Nursing in a Culturally Diverse World

Jordan Cox

Auburn University School of Nursing
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Abstract

Cultural diversity is becoming increasingly important to the nursing profession related to growing immigrant and minority populations in the United States (Lowe & Archibald, 2009). The purpose of this paper is to explain why cultural diversity should be addressed and to examine various viewpoints and theories of cultural diversity. This paper will also examine some of the advantages and disadvantages of cultural diversity once it is applied to nursing practice. Past theorizing in cultural diversity is criticized by nursing scholars in literature because of the stiffness an essentialist viewpoint brings. Current theorizing endorses having a critical constructivist viewpoint which stresses the importance of understanding and experiencing a culture rather than only knowledge. The concept of cultural safety, forming health care services from the patient’s own perspective is replacing cultural competence used alone (Gray & Thomas, 2006).
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Cultural diversity among patients and workers in healthcare is an ever-growing change that cannot be ignored. Nursing scholars are becoming increasingly critical of current and past culture theorizing due to stagnant improvement of health disparities, prejudices, and discrimination of minority populations and an increase international migration of nurses and other health care workers. Culturally competent and safe practice has become non-negotiable quality nurses are expected to possess. But, how do nurses achieve this quality of care? What is required for a nurse to implement cultural safety as a natural part of practice? The purpose of this paper is to explain why cultural diversity should be addressed and to examine various viewpoints and theories of cultural diversity. This paper will also examine some of the advantages and disadvantages of cultural diversity once it is applied to nursing practice.

Bearskin (2011) clearly describes culture and cultural competency in her article. Culture is the foundation and essence of a people. It shapes their worldview, communication, relationships, beliefs, traditions, customs, way of life, and view of health and health care services. Culture is affected by many factors including race, religion, environment, and language. Cultural competence is the consideration of the cultural differences of others in the skill, knowledge, and attitudes necessary to provide nursing care. One framework illustrates cultural competency as a 5 step process: a) cultural awareness, b) cultural knowledge, c) cultural skill, d) cultural encounter, and e) cultural desire. The outcome of the framework is expected to be a set of coinciding policies, behaviors, and attitudes among professionals to enable collaborative work in cross-cultural situations among themselves and in a macro system. Cultural safety differs from cultural competency by focusing on the importance of understanding the unique social,
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economic, and political backgrounds and perspectives of individuals (Vandenberg, 2010). Nurses are encouraged to promote the clients receiving their health services to define safe services. This should allow nurses the opportunity to become aware of how their own thoughts and attitudes affect their capability to provide quality care (Vandenberg, 2010).

Gray and Thomas (2006) claim that the predominant approach to cultural competence by the nursing profession is through an essentialist viewpoint. This viewpoint focuses on what factors make up a person’s differences, such as race, culture, social class, identity, etc. With this view, one is led to ask questions like, “What factors make up Asian-American culture?” to develop an identity. This “diverse” identity is usually created by a comparison to what is thought as the cultural “norm” or dominant culture. The essentialist viewpoint, differences between cultures is the focal point which overshadows possible similarities between cultures. An essentialist viewpoint limits what is determined as culture by forming a list of its components and failing to recognize the processes by which a culture was created and is changing continuously. An alternative perspective on culture is a critical constructivist view. This view illuminates the meanings and processes that shaped and are continually shaping a culture. It leads one to ask questions of “how?” and “why?” rather than just “what?” alone. An individual with a critical constructivist viewpoint will also look at how another’s cultural background will affect their needs and the purpose that their culture serves for them. This occurs through examination and engagement of that culture. Critical constructivist viewpoint is favored over the essentialist viewpoint in developing cultural competence in nursing practice (Gray & Thomas, 2006).
Lowe and Archibald (2009) quoted the U.S. Census Bureau that in 2007, a new international immigrant comes to the United States every seven seconds. One-third of the nation’s population is of a minority group. It is predicted that by 2050, minority groups will outnumber majority groups in the United States and represent 50% of the labor force. Interaction of people with vast cultural differences is rapidly becoming more and more apparent, and therefore need to learn how to communicate and collaborate with one another. An author wrote a case study about a 19 year old girl, Nicole from First Nations’ family in Canada who was in a car accident resulting in a severely damaged brainstem (Bearskin, 2009). The story continues about the constant miscommunication between the healthcare providers and the family; each side wanting the other to conform. The family expressed wanting to perform a ritual cleansing ceremony, and the staff denied it. After some misguided direction, the family went home to prepare for Nicole’s discharge. Nicole died alone the next day without the opportunity to release her spirit. Nurses are continually challenged to integrate safe nursing practice with the various cultural needs of their patients. However, in order to integrate those factors, nurses must know some qualities of the patient’s culture and possess a desire to understand the culture and its purpose for the patient.

In the past decade, there is an estimated 25% increase in the United States’ minority population, yet the ethnic diversity of the nursing profession has remain relatively unchanged. (Lowe & Archibald, 2009). This could be due to how the nursing profession’s patterns of handling cultural differences in the past has fallen short of compassionate. Kingma (2008) describes the discrimination, prejudice, and abuse many international immigrants faced in their new countries. Many are offered jobs below their
professional preparation. This often concludes in an individual’s de-skilling, the loss of skills as a result of a lack of regular use. Allowing de-skilling of international nurses to occur is a waste of professional nursing resources in a time of shortage. Moreover, nurses with a non-English speaking background are much less likely to receive a promotion than their those with an English speaking background despite experience and qualifications. Many nurses who are racially diverse also experience discrimination from their patients (Kingma, 2008). These discriminatory actions against culturally diverse healthcare professionals or patients are unacceptable, but could stem from past culture theorizing.

Terms such as “culture” and “cultural competence” became regularly apparent in nursing literature in the late 1960s. The idea of all people having a right to health care also emerged at this time. The initial theorizing to address the concept of cultural competence was based on an essentialist viewpoint, focusing on the differences and needs of particular culture groups (Vandenberg, 2010). This early essentialist viewpoint was also known as the transcultural nursing movement. This movement desired to bring sensitivity to the differences between the nurses’ own culture and the culture of their patients and integrate the idea of culture into all facets of nursing. The transcultural nursing movement became successful through integrating culture into nursing curriculum and certification and licensure exams and the development of organizations to promote the incorporation of culture into the nursing profession. Examples of such organizations are the National Association of Colored Graduate Nurses, Committee on Intergroup Relations, Council of Cultural Diversity, the Ethnic Minority Fellowship program, and the U.S. DHHS Division of Nursing Leadership Invitational Congresses. The Workforce
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Diversity Grants were developed for minority individuals from disadvantaged backgrounds to give them an opportunity to have a nursing career and to increase cultural diversity in the profession (Lowe and Archibald, 2009).

A common theme in nursing literature related culture is critiquing past theorizing attempts. The most common problem associated with the transcultural nursing movement and essentialist viewpoint is the lack of recognizing the underlying assumptions about the conceptualizations of culture and the repercussions these assumptions have on nursing clients. A common assumption is when the differences of a culture are seen in comparison to a perceived more dominant norm. Some scholars try to counteract this assumption by teaching that there are more differences within cultures than between cultures. Other critiques of past theorizing and essentialist views come from failures in its application into nursing practice. One of which is the thought of ‘treating all patients equally’ that many nurses possess. This thought does help decrease discrimination, but it is insufficient alone to meet cultural safety. An example being patients who do not speak English have an extra burden of finding a translator, and therefore cannot be exactly equal to patients who speak English. An additional shortcoming in application is its heavy focus on cultural safety being achieved at the individual-level and less focus on the broader organizational or population-levels. Many times nurses are subject to their environments and policies of their workplaces which can impede individual-level interventions. Evaluation of the effectiveness of cultural theorizing is largely a self-reflection of a caregiver’s effectiveness to provide culturally competent care. This is an incomplete evaluation because it does not address how their care influenced the patients’ experience (Vandenberg, 2010).
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However, current trends of culture theorizing is the focus on the critical constructivist viewpoints and cultural safety. A critical constructivist defines culture as being created to serve precise political, social, and economic purposes. This standpoint can steer nurses away from an objective essentialist viewpoint to one where nurses desire to see the deeper meaning and purpose within a culture. Likewise, the stance on ‘cultural safety’ is being supported as an alternative to ‘cultural competence’. By giving patients the ability to define safe healthcare services for themselves, nurses are ensuring that the patient is receiving all the care that they need in a way that best suits their culture. However, this stance can also put nurses in a problematic situation if the patient asks for services that the nurse thinks is unsafe. Cultural safety also calls for nurses to identify discrimination and mistreatment within nursing practice which can provoke defensiveness and bitterness. Because of the potential problems of cultural safety, many find it hard to promote in practice (Vandenberg, 2010).

The future of culture theorizing calls for continued evaluation of the application, attitudes, and beliefs of current standpoints and continued theorizing on how cultural diversity in healthcare can improve. The science of nursing should embody the desired characteristics of cultural diversity. The whole nursing profession should look far beyond the teaching of culture awareness to viewing individuals of a cultural group as human beings experiencing sickness. A healthcare provider should treat a patient from a particular cultural group as just that instead of treating a culture through a patient. Faculty in nursing schools must confront their own shortage of diversity to imitate and interpret cultural knowledge and the needs of culturally diverse students with diverse learning styles (Lowe & Archibald, 2009). Evaluation of a nurse’s practice with the
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implementation of cultural safety and critical constructivist viewpoint should come from a combination of a nurse’s self-reflection of the care given and the patient’s feelings and experiences of the care received. Asking the patient directly about their culture and their needs rather than consulting a list of objective factors of that culture will yield the best information for how to care for the patient (Vandenberg, 2010).

Conclusion

The increase in culture groups in the U.S. population gives no indication of slowing down. There is a world-wide phenomenon of healthcare professionals migrating internationally to practice in better environments, many of which have an ultimate goal of reaching the U.S. (Kingma, 2006). I think it is imperative that cultural diversity in healthcare should continue being a main concept addressed with nursing scholars, nursing school faculty, healthcare administrators, and staff nurses. Nursing has to keep moving forward in managing cultural diversity by looking at past theories to understand their lacking and improving upon current theories. As I learn how healthcare is adapting toward the idea of the patient being a consumer and meeting the patient’s needs before the needs of the healthcare providers, I wonder how cultural diversity will mold into this adaptation. I think true integration of cultural safety and diversity into our healthcare society will occur when individual caregivers and entire organizations possess a genuine desire and willingness to meet the needs of the human-being placed in front of them in a safe and efficient manner despite their differences. This desire for cultural safety will occur when one takes stance of a critical constructivist viewpoint to see the purposes behind a culture.
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Reference


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