DYNAMICS OF DIVERSITY

Becoming Better Nurses through Diversity Awareness

By Marianne Jeffreys

Every day, nurses make a positive difference in human lives by providing high quality health care. But now, in the 21st century, nurses are providing that health care within an increasingly multicultural and global society.

Doctor Madeleine Leininger, founder of the field of transcultural nursing, says that providing culturally competent—that is, culturally *specific*—nursing care must be customized to fit with the patient's own cultural values, beliefs, traditions, practices, and lifestyle (Leininger, 2002; Leininger & McFarland, 2002, 2006). Quality health care can only occur within the patient's cultural context. Also, we must create workplaces that embrace diversity among healthcare professionals and that seek to promote multicultural workplace harmony and prevent multicultural workplace conflict. Both of these endeavors begin with diversity self-awareness and diversity awareness.

Diversity Awareness vs. Diversity Self-Awareness

Diversity self-awareness occurs when we reflect on our own cultural identity, realize our own cultural values and beliefs, and recognize the differences within our own cultural group(s). *Diversity awareness* refers to an active, ongoing conscious process in which we recognize similarities and differences within and between various cultural groups. Diversity assessment necessitates cultural assessment of patients and cultural sharing among healthcare professionals. Assessment and sharing should aim to maximize health outcomes and facilitate multicultural workplace harmony and collaboration. Diversity awareness is most comprehensive when we recognize how the range of similarities and differences may influence the plan of care and professional collaboration:

"Diversity may exist based on birthplace, citizenship status, reason for migration, migration history, food, religion, ethnicity, race, language, kinship and family networks, educational background and opportunities, employment skills and opportunities, lifestyle, gender, socioeconomic status (class), politics, past discrimination and bias experiences, health status and health risk, age, insurance coverage and other variables that go well beyond the restrictive labels of a few ethnic and/or racial groups" (Jeffreys, 2006).

Is Diversity Awareness Really that Important for Patient Care?

Ignoring diversity and providing culturally incongruent nursing care can adversely affect patient outcomes and jeopardize patient safety. Let's consider a nurse who has some knowledge of transcultural nursing but lacks self-confidence about performing cultural assessments and avoids them. In this case, the nurse administers insulin and then leaves a tray of culturally forbidden foods with a diabetic patient. This nursing action is culturally incompetent and negligent. The patient will not eat the food. Even if a new tray is ordered, the time between insulin

administration and eating will be delayed. Health outcomes will be adversely affected. Additionally, cultural pain (psychological stress that occurs from culturally inappropriate actions), is emotionally stressful and also affects the metabolic rate and insulin needs (Leininger,1991; Leininger & McFarland, 2002; 2006). This potentially fatal situation could have been prevented by conducting a cultural assessment and accommodating the patient's cultural values into the plan of care.

Equally negligent is a nurse who does not assess patients for folk medicine use. Imagine a patient who regularly uses herbal teas with ginseng at home and has brought them with her to the hospital. Later the nurse administers the heart medication digoxin. Use of ginseng in conjunction with digoxin can result in drug toxicity and death. Again, this culturally incompetent and dangerous situation could have been prevented by culturally sensitive and competent nursing actions. Lack of transcultural nursing knowledge and avoiding cultural care assessments when planning and implementing care can have devastating consequences.

Overly confident nurses who think they do not need to learn and conduct routine cultural assessments can cause similarly devastating results. For example, making assumptions based on a patient's physical appearance rather than performing an individualized cultural assessment can cause cultural pain and set up long-lasting barriers in communication and care. Let's consider a nurse who provides a patient in the coronary intensive care unit with a booklet in Spanish entitled "Mexican Foods for Heart Health" and a booklet on "Free Health Service Resources for Non-U.S. Citizens" to a multiethnic bilingual (English and Spanish-speaking) patient who self-identifies as second-generation Puerto Rican and Italian American. These nursing actions are grossly inappropriate. Cultural insensitivity can cause the patient cultural pain and anguish, resulting in stress, elevated and irregular heart rate, high blood pressure, and other physiological manifestations that will adversely affect patient outcomes. Such effects could subsequently lead to a second heart attack with potentially fatal consequences. If discharged home, the patient may be reluctant to return for follow-up appointments due to the culturally insensitive care he received.

Malpractice cases today may involve issues concerning cultural incompetence. Patients and family members often win settlements because culturally specific health care was not provided, resulting in physical or emotional injury. **Cases of wrongful institutionalization or prolonged hospitalization of patients demonstrating severe side effects of certain medications should alert staff to screen patients' ethnic and genetic background**. For example, Hispanics, Arabs, Asians, and African Americans may require lower doses of psychotropic medications (such as antidepressants)

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than the commonly published recommended doses (Andrews & Boyle, 2002). The growing field of ethnopharmacology documents genetic differences in how drugs are metabolized among various ethnic groups (Munoz, C. & Hilgenberg, 2005; Purnell & Paulanka, 2008). It is important to differentiate between the many subgroups within the broad ethnic/racial categories to avoid stereotypical assumptions and to recognize ethnic-specific pharmacogenetic differences. Differences in response to certain asthma drugs between Mexicans and Puerto Ricans is one example attesting to the need for more research and detailed cultural assessments (Burchard, et al, 2004; Choudhry, et al, 2005).

Diversity Awareness in the Workplace

Diversity awareness also applies to healthcare professionals and other co-workers. Everyone belongs to one or more cultural groups. Additionally, it is important to acknowledge that diversity is ever changing, not static. Changes can occur within and between groups over time or individuals (and groups) can belong to different groups at different times. For example, beginning nursing students are challenged to learn the culture of nursing education and the nursing profession within the context of the cultural norms and expectations of a nursing student. Leininger (2002) refers to this as enculturation within the nursing profession. Similarly, a new graduate must make a transition to the new culture of the profession as a graduate nurse (and later as a registered nurse) as well as to the new organizational culture of the healthcare institution and the cultural nuances of a particular nursing unit. Hence, individuals belong to numerous diverse groups that have their own unique norms, values, and behaviors; yet some may be overlapping or similar.

Without appropriate diversity awareness, background knowledge, individual appraisal, and sensitivity, nurses' interactions with co-workers may adversely impact the workplace environment, collaboration, and patient outcomes. Consider the following scenarios:

- Lee is a new graduate nurse who emigrated from China three years ago prior to attending an associate degree nursing program in the United States. She graduated with a 3.5 GPA and passed the NCLEX exam on the first attempt. Her mastery of the English language in such a short time is remarkable, although she speaks with a heavy (but understandable) accent. The charge nurse assigns Lee to a Korean patient (who only speaks Korean) and says, "I am sure you will have no trouble communicating with your fellow immigrant."
- Carol is a 38-year-old, Irish American nurse who attended a technical college for nursing five years ago as part of the state's welfare-to-work program. She is a widowed parent of a 20-year-old, an 18-year-old, and a 3-year-old. During the weekly multidisciplinary patient-care rounds, a colleague comments about a 27-year-old single female patient with Medicaid insurance who was admitted for her third high-risk pregnancy and a history of sickle-cell anemia. The colleague says, "Once someone's on public assistance, they never get off. They just get pregnant again and never want to work."
- During the weekly patient care conference, the staff discusses a patient who was traveling back to his Navajo reservation when he was involved in a bus accident. During discharge planning, one

Developing our own cultural competence and assisting other health professionals in our cultural competence development is a priority in the multicultural workplace.

Multicultural Workplace COMPETENCE

CARING sincerely about one's own and co-workers' cultural values, and beliefs (CVB) is the first step towards developing multicultural workplace competence

ONGOING diversity awareness and sharing of CVB among co-workers fosters a workplace climate that openly embraces diversity and encourages dialogue

MULTIDIMENSIONAL aspects of multicultural workplace competence include cognitive (knowledge), practical (communication skills), and affective (attitudes) dimensions

PROACTIVE cultural dialogue and sharing among co-workers opens up discussion, decreasing the risk of unintentional cultural mistakes, pain, and conflict

ETHICS and patient advocacy underscore the need for multicultural workplace collaboration based on research, theory, personal, and clinical experience

TRUST is an essential component for building multicultural workplace harmony that begins with self-disclosure and demonstrated respect for diverse values

EDUCATION for developing cultural competence must include formal formats such as continuing education, college courses, and/or an advanced certificate program*

NETWORKING with experts in various cultures will assist one in becoming more culturally competent with patients and more culturally sensitive with co-workers

CONFIDENCE for cultural learning and initiatives should be realistic, avoiding overconfidence and low confidence behaviors

EVALUATION appraisal of strategies implemented and learning outcomes achieved provide guidance for future innovations within multicultural workplace settings

* Baccalaureate, masters, and doctoral prepared registered nurses interested in the mainly online Advanced Certificate Program in Cultural Competence (Three courses offered for either graduate college credit or continuing education at the City University of New York College of Staten Island) should contact the admissions office at **nursingmasters@mail.csi.cuny.edu** or (718) 982-2019.

nurse says, "We usually don't get Indian patients here. It's too bad that we don't have an Indian nurse working on our unit." Joseph, a registered nurse who self-identifies as a Black Indian (African American and Cherokee ancestry) says, "I'm Native American. We have had patients who are of Native ancestry." The first nurse answers, "Well, I was talking about a real Indian. You don't look and act like a real Indian." Joseph defensively replies, "What does an 'Indian' look like? How does an 'Indian' act?"

- During change of shift report, Elsa provides succinct and accurate details about every patient, including strategies for accommodating patient cultural needs within the care plan. Because Elsa is reporting to Margaret, an older, more experienced nurse, Elsa has minimal direct eye contact with Margaret. Within Elsa's culture, it is considered respectful to avoid eye contact with people of authority or older persons. Margaret's cultural values and beliefs strongly advocate direct eye contact at all times; avoidance of direct eye contact during communication is viewed as a sign of distrust. After report, Margaret tells one of her co-workers "I just can't trust the report that Elsa gives. It's extra work to check up on everything she said."

Promoting Multicultural Workplace Competence

Legal and ethical principles demand that all health professionals provide culturally competent care or face charges of negligence and malpractice. Culturally competent care begins with a thorough cultural assessment that is routinely integrated within the health assessment. Assessment, planning, implementing and evaluating culturally competent care requires active, learning-based theoretical support, research evidence, and collaboration. Collaboration will be most effective in an open, caring workplace environment that embraces a broad view of

Without appropriate diversity awareness, background knowledge, individual appraisal, and sensitivity, nurses' interactions with co-workers may adversely impact upon the workplace environment, collaboration, and patient outcomes. Consider how the following scenarios may result in adverse effects.

diversity and actively encourages diversity awareness and cultural sharing among staff members.

Developing our own cultural competence and assisting other health professionals should be emphasized in new employee orientations, ongoing in-service educational programs, and staff meetings. Other strategies include: inviting guest speakers on cultural issues and cultural competence; purchasing educational resources to enhance staff's cultural competence; and reimbursing tuition for courses in transcultural nursing and cultural competence (Jeffreys, 2008). Providing high quality, culturally competent care within a work environment that facilitates workplace harmony enhances the probability of career and workplace satisfaction-desirable rewards for any nurse. New graduates seeking employment should explore whether these opportunities are available in prospective workplace settings.

The acronym of "COMPETENCE" can assist you in remembering several essential elements for developing multicultural workplace competence (See sidebar on page 40). COMPETENCE refers to Caring, Ongoing, Multidimensional, Proactive, Ethics, Trust, Education, Networking, Confidence, and Evaluation. Details about each essential element specific to patient care may be found in Jeffreys (2006b).

Providing culturally competent nursing care is vital to continue constructing the most positive changes. In a constantly changing world, we must reach out to demand the highest quality of health care by embracing diversity and disseminating principles that will continue to promote harmony and prevent multicultural conflict. Through diversity awareness and diversity self-awareness these goals are within that reach.

references

Andrews, M. M. & Boyle, J. S. (2002). *Transcultural concepts in nursing care*. (4th ed.). Philadelphia: Lippincott Williams & Wilkins.

Burchard, E. G.; Avila, P. C.; Nazario, S.; Casal, J.; Torres, A.; Rodriguez-Santana, J. R.; et al. (2004). Lower bronchodilator responsiveness in Puerto Rican than in Mexican subjects with asthma. *American Journal of Respiratory Critical Care Medicine*, 169, 386-392.

Choudhry, S.; Ung, N.; Avila, P. C.; Ziv, E.; Nazario, S.; Casal, J., et al. (2005). Pharmacogenetic differences in response to albuterol between Puerto Ricans and Mexicans with asthma. American Journal of Respiratory Critical Care Medicine, 171, 563-570.

Jeffreys, M. R. (2008). *Advanced Certificate Program in Cultural Competence*, Unpublished document.

Jeffreys, M. R. (2006). *Teaching Cultural Competence in Nursing and Health Care: Inquiry, Action, and Innovation*. New York: Springer.

Jeffreys, M. R. (2006). Cultural competence in clinical practice. *Imprint*, 53(2), 36-41.

Leininger, M. M. (1991). *Culture Care Diversity and Universality: A Theory of Nursing*. New York, NY: National League for Nursing.

Leininger, M. M. (2002). Essential transcultural nursing care concepts, principles, examples, and policy statements. In Leininger, M. M. & McFarland, M. R.(Eds), *Transcultural Nursing: Concepts, Theories, Research, and Practice* (3rd Edition). New York, NY: McGraw-Hill, 45-69.

Leininger, M. M. & McFarland, M. R. (2002). *Transcultural Nursing: Concepts, Theories, Research, and Practice* (3rd Edition). New York, NY: McGraw-Hill.

Leininger, M. M. & McFarland, M. R. (2006). *Culture Care Diversity and Universality: A Worldwide Nursing Theory* (2nd Edition). Boston, MA: Jones and Bartlett.

Munoz, C. & Hilgenberg, C. (2005). Ethnopharmacology. *American Journal of Nursing*, 105(8), 40-49.

Purnell, L. D. & Paulanka, B. J. (2008). *Transcultural Health Care: A Culturally Competent Approach*. (3rd Edition). Philadelphia, PA: FA Davis.

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