

Of Goldfish Tanks and Moonlight Tricks

Can Cultural Competency Ameliorate Health Disparities?

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Within nursing, cultural competency is seen as an important mechanism for reducing racial and ethnic health disparities; however, after years of attempted implementation of “cultural competence,” minimal evidence exists demonstrating a relationship between culturally competent interventions and improved health outcomes or reduced disparities. We examine how cultural competency as an intervention for tackling health disparities is undertheorized and misguided, and deflects attention and efforts needed to address broader social determinants of health. We provide a historical overview of cultural competency, critiques of the concept, and recommendations for moving beyond cultural competency as a means of diminishing health disparities. **Key words:** *cultural competency, culturally competent care, culture, health disparities, nursing practice*

...cultural competence [is] illustrated by the [following]. . . . In the center of the waiting room . . . is a fish tank. It improved the atmosphere, officials thought, helped patients relax.¹

IN today's healthcare climate, 2 theoretical perspectives juxtapose one another: health disparities and cultural competence.* Cultural competence is understood as an important tool to advancing care delivery and enhanc-

ing patient outcomes.² An element of improving these patient outcomes is using cultural competence to address the racial and ethnic disparities in health so evident in US morbidity and mortality statistics.^{3,4} Although there seems to be general agreement that cultural competence and health disparities are important concepts for healthcare professionals, moving from these theoretical models to practice interventions is challenging.

We are particularly interested in the application of cultural competence as there is an explicit mandate within the discipline of nursing for evidence-based practice, that is, for implementing interventions that have demonstrated effectiveness when scientifically tested. However, when practice encompasses culturally competent care, this mandate has gone virtually unheeded. Despite the lack of evidence demonstrating that culturally competent care improves patients' health status, it continues to be promoted as a mechanism to reduce racial and ethnic health disparities.⁵

Although the discipline has focused on culturally competent care for more than 20 years, with more recent links to tackling health

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*Although cultural safety shares similarities with cultural competency, this article is limited to examining cultural competence/competency.

disparities, there is limited agreement on what constitutes this approach from either theoretical or practical perspectives. More importantly, despite decades of attending to the diversity of healthcare clients, little has changed in terms of health disparities, particularly for racial and ethnic groups. We contend that using cultural competency to address health disparities constitutes an activity that is oversimplified, undertheorized, and, ultimately, an undertaking that is not likely to succeed given that any practitioner who hopes to ameliorate health disparities by providing culturally competent care faces the nearly insurmountable task of overcoming the formidable workings of power that keep structural disparities in play and in place.

In this article, we offer a historical overview of cultural competence in nursing in the United States, a critique of cultural competence as a device to lessen health disparities, bring new insight into the role of cultural competency in the discipline, and offer suggestions about improving the health of underserved and marginalized populations beyond using cultural competence. We begin with the origins of cultural competence and the various ways in which *culture* and *cultural competency* are defined within the nursing discipline.

CULTURE AND CULTURAL COMPETENCE

Any discussion of cultural competence requires an initial explication of the meaning of *culture*. In nursing in the United States, variations of Leininger's definition are the most common: "the learned and transmitted values, beliefs, and practices that provided a critical means to establish culture care patterns from the people."^{6(p9)} The *Oxford English Dictionary*⁷ refers to culture as the "civilization, customs, artistic achievements, etc. of a people." In general, culture denotes the whole product of an individual, group, or society of intelligent beings. It includes technology, art, science, as well as moral systems and charac-

teristic behaviors and habits of the selected intelligent entities.

Contemporary definitions encompass the notion that culture cannot be separated from human activity. When culture is considered part of one's everyday existence, understanding the inherent complexities and nuances that exist within a cultural system becomes difficult. How is it possible then to target care that addresses *all* activities taken up by individuals, groups, and societies? Despite the enormity of this task, some within nursing have argued that understanding an individual's cultural perspective is critical to providing quality healthcare.^{5,6} This is not a point of contention; we agree that *individuals* most likely benefit from care that acknowledges cultural differences. We argue, however, that healthcare disparities exist at a population level, and therefore require broader theoretical acknowledgment of structural processes and practices of power.

Cultural competence beginnings

During the 1960s and 1970s, when issues of difference were coming to the fore in the United States through such actions as the civil rights and women's rights movements, health researchers began to gain a new awareness of cultural issues and the significance diversity held for education, healthcare, and employment practices. The 1970s were a time rife with a new consciousness of existing inequalities and discriminatory practices that were institutionalized within larger societal policies and endeavors.

The primary nursing theorist addressing cross-cultural issues in the United States during this time of radical change was Leininger, whose work served to establish the Transcultural Nursing Society. Leininger's efforts introduced a revolutionary new concept for nursing: awareness of cultural differences. She argued that with such an awareness came the obligation for nurses to provide health services in a manner that acknowledged, understood, and respected cultural differences; this obligation could and should be met by applying principles of cultural competence.

Numerous nurse authors have suggested a range of cultural competency definitions. Some understand cultural competence as various combinations of cultural knowledge, skills, sensitivity, attitudes, and encounters,⁸ whereas others see it as a discrete construct of transcultural nursing care.⁶ Leininger, who considers culturally congruent care analogous to cultural competence, offered the following definition: “the use of sensitive, creative, and meaningful care practices to fit with the general values, beliefs, and lifeways of clients for beneficial and satisfying health care, or to help them with difficult life situations, disabilities, or death.”^{6(p12)} For St. Clair and McKenry, cultural competency denoted “nurses’ ability to achieve ethnorelativism so as to work within the cultural context of patients.”^{9(p230)} Betancourt et al,¹⁰ applying cultural competence to healthcare systems, consider such a system as addressing culture, cultural knowledge, and cultural differences. Having defined the concept, efforts to link the idea of cultural competency to practice ensued.

Models of cultural competence

The next step in the cultural competency trajectory was determining how to best apply the concept to practice through development of cultural-competence models. The foundational nursing model for culturally competent care is Leininger’s theory of Culture Care Diversity and Universality.¹¹ The purpose of this theory was to uncover, describe, and explain some of the various factors that influence care from both inside and outside a particular culture, with the goal of providing culturally competent care.⁶

With Leininger having laid the groundwork for linking culture to nursing practice, additional frameworks followed. The *Culturally Competent Community Care Model* of Kim-Godwin et al¹² includes cultural competence, healthcare system, health outcomes, cultural sensitivity, cultural knowledge, cultural skills, and caring as key components. Giger and Davidhizar’s *Transcultural Assessment*

*Model*¹³ offers 6 cultural factors (communication, space, social organization, time, environmental control, and biological variations) to take into account during assessments, whereas *The Process of Cultural Competence in the Delivery of Healthcare Services*¹⁴ consists of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. In 2002, Purnell proposed the *Model for Cultural Competence*,¹⁵ which encompasses 12 cultural domains to be used in assessment and practice. In the same year, Narayanasamy¹⁶ described the ACCESS model for transcultural healthcare practice, with ACCESS serving as an acronym for Assessment, Communication, Cultural negotiation and compromise, Establishing respect and rapport, Sensitivity, and Safety. Thompson-Robinson’s¹⁷ conceptual framework for providing culturally competent care in public health consists of systems, subsystems, and context. Finally, Schim and colleagues¹⁸ recently presented their model of cultural competency, *3-dimensional Puzzle Model of Culturally Congruent Care*. Analogous to a 3-dimensional jigsaw puzzle, it contains outcomes for measuring cultural competence at both provider and client levels. These cultural competence models fostered the creation of new tools to measure model constructs.

Tools to measure cultural competence

Through the assorted cultural competency models, crucial aspects of culture were formed and named. Once culture became an objective list of facts (ie, the essential constructs of cultural competence), the next step was to determine how to apply those facts to the provision of healthcare services. As part of that process, researchers generated tools to measure cultural competence. Today, a number of cultural competency self-assessment tools exist, including the Inventory for Assessing the Process of Cultural Competence Among Health Care Professionals,¹⁹ Program Self-Assessment for Cultural Competence,²⁰ and Cultural Competence Self-Assessment Questionnaire.²¹ Although many of these

authors have pointed out the limitations of these instruments, including reliance on self-report and their almost exclusive focus on race and ethnicity, promotion of their use in practice continues unabated.

Although it is evident from this brief literature review that the concept of cultural competence is a prominent feature of the discipline, the ability to move the concept from theory to practice has proven to be more difficult, particularly in terms of demonstrating the effect cultural competence has on patient health. More importantly, cultural-competence models reinforce the discipline's focus on individuals, rather than on population-level efforts to decrease disparities. In the following section, we provide an overview of how nursing has formally endorsed and attempted to implement cultural competence into practice.

CULTURAL COMPETENCE IN NURSING PRACTICE

A dominant focus of healthcare in the 21st century is the recognition given to the multicultural global society and concomitant calls for culturally competent care.²² Culturally competent care serves as a criterion for healthcare quality by the Joint Commission (www.jointcommission.org), the National Committee on Quality Assurance (<http://web.ncqa.org>), the American Medical Association (www.ama-assn.org), and the US Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services for Health Care (CLAS) (www.omhrc.gov). The CLAS standards are identified frequently in cultural competency literature and advise healthcare agencies to have a diverse healthcare staff, to offer cultural competency training, and to provide language-assistance services, among others.

Similarly, many in nursing also assume that cultural competency is the "right" thing to do and advocate integrating cultural competence into nursing practice.²³ Three recognized US nursing organizations have promoted cultural

diversity and cultural competence: the Council on Nursing and Anthropology, the Transcultural Nursing Society, and the American Nurses' Association (ANA) Council on Cultural Diversity in Nursing Practice. In addition, cultural competence is enshrined in various official documents such as the ANA's *Code of Ethics*. Cultural competence appears internationally as well. For example, the Canadian Nurses Association has a position statement on culturally competent care²⁴ and it is also part of nursing competencies outlined by the Australian Nursing Council.²⁵

A common Western ideology is that "culturally congruent health care is a basic human right, not a privilege, and therefore every human should be entitled to it."^{26(pixiii)} There are repetitive appeals for nurses to provide culturally competent care as "there is no longer a question of whether cultural care is needed."^{27(p688)} In essence, health-care providers have produced legal, ethical, and moral obligations for providing culturally competent care. Given these imperatives, it is not surprising that efforts to extensively promote cultural competency within nursing practice have been attempted. However, these efforts have shown limited success.

Determining whether cultural competency "works"

Despite the increased attention on cultural competency, there are relatively few cultural competency interventions noted in the literature that have been tested and demonstrate positive results. Although an extensive review of the literature was conducted, only 1 study was found in which a culturally competent intervention showed a positive impact on health outcomes. In this example, Foley and Wurmser²⁸ discussed how to better respond to the needs of Orthodox Jews entering their care system through development of multicultural competencies. Using Leininger's culture care modalities, the community hospital made changes to accommodate the cultural group's particular religious needs (eg, dietary accommodations and places for worship on

hospital grounds). The authors attributed an increase in the percentage of out-of-hospital births by Orthodox Jewish women from less than 1% to nearly 10% to the hospital becoming “more culturally responsive.”^{28(p127)} They did not, however, explicate the relationship between being “responsive” and any improved mother or infant outcomes.

Other cultural competency interventions have shown less success. For example, Schlickau and Wilson²⁹ reported on the development and testing of a culturally appropriate breast-feeding education intervention targeted to Hispanic women. Despite determining Hispanic women’s breast-feeding beliefs, attitudes, and practices in a pilot study and designing the intervention based on those findings, results revealed that there were no significant differences between intervention and control groups in terms of duration of breast-feeding. The authors hoped that by repeating the intervention in a larger sample, they could reach statistical significance, but noted, “the unique mix of persons who make up the Hispanic population presents a challenge for health-care professionals,”^{29(p32)} suggesting that the “challenge” is ingrained within the Hispanic population rather than in the cultural competency efforts of healthcare professionals.

Anderson et al³⁰ reviewed 5 interventions used to promote cultural competence. Guided by the CLAS standards, these interventions encompassed using bilingual providers and interpreter services, recruiting and retaining diverse staff members, training for cultural competency, putting together health education materials that were linguistically and culturally appropriate, and developing culturally specific healthcare settings. The researchers found few studies in which interventions to improve cultural competencies were compared with usual care. Those that did provide some evaluation component determined that either no differences existed between intervention and control groups, or intervention patients reported greater satisfaction with care or were more likely to make return appointments, none of which mea-

sured actual improvement in patient health outcomes.

Although Kavanagh et al² stated that cultural competence results in “nursing care that is sensitive to issues of diversity and employs culturally-appropriate nursing theory, models, and research principles,”^{2(p12)} what little evidence that does exist focuses primarily on providers’ self-evaluation of their own cultural competence. The literature reiterates that “incorporating cultural competence in practice . . . improves quality and health outcomes,”^{31(p12)} yet reports of interventions demonstrating a relationship between cultural competency and patient outcomes in the practice setting are extremely rare. Foley and Wurmser’s²⁸ description of hospital changes directed toward Orthodox Jews is the only report located that specifically linked cultural competence to patient outcomes. It is important to note, however, that the in-hospital birth rate differences in their study were described anecdotally and not demonstrated through an intervention study. Despite this overwhelming lack of evidence, the call for developing cultural competence continues. Cultural competence is now seen as a means to closing the health disparities gap.

Cultural competence interventions and health disparities

Although the growing numbers of diverse groups and populations serve as the primary motive for endorsing cultural competence, some additional reasons include improving the quality of health services, meeting legislative mandates, gaining a competitive edge over other healthcare services’ competitors, and eliminating racial and ethnic health disparities.³² For these reasons, many institutions and organizations include cultural competence as part of their mission statements, have initiatives devoted to cultural competence, and/or have offices specifically designated to focus on the needs of minority populations. Given the plea from theorists, researchers, policy leaders, and governmental agencies to conduct culturally competent

care, ongoing efforts are directed toward "proving" that culturally competent interventions have a positive effect on health, with special emphasis on health disparities.

Given the minimal evidence supporting the effectiveness of culturally competent interventions in general, it is not surprising that few studies have demonstrated the usefulness of culturally competent interventions in ameliorating health disparities. Beach and colleagues³³ analysis of interventions targeting disparities in healthcare quality for racial/ethnic minorities found only 27 studies that met analysis inclusion criteria. Of these, only two were designed specifically for racial/ethnic minority patients and only one³⁴ addressed reducing health disparities. The analysis determined that while some strategies were promising and had the potential to improve healthcare quality, the evidence with respect to decreasing health disparities was very limited. In fact, in the only study that actually addressed health disparities, interventions designed to enhance the quality of depression care, did not demonstrate any improvements in terms of health outcomes for African Americans and Latino patients.³⁴

Brach and Fraser's³⁵ review of the cultural competency literature in relation to health disparities found that cultural competency activities were not connected to measurable outcomes, the disparities examined were minimally identified, and strategies needed to reduce or eliminate disparities were insufficiently detailed. A range of activities was usually associated with improving cultural competency, including provision of interpreter services, recruitment and retention of minority staff, training efforts, and cultural immersions. The authors' response was to incorporate these activities into another new model that they claimed could reduce disparities. Despite their own desire to develop another cultural competency model, Brach and Fraser³⁵ pointed out that interventions do not necessarily have to be culturally competent to be successful. We, therefore, question the need or rationale for another model when

the authors themselves do not equate cultural competence with successful outcomes.

Betancourt et al¹⁰ also offered a new model for applying cultural competency measures to address racial and ethnic health disparities. They specified 3 broad categories of sociocultural barriers to care for racial/ethnic groups: (1) *organizational*—lack of minorities in leadership positions and in the general healthcare workforce; (2) *structural*—lack of interpreter services, long waiting times; and (3) *clinical*—interactions between provider and patient. Their proposed framework would increase the numbers of minorities in the healthcare professions, create new healthcare systems that address cultural competence, and provide educational initiatives that give healthcare professionals the skills to care for diverse populations. As with Brach and Fraser's³⁵ model, this model is at the proposal stage and remains untested. More importantly, none of the identified barriers address issues of poverty, institutionalized racism, violence, or healthcare insurance—some of the larger institutional and environmental structures that often contribute to health disparities.

Overall, discussions of cultural-competence interventions have been limited to the issue of language, particularly in terms of language access or interpreter support.³⁶ In addition, patient outcomes have been restricted to process and survey tools, usually directed toward patient satisfaction or provider self-assessments. For example, a publication on cultural competence issued from the US Department of Health and Human Services Bureau of Primary Health Care¹ illustrated advancing cultural competence through the example of a clinic that, using principles of Feng Shui, installed a fish tank in the clinic's waiting room. Even if the health center's Chinese patients felt more welcomed and were more satisfied with services received "post-tank", we doubt goldfish and other "culturally appropriate" efforts are "panaceas for health disparities."^{37(p545)} Once again, this example demonstrates how cultural competence as presently practiced

attends to individual rather than population needs.

REEXAMINING THE CULTURAL COMPETENCY CRITIQUE

Critique of culture and cultural competency is not new. In general, these critiques note that cultural competency overgeneralizes, reinforces stereotypes, treats culture as something static, and is devoid of historical context.^{37,38} In the next section, we briefly examine some of the critiques of cultural competency that have been offered over the past 15 years.

Multiple meanings of cultural competency

Leininger asserted that the goal of transcultural nursing is “to provide culturally congruent, competent, and compassionate care.”^{39(p342)} She also suggested that “culturally constituted care” contributes to “the health and well being of people, or to help people face death and disabilities.”^{39(p342)} Are these forms of “cultural care” different? If not, what is the purpose of multiple terms? The culturally competent care literature is “saturated with confusions and ambiguities over terminology; such ambiguities constitute an ongoing handicap,”^{40(p447)} which may limit the usefulness of cultural competence as a mechanism to realistically address health disparities.

Also at issue is the impact such vague meanings have for accountability in nursing practice. For example, the following can all be found in the nursing literature: *culturally competent care*, *culturally congruent care*, *culturally specific care*, and *culturally constituted care*. Although these terms are by now familiar to most readers, some have asked how cultural competence can be used to develop interventions that address health disparities when a clear definition of the construct does not exist? Often used interchangeably or in concert in the literature, care that is attached to *culturally* can have various in-

terpretations. It therefore becomes difficult to hold nurses accountable for providing culturally competent care if it is not clear what such “care” is within the practice setting.

Finally, if, as the Bureau of Health Professions⁴¹ asserts, “no single definition of cultural competence is yet universally accepted . . . in practice,” how can nurses be held responsible for providing culturally competent care when agreement as to how this care is delivered does not exist? According to McKinnon,⁴² a theory in which the nurse is not held liable for the quality of patient care constitutes a major limitation of the theory. Although cultural competence is not a theory per se, it is similar to a theory in that cultural competence is considered the foundation on which care to particular groups has been built. To assume that culturally competent care can be part of the plan to “redress health disparities,”^{5(p96)} without a mechanism for ensuring responsible nursing practice, is naïve at best, dangerous at worst.

If one accepts that culture is a part of everyday existence, then understanding each person’s cultural perspectives seems important. Yet, the tendency within healthcare has been to equate culture with race and ethnicity, thereby limiting culture to those identified as members of particular racial and ethnic minority groups as illustrated by the following 2 examples. For the Bureau of Health Professionals,⁴¹ recipients of culturally competent care are patients from a particular ethnic or racial group. Similarly, the Institute of Medicine⁴³ focused its 2003 health disparities report on ethnic and racial groups that are disproportionately affected by the burden of disease and death. These narrow conceptualizations of culture are confined to persons primarily with visible or audible markers that denote them as *different* from white populations: dark skin, accents, and recognizable surnames, to name a few. Creating a situation in which only those *recognized* as being different from some unstated norm have “culture,” works against understanding culture as encompassing a broad range of human activities. This type of “othering” also makes it easy

to avoid examining differences among nurses themselves or those within the larger, dominant white culture.⁴⁴

The discipline of nursing has also participated in this narrowing of who “has” culture. Another example of equating race and ethnicity with culture is nursing guides to cultural competence in which select groups are featured.⁴⁵ By focusing primarily on racial and ethnic minority groups, these guides reinforce existing dominant beliefs that by virtue of their skin color, “whites” do not have a culture. Culture is simply not simple—defining it in an uncomplicated way leads to practices that separate culture from its social, economic, and political context while perpetuating ingrained binaries of us—whites—in opposition to them—racial and ethnic minorities. These binaries are particularly dangerous in the context of the nurse-patient relationship in which most white nurses are caring for their “other” clients.

Cultural competency and checkoff lists

A second area of critique has focused on how cultural competence is inscribed in nursing practice. According to Gray and Thomas, a cultural competence approach assumes that culture “can be simplified and then managed as other kinds of content in curricula or in practice—as a body of knowledge to be gained via lists of facts, and then applied to those who are defined as different.”^{38(p81)} Culture, however, is not a “thing” that is found but “constructed in the process of doing something else.”^{46(p96)} That “something else” often consists of nursing practice directed by cultural checklists and guidelines. The consequences of such lists are that inventory characteristics of healthcare beliefs of Haitians, for instance, construct what constitutes the “essential” Haitian. Nurses do the easy work of turning to these lists, rather than the more difficult work of interacting with the population groups themselves, for “cultural” knowledge.

Another example of the effect inventory lists have on identity is Haupt’s⁴⁷ use of a tool called Diversity Bingo. The game, de-

signed for increasing diversity awareness in educational settings, consists of descriptors of various individuals (eg, “A person who is a naturalized citizen”^{47(p242)}) written on bingo card spaces. Students then are asked to locate fellow students who they believe fit the descriptor and write the individual’s name in the appropriate box, figuratively and effectively restricting the individual to that particular space. Activities such as these not only circumscribe an individual’s identity, but also create someone who is always seen as “not me,” an “outsider.”

Dreher and McNaughton contended that although knowing about a particular culture may help providers understand clients’ behaviors so that clients are not termed “pathological, it does not allow us . . . to make assumptions about their behavior clinically.”^{22(p183)} As nurses, we have conceptualized culture as sets of unchanging beliefs and behaviors,²² often relying on a select few cultural representatives to tell us about the beliefs and behaviors of millions of people from similar backgrounds. As Samad, a character in Zadie Smith’s novel *White Teeth*, pleads:

If ever you hear anyone speak of the East . . . withhold your judgment until all the facts are upon you. Because that land they call ‘India’ goes by a thousand names and is populated by millions, and if you think you have found two men the same among that multitude, then you are mistaken. It is merely a trick of the moonlight.^{48(p85)}

Consequently, a narrowed view of diverse and often heterogeneous groups of people becomes integrated into nursing practice as task-based competencies and cultural checklists that allow nurses to “bypass the need to engage with the knowledge that underpins the experience and personal choice”^{49(p150)} of patients and their families. In the end, it is much easier for nurses to use checklists for certain ethnic and racial groups than to engage in meaningful, albeit difficult and uncomfortable conversations, especially given time and language limitations.

Culture, when identified through cultural competency training or the bedside checklist,

becomes an obstacle for nurses to work around and deal with, rather than a useful mechanism for providing care. For example, Galanti wrote that one of the benefits of learning about culture was that it can “ease some of the burdens of caring for patients from different cultures.”^{50(p97)} What is it like, echoing DuBois,⁵¹ for a group of people to be known as a “burden”? In the end, culture becomes a catchall category that explains all types of beliefs and behaviors, and in so doing distracts providers from paying attention to the many complex social factors that create and maintain those beliefs and behaviors.⁵²

Culturally competent care has been rendered the responsibility of individual practitioners and institutions. Through various cultural competency trainings, programs, and workshops, there is a feeling that once criteria are met and one is certified as being culturally competent, any obligations to those perceived as culturally “different” are satisfied. Distracted by obligations associated with becoming culturally competent, nurses have little time or energy to attend to larger societal factors that contribute to health disparities. Part and parcel of ignoring health determinants is failing to “address the dynamics of the practitioner-client relations within specific sociopolitical contexts.”^{40(p443)} The power that influences and surrounds these nurse-client relationships cannot be ignored if health disparities are to be eliminated. This leads to the final critique: inattention to power dynamics between nurses and patients within the healthcare system, as well as those acts of power within the nation as a whole.

The role of dominance and difference

We tend to forget that the models developed to attend to cultural difference are often created by dominant, privileged individuals.⁵³ Historically, it has been nursing leaders and educators, operating from predominately white, hegemonic perspectives, who have initiated and promoted the majority of the directives for professional nursing,⁵⁴ including those specific to cultural competence. Cul-

tural and diversity models used in nursing ignore colonizer and colonized histories, the role of resistance against colonial impulses, and the ways in which “these strategies reproduce dominance and maintain the purported ‘neutrality’ of the ‘scientific West’ to generate descriptions of ‘Others’.”^{53(p2)} Persons labeled as “other” are categorized primarily according to how their differences from the societal norm are perceived. Their “otherness” is signified by their relational differences; when compared with the “ordinary,” “usual,” and “familiar” attributes of persons, they appear “different,” “exotic,” other.⁵⁵

What we learn about “them,” assumes, of course, that cultural groups have stable identities and cultural needs that we ought to acknowledge, understand, and address.⁴⁹ Yet, “culture is not . . . fixed, finished or final. . . . Culture is constantly made and re-made—ever changing, fluid and shifting.”^{49(p148)} Cultural hybridity* tells us that identity is contested, complex, and transformative. There never really existed a world in which racial or ethnic groups were constituted by permanently fixed boundaries—it is something we romanticize about, much as we do about many so-called “nostalgic” concepts, such as community. As the poet T. S. Eliot penned: “neither arrest nor movement. And do not call it fixity, Where past and future are gathered.”^{56(p15)} Fixities are limiting, fictions, merely inventions of a discipline looking for easy answers to the complex.

A culturalist perspective entails the dominant group deploying *and* disregarding power. Creating difference involves categorizing—a human activity, a social accomplishment that mandates constructing borders and determining the attributes of border residents.⁵⁷ Through such performances, the performers (usually members of the dominant group) “can be fictitiously

*Cultural hybridity is not without its critiques; however, hybridity gives us a place to start in moving beyond the essentialist practices inherent to the language of culture and cultural competency.

maintained as a homogenous, unafflicted and normal group of people,^{38(p79)} while dominant group values are reinscribed in the interventions designed by members of the same dominant group. Since these performances and actions are acts of power,⁵⁷ dominant groups are at liberty to overlook how these acts of power affect others. Viewing disparities from a narrow cultural framework is less intimidating as it ignores the roles of power, discrimination, and class operating within larger societal structures, organizations, and practices.⁵⁷ Ultimately, those who are marginalized have their diversity tolerated, managed, or celebrated, whereas those in positions of power can opt to "tolerate" nondominant values and practices.⁵²

Although culturally competent care *may* be useful for the nurse providing individualized care, we contend that culturally competent practice is most likely *not* the answer to eliminating health disparities: it is an insufficient construct to address the complexities contributing to existing health disparities. In spite of numerous critiques offered from within and outside nursing, cultural competency remains supported and promoted even without evidence confirming its effectiveness. Nursing leaders and organizations continue to embrace a practice that does not accomplish what its own proponents claim: improving patient outcomes and reducing health disparities. Racine suggested that the lack of evidence points to a need for "new theories and methods to explore and understand cultural differences, and to challenge dominant culture stereotypes."^{58(p99)} Although we agree that challenging stereotypes is important, advocating for new theories and methods, even from the postcolonial lens Racine endorsed, continues to construct those who are "not me" as different.

If the discipline is to address the myriad problems contributing to poor health among underserved and marginalized populations—poverty, racism, an increasing gap between rich and poor—it needs to move beyond cultural competency and enter into a terrain that

is much more challenging, much less concrete, and clearly not amenable through fact files and checklists: confronting social and economic determinants of health. Otherwise, reducing larger social issues to ones solved by cultural competence merely ends up creating solutions that are technical and educational. Although these types of solutions may create change at a micro level, addressing macrodeterminants of health calls for social, economic, and political solutions.

ADVANCING THE DIALOGUE ON CULTURAL COMPETENCY

Although nurses claim that "culturally congruent care is generally thought to lead to improved health outcomes, better compliance with medical regimens, and less use of high-cost services,"^{18(p105)} these same nurses admit that "specific descriptions of the nature of such care are not yet available, and the links between congruent care and actual patient outcomes are yet to be explored."^{18(p105)} In 1992, the American Academy of Nursing (AAN) Expert Panel on Culturally Competent Care outlined 10 recommendations "to stimulate the development and implementation of knowledge related to culturally competent care."^{8(p282)} The 2007 AAN Expert Panel on Cultural Competence reiterated these same recommendations, stating that in the 15 years since the recommendations were initially developed, "the conceptualization, implementation, and evaluation of cultural competence remain unclear."^{5(p96)} Clearly, knowledge development surrounding cultural competence has stagnated.

Rather than supporting the 2007 AAN Expert Panel on Cultural Competence's promotion of the "adoption of the concept of cultural competence"^{5(p96)} to address health disparities, we suggest a reevaluation of the entire concept. Canales and Bowers⁵⁹ offered direction when they encouraged nurses to discuss the consequences of maintaining the artificial separation between competent and culturally competent practice. Their study

of Latina nurse educators' understanding of cultural competence suggested that there was little to distinguish between competent caring and culturally competent caring; cultural competence was an integral part of competent care. Their research proposed that competent nurses "conceptualize the provision of competent care to all persons who are perceived as different, rather than focusing only on those who are perceived as 'culturally' different."^{59(p102)} This is not to say that we advocate ignoring differences; we do not. We do, however, argue that much more dialogue, analysis, and critique of the use of cultural competency to tackle health disparities should proceed.

Focusing on culture and diversity can distract providers from examining personal interactions of the provider himself or herself and the social determinants of health that contribute to illness and death. Blaming factors such as lack of cultural competence for misunderstanding, miscommunication, dissatisfaction with treatment and lack of compliance does little to explain the reason for these problems when they occur between patients and providers of the same "culture." Indeed, these factors are common aspects of any clinical encounter. Dreher and MacNaughton contended that, "cultural competence is really nursing competence. It is the capacity to be equally therapeutic with patients from any social context or cultural background."^{22(p185)} All patients, regardless of cultural affinity, require respect, care, and ethical treatment.

Although cultural competence has, in fact, done little to address health disparities,²² there is much resistance to discarding the concept and practice altogether. For example, Dreher and MacNaughton's critique of cultural competence was "clarified" by the editor when the article appeared in *Nursing Outlook*. Reassuring journal readers that the article's authors were not arguing that "nursing should pay less attention to cultural or ethnic differences," the editor made it clear that the article was "in perfect alignment with the mission of *Nursing Outlook*."^{60(p175)} Given that *Nursing Outlook* is the publication of the

AAN whose 2007 Expert Panel continues to promote cultural competence as one means for reducing health disparities, it is not surprising that a defense of cultural competence was raised. Plainly, that defense points to how deeply rooted concepts of culture and cultural competence are within the discipline and constitute "cultural" aspects to the culture of nursing itself.

If fixed, homogenous cultural groups do not exist, does this mean total abandonment of the concept of culturally competent care? Abandonment to some degree? The trouble with cultural competence is that the concept always has a way of circling back to "essential" identities of particular groups that supposedly have some shared characteristics. It is not uncommon for those writing about cultural competence to begin by admonishing readers not to stereotype, followed by descriptions of clinical care for specific racial and ethnic groups, such as Italian Americans and Ethiopians.⁴⁵ However, the complexity of culture means that "we cannot 'read off' health status, health beliefs and behaviors from an individual's designated ethnic status."^{49(p150)}

Knowledge of cultural values does not mean the provider can foretell patients' behaviors because these values do not, in a straightforward manner, make patients act in certain, predictable ways.³⁷ As Gustafson noted, disregarding differences and treating everyone the "same," "reasserts the view that we are all *just people* negotiating interpersonal relations while simultaneously obscuring the power of the very social processes used to organize those engagements."^{52(p6)} Nurses, therefore, need to figure out how to take into account individuals' beliefs and practices without reifying those beliefs and practices as fixed cultural elements. We need to gather information and learn from individuals, rather than make assumptions and generalizations about their care needs on the basis of their "cultural" affiliation.

As a discipline, we need to think carefully about the language we use, the practices we engage in with our clients, and the consequences of all our decisions on the health

of persons perceived as “different” from ourselves. We do not need new words for “culture” or “diversity” or “ethnic.” We do not need new models or constructs or measurement devices. We do not need “basic and intervention research . . . to determine what culturally competent clinical practice looks like and the degree to which it is efficacious.”^{27(p755)} Instead, “we need an expanded sense of who we are, where we came from, how we did that, and how we identify and integrate ourselves in our complex world.”^{61(p48)} We need a broader understanding of the dynamics and context of power within relationships and the language of difference.

At some gut level, we know that health disparities are produced by a repertoire of complex factors; yet, actions required to rid our society of racism, poverty, or insufficient housing, for example, remain inexact. Even those who are strong proponents of cultural competence admit that larger economic, social, educational, and political factors hold greater sway over health than do “cultural” concerns.²⁷ Rather than continuing to rely on cultural competence, our profession needs to learn to deal with the very real issues of deprivation and hatred while striving to create methods that have a measurable impact on reducing health disparities.

We suggest that nursing move beyond the institutionalized healthcare setting to begin to devise and to implement care that directly targets broad determinants of health. Although institutions have focused their attention on establishing educational offerings to meet hospital and clinical accreditation requirements for cultural competence, the real arena for addressing disparities in healthcare is beyond the walls of these organizations.

For example, the city of San Francisco, California, has instituted a new initiative, *Healthy San Francisco*, which offers free or subsidized healthcare for residents without insurance.⁶² Care is offered through the city’s extensive network of public and community clinics, which emphasize prevention and management of chronic illness. Being part of this new initiative, whether as a direct care

provider in the health clinics or as a member of the public health team or as a consultant to the city government on health policy, are roles reminiscent of public health nurses’ earliest efforts, such as those of Lillian Wald, who directly targeted their services to the impoverished and vulnerable. These nurses brought care to populations marginalized and unacknowledged by most providers within healthcare delivery. Engagement in *Healthy San Francisco* is one way nurses can begin to work in concert with individuals, groups, and agencies outside the discipline to address social determinants affecting health and access to healthcare.

Another example positions nurses in secondary schools working together with teachers, counselors, and social workers to improve high school graduation rates.⁶³ “Education is one of the strongest predictors of health: the more schooling people have the better their health is likely to be.”^{63(p1)} Reframing school dropout as a public health issue provides an avenue for nurses to become involved in efforts to reduce health disparities by improving educational attainment. Nurses can participate in health interventions that contribute to improved school completion rates, including coordinated school health programs, school-based clinics, violence prevention programs, and substance abuse prevention and treatment programs, to name just a few. Evidence exists that support of these types of programs, aimed toward reducing disparities in educational achievement, can lead to concomitant reductions in health disparities.⁶³ By bringing together programs to improve health and school achievement, nurses have the opportunity to make a lasting contribution to reducing, and eventually eliminating, health disparities.

CONCLUDING REMARKS

It is evident from the literature reviewed in this article that the nursing discipline is not ready, or perhaps even willing, to consider abandoning the concept of culturally

competent care even while the discipline's limited advancement of the concept reveals an indifferent commitment to cultural competence. If cultural competence is "not a technical skill that one can master such as learning to take a blood pressure reading . . . [nor] a problem-solving skill that one can develop . . . [nor] a communication technique that one can refine,"^{64(p107)} we question how it can have an impact on reducing health disparities. Although cultural competence may be an important aspect of clinical care, a focus on culture does not address health risks. Although nurses continue to focus their attention on producing more culturally competent models, tools, and interventions, they remain distracted from the real problems facing marginalized populations.⁵⁷ We do not side with those who deny diversity; instead, we underscore that the causes of health disparities exist at much broader social, political, and economic levels, and therefore require much broader approaches if they are to be eliminated.

We encourage nurses to become part of a growing movement to improve social circumstances contributing to health disparities. We recommend that nurses who are committed to reducing and ultimately to eliminating health disparities, move efforts to attend

to social determinants of health out of institutionalized healthcare settings and into the greater environment. These efforts need to be collaborative, and orchestrated in conjunction with those outside the discipline who are dedicated to eradicating health disparities. The answer to health disparities will not be found in culturally competent interventions located within existing walls and halls of clinics and hospitals, nor through actions of individual practitioners and academics. The adage of "at least we're doing something" through the use of goldfish tanks, cultural checklists, or other moonlight tricks will not do—what it *does* is help us avoid dealing with a complex world and makes us complicit with sustaining health disparities. Rather than continuing to rely on cultural competence, we need to engage in critical thinking, reflective practice, and political action if we are to end existing health disparities and create a more socially just healthcare environment and society for all. As Leininger entered the turbulent landscape of the 1970s and introduced the nursing discipline to the concepts of culture and cultural diversity, the nursing discipline of the 21st century must embark into equally unsettled times and work toward creating more equitable social, political, and economic systems for all.

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