Cultural Diversity Training: The Necessity of Cultural Competence for Health Care Providers and in Nursing Practice

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Abstract

The purpose of this article is to discuss the need to provide culturally sensitive care to the growing number of diverse health care consumers. A literature review of national standards and research on cultural competency was conducted and specifically focused on the field of nursing. This study supports the theory that cultural competence is learned over time and is a process of inner reflection and awareness. The domains of awareness, skill, and knowledge are essential competencies that must be gained by health care providers and especially for nurses. Although barriers to providing culturally sensitive care exist, gaining a better understanding of cultural competence is essential to developing realistic education and training techniques, which will lead to quality professional nursing practice for increasingly diverse populations.

DEMOGRAPHIC SHIFTS IN the United States are occurring in record proportions. According to the 2010 US Census, Hispanics/Latinos are the largest minority group residing in the United States. In addition, it is estimated that by 2050 minorities will represent more than half of the total population (54%) in the United States (US Census Bureau, 2010).1 According to the US Census Bureau Population Estimates Program, 98% of all US residents belong to 1 of 5 single racial groups. Single racial groups refer to individuals who self-identify as being part of only 1 race. These include white, black or African American, Asian, American Indian, Alaska Native, and Pacific Islander populations. The remaining 2% of the total population includes those who identify with 2 or more single-race categories.[1]

While diversity in populations has steadily increased, so have challenges for health care providers and recipients of health care. Communication styles, cultural differences, explanatory styles, and interpreter services are several areas that require attention in providing care for diversified populations. According to the US Census Bureau, as of 2007, 20% of people in the United States spoke a language other than English in the home. Diversity and linguistic challenges have become increasingly complex. Not only is there lack of understanding of how culture may determine patients' perspectives of health or illness, but also reviewing details of health or illness in a culturally appropriate linguistic manner may escape the provider and leave much to misinterpretation.

The purpose of this article is to discuss the need for cultural diversity training and competency evaluation. A review of the literature recommends health care providers and specifically for nurses to demonstrate competencies in cultural assessment through ongoing education and training to recognize diversity of populations in order to provide culturally sensitive care to the increasing number of diverse health care consumers.

BACKGROUND AND THE NEED FOR CULTURAL DIVERSITY TRAINING

Culture is defined as values, beliefs, customs, traditions, patterns of thinking, norms, and mores of an individual or populations.[2] Learned behaviors, ideas, and perceptions are passed down through generations. Cultural beliefs frame our thinking, decision making, and perceptions of life. Culture determines where we see ourselves in the family setting, for example, as sister, brother, eldest, youngest, matriarch, or patriarch. Along with family order, there are further culturally determined definitions as to which roles are assumed within the family order. As unique as ethnic cultures may be, additional cultural norms exist within any given ethnic groups. Generational attributes define cultures that may be different within the same family. Not all of those within a single ethnic group may share like customs or religious beliefs. Therefore, the health care provider may face challenges when treating several members of 1 family consisting of several generations. The provider needs to be skillful in eliciting a health history that is accurate and communicate a plan of care in a culturally sensitive way.

Especially in Hawaii, its multicultural setting provides an opportunity to observe the blend of western and eastern health care practices. There are 9 prominent ethnicities

in the state of Hawaii. They include white (25.3%), Hawaiian/part Hawaiian (22%), mixed (except Hawaiian 19.3%), Japanese (16.5%), Filipino (11.3%), Chinese (3.2%), Black (0.9%), Samoan/Tongan (0.8%), and Korean (0.6%).3 The challenges of cultural diversity revolve around linguistic differences, verbal/nonverbal communication, and multigenerational differences. Superstitions passed down through families can be as prominent today as in years past. Health care advice given by someone outside a patient's own culture may be viewed with suspicion. Although Hawaii has a large Asian population, 32%, each ethnicity within Asian culture is different in beliefs and lifestyle. Moreover, even within the same cultural group, responses to and acceptance of health care can vary depending on generation and environment.[3]

The US Department of Human Services, Office of Minority Health (OMH), completed a detailed report named Setting the Agenda for Research on Cultural Competency in Health Care, with the final version published in August 2004. The document was developed to examine how cultural competency affects health care delivery and health outcomes.[4]

Specifically, cultural competence is defined using the descriptions from the Culturally and Linguistically Appropriate Services (CLAS) standards and the definition from Cross.

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. "Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. "Competence" implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.[5]

Leininger and McFarland[6] define cultural diversity as variables or differences in care beliefs, meanings, patterns, values, symbols, and life ways. These variables exist between individuals and cultures. This array of variables can increase the chances for miscommunication between providers and patients. Salimbene[7] emphasizes that health care providers need to be knowledgeable of different health care perceptions,

including an awareness of their own perceptions, as well as those of their patient populations.

Governmental agencies have recognized the need for cultural diversity education within the health care field. The US Department of Health and Human Services through the Office of Public Health and Science and the OMH has partnered with the Agency for Health care Research and Quality to examine cultural diversity and competence. The project Setting the Agenda for Research and Cultural Competency in Health Care was initiated to examine components of cultural competence, to determine what is accomplished by being culturally competent, and to measure the impact of this competence on the delivery of health care and health outcomes.[5]

In 1998, the OMH sponsored the development of the National Standards on CLAS. There are 14 standards divided into 3 major themes, Culturally Competent Care, Language Access Services, and Organizational Supports for Cultural Competence.[4] The need to provide culturally and linguistically appropriate services was apparent to the OMH. Existing guidelines were incomplete and fragmented. Without comprehensive guidelines, health care providers did not have a direction on the best way to treat culturally diverse patients and ensure the best outcomes. Recognition of the need for national standards prompted development of a national focus for CLAS standards. The final form was published in the Federal Register in 2000 with recommendations for all stakeholders including health care organizations, health communities, and health care providers.[4]

The Institute of Medicine report Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2003) directs attention to minorities and quality of care. The report states that minorities receive lower quality of care even when controlling for insurance, comorbidity, education, and socioeconomic status. The report further recognizes that disparities are complex within health care systems.[8]

A follow-up report One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations was published in 2008 by Wilson-Stronks et al.[9] The goal of this report was to further explore procedures and references for hospitals to meet the needs of diverse populations with attention to their own facilities. Wilkes-Stronks et al [8] report there is no-one-size-fits-all solution, and the complexity of the problem requires all health care stakeholders' attention.

A common theme exists for hospitals and health care providers to move forward in becoming culturally competent. Understanding the overall complexity of diverse cultures and ongoing training is essential. Although there is not a one-size-fits-all answer to increasing diversity and increasing cultural competence, themes relating to self-assessment, learning, and acceptance of cultural similarities and differences have been addressed by many experts in the field of health care and anthropology such as William Harvey from the University of Virginia, Dr Madeline Leininger, and Dr Yolanda Moses from the University of California. Guo and Castillo [10] developed a framework for guiding health care organizations and professionals by establishing a set of culturally competent strategies to improve quality of care and patient outcomes for diverse populations. They identified communication and monitoring and feedback as key components in the provision of culturally competent care.

The American Medical Association and American Nurses Association have joined the Institute of Medicine and The Joint Commission in recognizing the need for cultural diversity and competency training for health care professionals.[11] Cultural and linguistic competence is not only required of the seasoned professional. There has been a specific undertaking by the US Department of Health and Human Services to build upon the present curricula in nursing and medical schools. Although training in areas of cultural competency, diversity, race relations, and ethnic sensitivities has been in existence for 30+ years, the renewed emphasis has targeted institutions of education such as medical and nursing schools. The requirements, expectations, and prospects of curricula devoted to cultural diversity vary greatly.[12-14] This will be further discussed in the literature review to show various definitions, theories, and recommended frameworks are needed to educate health care workers so that they can become more culturally competent.

LITERATURE REVIEW

The literature review included scholarly books, journal articles, research documents, governmental publications, and research documents. Specifically, Internet research databases such as Ovid, CINAHL, Ovid MEDLINE, PubMed, and ERIC were searched. The literature is abundant with recommendations for educating health care workers on becoming culturally competent. There is a common theme among the theories. Cultural competency begins with knowing oneself first before building upon acceptance of others. In addition, the literature recognizes that cultural competency is

more than learning terms and observing different cultures. To be congruent with differing cultures, knowledge and acceptance, as well as openness to lifelong learning, must be included.

Campinha-Bacote [15] originally identified 4 domains for her model of cultural competence. They included cultural awareness, cultural knowledge, cultural skill, and cultural encounters. A fifth construct, cultural desire, was later included in the model. The first construct, cultural awareness, refers to understanding oneself and how culture is influential and how the world is viewed and biases developed. The second, cultural knowledge, incorporates understanding another's situation and belief system. Campinha-Bacote [15] refers to this as seeking knowledge of differing word views and becoming knowledgeable of biological ethnic differences. Differences can influence how medication is absorbed and reactions to different medications and herbs. Other biological attributes that are specific to ethnicity include genetics and hereditary conditions such as Mediterranean or thalassemia anemia.

Campinha-Bacote [15,16] describes cultural skill as the ability to collect cultural data that is applicable and significant for that particular patient. Perceptions of health and illness are viewed differently by each individual. She recommends that health care providers select assessment tools that gather information on the patient's beliefs and values. Understanding a patient's perception of their illness and beliefs surrounding treatment needs to be approached in a sensitive manner.[15,16] Cultural encounters and cultural desire are the last 2 constructs in Campinha-Bacote's [16] model. She believes there is more variation among groups than across groups. Realizing this becomes important when reviewing what is known or thought to be known for different cultural groups. She explains that health care providers should have varied encounters to help prevent stereotyping. Finally, Campinha-Bacote et al describe [17] cultural desire as wanting to engage in the process of cultural competence. As the most recently added construct to Campinha-Bacote's model, cultural desire is described as motivation and the desire to work with diverse populations. Most importantly, Campinha-Bacote et al [16-18] promote the concept of genuine caring that can be transferred to a patient from the health care provider. Without cultural desire, the other constructs of skill, awareness, knowledge, and encounters remain incomplete in the journey toward cultural competence.

Giger et al [19] further explain that structures for each cultural group have different importance and play a role in decision making regarding health care. Health care providers need to be aware that family members in cultures such as Mexican, Samoan, and Hawaiian actively participate in the care of the patient. With many family members at the bedside, this cultural trait can often upset hospital personnel. Nuclear families may be expanded to include nieces, nephews, and cousins. The matriarch or the patriarch (mother, father, grandmother, or grandfather) may well be the decision maker on health issues and communication, not the actual patient.[19] Campinha-Bacote et al [16,17] stress that cultural assessments need to be done for everyone, not only for those cultures unknown to the health care provider. All patients deserve to be treated and assessed in a culturally sensitive manner. Eliason and Macy [20] warn against stereotyping and grouping such as cultures. Social groups may be structured in several ways. Cultures can vary within cultures by gender, age, and religion.

Purnell and Paulanka [21] believe respect and acceptance do not happen immediately but rather constitute a process of becoming culturally aware. The range of awareness may be classified in a number of categories: unconscious incompetence (lack of awareness of cultural differences), conscious incompetence (aware of knowledge deficit for cultural competence), conscious competence (health care worker consciously seeks information regarding a patient's culture but is not comfortable caring for diverse patients), and unconsciously competent (ability to automatically provide culturally congruent care).[21]

Cross-cultural encounters and immersion programs are suggested as paths to develop awareness, knowledge, and desire to become culturally competent. A component in cross-cultural interactions is the integration of language. Jones et al [22] studied a cultural immersion project with American health care workers and a Mexican population. The project included living with Mexican families and learning Spanish. Although the project lasted only 1 week, the authors believed the immersion provided valuable knowledge and communication skills for the health care personnel. Subtleties in cultural communication styles such as gestures, engaging in small talk, tone of voice, and eye contact can influence how providers receive and distribute information to patients. An example includes that of the Hawaiian culture, where "talking story" asking about the family and small talk prior to conducting a health assessment is expected in engaging open communication.[22] Another example is asking where the health care provider is from, which is not intended as a physical location inquiry. A

culturally correct answer would be to describe where your parents live, including uncles and aunts, as the question is not about where you live but instead about your family and background. Awareness of the intent of the communication can greatly assist providers in obtaining and giving health information.

Nursing and cultural competence

Literature on research studies that examined cultural competence in nursing, nursing education, medicine, medical education, demographics, and transcultural nursing was reviewed for this study. There are several nursing scholars who have devoted their research to the field of nursing and anthropology, focusing on cultural diversity and competence. Transcultural nursing was first identified and named by Leininger [23] in 1950. Leininger [23] developed the Theory of Cultural Care Diversity and Universality, the first among culturally centered nursing theories. She argued that the key to providing good care is to individualize care to converge with the patient's cultural beliefs. The theory emphasizes discovery of what is universal, or commonalities, and what is diverse regarding human care beliefs. Leininger [23] predicted that minority groups would continue to increase and that culturally specific care would become an expectation for each health care encounter. As a leader in the field, she recognized and identified the challenges that exist in educating culturally competent health care professionals. Leininger [23] noted nurses were not able to provide culturally competent care because they lacked such education in their curricula because of inadequate faculty expertise in this area. Ryan et al [24] conducted a study of transcultural nursing concepts and practices in nursing curricula across the United States. A descriptive survey was sent to all baccalaureate and higher-degree National League of Nursing schools.[24] Six hundred ten surveys were sent with 217 or a 36% response rate. The surveys were sent to deans and directors of the nursing schools. The respondents indicated that incorporation of educational modules has been and is occurring. However, many schools did not have the expert resources available. In order to educate culturally competent student nurses, there needs to be consensus among nursing educators and leaders as to appropriate curriculum content and how best to ensure nursing educators can provide instruction to students.[24]

Transcultural nursing has provided guidance and definition to the importance of culture and its role in health care. The Transcultural Nursing Society, founded in 1974, declares in its mission statement "[horizontal ellipsis]The mission of

Transcultural Nursing Society is to enhance the quality of culturally congruent, competent, and equitable care that results in improved health and well-being for people worldwide."[25] In 1988, the first issue of the Journal of Transcultural Nursing was published, with Leininger as the editor.

Ryan et al [26] conducted a study on the effect of cultural immersion as an experiment with 9 nursing students. The intent was to investigate how the experience would enrich their culture experience, to provide feedback on the experience, and to examine the social interactions that occurred during it. The study revealed students identified early the resources needed for support, such as faculty and other group members, which helped them to properly prepare for the experience. Increased communication, thinking differently, adaptation, and an improved awareness of the importance of cultural awareness and competence were major findings.26 The authors asserted that cultural immersion experiences can provide an important component in nursing curricula. The hands-on experience affords a clear view into other cultures that cannot be acquired by only reading about backgrounds different from the students' own.[26]

Jeffreys [27] describes her model of Cultural Competence and Confidence as the interrelating of concepts that influence or predict the learning of cultural competence. She further explains a leading factor is the construct of transcultural self-efficacy (TSE) or confidence. Transcultural self-efficacy is differentiated from cultural competence in that TSE is perceived confidence in transcultural nursing skills. The learning process is key. The TSE is inclusive of cognitive, practical, and affective descriptions, which are not stagnant and can change over time.[27] Formal education, training, and experience contribute to any changes that may occur.

Jeffreys [27] refers to Bandura's [28] social cognitive theory, in which learning and motivation are influenced by self-efficacy perceptions. Those with strong self-efficacy perceptions think and act differently from those considered inefficacious or overly confident. Jeffreys [27] advises that use of the Transcultural Self-efficacy Tool can be helpful in differentiating these 2 groups. She cautions that self-efficacy as a predictor of cultural competence can be difficult to verify. This is due to self-reporting, which can have errors in verification. She recommends using a valid measurement tool to measure competence so that interpretation errors may be avoided.[27]

Papadopoulos et al [29] published the PTT (named after the authors) model for developing cultural competence. The model begins with cultural awareness in which the practitioner examines personal beliefs and values. The next stage, cultural knowledge, is necessary to bridge the gap of understanding variations and similarities of cultures in order to avoid stereotyping. Cultural sensitivity, in which the development of trust, respect, and empathy are fostered, leads to the final stage, cultural competence. This final stage is identified by assessment and diagnostic and clinically focused culturally competent care. Papadopoulos et al [29] further recommend that nurses be required to challenge discrimination and inequalities in health care actively as part of increasing cultural competence.

Some researchers suggest that cultural competence is a process rather than an outcome. While in-service and workshops are valuable, becoming culturally competent is an ongoing process and based on self-reflection of one's many experiences.[30]

DISCUSSION

The literature shows that to provide appropriate care for diverse populations in the United States patient care providers need knowledge, skill, culturally diverse experiences, and ongoing education. The education should begin in nursing and medical schools and continue throughout professional practice.

Just as important for patients to have a clear understanding of their health condition, nurses from different cultures may have differing beliefs surrounding health and health care. These differences can result in conflict with fellow health providers as well as patients. At present, there is not a consensus on how best to provide an educational strategy for cultural competence. Experts, however, do agree on the importance and value that a culturally competent health care worker can bring in providing quality of care and positive outcomes. The Joint Commission identifies patient safety as a priority in health care settings. Patients will not follow health care recommendations if time and patience have not been used in explaining the need for the treatment or medication. It may take additional time to explain to culturally diverse patients and family members why certain medications are ordered and how to administer medications. Many cultures will use traditional healing techniques advised

by their elders. This may include herbal remedies and practices that could cause serious interactions with current Western treatments.

The US Department of Health and Human Services OMH continues to recommend development and updating of cultural competence standards.[4] The Liaison Committee on Medical Education has recommended development of culturally competent medical education standards. The American Academy of Nursing and the American Association of Colleges of Nursing offer direction for schools of nursing to incorporate culturally competent curricular development.[19] For instance, Cueller et al [31] developed "Blueprint for Integration of Cultural Competence in the Curriculum" for undergraduate nursing curriculum, where they outlined a number of learning objectives that focused on cultural competence for each year in the nursing program. In freshman year, nursing students should have foundation knowledge of diversity. By sophomore year, students are expected to understand the theme of health disparities. At the end of junior year, students gain comparative knowledge of national health disparities and special, at-risk populations. By senior year, nursing students should be able to analyze cultural diversity issues and synthesize knowledge and skills needed as practicing nurses. They recommended the use of case studies, discussions, role play, community panels, and debates as teaching strategies for incorporating cultural diversity in the nursing curriculum. Nevertheless, they agree that it is extremely challenging to incorporate content related to cultural competence in an already very full nursing curriculum.[31] In fact, many nursing educators do not feel confident or comfortable teaching cultural competence content.[32] Thus, the need to transform nursing education is imperative. Currently, there is a huge gap between what is being taught and what needs to be learned. As diversity increases, making cultural competence a priority relies on expanded roles of leaders in nursing schools to be willing to take risks and develop a strategic plan that integrates cultural diversity in the nursing school curriculum.[33]

Recommendations for further study

Based on the literature review, this study supports the theory that cultural competence is learned over time and is a process of inner reflection and awareness. The domains of awareness, skill, and knowledge are essential competencies that must be gained by health care providers to provide care to diverse populations.[18] Health care providers must develop sensitivities to a diverse cultural community and demonstrate

competency. However, there are many challenges to providing culturally competent care. These include inadequate diversity in workforce and poor communication with health professionals and patients.[10] Furthermore, health care employers often lack resources to provide culturally and linguistically appropriate services. Some of these include not having enough interpreters for diverse patient populations and inadequate understanding of health literacy and cultural norms essential for the populations served.[34] As a result, miscommunication often occurs between providers and patients that lead to patient dissatisfaction and poorer health outcomes.[35]

While the federal government and nursing and medical school programs have provided guidelines to advance education and training, there still remains inadequate attention, knowledge, and consistency to improving various educational programs. Although this study has shown the importance of cultural competence and the necessary training techniques that are important for providing culturally competent care, this is only the first of several qualitative and quantitative studies to better understand cultural competency in nursing programs. Specifically, recommendations for nursing faculty will be made to help health professionals acquire expertise and embrace the value of cultural diversity and skills necessary to providing quality and culturally competent care. Additional studies are necessary to investigate the levels of cultural education needed in nursing programs and strategies to evaluate changes in cultural competence. This will aid in future curriculum development and evaluation of nursing programs so that nursing graduates will be trained to fully understand the needs of diverse patients and be able to provide culturally competent care.

CONCLUSION

Understanding cultural competence is more than just knowing the concept or its definitions. For health care professionals to be culturally competent, this means having the knowledge, skills, and tools to practice, as well as being dedicated and committed to the ongoing process of providing culturally competence care. This is especially so for nurses who may be the first health professional encountered by patients. Currently, many challenges exist because of the static nature of health care, diversity in patient populations, and uniqueness of various cultures. Although these barriers to providing culturally sensitive care exist, gaining a better understanding of cultural competence is essential to developing realistic education and training

techniques, which will lead to quality professional nursing practice for increasingly diverse populations.

REFERENCES

1. US Census Bureau's Population Estimates Program (Dynamic Version) [population profile of the United States], Washington, DC; 2010.
2. Cross. Towards a Culturally Competent System of Care. Washington, DC: Georgetown University Child Development Center. Original work published 1989 (1st ed, Vol 1).
3. Health Trends in Hawaii: A Profile of the Health Care System. 7th ed. Honolulu, HI: Published by HMSA Foundation; 2006: 12-30.
4. US Department of Health & Human Services: Office of Minority Health. Final report. In: IQ Solutions, ed. National Standards for Culturally and Linguistically Appropriate Services in Health Care. Rockport, MD: Department of Health and Human Services, OPHS; 2001: 25-109.
5. Fortier J, Bishop D. In: Brach C, ed. Setting the Agenda for Research on Cultural Competence in Health Care. Rockville, MD: US Department of Health and Human Services Office of Minority Health; 2003.
6. Leininger M, McFarland M. Transcultural Nursing, Concepts, Theories, Research, & Practice. 3rd ed. New York: 2002 Original work published 1978.
7. Salimbene S. Cultural competence: a priority for performance improvement action. J Nurs Care Qual. 1999; 13(3): 23-35. Ovid Full Text ExternalResolverBasic Bibliographic Links
8. Institute of Medicine, Committee on understanding, & eliminating racial and ethnic disparities in health care. In: Unequal Treatment. Confronting Racial and Ethnic Disparities in Healthcare. National Academy Press, ed. Washington, DC: Department of Health and Human Services; 2004.
9. Wilson-Stronks AM, Lee K, Codero C, Kopp A, Galvez E, The Joint Commission. One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations. 2008. http:www.jointcommission.org/PatientSafety/HCL/. Accessed September 1, 2008.
10. Guo KL, Castillo RJ. A framework for cultural competence in health care organizations. Health Care Manag. 2011; 30(3): 205-214.

11. US Department of Health and Human Services. Cultural Competency in Medical Education: A Guidebook for Schools. Washington, DC: Health and Human Services Administration; 2004. www.hrsa.gov. Accessed October 28, 2008.
12. Caudron S. Training can damage diversity efforts: ineffective programs can do more harm than good. Personnel Journal. 1993; 72: 50-61. ExternalResolverBasic
13. Henson HT. Gauging the Outcomes of Organizational Diversity Implementations: The Intersection of Attitudes, Awareness and Behavior [doctoral dissertation]. Des Moines, IO: Drake University; 1998.
14. MacDonald H. The diversity industry. New Republic. 1993; 209: 22-25. ExternalResolverBasic
15. Campinha-Bacote J. The process of cultural competence in the delivery health services: a model of care. J Transform Care. 2002; 13(3): 181-184.
16. Campinha-Bacote J. The Process of Cultural Competence in the Delivery of Healthcare Services: The Journey Continues. Vol. 3. Cincinnati, OH: Transcultural C.A.R.E. Associates; 2007. Original work published 1998.
17. Campinha-Bacote J, Yahle T, Langenkamp M. The challenge of diversity for nurse educators. J Contin Educ Nurs. 1996; 2(1): 31-34. ExternalResolverBasic
18. Campinha-Bacote J. Cultural desire: 'caught' or 'taught'? Contemp Nurse. 2008; 28 (1-2:) 141-148.
19. Giger J, Davidhizar RE, Purnell L, Harden JT, Philips J, Strickland O, et al American Academy of Nursing Expert Panel Report: developing cultural competence to eliminate health disparities in ethnic minorities and other vulnerable populations. J Transcult Nurs. 2007; 18: 95-102. ExternalResolverBasic Bibliographic Links
20. Eliason MJ, Macy NJ. A classroom activity to introduce cultural diversity. Nurse Educ. 1992; 17(3): 32-36. ExternalResolverBasic Bibliographic Links
21. Purnell L, Paulanka B. Transcultural Health Care: A Culturally Competent Approach. Philadelphia, PA: F. A. Davis Company; 1998.
22. Jones ME, Bond ML, Mancini ME. Developing a culturally competent work force: an opportunity for collaboration. J Prof Nurs. 1998; 14(5): 280-287. ExternalResolverBasic Bibliographic Links

23. Leininger M. Cultural Care Diversity & Universality: A Theory of Nursing. New York: National League for Nursing Press; 1991. Original work published 1991.
24. Ryan M, Carlton KH, Ali N. Transcultural nursing concepts and. experiences in nursing curricula. J Transcult Nurs. 2000; 11(4): 300-307. ExternalResolverBasic Bibliographic Links
25. Transcultural Nursing Society. Mission statement. 2002. http://www.tcns.org/. Accessed October 11, 2008.
26. Ryan M, Twibell R, Brigham C, Bennet P. Learning to care for clients in their world, not mine. J Nurs Educ. 2000; 39: 401-408.
27. Jeffreys MR. Teaching Competence in Nursing and Health Care. 1st ed. New York: Springer Publishing Company, Inc; 2006. Original work published 2006.
28. Bandura A. Social Foundations of Thought and Action: A Social Cognitive Theory. 1st ed. Englewood Cliffs, NJ: Prentice Hall; 1986.
29. Papadopoulos I, Tilki M, Taylor G. Transcultural Care. A Guide for Health Care Professionals. Wiltshire: Quay Books; 1998.
30. Bednarz H, Schim S, Doorenbos A. Cultural diversity in nursing education: perils, pitfalls, and pearls. J Nurs Educ. 2010; 49(5): 253-260. ExternalResolverBasic Bibliographic Links
31. Cueller NG, Brennan AW, Vito K, de Leon Siantz ML. Cultural competence in the undergraduate nursing curriculum. J Prof Nurs. 2008; 24(3): 143-149.
32. Starr S, Shattell MM, Gonzales C. Do nurse educators feel competent to teach culturally competency concepts? Teaching and learning in nursing. 6(2): 84-88.
33. de Leon Siantz ML. Leading change in diversity and cultural competence. J Prof Nurs. 2008; 24(30): 167-71. ExternalResolverBasic Bibliographic Links
34. Castillo RJ. Culture and Mental Illness: A Client-Centered Approach. Pacific Grove, CA: Brooks/Cole; 1997.
35. Betancourt JR, Green AR, Carrillo JE. Cultural Competence in Health Care:. Emerging Frameworks and Practice Approaches. New York: The Commonwealth Fund; 2002.