

Culture and Cultural Competence in Nursing Education and Practice: The State of the Art

Linda Harkess, MSN, RN, and Mahmoud Kaddoura, PhD, CAGS, APRN, NP-C

Linda Harkess, MSN, RN, is Staff Nurse, Brigham and Women’s Hospital, Boston, MA; and Mahmoud Kaddoura, PhD, CAGS, APRN, NP-C, is Assistant Professor, Duke University, Durham, NC.

Keywords

Cultural competence, cultural diversity, education, nursing research

Correspondence

Mahmoud A. Kaddoura, PhD, CAGS, APRN, NP-C, School of Nursing, Duke University, Durham, NC
E-mail: Mahmoud.kaddoura@duke.edu

PROBLEM. The concept of cultural competency has developed a substantial presence in nursing education and practice since first attracting widespread attention in the 1990s. While several theories and corresponding measures of cultural competency have been advanced and tried, much work remains, as many nursing professionals continue to call for greater evidence-based research and attention to patient perspectives and outcomes.

METHODS. Using a method provided by Hawker et al. to appraise articles, this paper compares nine recent (2008–2013) studies (including two composite studies) related to cultural competency, undergraduate curricula, and teaching strategies in nursing to assess the state of the art in this important area of care.

FINDINGS. The studies applied phenomenological, study abroad, online, and service learning strategies, four of which relied on some version of Campinha-Bacote’s IAPCC© model. These studies reported a general improvement in competency among students, though generally only to a level of cultural awareness, and admitted being constrained by several common limitations.

CONCLUSION. Improved results and more realistic expectations in this area may require a closer understanding of the nature of the “culture” that underlies cultural competence.

Introduction

The development of the concept of cultural competence in nursing may be linked to the emergence of several broader trends, including the embrace of multicultural education, educational reform emphasizing critical thinking skills, and trends toward experiential, practical, and applied training in the field. Although the embrace of the term “cultural competence” is not entirely universal (e.g., Thackrah and Thompson [2013] proposed a notion of “cultural humility”), today it has a foothold in many nursing school curricula and general discourse. The basics of what cultural competence has come to mean in relation to nursing first emerged in the 1970s with theories of transcultural nursing (Leininger, 1978). The concept gained much greater attention in the

mid-1990s, at which time the American Academy of Nursing attempted a standard definition for it as a complex integration of knowledge, attitudes, and skills that enhances cross-cultural communication and appropriate effective interactions with others (Kaddoura, 2012; Kaddoura & Williams, 2012; Long, 2012).

By 2004, the term had gathered enough steam to engender a substantial bibliography, and set of influential proposed models, including Leininger’s Cultural Care and Diversity and Universality theory, Purnell’s Model for Cultural Competence/Transcultural Health Care, Spector’s Health Traditions Model, Giger and Davidhizar’s Model of Transcultural Nursing, and Campinha-Bacote’s Cultural Competency model (American Association of Colleges of Nursing, 2008b; Shen, 2004), among others. Yet, Kardong-Edgren and

Campinha-Bacote's observation remains true today: "A universally agreed-upon definition of what cultural competency is, is still lacking" (Kardong-Edgren & Campinha-Bacote, 2008, p. 38). This is reflected in the varied approaches to integrate the concept into nursing education, as illustrated in the productive engagement generated by Lipson and DeSantis's (2007) treatment, which called attention to important issues such as debates about content, standards and tools for evaluating effectiveness, coursework on culture, the nurse-patient encounter, and faculty support.

As various theories of cultural competence have emerged, some have been more influential than others. The National CLAS Standards (National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care) have served as a guideline for some nursing schools and healthcare institutions (CLAS, 2014; Koh et al., 2014). Another, Campinha-Bacote's Cultural Competency model, defines cultural competency as "an ongoing process in which the healthcare professional continuously strives to achieve the ability and availability to work effectively within the cultural context of the patient (individual, family, community)" (Harris, Purnell, Fletcher, & Lindgren, 2013, p. 135). This model relies on the pillar constructs of cultural awareness, cultural knowledge, cultural skill, cultural desire, and cultural encounters.

Common training methods for cultural competency in nursing schools include "group discussion, lectures, case scenarios, clinical experiences, cultural immersion and presentations by ethnic minority speaker" (Long, 2012, p. 104). The frequently referenced Toolkit of Resources for Cultural Competent Education for Baccalaureate Nurses (American Association of Colleges of Nursing, 2008b) lists a varied set of classroom learning strategies to help achieve cultural competence, everything from more inward and classroom reliant activities (performing a cultural self-assessment, guest presentations by indigenous healers, role playing), to more outward directed ones (developing culturally specific nursing plans, community health fairs, faith-based wellness programs). Lipson and DeSantis (2007) grouped common approaches to implementing cultural competence education in nursing education in the categories: specialty focus, required courses, models, immersion experiences, and distance learning or simulation. In their implementation, the strategy designed to teach cultural competences varies from a few dedicated courses to "integrated curriculum" approaches that incorporate it as an essential element across numerous courses in a program.

Regardless of strategy, the experiential component of cultural competency courses and programs varies and deserves delineation. While "immersion" is often referenced as a strategy to satisfy the pillar of "cultural encounter," the immersion element, as Ballestas and Roller (2013) point out, can take various forms, including study abroad, exchange programs, local cultural immersion, or in service learning. Study abroad and exchange programs predate more recent understandings of cultural competence, and though they inherently might serve to partly promote cultural competence (e.g., through language instruction), such programs per se are not automatically fully geared to this purpose. The same may be said for the experientially grounded approach of service learning, or "academic service learning" (Kaddoura, Puri, & Dominick, 2014; Puri, Kaddoura, & Dominick, 2013). Academics and professionals draw from various models in what by now is a vast literature on service learning to define it, but Thackrah and Thompson's (2013) definition contains its typical features: service learning is "an educational experience in which students participate in service based on community need, and reflect on their involvement to gain understanding of the course content, a broader perspective on their discipline, and an enhanced sense of civic responsibility" (Curtin et al., p. 549). This can overlap with study abroad and exchange programs in the form of international service learning. Thus, study abroad, exchange programs, and service learning opportunities should not be presumed to support cultural competence, but they may overlap with the goal of enhancing cultural competence only in the extent to which they involve an intercultural encounter and apply sound principles of a cultural competence strategy. The relationship between ethnicity/race, language, and cultural competency is also an interesting one that deserves scrutiny and careful attention to presumptions.

The Inventory for Assessing the Process of Cultural Competency Among Healthcare Professionals-Revised (IAPCC-R[®]) has been a commonly referenced instrument for gauging achievements in cultural competency: "The IAPCC-R[®] is frequently used because of its length, ease of use, and reliability and validity" (Kardong-Edgren & Campinha-Bacote, 2008, p. 42).

A rationale for adopting cultural competence as a goal in nursing education and practice can rest on the pragmatic consideration that it has been adopted as a requirement: "Since 1986 teaching cultural competence in the delivery of nursing care is an expectation of accreditation and approval boards for schools of

nursing” by bodies like the American Nurses Credentialing Center, American Nurses Association, National League for Nurses Accreditation Commission, Joint Commission, among others (Long, 2012, p. 103). To date, while many schools and medical institutions have adopted it into their discourse and integrated its recommendations to some extent, adoption remains a largely dynamic and voluntary process, with much room for interpretation and innovation. Thus, “Although much has been defined about cultural competence, it is left to each school of nursing to choose the definition and methods to teach students about cultural competence” (Long, 2012, p. 103).

Differences in definition and approach can be telling with regard to the acceptance and potential future development of the concept of cultural competence. This paper does an integrative review of nine systematically appraised studies involving cultural competence, as presented in Table 1, to gauge what we can learn about its status and potential benefit to nursing education and practice.

Methodology

A comprehensive, computer-assisted search was conducted using the Cumulative Index to Nursing and Allied Health Literature, Educational Research Information Clearinghouse, Health Source/Academic Edition and Professional Development Collection, Ovid Nursing Journal Collection, Science Direct, and Google Scholar. The keywords “cultural competence,” “teaching strategies,” “undergraduate curricula,” “nursing education,” “faculty knowledge,” “cultural competency,” “nursing,” and “cultural sensitivity” were used as search terms, which yielded 139 research studies. The works selected were research studies published in peer-reviewed journals, written in English, dated from January 2008 through December 2013, and pertained to undergraduate nursing student populations. The time frame for the search was selected based upon the establishment of *The Essentials of Baccalaureate Education for Professional Practice* (American Association of Colleges of Nursing, 2008a). Only studies done in the United States were included. Studies that did not pertain to cultural competence, undergraduate nursing curricula, teaching strategies, undergraduate nursing students, or were from different disciplines such as medicine or pharmaceuticals were excluded. Studies pertaining to graduate nursing students, medical, and pharmaceutical students were

also excluded, as were nonpublished research and theoretical studies.

After this selection, the remaining 12 original research studies were then appraised using a modified version of Hawker, Payne, Kerr, Hardey, and Powell’s (2002) quality appraisal tool. The nine areas graded were abstract and title, introduction and aim, method and data, sampling, data analysis, ethics and bias, results, transferability or generalizability, and implication and usefulness. Each of these areas was divided into four subcategories similar to that of a 4-point Likert scale: good, fair, poor, and very poor. The subcategories were then assigned a numerical number rating; for example, “good” warranted a 4, with cumulative points 28–36 from all 9 sections. “Fair” equals 3, or cumulative points 19–27. “Poor” equals 2, or cumulative points 10–18, and “very poor” equals 1, or cumulative points 9, for a total of 36 points for each article (Hawker et al., 2002). The remaining 9 studies with scores of 28–36, or “good,” were then selected for this integrative review. Table 2 provides a summary of the appraisal process.

Results

The selected focus studies varied in their approaches, although five out of nine (Adamshick & August-Brady, 2012; Ballestas & Roller, 2013; Carpenter & Garcia, 2012; Curtin, Martins, Schwartz-Barcott, DiMaria, & Ogando, 2013; Larson, Ott, & Miles, 2010) could be described as study abroad. Two studies were self-described as “cultural immersion experience” classes (Adamshick & August-Brady, 2012; Larson et al., 2010) and were held abroad; two as “study abroad” (Ballestas & Roller, 2013; Carpenter & Garcia, 2012); two as “service learning” (one conducted domestically; Chen, McAdams-Jones, Tay, & Packer, 2012, and another held abroad described as “international service learning”; Curtin et al., 2013); and one took the form of an online-only summer class (Harris et al., 2013). Two of the articles (Kardong-Edgren & Campinha-Bacote, 2008; Kardong-Edgren et al., 2010) represented “composite” studies that culled data from more than one class/program (four in one case; Kardong-Edgren & Campinha-Bacote, 2008, and six in another; Kardong-Edgren et al., 2010). Of the seven noncomposite studies, class size varied from 8 students (Adamshick & August-Brady, 2012) to 35 students (Carpenter & Garcia, 2012), with a mean of 18 students. Consistent with the demographics of nursing

Table 1. Summary of Studies Reviewed

Study ^a	Purpose	Teaching strategy	Instrument /framework	Sample	Findings	Limitations	References
[1]	Uncover the meaning of a week-long immersion for RN students and its impact on their clinical practice post experience	Cultural immersion	Hermeneutic phenomenological reflection Van Manen's approach	Eight BSN students Male $n = 1$ Female $n = 7$ Latino = 2 White $n = 6$ Ages 24–50 Years of experience 2–16 Traveled outside the United States on mission trip $n = 1$	Students were actively engaged in practice prior to and post trip. <i>Themes</i> From the outside looking in Struggling with dissonance Searching for meaning From the inside looking out	Sample characteristics Lack globalization Small sample size, focus group attendance varied but was saturated	Adamshick and August-Brady (2012) Cultural immersion
[2]	To measure level of CC before and after a study abroad program	Study abroad	IAPCC-R Per/posttest data collection Campinha-Bacote's Cultural Competency Model	BSN students Sample size $n = 18$ Ages 20–47 Predominantly female <i>Ethnicity</i> African American $n = 3$ White $n = 8$ Asian $n = 2$, Hispanic/Latino $n = 1$ Other $n = 4$	CC score increase on 16 of the 18 students. Mean pre-score 66.3% of 100 Mean post-score increase to 78.8% $t = 5.62; p < .000$.	Small sample size Limits No follow-up post-test beyond the immediate post experience SV of the instrument would have been more suitable to use. Unknown prior content on cultural elements threaded throughout the four year curriculum. % of Hispanic students in sample compared to the school's population Hispanic culture may have reflected a specific interest in these students also.	Ballestas and Roller (2013) Carpenter and Garcia (2012) Study abroad
[3]	Assess the impact of a study abroad program on developing CC, cultural awareness, sensitivity, knowledge, and skills	Study abroad	Modified version of the Cultural Awareness Survey (CAS) Interviews Reflective journals Written responses to open-ended questions	35 undergraduate nursing students Ages 19–35 Female 85.7% White 63% 75% of students tested into the beginner levels of Spanish. No significant difference between the two cohorts in the studies. More male students participated in 2008 than in 2007. Chi-square = 7.78, $df = 1, p = .005$	Experiential teaching such as field trips, post conferences, and reflective journaling may be more effective than classroom content. <i>Themes</i> Cultural awareness Cultural sensitivity Cultural knowledge Cultural skills Effects of the experience of nursing practice	Small sample size Lack generalization Need longitudinal studies to evaluate the long-term impact of culture on nursing students' education	Carpenter and Garcia (2012) Study abroad

Table 1. Continued

Study ^a	Purpose	Teaching strategy	Instrument/framework	Sample	Findings	Limitations	References
[4]	Enhance students' CC through a service learning project in a community clinic	Service learning (domestic)	IAPCC-SV Pre-/post-test Control group Design Campinha-Bacote's Cultural Competency Model	26 ASN students volunteer 13 per group 2 speak conversational Spanish <i>Comparison group</i> Male <i>n</i> = 3 Female <i>n</i> = 10 Married <i>n</i> = 6 Employed <i>n</i> = 12 White <i>n</i> = 12 <i>Experimental group</i> Male <i>n</i> = 4 Female <i>n</i> = 9 Married <i>n</i> = 7 Employed <i>n</i> = 10 White <i>n</i> = 13 No significant difference in demographic in comparison group	Experimental group improved their CC from cultural awareness to being culturally competent throughout the service-learning project. <i>Themes</i> Learned their culture Learned their language	Small sample size Limit globalization was impossible due to voluntary participation. Did not surmise how students translate cultural competence into clinical practice Needs consistent psychometric evaluation of IAPCC-SV	Chen et al. (2012)
[5]	Describe a short-term international service learning program to meet the needs of senior baccalaureate students	Service learning	Thematic analysis Daily reflective and post-experience seminars Onsite group debriefing sessions Audit trail Interactive comparison of themes by researchers Rimer's Framework	10 senior female BSN students Ages 21–24 Five students traveled to European Countries for vacation but not developing countries. Six students had minimal to some Spanish language skills, and one spoke Spanish fluently. All 10 students expressed interest in studying abroad and being immersed in the culture.	Transferability: information was shared at national conferences by nursing faculty. <i>Themes</i> Adapting physically Encountering frustration in the ability to fully meet patients' needs Increasing confidence in speaking Spanish and assessing health problems Increase cultural awareness Shifting focus from self to others	Small sample size Highly motivated participants	Curtin et al. (2013)
[6]	Employ an alternative learning strategy while addressing issues relevant to develop CC	Online learning	Thematic analysis Reflection stimulated by five key questions Creative PowerPoint class presentation, online assessment, blackboard discussion Campinha-Bacote's Cultural Competency Model	16 BSN students Female <i>n</i> = 15 Ages 20–25 Caucasian <i>n</i> = 12 African American <i>n</i> = 2 American Indian <i>n</i> = 1 Asian <i>n</i> = 1 2nd semester <i>n</i> = 6 3rd semester <i>n</i> = 5 4th semester <i>n</i> = 4 5th semester <i>n</i> = 1	Positive feedback from all students Awareness of own biases and importance for being prepared to provide culturally sensitive care to diverse patient population Appreciation for hardships experienced by others	None discussed	Harris et al. (2013)

Table 1. Continued

Study ^a	Purpose	Teaching strategy	Instrument /framework	Sample	Findings	Limitations	References
[7]	Evaluate CC of graduating nursing students from programs using different curricular approaches Two used a well-known transcultural theory One used an integrative approach, no specific model One program utilized a free-standing two-credit culture course	Composite	IAPCC-R Data were analyzed using ANOVA $F, 3.214 = 1.24, p > .05$ Campinha-Bacote's Cultural Competency Model	218 graduating nursing students Ages 20–53 Female $n = 196$ Male $n = 20$ Asian $n = 24$ Black $n = 13$ Native American/Alaskan $n = 1$, Pacific Islander $n = 6$ White $n = 161$ Other $n = 13$ Black and White $n = 1$, Hispanic $n = 8$, Hispanic/White $n = 1$ Mexican American $n = 1$ Italian American $n = 1$, Spanish, Italian, French, Irish $n = 1$ International student status $n = 12$ Students traveled outside the United States on vacation $n = 218$ 559 students participated 44 students' data were missing 515 total students Ages 20–60 White $n = 371$ or 72%, Female $n = 89%$, second degree students $n = 45%$	No significant difference was found between programs. Graduates only score in the culturally awareness range.	Need challenging evaluation tool so that students can demonstrate cultural competence	Kardong-Edgren and Campinha-Bacote (2008)
[8]	Evaluate curricular methodology for teaching CC Six programs were evaluated for curricular integration	Composite	IAPCC-R Campinha-Bacote's Cultural Competency Model; 5/6 programs incorporated all Campinha-Bacote's concepts into program with the exception of one program that included only two concepts; 2/6 integrated CC throughout the program; 1/6 integrated CC in all clinical courses	13 junior and senior students Participated in pre-experience $n = 7$; participated in reflective journals and post-experience interview $n = 13$ Married with children and prior college degree $n = 2$ Traditional students $n = 11$ Ages 21–45	No approach appears to be superior for teaching cultural contents. Evaluation tool may have telegraphed how students should respond.	Students are influenced by other environmental experiences and courses. Evaluation tool may have telegraphed how students should respond.	Kardong-Edgren et al. (2010)
[9]	To explore the impact of a cultural immersion experience on student nurses' cultural competence	Cultural immersion	Thematic analysis Interviews were transcribed and verified. Reflective journals were matched with respective transcript. Matrices were developed from transcripts and journal data contrasting students' responses with interview questions. Data were then analyzed by major course concepts such as culture, communication, immigration, health, and community.	Provide all aspects of students' experience from conducting an outreach clinic to living with host families Gained language skills Addresses the goal set by NLNAC and CCNE <i>Themes</i> Navigating daily life Broadening the lens Making a difference	None discussed	Larson et al. (2010)	

^aArticles, Type. ASN, Associate in Science in Nursing; BSN, Bachelor of Science in Nursing; CC, cultural competency; IAPCC-R/SV, Inventory for Assessing the Process of Cultural Competency among Healthcare Professionals-Revised/SV, student version.

Table 2. Quality Appraisal Tool and Appraisal Score

Criteria	Good = 4 Cumulative points 28–36	Fair = 3 Cumulative points 19–27	Poor = 2 Cumulative points 10–18	Very Poor = 1 Cumulative points 1–9
1. Abstract and title 2. Introduction and aim 3. Method and data 4. Sampling 5. Data analysis 6. Ethics and bias 7. Results 8. Transferability or generalizability 9. Implication and usefulness	Concise, easy to understand, contained current literature reviews, highlighted gaps in knowledge, and contributed new knowledge to the topic of study. Populations were described, and ethical issues were addressed.	Minimal information was missing, further explanation or clarification in data was needed for findings.	Minimal background information, no aim, no research question or objectives. Research lacked sufficient details such as method, data, sample, analysis, and context. Ethics and bias were not mentioned, findings were not explained, or did not correlate with the results, and are not useful to practice.	Contained no abstract, aims, objectives or background information; method was inappropriate and no details of data, sample, or analysis were provided. Ethics were not mentioned, findings were not related back to title, transferability or generalizability was not discussed.

in general, the majority of student participants were female, and their age range was wide, between those in their 20s to those in their 40s and 50s, although most of the students were in their mid-20s. Two of the focus articles did not report on the ethnic/racial composition of students, but the data for those that did indicated that students were predominantly White (median = 75%). This matches the finding by Health Resources Services Administration that 83.2% of the RN workforce consisted of non-Hispanic White females (Harris et al., 2013, p. 134).

Most classes incorporated either pre-class experience preparation, post-experience follow-up, and—in line with the definition of service learning provided above and educational trends toward critical thinking—opportunities for reflection throughout the class, typically in the form of a journal. Three employed some sort of orientation class as pre-experience (Chen et al., 2012; Harris et al., 2013; Kardong-Edgren et al., 2010). Five drew from student journal reflections post experience, two of these led by the researchers (Curtin et al., 2013; Kardong-Edgren & Campinha-Bacote, 2008). In one case (Adamshick & August-Brady, 2012), the post-class experience consisted of focus groups led by the researcher, and in another the post-experience took the form of a researcher-led interview 4–6 weeks post experience (Larson et al., 2010).

While one study (Kardong-Edgren et al., 2010) was conducted via an online format, and another based

instruction locally (Chen et al., 2012; Harris et al., 2013), the remaining five held classes abroad, all in Latin America—in Honduras (Adamshick & August-Brady, 2012), Costa Rica (Ballestas & Roller, 2013), Mexico (Carpenter & Garcia, 2012), the Dominican Republic (Curtin et al., 2013), and Guatemala (Larson et al., 2010). The noncomposite classes lasted anywhere from approximately 1 week to 6 weeks, with an average of about 3 weeks and a median of about 2 weeks.

Only two of the five study abroad courses gave language instruction-focused attention. One course (Carpenter & Garcia, 2012) focused specifically on language skills: “The course was designed to teach nurses to do specific things in Spanish, including, but not limited to, taking a health history, doing an analysis of symptoms, and scheduling an appointment” (p. 86), and another course (Larson et al., 2010) also integrated Spanish language instruction where “Students attended intensive one-on-one Spanish language classes while in Guatemala” (p. 45). One study (Chen et al., 2012) specifically mentioned that, despite having at least a couple of students who spoke conversational Spanish, conveying detailed information still required the use of translators. One study (Curtin et al., 2013) had one fluent Spanish speaker and six who had “minimal to some” facility mentioned that “Spanish language skills and international experience were desired, but not required, for participation” (p. 552).

In terms of measuring cultural competence, the most commonly used instrument was Campinha-Bacote's IAPCC and variants, based on their Culturally Competent Model of Care.

Results for efficacy in teaching cultural competence vary a good deal among common current approaches. In particular, the technique of integrating a cultural competence component across the curriculum, while an appealing concept, is by no means a guarantee because it can suffer from inconsistencies in conceptualization and administrative support (Brennan & Cotter, 2008, as cited in Kardong-Edgren & Campinha-Bacote, 2008). In Loftin, Hartin, Branson, and Reyes's (2013) extensive overview of cultural competency measures, the IAPCC was well represented, given that it, along with three others that draw upon it, constitute 4 of the 11 instruments encountered in the article. The IAPCC, along with the Transcultural Self-Efficacy Tool, IAPCC-R, Cultural Self-Efficacy Scale, and the Cultural Competence Assessment, was noted as having "been used in multiple studies and in a variety of situations and settings" (p. 9), which is advantageous given the expressed desire for more evidence-based determinations for cultural competency.

A certain level of quantitative specificity is provided by IAPCC and other instruments based upon it, that is, the Cultural Knowledge Scale, Cultural Diversity Questionnaire for Nurse Educators, and the Nurse Cultural Competence Scale. But a reliable determination of improvement in cultural competency was hard to come by. The IAPCC uses a scale ranging from culturally incompetent, culturally aware, culturally competent, and culturally proficient. Of the four noncomposite focus studies that used the IAPCC, one class raised the majority of students (i.e., 14 of 18) to the culturally competent level (Ballestas & Roller, 2013). Similarly, in another study, students' total score was raised by about 5 points, which represented a change from culturally aware to culturally competent (Chen et al., 2012, p. 70). However, the two composite studies, one involving a total of 218 students (Kardong-Edgren & Campinha-Bacote, 2008) and the other 515 students (Kardong-Edgren et al., 2010), both reported competence raised to only the level of culturally aware. The focus studies that used more qualitative assessments reported impacts in terms of transformative impressions based on themes, typically themes like those categorized in one study as navigating daily life, "broadening the personal lens," and "making a difference" (Larson et al., 2010; Lytes et al., 2011).

The need for better measurements was frequently acknowledged. Issues with the IAPCC have to do with a lack of a student measure and its reliance on self-

reporting: "Is a self-report evaluation tool the best way to assess cultural competence?" (Kardong-Edgren & Campinha-Bacote, 2008, p. 43). Using this technique, "students are not actually challenged to demonstrate cultural competency in any meaningful way" (Kardong-Edgren & Campinha-Bacote, 2008, p. 42). A student version, the IAPCC-SV[®], has been tested and used more recently. Yet questions remain regarding ways of measuring the long-term efficacy of such tools, especially by taking into consideration the patients' point of view: "challenges in evaluating cultural competence in nursing practice and education have led to the development of instruments that focus on the cultural competence attributes of health care providers rather than on patient perceptions of their care or their health outcomes. . . . The challenge remains to develop measures to assess cultural competence in practice and on patient outcomes" (Loftin, Hartin, Branson, & Reyes, 2013, p. 9). In other words, it is important to measure how students returning from some form of immersion "actually relate to diverse populations in their practice" (Ballestas & Roller, 2013, p. 132).

Comments regarding language instruction per se were limited, but its importance was acknowledged: "As they immersed themselves in Spanish language practice, they were simultaneously able to develop their understanding of Mexican culture and their ability to function effectively" (Carpenter & Garcia, 2012, p. 89). One student had a mixed reaction: "Teaching was very difficult, especially with the language barrier. Interestingly, I was able to muster up enough Spanish and visual cues to teach. . . ." (Carpenter & Garcia, 2012, p. 554). Another student expressed struggles with it: "I feel that I have gleaned more of a cultural understanding than an understanding of the language this past week" (Carpenter & Garcia, 2012, p. 88). Several studies commented about a potential link between prior professional experience or cultural interaction by students and their measured post-experience cultural competence.

Discussion

Rationale and Theory

Often citing figures from the U.S. Census and policy statements like that of the AACN (American Association of Colleges of Nursing, 2008a, p 6), studies almost universally emphasized the importance of cultural competence by pointing to the challenges of changing internal domestic demographics, that is, the

need for nurses to provide care in a country whose population is increasingly diverse. But statements of rationale found in many studies may be distinguished by the level to which they, moving beyond generic statements of “cultural sensitivity” and “global awareness,” call attention to the issue, and potential causes of, disparities in health and health care according to cultural and ethnic/racial affiliation, and to the role of nursing in addressing these as social injustices. Social injustices may be linked to wider inequities associated with the domestic impact of the global economy (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). Some have called attention to the issue of diversification of the nursing workforce itself.

Importance of Interactivity

The focus studies did not point to one theory or teaching strategy that proved clearly superior to another, and all reported some level of substantial progress in competency as a whole or some subscale component, such as knowledge, cultural skill, or cultural desire. Interestingly, one composite study that sampled 218 students from 4 programs that differed in size, geography, and model used (i.e., freestanding course, integrated into curriculum) (Campinha-Bacote & Padgett, 1995; Leininger, 1978; Thackrah & Thompson, 2013) found that improvement, at least to the level of cultural awareness, was achieved regardless of the different types of strategies used.

Perhaps indicating something more important than adherence to a given model, the focus studies pointed to the importance of sustained intercultural interactivity as key to raising cultural awareness and competence. This became evident when comparing the levels of interactive immersion and engagement of students with people from backgrounds and cultures different from their own, which itself may be linked to the years of prior experience of a given student. One composite study found that, among the various programs included, students from the program with the highest mean score reported the largest percentage of students who had been on foreign mission trips, demonstrating the opportunity for cultural encounters, a key element in the development of cultural competency. But preparing students to have meaningful and satisfying cultural interactions in their nursing education and practice came across as elusive in both quantitative and qualitative studies. This study reported relatively low scores in response to the proposal of feeling comfortable working with patients of all ethnic

groups and speculated that the large variation in responses (range 1.0 to 7.0) likely illustrates the wide range of experiences and educational maturity among participants in the course. Thus, to some extent age and experience may be serving as a proxy for levels of immersion and interaction that improve competency. As one composite study suggested, the potential effect of age and accompanying life experience versus prior education on the IAPCC-R score is intriguing (Campinha-Bacote & Padgett, 1995).

The difficulties in achieving meaningful cultural interactions that provide positive transformative experience for the nurse, and quality care for the patient, may hinge significantly upon the complexity of cultural processes, identified well in one study to include “the embodiment of meaning in psychophysiological reactions, the development of interpersonal attachments, the serious performance of religious practices, common-sense interpretations, and the cultivation of collective and individual identity” (Kleinman & Benson, 2006, p. 1674). Thus, it perhaps should not be surprising that results are often modest. Long’s (2012) recent survey of programs found that although most studies demonstrate at least a modest positive outcome, none were able to declare the students as culturally competent. Quite appropriately, much of the literature recognizes cultural competence as a process whose achievement takes a lifelong commitment. As such, and in light of modest results to date, one focus study more soberly asked the question: Is cultural awareness a more realistic goal for graduating nursing students as opposed to expecting a quick ascent to cultural competency?

Part of this desire for a better tool may reflect the remaining elusiveness of the concept of cultural competence itself. As one study suggested, the particular tool, the IAPCC-R chosen for this study, may be problematic. A paper and pencil self-report tool is probably not the best method for evaluating such a value-laden multidimensional concept like cultural competency. A few sources expressed some hope for assistance from technology: Technology will soon allow us to evaluate cultural competency in a more meaningful way, including filmed standardized patient encounters, the writing of cultural material into human patient simulation scenarios, the development of standardized patients from different cultural backgrounds, and objective structured clinical examinations.

But a technological fix alone seems insufficient to fully address the broader issue of cultural competency

training, application, and evaluation—for, at the very least, the application of technology is reliant on a sound foundational understanding of cultural competence by humans who design and use it. The multidimensional nature of the founding component of cultural competence, namely, “culture,” suggests caution must be taken to avoid a comfortable sense of quantification and avoid essentialization: “Cultural processes frequently differ within the same ethnic or social group because of differences in age cohort, gender, political association, class, religion, ethnicity, and even personality” (Kleinman & Benson, 2006, p. 1673). In addition, culture is “inseparable from economic, political, religious, psychological, and biological conditions” (Kleinman & Benson, 2006, p. 1674). Given this socially embedded complexity, cultural competence may be best approached by combining the insights of qualitative approaches with more quantitative ones.

Conclusion

Cultural competency may indeed require a transformation. Such transformations may indeed be inspired by a given course or curriculum, but it may also need to be realized over the course of an entire career reinforced by lifelong formal and informal education. This study found both a certain level of coalescing in the definition of cultural competency and measures needed to assess the efficacy of related training methods in nursing, and a realization of the amount of work that remains in developing these areas. The study highlighted the central importance of cultural immersion, encounters, and interactivity in achieving successful cultural competency training. Thus, future improvements in cultural competence training should examine methods that enhance meaningful interaction, because much depends on the *kinds* of interactions and the *quality* of the experiences, with contact alone not necessarily fostering insight.

A promising avenue for addressing several of the issues and questions raised in this study that go at the core of the concept of culture itself is represented in a proposal promoting training in a particular form of “mini-ethnography.” Ethnography provides a well-established and time-tested technique targeted to the understanding of culture. This is not to say that ethnographic techniques have not already been tried. It is encouraging that one composite study noted the better performance by students who had taken a previous Anthropology course, which one assumes

may have included an element of ethnography. Yet one focus study that promoted interaction using participant-observation admitted that “undergraduate students have limited participant-observation skills. Most of the students had completed an undergraduate research course, but application of theoretical content in fieldwork was new for all of these students and did not come easily in a setting where sights and sounds were unfamiliar. Kleinman and Benson (2006) emphasize particular goals in ethnographic training for clinicians to develop in determining the following key areas: to what extent ethnicity is relevant in a given case, a determination of what is at stake for patients, the mapping of a patient’s illness narrative, an evaluation of a patient’s psychosocial stresses, and reflection regarding clinician bias. Such ethnographies can enhance and/or complement best practices currently underway in teaching and practicing nursing in a cultural competent way as a lifelong process that represents a long-term commitment toward interactive care between nurse and communities of patients.

Drawing upon a large history of ethnographic expertise, professionals could call attention to inequities and help fulfill the theme of making a difference found to be of major concern and theme for students, and would appropriately incorporate an emphasis on nursing ethics, values, and compassion, as called for in one study. For example, such ethnographies could point the way toward fulfilling the “social justice” rationale proposed by some professionals by exploring the relation between cultural competency and income disparities, racial injustices, linguistic intolerance, and other inequities associated with culture broadly defined (sexual orientation, religion, able-bodiedness, etc.). With the caution that schools and institutions should not fall into the common trap of oversimplifying culture, since culture is often made synonymous with ethnicity, nationality, and language, application of targeted ethnographic techniques and analysis can nevertheless reflect the fact that health disparities according to race are still quite real, and therefore would be expected to appear as salient features in research. Thus, it could help address the condition that the vast majority of nurses identify as non-Hispanic White and many have had limited experience with diverse ethnic and racial groups. True cultural competence may consist of training to recognize the salience of racism to health outcomes and its structural underpinnings in biomedicine, factors which may contribute to their muted presence in self-reported measures. At

the same time, it would aid in the ability to discount ethnicity/race as a prevailing factor when nurses “misdiagnose” its importance by applying preconceived stereotypes and bias, thereby neglecting other more relevant factors in given cases. Similarly, ethnographic training in cultural competency, while avoiding reducing culture to language, would nonetheless recognize the key importance of linguistic competence to meaningful engagement with patients, something that takes concerted individual training and/or cooperation with qualified interpreters.

There seems to be inadequate resources dedicated to the development and application of the notion of cultural competency in nursing. There exist many studies which have described schools of nursing that made practical decisions and trade-offs to incorporate cultural competency in distinct courses. Yet, there is a dearth of research that has followed up on the integration of cultural immersion and interactivity across the curriculum. It is recommended that ample resources to conduct longitudinal research on cultural competence are allocated and that various nursing programs and large sample sizes are included. The fact that there are few tools to evaluate cultural competency, something that is becoming increasingly important as the demographics of the United States change, may be indicative of what we as nurses truly value. To this we add, what nursing schools, medical institutions, and the society as a whole truly value.

References

- Adamshick, P., & August-Brady, M. (2012). Reclaiming the essence of nursing: The meaning of an immersion experience in Honduras for RN to Bachelor of Science students. *Journal of Professional Nursing, 28*(3), 190–198.
- American Association of Colleges of Nursing. (2008a). *The essentials of baccalaureate education for professional nursing practice*. Retrieved from <http://www.aacn.nche.edu/education-resources/BaccEssentials08.pdf>
- American Association of Colleges of Nursing. (2008b). *Toolkit of resources for cultural competent education for baccalaureate nurses*. Retrieved from <http://www.aacn.nche.edu/education-resources/toolkit.pdf>
- Ballestas, H. C., & Roller, M. C. (2013). The effectiveness of a study abroad program for increasing students' cultural competence. *Journal of Nursing Education and Practice, 3*(6), 125–133.
- Betancourt, J., Green, R., Carrillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*, 293–302.
- Brennan, A. W., & Cotter, V. T. (2008). Student perceptions of cultural competence content in the curriculum. *Journal of Professional Nursing, 24*(3), 155–160. doi:10.1016/j.profnurs.2008.01.003
- Campinha-Bacote, J., & Padgett, J. J. (1995). Cultural competence: A critical factor in nursing research. *Journal of Cultural Diversity, 2*(1), 31–34.
- Carpenter, L. J., & Garcia, A. A. (2012). Assessing outcomes of a study abroad course for nursing students. *Nursing Education Perspectives, 33*(2), 85–89.
- Chen, H., McAdams-Jones, D., Tay, D. L., & Packer, J. M. (2012). The impact of service-learning on students' cultural competence. *Teaching and Learning in Nursing, 7*(2), 67–73.
- CLAS. (2014). *What are the National CLAS Standards?* Retrieved October 15, 2014, from <https://www.thinkculturalhealth.hhs.gov/content/clas.asp>
- Curtin, A. J., Martins, D. C., Schwartz-Barcott, D., DiMaria, L., & Ogando, B. M. (2013). Development and evaluation of an international service learning program for nursing students. *Public Health Nursing, 30*(6), 548–556.
- Harris, M. S., Purnell, K., Fletcher, A., & Lindgren, K. (2013). Moving toward cultural competency: Dream work online summer program. *Journal of Cultural Diversity, 20*(3), 134–138.
- Hawker, S., Payne, S., Kerr, C., Hardey, M., & Powell, J. (2002). Appraising the evidence: Reviewing disparate data systematically. *Qualitative Health Research, 12*(9), 1284–1299.
- Kaddoura, M. (2012). New graduate nurses' perceived definition of critical thinking during their first nursing experience. *Educational Research Quarterly, 36*(3), 3–21.
- Kaddoura, M., Puri, A., & Dominick, C. A. (2014). International academic service learning: Lessons learned from students' travel experiences of diverse cultural and health care practices in Morocco. *Journal of Nursing Education, 53*(1), 45–47.
- Kaddoura, M. A., & Williams, C. (2012). Comparison of generic accelerated nursing students' critical thinking skills before and after implementing the case study pedagogical method. *Educational Research Quarterly, 35*(4), 3–28.
- Kardong-Edgren, S., & Campinha-Bacote, J. (2008). Cultural competency of graduating US Bachelor of Science nursing students. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 28*(1–2), 37–44.
- Kardong-Edgren, S., Cason, C. L., Brennan, A. W., Reifsnider, E., Hummel, F., Mancini, M., & Griffin, C. (2010). Cultural competency of graduating BSN nursing students. *Nursing Education Perspectives, 31*(5), 278–285.
- Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. *PLoS Medicine, 3*(10), e294–e295.
- Koh, H. K., Nadine Gracia, J., & Alvarez, M. E. (2014). Culturally and linguistically appropriate services—Advancing health with CLAS. *New England Journal of Medicine, 371*, 198–201.
- Larson, K. L., Ott, M., & Miles, J. M. (2010). International cultural immersion: En vivo reflections in cultural competence. *Journal of Cultural Diversity, 17*(2), 44–50.

- Leininger, M. (1978). *Transcultural nursing: Concepts, theories, and practices*. New York: Wiley & Sons.
- Lipson, J., & DeSantis, L. (2007). Current approaches to integrating elements of cultural competence in nursing education. *Journal of Transcultural Nursing, 18*(1), 10–20.
- Loftin, C., Hartin, V., Branson, M., & Reyes, H. (2013). Measures of cultural competence in nurses: An integrative review. *Scientific World Journal, 2013*, Article ID 289101. doi:10.1155/2013/289101
- Long, T. B. (2012). Overview of teaching strategies for cultural competence in nursing students. *Journal of Cultural Diversity, 19*(3), 103–104.
- Lytes, C. R., Karter, A. J., Young, B. A., Spigner, C., Grembowski, D., Schillinger, D., & Adler, N. E. (2011). Correlates of patient-reported racial/ethnic health care discrimination in the diabetes study of Northern California (DISTANCE). *Journal of Health Care for the Poor and Underserved, 22*(1), 211–225.
- Puri, A., Kaddoura, M., & Dominick, C. (2013). Student perception of travel service learning experience in Morocco. *Journal of Dental Hygiene, 87*(4), 234–243.
- Shen, Z. (2004). Cultural competence models in nursing: A selective annotated bibliography. *Journal of Transcultural Nursing, 15*(5), 317–322.
- Thackrah, R., & Thompson, S. C. (2013). Refining the concept of cultural competence: Building on decades of progress. *Medical Journal of Australia, 199*(1), 35–38.