Cultural Competence in Nursing: Foundation or Fallacy?

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Propelled by a national concern with social justice and health disparities, the notion of cultural competency is being incorporated into both government regulation and professional standards. Although most of the standards that are being developed nationally apply at the institutional level, it is in the clinical setting where the expectation of cultural competency is the most demanding. The recommendations for clinicians to become culturally competent generally fall into 2 major categories. The first focuses on the content and structure of the clinical encounter between provider and patient. The second category charges providers with becoming knowledgeable about the cultures of their constituent patients and learning their lifestyles, health beliefs, and behaviors. Although individuals may belong to the same cultural group, the assumption that they are, in fact, the same, is an ecological fallacy. The health care system has nested the accountability for cultural competence with the clinician who provides direct services to individuals, where the application of cultural information is likely to be least useful. We contend that cultural competence is really nursing competence.

Culturally competent care has emerged as the mantra of contemporary nursing practice.2-7 Clinical practice publications (eg, Nurse Week, Journal of Pediatric Nursing, and Caring) abound with formulas and instruction for health providers on how to become more culturally sensitive and celebrate diversity, preparing nurses for a practice world in which ethnic diversity is the norm. The Transcultural Nursing Society, whose mission is to enlighten nurses about cultural diversity and promote culturally competent care, now has been joined by other professional organizations, including the American Nurses Association8 and the American Association of Colleges of Nursing,9 along with a variety of clinical specialty organizations such as the Emergency Nurses Association.10

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Propelled by a national concern about social justice and health disparities,11 the notion of cultural competency is being incorporated into both government regulation and professional standards. For example, the US Office of Minority Health recently issued new guidance in the form of 14 draft standards for culturally and linguistically appropriate services. Title VI guidance, the “Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency,” was issued in 2000. It details legal requirements and explains how organizations can comply with the law. The Joint Commission on the Accreditation of Healthcare Organizations already requires language assistance and written notice of patients’ rights and patient and family education that is guided by culture and language. In 2000 the US National Advisory Council on Nurse Education and Practice issued a national agenda for the nursing workforce regarding racial and ethnic diversity in which it addresses the significance of cultural competence.

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One would be hard pressed to deny that the flurry of activity around cultural competency is a very good thing. Recognition that the ethnic composition of the population of the United States is changing dramatically and challenging a health care system that is narrowly based in a white, male, middle-class, biomedical model is long overdue. As the United States continues to evolve as a multi-ethnic, culturally diverse society, a standard of cultural competency in all human services is wholesome, desirable, and consistent with the democratic principles on which this nation was founded. It may be time, however, to
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Although most of the standards that are being developed nationally apply at the institutional level (e.g., appropriate interpreter services, continuing education, monitoring procedures, and community cultural assessments), it is in the clinical setting where the expectation of cultural competency is the most demanding. Nurses, physicians, and other health care providers are not simply encouraged to provide culturally sensitive care but are enjoined to do so by institutional policies and regulations. With governmental and organizational standards in place, culturally sensitive care, cultural awareness, and cultural competence have been laid squarely at the feet of direct care providers. Indeed, the push to achieve cultural competency among the provider staff has given rise to a burgeoning industry of cultural awareness training programs ranging from hours to months long. Even Internet sources such as Cross-Cultural Health Care Program at Pacific Medical Clinics, Diversity Rx, EthnoMed, Maternal and Child Health National Center for Cultural Competence, and the National Multicultural Institute have been established to assist clinicians in their attempts to be culturally sensitive.

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The second category of actions recommended to achieve cultural competence (and the one we take issue with in this article) charges providers with becoming knowledgeable about the cultures of their constituent patients and learning about their lifestyles and culturally determined health beliefs and behaviors. These include cultural attitudes, communication styles, taboos, and all the health/illness beliefs and practices of the specific population groups served by the particular health care provider. According to Salimbene, the provider should acquire enough cultural information to anticipate possible barriers to access or hindrances to compliance with care. The goal is to minimize cultural dissonance and improve patient-provider communication, thus reduce opportunities for errors, increase compliance, and produce better clinical outcomes. According to Leininger, “culture is largely the blueprint for predicting human motivation, action, patterns and consequently nursing interventions” and it is necessary to have an “in depth awareness of different cultures so that the provider can be knowledgeable about the clients’ cultural background in order to provide culture-specific care.”

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On the surface, these assumptions appear intuitively correct. A closer look, however, suggests that they are flawed in their application both by a narrow definition of culture and a failure to appreciate the complexities of the relationship between the individual and culture. The term culture refers to a social construction of the learned patterns of behavior and a range of beliefs attributed to a specific group. As individuals, most of us have only minimal impact on our culture, which has a life of its own and changes over time, independent of any one member. Cultural groups are composed of generations of families and communities who enjoy varying levels of adherence to traditional cultural norms. Thus, although humans are indeed “culture carriers,” most are born, live, and die having assumed only some features of their reference culture. Some members of a culture may embrace its traditional norms, others may reject them, and still others may deploy cultural values situationally.

Although individuals may belong to the same cultural group, the assumption that they are, in fact, the same is an ecologic fallacy. An ecologic fallacy is defined as “drawing conclusions about the wrong unit of analysis—making generalizations about people, for example, from data about groups or places.” To illustrate the ecologic fallacy inherent in the application of cultural information in a clinical context, we might use an analogy drawn from an article that appeared in a news magazine stating, “America cannot make up its mind” on the issue of divorce. Does this mean that individual Americans do not have specific opinions about divorce and optimal family structure? Certainly not; it simply means that within the group we know
As Americans, there is a range of opinion about the issue, or, even more likely, that the traditional societal norms regarding divorce are becoming increasingly equivocal. Likewise, when we say that “the Catholic Church is opposed to divorce,” are we saying that each and every member of the Catholic faith embraces and practices that policy? Again, the answer is “no.” As an organization, the Catholic Church formally opposes divorce; but there are individuals who consider themselves practicing Catholics who nevertheless are critical of the policy, associate with people who are divorced, and may be divorced themselves.

In a more clinical, but very simple, example, can a nurse assume that an elderly man subscribes to the notion that pineapple is a “hot” food just because he is West Indian? Once again, the answer is clearly “no.” The belief that food has “hot” and “cold” properties, irrespective of temperature, is a cultural norm that refers to groups and cannot be applied reflexively to specific patients. On the other hand, would the knowledge that pineapple is considered a “hot” food in some places in the West Indies help us to interpret why a patient from Jamaica with intermittent fevers refuses to eat the pineapple on his or her food tray. The answer to that question is a qualified “yes”; it would help us in our understanding of why the patient may not have eaten the pineapple, but we still cannot discount the possibility that he or she may be allergic to pineapple or doesn’t like pineapple or he is not hungry. Cultural (group) knowledge may help us to understand the behavior of our individual patients and families so that we do not regard it as pathological. It does not allow us, however, to make assumptions about their behavior clinically. For instance, we cannot assume that a patient is not making eye contact because he is Korean, that a patient is not smiling because he is Native American, that we should not talk about death with a Bosnian patient, or that a Latino patient believes in the evil eye.

As a result, we are left in a kind of intellectual muddle about the role of culture in nursing practice. We have placed the accountability for cultural competence with the clinician who provides direct services to individuals, a setting in which the application of cultural information is likely to be the least useful. In the pursuit of “culturally sensitive care,” we often have misapplied cultural information and conceptualized cultures as monolithic collections of “traditional” behaviors and beliefs that are frozen in time. We have relied on reports from a few “cultural carriers,” usually selected by members of the dominant group, who have varying degrees of awareness of their own ethnicity and varying ability to articulate that awareness. The literature is replete with examples of the clinical application of cultural knowledge, with only tacit reference to intracultural variation. Thus, despite of the array of cultural sensitivity programs and cultural exposure opportunities, busy nurses continue to be frustrated and discouraged by the burden of cultural competence, often regarding institutional requirements as a bothersome distraction from their pressing responsibilities for patient care.

Even the *Cultural Competence Works* publication acknowledges the ecologic fallacy inherent in cultural competence programs: “Most people understand culture in its broadest sense, and usually interpret it as something that groups possess. But health care is generally dispensed to individuals.” The Department of Health and Human Services Administration then deals with this untidiness simply by broadening the definition of culture to include, for example, sexual orientation, gender, homelessness, occupation, education, victim status, and income. However, framing these individual characteristics as “cultural” serves only to further compromise the usefulness of the concept in health care.

**CULTURE AND PUBLIC HEALTH NURSING**

In contrast, culture is a highly effective concept for use in public health, where populations, rather than individuals, constitute the standard unit of intervention. Here, information about social rules, norms, and patterns of behavior is very useful. If we found, for example, that a particular cultural group endorses a normative definition of female beauty as being 5 feet tall and weighing 180 pounds, this cultural information may have practical value in responding to the high rates of obesity-related illness in a specific population. It also would have theoretical value in explaining the relationship between culture and obesity. However, we still would not know whether and to what extent the obesity in a particular woman of that cultural group was attributable to cultural, physiologic, and/or psychologic factors. Nevertheless, knowledge about the cultural norms regarding socially desired body mass might have substantial value for designing nutritional health programs for whole communities. Cultural knowledge provides guidance for social marketing and public education program content, for community-based prevention and health promotion initiatives, and for organizing therapeutic and related services. This is demonstrated in the many examples provided by Tripp-Reimer and colleagues in their continuum of successful culturally responsive interventions. Virtually all of the interventions were community-based programs, targeted to specific social groups, that engaged community leaders, worked through local institutions, and used culturally established channels of communication. Similarly, the best contemporary examples of cultural competence are programs directed at whole communities that involve the community in identifying and attending to service needs.

Thus, it is not surprising that the nursing profession’s interest in culture emerged in the public health arena. Tracing the development of culture as an organizing concept in nursing, Tripp-Reimer observed that it first appeared with public health nurses who, working with immigrant groups at the turn of the century, reported differences in their lifestyles and “health ways.” Later, when nursing education moved from hospitals to universities, increased exposure to social sciences, including anthropology, generated a broader understanding of health care, especially those aspects intensely shaped by cultural context, such as dietary practices, child rearing, self-treatment, and reporting of symptoms.

On the other hand, Tripp-Reimer noted that the steady and growing importance of culture has not resulted in the acknowledgment of a specific orientation from anthropology, such as structural functionalism, cultural materialism, or cultural ecology. This disinclination on the part of nursing to
Cultural competence requires that we reject simplistic views of culture as monolithic and unchanging and the notion that people are fixed in cultural traditions, unable to modify their behavior, and learn new ways. In addition to making assumptions about cultural uniformity, we have failed to account for the shifting nature of cultures and the situational use of ethnic identities. Although cultures differ in the speed with which change occurs and the degree of internal variation, few could be described as static and/or homogenous. Cultures are fluid and constantly changing vis-à-vis new environments and inconstant physical, social, economic, and political circumstances. People do not live out their lives in cultures, they live out their lives in communities, where circumstances generate conflict, where people do not always follow the rules, and where cultural norms and institutions are massaged and modified in the exigencies of daily life.
Cultural competence means that we not underestimate the capacity of patients and their families to have figured out that physicians and nurses represent a biomedial tradition that may not meet all of their health-related needs. They, like the rest of us, have watched television programs such as “ER,” “Trauma: Life in the ER,” “St Elsewhere,” and “Chicago Hope” and know that white, middle-class, Western-trained providers may not share their beliefs and traditions. Interestingly, Purnell’s study of the perceptions of preferred care of patients in a Guatemalan clinic indicated little concern for sensitivity to cultural traditions (to which even many of the patients did not subscribe). Rather they looked for behaviors such as greeting the patient with a handshake, calling the person by name, explaining procedures at every opportunity, asking permission for and explaining the necessity of examination, informing the patient ahead of time whether procedures were painful, and maintaining a professional demeanor. Similar conclusions were reached by Mc Gee,” who cited that caring, respect, compassion, and sincerity were key to cultural competence.

The cultural competence literature would have us assume, by implication, that when cultural barriers do not exist, patients are respected and treated politely, appropriate time is allotted for questions, explanations are clear and adapted to the patient’s lifestyles, families are fully included in the process, and treatment plans are developed in partnership with the patient. We are led to believe that with cultural dissonance at a minimum, communication and compliance are maximized. If this is so, how do we explain the countless reports of miscommunication and lack of compliance and the widespread dissatisfaction with treatment when patients and providers are of the same culture? The examples of insensitivity cited in the cultural competency literature and training programs are ones that are as likely to occur in any clinical encounter.

All patients deserve family-centered care, greater allocation of time, and openness to biomedical alternatives. The use of herbs to prevent and treat illness, for example, is certainly not limited to those from Asian and Latin-American cultures in the United States where complementary therapies account for billions of dollars in out-of-pocket expenditures each year. Patients of Japanese and Russians cultures are not the only ones for whom death and terminal illness are sensitive issues. (Is there a culture in which terminal illness and death are not sensitive issues?) White, middle-class, vegetarians have dietary restrictions that deserve the same consideration as those of Hindus. Faith and spiritualism in the management of illness cannot be exclusive to ethnic groups in a country where parish nursing is the fastest growing nursing specialty. Members of the Muslim faith are not the only persons who endorse predetermination, and one would not have to look hard to find members of the dominant ethnic groups who view illness as a repayment for past transgressions. Finally, we dare say that significant portions of mainstream American culture place a high premium on modesty.

We contend that cultural competence is really nursing competence. It is the capacity to be equally therapeutic with patients from any social context or cultural background. Framing the issue as “cultural” diverts us from a serious examination of the inadequacy of patient-provider communication in general. A reality check on cultural competence suggests that the real issue in a clinical event is individualized patient care—the signature of contemporary nursing—which has been repackaged by the medical profession as “culturally competent care.” Indeed the eminent Hildegard Peplau’s interpersonal theory on the significance of individualized care preceded physician and anthropologist Arthur Kleinman’s explanatory model by 30 years. So-called cultural assessments are simply strategies for eliciting the patient’s understanding of his or her illness, individualizing his or her care and improving communications. The contextualization of health and illness in relation to family and community is not a new concept in nursing. Indeed, it is one of our most fundamental principles. We must acknowledge that cultural information is, in fact, embedded in the illness events of all of our patients, not just our “ethnic” patients.

The misapplication of the concept of culture is serious enough, but attributing failed communication to “cultural barriers” creates an even greater problem. By conveniently presenting the problem as a cultural barrier which the physician must strive to overcome by taking courses, meeting regulated mandates, and being more informed about various cultures, we are distracted from the more serious problems of institutionalized racism and socio-economic pluralism that should be addressed with far-reaching, transformative public health action. The value in learning as much as we can about the cultures and communities from which our patients derive is incontestable; such knowledge has the potential to make us more respectful and tolerant clinicians and to sensitize the larger nursing community to the vast range of human responses to health and illness. However, the notion that cultural knowledge, translated into “culture-specific” care, will necessarily result in improved clinical outcomes or in the reduction of health disparities remains dicey, at best.

REFERENCES