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**Consider the Person:
How Cultural Competency Can Change the Future of Nursing Education**

A THESIS
SUBMITTED IN PARTIAL FULFILLMENT OF
THE REGIS HONORS PROGRAM

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Abstract

Being culturally competent means being able to understand your own personal biases to avoid behaviors that may be considered discriminatory. In healthcare, it also means treating patients with respect and providing optimal care regardless of their background. If patients lack the care that they need or are provided with less than optimal care, then health care disparities arise, increasing the inequalities that are already present within the health care system. At the center of this care are the nurses who interact with patients the most during their clinical session. Thus, it is vital for nurses to be culturally competent and this training should be provided at the undergraduate level to ensure that they are well-prepared when entering the workforce. This thesis highlights the methods and techniques available for optimal training and provides a new teaching model, the Culturally Connected Model of Care, that considers not only the patient's background but the nurse's background as well.

Introduction

The American health care system is attempting to heal itself in efforts to heal patients. For many patients, their health outcomes are dictated by social determinants of health. The World Health Organization has defined social determinants of health as conditions that people are born, grow, live, work, and age (*WHO / About Social Determinants of Health*, n.d.). These include, but are not limited to, socioeconomic status, ethnicity, gender, age, and sexual orientation (National Academies of Sciences et al., 2017). When the cost and accessibility of care are paired together with the social determinants of health, healthcare disparities arise. Healthcare disparities are not just differences that exist across populations but refer to the inconsistency of care among populations due to the differences that exist.

In 2003, the Institute of Medicine released the report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, summarizing the scientific evidence that health care disparities existed during that time. It stated that disparities arose from the historic and social context where minorities received inferior healthcare, and this reflected a broader socioeconomic disadvantage and discrimination within society (Institute of Medicine, 2003). For example, when documenting pain across racial and ethnic populations, it was found that analgesics were underused among minorities. A 1993 report by Todd, Samaroo, and Hoffman (as cited in Institute of Medicine, 2003) found that Hispanic patients were twice as likely to not receive pain medication in comparison to White patients even after controlling for characteristics concerning the injury, patient, and provider. Unfortunately, the difference in the prescription for analgesics was a small example of how health care providers treated patients differently on the basis of their race or gender. The Institute of Medicine has suggested that improving the quality of care for the patient will greatly reduce the disparities that exist.

The Institute of Medicine (IOM) has defined quality of care as the “degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (*Crossing the Quality Chasm: The IOM Health Care Quality Initiative : Health and Medicine Division*, 2018). Although physicians are generally the face of health care, it is important to acknowledge the role that non-physician healthcare professionals have when providing care to patients. Nurses, who are known for being advocates for patients, are key players when it comes to providing safe, effective, efficient, equitable, patient-centered, and timely mannered care (*Quality Care for Every Patient*, n.d.; *Six Domains of Health Care Quality*, n.d.). Nurses are expected to communicate to the physicians the patients’ concerns for any medical procedure that may conflict with their beliefs or circumstances. They must customize care plans to adhere to the patients’ preferences. This practice may appear as a simple process, but the ability to provide patient-centered care requires the nurse to understand disease and illness through the eyes of the patients.

Inspired by my internship at the Undergraduate Pre-Health Program, which aimed to increase the representation of underrepresented individuals in healthcare to reduce health disparities in underserved communities in Colorado, I realized that cultural competency is a major factor in reducing disparities. One of the readings assigned during this internship was *Difference Matters: Communicating Social Identity* by Dr. Brenda J. Allen. Dr. Allen provided guidelines on how to communicate our own social identities and differences with others. She wanted her readers to perceive the differences of others as positive features of our society as opposed to holding a negative perspective. She emphasizes six main social identities that we identify with: race, gender, sexuality, age, social class, and ability. There was one line in the book that made me reflect on how I interact and communicate with those who identify

differently as I do. Dr. Allen reflected on a conversation she had with a student who had muscular dystrophy and he told her, “People judge me for what I *can't* do instead of what I *can* do”(Allen, 2011, p. 137). This line made me realize that many of my interactions with people are based on the unconscious biases that I held before the interactions. I often directly think about a person’s disability, when I should be thinking about their ability. It also uncovered the power of language and how changing the way we address someone can make them feel like a person. For example, saying “people with disabilities” instead of “the disabled” or “the handicapped” (Allen, 2011, p. 153). Reading the book with my cohort helped uncover the unconscious biases that lead to discriminating against others.

Reflecting on my experience working as a scribe in the emergency department, I noticed how diverse the patient population was. A diverse population often refers to race, ethnicity, and socioeconomic status, but it has since expanded to include gender, sexuality, age, and ability. These identifications often determined how the patients were treated by the providing team. Before being admitted into the emergency department, patients have to be triaged to determine if their condition is emergent enough for a room in the department. Triage is an extremely fast process where the patient-provider interaction is less than 5 minutes and cannot be extended due to a language barrier. If the patient, or anyone with them, cannot communicate effectively in English, then they bypass intake and are assigned a room in the emergency department where there adequate time is allotted to understand the patient with a translator. Patients who require outside translators are sometimes seen last because of how time-consuming it is to communicate with a patient, unless the patient presents with an emergent condition. Although this is understandable in the sense of the efficiency of the emergency department, I could not help but think how unfair it is that something as simple as language can be a factor in how fast someone

is seen by a provider. After a translator is in place, the attending team can spend more time than usual explaining the treatment plan and possible medication regimes, but the initial wait can have serious and lethal consequences. I noticed how difficult it must be to balance quality care and efficiency, especially in the emergency department. I believe it is important for the attending team to provide quality care to all patients, regardless of their background. Our diverse society calls for every healthcare professional to be aware of our differences and potential biases to treat each patient with the same quality of care.

Being a health care provider means not only healing a person of their disease but taking care of the whole person, which includes their diverse background. My goal of becoming a health care provider has inspired me to explore the options available for cultural competency training, specifically for undergraduate nursing students. I want to determine if cultural competency training is successful in developing nurses who understand their own biases and accept the differences that exist among a diverse patient population. To do so requires understanding the models that outlined the components of cultural competency from the beginning of diverse care to the current models available. This will provide an outlook for where cultural competency could be in the future and its effect on reducing health care disparities.

The Movement Toward Cultural Competency

Previously, the United States was considered a “melting pot” due to the fusion of different ethnic backgrounds, nationalities, and cultures. However, this term has become outdated as it implies that all the components of the pot, such as the meats, potatoes, carrots, etc., which represent the minority population, begin as individual ingredients with their own identities, but will all eventually blend into the main soup, representing the majority population. This analogy misrepresents populations who do not wish to assimilate and want to keep their identities separate while existing in one system. The term that has emerged in an attempt to accurately represent the United States' diverse population is “tossed salad”, where the salad components all exist with their separate identities intact. The tossed salad metaphor allows for individual beliefs and practices to be appreciated while existing in a larger society. However, this metaphor is also flawed in the sense that the dressing represents the overarching changes that one must undergo to still fit into society, such as learning English.

Regardless of the effectiveness and criticisms of food metaphors to describe the population of the United States, they each address the diverse population of the United States. The United States Census Bureau projected that the population will be more diverse in terms of not only race and ethnicity, but also age. It is expected that the 65-and-older population will double by 2060, from 49 million in 2016 to 95 million people, which will represent a quarter of the population (Vespa et al., 2020). Non-Hispanic White populations are expected to shrink from 199 million in 2020 to 179 million by 2060, due to falling birth rates and increased deaths as this population ages. Additionally, the percentage of people who are a race other than White is expected to grow to represent 32% of the population, that is, one in three people will non-White. In the 1990s, this representation was 1 in every 5 people. Interestingly, 49.8% of children are

projected to be non-Hispanic White in 2020, suggesting that the majority of children will be a race other than non-Hispanic White. By 2060, two-thirds of children are expected to be another race than non-Hispanic White (Vespa et al., 2020). Unfortunately, diverse populations are prone to more health care disparities, such as limited access to care and education, unhealthy living conditions, and recipients of less than proper care by health professionals. Despite some health care disparities being linked to race or ethnicity, many exist due to a person's socioeconomic status, environment, sexuality, or ability. This necessitates training healthcare professionals on how to deliver quality care to patients with different backgrounds than their own.

According to the Center for Disease Control and Prevention, health care disparities are preventable differences in achieving optimal health that is associated with disadvantaged populations and are related to inequalities concerning the allocation of resources ("Disparities | Adolescent and School Health | CDC," 2018). Many factors contributed to the existence of health disparities, mainly, America's societal views towards minorities throughout history.

Racial divides were intensified when Jim Crow laws legally separated facilities based on race. Minority physicians were excluded from practicing in predominantly white hospitals, and as a result, created their facilities within the minority communities. However, in 1964 and 1965, the passage of civil rights legislation and Medicare and Medicaid legislation, respectively, changed the healthcare structure. Hospitals were forced to merge with white facilities or were closed. Over 70 black hospitals between 1961 and 1988 were closed, forcing minority communities to be left without adequate care. There was a loss of convenience, accessibility, safety in a known institution, and employment. Public facilities that served minority patients also experienced the same fate (Institute of Medicine, 2003).

The unethical treatment of minority populations in American history has developed mistrust toward the medical community. Although societal progress was achieved through legislation, it further intensified the health care disparities among minority populations as they do no longer have the same quality of care as the majority. One solution to this is the delivery of quality care to all patients. Despite strict regulations for how patients are to be treated in the research component of medical care, the treatment of patients still varies among clinics and hospitals.

Health care providers should provide quality care to a diverse population to reduce health care disparities. These health care disparities can be addressed and alleviated through various solutions, such as increasing the number of providers in underserved communities, increasing the diversity of the healthcare staff (“Cultural Competence in Health Care,” n.d.), and ensuring that all staff receive intensive cultural competency training.

Cultural competence, in general, refers to a person’s ability to effectively interact with people across cultures. Beginning in the late 1980s, it was defined as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations” (Thackrah & Thompson, 2013). In healthcare, this encompasses the provider’s ability to meet the patient’s social, linguistic, ethnic needs of the patients. Different definitions of cultural competency do exist, but it essentially comprises of the health care professional’s ability to interact and deliver care across a diverse patient population by using culturally-based care and knowledge in a way that aligns with the wants and needs of the patient (Darnell & Hickson, 2015; Shen, 2015; Shepherd et al., 2019). Although the concept of cultural competence can be extended and applied to all professions, for this paper, I will evaluate how

nursing schools have taught cultural competency to their nursing students. Nursing professionals are at the center when providing care since they interact with patients more so than any other health care professional. Culturally competent practices ensure that care in the hospital is patient-centered and helps reduce the health care disparities that currently exist and improve health outcomes (Shen, 2015).

According to the 2017 National Nursing Workforce Survey, there are approximately 3.8 million registered nurses with approximately 10 nurses per 3 physicians, making nursing the largest healthcare profession (Rosseter, 2019; Smiley et al., 2018). The demographics of the nursing population are 81% White/ Caucasian, 7.5% Asian, 6.2% Black/ African American, 2.9% other, and 1.7% identified as two or more races. This contrasts with the United States' changing population where minorities will soon become the majority.

The cultural background of the patients dictates how one interprets and seek out medical care. Sometimes, this leads to conflicts between the health professional and the patient as values, attitudes, beliefs, and practices may differ. It is up to the health care professional to understand the patient's perspective to curate a treatment plan that places the values of the patients first while delivering quality care. Acknowledging that modern Western medicine is not accepted by all cultures is important.

The book, *The Spirit Catches You and You Fall Down* by Anne Fadiman (1997), is a story about a Hmong child, Lia, suffering from epilepsy and her journey through the American healthcare system. It becomes obvious that the American doctors and Lia's parents do not see eye-to-eye when it comes to treating Lia. Culturally, Lia's parents perceived her epilepsy as a gift from the spirit and knew that this was her diagnosis before her healthcare team did.

Lia was admitted to the Merced Community Medical Center (MCMC) several times throughout her life for focal and grand mal seizures with unknown etiology. When Lia first presented in the emergency room on October 24, 1982, she was misdiagnosed with “early bronchopneumonia or tracheobronchitis” (Fadiman, 1997, p. 27) as her seizure stopped before arrival and her only notable symptoms were coughs and a congested chest. She presented to the emergency room similarly again on November 11th and was diagnosed similarly. Only when Lia arrived at the emergency department five months after her initial visit was she correctly diagnosed with epilepsy. Lia’s doctor reflected on her notes and thought about how her life would have been different if the hospital had provided her with optimal care from the beginning (41). Cases like Lia, although seemingly an experience of the past, are still present in modern times.

Nursing professionals are essential in bridging the gap that exists between the culture of diverse patient populations and the culture of Western medicine. To do so requires training in cultural competency so that nurses become aware of the differences that exist among people. Thus, transcultural nursing was created for this purpose.

Cultural Competency Models

Developed in the 1950s, and published in 1991, Madeleine Leininger's Transcultural Nursing Theory, or Culture Care Theory, aimed to improve the nurses' knowledge and skills when delivering care to a culturally diverse patient population. Leininger defined transcultural care as "a substantive area of study and practice focused on comparative cultural care (caring) value, beliefs, and practices of individuals or groups of similar or different cultures to provide culture-specific and universal nursing care practices in promoting health or well-being or to help people to face unfavorable human conditions, illness, or death in culturally meaningful ways" (as cited in Gonzalo, 2019, p. 2.1; Murphy, 2006).

Leininger dedicated her studies to develop a more caring system within the nursing profession, and she highlighted the importance of care during cross-cultural interactions. She states that "caring behavior and practices *uniquely* distinguish nursing from the contributions of other disciplines" (Leininger, 1988, p. 4) and recognized that caring has different appearances among different populations. Leininger further emphasized that caring is critical in the nursing field because it appeared to be critical in human growth and development, as well as survival, for humankind. She asked questions such as "how is caring expressed among different cultures in the world", "what are the cross-cultural differences in human caring and professional caring", "why has nursing failed to study the epistemological, philosophical, and cultural aspects of caring as a generic to nursing"? (Leininger, 1988, p. 4). It is almost nearly impossible to fully answer the question as it requires vast knowledge on every culture that exists America, and the debate on whether humanitarian values, like caring, can be taught to nursing students, or whether these are innate qualities a nursing professional should possess still exist.

Regardless, Leininger developed the Sunrise Model (Appendix 1) to help nurses integrate cultural and social structures while caring for patients. This model acknowledges the strong influences that cultural and societal structures have on the patient's belief system and other factors (i.e. economic, education, political, religious, technological, kinship, etc.), and how these influence the decisions and actions of nursing care to balance the medical and cultural needs of patients to provide culturally congruent care. Leininger address three modes of cultural nursing care, which are Maintenance, Negotiation, or Restructuring. Maintenance requires nurses to help patients of a particular culture to retain care values so that they can maintain overall well-being. Negotiation requires nurses to help patients adapt to certain medical practices that can result in beneficial health outcomes. Restructuring requires nurses to help patients modify lifestyles to create a healthy life pattern while respecting cultural differences (as cited in Gonzalo, 2019). Since Leininger, there have been conscious efforts to increase the cultural awareness of nurses to develop cultural competency.

The definition of cultural competency evolved and branched out so much that there is no longer one single definition of cultural competency. Terms similar to cultural competency have emerged, such as cultural awareness, cultural proficiency, and cultural humility. All these refer to a health professional's ability to communicate effectively across cultures and are often used interchangeably. This emphasizes the growing attempt to truly capture what it means to care for culturally diverse patients.

Many models have been implemented to promote cultural competency in healthcare professionals. Studies have addressed the efficacy of these methods on a short-term scale, however, there is insufficient data to conclude long-term effects. Nevertheless, the efforts to generate a model that captures the complexity of a person and how nursing professionals should

cater care toward individuals are still valuable. This section will address the overlapping commonalities across models and the differences that exist between them.

Cultural Awareness

Included in multiple models, the idea of cultural awareness refers to the self-reflection and self-awareness of one own's cultural backgrounds and biases, which requires nurses to understand their own complex cultural identity. The Culturally Competent Model of Care (Appendix 2) states the implicit and explicit biases influences how nurses treat and care for patients. Self-examination reduces the risk of cultural imposition, where a person is inclined to impose their values and beliefs onto another (Campinha-Bacote, 2002). This is dangerous because it demonstrates insensitivity towards another's cultural beliefs and disregards it. Similarly, the Model for the Development of Culturally Competent Health Practitioners (Appendix 3) presents cultural awareness as the first stage to becoming more culturally competent (Papadopoulos et al., 2016).

The aspects of cultural awareness that Papadopoulos et al. (2016) considered were self-awareness, ethnocentricity, cultural identity, heritage adherence, ethnohistory, and stereotyping. A workshop in Cyprus was hosted to gauge the level of cultural competency across different types of nurses, which included community, home, mental health center, and rural nurses using the Papadopolous et al. model of culturally competent care (Kouta & Raftopoulos, 2016). For the first stage, nurses were asked to examine their own cultural believes and practices so that they can understand the complexity of cultural identity. They were asked to openly discuss the stereotypes and biases that they held against common minority groups in Cyprus as an attempt to break down the "truths and myths of different stereotypes". The nurses were then asked to reflect on how stereotyping affects patient care. This stage concluded with a session focused on building

interpersonal relationships with patients who did not speak Greek to build trust and rapport (Kouta & Raftopoulous, 2016).

In the case of Lia Lee, her parents opted for traditional medicine to treat Lia because they noticed that the medications were not healing her. Lia's parents spent \$1,000 on sacred herb amulets from Thailand and traveled to Minnesota from California to visit a txiv neeb, a shaman who can negotiate the health of the patient with the spirits in an unknown realm. The American doctors at MCMC, however, complained that Hmong parents did not care about the health of their children. In reality, the Hmong invested money or indebted themselves to other relatives to pay for services that are not covered by their insurances. To confuse the dab that was responsible for stealing Lia's soul, her parents tried to change Lia's name to Kou. The spirit would think that Lia was someone else and return her soul, but the doctors insisted on calling her Lia and ruined the Lee's plans to heal their daughter.

Cultural awareness can be considered the foundation of being culturally competent. It is important for health care professionals to examine their own biases before treating patients so that they can recognize that differences between beliefs may exist between them and the patient. Being culturally aware does not mean sacrificing one's values and beliefs for another's, but rather accepting and respecting another culture as well as our own.

According to the 3-Dimensional Puzzle Model of Culturally Congruent Care (Appendix 4), cultural awareness acknowledges the risk of "unconscious incompetence", where health care providers are unaware of their lack of cultural knowledge (Gonzalo, 2019; Schim et al., 2007). This is a dangerous position to be in as there would be little respect toward cultures different from your own.

The ability to be culturally aware strengthens the ability to be culturally humble. When nurses reflect on and recognize their own biases, they can learn how personal experiences and social environments have shaped their own lives (Yeager & Bauer-Wu, 2013). They then can apply this thought process to their patients and recognize that the patients have different experiences that shaped their belief system. This humility allows nurses to adjust and personalize treatment for individual patients to promote respect for the person.

The process of becoming culturally aware and practicing cultural humility is a life-long process. Culture is not a stagnant being, it is dynamic and constantly changes throughout a person's life. It requires constant self-reflection and self-assessment of personal values and beliefs. When nurses are culturally aware, there is less risk for cultural imposition and stereotyping.

Cultural Knowledge

Another strong component in multiple cultural competency models is the concept of cultural knowledge. Campinha-Bacote (2002, p.182) defined cultural knowledge as the “process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups”. Health care providers should be knowledgeable in three specific areas of the health of individuals: beliefs and cultural values concerning health, disease incidence and prevalence, and treatment efficacy (Campinha-Bacote, 2002).

Understanding the incidences and prevalence of a disease among ethnic groups is important because of disease that occur in certain ethnic populations. Having incorrect epidemiological data will result in the inability to decide on the best treatment plan for the patient. Treatment efficacy refers to ethnic pharmacology, which is the study of how the

medication is metabolized among ethnic groups. This knowledge helps guide the healthcare professional in choosing the best medication for the patient.

Although Campinha-Bacote's model has identified understanding the biological variances within communities as cultural knowledge, some models, such as the Transcultural Assessment Model (Appendix 5) or Purnell Model (Appendix 6), have categorized this definition separately and are considered the biological variations that exist between people (Giger & Davidhizar, 2002; Purnell, 2002). It recognizes that biological differences between racial groups have been less recognized, such as the metabolism of drugs, susceptibility to illnesses, and the detection of certain diseases. For example, incidences of skin cancer are higher among Caucasians and have been increasing, however, it is low among people of color (Bradford, 2009). However, when skin cancer is detected in patients of color, it presents at a more advanced stage when compared to Caucasian patients. This is due to the increased epidermal melanin providing photo-protection which filters ultraviolet light radiation more. Thus, skin cancer in people of color presents atypically and health care providers must take extra care when examining skin lesions, as well as broadening the research fields to include patients from different cultural backgrounds (Bradford, 2009).

Other models have defined it as the meaningful interactions with diverse people to learn about their beliefs, practice, and any other problems that may arise during treatments, and is the integration of multiple disciplines (e.g. sociology, psychology, biology, medicine, arts) to understand the beliefs and behaviors of patients surrounding problems that may arise (Papadopoulos et al., 2016).

It is not feasible for nurses to learn everything there is to know about every cultural belief. Being aware of the traditions, practices, and beliefs of multiple cultures only provides the

nurse with a general outline of a population. With this, there is the risk of stereotyping and placing patients into categories where they do not belong. This is one major flaw that occurs when teaching about various cultures. The belief system within one group of people can vary between individual people as some have their interpretations based on life experiences. Many people may be committed to well-known practices and traditions, but some may not.

Being culturally humble allows the nurse to recognize that the patient may participate in the practices of their culture but remain open-minded and accepting of their decisions if they are informed of differing belief systems.

Cultural Sensitivity

Cultural sensitivity refers to the behaviors the nurse should exhibit while interacting with patients and understanding the cultural differences and similarities. According to the Model for the Development of Culturally Competent Health Practitioners, being culturally sensitive requires exhibiting empathy, trust, acceptance, appropriateness, and respect while interacting with patients. This requires providers to view patients as true partners to achieve being culturally sensitive (Papadopoulos et al., 2016). The Transcultural Assessment Model considers the behaviors of the nurse and divides it into three different cultural phenomena, which are: communication, space, and time. Communication is considered human behavior and interactions based on verbal and nonverbal cues. Space is the distance between the nurse and patient during the interaction, and a violation of the patient's personal space may result in discomfort during care or refusal of treatment. Time refers to the method of care given depending on interpersonal communication. Patients, depending on their culture, can be focused on the past, present, or future status of their illnesses and nurses should adjust accordingly.

In the Purnell Model for Cultural Competence, cultural sensitivity exists in specific domains. The first domain, communication, is similar to the Transcultural Assessment model. It encompasses verbal language and its paralanguage variations, such as tone, volume, intonations, and willingness to share thoughts and feelings. It also includes the use of nonverbal cues, like eye contact, body language, touch, spatial distancing, and greetings. Perspectives on time are also acknowledged, as well as the names of important concepts.

The 3-Dimensional Puzzle Model of Culturally Congruent Care (Schim et al., 2007) defines cultural sensitivity as an affective or attitudinal construct that depends on the person's attitude toward themselves and toward others as well as their willingness to learn about another cultural dimension. It emphasizes that nurses should take on the role of a learner as opposed to assuming a position of knowing sufficient information about one particular group or individual. It is a practice of cultural humility, where the health care provider acknowledges that they do not know everything about a person and their culture but are willing to learn about their traditions and beliefs to provide them with the most culturally respectful and culturally congruent care.

This idea is similar to Campinha-Bacote's (2002) model of care where cultural sensitivity is known as cultural desires. It is defined as a genuine passion to learn and accept the differences between one another while building relationships with the commonalities and the willingness to be open and flexible with knowledge from others as cultural informants. It relies on the health care provider's wanting engage in culturally congruent practices as opposed to having to provide care. Campinha-Bacote stated, "people don't care how much you know, until they first know how much you care" (Campinha-Bacote, 2002, p. 183). It is not enough for nurses to say they are respectful of differences in others, but they have to have authentic compassion and desire to provide culturally responsive care.

Health Outcomes

Some models have included how health outcomes are connected to culturally competent models. It is generally agreed upon that care that aligns with the patient's lifestyle and beliefs results in positive attitudes towards nursing care. If care is given in the perspective of Western medicine and is misaligned with the patient's beliefs, then misdiagnoses, misunderstanding, and negative attitudes will result from this. Of course, this is a major assumption. Some patients may not practice the traditions or beliefs of their culture and prefer Western medicine. Or, despite providing culturally congruent care, patients may still demonstrate non-compliance with the treatment plan. Regardless, the goal of a nursing professional is to improve care in any aspect as much as they can.

The model for the Delivery of Culturally Competent Community Care (Appendix 7) outlined by Kim-Godwin et al. (2001) has included health outcomes as one of the three constructs of health care, the others being cultural competence and health care system. Smith (1998, as cited in Kim-Godwin et al., 2001) observed seven positive outcomes when culturally competent care was given, which are (1) empowerment and respect toward health care professionals, (2) decreased negative attitudes toward the health care system, (3) increased cultural group members seeking care and receiving appropriate care, (4) increased patient satisfaction with health services, (5) improved educational experiences, (6) improved health statuses for minority patients, and (7) increased respect among health care professionals.

Kim-Godwin et al. (2001) then interviewed community health nurses and nurse experts who worked with migrant farmworkers, 13 participants in total, and they reported that care that was culturally congruent with their patients resulted in positive health outcomes. They identified several potential outcomes that may result from culturally competent care, such as (1) prenatal

care visits increasing, (2) increased immunizations, (3) reduced morbidity and mortality rates, (4) increased compliance with medicine, (5) increased emotions of self-worth, (6) increased the number of people seeking treatment, and (8) increased interest in the prevention of serious diseases and promotion of a healthier life (Kim-Godwin et al., 2001).

Improving the health outcomes of all patients is a common goal that all health care professionals should have in mind. It provides the foundation for all health practices as questions concerning efficiency, convenience, adaptability, affordability, and accessibility are considered. If there are medical practices that exclude populations then this generates a risk for health care disparities within that population. In essence, health care outcomes should be a positive experience for all patients and nursing professionals have a direct role in providing culturally competent care with efforts to increase improve patient health outcomes. Whether that role is to be an active listener or finding ways to combine medicine with a patient's belief system.

Other Components

As models evolved, many include elements that should be considered when providing culturally competent care that does not necessarily fall into the categories mentioned above. The Purnell Model, for example, has domains that factor in high-risk behaviors, nutrition, workforce issues, death rituals, and spirituality. The Purnell model recognized that these domains are not independent of each other but rather are connected and affected by each domain. It takes into account practices that are generally not related to culture directly and prioritizes it as important factors to a patient's life (Purnell, 2002)

Interestingly, Purnell's model also includes a section that is simply a black hole in the middle of the circle. This black hole represents the knowledge that we do not possess about a culture. It acknowledges the fact that while we can attempt to learn every practice, tradition,

behavior, and social aspects of a culture, it will never complete (Purnell, 2002). There is always something new to learn about a culture, especially as an outsider to that culture. This helps us adopt a humbler approach to learning, as not everything can be taught.

The Transcultural Assessment Model considers the patient's environmental control. This model focuses on the idea of internal vs external control. Many Americans believe that they can control nature and can seek medical attention when needed. This contrasts cultural groups that believe there is an external control over their health, and seeking medical attention is unnecessary (Giger & Davidhizar, 2002).

One model focuses on homeopathic medicine and how nursing professionals can accommodate the body, mind, and spirituality. The HEALTH Traditions Model (Appendix 8) (Spector, 2002) emphasizes what people do to main, protect, prevent illness/restore their health. The body component includes physical aspects, like genetics, gender, age, nutrition, physical condition, chemistry, etc. The mind is the cognitive processes of a person, their thoughts, memories, emotion, and self-esteem. The spiritual component is the learned spiritual practices, teachings, symbols, dreams, stories, and the metaphysical or innate forces that exist. These all exist within the context of family, culture, work, community, and environment. This model considers the homeopathic remedies that can be used to restore the health of the body and considers superstitions that a person's spirit may be drawn to. HEALTH is defined as a state of balance between all three components: body, mind, and spirit and all work in harmony with the patient's environment (Spector, 2002).

This is a unique perspective on caring for the patient as many traditional methods of care, such as exorcisms, symbolic clothing, or changing names are often not considered in an allopathic-dominant environment. It is important to acknowledge that allopathic medicine, or the

use of modern medicine and medical practices to treat diseases, is the most common method to treat patients, but this model suggests that homeopathic approaches should be considered as it may be beneficial for the patient and their treatment of diseases.

The 3-Dimensional Puzzle model accounts for the diversity in the United States. This includes race, ethnicity, sexual orientation, generation, national origin, and ideology. It acknowledges that diversity has increased over the past decades, and this is a reality for the united states. This model acknowledges that inequalities exist for certain populations. This problem of limited access for all people is still a problem today. Within this diversity category, it acknowledges that any environment at any given time will experience different levels of diversity. Sine communities are more homogenous while others are more heterogeneous. Thus, the nursing population may or may not treat populations with various representations.

This is an interesting perspective as some may argue that cultural competency training is unnecessary when there is one majority population. It may not seem relevant to learn about different cultures and belief systems when everyone has the same perspective on healthcare. However, it is better to be aware of all the cultural possibilities that exist outside of the community and be prepared to care for any patient.

In general, all these models share the common goal of wanting to provide culturally competent care for the patient, whether it is in the form of the skills a nurse should master, or in the form of factors in a patient a nurse should consider when caring for them. These models have evolved since Leininger's approach to transcultural nursing, but only to account for changing demographics and a more inclusive definition of culture.

Not one single model is used across all nursing schools, rather some schools prefer a specific model opposed to others. This can be seen as problematic because the levels of cultural

competency will differ among nursing students, resulting in different levels of care toward minority patients. It is unsure if a standardized model of culturally competent care would be helpful to nursing students as there is limited research on the long-term effects of cultural competency training programs. Because of this, multiple models exist in efforts to create a more inclusive, long-lasting cultural competency model for nursing instructors to teach the nursing students.

Developing the Nursing Student

The main courses offered in the Bachelor of Science in nursing curriculum mainly focus on the sciences as well as practicing the hard skills required to take care of patients. These courses include, but are not limited to, anatomy, physiology, microbiology, human development, pharmacology, and hands-on procedural techniques. When caring for the whole body, however, it is necessary to take courses that evaluate the relationship between people and society as well as the ethics of medical practices. These are taught with courses pertaining to sociology and health care ethics. There are no courses available specifically for cultural competency. In most nursing programs, cultural competency is limited to one or two class periods. This sporadic and fragmented method of teaching cultural competence is inadequate in preparing nursing students for the real-world diversity they would encounter in the population (Calvillo et al., 2009).

What exactly does it mean to be a culturally competent nurse? The American Association of Colleges of Nursing (AACN, 2008) has established standards required for Baccalaureate nursing education to teach and train for students to be considered culturally competent. These standards include:

1. Applying knowledge of social and cultural factors that affect nursing and health care across multiple contexts.
2. Using relevant data sources and best evidence in providing culturally competent care.
3. Promoting achievement of safe and quality outcomes of care for diverse populations
4. Advocating for social justice, including the commitment to the health of vulnerable populations and the elimination of health disparities.
5. Participating in continuous cultural competence development.

The rationale for the importance of cultural competency according to the AACN is so that nurses can “support the development of patient-centered care” as well as respect any differences a patient has in terms of needs, preferences, and values (2008). It also emphasizes how social justice should be a motive for nurses to be culturally competent. There should be a shared sentiment that all people have access to the benefits of society and fair treatment. Nurses, specifically emergency department nurses may be exposed to vulnerable populations where basic rights, freedoms, and access to care are limited. The AACN argues that “providing culturally competent care to vulnerable populations is a moral mandate, congruent with social justice and human rights orientation” (2008).

When the nursing student transitions to a practicing nurse professional, the main hope is that the school has adequately prepared them to handle all situations in the medical field and that the students have learned all that they needed to care for patients. Studies, however, have shown that graduating baccalaureate nursing seniors were not necessarily prepared to care for diverse patients.

In a 2017 study assessing the cultural competency of 295 nursing students in southern Finland, it was concluded that the level of cultural competence was moderate (Repo et al., 2017). The students were assessed via the Cultural Competence Assessment Tool which includes a background section (age, gender, linguistic skills, religion, native country, frequency of interactions with different cultures, and whether multicultural nursing was included in education) and four sections with 10 statements each to measure cultural awareness, knowledge, sensitivity, and practice on a 4-point scale.

Cultural competency was measured in four levels, as outlined by Papadopoulos (as cited in Repo et al., 2017):

1. Cultural incompetence: scoring less than 5 in cultural awareness regardless of other scores
2. Cultural awareness: scoring 5 or more in cultural awareness and generic statements in other sections do not necessarily have to be correct
3. Cultural safety: scoring 5 or more in cultural awareness and all generic statements in other sections are correct
4. Cultural competence: scoring 10 in all sections

Of the four levels of competence, 74% were culturally aware and 26% were culturally safe. None of the nurses measured at the incompetent or competent level. Nurses who had received education on multicultural nursing obtained higher scores in cultural awareness and cultural sensitivity. Nurses who were also not born in Finland or spoke another language other than Finnish were exchange students or interacted with different cultures daily either in leisure or on duty scored higher on cultural competence overall.

It was important to measure the cultural competence of nurses in Finland as their immigration rates had doubled within the past two decades and approximately 5.5% of the population are immigrants. The health care system in Finland is homogenous and may have difficulties responding to the needs presented in a diverse population (Repo et al., 2017). Of course, this study can only be generalized for graduating nursing students in southern Finland, however, implications drawn from this study can be applied to the United States.

The process of instilling cultural competency in nursing students can always be improved upon and several recommendations have been proposed by the American Association of Colleges of Nursing in 2008. Many of these recommendations rely on faculty and their active commitment towards cultivating a culturally competent nurse. The first recommendation requires

the administration to create a well-structured curriculum that clearly outlines the expectations and outcomes of achievements. By doing so, faculty, staff, and the students have a clear understanding and vision of what it means to be culturally competent. In addition to the structured curriculum, the administration can implement policies to improve and enhance the recruitment and retention of diverse students and faculty (Calvillo et al., 2009). This includes offering financial support, social and academic support, mentorships, and professional counseling (Altman et al., 2016).

By diversifying the nursing population so that it reflects the diversity in the general population, multiple experiences and perspectives can be shared within the nursing community to effectively treat the patients with respect. There are opportunities to address differences among a variety of cultures, as well as opportunities to dismantle harmful stereotypes. With this mindset, a supportive educational climate for diversity is created. To further enhance awareness of cultural differences, immersion experiences in different communities are recommended. The realities of health care disparities and the implementation of disease prevention are highlighted and community engagement is encouraged (Calvillo et al., 2009).

Without a clear understanding or awareness of different cultures and how it can affect a patient's treatment course, the nurses' health is also impacted. The inability and unpreparedness of a nurse to manage cultural differences result in stressful situations for both the nurse and the patient (Cang-Wong et al., 2009; Murcia & Lopez, 2016). One study has identified a negative correlation between cultural sensitivity and perceived stress, and cultural sensitivity was affected by perceived stress (Uzun & Sevinç, 2015). Thus, not only will the patient benefit from a knowledgeable nurse, but the health and well-being of the nurse will benefit as well.

Multiple practicing nurses have suggested increased cultural competency training to better care for diverse populations. Koutas and Raftopoulous' (2016) intervention to provide nurses in Cyprus aimed to study their levels of cultural competency. As mentioned in an earlier section, Koutas and Raftopolous presented the Papadopoulos et al. model in various stages where nurses were asked to examine their own biases, have conversations about stereotypes and biases that they hold against common minority groups, and to work on building interpersonal relationships with patients whose first language was not Greek.

At the end of the intervention, a survey was given to obtain feedback from the nurses, which included community nurses (48.9%), home nurses (21.7), mental health center nurses (25%), and nurses from rural centers (4.3). Of course, this was not a random, controlled experiment, however, the feedback is still valuable. 22.8% of the community nurses stated that the workshop helped them while 54.8% was considerably helped, 20.6% reported it slightly helped, and 1.8% reported that it did not help them at all.

The community nurses were then asked why some may not want to learn about other cultures and the answers were: a) not being interested in learning about other cultures, b) never taught about other cultures, c) did not have a colleague from another culture. However, overall, the participants did report the necessity to participate in similar workshops again to improve transcultural health care. Some improvements to sessions offered by Koutas and Raftopouous were: 1) avoid required attendance as it would lead to superficial participation or resistance. It would be more beneficial to approach it as training that would benefit all patients and the community as a whole, 2) allow adequate time away from the intense work environment so that the nurses can engage fully in the training, 3) provide a clear framework on how to deliver cultural competency training, 4) factual knowledge, habits, and customs of diverse groups may

be accepted, but “challenging ethnocentric beliefs, practices, and unwitting prejudice” is necessary, 5) pre- and post-training assessment would provide information on the existing levels of cultural competence, the effectiveness of the training, and a measure of progress, 6) training programs should be thoroughly evaluated and shared with others (Koutas and Raftopoulous, 2016).

Concerning the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) community, the nursing programs in the United States dedicate an average of 2.13 hours of formal content regarding their health, which further exacerbates the health disparities that exist within this community that accounts for 3.5% of the population (as cited in Kuzma et al., 2019). To address this, Kuzma et al. piloted a project with LGBTQ-identifying standardized patients to create valuable clinical experiences for nursing students as LGBTQ content was presented in course readings, lectures, or simulations with high-fidelity mannequins or standardized patients identifying as gay men. The project included six standardized patients ranging in age, gender, and sexuality who were instructed to memorize a case for the nursing students to practice their assessment and interview skills in a safe environment.

From this project, the students were asked to self-evaluate their experience with the project. Five main themes emerged from student responses: 1) skill development, clinical environment, 3) LGBTQ experience, 4) debriefing, and 5) cultural humility and assumptions. Students that they were “not prepared for the patient to state he is trans-identity individual...and my response reflected so” or that they were “challenged by [their] lack of exposure to patients of transgender background. There was so much [they] did not know related to gender reassignment therapy and surgeries, and I felt ignorant for not knowing these things”. However, upon debriefing and reflecting on their experience with standardized patients, students felt that the

experience was worthwhile because they were allowed to practice interacting with patients from the LGBTQ community when education about this community was mainly in the form of lectures. It also allowed students to grow in their process of becoming culturally humble since. One student stated that “learning to ask the tough questions and to admit when I don’t know something will be beneficial not only can strengthen the provider-patient relationship and empower the patient to be more involved in their care”.

It was suggested that similar standardized patient experience should be added to the curriculum for nursing students as it identified areas for students to improve despite topics being covered in class. For example, some students avoided conversations about the transgender patient’s experiences with transitioning or gender-affirming therapies or procedures (Kuzma et al., 2019). It provided the nursing students with an enriching training experience that can be applied to the professional experience as they were allowed to make mistakes in a safe environment where feedback was provided.

Although cultural competency training is available to nursing students, many nursing professionals have relied on informal experiences to treat patients. This suggests that it is even more crucial to provide explicit cultural competency training for student nurses so that they are more prepared in the work environment.

A study using Camphina-Bacote’s model of cultural competence compared the levels of cultural competency between undergraduate and graduate nursing students (Mareno & Hart, 2014). It was found that undergraduate nurses had statistically significant lower levels of cultural knowledge when compared to their graduate counterparts. Levels of cultural awareness, skills, and comfort when interacting with patients were also lower than graduate nurses, but these results were not statistically significant. This supports that further education can improve cultural

knowledge of nurses, but does not necessarily indicate higher levels of awareness, skills, and comfort when interacting with patients.

Both undergraduate and graduate-degree nurses reported not actively seeking to continue their cultural competency training despite having many online resources (as cited in Mareno & Hart, 2014). This further emphasizes the need for nursing faculty to incorporate and integrate cultural knowledge in the nursing program as students may not seek to improve their cultural competency after graduation or feel unprepared when encountering patients of different backgrounds.

When nursing graduates report that there is a lack of motivation or incentive to continue their education in cultural competency, this speaks to a greater need for nursing schools to focus on providing nursing students with the necessary tools to treat patients of all backgrounds. It suggests that the models alone are not adequate in the teaching of cultural competency, but it should be paired with theoretical and clinical approaches. Most models do not outline a lesson plan that could be implemented for nursing instructors, but some have reported suggestions to improve how schools teach cultural competency.

With this, I decided that most of the models that outline how to be a culturally competent nurse would have been too difficult to outline a course that accomplished all aspects of cultural competencies, such as awareness, knowledge, sensitivity, and all the factors of a patient. Thus, I have generated my own understanding of what cultural competency is with the Culturally Connected Model of Care.

The Culturally Connected Model of Care

Several models of providing culturally competent care exist to outline how a health care provider should care for a more diverse population with efforts to reduce the health disparities that exist within communities. Some models are specific to nursing professionals while others can be applied to any profession. This shows that there is a need for culturally congruent care and treatment of others in any context.

Many models emphasized the characteristics of a culturally competent nurse, such as being culturally aware, knowledgeable, and sensitive. In addition, there was an emphasis on factors that had to be considered when treating patients, including religion, gender, race, and age. Some provided a connection between the nursing practice and patient by explaining how cultural and social structure influences the patients' decisions and how those decisions influence the approach the nurses take when caring for patients.

I have realized, however, that a majority of the cultural competency models that I have examined did not include the nurses' own life experiences and beliefs. The Culturally Connected Model of Care (Appendix 9) recognizes that both the patient and nurse are actively participating in the care given and that each party brings their own experiences and biases. This model recognizes that a person's culture is dynamic and not static. It is up to the nurse, however, to be aware of their implicit biases when treating patients and demonstrate cultural humility. If the nurse is unable to be aware of their own biases, then cultural imposition may occur, which will further damage the relationship between the nurse and patient, resulting in sub-optimal care.

Assumptions of the Models

The model operates on the following assumptions:

1. The characteristics, values, beliefs, and traditions of a person are constantly evolving and never static
2. Being aware of one's biases requires frequent reflection
3. Different cultures understand, interpret, and practice care in different ways, but there are similarities between cultures
4. People do not always abide by their ascribed statuses
5. The ability to be culturally humble is required when delivering culturally competent care
6. Delivering culturally competent care will help reduce health care disparities
7. Patients who receive care that does not align with their personal beliefs or practices will experience negative health outcomes, such as stress or non-compliance to the medical treatment plan

Defining the Model

The Culturally Connected model acknowledges that the nurse and the patient both have different backgrounds and experiences that have shaped how each one perceives care. These include traditional factors, like race, ethnicity, gender, religion, and socioeconomic status, but have expanded to encompass education, biology and genetics, environment, occupation, age, sexuality, and more. This expanded list emphasizes the distinct background people have that cannot be fully understood despite efforts of developing an inclusive care plan. With these factors, it important to recognize that these beliefs, values, and experiences are dynamic, possibly even on a day-by-day basis. Opinions may shift due to new life experiences that cannot

be predicted, and that is acceptable and should be considered a fact of life. This applies to both the patient and the nurse.

One distinction between the nurse and the patient is the nurses' awareness of their own biases, both implicit and explicit. This allows the nurse to exhibit and practice cultural humility. If successful, the patient will trust the providing team and adhere to the treatment plan. Together, the nurse can provide quality care and the patient will receive quality care. There should always be a stride toward providing a positive health care experience that results in quality care to increase positive health outcomes. Thus, when nurses can demonstrate cultural humility toward the patient, the patient will, in return, show the nurses' trust. This allows the patient to be open about their thoughts and concerns to the nurse and providing team.

An important aspect of cultural humility is the fact that nurses have to understand care from the patient's perspective. This is so they understand the reasoning behind the differences or fears that may arise throughout the patients' experiences. Cooperation between the nurse and the patient creates a cohesive team with the common goal of healing the patient and preventing future diseases. The increased quality of care will help reduce the health care disparities that exist and can be applied to the larger communities as trust toward the health care profession will increase. This allows for positive outcomes such as increased clinical visits from the community, more patient satisfaction toward the care given, and improved health statuses for vulnerable populations.

Implementing the Model

Outlining a perfect and comprehensive course on how cultural competency should be taught is a challenge itself. Teaching nurses about the signs, symptoms, and treatments of

diseases and how to perform clinical tasks while trying to incorporate aspects of caring and cultural respect requires a balance. It is important to acknowledge that learning about the body is more than learning about the anatomical parts and functions. It is important to know the person and approach care holistically. Patients bring their whole life to the clinic, and this life should be considered when caring for them.

Short-term interventions to teach nurses about how to be culturally competent have been proven to be effective, but there is limited research on the effects in the long-term. Those short-term interventions include a few days dedicated to learning about what it means to be culturally competent. Teaching cultural competence should not be dedicated to just one or two full days, but rather it should be treated as a continual process and incorporated into the curriculum with a variety of learning experiences. Experienced nurses have expressed that holding seminars with guest speakers of different backgrounds would be useful when presenting on what the majority of one culture may believe (Kouta & Raftopoulos, 2016). It would provide an environment where students can ask questions about that culture in a safe learning environment. However, this can be detrimental as one person cannot speak for the entire culture. It may lead to stereotypes and false assumptions about a person if the nursing students encounter a patient who does not practice the culture. Regardless, this format would be beneficial for students as it would present health care from a different perspective, as long as it is clear that some people may not follow the beliefs of a culture.

Teaching cultural humility through literature is a teaching technique that would create lasting impressions for nursing students. Literature can form engaging conversations and evoke feelings of motivation to do better. Literature portrays instructional text in a humanistic way so that the students are engaged not only by science but emotionally as well (Clark et al., 2000).

Reading literature will allow students to view care from the perspective of the patient and develop a passion to fight against injustices that exist. Reading allows students to discuss the theoretical approaches to care, what they would have done instead, or what practice they would carry on while they are caring for patients themselves. Clark et al. (2000) suggested *The Spirit Catches You and You Fall Down* by Anne Fadiman, *Yes is Better Than No* by Byrd Baylor, and *The Tortilla Curtain* by T.C. Boyle. Although nurses are not at the forefront of these novels, the cultural impacts of each novel would still be beneficial for nursing students as they can understand healthcare through the patients' perspective. This would further enhance their ability to become a more culturally humble nurse.

As discussed previously with the LGBTQ community, practicing clinical skills with live patients from different communities would be beneficial as it allows students to fully assess how skilled and how comfortable they truly are when interacting with patients from different backgrounds. Like having guest speakers, the practice clinical setting will provide the nursing students with a safe space to practice understanding patients different from them, a space to make mistakes, and a space to ask questions. This aligns with developing cultural humility in nursing students because there is an opportunity for them to acknowledge that they will not know everything about a culture and will have to learn from the patient. It can be a humbling experience.

One last intervention for nursing students would be to involve them in community outreach programs or service-learning projects. Service-learning complements academic goals while providing context for understanding life, so that civic responsibility and duty is developed (Adegbola, 2013). Nursing students are taught to appreciate others and develop a desire to serve those in their surrounding communities. One key component of service-learning is the act of

reflection. In a survey of 98 nursing students, a majority reported that reflective practices helped them apply theoretical lessons into practice as well as allowed them to look at clinical situations from different perspectives (Caldwell & Grobbel, 2013). It also allowed the nursing students to identify their areas of strength and weakness and reflect on what they can do to improve their care for patients.

With reflection, there is an additional benefit of relieving emotional stress that nursing students may encounter during clinical examinations. A student stated that they “absorbed her [patients’] emotional trauma ‘like a sponge’”. The chance to reflect on allowed the nursing student to release some of that emotional trauma that was stored inside (Rees (2012) as cited in Caldwell & Grobbel, 2013). It allows students to better understand patients’ responses and think of solutions to better approach emotionally-heavy topics.

In terms of the Culturally Connected Model of Care, these methods would allow nursing students to continuously develop their ability to be culturally humble. It is not enough to simply know a culture, it is, however, enough to understand and know a person based on their experiences and develop a meaningful relationship that allows for the opportunity to provide quality care.

This model, of course, is not perfect. It does not consider how to measure the cultural humility of a person. How does one measure cultural competency? It is often by providing surveys to nurses and asking them to rate their perception of how culturally competent they are. One flaw when evaluating the cultural competency of nursing students is the fact that most of the evaluations were self-reported. This is critical as some may report themselves as being more or less culturally competent than they are.

This is still an area that requires further development. A possibility would be to ask patients to evaluate the care given to them by the nurses, but this may be last on their priority list following a medical examination. Nursing instructors may have exhibit biases toward their nursing students as there is a prior relationship. For future evaluations, objective analyses have to be provided by third-party evaluators to determine cultural competencies in efforts to reduce all biases that exist.

This is an important aspect of the Culturally Connected Model of Care. It calls on nurses to constantly self-reflect on their own experiences to see how those have defined who they are as people. It allows nurses to recognize when they might have not given someone quality care or judged someone implicitly based on certain factors. These can manifest in verbal and nonverbal communication.

Although this model of care is generally for nursing professionals, this model can be used for any professional setting. Everyone needs to realize that they hold implicit biases towards people, but they have to work on acknowledging those implicit biases explicitly. When interacting with those from different backgrounds, it is not right to assume that we know everything about their culture. Instead, we have to demonstrate humility and willingness to learn about each other. That is how one develops trust.

Applying this model to an actual learning space is still required to test its efficacy. With this model, there is hope that the curriculum will last throughout the nursing students' career. They would be given tools on how to reflect upon their actions and how their opinions and values have evolved over time. Although formal education may have ended for the nursing students, this model will allow them to continue learning about different cultures through the eyes of their patients.

Nevertheless, the Culturally Connected Model of Care aims to simplify yet enhance the nursing students' experience of learning about cultural competency. It does not focus on specific skill sets that a nurse should have nor does it focus on the endless factors a nurse should consider in their patients. Rather, it focuses on the importance of self-reflection and a demonstration of cultural humility to better serve the patient population. In return, trust and rapport are built, and together, cultural humility and trust can result in improved quality of care. This improved quality of care will transcend into larger communities with hopes of reducing the health care disparities that exist so that all patients, regardless of background, will receive optimal care.

Future of Nursing

So, what does this mean for the future of nursing?

With the population of the United States rapidly becoming more diverse, there is a stronger need to ensure that quality care is given to each of these patients. Many vulnerable communities have been left out of quality care, due to limited access to resources or because there is little trust in the healthcare system.

It is up to the nurses, the ones who interact with the patients the most, to reestablish a system of care. Caring for someone in a clinical setting does not mean caring for just the body and the diseases they present with, it means caring for the whole person. Unfortunately, nursing students may feel unprepared or not qualified enough to take care of someone different from themselves. It is incredibly overwhelming to learn everything about how race, ethnicity, gender, age, environment, socioeconomic status and the effects on the care given to a person. However, this does not mean it should be ignored, or only superficial information about each culture should be taught. Some nurses may argue that they do not see ethnicity or age or socioeconomic status when treating patients and view them just as a person. Yet, a person's background greatly defines their medical history and how they perceive care moving forward.

Instead, nursing programs should allow nursing students to learn about and understand multiple cultures while maintaining the mindset that not everything can be known about a culture. This allows nursing students to approach care with humility and provides them with an opportunity to learn from the patients, resulting in trust between the nurse and the patient.

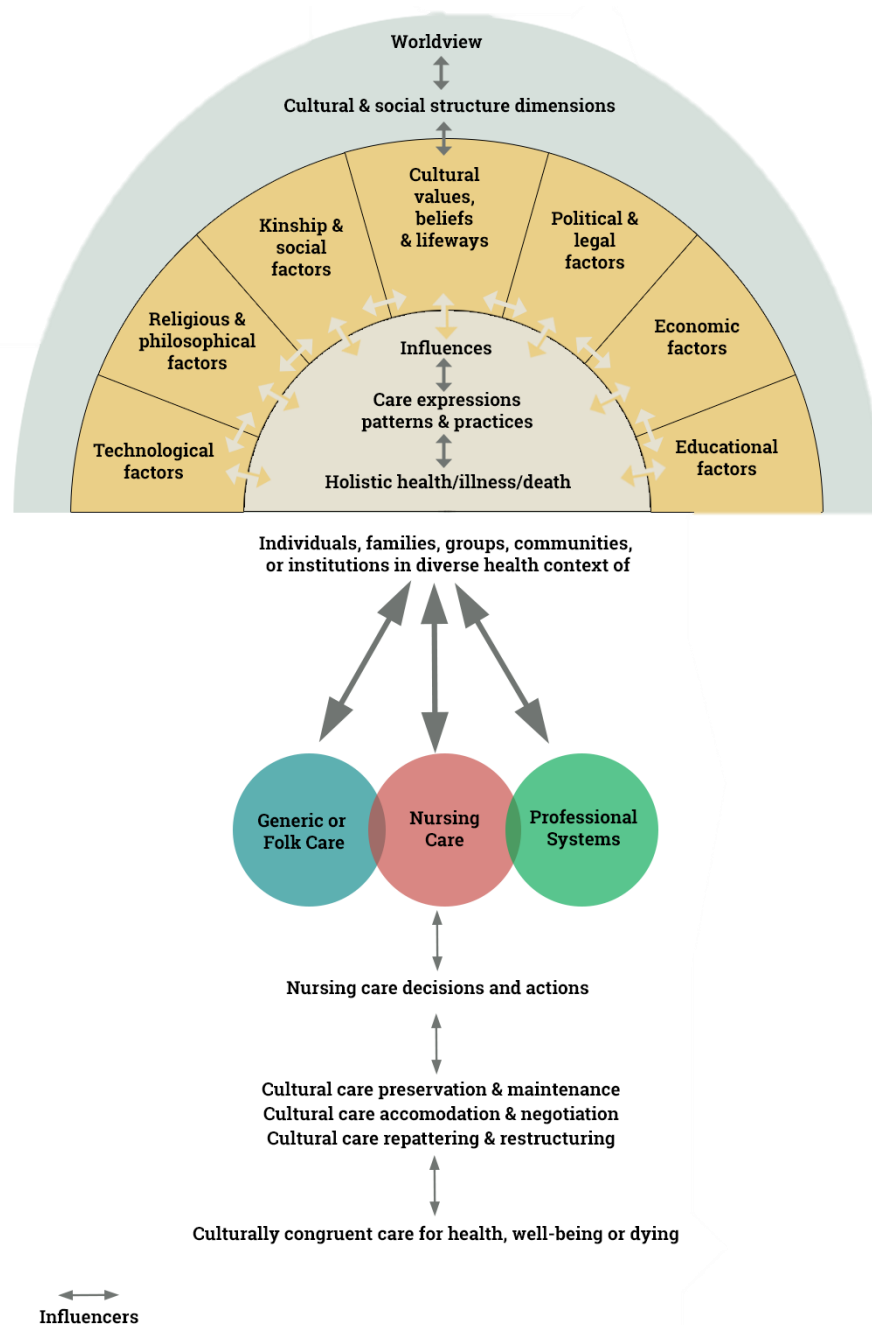
However, the patient is not the only one who should be considered in the process of giving care. The nurse should be considered as well. Nurses bring their own set of life

experiences, values, beliefs, and traditions, and these will greatly influence how one will deliver care. If a nurse is ignorant of their own beliefs while ignoring the beliefs of others, risks of cultural imposition, increased health disparities, and increased negative health outcomes will be the resulting products. Nurses will unconsciously discriminate or think less of a person because they hold implicit biases against a culture. Thus, nurses need to constantly practice self-reflection on their values, traditions, beliefs, and actions so that they can provide optimal care for every patient.

While America's history with medicine was not exemplary show of just, ethical, and equal treatment, it provided a foundation of how treatments of patients should be. We need to encourage nursing professionals to care for the whole body and whole person so that we do not return to how we have treated vulnerable communities in the past. The future of healthcare and equal treatment rests on the hands of nursing professionals, and to ensure that they are prepared to treat anyone, we have to ensure they are prepared as nursing students.

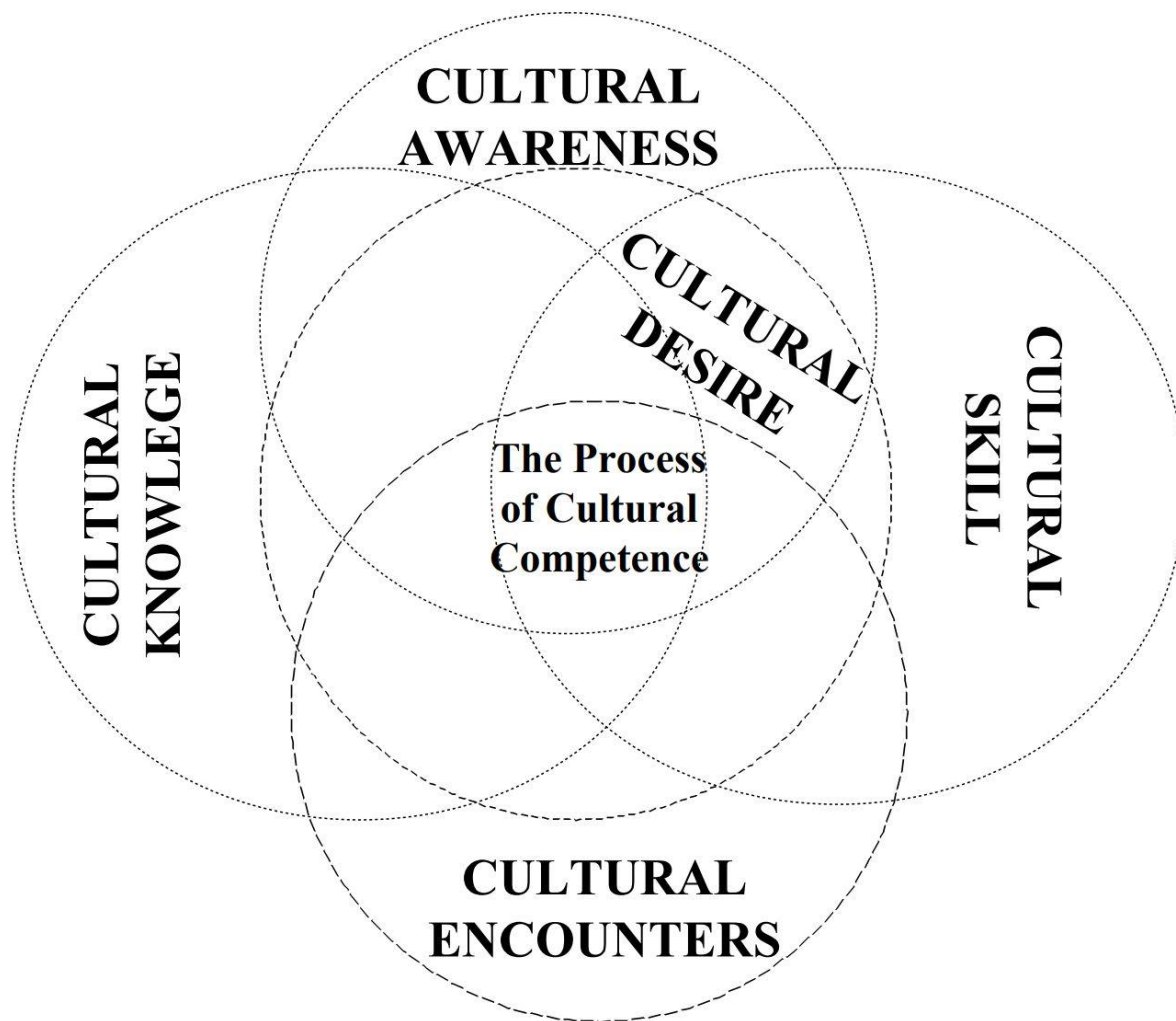
Appendix:

1. Leininger's Transcultural Nursing Sunrise Model (Adapted from Gonzalo, 2019)

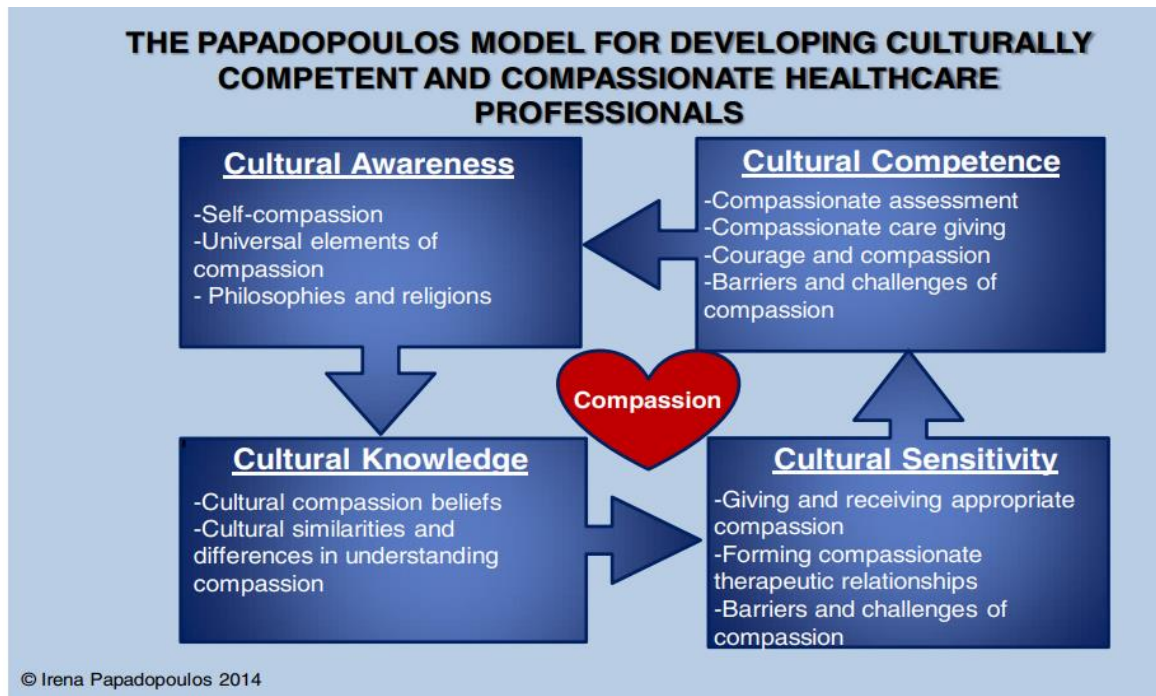


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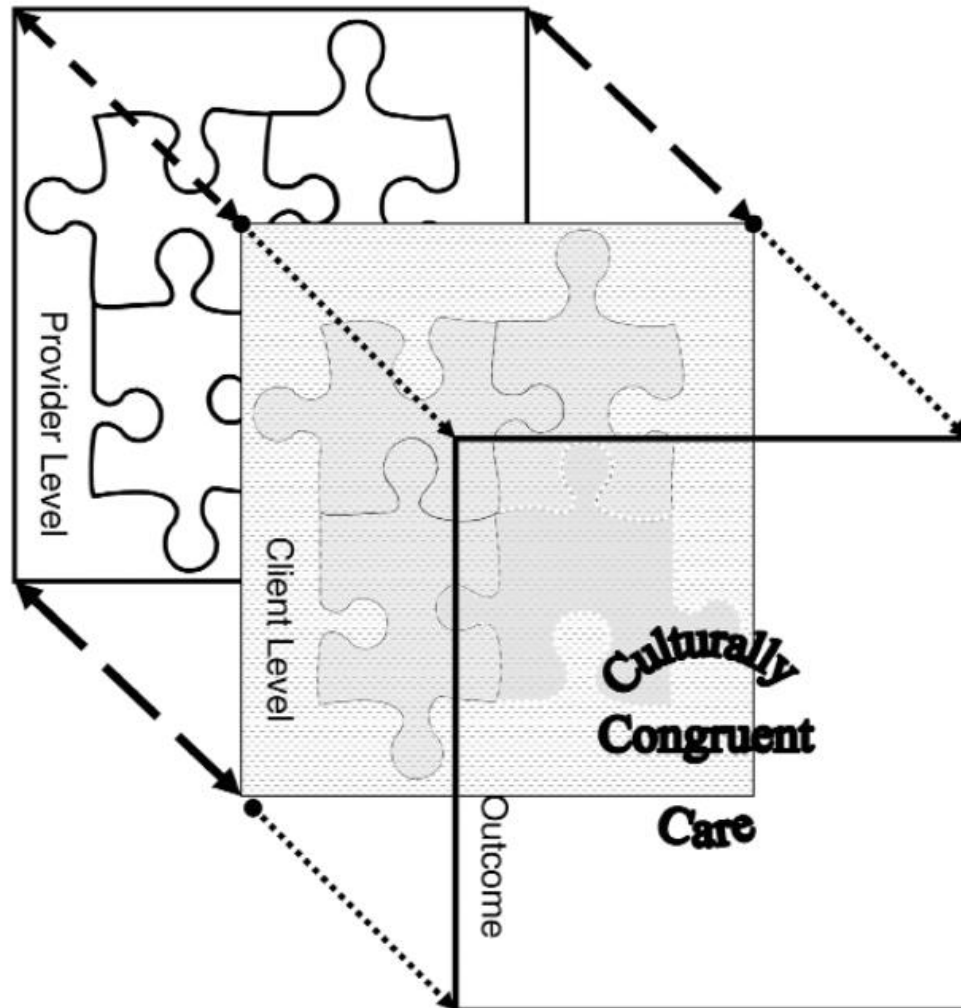
Culturally Competent Model of Care (Adapted from Campinha-Bacote, 2002)



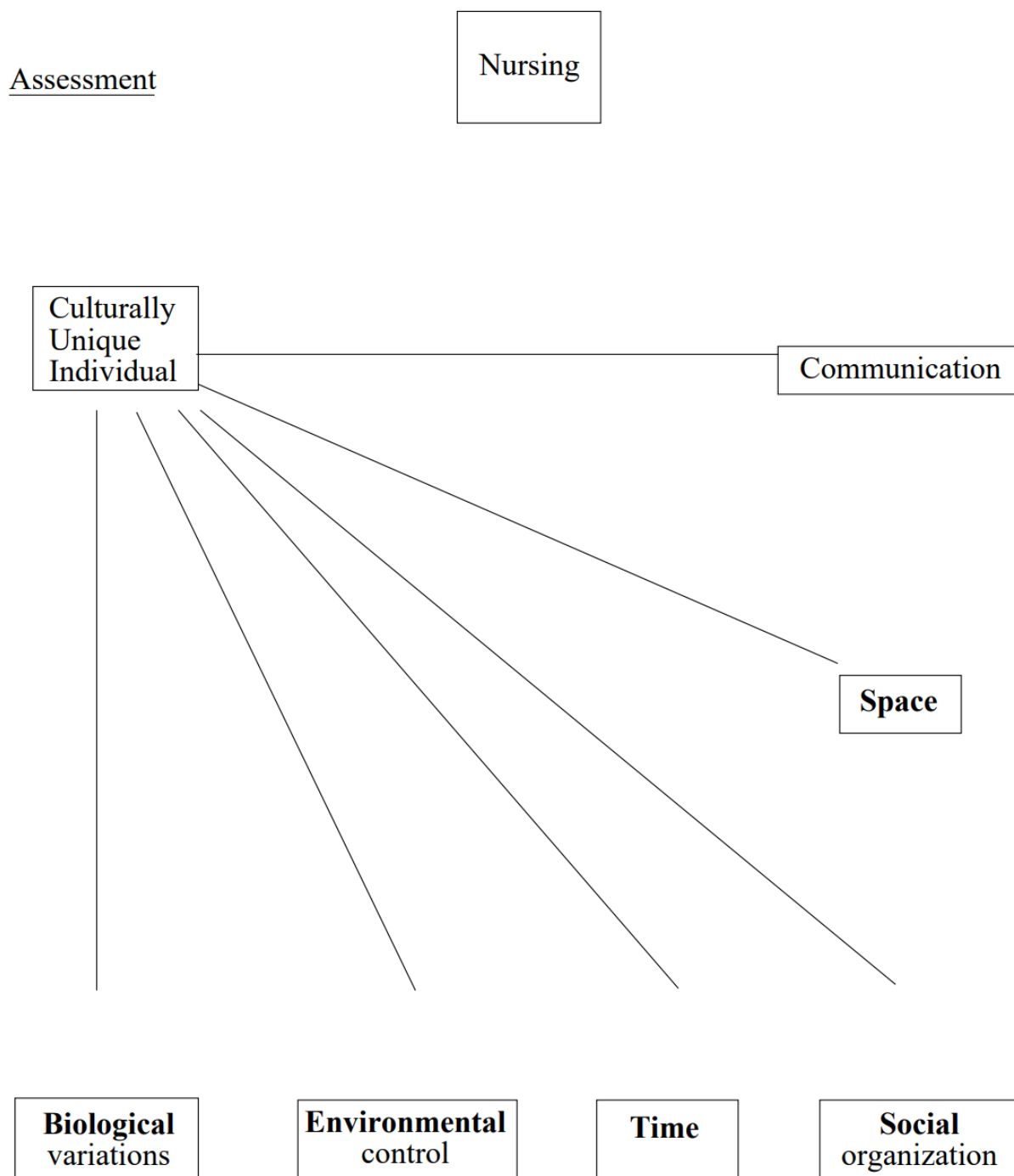
3. Model for the Development of Culturally Competent Health Practitioners (Adapted from Papadopoulos et al., 2016)



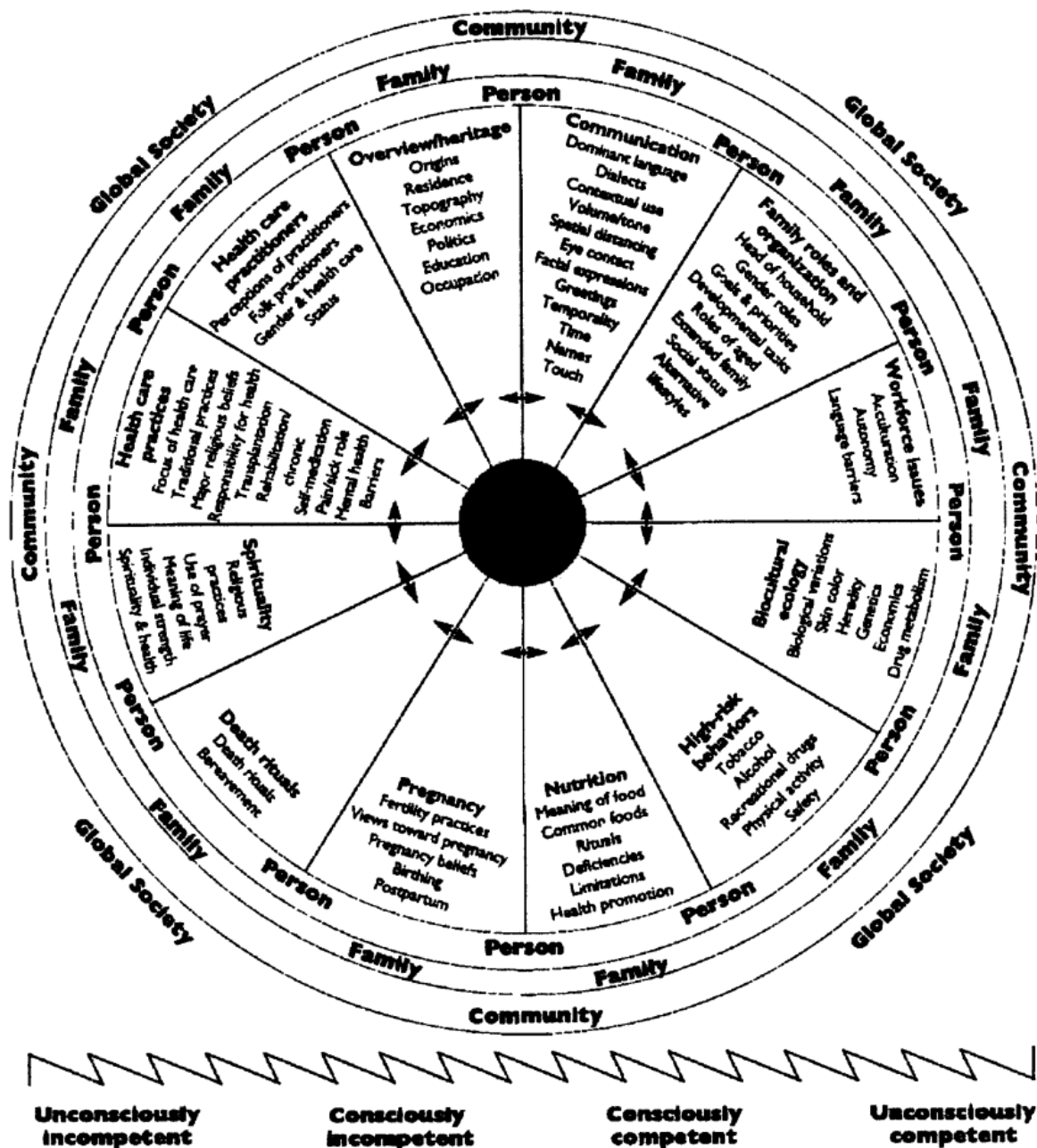
4. 3-Dimensional Puzzle Model of Culturally Congruent Care (Adapted from Schim et al., 2007)



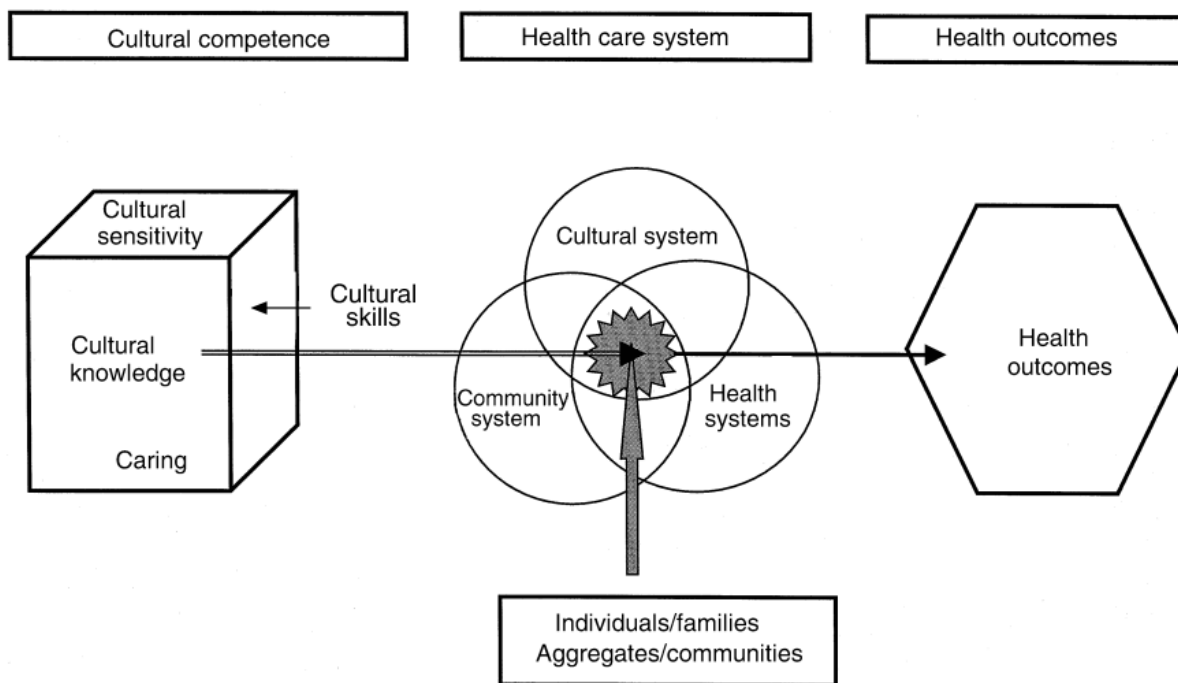
5. Transcultural Assessment Model (Adapted from Giger & Davidhizar, 2002)



6. Purnell Model for Cultural Competence (Adapted from Purnell, 2002)



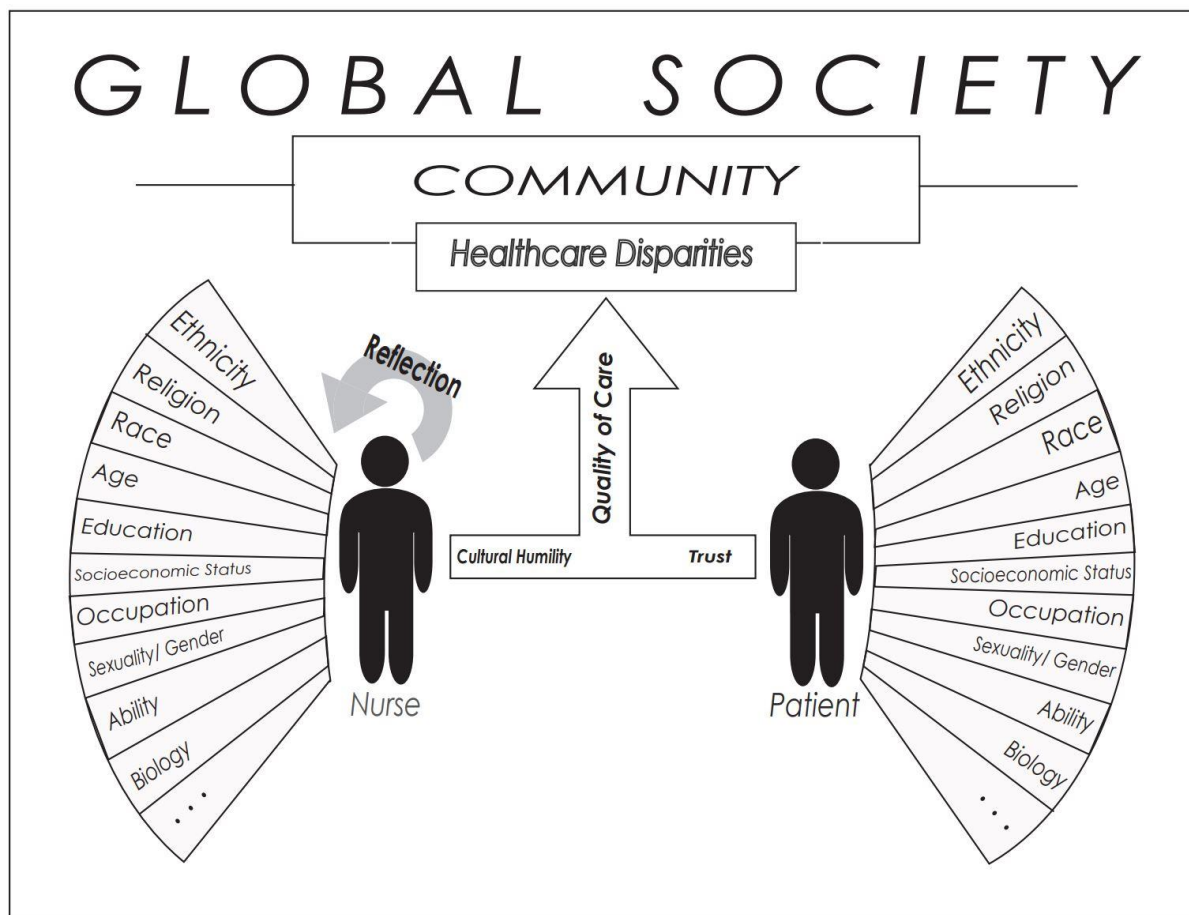
7. A Model for the Delivery of Culturally Competent Community Care (Adapted from Kim-Godwin et al., 2001)



8. HEALTH Traditions Model

HEALTH	Body	Mind	Spirit
Maintain	Traditional clothing, diet, and activities	Social and family supports; hobbies	Religious practices; prayer and/or meditation
Protect	Special diets and food taboos; symbolic clothing	Family and community activities	Superstitions; amulets and talisman
Restore	Homeopathic remedies	Relaxation; exorcism	Religious rituals; changing names

9. Culturally Connected Model of Care



References

- Adegbola, M. (2013). Relevance of Service Learning to Nursing Education. *The ABNF Journal : Official Journal of the Association of Black Nursing Faculty in Higher Education, Inc*, 24(2), 39.
- Allen, B. J. (2011). *Difference Matters: Communicating Social Identity* (2nd ed.). Waveland Press, Inc.
- Altman, S. H., Butler, A. S., Shern, L., Committee for Assessing Progress on Implementing the Recommendations of the Institute of Medicine Report The Future of Nursing: Leading Change, A. H., Medicine, I. of, & National Academies of Sciences, E. (2016). *Promoting Diversity*. National Academies Press (US).
<http://www.ncbi.nlm.nih.gov/books/NBK350167/>
- Bradford, P. T. (2009). Skin Cancer in Skin of Color. *Dermatology Nursing / Dermatology Nurses' Association*, 21(4), 170–178.
- Caldwell, L., & Grobbel, C. C. (2013). *The Importance of Reflective Practice in Nursing*. 6(3), 8.
- Calvillo, E., Clark, L., Ballantyne, J. E., Pacquiao, D., Purnell, L. D., & Villarruel, A. M. (2009). Cultural Competency in Baccalaureate Nursing Education. *Journal of Transcultural Nursing*, 20(2), 137–145. <https://doi.org/10.1177/1043659608330354>
- Campinha-Bacote, J. (2002). The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care. *Journal of Transcultural Nursing*, 13(3), 181–184.
<https://doi.org/10.1177/10459602013003003>
- Cang-Wong, C., Murphy, S. O., & Adelman, T. (2009). Nursing Responses to Transcultural Encounters: What Nurses Draw on When Faced with a Patient from Another Culture. *The Permanente Journal*, 13(3), 31–37.
- Clark, L., Zuk, J., & Baramée, J. (2000). A Literary Approach to Teaching Cultural Competence. *Journal of Transcultural Nursing*, 11(3), 199–203.
<https://doi.org/10.1177/104365960001100306>
- Crossing the Quality Chasm: The IOM Health Care Quality Initiative: Health and Medicine Division*. (2018, October 19). The National Academies of Sciences Engineering Medicine.
<http://www.nationalacademies.org/hmd/Global/News%20Announcements/Crossing-the-Quality-Chasm-The-IOM-Health-Care-Quality-Initiative.aspx>
- Darnell, L. K., & Hickson, S. V. (2015). Cultural Competent Patient-Centered Nursing Care. *Nursing Clinics of North America*, 50(1), 99–108.
<https://doi.org/10.1016/j.cnur.2014.10.008>
- Fadiman, A. (1997). *The Spirit Catches You and You Fall Down*. Farrar, Straus and Giroux.
- Giger, J. N., & Davidhizar, R. (2002). The Giger and Davidhizar Transcultural Assessment Model. *Journal of Transcultural Nursing*, 13(3), 185–188.
<https://doi.org/10.1177/10459602013003004>
- Gonzalo, A. (2019, September 10). *Madeleine Leininger: Transcultural Nursing Theory*. Nurseslabs. <https://nurseslabs.com/madeleine-leininger-transcultural-nursing-theory/>
- Institute of Medicine. (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (B. D. Smedley & A. R. Nelson, Eds.). National Academies Press (US).
<https://doi.org/10.17226/12875>
- Kim-Godwin, Y. S., Clarke, P. N., & Barton, L. (2001). A model for the delivery of culturally competent community care. *Journal of Advanced Nursing*, 35(6), 918–925.
<https://doi.org/10.1046/j.1365-2648.2001.01929.x>

- Kouta, V. M., & Raftopoulos, V. (2016). Improving the Cultural Competence Level of Community Nurses through an Intervention. *Journal of Family Medicine*, 3(9).
- Kuzma, E., Graziano, C., Shea, E., Schaller, F., Pardee, M., & Darling-Fisher, C. (2019). Improving lesbian, gay, bisexual, transgender, and queer/questioning health: Using a standardized patient experience to educate advanced practice nursing students. *Journal of the American Association of Nurse Practitioners*, 31(12), 714–722. <https://doi.org/10.1097/JXX.0000000000000224>
- Leininger, M. M. (1988). *Caring: An Essential Human Need*. Wayne State University Press.
- Mareno, N., & Hart, P. (2014). Cultural Competency Among Nurses with Undergraduate and Graduate Degrees: Implications for Nursing Education. *Nursing Education Perspectives*, 35(2), 83–88. <https://doi.org/10.5480/12-834.1>
- Murcia, S. E. A., & Lopez, L. (2016). The experience of nurses in care for culturally diverse families: A qualitative meta-synthesis 1. *Revista Latino-Americana de Enfermagem*, 24. <https://doi.org/10.1590/1518-8345.1052.2718>
- Murphy, S. C. (2006). Mapping the literature of transcultural nursing. *Journal of the Medical Library Association : JMLA*, 94(2 Suppl), E143–E151.
- National Academies of Sciences, E., Division, H. and M., Practice, B. on P. H. and P. H., States, C. on C.-B. S. to P. H. E. in the U., Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (2017). The State of Health Disparities in the United States. In *Communities in Action: Pathways to Health Equity*. National Academies Press (US). <http://www.ncbi.nlm.nih.gov/books/NBK425844/>
- Papadopoulos, I., Shea, S., Taylor, G., Pezzella, A., & Foley, L. (2016). Developing tools to promote culturally competent compassion, courage, and intercultural communication in healthcare. *Journal of Compassionate Health Care*, 3(1), 2. <https://doi.org/10.1186/s40639-016-0019-6>
- Purnell, L. (2002). The Purnell Model for Cultural Competence. *Journal of Transcultural Nursing*, 13(3), 193–196. <https://doi.org/10.1177/10459602013003006>
- Quality Care for Every Patient*. (n.d.). Stanford Health Care. Retrieved January 9, 2020, from <https://stanfordhealthcare.org/about-us/quality.html>
- Repo, H., Vahlberg, T., Salminen, L., Papadopoulos, I., & Leino-Kilpi, H. (2017). The Cultural Competence of Graduating Nursing Students. *Journal of Transcultural Nursing*, 28(1), 98–107. <https://doi.org/10.1177/1043659616632046>
- Rosseter, R. (2019). *American Association of Colleges of Nursing (AACN) > News & Information > Fact Sheets > Nursing Fact Sheet*. <https://www.aacnnursing.org/News-Information/Fact-Sheets/Nursing-Fact-Sheet>
- Schim, S. M., Doorenbos, A., Benkert, R., & Miller, J. (2007). Culturally Congruent Care: Putting the Puzzle Together. *Journal of Transcultural Nursing*, 18(2), 103–110. <https://doi.org/10.1177/1043659606298613>
- Shen, Z. (2015). Cultural Competence Models and Cultural Competence Assessment Instruments in Nursing: A Literature Review. *Journal of Transcultural Nursing*, 26(3), 308–321. <https://doi.org/10.1177/1043659614524790>
- Shepherd, S. M., Willis-Esqueda, C., Newton, D., Sivasubramaniam, D., & Paradies, Y. (2019). The challenge of cultural competence in the workplace: Perspectives of healthcare providers. *BMC Health Services Research*, 19(1), 135. <https://doi.org/10.1186/s12913-019-3959-7>

- Six Domains of Health Care Quality*. (n.d.). Agency for Healthcare Research and Quality. Retrieved January 9, 2020, from <http://www.ahrq.gov/talkingquality/measures/six-domains.html>
- Smiley, R. A., Lauer, P., Bienemy, C., Berg, J. G., Shireman, E., Reneau, K. A., & Alexander, M. (2018). The 2017 National Nursing Workforce Survey. *Journal of Nursing Regulation, 9*(3), S1–S88. [https://doi.org/10.1016/S2155-8256\(18\)30131-5](https://doi.org/10.1016/S2155-8256(18)30131-5)
- Spector, R. E. (2002). Cultural Diversity in Health and Illness. *Journal of Transcultural Nursing, 13*(3), 197–199.
- Thackrah, R. D., & Thompson, S. C. (2013). Refining the concept of cultural competence: Building on decades of progress. *Medical Journal of Australia, 199*(1), 35–38. <https://doi.org/10.5694/mja13.10499>
- Uzun, Ö., & Sevinç, S. (2015). The relationship between cultural sensitivity and perceived stress among nurses working with foreign patients. *Journal of Clinical Nursing, 24*(23–24), 3400–3408. <https://doi.org/10.1111/jocn.12982>
- Vespa, J., Medina, L., & Armstrong, D. M. (2020). *Demographic Turning Points for the United States: Population Projections for 2020 to 2060*. 15.
- WHO | *About social determinants of health*. (n.d.). WHO; World Health Organization. Retrieved March 4, 2020, from http://www.who.int/social_determinants/sdh_definition/en/
- Yeager, K. A., & Bauer-Wu, S. (2013). Cultural humility: Essential foundation for clinical researchers. *Applied Nursing Research : ANR, 26*(4). <https://doi.org/10.1016/j.apnr.2013.06.008>