism, Roman

Catholicism, and Seventh-day Adventism. Each group may have very different cultural considerations for healthcare. A few will be addressed here.

a. **Christian Science** - Usually, individuals do not donate organs. Some avoid caffeine and alcohol. Illness is believed to result from disharmony between the mind and matter. Many practice spiritual healing.

b. **Eastern Orthodox** - Prayer often includes icons and incense. Fasting may be observed during different periods, though it is flexible for those with health concerns.

c. **Jehovah's Witness** - Do not generally celebrate traditional Christian holidays. An autopsy is acceptable if it is legally necessary. The use of blood products is usually forbidden. Food that contains blood is avoided.

d. **Mormon** - May request privacy for prayer or ritual. Alcohol, tea, and coffee are discouraged. Fasting is required monthly, though exceptions are made for ill persons. There is often a belief in a combination of faith healing and medical treatment. Birth control is generally believed to be contradictory to beliefs. Two elders are usually required to bless the sick.

e. **Roman Catholicism** - Individual practice is often closely linked to ethnic origins. Frequent prayer is observed. Sacramentals, such as rosary beads, candles, and holy images, are common. Meat is often avoided on Fridays, especially during Lent, though fish is acceptable. Adherence to natural methods of birth control is often observed. Frequent, even daily, attendance at services (mass) is common. Baptism of infants may be indicated if the prognosis is poor.

f. **Seventh-Day Adventist** - A Vegetarian diet is encouraged. It is believed that healing is a combination of medical intervention and divine healing. Some may avoid the use of narcotics and stimulants. The Sabbath, or holy day, is

observed on Saturday. Pastors and elders may administer praying and anointing with oil.

Islam - This religion encompasses many ethnicities. Privacy is highly valued. A female patient may prefer that a male healthcare worker discuss the patient's health with a male family member or that a male member be present for the conversation. A female patient may prefer a female healthcare worker to conduct a physical assessment. Beards are religiously significant, and shaving should be avoided unless absolutely necessary. Men and women both dress modestly. Ramadan and the associated required fasting is usually observed. Certain populations, like the chronically ill, pregnant, or very young, will be exempt from fasting even during Ramadan. Alcohol is prohibited. Specific prayer times throughout the day are observed. Hospital food may be declined, and food made by family is preferred to ensure it does not violate dietary customs. Folk remedies are commonly used. Medications containing gelatin may be problematic. Organ donation is usually prohibited. (Galanti, 2019)

(Attum et al., 2024)

Judaism - Different groups within the Jewish faith practice varying levels of traditional religious culture. The main distinctions are Orthodox, Conservative, and Reform. These are often fluid, depending on the congregation the patient belongs to. Prayer times may be specific or at the discretion of the individual, though Orthodox prayer tends to be more liturgical. Fellowship with the community is encouraged, especially when facing a terminal illness. Autopsy and organ donation beliefs may vary. Always discuss these with the patient's family and Rabbi. Many adhere to a kosher diet. There are many Holy days and festivals that the patient may wish to observe. The lighting of candles on the Sabbath is an important practice. The use of electric candles is often approved, though further discussion with the patient or their family is appropriate. Members of the

Orthodox Jewish faith may wish to consult with their Rabbi regarding certain medical decisions. Medications containing gelatin may be problematic.

(Wintz & Handzo, 2014) (Galanti, 2019)

Eastern Religions

a. **Buddhism -** Calm and peace are necessary for a healing environment. Pain medication may be refused if it interferes with clarity of mind. People may be vegetarians or may consume meats. Stimulants may be avoided. Illness is believed to result from karma and may have been caused by actions in this or a previous life. Burning of incense, offerings of flowers and fruits, images of the Buddha, and use of prayer beads and chant boxes are all common but depend on individual faith practices.

b. **Hinduism -** Personal hygiene is paramount, and bathing daily is common, though bathing immediately after a meal is discouraged. Shoes are usually removed before entering a home. In hospice settings, religious chanting by those close to the patient is expected before and after death. People are usually vegetarians. The right hand is considered “clean” for eating and interacting with others, while the left is considered “dirty” and used for toileting and hygiene. Pain and suffering are seen as a result of karma. Different objects may be used for religious rituals.

c. **Sikhism -** Private worship is observed twice daily, in the morning and the evening. Religious objects, such as jewelry, should only be removed from the patient with permission and explanation. Adult members usually vow not to cut their hair. A turban may be worn as a symbol of personal sovereignty and respect for others.

(Wintz & Handzo, 2014)

As previously mentioned, these are only a few cultural differences to consider when providing care to a diverse population. There are many other cultures and subcultures that may require healthcare workers to educate themselves on the beliefs of that group—having a conversation about culture with the patient to determine what they value as essential. As previously mentioned, assuming cultural beliefs based on race, religion, sexual orientation, or geographical location can lead to stereotyping, which, in turn, can lead to distrust and inaccuracies between the patient and healthcare worker.

Cultural competence is achieved when the cultural characteristics of the patient are respected and incorporated into the patient's care to produce a favorable outcome. At times, this is simple, like making sure a professional interpreter is available, accommodating dietary needs, and allowing clergy to attend the bedside. Sometimes, this is more challenging. The medical safety of the patient, staff, and other patients must be considered. Providing culturally competent care may require creativity by healthcare workers. It may also require the involvement of other healthcare team members or community members. The patient and their family members will be the best source to determine if accommodations meet the patient's needs while also maintaining a safe care environment.

Section 7 Case Studies

1. Daniel is caring for Mr. Lin in the Cardiac ICU. Daniel is aware that Mr. Lin is Asian and may not want to discuss the prognosis of his illness. Daniel does not want to stereotype, so he tells Mr. Lin, “I know that some patients do not want to know all the details of their prognosis, and for others, it is helpful to discuss it. How do you feel about talking about your prognosis?”

   How is Daniel incorporating cultural competence in his care of Mr. Lin?

Daniel does not assume that because Mr. Lin is Asian, he does not want to discuss his prognosis. Instead, Daniel respectfully asks how Mr. Lin feels about it.

2. Mrs. Green is a 68-year-old African American woman who is homebound after a recent stroke. She receives home health care visits for nursing care and physical and occupational therapy. Mrs. Green has a supportive family and is well taken care of, but her home health nurse, Tony, has noticed that Mrs. Green has become less engaged in her care and recovery over the last few visits. Tony asks Mrs. Green, "How has your condition affected your usual routines?" Mrs. Green expresses to Tony that she has not been able to attend church since her stroke, and that has been particularly hard for her. Tony asks Mrs. Green's son to help find the website of his mother's church. The church has a service streamed online on Sundays. Tony and Mrs. Green's son plan to help Mrs. Green access the website to watch the service on Sunday mornings. At the next home visit, Mrs. Green seemed more engaged in her treatments.

   How was Tony's approach culturally competent?

   Tony asked questions about how Mrs. Green is coping and identified a deficit in Mrs. Green's ability to participate in her usual culturally essential routines. By finding a way to incorporate those routines in some way in Mrs. Green's care, her participation in her therapies improved, increasing her ability to achieve a better health outcome.

3. Cora is caring for 25-year-old Ye Xin in a primary care setting. Ye Xin states she is Chinese but has lived in the United States since her family immigrated when she was six months old. She is a first-grade teacher at a local elementary school. Ye Xin converses easily with Cora and explains her health concerns. She states she has had migraines for the last few months,

which are not improving with her previous medication treatment. The physician discusses a new clinical trial of medication that Ye Xin may qualify for that can help treat migraines. When Cora brings the trial consent forms for Ye Xin to sign, she states she wants to try the trial medication but must speak to her parents first.

What is the most culturally competent response for Cora?

Although Ye Xin is an adult raised in Western culture, Cora understands that she may still defer to her elders for medical decision-making. Cora asks Ye Xin if she wants the physician to call her parents via conference call to inform them of the options and decide together. Ye Xin agrees this is a good solution, and a phone call is arranged between Ye Xin, the physician, and Ye Xin's parents.

Section 7 Reflection

What ethnic or religious cultural aspects were previously unknown to you? How can you incorporate this into your care of patients in the future? Why is it important to not assume cultural preferences for your patient?

Section 8: Conclusion

It is estimated that by 2044, the majority of people living in the United States will belong to minority groups. While the non-Hispanic white population will remain the largest single group, they will be less than 50% of the total population (NCCC). As the population continues to diversify, achieving health equity becomes even more critical. Cultural competence is an effective strategy to reduce health disparities by creating more trusting relationships between healthcare workers and their patients, improving preventative care, providing more accurate data for

research, improving adherence to instructions, and positively affecting patient outcomes. Cultural competence in the health care setting can lead to higher rates of patient satisfaction and improved safety (Deering, 2024).

Self-assessment can help healthcare workers be aware of their own level of cultural competence and reveal implicit biases. Including cultural assessment tools as part of the patient assessment can reveal areas of diversity that may require accommodation. Ongoing education is necessary for healthcare workers to continue integrating cultural competence into the planning and delivery of care. Exposure to different cultures in non-healthcare settings can help healthcare workers develop cultural competence, which can be applied to patient care experiences. Reviewing literature, reading books, and conversing with those of differing cultures are also effective at helping healthcare workers become more culturally competent.

Nurses are at the forefront of patient interactions in healthcare settings. They are often the first to encounter the patient as they navigate the health care system and have the responsibility to identify potential barriers to receiving quality care, as well as opportunities to incorporate the patient's culture into the care they receive. Determining what is culturally important to the specific patient can help the healthcare worker understand potential causes of health conditions, as well as determine what interventions may be most successful given the cultural norms of that patient. By incorporating cultural competence into care delivery, nurses can be part of the solution to reduce health disparities and improve health equity.

References

Abualhaija, N. (2021). Clarifying cultural competence in nursing: A concept analysis approach. *Journal of Cultural Diversity*, *28*(1), 3-14.

AHRQ. (2024, February 2024). *Consider Culture: Tool 10*. Agency for Healthcare Research and Quality. https://www.ahrq.gov/health-literacy/improve/precautions/tool10.html#:~:text=Here%20are%20some%20examples%20of,role%20in%20healthcare%20decision%20making

Argyriadis, A., Paoullis, P., Samsari, E., & Argyriadi, A. (2023). Self-Assessment Inclusion Scale (SAIS): a tool for measuring inclusive competence and sensitivity. *Perspectives in Education*, *41*(4), 34-49. https://doi.org/https://doi.org/10.38140/pie.v41i4.7294

ASHA. (2021). *Cultural Competence check-in: Self-reflection*. American Speech-Language-Hearing Association. https://www.asha.org/siteassets/uploadedfiles/multicultural/self-reflection-checklist.pdf

Attum, B., Hafiz, S., Malik, A., & Shamoon, Z. (2024). Cultural Competence in the Care of Muslim Patients and Their Families. In *StatPearls*. StatPearls Publishing Copyright © 2024, StatPearls Publishing LLC.

Bauer, B. C. P., & Baum, N. M. D. (2022). ENVIRONMENTAL INFLUENCES CULTURAL COMPETENCY IN HEALTHCARE. *Physician Leadership Journal*, *9*(1), 52-57. http://search.proquest.com.ezp-prod1.hul.harvard.edu/scholarly-journals/environmental-influences-cultural-competency/docview/2655177779/se-2?accountid=11311

https://hollis.harvard.edu/openurl/01HVD/HVD_URL??url_ver=Z39.88-2004&rft_val_fmt=info:ofi/

fmt:kev:mtx:journal&genre=article&sid=ProQ:ProQ%3Apq1busgeneral&atitle=ENVIRONMENTAL+INFLUENCES+CULTURAL+COMPETENCY+IN+HEALTHCARE&title=Physician+Leadership+Journal&issn=23744030&date=2022-01-01&volume=9&issue=1&spage=52&au=Bauer%2C+Brittney+C%2C+PhD%3BBaum%2C+Neil%2C+MD&isbn=&jtitle=Physician+Leadership+Journal&btitle=&rft_id=info:eric/&rft_id=info:doi/

Berardo, K. (2023). Manage Cultural Transitions- Framework: Four key components of transition planning. In F. Trompenaars (Ed.), *Building Cultural Competence: Innovative Activities and Models* (pp. 183-189).

Bryant, S. (2021). Health Literacy. *MEDSURG Nursing*, *30*(2), 73-74.

Carlos, A. M., & Doll, K. (2023). Southern California Asian Americans and the obesity epidemic: A qualitative study to improve understanding and cultural competence. *American Journal of Health Education* 54(6), 463-471.

Cattlesite. (2008). *Got Milk Campaign Lost in Translation*. Retrieved 6-9-2024 from https://www.thecattlesite.com/news/22636/got-milk-campaign-lost-in-translation

CDC. (2022, 3-29-2022). *COVID-19 Vaccine Equity for Racial and Ethnic Minority Groups*. Centers for Disease Control. Retrieved 6-6-2024 from https://archive.cdc.gov/www_cdc_gov/coronavirus/2019-ncov/community/health-equity/vaccine-equity.html

CDC. (2023, 5-26-2023). *Health Disparities*. Centers for Disease Control. Retrieved 6-6-2024 from https://www.cdc.gov/healthyyouth/disparities/index.htm

CDC. (2024). *Cultural Competence in Health and Human Services*. Centers for Disease Control and Prevention. Retrieved 6-6-2024 from https://npin.cdc.gov/pages/cultural-competence-health-and-human-services

Clay, R. (2010). How do I become culturally competent? *gradPsych Magazine*, *09*, 24. https://www.apa.org/gradpsych/2010/09/culturally-competent

Cross, T. L., & al., e. (1989). *Towards a Culturally Comptent System of Care: A monograph on effective services for minority children who are severely emotionally disturbed*. https://files.eric.ed.gov/fulltext/ED330171.pdf

DATAUSA. Deloitte. Retrieved 6-6-2024 from https://datausa.io/profile/geo/united-states#demographics

Dave, A. (2019). The need for cultural compentency and healthcare literacy with refugees. *Journal of the National Medical Association 111*(1), 101-102.

Deering, M. (2024). *Cultural Competence in Nursing* Retrieved 6-6-2024 from https://nursejournal.org/resources/cultural-competence-in-nursing/#cultural-competence

Farsangi, S. N., Khodabandeh Shahraki, S., Cruz, J. P., & Farokhzadian, J. (2023). Designing, implementing, and evaluating a mobile app-based cultural care training program to improve the cultural capacity and humility of nursing students. *BMC Med Educ*, *23*(1), 979. https://doi.org/10.1186/s12909-023-04952-4

Flores-Luevano, S., Pacheco, M., Shokar, G. S., Dwivedi, A. K., & Shokar, N. K. (2020). Impact of a Culturally Tailored Diabetes Education and Empowerment Program in a Mexican American Population Along the US/Mexico Border: A Pragmatic Study. *J Clin Med Res*, *12*(8), 517-529. https://doi.org/10.14740/jocmr4273

Galanti, G.-A. (2019). *Understanding Cultural Diversity: Creating awareness for compassionate healthcare*. Retrieved 6-8-2024 from https://ggalanti.org/cultural-diversity-in-healthcare/

Gopal, D. P., Chetty, U., O'Donnell, P., Gajria, C., & Blackadder-Weinstein, J. (2021). Implicit bias in healthcare: clinical practice, research and decision making *Future Healthcare Journal*, *8*(1), 40-48. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8004354/

Green, A. (2019, 6-6-24). Cultural Awareness in Healthcare: A Checklist *Quality Interactions*. https://www.qualityinteractions.com/blog/cultural-awareness-in-healthcare-checklist#:~:text=Culture%20influences%20patients'%20responses%20to,erode%20trust%20and%20patient%20adherence

Hill, L., Ndugga, N., & Artiga, S. (2023). *Key Data on Health and Health Care by Race and Ethnicity* (Racial Equity and Health Policy, Issue. https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity/#top

Ihara, E. *Cultural Competence in Health Care: Is it important for people with chronic conditions?* The Center on Aging Society at Georgetown University. Retrieved June 6, 2024 from https://hpi.georgetown.edu/cultural/

Lee, M., Tasa-Vinyals, E., & Gahagan, J. (2021). Improving the LGBTQ2S+ cultural competency of healthcare trainees: advancing health professional education. *Canadian Medical Education Journal*, *12*(1), e7-e20.

MacKinnon, N. J., Emery, V., Waller, J., Ange, B., Ambade, P., Gunja, M., & Watson, E. (2023). Mapping Health Disparities in 11 High-Income Nations. *JAMA Network Open*, *6*(7), e2322310-e2322310. https://doi.org/10.1001/jamanetworkopen.2023.22310

Merriam-Webster. (n.d.). *Merriam-Webster.com dictionary*. Retrieved 6-6-2024, from https://www.merriam-webster.com/dictionary/culture

NASEM. (2023). *Advancing Antiracism, Diversity, Equity, and Inclusion in STEMM Organizations: Beyond Broadening Participation*. National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK593023/

NCCC. *The Compelling Need for Cultural and Linguistic Competence*. Georgetown University. Retrieved 6-6-2024 from https://nccc.georgetown.edu/foundations/need.php

NCCC. (2024a). *Cultural and Linguistic Competence Health Practitioner Assessment* Georgetown University. Retrieved 6-8-2024 from https://www.clchpa.org

NCCC. (2024b). *Self-Assessments*. https://nccc.georgetown.edu/assessments/rationale.php

ODPHP. (2022). *Health Equity and Health Disparities Environmental Scan*. https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030

ODPHP. (2024). *Objectives by Topic*. US Department of Health and Human Services. Retrieved 6-8-2024 from https://health.gov/healthypeople/objectives-and-data/browse-objectives#population-groups

Papadopoulos, I. (2022). The Covid-19 pandemic and cultural competence: Global implications for managers, nurses and healthcare workers during major health disasters and emergenices. *Journal of Nursing Management*, *30*, 2451-2452.

Parker, R. M., & Ratzan, S. (2019). Re-enforce, not re-define health literacy-Moving Forward with Health Literacy 2.0. *Journal of Health Communication*, *24*(12), 923-925. https://doi.org/10.1080/10810730.2019.1691292

PRRI. (2021). The American Religious Landscape in 2020. https://www.prri.org/research/2020-census-of-american-religion/

Raine, G. (2001). Lost in the translation/ Milk board does without its famous slogan when it woos a Latino audience. *SFGate*. https://www.sfgate.com/business/article/lost-in-the-translation-milk-board-does-without-2884230.php

Roberts, M., Ferro, J., Mueller, A., & Lin, A. (2024). *Assessment- Culture: Nursing*. Osmosis from Elsevier. Retrieved 6-8-2024 from https://www.osmosis.org/learn/Assessment_-_Culture:_Nursing

Slavin, S., Kuo, A., & Galanti, G.-A. (2021). *The 4C's of Culture* Retrieved 6-8-2024 from https://ggalanti.org/the-4cs-of-culture/

Tulane. (2021, 3-1-2021). How to Improve Cultural Competence in Health Care. https://publichealth.tulane.edu/blog/cultural-competence-in-health-care/#:~:text=Importance%20of%20Cultural%20Competence%20in,Increased%20patient%20safety

United Nations Department of Economic and Social Affairs, P. D. (2020). *International Migrant Stock 2020* (

USDJ. (2021). *Understanding Bias: A Resource Guide* (Community Relations Services Toolkit for Policing, Issue. https://www.justice.gov/d9/fieldable-panel-panes/basic-panes/attachments/2021/09/29/understanding_bias_content.pdf

Vela, M. B., Erondu, A. I., Smith, N. A., Peek, M. E., Woodruff, J. N., & Chin, M. H. (2022). Eliminating Explicit and Implicit Biases In Health Care: Evidence and Research Needs. *Annual Review of Public Health*(43), 477-501. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9172268/

Wilson, S. (2021). Understanding Cultural Competency. *Human Services Guide*. Retrieved 6-6-2024, from https://www.humanservicesedu.org/cultural-competency/

Wintz, S., & Handzo, G. (2014). Handbook: Patients' Spiritual and Cultural Values for Health Care Professionals. In *HealthCare Chaplaincy Network*.

Wu, A., Maddula, V., Singh, J., Sagoo, M. G., Chien, C.-L., Wingate, R., Kielstein, H., Traxler, H., Brassett, C., Waschke, J., Vielmuth, F., Sakurai, T., Zeroual, M., Olsen, J., El-Batti, S., Viranta-Kovanen, S., Kitahara, S., Keay, K., Kunzel, C., . . . Noel, G. (2021). Alternatives to student outbound mobility-Improving students' cultural competency skills online to improve global health without travel. *Medical Science Educator*, *31*(4), 1441-1451.