Textbook for Transcultural Health Care: A Population Approach

Cultural Competence Concepts in Nursing Care

Larry D. Purnell
Eric A. Fenkl
Editors

Fifth Edition

Springer

Textbook for Transcultural Health Care: A Population Approach

Larry D. Purnell • Eric A. Fenkl
Editors

Textbook for Transcultural Health Care: A Population Approach

Cultural Competence Concepts in Nursing Care

Fifth Edition

Springer

Editors
Larry D. Purnell
College of Health Sciences
University of Delaware/Newark
Sudlersville, MD
USA

Eric A. Fenkl
College of Nursing and Health Sciences
Florida International University
Miami, FL
USA

ISBN 978-3-030-51398-6 ISBN 978-3-030-51399-3 (eBook)
https://doi.org/10.1007/978-3-030-51399-3

This Springer imprint is published by the registered company Springer Nature Switzerland AG
The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

Preface

With an increase in global migration, the need for culturally competent and congruent health-care providers is a priority. This need is not only driven by the actual numbers of immigrants and migrants, but other dimensions such as the mounting rise of multiculturalism and the waning of the social ideology that includes the idea of the "melting pot."

From within health care, the advocacy for culturally competent approaches is driven in part by recognizing the danger to patient safety, overall inadequacy in the quality of outcomes essential to health care, and costs that are driven up by health care that is not culturally competent and congruent. These concerns include the health disparities experienced by individuals who may or may not be socially and economically disadvantaged. Some of the excess expenditures are associated with poor communication in patient assessment data. As health-care systems move to more consumer and individual responsiveness, the systems are recognizing that a cultural perspective is essential for providing services that earn high levels of consumer satisfaction.

This book, *Textbook for Transcultural Health Care: A Population Approach: Cultural Competence Concepts in Nursing Care*, provides critical lessons to introduce students and practitioners to how different cultures construct their social world and the dramatic impact that culture has on how health-care providers, the community, and their families interact. These insights into the rich variety of human culture are only small steps toward developing real wisdom regarding culture competence and culturally congruent care.

Much of what is done in health care follows "procedures," which implies that there are predetermined steps by which anyone receiving the care or service must fit the intervention rather than vice versa. For an increasingly large part of the population, nothing could be further from the truth.

A culturally competent practitioner must have a sense of comfort with the *experiential* process of engaging others from different cultures. This is perhaps the most difficult of all skills to teach and may only be learned through the practice of engaging others and being able to reflect critically on the experience and its impact on the patient and on the provider. This process is a familiar one as is the core of clinical education. Care providers must learn how to adapt their clinical expertise to different cultures and the individual unique development in a multicultural context.

This textbook is based on the Purnell Model for Cultural Competence and its accompanying organizing framework that have been used in education,

clinical practice, administration, and research, giving credence to its usefulness for health-care providers. The model has been translated into Arabic, Danish, Flemish, French, Korean, German, Portuguese, Spanish, and Turkish. Health-care organizations have adapted the organizing framework as a cultural assessment tool, and numerous students have used the Model to guide research for theses and dissertations in the United States and other countries. Thus, the Model's usefulness has been established in the global arena, recognizing and including the clients' cultures in assessment, health-care planning, interventions, and evaluation.

The introductory chapters lay the foundation for individual and organizational cultural competence with five chapters: (a) *Transcultural diversity and health care* that includes essential terminology and concepts related to culture, (b) a comprehensive description of *The Purnell Model for Cultural Competence*, (c) *Individual Competence and Evidence-based Practice* with the inclusion of international standards, (d) *Organizational Cultural Competence*, and (e) *Perspectives on Nursing and Health Care in a Global Context*.

Section two of the textbook includes aggregate data for population-specific groups. We have made a concerted effort to use non-stereotypical language when describing cultural attributes of specific cultures, recognizing that there are exceptions to every description provided and that the differences within a cultural group may be greater than the diversity between and among different cultural groups. We have also tried to include both the sociological and anthropological perspectives of culture. Each chapter in this section has reflexive exercises and case studies.

Specific criteria were used for identifying the groups represented. Groups included in the book were selected based on any of the criteria that follow.

- The group has a large population in North America such as people of Appalachian, Mexican, German, and African American heritage.
- The group is relatively new in its migration status such as people of Asian, Cuban, and Middle Eastern heritage.
- The group is widely dispersed throughout the world such as people of Iranian, Korean, and Filipino heritage.
- The group has little written about it in the health-care literature such as people of Guatemalan, Russian, and Thai heritage.
- The group holds significant disenfranchised status such as people of American Indian and Alaskan native heritage.
- The group is of particular interest to readers such as people of Amish heritage, a group that exists only in the United States.

We have strived to portray each culture positively and without stereotyping with an emphasis on the variant characteristics of culture portrayed on the Purnell Model for Cultural Competence.

Caring for culturally diverse patients and families has become commonplace throughout most of North America and worldwide. Areas that previously were largely homogenous, except for possibly one or two culturally diverse groups, are no longer the norm. The mosaic of diverse ethnicities and

cultures being created is adding richness to our communities and societies at large.

Many cultural groups fall into the category of vulnerable populations with increased health and health-care disparities. Even when disparities are not a concern, patient satisfaction may be of concern. If we are to decrease health and health-care related disparities, more attention must be given to cultural values, beliefs, and practices, which includes spirituality and complementary and alternative therapies. If health-care providers and the health-care delivery system do not adapt and include diverse practices, patient and family care are compromised, resulting in not only poorer health outcomes but also an increase in cost.

Recent efforts to promote global recognition of multiculturalism have encouraged health-care providers to become more aware of their own cultures and to cultural differences in order to provide effective, acceptable, and safe health care. Each provider and organization must make a strong commitment to providing culturally competent care, regardless of the setting in which the care is provided and the backgrounds of the participants in care. As a result of this commitment, health-care organizations and educational programs have begun to recognize the need to prepare health-care professionals with the knowledge, skills, and resources essential to the provision of culturally competent care.

Culturally competent providers value diversity and respect individual differences regardless of one's own race, religious beliefs, or ethnocultural background. The major goal of this textbook is to provide a framework that promotes culturally competent care, respecting a person's right to be understood and treated as a unique individual. Foreign works are in italics. A glossary is included. Key words in each chapter are in boldfaced type and are included in the glossary for easy retrieval.

Sudlersville, MD, USA — Larry D. Purnell
Miami, FL, USA — Eric A. Fenkl

Contents

Part I

Foundations for Cultural Competence

1 Transcultural Diversity and Health Care: Individual and Organizational

Larry D. Purnell and Eric A. Fenkl

1.1 Introduction

Cultural competence is one of the most important initiatives in health care in the United States and throughout most of the world. Diversity has increased in many countries due to wars, discrimination, political strife, worldwide socioeconomic conditions, and the creation of the European Union. Due to an increase in the number of migrants across the world over the last two decades (the number reached 258 million in 2017) (U.N. 2017), populations of many countries are becoming more culturally and ethnically diverse. Working with patients of different cultural backgrounds can be challenging due to differences in opinions, beliefs, thoughts, norms, customs, and traditions. If poorly managed, cultural diversity can result in miscommunication, maladaptive behaviors, and interpersonal conflicts. Thus, it has been widely suggested that native and foreign-born health care professionals need to be equipped with cross-cultural competence.

1.2 The Need for Culturally Competent Health Care

Health ideology and health-care providers have learned that it is just as important to understand the patient's culture as it is to understand the physiological responses in illness, disease, and injury. The health-care provider may be very knowledgeable about laboratory values and standard treatments and interventions for diabetes mellitus, heart disease, and asthma, but if the recommendations are not compatible with the patient's own health beliefs, dietary practices, and views toward wellness, the treatment plan is less likely to be followed (Giger et al. 2007). To this end, a number of worldwide initiatives have addressed cultural competence as a means for improving health and health care, decreasing disparities, and increasing patient satisfaction. These initiatives come from the U.S. Office of Minority Health, the Institute of Medicine, Healthy People 2020, the National Quality Forum, the Joint Commission, The American Medical Association, the American Association of Colleges of Nursing, and other professional organizations. Educational institutions—from elementary schools to colleges and universities—

This chapter is an update from a previous edition written by Larry Purnell.

L. D. Purnell
University of Delaware, Newark, DE, USA
e-mail: lpurnell@udel.edu

E. A. Fenkl (✉)
Nicole Wertheim College of Nursing and Health Sciences, Florida International University, Miami, FL, USA
e-mail: efenkl@fiu.edu

L. D. Purnell, E. A. Fenkl (eds.), *Textbook for Transcultural Health Care: A Population Approach*,
https://doi.org/10.1007/978-3-030-51399-3_1

are also addressing cultural diversity and cultural competency as they relate to disparities; health promotion and wellness; illness, disease, and injury prevention; and health maintenance and restoration.

Many countries are now recognizing the need for addressing the diversity of their societies. Societies that were largely homogeneous, such as Portugal, Norway, Sweden, Korea, and selected areas in the United States and the United Kingdom, are now facing significant internal and external migration, resulting in ethnic and cultural diversities that did not previously exist, at least not to the degree they do now. Several European countries, such as Denmark, Italy, Poland, the Czech Republic, Latvia, the United Kingdom, Sweden, Norway, Finland, Italy, Spain, Portugal, Hungary, Belgium, Greece, Germany, the Netherlands, and France, either have in place or are developing national programs to address the value of cultural competence in reducing health disparities (Judge et al. 2006).

Whether people are internal migrants, immigrants, or vacationers, they have the right to expect the health-care system to respect their personal beliefs, values, and health-care practices. Culturally competent health care from providers and the system, regardless of the setting in which care is delivered, is becoming a concern and expectation among consumers. Diversity also includes having a diverse workforce that more closely represents the population the organization serves. Health-care personnel provide care to people of diverse cultures in long-term-care facilities, acute-care facilities, clinics, communities, and patients' homes. All health-care providers—physicians, nurses, nutritionists, therapists, technicians, home health aides, and other caregivers—need similar culturally specific information. For example, all health-care providers communicate, both verbally and nonverbally; therefore, all health-care providers and ancillary staff need to have similar information and skill development to communicate effectively with diverse populations. The manner in which the information is used may differ significantly based on the discipline, individual experiences, and specific circumstances of the patient, provider, and organization. If providers and the system are competent, most patients will access the health-care system when problems are first recognized, thereby reducing the length of stay, decreasing complications, and reducing overall costs.

A lack of knowledge of patients' language abilities and cultural beliefs and values can result in serious threats to life and quality of care for all individuals (Joint Commission 2010). Organizations and individuals who understand their patients' cultural values, beliefs, and practices are in a better position to be co-participants with their patients in providing culturally acceptable care. Having ethnocultural-specific knowledge, understanding, and assessment skills to work with culturally diverse patients ensures that the health-care provider can conduct a more targeted assessment. Providers who know culturally specific aggregate data are less likely to demonstrate negative attitudes, behaviors, ethnocentrism, stereotyping, and racism. The onus for cultural competence is health-care providers and the delivery system in which care is provided. To this end, health-care providers need both general and specific cultural knowledge when conducting assessments, planning care, and teaching patients about their treatments and prescriptions.

1.3 World Diversity and Migration

The current world population is 7.8 billion as of February 2020 according to the most recent United Nations estimates with a median age of 29.6 years. The population is expected to approach 9.8 billion by 2050. The estimated population growth rate remains relatively stable at 1.03%, with 18.10 births per 1000 population; 7.7 deaths per 1000 population; and an infant mortality rate of 30.80 per 1000 population, down from 44.13 in 2010. Worldwide life expectancy at birth is currently 70.50 years, up from 66.12 years in 2010 (CIA World Factbook 2020). The ten largest urban populations where significant migration occurs are Tokyo, Japan with 37.3 million; Mumbai, India with 25.97 million; Delhi, India with 25.83 million; Dhaka,

Bangladesh with 22.04 million; Mexico City, Mexico with 21.81 million; São Paulo, Brazil with 21.57 million; Lagos, Nigeria with 21.51 million; Jakarta, Indonesia with 20.77 million; New York, United States with 20.4 million; and Karachi, Pakistan with 18.94 million (CIA World Factbook 2020).

As a first language, Mandarin Chinese is the most popular, spoken by 1.1 billion people; followed by English spoken by 983 million people; Hindustani (544 million speakers); Spanish (527 million speakers); Arabic (422 million speakers); Malay (281 million speakers); Russian (267 million speakers); and Bengali (261 million speakers). On a global scale, 86.3% of the world population is literate. When technology is examined, more people have a cell phone than a landline—with a ratio of 3:1. The internet has been one of the most transformative and fast-growing technologies. Globally the number of internet users increased from only 413 million in 2000 to over 3.4 billion in 2016 (CIA World Factbook 2020). Language literacy has serious implications for immigration. Over two-thirds of the world's 785 million illiterate adults are found in only eight countries: Bangladesh, China, Egypt, Ethiopia, India, Indonesia, Nigeria, and Pakistan. Of all the illiterate adults in the world, two-thirds are women; extremely low literacy rates are concentrated in three regions: the Arab states, South and West Asia, and Sub-Saharan Africa, where around one-third of the men and half of all women are illiterate (CIA World Factbook 2020).

The number of refugee status individuals has increased dramatically in the last several years. As of 2019, an unprecedented 70.8 million people have been forcibly displaced worldwide, and 37,000 people are forced to flee their homes every day due to conflict or persecution. The global number of migrants worldwide reached an estimated 272 million in 2019, an increase of 51 million since 2010. Currently, international migrants comprise 3.5% of the global population, compared to 2.8% in the year 2000 (U.N. Refugee Agency 2009).

In 1997, the International Organization for Migration studied the costs and benefits of international migration. A comprehensive update has not been undertaken since that time. According to the report, ample evidence exists that migration brings both costs and benefits for sending and receiving countries, although these are not shared equally. Trends suggest a greater movement toward circular migration with substantial benefits to both home and host countries. Migration boosts the working-age population. Migrants arrive with skills and contribute to human capital development of receiving countries. Migrants also contribute to technological progress. Understanding these impacts is important if our societies are to usefully debate the role of migration.

The perception that migrants are more of a burden on than a benefit to the host country is not substantiated by research. For example, in the Home Office Study (2002) in the United Kingdom, migrants contributed US$4 billion more in taxes than they received in benefits. In the United States, the National Research Council (1998) estimated that national income had expanded by US$8 billion because of immigration. Thus, because migrants pay taxes, they are not likely to put a greater burden on health and welfare services than the host population. However, undocumented migrants run the highest health risks because they are less likely to seek health care. This not only poses risks for migrants but also fuels sentiments of xenophobia and discrimination against all migrants.

- *What evidence do you see in your community that migrants have added to the economic base of the community? Who would be doing their work if they were not available? If migrants (legal or undocumented) were not picking vegetables (just one example), how much more do you think you would pay for the vegetables?*

1.4 U.S. Population and Census Data

As of 2020, the U.S. population is estimated at 331 million people according to UN data. The United States population is equivalent to

4.25% of the total world population. This is an increase of 15 million since the 2010 census. The 2010 census data included changes designed to more clearly distinguish Hispanic ethnicity as not being a race. In addition, the Hispanic terms have been modified to include *Hispanic* (used more heavily on the East Coast), *Latino* (used more heavily in California and the West Coast), and *Spanish*. The most recent census data estimate that the White, non-Hispanic or Latino population make up 61.3% of the nation's total, 17.8% are Hispanic/Latino, 13.0% are Black, 5.0% are Asian, 2.0% are American Indian or Alaskan Native, and 0.2% are Native Hawaiian or other Pacific Islander. These groupings will be more specifically reported as the census data are analyzed. The categories to be used in the 2020 U.S. Census will remain the same as those used in the 2010 census and are as follows:

1. *White* refers to people having origins in any of the original peoples of Europe and includes Middle Easterners, Irish, German, Italian, Lebanese, Turkish, Arab, and Polish.
2. *Black,* or *African American,* refers to people having origins in any of the black racial groups of Africa and includes Nigerians and Haitians or any person who self-designates this category regardless of origin.
3. *American Indian* and *Alaskan Native* refer to people having origins in any of the original peoples of North, South, or Central America and who maintain tribal affiliation or community attachment.
4. *Asian* refers to people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. This category includes the terms *Asian Indian*, *Chinese*, *Filipino*, *Korean*, *Japanese*, *Vietnamese*, *Burmese*, *Hmong*, *Pakistani*, and *Thai*.
5. *Native Hawaiian* and *other Pacific Islander* refer to people having origins in any of the original peoples of Hawaii, Guam, Samoa, Tahiti, the Mariana Islands, and Chuuk.
6. *Some other race* was included for people who are unable to identify with the other categories.
7. In addition, the respondent could identify, as a write-in, with two races (U.S. Census Bureau 2020).

The Hispanic/Latino and Asian populations continue to rise in numbers and in percentage of the overall population; however, although the Black/African American, Native Hawaiian and Pacific Islanders, and American Indian and Alaskan Natives groups continue to increase in overall numbers, their percentage of the population has decreased. Of the Hispanic/Latino population, most are Mexicans, followed by Puerto Ricans, Cubans, Central Americans, South Americans, and Dominicans. Salvadorans are the largest group from Central America. Three-quarters of Hispanics live in the West or South, with 50% of the Hispanics living in just two states: California and Texas. The median age for the entire U.S. population is 38.0 years, and the median age for Hispanics is 30.2 years (U.S. Census Bureau 2020). The young age of Hispanics in the United States makes them ideal candidates for recruitment into the health professions, an area with crisis-level shortages of personnel, especially of minority representation.

Before 1940, most immigrants to the United States came from Europe, especially Germany, the United Kingdom, Ireland, the former Union of Soviet Socialist Republics, Latvia, Austria, and Hungary. Since 1940, immigration patterns to the United States have changed: Most are from Mexico, the Philippines, China, India, Brazil, Russia, Pakistan, Japan, Turkey, Egypt, Thailand, and countries of the Middle East. People from each of these countries bring their own culture with them and increase the cultural mosaic of the United States. Many of these groups have strong ethnic identities and maintain their values, beliefs, practices, and languages long after their arrival. Individuals who speak only their indigenous language are more likely to adhere to traditional practices and live in ethnic enclaves and are less likely to assimilate into their new society. The inability of immigrants to speak the language of their new country creates additional challenges for health-care providers working with these populations. Other countries in the world face similar

immigration challenges and opportunities for diversity enrichment. However, space does not permit a comprehensive analysis of migration patterns.

What changes in ethnic and cultural diversity have you seen in your community over the last 5 years? Over the last 10 years? Have you had the opportunity to interact with these newer groups?

1.5 Racial and Ethnic Disparities in Health Care

A number of organizations have developed documents addressing the need for cultural competence as one strategy for eliminating racial and ethnic disparities. The Agency for Healthcare Research and Quality (AHRQ) released in 2018, the National Healthcare Quality and Disparities Report" (AHRQ 2018), which provided a comprehensive overview of health disparities in ethnic, racial, and socioeconomic groups in the United States. This report was a combined document with the National Healthcare Quality Report released initially (2006), which was an overview of quality health care in the United States. Healthy People 2010's (www.healthypeople.gov) goals were to increase the quality and the length of a healthy life and to eliminate health disparities. Healthy People provided science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time in order to (a) encourage collaborations across communities and sectors, (b) empower individuals toward making informed health decisions, and (c) measure the impact of prevention activities (http://www.healthypeople.gov/2020/about/default.aspx).

The Healthy People 2020 (www.healthypeople2020.gov) report had a renewed focus on identifying, measuring, tracking, and reducing health disparities through determinants of health such as the social and economic environment, the physical environment, and the person's individual characteristics and behaviors.

Although the term *disparities* is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen in a greater or lesser extent among different populations, a disparity exists. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health. During the past two decades, one of *Healthy People's* overarching goals focused on disparities. Indeed, in *Healthy People 2000,* the goal was to reduce health disparities among Americans; in *Healthy People 2010,* it was to completely eliminate, not just reduce, health disparities; and in Healthy People 2020*,* the goal was expanded to achieve health equity, eliminate disparities, and improve the health of all groups.

Healthy People 2020 defines a *health disparity* as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage." Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. In addition, powerful, complex relationships exist among health and biology, genetics, and individual behavior, and among health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual's or population's health, are known as determinants of health (Healthy People 2020).

What health disparities have you observed in your community? To what do you attribute these disparities? What can you do as a professional to help decrease these disparities?

More specific data on ethnic and cultural groups are included in individual chapters. As can be seen by the overwhelming data, much more work needs to be done to improve the health of the nation.

1.6 Culture and Essential Terminology

1.6.1 Culture Defined

Anthropologists and sociologists have proposed many definitions of *culture*. For the purposes of this book, which is primarily focused on individual cultural competence instead of the culturally competent organization, **culture** is defined as the totality of socially transmitted behavioral patterns, arts, beliefs, values, customs, lifeways, and all other products of human work and thought characteristics of a population of people that guide their worldview and decision making. Health and health-care beliefs and values are assumed in this definition. These patterns may be explicit or implicit, are primarily learned and transmitted within the family, are shared by most (but not all) members of the culture, and are emergent phenomena that change in response to global phenomena. Culture refers to a large and diverse set of mostly intangible aspects of social life consisting of the values, beliefs, systems of language, communication, and practices that people share in common and that can be used to define them as a collective (Cole 2020).

Culture, a combined anthropological and social construct, can be seen as having three levels: (a) a tertiary level that is visible to outsiders, such as things that can be seen, worn, or otherwise observed; (b) a secondary level, in which only members know the rules of behavior and can articulate them; and (c) a primary level that represents the deepest level in which rules are known by all, observed by all, implicit, and taken for granted (Koffman 2006). Culture is largely unconscious and has powerful influences on health and illness.

An important concept to understand is that cultural beliefs, values, and practices are learned from birth: first at home, then in other places where people congregate such as educational settings and places of worship. Therefore, a 3-month-old female child from Russian of Ashkenazi Jewish heritage who is adopted by a European American family and reared in a dominant European American environment will have a European American worldview. However, if that child's heritage has a tendency toward genetic/hereditary conditions, they would come from her Russian Jewish ancestry, not from European American genetics.

Who in your family had the most influence in teaching you cultural values and practices? Outside the family, where else did you learn about your cultural values and beliefs? What cultural practices did you learn in your family that you no longer practice?

When individuals of dissimilar cultural orientations meet in a work or a therapeutic environment, the likelihood for developing a mutually satisfying relationship is improved if both parties attempt to learn about one another's culture. Moreover, race and culture are not synonymous and should not be confused. For example, most people who self-identify as African American have varying degrees of dark skin, but some may have white skin. However, as a cultural term, *African American* means that the person takes pride in having ancestry from both Africa and the United States; thus, a person with whiter skin tones could self-identify as African American.

1.6.2 Important Terms Related to Culture

Attitude is a state of mind or feeling about some aspect of a culture. Attitudes are learned; for example, some people think that one culture is better than another. No one culture is "better" than another; they are just different, and many different cultures share the same customs. A **belief** is something that is accepted as true, especially as a tenet or a body of tenets accepted by people in an ethnocultural group. A belief among some cultures is that if you go outside in the cold weather with wet hair, you will catch a cold. Attitudes and beliefs do not have to be proven; they are unconsciously accepted as truths. **Ideology** consists of the thoughts and beliefs that reflect the social needs and aspirations of an individual or an ethnocultural group. For example, some people believe that health care is the right

of all people, whereas others see health care as a privilege.

The literature reports many definitions of the terms *cultural knowledge*, *cultural awareness, cultural sensitivity,* and *cultural competence*. Sometimes, these definitions are used interchangeably, but each has a distinct meaning. **Cultural knowledge** is all we know that characterize a particular **culture**. It can include descriptions such as those known as **cultural** dimensions and can also include other information that may explain why people conduct themselves in a particular way. **Cultural awareness** has to do with an appreciation of the external signs of diversity, such as the arts, music, dress, foods, and physical characteristics. **Cultural sensitivity** has to do with personal attitudes and not saying things that might be offensive to someone from a cultural or ethnic background different from that of the health-care provider's cultural or ethnic background. **Cultural competence** in health care is having the knowledge, abilities, and skills to deliver care more congruent with the patient's cultural beliefs and practices. Increasing one's consciousness of cultural diversity improves the possibilities for health-care practitioners to provide culturally competent care. Cultural competence should be a part of health-care provider basic training and based on cultural knowledge and experiential learning methods as well as having the opportunity to be exposed to different cultures (Khatib and Hadid 2019).

What activities have you done to increase your cultural awareness and competence? How do you demonstrate that you are culturally sensitive?

One progresses from unconscious incompetence (not being aware that one is lacking knowledge about another culture), to conscious incompetence (being aware that one is lacking knowledge about another culture), to conscious competence (learning about the patient's culture, verifying generalizations about the patient's culture, and providing cultural-specific interventions), and, finally, to unconscious competence (automatically providing culturally congruent care to patients of diverse cultures). Unconscious competence is difficult to achieve and failure to do so is potentially dangerous as individual differences exist within cultural groups. To be even minimally effective, culturally competent care must have the assurance of continuation after the original impetus is withdrawn; it must be integrated into, and valued by, the culture that is to benefit from the interventions.

Developing mutually satisfying relationships with diverse cultural groups involves good interpersonal skills and the application of knowledge and techniques learned from the physical, biological, and social sciences as well as the humanities. An understanding of one's own culture and personal values and the ability to detach oneself from presumptions and biases associated with personal worldviews are essential for cultural competence. Even then, traces of ethnocentrism may unconsciously pervade one's attitudes and behavior. **Ethnocentrism**—the universal tendency of human beings to think that their ways of thinking, acting, and believing are the only right, proper, and natural ways (which most people practice to some degree)—can be a major barrier to providing culturally competent care. Ethnocentrism perpetuates an attitude in which beliefs that differ greatly from one's own are strange, bizarre, or unenlightened and, therefore, wrong. Values are principles and standards that are important and have meaning and worth to an individual, family, group, or community. For example, the dominant U.S. culture places high value on youth, technology, and money. The extent to which one's cultural values are internalized influences the tendency toward ethnocentrism. The more one's values are internalized, the more difficult it is to avoid the tendency toward ethnocentrism.

Given that everyone is ethnocentric to some degree, what do you do to become less ethnocentric? With which groups are you more ethnocentric? If you were to rate yourself on a scale of 1 to 10, with 1 being only a little ethnocentric and 10 being very ethnocentric, what score would you give yourself? What score would your friends give you? What score would you give your closest friends?

The Human Genome Project (2003) determined that 99.9% of all humans share the same

genes. One-tenth percent of genetic variations account for the differences among humans, although these differences may be significant when conducting health assessments and prescribing medications and treatments. Ignoring this small difference, however, is ignoring the beliefs, practices, and values of a small ethnic or cultural population to whom one provides care. The controversial term *race* must still be addressed when learning about culture. A race is a grouping of humans based on shared physical or social qualities into categories generally viewed as distinct by society. The word "**race**" itself, intended to define an identifiable group of people who share a common descent, was introduced into English in about 1580, from the Old French "rasse" (1512) and from Italian "razza." The term was first used to refer to speakers of a common language and then to denote national affiliations. By the seventeenth century the term began to refer to physical (phenotypical) traits. Race is genetic in origin and includes physical characteristics that are similar among members of the group, such as skin color, blood type, and hair and eye color (Giger et al. 2007). People from a given racial group may, but do not necessarily, share a common culture. Race as a social concept is sometimes more important than race as a biological concept. Race has social meaning, assigns status, limits or increases opportunities, and influences interactions between patients and clinicians. Some believe that race terminology was invented to assign low status to some and privilege, power, and wealth to others (American Anthropological Association 1998). Thus, perhaps the most significant aspect of race is social in origin. Moreover, one must remember that even though one might have a racist attitude, it is not always recognized because it is ingrained during socialization and leads to ethnocentrism.

How do you define race? What other terms do you use besides race to describe people? In what category did you classify yourself on the last census? What categories would you add to the current census classifications?

Worldview is the way individuals or groups of people look at the universe to form basic assumptions and values about their lives and the world around them. Worldview includes cosmology, relationships with nature, moral and ethical reasoning, social relationships, magico-religious beliefs, and aesthetics.

Any **generalization**—reducing numerous characteristics of an individual or group of people to a general form that renders them indistinguishable—made about the behaviors of any individual or large group of people is almost certain to be an oversimplification. When a generalization relates less to the actual observed behavior than to the motives thought to underlie the behavior (i.e., the *why* of the behavior), it is likely to be oversimplified. However, generalizations can lead to **stereotyping**, an oversimplified conception, opinion, or belief about some aspect of an individual or group. Although generalization and stereotyping are similar, functionally, they are very different. Generalization is a starting point, whereas stereotyping is an endpoint. The healthcare provider must specifically ask questions to determine these values and avoid stereotypical views of patients. See the section on Variant Characteristics of Culture in this chapter.

Everyone engages in stereotypical behavior to some degree. We could not function otherwise. If someone asks you to think of a nurse, what image do you have? Is the nurse male or female? How old is the nurse? How is the nurse dressed? Is the nurse wearing a hat? How do you distinguish a stereotype from a generalization?

Within all cultures are subcultures and ethnic groups whose values/experiences differ from those of the dominant culture with which they identify. Indeed, subcultures share beliefs according to the *variant characteristics* of culture, as described later in this chapter. In sociology, anthropology, and cultural studies, a **subculture** is defined as a group of people with a culture that differentiates them from the larger culture of which they are a part. Subcultures may be distinct or hidden (e.g., gay, lesbian, bisexual, and transgendered populations). If the subculture is characterized by a systematic opposition to the dominant culture, then it may be described as a counterculture. Examples of subcultures are Goths, punks, and stoners, although popular lay literature might call these groups cultures instead

of subcultures. **Countercultures**, on the other hand, are cultures with values and mores that run counter to those of established society and whose norms and values may be incompatible with prevailing cultural norms. A counterculture might include religious cults or other groups whose behaviors contradict societal norms and expectations (Merriam Webster Online Dictionary 2020).

The terms *transcultural* versus *cross-cultural* have been hotly debated among experts in several countries but especially in the United States. Specific definitions of these terms vary. Some attest that they are the same, whereas others say they are different. Historically, nursing seems to favor the word *transcultural*. Indeed, the term has been credited to a nurse anthropologist, Madeleine Leininger, in the 1950s (Leininger and McFarland 2006), and it continues to be popular in the United States, the United Kingdom, and many European countries. The term *cross-cultural* can be traced to anthropologist George Murdock in the 1930s and is still a popular term used in the social sciences, although the health sciences have used it as well. The term implies comparative interactivity among cultures.

Cultural humility, another term found in cultural literature, focuses on the process of intercultural exchange, paying explicit attention to clarifying the professional's values and beliefs through self-reflection and incorporating the cultural characteristics of the health-care professional and the patient into a mutually beneficial and balanced relationship (Trevalon and Murray-Garcia 1998). This term appears to be most popular with physicians and some professionals from the social sciences.

Cultural safety is a popular term in Australia, New Zealand, and Canada, although it is used elsewhere. Cultural safety expresses the diversity that exists within cultural groups and includes the social determinants of health, religion, and gender, in addition to ethnicity (*Guidelines for Cultural Safety* 2005). **Cultural leverage** is a process whereby the principles of cultural competence are deliberately invoked to develop interventions. It is a focused strategy for improving the health of racial and ethnic communities by using their cultural practices, products, philosophies, or environments to facilitate behavioral changes of the patient and professional (Fisher et al. 2007).

Acculturation occurs when a person gives up the traits of his or her culture of origin as a result of contact with another culture. Acculturation is not an absolute, and it has varying degrees. Traditional people hold onto the majority of cultural traits from their culture of origin, which is frequently seen when people live in ethnic enclaves and can get most of their needs met without mixing with the outside world. Bicultural acculturation occurs when an individual is able to function equally in the dominant culture and in one's own culture. People who are comfortable working in the dominant culture and return to their ethnic enclave without taking on most of the dominant culture's traits are usually bicultural. Marginalized individuals are not comfortable in their new culture or their culture of origin. **Assimilation** is the gradual adoption and incorporation of characteristics of the prevailing culture (Portes 2007).

Enculturation is a natural conscious and unconscious conditioning process of learning accepted cultural norms, values, and roles in society and achieving competence in one's culture through socialization. Enculturation is facilitated by growing up in a particular culture, and it can be through formal education, apprenticeships, mentorships, and role modeling (Clarke and Hofsess 1998).

1.6.3 Individualism, Collectivism, and Individuality

All cultures worldwide vary along an individualism and collectivism scale and are subsets of broad worldviews. A continuum of values for individualistic and collectivistic cultures includes orientation to self or group, decision making, knowledge transmission, individual choice and personal responsibility, the concept of progress, competitiveness, shame and guilt, help-seeking, expression of identity, and interaction/communication style (Hofstede 1991; Hofstede and Hofstede 2005).

Elements and the degree of individualism and collectivism exist in every culture. People from an individualist culture will more strongly identify with the values at the individualistic end of the scale. Moreover, individualism and collectivism fall along a continuum, and some people from an individualistic culture will, to some degree, align themselves toward the collectivistic end of the scale. Some people from a collectivist culture will, to some degree, hold values along the individualistic end of the scale. Acculturation is a key component of adopting individualistic and collectivistic values. Those who live in ethnic enclaves usually, but not always, adhere more strongly to their dominant cultural values, sometimes to such a degree that they are more traditional than people in their home country. Acculturation and the variant characteristics of culture determine the degree of adherence to traditional individualistic and collectivist cultural values, beliefs, and practices (Hofstede 1991; Hofstede and Hofstede 2005).

Communicating, assessing, counseling, and educating a person from an individualistic culture, where the most important person in society is the individual, may require different techniques than for a person in a collectivist culture where the group is seen as more important than the individual (Hofstede and Hofstede 2005). The professional must not confuse individualism with individuality—the degree that varies by culture and is usually more prevalent in individualistic countries. **Individuality** is the sense that each person has a separate and equal place in the community and where individuals who are considered "eccentrics or local characters" are tolerated (Purnell 2010).

Some highly individualistic cultures include traditional European American (in the United States), British, Canadian, German, Norwegian, and Swedish, to name a few. Some examples of collectivist cultures include traditional Arabic, Amish, Chinese, Filipino, Korean, Japanese, Latin American, Mexican, American Indians (and most other indigenous Indian groups), Taiwanese, Thai, Turkish, and Vietnamese. Far more world cultures are collectivistic than are individualistic. It may be difficult for a nurse who is from a highly collectivist culture to communicate with patients and staff in highly individualistic cultures, such as the United States and Germany (Hofstede and Hofstede 2005).

Cultures differ in the extent to which health and information are explicit or implicit. In low-context cultures, great emphasis is placed on the verbal mode, and many words are used to express a thought. Low-context cultures are individualistic. In high-context cultures, much of the information is implicit where fewer words are used to express a thought, resulting in more of the message being in the nonverbal mode. Great emphasis is placed on personal relationships. High-context cultures are collectivistic (Hofstede 1991, 2001).

Consistent with individualism, individualistic cultures encourage self-expression. Adherents to individualism freely express personal opinions, share many personal issues, and ask personal questions of others to a degree that may be seen as offensive to those who come from a collectivistic culture. Direct, straightforward questioning is usually appreciated with individualism. However, the professional should take cues from the patient before this intrusive approach is initiated. Small talk before getting down to business is not always appreciated. Individualistic cultures usually tend to be more informal and frequently use first names. Ask the patient by what name he or she prefers to be called. Questions that require a "yes" or "no" answer are usually answered truthfully from the patient's perspective. In individualistic cultures that value autonomy and productivity, one is expected to be a productive member of society. Among collectivistic cultures, people with a mental or physical disability are *more likely* to be hidden from society to "save face," and the cultural norms and values of the family unit mean that the family provides care in the home (Purnell 2001).

Indeed, it is absolutely imperative to include the family, and sometimes the community, in health care for effective counseling; otherwise, the treatment plan may falter. However, among many Middle Eastern and other collectivistic cultures, family members with mental or physical disabilities are hidden from the community for