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Ida Spruill

Hampton University School of Nursing, ida.spruill@hamptonu.edu

Bertha L. Davis

Hampton University School of Nursing, bertha.davis@hamptonu.edu

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Cultural Competence: Myth or Mandate

Ida Spruill, MSN, RN, LISW
Hampton University School of Nursing
Hampton Virginia

Bertha L. Davis, PhD, RN, FAAN, CFC
Hampton University School of Nursing
Hampton Virginia

Abstract

The ability to provide effective, quality health care to clients from different cultures is becoming increasingly important to health care providers from all disciplines (Davidhizar, Bechtal, & Gregory, 1998). The United States census reported that by the year 2000, one third of Americans would be members of an ethnically diverse cultural group. The developmental process of the cultural competency continuum is often misunderstood and/or left out of many cultural competency and sensitivity training programs, resulting in the inadequate preparation of trained health professionals. When organizational systems and/or professionals strive to become culturally competent, they must first perform an assessment of self. A case study approach of the Project Sugar research study will be used to examine cultural competency and identify its placement on the Cultural Competency Continuum. Tools to retain cultural prudence will also be offered.

Keywords:

Cultural Competence, Community Assessment, Culturally Competent Professional

Cultural Competence: Myth or Mandate

INTRODUCTION

Despite the mandates that provide research dollars to study disparities and programs to increase access to care, health disparities continue to exist. The term health disparity is almost exclusively used in the United States, while other terms such as health inequity or health inequality are most commonly used outside of the United States (Pokras, 2002, p. 117).

Negative experiences in the health care setting may profoundly impact attitudes toward receiving care and influence the further utilization of health care services and participation in health care research. To better understand why patients continue to have negative experiences, we must study culture and other factors, such as socioeconomic differences, and learn how these factors influence the providers' behavior (Smedley, Stith, & Nelson, 2002).

The myth that health disparities do not exist in the United States should have been exposed long ago. These myths may have stemmed from historical, political or sociological bases and have been uncovered by culturally competent researchers. The literature is replete with references to expose these myths and studies have found that racial and ethnic minorities suffer from certain maladies at an alarming rate that far exceeds their numbers in the general population. A 2002 report from the Institute of Medicine (IOM) shows that racial minorities receive appropriate care less frequently, which has an adverse impact on their health outcomes, including a higher recurrence of morbidity and mortality rates.

According to the report:

- 1) Racial/ethnic disparities in health care occur within a broader historic and contemporary context of social and economic inequality that reflects the persistent racial and ethnic discrimination that occurs in many sectors of American life;
- 2) Health systems, health care providers, patients and utilization managers may contribute to racial and ethnical disparities in health care;
- 3) Health providers' bias, stereotyping, prejudices and clinical uncertainty may contribute to racial and ethnical disparities in health care.

The reality of health disparities among racial and ethnic minorities highlights the need for increased numbers of culturally competent health care providers as called for in Healthy People 2010. It is equally imperative that schools increase their numbers of individuals from culturally diverse backgrounds because racial and ethnic minorities tend to go back to their communities to provide care. However, minorities are too few in number to be able to meet the Healthy People 2010 mandate to eliminate health disparities. Nonetheless, competent providers and researchers are needed to develop

methodologies and define specific ways in which institutions or personal bias influence the health status, health outcomes and utilization of services by communities of color.

The ability to provide effective, quality health care to clients from different cultures is becoming increasingly important to health care providers from all disciplines (Davidhizar, Bechtal, & Gregory, 1998). The United States census reported that, one third of Americans were members of an ethnically diverse cultural group in 2000. Similarly, the Pew Commission (1995) emphasized that in order for the health status of minority communities to improve, quality healthcare must be culturally sensitive. In 1996, the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) identified culturally appropriate care as a priority, and the commission's standards mandated educating staff in providing culturally appropriate care to all clients. However, the Commission failed to include specific guidelines and standard of care for providing cultural competent care and conducting cultural appropriate research.

For professionals and researchers from any discipline to develop cultural competent skills, they must first:

- Perform a cultural self-assessment,
- Have an awareness of their own culture and,
- Recognize the influence of culture on clients' behaviors. Thus, medical, nursing schools and others have a responsibility to train their students on how to use cultural competency in their practice and daily interactions. (Davis, Cross, & Perry, 2003).

Personal Definition

It is equally imperative that in order for any providers to deliver health care in a culturally competent manner, they must embrace an operational and personal definition of cultural competency because proper preparation in cultural competency is necessary to effectively prevent, identify and treat health problems. A personal operational definition for use is the one offered in 1998 by Tervalon and Garcia. They argued to replace cultural competency with cultural humility and defined cultural humility as a commitment to active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, families, colleagues and themselves. Cultural humility is the process of equalizing the power imbalances that exist in the dynamics of provider-patient communication by using patient-focus interviewing and care. The key appealing points of this definition are the commitment to a lifelong process and the recognition of power imbalance between the patient and the provider.

Definition of Cultural Competency

Many definitions exist for cultural competency, and the term is often used interchangeably with cultural sensitivity and cultural awareness. There is a distinct difference between the terms. Cultural sensitivity acknowledges cultural differences as well as similarities, without assigning values to those cultural differences. Cultural

sensitivity implies that the person appreciates how one's own cultural background may influence professional practices. Cultural awareness involves the development of sensitivity and understanding toward another ethnic group, which usually involves one making internal changes in terms of his or her own attitudes and values. Both awareness and sensitivity refer to qualities of openness and flexibility that people develop in relationship to others. Cultural awareness must be supplemented with cultural knowledge and/or learning about select characteristics of another ethnic group. Many authors agree that cultural awareness exists when one explores one's own culture while recognizing the existence of similarities and differences between and among cultures. However, neither definition cited in the literature addresses the steps and/or processes needed in becoming culturally competent or the concept of operating in different cultural contexts. Cross, Bazron, Dennis, and Isaacs (1989) offer the most popular definition of cultural competency, and they offer the following definition of culturally competency:

A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in a cross-cultural situation. Operationally defined, cultural competency is the integration and transformation of knowledge about individuals and groups into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of health care thereby improving or producing better health outcomes (Davis, 1995).

Cross et al. offered six possibilities along the Cultural Competent Continuum, starting from the negative end of the continuum and moving toward the positive end of the continuum. These possibilities are identified below and include examples (See figure 1).

Cross et al. (1989) cite five essential elements that contribute to a professional providing cross-cultural care. These are the same elements that are needed for a system to become culturally competent thus ensuring better health outcomes and quality of care. The elements are : value diversity, develop mechanisms to perform a cultural assessment of the institution or organization, understand the history surrounding distrust, strive to appreciate the dynamics of differences, integrate and/or institutionalize cultural dynamics, concepts in policies and practices.

Once health providers and institutions embark on finding where they are on the cultural competency continuum, they can correct their shortcomings and become culturally competent. The implication of providers becoming culturally competent is that the quality and standard of care will be improved. Culturally competent health care providers realize that they have limitations and work with the health care team to insure that patients who are different from them get adequate care, such as making interpreters available to patients. Conversely, culturally incompetent health providers provide care based on textbook scenarios with no regard to specific client's needs. In addition, culturally competent health care providers understand that there are some conditions/health care deficits that exist among certain population groups in numbers

greater than that of the general population and that providers must perform certain procedures or tests to insure that they have checked for those maladies. However, incompetent health care providers only test for conditions common to the general population. Last, culturally competent health providers study the nuances of different populations, such as dietary patterns, religious rites, and blood transfusion restrictions. In contrast, culturally incompetent providers treat all patients the same without regard to inherent cultural variations.

More importantly, both providers, and institutions need to be culturally competent in order to improve and equalize standards of care. Meleis (1996) supports cultural competent providers and listed several reasons for the urgency to become culturally competent. Among these reasons cited were increased diversity and increased inequities in minority health care. However, the developmental process of the cultural competency is often misunderstood and/or left out of many cultural competency and sensitivity training programs, resulting in culturally incompetent providers and inadequate preparation of trained professionals.

Cultural Competent Continuum



The word Gullah derives from the word Gul, was a Creole language formerly spoken by the Gullah, an African-American community of the Sea Islands and the Middle Atlantic coast of the United States. Many of the slaves spoke similar, but distinctively different languages (Pollitzer, 1999, p. 15). The word Gullah also refers to the descendants of slaves from the Rice Coast of West Africa who lives in coastal South Carolina, Georgia, and northeastern Florida.

The homeland of the Gullah people is a coastal strip 250 miles long and 40 miles wide where low, flat islands, separate from the mainland by salt-water rivulets. The Sherman Marshall Plan identified the Sea Islands as extending 17 miles north from Georgetown County to 17 miles south in St. Helena Island in Beaufort County and 30 miles inland. The term Gullah refers to the unique cultural and linguistic patterns of African Americans living on the Sea Islands of South Carolina.

The word Gullah will be used interchangeably with the term Sea Islanders in hopes of sensitizing the reader because the word Gullah has negative connotations for people of color in South Carolina.

Cultural practices (food, basket weaving) and historical records link the ancestors of the Sea Islanders to rice cultivating tribes in West Africa during the 18th century. Joseph Opalo also states that the Gullah language is very similar to the modern day language of Krio in Sierra Leone.

During slavery, Gullah people lived a relatively secluded existence, and by virtue of their isolation in the Sea Islands, the Gullah population received little acculturation into the ways of Eurocentric colonists as other enslaved Africans had while living on the mainland. The geographical isolation of the Sea Islands and the insistence of South Carolinas plantation owners on importing slaves from West Africa were significant to the preservation of the Gullah culture and language.

The elderly residents on the Sea Islands enjoy a rich culture, and the families are large and multigenerational. The Gullah people are an ideal population to study because the Caucasian admixture among the Gullah is only 3.5% (Parra & Garvey, 2001). The prevalence of chronic diseases, such as hypertension, obesity, and diabetes, lead most counties in South Carolina. The culture of the Sea Islanders has been shaped by the history of African Americans in the South (wearing a mask to hide true feelings, developing accommodating behaviors, and using Southern etiquette).

Project Sugar Research Study

Over the past eight years, the Project Sugar research study has pursued the study of diabetes and obesity in African American families living on the coast of South Carolina. The project has established a service-oriented track record in the local community by adhering to the principle of coordinated research. The principle suggests that in addition to scientific studies, the researchers should work with the community to address existing programs and also provide a service to and for the community.

Therefore, the project has two main goals. First, the scientific objective is to identify genes contributing to diabetes and obesity in African Americans families. The second objective is a community outreach objective to promote health education and health screenings relative to metabolic and cardiovascular diseases. The project has been successful in recruiting more than 600 families into the research study. That success may be attributed to an interactive Citizen Advisory Committee and a recruitment model known as CPR (Community, Plan, and Reward). The project was the first research study at the institution to organize a local Citizen Advisory Committee (CAC) and the CAC worked to ensure that the research design is sensitive to the cultural and ethnical background of the community. The CAC was involved in all phases of the research study and met on a quarterly basis. The membership represents community leaders with diverse backgrounds.

CPR Recruitment Model

The CPR recruitment model is a coordinated approach to the recruitment of minorities into research protocols and utilizes the concept of coordinated research in the delivery

of services to the community. The CPR model uses the community empowerment theory and the middle range theory as a conceptual framework for research and practices. The middle range theory is a merging of the empowerment and community development theories for promoting health by building relationships both at the individual and community levels (Smith & Liehr, 2003, p. 111). The community empowerment theory structures community participation with lay workers to promote reciprocal health. The CPR model also derives from the PRECEDE model framework that Green (1991) applied to health promotion programs. PRECEDE/PROCEED is an acronym for predisposing, reinforcing, enabling, constructs, educational, ecological, and diagnoses. According to Green, the goal of this model is to explain health-related behaviors and environments, and to design and evaluate the interventions that influence both the behaviors and living conditions that influence them and their consequences. The Project Sugar investigators applied this model to different settings, and recruitment of subjects is the outcome rather than health or quality of life. In our CPR model, the community and its characteristics represent the predisposing factors; the plan represents the enabling factors; and the reward represents the reinforcing factors.

Project Sugar Placement on the Cultural Competency Continuum

Cross et al. offered six possibilities along the Cultural Competent Continuum and these possibilities move from the negative end to the positive end. Once researchers, providers and or institutions embark on finding where they are on the continuum, they can correct their short coming and strive to become culturally competent (See figure 2).

The intentions by the majority institution located in the southeastern part of the country to approach this population were honorable; however, the institutions services would initially be categorized as an example of cultural blindness. Cultural blindness operates within a liberal philosophy; however, it ignores the strengths of local groups and communities. The Gullah language can be difficult to understand by outsiders, and because the language can be difficult to understand, providers oftentimes assume that the client is unlearned. Nevertheless, the institution has made strides to provide culturally sensitive health services. It currently has a diversity committee to address culturally appropriate solutions, but inconsistencies in funding hampers recommendations for meaningful and lasting changes.

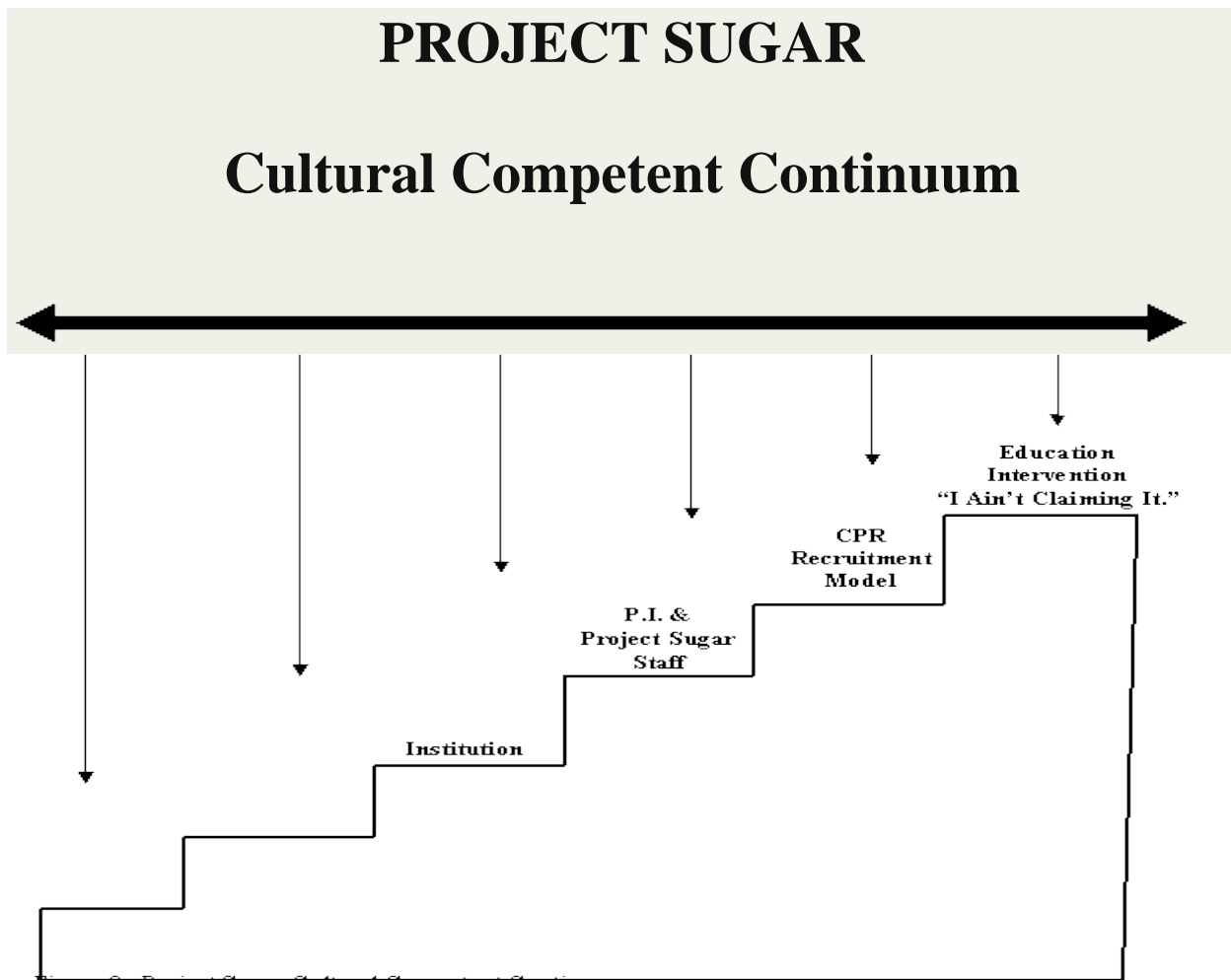


Figure 2. Project Sugar Cultural Competent Continuum.

NOTE:

The institution and project entered at midpoint on the continuum.

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Some of the health services administered by the institution were delivered by culturally insensitive providers. The continuum of cultural competence defines insensitivity as having biased and paternalistic behaviors toward clients, and according to the definition, clients who assimilated into the major culture, and spoke clear standard English were rewarded more favorably. The institution did not plan for a dynamic of differences and failed to recognize the strengths of the rural Sea Island community. The dynamic of differences refers to a clashing of cultures that is magnified by a history of distrust and indifference.

Prior to this research project, the institution did not make any attempts to recruit the Gullah population into clinical genetic research, nor gain knowledge about the culture and strengths of the Sea Island community. Thus, ethnocentrism was reflected in the attitudes, policies, and practices of the institutions services and past research projects, and the study began at the midpoint of the cultural competent continuum.

The first principal investigator (PI) was of Anglo-European descent with a history of past research in diverse communities. He was aware of the high incidence of diabetes and other chronic diseases that plagued this population as well as the lack of research involving the Gullah population. He began to seek additional knowledge about the culture and gained support from both the formal and informal leaders within the community. According to the continuum of cultural competency, this investigator was both culturally aware and culturally sensitive. He recognized his limitations in gaining entry into the community and sought to identify strengths within the community and hired competent staff who reflected the study population. The PI moved back and forth on the continuum between cultural pre-competence and cultural competence.

Once a culturally competent nurse manager was identified and hired, the PI gained additional knowledge about the community, established trust, developed partnerships and provided services requested by the community. He identified and acquired funds to purchase a mobile health unit, and the unit provides free education and diabetes screenings at various planned community events. Most importantly, he supported the organization of a Citizens Advisory Committee (CAC) to provide guidance to the project.

The project has been successful in reaching its goal of recruiting 400 African American families and has developed a recruitment strategy known as the CPR (Community, Plan, and Reward). The recruitment plan has been flexible and has used its resources to provide community outreach. Graduate and undergraduate social work students worked with the project to provide direct services and agencies referrals to the study participants.

Last, under the guidance of both the PI and nurse manager the project has begun to design an educational intervention. This intervention is known as "I ain't claiming it," which is a local term used in the Sea Island community. The term is used as a positive reinforcement message to educate and prevent the development of diabetes

Even though the project is placed at the positive end of the continuum, efforts and activities are ongoing to remain at the positive end of the continuum. For example, the original PI has relocated to another institution but is still involved with the project and attends the CAC quarterly meetings. The nurse manager also has remained in contact with the project and is developing a research proposal using secondary data from the project to define a research question for graduate school. The new PI, initially unaware of the culture, is now making a consistent effort to understand, embrace and respect the culture. Two new nurses have been hired, and they are also gaining knowledge of the Gullah culture. Each nurse is required to perform a cultural self-assessment test and gain additional knowledge about the culture.

The Community Plan and Reward (CPR) recruitment model has been modified to reflect the skills essential for maintaining cultural competency. In order for the model to remain at the positive end of the continuum, the following skills must be cultivated and maintained toward a Culturally Competent System of Care (1991).

- Articulation and clarification of the workers personal values, stereotypes, and biases about their own ethnicity and the ethnicity of others (Ongoing training of Project Sugar new staff members).
- Knowledge of the Gullah cultures history, traditions, values, family systems, and artistic expressions.
- Knowledge of local resources that can be utilized on behalf of the community.
- Knowledge of power relationships within the community, agency, or institutions and the impact of these relationships on the clients and the community.
- Interviewing techniques skills reflective of the workers understanding of the role of language in the client's culture (Communication style and nondirective questions).
- Capability of using resources on behalf of the community.
- Ability to evaluate new techniques, research, and knowledge as to their validity and applicability in working in the communities (Learning to share research results with the community).

Conclusions and Recommendations

The five essential elements that contribute to a professional providing cross-cultural care are the same elements needed for a system to become cultural competent thus ensuring better health outcomes and quality of care. The institution needs to examine each level of its organizational structure to find those allies who are supportive of the direction of the project and to help form coalitions out of which future leadership can be developed and supported. In addition, the institution needs to embrace and implement the five elements, cited in the monograph:

- Value diversity and develop aggressive recruitment strategies with a budget to attract minority faculty because the current faculty does not reflect the state's population.
- Develop mechanisms to perform a cultural assessment of the institution or organization. An outside consultant was hired by the Office of Diversity, but funds are limited and university diversity training is minimal.
- Understand the history surrounding distrust and strive to appreciate the dynamics of differences. Use Project Sugar as a model and share the uniqueness of the Gullah culture nationwide.
- Integrate and/or institutionalize cultural dynamics and concepts in policies and practices. Promote hiring minority staff and faculty from within the institution.
- Adapt to diversity and design programs to fit the cultural norms such as hiring a paid Spanish translator for a migrant population. Continue to provide funds for the Spanish translator.

The rationale for being culturally aware, culturally knowledgeable, culturally sensitive, and culturally competent is the same whether one is a practitioner, an institution, or a health researcher. The only difference between a culturally competent practitioner and a researcher lies in the application of specific skills, i.e., practice versus research, and the mandate is the same. A practitioner would use culturally competent assessments and appropriate planning tools. Similarly, a researcher would develop culturally competent and appropriate data collection tools, methods of analysis, and reports. Yet the aim is the same for both: improve the quality of care and improve health outcomes. We must continue to study the complex racial and cultural differences in society and emphasize cultural competent values for families and communities where these families reside. It should not have to be mandated by law, and it should not be a mythical or occasional effort. Even though demographic barriers restrict access and the lack of culture competence among providers and supporters of care is a barrier, the attainment of adequate quality in the health care system maximizes outcomes (Spector, 2000).

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Author Contact Information:

Ida Spruill, MSN, RN, LISW

Hampton University School of Nursing
Recruiter and Doctoral Student
Hampton, VA 23668

Phone: 757-637-2816

Fax: 757-727-5423

E-mail: ida.spruill@hamptonu.edu

Bertha L. Davis, PhD, RN, FAAN, CFC

Hampton University School of Nursing
Assistant Dean for Research
Hampton, VA 23669

Phone: 757-727-5672

Fax: 757-727-5423

E-mail: bertha.davis@hamptonu.edu