OPEN ACCESS

GAVIN PUBLISHERS

International Journal of Nursing and Health Care Research

Abualhaija N. Int J Nurs Health Care Res 11:1127.

DOI: 10.29011/IJNHR-1127.101127

Review Article

The Transformational Expedition of Cultural Competence in Nursing

Nashat Abualhaija*

School of Nursing, The University of Texas Permian Basin Odessa, Texas, USA

***Corresponding author:** Nashat Abualhaija, School of Nursing, The University of Texas Permian Basin Odessa, 4901 E. University, Odessa, Texas 79762, USA

Citation: Abualhaija N (2019) The Transformational Expedition of Cultural Competence in Nursing. Int J Nurs Health Care Res 11:1127. DOI: 10.29011/IJNHR-1127.101127

Received Date: 12 November, 2019; **Accepted Date:** 25 November, 2019; **Published Date:** 27 November, 2019

Abstract

The robustness of cultural diversity is increasing immensely within the landscape of the United States (U.S). Yet, health and health care disparities among disfranchised minorities are still high. Cultural competency has been proposed as a strategy to reducing health disparities among minorities. Hence, it was important to illume some light into cultural competence in the nursing profession. The prime aim of this research article is to provide a brief description of the transformational expedition of cultural competence in nursing. It also discusses the background of cultural competence, the historical revolution of cultural competence in nursing. Furthermore, it discusses five transcultural theoretical frameworks that have been developed and have been used to further improve cultural competence in nursing. Additionally, this research article discusses cultural competency from an ethical and moral stance. Finally, implications for nursing education, practice, research, and public health are further discussed.

Introduction

The growth of multiculturalism and pluralism in the US are impressively becoming more vibrant and profound. As the numbers of culturally diverse groups continue to change the demographic profile, the racial gap and mismatch between nurses and their patients continues to widen as well; adversely, resulting in more health disparities due to lack of cultural competence. Coincidently, many of the racial/ethnic groups do fall under the category of vulnerable populations who witness the most severe cases of health disparities in our health care systems [1,2]. According to Giger, et al. [3], "Demography is destiny, demographic change is reality, and demographic sensitivity is without doubt imperative" [3]. In response to these demographic changes and in an effort to meet the health needs of racially diverse patients, greater importance was placed on integrating cultural competency modalities both in nursing practice and education as a tactic to reducing health and health care disparities among minorities [4-6].

Furthermore, the racial disparity between patients and their nurses has brought with it some challenges. For instance, how can these nurses address and appropriately meet the health needs of these culturally diverse patients, which are inherently shaped by their worldviews, cultural values, attitudes, and beliefs? [7] affirmed that culturally diverse patients usually present an extensive range of perceptions, attitudes, lifeways, and values regarding health and illness formed by their social and cultural backgrounds. Hence, it was very imperative to teach nurses how to render culturally sensitive, safe, and congruent nursing care while integrating patients' cultural values and beliefs in their plans of care.

Background of Cultural Competence in Nursing

Cultural diversity has proliferated intensely in recent years in every junction of our lives; therefore, lexicons of culture, ethnicity, and diversity are more frequently exchanged by health care professionals. The current sweeping demographic shift and diffusion between different cultures has defied health care professionals and systems to provide culturally congruent and safe care. Accordingly, culture with its covert and overt values, beliefs, and connotations should be understood, appreciated, and experientially mastered by the health care provider to develop meaningfully safe and effective cultural care [1,2,7-10]. Presently, the 2018 U.S. Census Bureau report shows total populations of approximately 327 million people living in the U.S, 60.4% of whom

are non-Hispanic or Latinos Whites, the remaining are of other multiethnic and/or diverse races. Additionally, the U.S. Census Bureau projection for the next quadruple decades accentuates the notion that minorities are predicted to outnumber the current majority population numbers, and for the first time, these minorities will become the majority population. This continuous, yet progressive shift in population makes an astounding statement of how the threads of the demographic canvas are rapidly changing.

Furthermore, it underlines the urgency of addressing the health needs of these patients in a culturally sensitive and appropriate manner to reduce their health disparities [4,11,12]. One of these strategies was addressing the cultural educational needs of nursing students, nursing faculty, and practicing nurses [6,13]. Nonetheless, in the midst of this movement of translating the blueprints of cultural competence into nursing academia and practice, nurses and nursing educators were uncertain of how to teach or even learn cultural competence as discipline in nursing; leading to an obvious lack of curricular congruencies among nursing programs regarding what would be the best evidence-based pedagogical approach to teaching cultural competence in nursing [2,14].

The significance of integrating cultural competence in health care is fundamentally rooted in its noble purpose, which is reducing health and health care disparities among minority groups, and to provide culturally competent and sensitive care to patients regardless of their racial and cultural backgrounds. This objective yet philanthropic purpose serves a humanoid goal of improving patients' care, reducing health disparities, and overall improving the quality of life for these disenfranchised people. Jeffreys, et al. [2], as well as the International Council of Nurses (ICN) (1973), assert that human beings should be entitled to culturally congruent care since rendering culturally competent care is a basic human right and not a privilege. Additionally, [7] asserts, "Human beings of any culture in the world have a right to have their culture care values known, respected, and appropriately used in nursing" (p. 21). Therefore, the concept of culture is an important element of the holistic view of health.

Defining Cultural Competence

Understanding what is meant by cultural competence is fundamental in increasing one's awareness of other cultural values and beliefs. Madeleine Leininger defines culture as "The learned, shared, and transmitted knowledge of values, beliefs, and lifeways of a particular group that are generally transmitted inter generationally and influence thinking, decisions, and actions in patterned or certain ways" [7]. Hence, the term "Competence" has been recognized in nursing academia as having the knowledge, attitude, and skill to perform nursing tasks. It is further defined as "having the capacity to function effectively as an individual or an organization within the context of cultural beliefs, practices, and needs presented by patients and their communities" [11]. Therefore, competence is viewed from a cultural context and it conveys having the aptitude, motivation, and self- efficacy to work within the cultural contexts of patients.

When both of these terms are joined, they make the compounding concept "Cultural Competence". There were many efforts made in defining cultural competence in nursing and outside of nursing. However, Madeleine Leininger was the first to coin the term cultural competence in nursing. She defines cultural competence as "The use of culturally based care and health knowledge in sensitive, creative, and meaningful ways to fit the general lifeways and needs of individual or groups for beneficial and meaningful health and well-being or to face illness, disabilities, or death" [7]. Another salient definition of cultural competence outside of nursing was created back in 1989 and it describes cultural competence as, "A set of congruent behaviors, attitudes and policies that come together as a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations" [15].

Other nursing scholars added their interpretations of cultural competence. For example, Jeffreys [2] defined cultural competence as "A multidimensional learning process that integrates transcultural skills in all three dimensions (cognitive, practical, and affective). It Involves transcultural self-efficacy (confidence) as a major influencing factor and aims to achieve culturally congruent care" [2]. Campinha-Bacote, et al. [10] regards cultural competence as an ongoing process that includes five interrelated constructs, such as cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire, but the last construct of cultural desire is the ultimate objective and the final destination of the whole process of "Becoming" culturally competent. She further elucidates that cultural competency begins with one's increased self- awareness and self-examination of his/her own attitudes, beliefs, and biases towards other dissimilar cultures. In 2008, Purnell and Paulanka defined cultural competence as, "Developing an awareness of one's own existence, sensations, thoughts, and environment without letting it have an undue influence on those from other backgrounds; demonstrating knowledge and understanding of the patient's culture; accepting and respecting cultural differences; adapting care to be congruent with the patient's culture" [16].

Historical Revolution of Cultural Competence

Herodotus, an ancient Greek explorer was the first to use the term cultural diversity in the 4th century B.C. with his chronicles of other nations, such as Egyptians, Lydian, Scythians, Medes, Assyrians, and Persians. However, the use of the concept cultural competence can be traced to the 1930s when some anthropologists and psychologists were examining personality traits of culturally

diverse persons using instruments that were biasedly and solely based on Western Individuals' personality characteristics. Needless to say, their approach created false assumptions and biases about the universality of personalities [17]. In nursing though, Florence Nightingale can be considered the first international nurse with her work with the Australian Aboriginal tribes and soldiers during the Crimean War [17]. Oermann, et al. [18] asserted that a needed call for inclusion of diversity in nursing was evident in Harmer's book, The Principles and Practice of Nursing (1928) describing elements of nursing to include "A democratic spirit which leaves class and race prejudice behind. It is the aim…to give the same kind of care to men, women, and children, to all colors and creeds, rich and poor, enemies and friends" (p. 8). Furthermore, Nursing has been always leading the way in proving skillful nursing care across history as evident with the works of "Lillian Wald in establishing the Henry Street Settlement, Lavinia Dock in working for suffrage, and Mary Breckinridge in establishing the Frontier Nursing Services" [18].

Another influential nursing scientist who contributed also to the historical evolution and the birth of cultural competence in modern nursing was Madeleine, et al. [7]. In the 1950s, Leininger worked as a mental health specialist with slightly troubled children from different cultures. She concluded that there were a clear disassociation and lack of cohesiveness between children's cultural values and beliefs and the provision of care. She decided that culture was not considered in their care and there is a lack of research on the topic of culture care. This intuition was the trigger to the birth of cultural competence in nursing and the development of her theory later. Madeleine Leininger went on and obtained her doctoral education in anthropology and eventually integrated her dogmas of incorporating cultural competence in all spectrums of the nursing discipline. In the 1970s with the publication of her book, Nursing and Anthropology: Two Worlds to Blend and later her theory, Culture Care: Diversity and Universality, she formerly establishes transcultural nursing as a genuine discipline within the field of nursing.

Leininger defined transcultural nursing as "a discipline of study and practice focused on comparative culture care differences and similarities among and between cultures in order to assist human beings to attain and maintain meaningful and therapeutic health care practices that are culturally based" [7]. Leininger developed the Transcultural Cultural Nursing Society in 1974 with a mission to render culturally sensitive and congruent nursing care to culturally diverse patients [18].

Theoretical Frameworks for Developing Cultural Competence in Nursing

The revolution of cultural competence in nursing with the apparent increase in multiculturalism evoked other nursing scholars beside Leininger to contribute to establishing transcultural nursing as a valid and needed discipline in the nursing profession. Some of these nursing scientists who contributed to the progression of transcultural nursing were Larry Purnell, Joyce Giger and Ruth Davidhizar, Josepha Campinha-Bacote, and Marianne Jeffreys.

Madeleine Leininger

Leininger in her theory, "Culture Care: Diversity and Universality" attempts to provide culturally congruent nursing care through "cognitively based assistive, supportive, facilitative, or enabling acts or decisions that are mostly tailor-made to fit with individual, group's, or institutions' cultural values, beliefs, and lifeways" [7]. The main underpinning of her theory is comparative practice of differences and similarities between cultures as they relate to the core of the concept of caring. She explains that caring, culture, and nursing are completely related and dependent on each other's to produce cultural competence. She asserts that there can be no curing without caring.

Leininger proposes three theoretical and philosophical pillars to support nurses in delivering culturally congruent care. First, culture care preservation and or maintenance, which refer to those facilitative and assistive professional acts that help cultures retain or maintain beneficial care beliefs and values to face handicaps and death. Next, culture care accommodation and/or negotiation, which refer to those accommodating or assistive acts that help cultures adapt to or care for their health and wellbeing. Finally, culture care repatterning and/or restructuring, which refer to assistive or enabling professional actions and mutual decisions that would help people to reorder, or restructure their lifeways for better health care patterns and outcomes [7]. Clients who experience culturally incongruent nursing care will show signs of cultural conflict, noncompliance, and distress. Leininger further postulated that culture, caring, and nursing were all entwined with each other, and they must be teased out to further comprehend the intertwining relationship within a cultural context. Clients who experience culturally incongruent nursing care will show signs of cultural conflict, noncompliance, and distress.

Leininger further proposed that culture, caring, and nursing were all interwoven with each other, and they must be teased out to further comprehend the intertwining relationship within a cultural context. Some of the philosophical assumptions that were derived from Leininge r' s theory were: (a) Care is the essence and central to nursing; caring is essential to curing, for there can be no curing without caring; (b) Culture care is the synthesis of the two major constructs that will help in understanding the account for health, and culture care values and beliefs are embedded in the individuals' world view, philosophy of life, and the ethno-historical and environmental context; (c) Every culture has generic folk emic and professional etic care to be discovered and used for culturally congruent care [7].

Larry Purnell

Another important transcultural nursing contribution is the Purnell Model for Cultural Competence which has many applications in nursing and in other disciplines. Purnell defines culture as "the totality of socially transmitted behavior patterns, beliefs, values, customs, lifeways, arts, and all other products of human work and thought characteristics of a population of people that guide their worldview and decision making" [1]. Furthermore, this theoretical framework has two pivotal tenets. First, this model views cultural competence as an ongoing and dynamic process. And, second is the idea that learners during their cultural competence trajectory move in a nonlinear continuum; moving from unconsciously incompetent, to consciously incompetent, to consciously competent, and finally reaching the mastery phase of becoming unconsciously competent [1,19].

The Purnell Model for Cultural Competence has a pictographic image of a circle with multiple rims; these rims move from general/global to specific/local. For example, the outermost rim denotes global society, then community, then family, and then person. The interior of the circle is divided into 12 pie-shaped slices portraying cultural domains or construct and their related concepts. For instance, the first domain is overview/heritage, which includes information regarding country of origin, current residence, economics, and reasons for emigration, educational status, and occupation. Moving toward more specific is the second domain of communication. In this domain, verbal and non-verbal communications are discussed. Other domains include family role and organization, workforce issues, biocultural ecology, high-risk behaviors, nutrition, pregnancy, and childbearing practice, death rituals, spirituality, healthcare practice, and finally health care practitioner. Inside this inner circle is a darkened circle representing the unknown phenomena [1].

Moreover, this model has 20 assumptions; some of these assumptions include all healthcare professionals need similar information about cultural diversity; all healthcare professionals share the metaparadigm of global society, community, family, person, and health; one culture is not better than another; cultures are just different; biases can be minimized with cultural understanding; there are primary and secondary characteristics of culture; learning culture is an ongoing process and develop in different ways, but primarily through cultural encounter; and, finally, cultural awareness improves caregivers' awareness [1].

Joyce Giger and Ruth Davidhizar

Other significant transcultural nursing theorists are Joyce Giger and Ruth Davidhizar who developed the Transcultural Assessment Model. This theoretical framework was developed to assist nursing students during cultural encounters and has five metaparadigms: Transcultural nursing and culturally diverse nursing, culturally competent care, culturally unique individuals, culturally sensitive environments, and health and health status based on culturally specific illness and wellness behavior [3]. Additionally, this model asserts that each individual is culturally unique and should be assessed according to the six assumptions that affect health care. Those assumptions are communication, space, social organization, time, environmental control, and biological variations. First, communication encompasses the whole world of human interaction and behavior. Communication is the vehicle by which an individual's culture is interchanged and preserved. It includes both verbal and non-verbal communications that are learned by each culture.

The second assumption is space which refer to the physical space and distance between people when they interact. All communication transpires in the context of space; there are four kinds of space (intimate, personal, social, and public). The third assumption is social organization which refer to the method in which a cultural group organizes and aligns itself around the family group. For example, family structure, religious values and beliefs, and role assignments may all relate to ethnicity and culture. The fourth assumption is time which is a vital facet of interpersonal communication; various cultures differ in their orientation to time. For instance, some cultures are past-oriented, present-oriented, or future-oriented. The fifth assumption is environmental control which refer to an individual's intrinsic ability to control nature and to plan and direct aspects of the environment that affect them. Some cultures believe in their internal ability to control the environment, whereas other cultures believe in the environment's ability to control their lives. The last assumption is biological differences, particularly genetic variations which exist between individuals in dissimilar cultures [3].

Josepha Campinha-Bacote

Another influential scholar who contributed to the evolution of transcultural nursing is Campinha-Bacote. She developed The Process of Cultural Competence in the Delivery of Healthcare Services in 1991 to assist health care professionals in rendering culturally competent care. This theoretical framework views cultural competence as an "Ongoing process in which the health care provider continuously strives to achieve the ability to work within the cultural context of the client (individual, family, community)" [10]. Furthermore, this theoretical framework requires health care professionals to see themselves as "becoming" culturally competent instead of only "Being" culturally competent and to view the process of cultural competence not as a final destination, but rather as a journey.

Five cultural constructs make up this model; these are cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. The process of cultural competence

requires learners to integrate these five constructs since they have dependent and interrelated relationships with each other. However, cultural desire is considered the spirit for this model and in essence is considered the fuel that energizes health care professionals during their journey to becoming culturally competent providers. Campinha-Bacote defines cultural awareness as "The deliberate self-examination and in-depth exploration of our personal biases, stereotypes, prejudices, and assumptions that we hold about individuals who are different from us". Cultural knowledge on the other hand is defined as "the process of seeking and obtaining a sound educational base about culturally diverse groups".

Cultural skill, "is the ability to collect relevant cultural data regarding the client's presenting problem, as well as accurately performing a culturally based physical assessment in a culturally sensitive manner". Cultural encounter, "is the act of directly interacting with clients from culturally diverse backgrounds". Finally, cultural desire, "is the motivation of the health care professional to "want to" engage in the process of becoming culturally aware, culturally competent; not the "Have to" [10]. Campinha-Bacote, et al. [10] addressed six basic assumptions for this model:

- Cultural competence is a process, not an event; a journey, not a destination; dynamic, not static; and involves the paradox of knowing (the more you think you know; the more you really do not know; the more you think you do not know; the more you really know).
- Cultural competence consists of five interrelated constructs: cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters.
- The spiritual and pivotal construct of cultural competence is cultural desire.
- There is variation within cultural groups as well as across cultural groups (intra-cultural variation).
- Cultural competence is an essential component in rendering effective and culturally responsive care to all clients.
- All encounters are cultural and sacred encounters.

Marianne Jeffreys

Jeffreys, et al. [2] views cultural competence as an ongoing, multidimensional learning process that assimilates transcultural competency skills in all three learning domains (cognitive, affective, and practical). Furthermore, cultural competence includes the construct of transcultural confidence or self-efficacy which serve as a major contributor to achieving Transcultural Self-efficacy (TSE). Persons with high self-perceived self-confidence will visualize learning new tasks as a challenge, whereas students with low self-confidence will avoid new learning tasks. Jeffreys', et al. [2] Cultural Competence and Confidence (CCC) model is one of the few cultural frameworks that links the role of Transcultural Self-efficacy with cultural competence development. One of its underpinnings is Bandura's (1986) Social Cognitive Theory (SCT) which underlines the relationship between learning and motivation.

Bandura's Social Cognitive Learning theory assumes that learning is a cognitive skill that can be acquired via modeling and observation and within social contexts and via vicarious reinforcement by employing both internal and external motivators. According to Bandura, self-efficacy is one's belief that he/she can perform or succeed at learning a specific task, despite impediments [20]. To be culturally competent health care providers, it is very vital to integrate all three learning domains during your voyage toward cultural competence. Jeffreys' instrument, Transcultural Self-Efficacy Tool (TSET) was developed in 1994 as an instrument that can measure students' confidence (self-efficacy) in becoming culturally competent. The Cultural Competence and Confidence model was framed as a tool that can provide the blueprints and guidance for students to better understand the multidimensional process of cultural competence. There are 14 philosophical assumptions for the Jeffreys' theoretical framework. Some of these assumptions were derived from other disciplines besides nursing, such as education and psychology.

- Cultural competence is an ongoing, multidimensional learning process that integrates transcultural skills in all three dimensions (cognitive, practical, and affective), involves TSE (confidence) as a major influencing factor, and aims to achieve culturally congruent care.
- A dynamic construct, TSE, changes over time and is influenced by formalized exposure to culture care concepts (transcultural nursing).
- The learning of transcultural nursing skills is influenced by self-efficacy perceptions (confidence).
- The performance of transcultural nursing skill competencies is directly influenced by adequate learning of such skills and by TSE perceptions.
- The performance of culturally congruent nursing skills is influenced by self-efficacy perceptions and by formalized educational exposure to transcultural nursing care concepts and skills throughout the educational experience.
- All students and nurses (regardless of age, ethnicity, gender, sexual orientation, lifestyle, religion, socioeconomic status, geographic location, or race) require formalized educational experiences to meet cultural care needs of diverse individuals.

- The most comprehensive learning involves the integration of cognitive, practical, and affective dimensions.
- Learning in the cognitive, practical, and affective dimensions is paradoxically distinct yet interrelated.
- Learners are most confident about their attitudes (affective dimension) and least confident about their transcultural nursing knowledge (cognitive dimension).
- Novice learners have lower self-efficacy perceptions than advanced learners.
- Inefficacious individuals are at risk for decreased motivation, lack of commitment, and/or avoidance of cultural considerations when planning and implementing nursing care.
- Supremely efficacious (overly confident) individuals are at risk for inadequate preparation in learning the transcultural nursing skills necessary to provide culturally congruent care.
- Early interventions with at-risk individuals will better prepare nurses to meet cultural competency.
- The greatest change in TSE perceptions will be detected in individuals with low self- efficacy (low confidence) initially, who have then been exposed to formalized transcultural nursing concepts and experiences [21].

Ethical and Moral Stance of Cultural Competence in Nursing

The need to implement measures to ensure providing culturally competent care in nursing has become a priority in health care. Furthermore, preparing culturally competent health care cadre such as nurses should be approached from an ethical and a moral stance. For instance, when teaching nursing ethics courses, one of the underpinning pedagogies should include cultural competency as a learning outcome. Moreover, nursing students should be taught that culture is an essential component to complement the holistic view of health. It should also be clearly understood and stated that cultural competence is not a privilege, but a basic human right, and rather it is a matter of patient safety. Additionally, it is a moral obligation for everyone in health care to respect other cultures and to develop "cultural humility" as an end during their practice. Hence, all efforts should be geared toward achieving social justice in accessing health and health care services.

The American Nurses Association's [22] position statement asserted that within the code of ethics for nurses is a call to move beyond the rhetoric of universal human rights to attention on social justice. This code of ethics alerts nurses to be cognizant of societal influences and their consequences on care. Social justice is central to both the ANA's code of ethics and its social policy statement, which is defined as "Acting in accordance with fair treatment regardless of economic status, ethnicity, age, citizenship, disability, or sexual orientation" [6]. Rendering culturally competent care aligns with achieving social justice by improving health care outcomes and by reducing health and health care disparities among culturally diverse patients secondary to providing culturally competent nursing care. Rendering culturally incompetent nursing care can lead to social injustices of marginalized minorities due to increases in their health disparities.

Culturally congruent care is a basic human right, not a privilege [20] ICN, 1973 [22]. The ethical dilemma that stems from rendering culturally incompetent nursing care can be demise to some of the ethical principles that guide our nursing profession, such as justice-based, rights-based, virtue-based, and duty-based. Additionally, realizing and glorifying ethical pillars, such as beneficence, non-maleficence, prima facie, and veracity obliges healthcare leaders and public officials to critically analyze current approaches employed toward achieving health for unfortunate and disenfranchised minorities and vulnerable population. Realizing a holistic approach of health requires the establishment of culture care as an essential element, thus embarking on effective approaches to enhance cultural safety and social justice in accessing healthcare.

The Nursing Council of New Zealand defined cultural safety as, "Effective nursing practice of a person or family from another culture that is determined by that person or family" [23]. Furthermore, cultural safety is an essential framework that illustrate how the sense of self is connected to safe and ethical care of patients. Cultural safety is an essential constituent to cultural competency, and it can be viewed as power inequality and imbalance between patients and their nurses [24]. Therefore, nurses need to be cognizant of the power gap between themselves and their patients. To be culturally safe, nurses need to assess the current social, economic, and political among their patients. Unfortunately, patients become at risk for culturally unsafe practice and care when nurses ignore, disempower, diminish, and compromise cultural identity [10].

Furthermore, Emmanuel Kant asserted in his moral philosophy of the formula of humanity's "Critical Imperative" that everyone "exists as an end in himself, not merely as a means for arbitrary use by this or that: he must in all his actions, whether they are directed to himself or to other rational beings always be viewed at the same time as an end" [25]. Consequently, humans in themselves are not viewed as a means to other people's ends, purposes, or pleasures; rather, humans should be treated in a humane and respectful way signifying their worth. Hence, when addressing the notion of rendering culturally competent care, the approach should be examined from an ethical scope, and it should be reiterated by policymakers that rendering culturally competent care is a fundamental human right and not a privilege. Rogers, et al. [26] argued that the ethical principles of non-maleficence, beneficence, and autonomy are all well established in health research. Nonetheless, the ethical principle of justice has received

less consideration and recognition by researchers and scholars in healthcare. Social justice as a framework aligns with human rights and illuminates how the burdens and benefits of society should be equally, fairly, and equitably distributed.

Cultural competence has an ethical and a moral opus that enhance patients' autonomy and fosters justice [27]. The International Council of Nurses (ICN) in 1973 articulated this ethical and moral value eloquently by postulating that rendering culturally competent care is a basic human right and not a privilege. As the U.S. demographic canvas continues to become more colorful, it is crucial for nurses to deliver culturally competent nursing care. Moreover, reducing and/or trying to eliminate health and health care disparities should be examined from the ethical lens, that in doing so, it is a right and not a privilege, and it should be considered as a basic human right. The nursing profession led the path toward delivering culturally competent nursing care with the birth of transcultural nursing back in the 1950s. However, health and health care disparities remain robust; hence, it is imperative to overcome these challenges by preparing culturally competent nursing cadre.

Implications for Nursing

As cultural diversity continues to increase and the number of minorities approaching at all-time record numbers, it is becoming critical for health care industry and any industry to start addressing the cultural competency of its employees. Nursing is no different and cultural competency has to be addressed in both in academia and in practice. Furthermore, it is within our code of ethics as nurses to address such limitations in our discipline.

Nursing education can benefit from emphasizing cultural competency in academia, a good example would be increasing nursing educators' awareness of their own cultural beliefs and values and of other dissimilar cultures, thus enhancing their cultural sensitivity and limiting stereotyping while teaching. Furthermore, with increasing myriad numbers of minorities in the U.S., it is pivotal to prepare nurses who are well-equipped with knowledge, values, and skills to face cultural impediments. Ultimately, nursing educators have a responsibility to educate and prepare culturally competent prospect nurses. Incorporating ongoing, evidence-based, patient-centered cultural competency pedagogical frameworks into nursing education will be vital to producing culturally aware, knowledgeable, and skillful nursing cadre.

It is also essential to stress the significance of cultural competency in nursing practice as a tactic to eliminating health disparities among minorities. Increasing nurses' awareness of their own cultures and other cultures can promote cultural sensitivity and eliminate cultural imposition and stereotype. Rendering culturally competent nursing care can eventually improve patients' satisfaction and compliance with the prescribed care, subsequently improving their clinical outcomes. More research is still needed on cultural competence as diversity continues to proliferate in the U.S. For example, there is a necessity to improve nursing cultural knowledge of ethno-epidemiology and diseases that are particular to some racial and ethnic groups.

Furthermore, there is a need to promote nursing research into cultural topics that might have an influence on health, such as ethnobiology, ethnographic approaches toward health and illness, healing practices and folk medicines, and nutritional practices/restrictions during the presentation of illness. Finally, there should be additional push among healthcare officials and public policymakers for instituting cultural competency across all spectrums of healthcare as a strategy to minimizing health disparities among minorities and vulnerable populations. Addressing culturally sensitive indicators, such as health inequalities, social determinants of health, and social injustices in accessing health care are all integral approaches to improving clinical outcomes among disfranchised minorities. The cultural competence paradigm can improve all of these culturally sensitive indicators in a respectful and sensitive manner.

Summary

Multiculturalism and pluralism are expanding immensely within the landscape of the U.S. It has been extensively documented that racial and ethnic minorities are disproportionately burdened by chronic illness, disability, and reduced access to health services. To that end, instituting cultural competency has the potential to improve health disparities and access to healthcare among minorities [2,9,19,28]. The robustness of multiculturalism has brought some challenges for health care providers and systems. Therefore, understanding the cultures of clients we serve requires from us perseverance and a commitment to be sensitive to their cultural needs. Uncovering what lies below the tip of the iceberg of cultural competence is a lifelong pledge to continuing cultural competency trajectories among all health care professionals.

References

1. Purnell LD (2014) Guide to culturally competent health care (3rd Edition). Philadelphia, PA: F.A. Davis Company.
2. Jeffreys MR (2006) Teaching Cultural Competence in Nursing and Health Care. New York, NY: Springer Publishing Company, Inc.
3. Geiger J, Davidhizar R, Purnell L, Harden T, Philips J, et al. (2007) American Academy of Nursing Expert Panel Report: Developing Cultural Competence to Eliminate Health Disparities in Ethnic Minorities and Other Vulnerable populations. Journal of Transcultural Nursing 18: 95-102.
4. National Academy of Sciences (2000) Institute of Medicine: Crossing the Quality Chasm: A New Health System for the 21st Century.
5. Joint Commission (2010) Advancing effective communication, cultural competence and patient- and family-centered care in hospitals: A roadmap for hospitals.

6. American Association of Colleges of Nursing (2008) Tool Kit of Resources for Cultural Competent Education for Baccalaureate Nurses. Pg No: 1-29.

7. Leininger MM (1995) Transcultural Nursing: Concepts, theories, research, & practice. (5th Edition). New York: McGraw Hill.

8. Purnell LD (2013) Transcultural health care: A cultural competent approach (4th Edition). Philadelphia, PA: F. A. Davis.

9. Campinha-Bacote J (2002) The Process of Cultural Competence in the Delivery of Healthcare services: A Model of Care. Journal of Transcultural Nursing 13: 181-184.

10. Campinha-Bacote J (2007) The process of cultural competence in the delivery of healthcare services: The journey continues (5th Edition). Cincinnati, OH: Transcultural C.A.R.E Associates.

11. Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE, Normand J (2003) Culturally competent healthcare systems: A systematic review. American Journal of Preventive Medicine 24: 68-79.

12. United States Department of Health and Human Services (2009) Healthy people 2020 Proposed Objectives.

13. National League for Nursing (2009) Diversity toolkit.

14. Kardong-Edgren S, Cason CL, Brennan AW, Reifsnider E, Hummel F, et al. (2010) Cultural Competency of Graduating BSN Nursing Students. Nursing Education Perspectives 31: 278-285.

15. Cross TL, Bazron BJ, Dennis KW, Isaacs MR (1989) Towards A Culturally Competent System of Care. CASSP Technical Assistance Center, I.

16. Purnell L, Paulanka B (2003) Transcultural health care: A cultural approach (2nd Edition). Philadelphia, PA: F. A. Davis.

17. Zander PE (2007) Cultural competence: Analyzing the construct. The Journal of Theory Construction & Testing 11: 50-54.

18. Oermann MH, Heinrich KT (2005) Annual Review of Nursing Education. New York: Springer Publishing Company.

19. Purnell LD (2009) Guide to Culturally Competent Health Care (2nd Edition). Philadelphia, PA: F.A. Davis Company.

20. Jeffreys MR, Smodlaka I (1999) Changes in students' transcultural self-efficacy perceptions following an integrated approach to culture care. Journal of Multicultural Nursing & Health 5: 6.

21. Jeffreys, M. R. (2010). Teaching Cultural Competence in Nursing and Health care. New York, NY: Springer Publishing Company, Inc.

22. American Nurses Association (2010) American Nurses Association Position Statement.

23. Doutrich D, Dekker L, Spuck J, Hoeksel R (2014) Identity, ethics, and cultural safety: Strategies for change. Whitireia Nursing and Health Journal 2014: 15-21.

24. Montenery SM, Jones AD, Perry N, Ross D, Zoucha R (2013) Cultural competence in nursing faculty: A journey not a destination. Journal of Professional Nursing 29: 51-77.

25. Papadimos TJ (2007) Healthcare access as a right, not privilege: a construct of Western thought. Philosophy, Ethics, and Humanities in Medicine 2: 1-8.

26. Rogers J, Kelly UA (2011) Feminist intersectionality: Bringing social justice to health disparities research. Nursing Ethics 18: 397-407.

27. Pacquiao DF (2008) Nursing care of vulnerable populations using a framework of cultural competence, social justice and human rights. Contemporary Nurse 28: 189-197.

28. Maddalena V (2009) Cultural competence and holistic practice: Implications for nursing education, practice, and research. Holistic Nursing Practice 23: 153-157.