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# Cultural diversity: what do we fear?

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Address to come?

## ABSTRACT

Issues surrounding cultural diversity have taken on a new priority for the nursing in the 21st century, engendering considerable anxiety and reluctance to openly confront many of the issues that affect the profession: the provision of culturally competent care, educating nurses to be culturally competent, and accepting nurses from culturally diverse backgrounds. Despite claiming to value diversity, the profession has been either unable or unwilling to fully embrace diversity and respond to the challenges that it presents to nursing and to healthcare. If the profession is to move forward, it must confront these issues and the challenges that they present. This article addresses the fears related to acknowledging cultural differences, power and control, confronting complex racial issues, cultural competency, and acknowledging biases in research.

**Keywords**: cultural competency, cultural diversity, cultural differences, power and control, racism, research bias

## Introduction

Cultural diversity is a major issue in healthcare in the US because of demographic changes, which mean that services can no longer cater solely for a single, homogenous population. In some states such as ??, the white population is no longer the numerically dominant majority. These demographic changes present a major challenge for the nursing profession in providing culturally congruent care for all patients. Individual nurses have sought to address this challenge by instigating new approaches to educating students and staff (see for example Campinha Bacote, 2002; Purnell and Paulanka, 2004). However, considerable dissonance exists between the profession's philosophical beliefs and actual practices. Nursing, the caring profession, has demonstrated inconsistencies regarding its commitment to acknowledging and managing issues related to promoting cultural diversity within the profession. It continues to struggle with the question of how best to provide culturally competent care to diverse populations, increase the representation and acceptance of nurses from culturally diverse backgrounds and train all nurses in the skills required for culturally competent practice (Gonzales *et al*, 2000).

It is argued here that these inconsistencies arise from misplaced fear and misunderstanding of difference that have thwarted the profession's ability to fully embrace cultural diversity as a professional value. Fear of difference manifests as anxiety and reluctance to face certain persons or situations perceived as threatening or dangerous. To ensure cultural competency in nursing care, the profession must identify and confront these fears. This article discusses the factors that have affected the nursing profession's ability to embrace cultural diversity and respond to the challenges that it presents to healthcare and to the nursing profession.

## Cultural competency issues

Nurses generally take for granted that their education and experience have adequately prepared them to provide nursing care to any patient that they might encounter. They assume that they not only have the prerequisite knowledge and skills but also know what is best for their patients, whom they expect to accept their decisions without question. Encountering patients who are committed to their own cultural beliefs, and who demand that these be considered, can come as something of a shock and be experienced as a challenge to professional authority. Experiencing such challenges creates a sense of insecurity that increases the risk of misinterpreting, miscommunicating, labelling,

stereotyping or making negative judgments. Harmful complications and needless patient suffering can result, with both nurses and patients experiencing avoidance behaviour, feelings of alienation and fear (Villaruel, 1999).

Understanding and accepting a perspective that is different from one's own world view and lifeways can be threatening. Cultural norms and standards are deeply ingrained in all of us; we tend to take our world views for granted. Nurses and patients alike are products of their own cultures. The primary characteristics of culture include nationality, age, generation, race, colour gender, and religion. Secondary characteristics of culture include socio-economic status, educational status, military status, political beliefs, urban versus rural residence, enclave identity, marital status, parental status, physical characteristics, sexual orientation, gender issues, and reason for migration (Purnell and Paulanka, 2004). Given this range of factors, it is difficult to completely separate professional behaviours from the ethnocentric 'tendency for human beings to think that our own ways of thinking, acting, and believing are the only right, proper, and natural ones and to believe that those who differ greatly are strange, bizarre, or unenlightened' (Purnell and Paulanka, 2003, p. 4) that can affect the nurse's attitude, behaviour, and delivery of culturally competent care.

In the nursing literature, the term cultural competency describes the need for nurses to be prepared to integrate cultural concepts, knowledge, and skills into nursing practice (Campinha-Bacote, 2002; Purnell and Paulanka, 2004, Table 1). The concept of competence forms the framework for formulating guidelines aimed at improving healthcare for diverse patient populations. Competence in this context embodies the knowledge, attitudes, skills, and protocols that allow an individual to deliver care that is congruent with and affirming of the patient's values, cultural beliefs, and lifeways. It reflects a shift away from traditional notions of a continuum, in which competence is the antithesis of incompetence, towards one of ongoing development, a state of becoming in which the practitioner continuously strives towards working more effectively within the patients' cultural context. Thus the practitioner evolves through several stages from a state of unconscious incompetence, being unaware of how to act, to first becoming consciously incompetent. Conscious incompetence means that the practitioner is aware of cultural differences but may not know how to act appropriately or deliberately chooses to act in ways that demonstrate intolerance and make value judgments about others who are different. Recognising and detaching from one's cultural impediment and blind spots takes great effort and reflective examination of the self, but can lead the practitioner towards a greater understanding of differences and a willingness to meaningfully engage with those of diverse backgrounds. The experience of such engagement and the creative adaptation of practice helps the practitioner towards conscious competence, a state in which the individual can function appropriately with conscious effort. The final stage, unconscious competence, is that in which the practitioner can provide culturally appropriate care unselfconsciously. Achieving completely unconscious cultural competence is perhaps more of an ideal than a reality, in that in any healthcare setting the practitioner is likely to encounter a very wide range of different cultural traditions. However, the open-mindedness and willingness to learn enable the individual to grow, gradually increasing both the knowledge and skill required to meet the needs of culturally diverse patients.

**Box 1** A summary of the criteria for cultural competence

- 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 client's culture, health-related needs, and meanings of health and illness.
- Accepting and respecting cultural differences.
- Not assuming that the healthcare provider's beliefs and values are the same as the client's.
- Resisting judgmental attitudes such as 'different is not as good'.
- Being open to cultural encounters.
- Adapting care to be congruent with the client's culture. Cultural competence is a conscious process and not necessarily linear.

Summarised from Purnell and Paulanka, 2003, pp. 3–4.

## Acknowledging cultural differences

The apprehension that some nurses experience when discussing issues of cultural diversity is sometimes so extreme that it has caused factions within nursing that have the potential for immobilising the profession. Malone (1998) declared that cultural diversity is perceived as divisive, and the mere mentioning of the topic can lead to extreme polarisation. Discussions about cultural diversity and the issues surrounding it tend to make people uncomfortable because they challenge existing values, beliefs, attitudes, and behaviours. Terms such as 'prejudice', 'racism', 'discrimination',

'ethnic', and 'minority' can trigger negative responses that include anger and denial. Talking about issues that relate to cultural diversity is sometimes so painful and threatening that many avoid doing so (Gary *et al*, 1998), retreating into colour blindness (Villarruel, 1999; Campinha-Bacote, 2002), touting with pride their inability to perceive differences, and claiming to provide care to all people regardless of race, creed, or colour as if one size fits all (Clark and Robinson, 1999; Gary *et al*, 1998). Such behaviour betrays fear of cultural differences. It reinforces the values and norms established by the majority culture, while ignoring those of individuals from culturally diverse backgrounds.

Clinging to such values and norms is to ignore the way in which our society is changing. It represents a refusal to not only recognise these changes, but also to face up to the impact of cultural diversity on patients' experiences of healthcare and the ways in which these influence the effectiveness of interventions by professionals. Hiding behind timeworn excuses is no longer an option. As professionals, nurses must confront their fears and insecurities and begin to recognise that they too are cultural beings. Their beliefs, values, and patterns of behaviour can have a profound influence on patients generally, but are especially important when interacting with individuals from other backgrounds (Purnell and Paulanka, 2003, pp. 3–4).

## Cultural and racial issues in the workforce

Racism in American nursing has been a well-documented reality for more than a decade (see for example, Allen *et al*, 1988; Tullman, 1992; Wilson, 2002; American Nurses' Association, 2004; BBC News, 2004). Racism is a belief that inherent differences determine cultural or individual achievement, coupled with the idea that one's own race is superior and has the right to overrule others. Perceptions of racism, discrimination, prejudice, and inequality are a consistent underpinning presence in the healthcare setting and affect the manner in which people from different racial groups interact (Wilson, 2002; Minoritynurse.com, 2004). Attitudes, beliefs, and values based on race can influence the nurse's perceptions and professional behaviour. For example, Tullman (1992) observed that in the hospital, racism was apparent in the prejudicial and discriminatory behaviours of Caucasian nurses toward minority patients and toward minority nurses. Obviously, this is not representative of the behavior of all Caucasian nurses; however, there is substantial evidence that prejudice and discrimination is alive and well in the nursing profession contributing to mistreatment and inequality in nursing care (Wilson, 2002; American Nurses' Association, 2004).

Racism is a difficult topic to discuss because it is viewed by many whites as 'individual acts of meanness, not as invisible systems and patterns of interaction that silently confer dominance on a particular group' (McIntosh, 1989, p. 10). Thus whites, as members of the dominant group, subvert discussions about racism by claiming that it does not exist or exists as isolated individual events, and is therefore not an issue. Mentioning the terms ethnicity, minority, prejudice, and discrimination can evoke anxiety among whites because of their perceived association with racism. Avoiding the use of these terms and assuming a colour-blind perspective allows individuals to feel comfortable in denying racism (Barbee, 1993). Anyone who seeks to challenge this avoidance or raise concerns about racism runs the risk of being labelled as a racist or accused, if they are black, of playing the race card for bringing the subject up (Wilson, 2002).

Barbee (1993) suggested that nursing disguises its inability to confront the realities of racism, discrimination, and prejudice in the profession through its misuse of the term cultural diversity. She declared that any open discussion of racism in nursing would be acknowledgement that the rhetoric of caring had been violated. The struggle of working toward diversity and equality in nursing will continue as long as the profession ignores and denies the existence of racism, by attempting to incorporate it under discussions of cultural diversity. The American Nurses' Association (2004) argues that it is critically important for Americans to recognise the impact of discrimination on the health of minority populations and the health care system. Additionally, Watson (BBC News, 2004) cited similar concerns when she reported to the Royal Academy of Nurses that one of the most important challenges that they faced was to tackle the inequalities in nursing, challenge racism, and change the culture.

## Power, politics, and control

Power dynamics and reactions to them are a common cause of cultural conflict within an organisation (Gary *et al*, 1998; Clark and Robinson, 1999). Power is the ability to substantially influence someone else's behaviour. It includes the possession of considerable control or authority over others and the ability to wield force. Power differentials exist between nurses as well as between practitioners and patients.

At the professional level, power may be acquired through one's position within the organisation or through personal characteristics. Nurses who have positional power belong to the upper organisational

hierarchy as administrators, managers, or supervisors. These nurses generally have control over resources, information, the environment, task allocation, rewards, and punishment. In contrast, nurses with personal power are recognised for their friendliness, special skills, knowledge, and trust (Norwood, 2002). The US registered nurse workforce is composed of 86% Caucasian females (Bureau of Health Professionals, 2000). Nursing, the largest group of healthcare providers is culturally homogenous, reflecting the cultural values of the majority population of the US. The upper organisational hierarchy positions within nursing are primarily occupied by these nurses. Thus 'the highest positions in nursing belong to whites who are believed to be of superior intelligence and ability' (Tullman, 1992, p. 323). These nurses have been professionally socialised and educated to believe that the majority culture's perspective of nursing is appropriate for all patients, regardless of their unique cultural background and needs. Nurses of the upper organisational hierarchy may also accept the American melting pot paradigm that represents assimilation rather than acculturation. The dominance of a particular culture within the nursing workforce means that practitioners from culturally diverse backgrounds are expected to adopt and conform to the values, beliefs and practices of that culture, and to suppress their own.

Nurses from culturally diverse backgrounds are thus placed in a position of conflict, whether to conform to the professional norms or to those of their own cultures. Assimilation into a system that recognises the standards of the majority culture as the norm creates enormous challenges for these nurses that lead them to negatively interpret the organisation's actions and decisions as unfair, unjust, lacking in transparency – factors which can be detrimental to working relationships in the healthcare environment (Purnell and Paulanka, 2003).

Ironically, nurses who belong to the dominant majority may themselves experience challenges related to their fear of potential loss of power and control over nursing practice and the profession. In their view culturally diverse nurses who demonstrate high levels of competence and who challenge the hierarchical order, pose a threat to their decision making and positions (Purnell and Paulanka, 2003). Power dynamics and reactions to them are common causes of organisational conflict and problems and can occur when the power and authority of those in upper organisational positions are threatened (Norwood, 2002). Changes in the power dynamics in nursing can result in decreased homogeneity within the workforce and profession, which may intensify cultural differences and conflict. Nurses who have systematically denied the contributions of culturally diverse nurses, refused them career opportunities, or disregarded the need to provide culturally competent care to a diverse patient population, find that they now have to share their authority and power. They fear the loss of authority, security, status and power. These fears, real or perceived, must be addressed if the nursing profession is serious about promoting diversity in nursing.

## Bias in research

There is a need for culturally competent research that can guide culturally competent care for diverse populations. According to Villaruel (1999), the movement towards cultural competence in nursing research should be directed toward developing a cultural research base for nursing practice, recognising the inherent dynamics when cultures interact, and valuing and including a diverse perspective in the design of both practice and research. Through culturally competent research, nursing can expand its knowledge base and implement nursing care based on the values, beliefs, behaviours and practices of diverse populations.

Research tends to reflect the current socio-cultural environment. Therefore, all research carries with it cultural baggage. It is erroneous to assume that research approaches that are appropriate for the majority culture are applicable for culturally diverse groups. The design of research with culturally diverse populations should reflect an understanding of the cultural characteristics of the research participants. The research should examine and address relevant cultural issues throughout the research process.

Research approaches that suggest a bias toward the superiority of the majority culture are not culturally relevant. Biases in research can be manifested in the design, method, results, funding decisions, analysis, interpretation, and even the publication decisions (Gills and Jackson, 2003, pp. 298–304). Problem formulation, development of theoretical perspectives, selection of data collection instruments, and the analysis and interpretation of findings should be grounded in culturally sensitive ways of knowing (Wilson, 2002). Villarruel (1999) contends that the failure to examine differences or similarities between samples of majority and diverse populations, and the use of existing theories, instruments, and interventions, without validity and reliability testing with diverse populations, are research approaches that may represent bias. The interpretation of the study findings must be culturally relevant and reflect the world view of the participants. Findings that are biased or generalised to the norms of the majority culture can result in negative consequences and cause harm to patients (Villarruel, 1999). Nursing interventions based on these research findings have potential for placing serious limitations

on the nurse's ability to provide safe, effective and culturally relevant nursing care.

It is not easy for nurse researchers, who claim objectivity, to acknowledge that some nursing research reflects an underlying bias toward the superiority of the majority group. Even more difficult may be the acknowledgement that current theories and research paradigms do not adequately encompass or address the behaviours observed in culturally diverse populations (Gary *et al*, 1998). Nursing researchers are beginning to challenge traditional research approaches that do not consider the impact of culture and the participant's world view. They have documented the significance and need for such research. However, it is still difficult for some to consider the relevance of cultural diversity when conducting research with culturally diverse populations. The profession continues to struggle with how, and to what extent, to address issues related to cultural diversity and competence in nursing research. Villarruel (1999) cites progress in the areas of programme design and evaluation, research that focused on specific aspects of care for diverse populations, the development of programmes of research, and theoretical and methodological issues and approaches. Even though progress is evident, she stated regarding culturally competent research, 'we are not quite there but continue to make slow and steady progress' (Villaruel, 1999).

## Conclusion/recommendations

We are facing radical changes in the healthcare system that challenge us to provide culturally sensitive and appropriate nursing care and to make doing so a priority. Growing patient diversity has forced nurses, and all other healthcare providers, to view health, illness, and nursing care from many different perspectives. If we are to provide care to all people, it is imperative that we address issues related to caring for diverse patient populations.

Despite the conflict and tension that may accompany issues of cultural diversity, nurses must confront their fear of acknowledging that cultural differences exist. They must also commit to considering these differences when providing nursing care to all patients. In order to change nursing practice it is recommended that all nurses be educated to understand the cultural perspective of others. As nurses increase their understanding and knowledge of other cultures, they are more likely to provide culturally competent care. Additionally, the nursing profession must assure the training of all nurses to conduct cultural assessments and to adapt their nursing care to become congruent with identified cultural needs and preferences. Purnell's Model for Cultural Competence (Purnell and Paulanka, 2004) provides a framework for learning, understanding, and conducting cultural assessments. The model includes the metaparadigm concepts of global society, community, family, and person. The organising framework consists of 12 cultural domains and their associated concepts, which are common to all cultures. This model can be used by a variety of disciplines in clinical practice, education and research.

Barbee (1993) argued that we should confront and explore racism, and form alliances to alter existing power relationships. A high level of self-awareness, including values and beliefs regarding racism, is essential to developing cultural competence. All nurses must explore their own values and beliefs about racism, and commit themselves to combating racial inequalities in nursing. Combating racial inequalities will be impossible if nurses do not openly acknowledge that some form of racism exists within the nursing profession and that it affects nursing practice.

Both student and practising nurses need the opportunity to learn about cultural diversity and express their concerns in supportive environments. To accomplish this, it is recommended that:

1 nursing curricula require specific courses that address issues of cultural diversity and competency. These courses should include discussion of racial attitudes of nurses, self-examination, and the effect of racial and cultural issues on patients and other nurses
2 in the workplace, the nursing profession provides cultural diversity education to staff, administration, faculty, and students. Employees must receive general and culturally specific information regarding the population for whom they serve. The employee's annual evaluation should reflect the achievement of specific behavioural outcomes related to cultural diversity. The organisation can demonstrate cultural competence by ensuring that its mission, policies and communications acknowledge and address cultural diversity (Purnell and Paulanka, 2003)
3 the nursing profession recognises registered nurses from culturally diverse backgrounds as a valuable resource for educating other nurses to improve intercultural awareness, communication and culturally competent care. These nurses should occupy positions within the nursing organisation where they can teach their nurse colleagues about important aspects of care for diverse patient populations. They might also serve as cultural brokers, representing the patient's cultural perspective and needs to other healthcare providers. Cultural brokers may also serve as mentors or preceptors to assist culturally diverse nurses to adjust to the workforce (Purnell and Paulanka, 2003)

4 registered nurses from culturally diverse backgrounds are included in decision-making positions within the organisation's hierarchy. One suggestion would be to include these nurses in the recruitment and selection process as well as on retention and promotion committees
5 research related to issues of cultural diversity and competency continues. Also recommended is that in addition to the valuable descriptive studies, nursing scholars begin to conduct more intervention studies. Of equal importance is the need to continue to develop guidelines for conducting culturally competent research.

If the profession is to move forward, it must prepare and demand that all nurses provide culturally competent care to all patients. Nurses must recognise the importance of culture in the delivery of nursing care. They must abandon their ethnocentric perspective and accept perspectives that may be different from their own. They must be able to recognise their own biases and ethnocentric beliefs, which shape their world view and affect how they approach patients from diverse populations.

The nursing profession cannot continue to ignore the many challenges that cultural diversity presents. Even though nurses are beginning to address a number of the issues related to cultural diversity, they must directly confront the many fears, such as confronting racism, acknowledging differences, loss of power and control, and biases in research, that keep them from embracing it as a professional value. The profession must decide if it truly values cultural diversity in nursing enough to openly embrace it and consider it vital at all levels of nursing practice, administration, education, and research.

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## CONFLICTS OF INTEREST

None.

## ADDRESS FOR CORRESPONDENCE

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