Concept Paper: Culturally Competent Care

Prepared by Linda L. Barnes, Ph.D., M.T.S.
Boston Medical Center

Purpose: To provide input to the National Project Advisory Committee (NPAC), for the design and definition of curriculum modules on culturally competent care for nurses based on the corresponding subset of National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards.

This was a commissioned "concept paper" for the May 2004 Consensus Building Meeting for the Culturally Competent Nursing Modules (CCNM) project. Funding for the paper and the CCNM project was provided by the Office of Minority Health, Office of Public Health and Sciences, U.S. Department of Health and Human Services.

Introduction

The United States has always been multicultural. Yet in recent decades, the presence and interests of different cultural constituencies have made themselves more strongly felt in medicine and nursing. Many minority cultural groups experience a disproportionate burden of health disparities (Collins *et al*, 1999). The imperative to provide cross-cultural care is related to such disparities, access to health care, and quality of care. It involves patient-provider communication, and the ways that cultural and linguistic differences can compromise communication and jeopardize trust. Patient trust enhances understanding, satisfaction, and adherence (DiMatteo & Hays, 1980; Greenfield, Kaplan, & Ware, 1985; Bertrakis, Roter, & Putnam, 1991). When patients do not understand the rationale or procedures related to a recommended therapy, they are unlikely to adopt it (Coleman-Miller, 2000), or may do so incorrectly, with harmful outcomes. When their health-related worldview differs from the provider's, they may resist recommendations (Vermeire *et al*, 2001), potentially leading to health disparities (Smith, 1998).

This paper is grounded in the National Standards for Culturally and Linguistically Appropriate Services (CLAS), specifically Standards 1-3, related to Culturally Competent Care (Office of Minority Health, 2001). The CLAS standards define cultural and linguistic competence as:
…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 (Office of Minority Health 2002:7).

The Office of Minority Health (OMH) (2002) adds gender, sexual orientation, age, disability, and socio-economic status, linguistic-minority status, low literacy skills, and hearing impairment. One must also include intraethnic variation, and the impact of institutionalized classism, racism, colonialism, and foreign policy on how individuals and families perceive and interact with U.S. health care. Cultural competence, as a concept, has undergone change over time (Burchum 2002). Cross *et al* (1989) posit five factors: 1) valuing diversity; 2) being able to engage in cultural self-assessment; 3) being conscious of dynamics inherent in cross-cultural interactions; 4) having institutionalized cultural knowledge; and 5) adapting service delivery to reflect an understanding of cultural diversity.

Betancourt *et al* (2003) add that it requires understanding how cultural and social influences shape patients' health worldviews and related behaviors; recognizing how such factors "interact at multiple levels of the health care delivery system"; and developing interventions to address these issues in the interest of equitable quality health care for all patients (p.297). All these aspects readily translate into nursing practice, within a broader commitment to a holistic view of the patient and to the nurse-patient relationship. Because nurses spend more time involved in direct patient care than other healthcare providers, and work across the healthcare system, they are uniquely positioned to implement effective cross-cultural care. Moreover, insofar as the essence of good nursing is care for the patient as a whole person (Kitson, 1999), then culturally competent nursing *is* good nursing.

Nurses and Cultural Competence

Over sixty national nursing organizations participated in a summit in 2001, formulating the profession's vision as "Nursing's Agenda for the Future" (Steering Committee, 2002). Part of that vision included a focus on diversity. The participating organizations proposed to create "diversity and cultural competence through educational programs and standards in the workplace," to increase "diversity of faculty, students and curricula in all academic and continuing education," to focus

“recruitment and retention programs to greatly increase diversity,” and to target “legislation and funding for diversity initiatives” (p.19). Increasingly, nursing education programs are being mandated by their accrediting agencies to address diversity and multiculturalism in their curricula (Black, 2001). Nurses have traditionally characterized their practice orientation as holistic (Owen & Holmes, 1993). A core component of nurses’ self-understanding involves a patient-centered focus, together with promoting health (Engebretson, 2003). Attention to cultural differences is intrinsic to this orientation.

Indeed, nurses have long engaged in cross-cultural care, particularly through public health involvement with new immigrant communities. Mendyka (2000) argues that caring represents the moral ideal of nursing. He proposes Watson’s Model of Human Care (Watson, 1989), to integrate cross-cultural understanding and holistic care. Holistic nursing advocates have begun to bring to the foreground ethnicity and culture as key issues in nursing care (Anderson & Kelley, 1998; Barnes *et al*, 2000; Engebretson, 2003). When holism is defined as encompassing cross-cultural care, then cultural competence education is not a dispensable add-on, but rather is fully congruent with, and intrinsic to, core issues in nursing education.

“Transcultural nursing” emerged in the 1970s, through the work of nurses like Leininger (1978). Since then, it has grown as a sub-discipline. Dreher and MacNaughton (2002) contend that cultural competence *is* nursing competence. Drawing on Leininger (1995) and Campinha-Bacote, the Minnesota Chapter of the Transcultural Nursing Society has formulated standards for transcultural nursing (Leuning *et al*, 2002). These include attention to theory, cultural information gathering, caring and healing, cultural health patterns and caring practices, health care planning, evaluation, research, and professional development.

Defining Educational Content: Attitudes, Knowledge, Skills, and Assessment

Schön (1987) argues that professions like medicine and nursing involve judgment and wise decision-making in the face of complexity and uncertainty, and potentially conflicting values and ethics. Theoretical and technological knowledge, while indispensable, are insufficient. Providers must be able to merge practical knowledge and skills with reflection, and apply the results. A primary goal of cross-cultural training involves learning the skills with which to remain creatively flexible and intuitively adaptive in the midst of difference. Such training has increasingly been understood as an evolving, non-linear process, with multiple phases and stages of emerging awareness (Cross *et al*, 1989; Borkan & Neher, 1991; Culhane-Pera *et al*, 1997, 2000; Campinha-Bacote 2002). It involves both cognitive and emotional intelligence (Goleman, 1997), and the related interplay between reflection (Hardy & Laszloffy, 1995; Tervalon & Murray-García 1998) and practice (Lutz *et al*, 1997).

As Betancourt (2003) argues, cross-cultural care is based on *attitudes*, including “humility, empathy, curiosity, respect, sensitivity, and awareness of all outside influences on the patient” (p.561). He correlates this foundation with “cultural sensitivity/awareness” approaches. In contrast, “multicultural/categorical” approaches focus on *knowledge* about diverse cultural lifeworlds. Finally, “cross-cultural” approaches focus on *skills* that meld patient interviewing with the ethnographic tools of medical anthropology” (p.562), with an emphasis on communication skills as central to the building and deepening of the nurse-patient relationship (Mahoney & Engebretson, 2000).

Attitudes: Cultural Sensitivity and Self-Awareness Approaches

What is considered “good care” is culturally based (Cooper, 1996). The culture of nursing—much like the culture of biomedicine—continues to reflect the predominant values of the majority culture, in this regard, in ways that can unintentionally perpetuate ethnocentrism and cultural imposition (Imes & Landry, 2002). Nurses may project their own culturally based values and

expectations onto patients from backgrounds different from their own (Thiederman, 1986). One target of cultural competence training is ethnocentrism—a belief that one's way of life and view of the world are inherently superior, and desirable to others (Leininger, 1978). Gender matters in this context, insofar as one study shows men reporting higher apprehension about intercultural communication and being more ethnocentric than women (Lin & Rancer, 2003). Because unaddressed ethnocentrism can not only compromise the nurse-patient relationship, but also lead to misdiagnosis, mistreatment, and undertreatment (Greipp, 1995, 1996), recognizing ethnocentric and racist attitudes and behaviors is central to developing strategies for providing culturally competent care in nursing (Harris & Cummings, 1996). Because reflection and reflective practice often constitute core components of nursing education and practice, a lack of awareness of bias can lead to hindsight bias that can compromise the reflective process (Jones, 1995). The first step in a cultural assessment, therefore, is to know one's own beliefs and attitudes (Kagawa-Singer, 1997). Awareness of one's own values and those of the healthcare system are the foundation of culturally competent nursing (Leonard & Plotnikoff, 2000).

A second target is essentialism, in which groups are defined as "essentially" different, characterized by traits construed as "natural" to that group (Fuller, 2002), without taking into account intracultural variation. Closely related is the tendency to stereotype groups (Machado, 2001). Habayeb (1995) suggests that nurses exposed to largely homogeneous cultural contexts may find it difficult to identify distinctive features of their own culture. Majority-culture nurses may just think of themselves as "American," forgetting how their own background may be the outcome of different European origins. Or, they may resent what seems to be the prioritizing of others' cultures. A focus on each person's cultural formation and its implications for clinical practice provides an inclusive approach.

One core content aspect of self-understanding entails learning to recognize one's own positioning in relation to various forms of social power and privilege. Moreover, one can occupy multiple positions, depending on context (European-American women, for example, have racial privilege, but not gender privilege). One must also learn to recognize the effects of provider enculturation into biomedicine, which tends to present itself as a "culture of no culture" (Taylor, 2003) rather than a culture with its own tendencies toward ethnocentrism (Kleinman, 1994; Good, 1995).

The provider-patient relationship is characterized by certain power imbalances, all intentions to the contrary notwithstanding (Henderson, 1994). Efforts to enhance communication and increase mutuality have been one approach to reduce this imbalance (Lupton, 1995). Nevertheless, those with power often are not fully aware of its daily effects (Hewison, 1995; Johnson & Webb, 1995). Therefore, an additional core content area in cultural competence education involves learning to discern the presence and effects of institutionalized power disparities and their place in one's own experience (Rorie *et al*, 1996). Such disparities disenfranchise particular social groups through different aspects of "structural violence," such as institutionalized racism and other forms of privilege enjoyed by dominant groups (Farmer, 1997; Singer & Clair, 2003). Green *et al* (2002) propose a focus on patients' social context and locus of control (Landau, 1995), with related training in advocacy skills, so that providers will not simply encourage mechanisms of coping and accommodation.

Advocacy, in such cases, involves learning to recognize a broader definition of patient vulnerability and patient human rights (Farmer, 1999), as part of building the nurse-patient relationship (Mallik, 1997). This social context includes learning how the global environment affects cultures differently (Duffy, 2001). When issues of structural violence are not brought to the foreground, students may see "Others" as the only ones who have culture, and whose differences represent deviations from a norm (Beagan, 2003; Wear, 2003). They may also not recognize how they themselves partake of certain

forms of social power and privilege, in ways that can lead them unconsciously to perpetuate health disparities. In contrast, recognition and understanding of such factors increase the range of ways in which nurses can enhance their relationship with patients and support patient empowerment as part of a relational ethics (Rafael, 1995).

Knowledge: Multicultural/Categorical Approaches

The next approach can be characterized as "fact-centered," focused on general information about specific groups. A "culture-facts" approach may enable providers to understand a group's history, experience of structural violence and related health disparities, and broad cultural patterns. However, it can foster stereotyping by encouraging learners to draw generalizations. It can also create the impression that cultures are monolithic and static (Dreher and MacNaughton, 2002). Five broad content areas fall under this heading, and are formulated here in ways designed to reduce problematic outcomes.

The first involves the different theories of cultural competence, to provide comparative frames of reference. This domain includes key concepts, such as diversity, pluralism, culture, and cultural competence (Carrillo *et al*, 1999). It also involves theories of structural issues (e.g., institutionalized racism, sexism, homophobia) and their routine manifestations at institutional, group, and individual levels (Ridley, 1995; Tatum, 1992). The second includes content related to particular cultural groups— preferably in the patient population—with attention to interethnic diversity. It also includes data on health disparities, health issues prevalent in specific groups, and related epidemiological issues (Welch, 2002). It suggests ways that cultural factors may influence clinical interactions (Carrillo *et al*, 1999), with cues for recognizing a culture-related issue (Welch, 2002). The third involves overviews of how cultural competence training can be applied in different fields of nursing. Examples include hospital-based patient care teams (Peterson & Smith, 1996; Boyle *et al*, 2002), critical care (Covington, 2001), home care (Blanter & Page, 1995); care of women and newborns (Callister, 2001), women's health (Salimbene & Gerace, 2003a); mental health (Gerace & Salimbene, 2004); pain management (Salimbene & Gerace, 2003b); and respiratory care (George, 2001). Learners thereby develop an overview on issues in implementing culturally competent care.

Fourth, the United States has always been characterized by medical pluralism (Starr, 1982; Kaptchuk & Eisenberg, 2001a). Currently, American therapeutic pluralism is represented as the relationship between biomedical and nonbiomedical therapies. The latter are categorized as "complementary and alternative medicine," or CAM—except when involving practices used in minority groups, which are routinely relegated to the categories of "folk medicine," "ethnic/ethno medicine," or "home remedies" (Hautman, 1979; Mathews, 1987; Pachter, 1994; Risser & Mazur Gray, 1995; 1996; Jackson, 1997; Plotkin & Post, 1999; Fletcher, 2000; Miller, 2000; Boyd *et al*, 2000). Folk and ethno-medicines are sometimes defined as a sub-set of CAM, but are then characterized as parochial forms (Kaptchuk & Eisenberg, 2001b). Such designations overlook the cultural grounding of dominant versions of CAM among middle- and upper-middle class European-Americans. Only more recently have minority nonbiomedical practices also begun to be categorized as CAM (American Medical Association, 2001; Cushman *et al*, 1999; Gomez-Beloz, 2001; Allen *et al*, 2000; Bailey, 2002; Rivera *et al*, 2002; Cherrington *et al*, 2003; Mackenzie *et al*, 2003; Najm *et al*, 2003; Barnett *et al*, 2003), and the NIH's National Center for Complementary and Alternative Medicine begun to direct attention to minority versions and uses of CAM (Block, 2003).

A persisting bifurcation, however, contributes to the perception that "CAM" refers to majority practices, and "folk/ethnic" to minority ones, with only the latter a part of cross-cultural care. Integrating culture, CAM and, where appropriate, related religious/spiritual worldviews, offsets this tendency (Barnes *et al*, 2000; Kemper & Barnes, 2003; Leonard, 2004). To date, relatively little

sociological study has been directed at the connections between CAM, nursing as a profession, and its practitioners (Tovey & Adams, 2002). Yet nurses are often in the best position to identify CAM therapies that patients may be using (Lengacher *et al*, 2002), and are often interested in including CAM in the provision of care themselves (Ward, 1998; Corless *et al*, 2000; Snyder & Lindquist, 2001; Burman, 2003; Frisch, 2004).Nurses have also taken steps to incorporate training related to CAM into nursing education (Richardson, 2003; Gaydos, 2004). It is important to convey that each CAM modality grows out of a cultural background, although other groups may adopt it. Understanding the prevalence, uses, and meanings of all nonbiomedical therapies must, therefore, be a cross-cultural endeavor. For that matter, as Spector (2000) has observed, biomedicine may, for some patients, function as CAM.

Finally, the CLAS Executive Summary (Office of Minority Health 2001) includes encouraging "patients/consumers to express their spiritual beliefs and cultural practices" (Office of Minority Health 2001:5). Nurses have often defined spirituality as intrinsic to holistic care. Indeed, some nursing curricula include spirituality (Goddard, 1995; Nolan & Crawford, 1997; Greenstreet, 1999; Narayanasama, 1999; Catanzaro & McMullen, 2001; Lemmer, 2002; Pesut, 2002, 2003; Meyer, 2003).

A popular tendency to contrast religion and spirituality (Fuller, 2001) has coincided with assumptions in biomedicine that religion is institutional, its practices pertinent primarily when they obstruct biomedical therapies (Greenberg, 1998). The role of religious traditions as sources of support, resilience, and healing (Gudorf, 2001; Núñez Molina, 2001) is thereby ignored. In contrast, spirituality is viewed as personal and universal, in ways that can lead to unexamined bias, if one assumes that everyone else's spirituality is just like one's own. A nuanced approach is required, that recognizes the roles of world religions in America (Barnard *et al*, 1995; Eck, 2001; Barnes and Sered, In press; Pluralism Project website; Boston Healing Landscape Project website).

Skills: Cross-cultural Approaches

Attitude changes and content knowledge need to find active expression through practice, requiring training in related skills. As the different nursing disciplines and accreditation agencies articulate required competencies, nurses need to learn the skills that will improve their ability to communicate across cultural differences, to enrich their relationships with their patients, and to improve the care they are able to deliver. Such skills—most of which are related to communication— include:

- Being able to recognize the components of one's own cultural formation, and their potential impact on one's practice, including the risk of projecting onto patients (Comas-Diaz & Jacobsen, 1991)
- Applied familiarity with models for ascertaining cross-cultural understandings of illness, health, and care (Leininger, 2002; Giger & Davidhizar, 2002; Purnell, 2002; Spector, 2002). Such familiarity is related to skills for eliciting patient's explanatory models (Carrillo *et al*, 1999; Lang *et al*, 2000) and related worldviews, sometimes formulated as patients "health beliefs" (McAllister & Farquhar, 1992). These skills are crucial for developing greater congruence between the nurse's and patient's understanding, enhancing communication, learning, and adherence (Nunnelee & Spaner, 2000)
- Being able to discuss CAM with patients, and knowing how to locate information about related modalities
- Eliciting the patient's social context, including stressors and supports, and their impact on the patient's health and sense of wellbeing (Carrillo *et al*, 1999; Green *et al*, 2002)

- Becoming able to work across cultural difference: forming a relationship, patient-centered interviewing, assessment, addressing conflict, negotiation, and case management (Kleinman *et al*, 1978; Berlin & Fowkes, 1983; Ventres & Gordon, 1990; Jackson, 1993). Medical anthropology has developed pertinent ethnographic strategies (Weidman, 1982; Dougherty & Tripp-Reimer, 1985; Taylor, 2003b)

Growing competence in communication skills occurs as learners transition from one stage to the next (Crandall *et al*, 2003). All these strategies involve negotiation, and the jettisoning of the pursuit of patient "compliance" in favor of compromises that address the goals most deeply at stake for each party.

Pedagogical Strategies

Historically, nursing education has been influenced by biomedical models that can be reductionistic, and counter to the holistic orientation of nursing (Morse, 1997). Current pedagogy still often focuses on scientific inquiry and received knowledge (Gendrop & Eisenhauer, 1996), and is often content and curriculum driven, as well as teacher focused (Peters, 2000). Pedagogical strategies often face eight barriers to transcultural communication:

1. Lack of knowledge
2. Fear and disgust
3. Racism
4. Bias and ethnocentrism
5. Stereotyping
6. Ritualistic behavior (nursing rituals in patient care)
7. Language barriers
8. Differences in perceptions and expectations (Luckmann, 1999).

Many of these factors function at an unconscious level. Anderson and Kelley (1998) suggest that members of mainstream U.S. society are often "problem-solution" oriented, perceiving differences between patients' worldviews and those of biomedine as "problems" to be solved. When cultural differences proved difficult to reconcile, it can be tempting to dismiss them.

Curricular interventions need to be predicated on pedagogical theory. Critical pedagogy, for example, orients learners toward recognizing social structures that compromise patient health and health equity (Harden, 1996). Transcultural nursing practice calls for training in a comprehensive, sociopolitically conceptualized, multicultural pedagogy and related curriculum (Clark & Robinson, 1999). Additionally, a pedagogy that promotes an understanding of ethics as a lived, personal process, and supports what Doane refers to as "becoming" a moral agent, is intrinsic to the creative spirit of nursing (Doane, 2002b). Moreover, cross-cultural education and training require interventions geared to different levels of learner, across the curriculum, throughout post-graduate professional development. Preparation at the baccalaureate level, for example, differs from the specialist level competencies reflected in master's level training, advanced-practice nursing (American Nurses Association, 2004), and continuing education. There are also different ways to introduce a topic into a curriculum.

One can add a single lecture to a course, leaving the rest of the course untouched. One can add a full course without otherwise modifying the curriculum. This approach can result in the topic being marginalized, particularly if the course is an elective. Or, one can review each session of each course to incorporate cross-cultural issues. If one begins with the premise that such issues are always present, then there is no course topic that cannot be enriched by their explicit incorporation.

The modules that emerge from this project will need to into account the level of the learners involved and promote an integrative orientation that encourages learners to introduce related issues into every learning context. A review of studies on how different pedagogical strategies correlate with changes in physician behavior suggests that more passive learning styles, like those frequently used in traditional continuing medical education and passive dissemination of information, are not effective. In contrast, more interactive forms of CME do work (Bauchner *et al*, 2001). Generally, strategies related to active learning pedagogy geared for adult learners have a greater impact and yield greater behavioral changes (Johnson *et al*, 1991). Pedagogy that is student focused, and includes prior learning and experience of students as a foundation for new knowledge is also likely to result in greater change (Peters, 2000). Therefore, the following combination of strategies is recommended as potential components in the curricular modules.

Attitudes

Bias and prejudice tend to function at many levels. On a *personal* level, both express themselves through feelings that particular groups are superior or inferior, based on cognitive or affective misinformation. On an *interpersonal* level, both translate into behaviors based on conscious and/or unconscious negative assumptions. On an *institutional* level, social structures and systems restrict access to resources and rights based on targeted forms of difference. Political, economic, social, educational, and historical variables may mutually reinforce the institutional expressions of bias. At the level of a dominant *culture*, the preferences, norms, and practices of the dominant group are assigned a privileged place as somehow better and right. To be accepted is to conform to that norm (Batts, 1998). The strategies proposed here focus primarily on the personal and interpersonal levels, with the expectation that transformation at these levels can exercise an influence on institutions and the broader culture.

- Strategies promoting reflection related to personal cultural formation, particularly in relation to issues of social power and privilege, and their effects (Pinderhughes, 1989). A fruitful approach to exploring the different dimensions of these factors involves preparing a cultural genogram (Hardy & Laszloffy, 1995), to explore how one has learned about various forms of difference
- Self-assessment of one's racial identity formation in relation to one's interactions and abilitiesto communicate across racial/cultural differences (Root, 1998; Thandeka, 1999)
- In addition to the explicit focus on power-related factors, other ways of getting at one's own cultural background can include storytelling by older family members; journaling; critical incident narratives (Ramos, 1992; Lichstein & Young, 1996; Luker *et al*, 2000) and Balint Group discussions (Rabinowitz *et al*, 1996).
- Self-assessment, using different models defining stages of cultural awareness, including the awareness of one's own social location and its relationship to power/privilege (Purnell & Paulanka, 1998). Such assessments could be used at different points along the learning trajectory, to promote ongoing reflection
- Strategies to develop an "inequalities imagination" (Hart *et al*, 2003) and a social justice orientation as a core nursing value (Fahrenwald, 2003)

Knowledge

- Lectures and didactic sessions about different cultural groups and related epidemiological issues, supported by related reading
- Web-based resources (Wendler & Struthers, 2002; De Ruiter & Larsen, 2002)
- Didactic presentation, discussion, and application of multiple models of cultural competence, to develop nurses' critical ability to assess their relative strengths and limitations

- Critical thinking exercises that train learners to apply concepts from anthropology to clinical care (e.g., concepts such as cultural brokering, multiple clinical realities, the patient as a cultural informant, and the cultural assessment of the patient's worldview and view of the clinical setting) (DeSantis, 1994).
- Talks on the cultures of the communities where learners are situated, involving community members as faculty (Leppert *et al*, 1996; Ferguson *et al*, 2003)
- Speakers from different cultural groups (community members, guest lecturers, panels) describing their experiences of nursing care

The limitations of the cultural facts approach can be fruitfully addressed through alternative pedagogies. For example, one can design exercises to contrast "covering content" and thinking about that content (Ironside, 2004). As Ironside proposes, for example, the use of Narrative Pedagogy supports "Thinking as Questioning: Preserving Perspectival Openness" and "Practical Thinking: Preserving Fallibility and Uncertainty" (Ironside, 2003). Both types are crucial to cross-cultural care (see also Nehls, 1995). In addition, one can draw on methods developed for teaching about mainstream versions of complementary and alternative medicine, to introduce content about other healing systems (Burman, 2003; Cuellar *et al*, 2003).

Skills

It is also essential to develop exercises with which students can practice applying different models of cross-cultural assessment and care, especially in relation to their communication skills.

Examples include:

- Role play exercises, in which learners implement different models of cross-cultural interviewing skills (Carrillo *et al*, 1999; Campinha-Bacote, 2002; Sorrell, 2003; Kagawa-Singer & Kassim-Lakha, 2003).
- Interviews with actor-patients, with feedback, to assess how broader "cultural facts" do and do not apply
- Video vignettes of nurse-patient interactions, with discussion
- Teaching cases that elicit a range of issues and related affect, and that resist stereotyping different groups. Even thoughtful in-depth studies, like *The Spirit Catches You and You Fall Down* (Fadiman, 1997) can be read narrowly (Barnes & Plotnikoff, 2001). Such cases can provide practice in reviewing the variables involved in decision-making

Attention to particular topics, such as prior trauma experienced by the patient, and its impact on the empathic nurse-patient relationships may be important, along with related interviewing skills, to prepare nurses to work with immigrants who have suffered violence and other traumatic experiences (Hartman, 1995).

Combined Strategies with an Experiential Focus

Experiential learning both creates and draws on lived experience on the part of the learner. In preparing learners for cross-cultural nursing practice, it engages not only the cognitive, but also the affective aspects of learning (Carpio & Majumdar, 1993). Experience also tends to take learners beyond a narrower focus on "methods," and into the more transformative aspects of relationship in ways that support humanistic, relational nursing (Doane, 2002a).

- Small group discussions of course materials and experiences, with related tasks
- Role playing, whether individual (Shearer & Davidizar, 2003) or group
- Being videotaping interviewing a patient, with follow-up discussion

- Home visits and discussions with community members in their own homes
- Community tours with community members
- Visits to traditional healers
- Opportunities for cultural immersion (St. Clair & McKenry, 1999; Warner, 2002; Crampton *et al*, 2003)
- Ethnographic interviewing, and collecting of patient narratives (Smith & Hoppe, 1991)
- Service learning (Bittle *et al*, 2002; Albritton & Wagner, 2002)
- Courses in nursing humanities that use literature from different cultures (Darbyshire, 1995)
- Opportunities to write narratives about one's own lived experience as one bears witness to the suffering of others in the course of one's training and practice (Eifried, 2003)
- Discussion exercises that promote an understanding of ethics as a personal process, rooted in one's identity (Doane, 2002b)

Assessment

Although knowledge of cultural facts can be assessed using pre- and post- evaluation, there are no standardized measures for the more complex aspects of cross-cultural care (Betancourt, 2003; Peña Dolhun *et al*, 2003; Rew *et al*, 2003). Still, assessment tools do exist, such as the Inventory for Assessing the Process of Cultural Competence (IAPCC) Among Health Care Professionals (Campinha-Bacote, 1997), among others. The challenge parallels that of assessing professional competency beyond knowledge of facts and mastery of clinical skills (Office of Minority Health, 2002). It is difficult to quantify interpersonal skills. Some methods have been developed for assessing communication-skills courses (Wilkinson *et al*, 1998) that might be adapted, but assessment may also require additional methods—qualitative reviews (Walker, 1989); self-evaluation; participant observation; journals and fieldnotes; observation and feedback from community, peer, patient, faculty, and mentor observers, and other key informants (Epstein & Hundert, 2002). Assessment should be longitudinal, as an integral component of the nursing process (Wells, 2000; Rew *et al*, 2003).

One way of assessing the longitudinal dimensions of learning cultural competence involves stage theories—various formulations of the shift from extreme lack of awareness to skillful crosscultural practice. Cross, Bazron, Dennis, and Isaac (1989) propose six stages—a Cultural Competence Continuum—moving from "cultural destructiveness," in which one's behaviors and attitudes have a harmful effect on persons from other cultures, to "cultural proficiency" pervading one's practice, teaching, and research. Louie (1996) defines the continuum as one of "individual intercultural sensitivity" (p.230). One may begin embedded in ethnocentrism, in which one virtually denies the existence of other cultures, and move across six stages toward an ethnorelative stage, where one integrates cultural knowledge into policy and practice. Purnell and Paulanka (1998) also write:

One progresses from unconscious incompetence (not being aware that one is lacking knowledge about another culture) to conscious incompetence (being aware that one is lacking knowledge about another culture); then to conscious competence (learning about the client's culture, verifying generalizations about the client's culture, and providing culturally specific interventions); and finally to unconscious competence (automatically providing culturally congruent care to clients of a diverse culture). (p.2)

Wells (2000) synthesizes multiple models. Capinha-Bacote (2004) advocates a focus on *becoming* culturally competent as a lifelong undertaking, grounded in "cultural desire," characterized by humility, curiosity, seeking cross-cultural encounters, and building cross-cultural skills.

Stage theories are both useful, and susceptible to two limitations. First, they privilege the final stage, in ways that can perpetuate blind spots. For example, Kohlberg's theory of moral reasoning moves toward a final stage of abstract, "philosophical" reasoning (Duska & Whelan, 1975). As Gilligan's (1982) subsequent work illuminated, however, Kohlberg based his theory on male experience, and on Eurocentric models of moral reasoning. When Gilligan introduced gender differences, the nature of the stages changed. Second, stage theories can suggest that one advances directly and completely from one stage to another, rather than sometimes slipping back and forth, particularly in new contexts. The fluid, contextual nature of personal change must, that is, be taken into account. Nevertheless, in developing learner modules and other curriculum, the self-assessment mechanisms that are part of these different stage theories can be useful tools for tracking learners' starting points and development of cross-cultural competency.

Underrepresentation of Minorities in the Nursing Profession

As of 1995, blacks and other minorities comprised 9.8% of registered nurses (Greer, 1995). Similar under-representation is evident in nursing leadership (Schmieding, 2000). The recruitment, training, and retention of minority nurses remain issues within the larger challenge of nursing shortages Campbell & Davis, 1996; Jordan, 1996; Baldwin, 2004). Some institutions have countered high attrition rate of minority nursing students with strategies related to improving critical thinking, stress management, and reading comprehension skills (Abdur-Rahman & Gaines, 1999), or by providing mentors (Meleis, 1994), minority role models, faculty, and recruiter, as well as an advisory group coordinated by the minority recruiter (Houldin *et al*, 2002; Wright *et al*, 2003). Potentially, a module on training mentors to work with minority could be useful.

Yet such strategies, while crucial, do not necessarily address pervasive racism that is frequently invisible to European-Americans. Examples include the privileging of a Eurocentric curricula and scholarly tradition, while marginalizing discussion of non-European-American groups, or discouraging the use of theoretical models grounded in minority experience. Instructional materials can communicate bias through overrepresentation of dominant groups' experiences, and underrepresentation or absence of minority groups' experiences (Curry, 2001). The Byrne Guide for Inclusionary Cultural Content (Byrne *et al*, 2003) can help educators review and evaluate materials for bias, and create materials that represent diverse groups. Training educators to recognize the presence and influence of Eurocentrism, and to assess curricular materials for its presence could be an important module (Brown, 2001).

Majority faculty and students may avoid examining their own racism, and/or may choose not to challenge racist behavior when they witness it (Hassouneh-Phillips & Beckett, 2003). Such factors generate a "chilly" climate for minority nursing students and faculty. Providing faculty development for non-minority faculty becomes another important response. It must involve training in selfreflection related to one's own social power, privilege (Vasquez, 2000), and related biases and blind spots, as well as training to recognize specific ways in which faculty awareness or lack thereof affects interactions with minority students and colleagues (Yoder, 1996). The earlier sections in this paper on attitudes and related pedagogical strategies are particularly important in this regard.

Implications for General Nursing Education and Training through the Cultural Competence Nursing Modules

Individuals are likely to make a cause their own when they can see how it relates directly to their own sense of personal and professional identity. A holistic approach to nursing includes the personal growth of the nurse. It is therefore critical to emphasize that self-awareness resulting from this aspect of cross-cultural training enhances one's self-understanding, and increased ability to interact with others. The personal rewards, that is, coincide with the benefits of enhanced professional

competence. Additionally, cultural competence is one step toward creating social justice (Rosenjack Burchum, 2002), falling under the purview of nurses' role as patient advocates. Insofar as it provides additional tools towards deepening the nurse-patient relationship, it enhances nurses' abilities to advocate for their patients (Chafey *et al*, 1998). The Cultural Competence Nursing Modules (CCNM) must make these connections explicit, to promote individual and institutional identification with the importance of cross-cultural nursing. Modules cannot be expected to comprehensively cover all three areas (attitudes, knowledge, skills) in depth, but should ensure that all three are addressed electively. This paper has cited sources that discuss specific methods for each of the strategies recommended, hopefully providing useful resources to the module designers.

Cultural competence can be viewed as a key lens through which to look at professional nursing competence as a whole (Dreher & MacNaughton, 2002). To the extent that it has not yet been routinized throughout the training of nurses, however, it must continue to be conceptualized as simultaneously integral and separate, for heuristic purposes. The promotion of cultural competence requires institutional commitment to this kind of curriculum (Sturch, 1994) and the pursuit of related grants and other funding. Without strong attention to faculty development, it will be more difficult to incorporate cross-cultural issues throughout the curriculum. At the levels of graduate and faculty research and research mentoring, the incorporation of cross-cultural issues must become a scholarly norm (Bing & Reid, 1996; Johnson & Malgady, 1999; Kincheloe & McLaren, 2000; Krumeich *et al*, 2001; Mendias & Guevara, 2001; Kirkham & Anderson, 2002), as must cross-cultural methodologies (Eyton & Neuwirth, 1984; Papadopoulos & Lees, 2002). In addition to expanding the agenda of research on the nurse-patient relationship to take a more generally holistic approach (Lowenberg, 1994), such research must also incorporate cross-cultural issues and methods as a matter of standard practice. There is no moment when cultural differences are not present. As Betancourt and Like (2000) have observed, "Every clinical encounter is a cross-cultural experience." Competence in cross-cultural nursing, therefore, must be conceptualized as a foundational issue—and not a potentially dispensable add-on—in which all parties have a stake.

References

1. Abdur-Rahman V, Gaines C. Retaining Ethnic Minority Nursing Students (REMNS): A Multidimensional Approach. *ABNF Journal* 1999; 10(2):33-36.

2. Albritton TAQ, Wagner PJ. Linking Cultural Competency and Community Service: A Partnership between Students, Faculty, and the Community. *Academic Medicine* 2002; 77(7):738-739.

3. Allen R, Cushman LF, Morris S, Feldman J, Wade C, McMahon D, Moses M, Kronenberg F. Use of Complementary and Alternative Medicine Among Dominican Emergency Department Patients. *American Journal of Emergency Medicine* 2000; 18(1):51-54.

4. American Medical Association. *Cultural Competence Compendium* (2nd ed.). American Medical Association, 2001.

5. American Nurses Association. Nursing Facts: Advanced Practice Nursing: A New Age in Health Care. (http://www.nursingworld.org/readroom/fsadvprc.htm, Accessed 3/15/04).

6. Anderson WD, Kelley J. Immigration and Ethnicity: Implications for Holistic Nursing. *Journal of Holistic Nursing* 1998; 16(3):301-319.

7. Andrew M, Boyle J. *Transcultural concepts in nursing care* (3rd ed.). Philadelphia: J.B. Lippincott, 1999.

8. Andrulis DP, Delbanco T, Avakian L, Shaw-Taylor Y. *The cultural competence self-assessment protocol.* Washington, D.C.: National Public Health and Hospitals.

9. Bailey EJ. *African American Alternative Medicine: Using Alternative Medicine to Prevent and Control Chronic Disease*. Pp. 33-60. Westport, CT: Bergin & Garvey, 2002.

10. Baldwin DM. Disparities in Health and Health Care: Focusing Efforts to Eliminate Unequal Burdens. *Online Journal of Issues in Nursing* 2003; 8(#1, mss 1). (http://nursingworld.org/ojin/topic20/tpc20_1.htm, Accessed 3/10/04).

11. Barnard D, Dayringer R, Cassel CK. Toward a person-centered medicine: religious studies in the medical curriculum. *Academic Medicine* 1995; 70(9):806-13.

12. Barnes DM, Craig KK, Chambers KB. A Review of the Concept of Culture in Holistic Nursing Literature. *Journal of Holistic Nursing* 2000; 18(3): 207-221.

13. Barnes LL. Spirituality and Religion in Health Care. In *Cross-cultural Medicine*, JudyAnn Bigby, ed. Pp. 237-267. Philadelphia: American College of Physicians, 2003.

14. Barnes LL, Plotnikoff GA. Fadiman and Beyond: The Dangers of Extrapolation. *Bioethics Forum* 2001; 17(1):32-40.

15. Barnes LL, Plotnikoff GA, Fox K, Pendleton S. Religious Traditions, Spirituality and Pediatrics: Intersecting Worlds of Healing: A Review. *Journal of the Ambulatory Pediatric Association* 2000;106(4):899-908.

16. Barnes LL, Sered SS, ed. *Religion and Healing in America*. New York: Oxford University Press (In press).

17. Barnett MC, Cotroneo M, Purnell J, Martin D, Mackenzie E, Fishman A. Use of CAM in Local African-American Community-Partnered Research. *Journal of the National Medical Association* 2003; 95(10):943-950.

18. Batts V. *Modern Racism: New Melody for the Same Old Tunes*. Cambridge, MA: Episcopal Divinity School, 1998.

19. Bauchner H, Simpson L, Chessare J. Changing physician behavior. *Archives of Disease in Childhood* 2001; 84:459-462.

20. Beagan BL. Teaching Social and Cultural Awareness to Medical Students: “It’s All Very Nice to Talk about It in Theory, But Ultimately It Makes No Difference. *Academic Medicine* 2003; 78(6):605-614.

21. Berlin EA, Fowkes WC Jr. A teaching framework for cross-cultural health care: Application in family practice. *Western Journal of Medicine* 1983; 139(6):934-938.

22. Bertrakis KD, Roter D, Putnam SM. The Relationship of Physician Medical Interview Style to Patient Satisfaction.

Journal of Family Practice 1991; 32:175-181.

23. Betancourt JR. Cross-cultural Medical Education: Conceptual Approaches and Frameworks for Evaluation. *Academic Medicine* 2003; 78(6):560-569.

24. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O. Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care. *Public Health Reports* 2003; 118(July-August):293-302.

25. Betancourt JR, Like RC. Invited Editorial. A New Framework of Care. Patient Care Special Issue—Caring for Diverse Population: Breaking Down Barriers, 2000; 34(9):10-12.

26. Bing VM, Reid PT. Unknown Women and Unknowing Research: Consequences of Color and Class in Feminist Psychology. *Knowledge, Difference, and Power: Essays inspired by Women's Ways of Knowing*. Nancy Rule Goldberger, et al., ed. New York: Basic Books, 1996.

27. Bittle M, Duggleby W, Ellison P. Implementation of the Essential Elements of Service Learning in Three Nursing Courses. *Journal of Nursing Education* 2002; 41(3):129-132.

28. Black RM. Comparison of multicultural literature in three health professions: physical therapy, nursing & social work. *Journal of Cultural Diversity* 2001; 8(1):3-15.

29. Blanter R, Page PM. Creating a Successful Culturally Sensitive Home Care Program. *CARING Magazine* 1995; (December):12-14.

30. Block B. State-of-the-Center, Mental Health, NIH Policies for Women and Minorities are Topics of 13th NCCAM Meeting. *Alternative Therapies* 2003; 9(2):22-26.

31. Borkan JM, Neher JO. A developmental model of ethnosensitivity in family practice training. *Family Medicine* 1991; 23(3):212-217.

32. Boston Healing Landscape Project. Website. Boston University School of Medicine (http://www.bmc.org/pediatrics/special/bhlp).

33. Boyd EL. Taylor SD, Shimp LA, Semler CR. An Assessment of Home Remedy Use by African Americans. *Journal of the National Medical Association* 2000; 92(7):341-353.

34. Boyle DA, Sheridan A, McClary J, White J. A Multifocal Education Strategy to Enhance Hospital-Based Cultural Competency in Professional Staff. *Oncology Nursing Forum* 2002; 29(5):764-768.

35. Brown G. Culture and diversity in the nursing classroom: an impact on communication and learning. *Journal of Cultural Diversity* 2001; 8(1):16-20.

36. Burchum JLR. Cultural Competence: An Evolutionary Perspective. *Nursing Forum* 2002; 37(4):5-15.

37. Burman ME. Complementary and Alternative Medicine: Core Competencies for Family Nurse Practitioners. *Journal of Nursing Education* 2003; 42(1):28-15.

38. Byrne MM, Weddle C, Davis E, McGinnis P. The Byrne Guide for Inclusionary Cultural Content. *Journal of Nursing Education* 2003; 42(6):277-281.

39. Callister LC. Culturally Competent Care of Women and Newborns: Knowledge, Attitude, and Skills. *JOGNN* 2001; 30(2):209-215.

40. Campbell A, Davis S. Faculty commitment: Retaining minority nursing students in majority institutions. *Journal of Nursing Education* 1996; 35:298-303.

41. Campinha-Bacote J. Cultural Desire: The Key to Unlocking Cultural Competence. *Journal of Nursing Education* 2003; 42(6):239-240.

42. Campinha-Bacote J. *Inventory for Assessing the Process of Cultural Competence (IAPCC) among health care professionals.* Cincinnati, OH: Transcultural C.A.R.E. Associates, 1997.

43. Campinha-Bacote J. The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care. *Journal of Transcultural Nursing* 2002; 13(3):181-184.

44. Carpio BA, Majumdar B. Experiential learning: an approach to transcultural education for nursing. *Journal of Transcultural Nursing* 1993; 4(2):4-11.

45. Carrillo J, Green A, Betancourt J. Cross-cultural primary care: a patient-based approached. *Annals of Internal Medicine*
1999; 130:829-834.

46. Catanzaro AM, McMullen KA. Increasing nursing students' spiritual sensitivity. *Nurse Educator* 2001; 26(5):221-226.

47. Chafey K. Rhea M. Shannon AM. Spencer S. Characterizations of advocacy by practicing nurses. *Journal of Professional Nursing* 1998;14(1):43-52.

48. Cherrington A, Lewis CE, McCreath HE, Herman CJ, Richter DL, Byrd T. Association of Complementary and Alternative Medicine Use, Demographic Factors, and Perimenopausal Symptoms in a Multiethnic Sample of Women: The ENDOW Study. *Family and Community Health* 2003; 26(1):74-83.

49. Clark C, Robinson TM. Cultural diversity and transcultural nursing as they impact health care. *Journal of National Black Nurses Association* 1999; 10(2):46-53.

50. Coleman-Miller B. A physician's perspective on minority health. *Health Care Financing Review* 2000; 21(4):45-56.

51. Collins KS, Hall A, Neuhaus C. U.S. Minority Health: A Chartbook. The Commonwealth Fund, May 1999.

52. Comas-Diaz L, Jacobsen FM. Ethnocultural Transference and Countertransference in the Therapeutic Dyad. *Amer. J. Orthopsychiatric Assoc*. 61(3), July 1991, pp. 392-402.

53. Cooper TP. Culturally appropriate care: optional or imperative. *Advanced Practice Nursing Quarterly* 1996; 2(2):1-6.

54. Corless IB, Abrams D, Nicholas PK, McGibbon CA. The Use of Complementary and Alternative Therapies. *AACN Clinical Issues* 2000; 11(1):4-6.

55. Covington LW. Cultural Competence for Critical Care Nursing Practice. *Critical Care Nursing Clinics of North America* 2001; 13(4):521-530.

56. Crampton P, Dowell A, Parkin C, Thompson C. Combating Effects of Racism Through a Cultural Immersion Medical Education Program. *Academic Medicine* 78(6):595-598.

57. Crandall SJ, George G, Marion GS, Davis S. Applying Theory to the Design of Cultural Competency Training for Medical Students: A Case Study. *Academic Medicine* 2003; 78(6):588-593.

58. Cross T, Bazron B, Dennis K, Isaacs M. *Towards a culturally competent system of care*. Washington, D.C.: Georgetown University Child Development Center, 1989.

59. Cuellar NG, Cahill B, Ford J, Aycock T. The development of an educational workshop on complementary and alternative medicine: what every nurse should know. *Journal of Continuing Education in Nursing* 2003; 34(3):128-135.

60. Culhane-Pera KA, Like RC, Lebensohn-Chailvo P, Loewe R. Multicultural curricula in family practice residencies. *Family Medicine* 2000 Mar; 32(3):167-173.

61. Culhane-Pera KA, Reif C, Egil E, Baker NJ, Kassekert R. A curriculum for multicultural education in family medicine. *Education Research Methods* 1997; 29:719-723.

62. Curry MD. Patterns of Race and Gender Representation in Health Assessment Textbooks. *Journal of National Black*

Nurses Association 2001; 12(2):30-35.
63. Cushman LF, Wade C, Factor-Litvak P, Kronenberg F, Firester L. Use of Complementary and alternative medicine among African-American and Hispanic women in New York City: a pilot study. *Journal of the American Medical Women's Association* 1999; 54(4):193-195.
64. Darbyshire P. Lessons from literature: caring, interpretation, and dialogue. *Journal of Nursing Education* 1995; 34(5):211-216.
65. De Ruiter HP, Larsen HE. Developing a Transcultural Patient Care Web Site. *Journal of Transcultural Nursing* 2002; 13(1):61-67.
66. DeSantis L. Making anthropology clinically relevant to nursing care. *Journal of Advanced Nursing* 1994; 20(4):707-715.
67. Doane GA. Beyond behavioral skills to human-involved processes: relational nursing practice and interpretive pedagogy. *Journal of Nursing Education* 2002a; 41(9):400-404.
68. Doane GH. In the spirit of creativity: the learning and teaching of ethics in nursing. *Journal of Advanced Nursing* 2002b; 39(6):521-528.
69. Dougherty M, Tripp-Reimer T. The interface of nursing and anthropology. In *Annual Review of Anthropology*, BJ Siegel, ed. Pp. 219-241. Palo Alto, CA: Annual Reviews, 1985.
70. Dreher M, MacNaughton N. Cultural Competence in Nursing: Foundation or Fallacy? *Nursing Outlook* 2002; 50(5):181-186.
71. DiMatteo MR, Hays R. The Significance of Patients' Perceptions of Physician Conduct: A Study of Patient Satisfaction in a Family Practice Center. *Journal of Community Health* 1980; 6:18-34.
72. Duffy ME. A critique of cultural education in nursing. *Journal of Advanced Nursing* 2001; 36(4):487-495.
73. Duska R, Whelan M. *Moral Development: A Guide to Piaget and Kohlberg*. New York: Paulist Press, 1975.
74. Eck DL. *A New Religious America: How a "Christian Country" Has Now Become the World's Most Religiously Diverse Nation*. San Francisco: HarperSanFrancisco, 2001.
75. Eifried S. Bearing witness to suffering: the lived experience of nursing students. *Journal of Nursing Education* 2003; 42(2):59-67.
76. Eisenberg L. Disease and illness. Distinctions between professional and popular ideas of sickness. *Culture, Medicine & Psychiatry* 1977; 1:9-23.
77. Engebretson J. Cultural Constructions of Health and Illness: Recent Cultural Changes Toward a Holistic Approach. *Journal of Holistic Nursing* 2003; 21(3):203-227.
78. Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA* 2002; 287(2):226-235.
79. Eyton J, Neuwirth G. Cross-cultural validity: ethnocentrism in health studies with special reference to the Vietnamese. *Social Science & Medicine* 1984; 18(5):447-453.
80. Fadiman A. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* (1st ed.). New York: Farra, Straus, and Giroux, 1997.
81. Fahrenwald NL. Teaching social justice. *Nurse Educator* 2003; 28(5):222-226.
82. Farmer P. On Suffering and Structural Violence: A View from Below. In *Social Suffering*, A Kleinman, V Das, M Lock, ed. Pp. 261-283. Berkeley: University of Califormia Press, 1997.
83. Farmer P. Pathologies of power: rethinking health and human rights. *American Journal of Public Health* 1999; 89(10):1486-1496.

84. Ferguson WJ, Keller DM, Haley HL, Quirk M. Developing Culturally Competent Community Faculty: A Model Program. *Academic Medicine* 78(6):1221-1228.

85. Fletcher AB. African American Folk Medicine: A Form of Alternative Therapy. *ABNF Journal* 2000; 11(1):18-20.

86. Frisch N. Nursing as a Context for Alternative/Complementary Modalities. *Online Journal of Issues in Nursing* 6(2) (http://www.nursingworld.org/ojin/topic15/tpc15_2.htm, Accessed 3/13/04).

87. Fuller K. Eradicating Essentialism from Cultural Competency Education. *Academic Medicine* 2002; 77(3):198-201.

88. Fuller R. *Spiritual, But Not Religious: Understanding Unchurched America*. New York: Oxford University Press, 2001.

89. Gaydos HL. Complementary and Alternative Therapies in Nursing Education: Trends and Issues. *Online Journal of Issues in Nursing* 6(2) (http://www.nursingworld/org/ojin/topic15/tpc15_5.htm , Accessed 3/13/04).

90. Gendrop SC, Eisenhauer LA. A transactional perspective on critical thinking. *Scholarly Inquiry for Nursing Practice* 1996; 10(4):329-345; discussion 347-350.

91. George M. The challenge of culturally competent health care: Applications for asthma. *Heart & Lung* 2001; (September/October):392-400.

92. Gerace LM, Salimbene S. Cultural Competence for Today's Nurses—Part Two—Culture and Mental Health. *Nursing Spectrum* (http://nsweb.nursingspectrum.com/ce/m29a-1.htm, Accessed 2/14/03).

93. Giger JN, Davidhizar R. The Giger and Davidhizar Transcultural Assessment Model. *Journal of Transcultural Nursing* 2002; 13(3):185-188.

94. Gilligan C. *In a Different Voice: Psychological Theory and Women's Development*. Cambridge: Harvard University Press, 1982.

95. Goddard NC. 'Spirituality as integrative energy'" a philosophical analysis as requisite precursor to holistic nursing practice. *Journal of Advanced Nursing* 1995; 22(4):808-815.

96. Goleman D. *Emotional Intelligence*. New York: Bantam Books, 1997.

97. Gomez-Beloz A, Chavez N. The *Botánica* as a Culturally Appropriate Health Care Option for Latinos. *Journal of Alternative and Complementary Medicine* 2001; 7(5):537-546.

98. Good MJD. *American Medicine: The Quest for Competence*. Berkeley, CA: University of California Press, 1995.

99. Gray MA. Herbs: Multicultural Folk Medicines. *Orthopaedic Nursing* 1996; 15(2):49-56.

100. Green AR, Betancourt JR, Carrillo JE. Integrating Social Factors into Cross-cultural Medical Education. *Academic Medicine* 2002; 77(3):193-197.

101. Greenberg LA. In God we trust: faith healing subject to liability. *Journal of Contemporary Health Law & Policy* 1998; 14(2):451-476.

102. Greenfield S, Kaplan S, Ware JE. Expanding Patient Involvement in Care: Effects on Patient Outcomes. Annals of Internal Medicine 1985; 102:520-528.

103. Greenstreet WM. Teaching spirituality in nursing: a literature review. *Nurse Education Today* 1999; 19(8):649-658.

104. Greer DB. Minority Underrepresentation in Nursing: Socioeconomic and Political Effects. *ABNF Journal* 1995; 6(2):44-46.

105. Greipp ME. Culture and ethics: a tool for analysing the effects of biases on the nurse-patient relationship. *Nursing Ethics: an International Journal for Health Care Professionals* 1995; 2(3):211-221.

106. Gudorf CE. Not Only Poverty: The Richness of Religious Healing in Latin America. *Second Opinion* 2001; 7/July.

107. Habayeb GL. Cultural diversity: A nursing concept not yet reliably defined. *Nursing Outlook* 1995; 43:224-227.

108. Harden J. Enlightenment, empowerment and emancipation: the case for critical pedagogy in nurse education. *Nurse Education Today* 1996; 16(1):32-37.

109. Hardy KV, Laszloffy TA. The cultural genogram: key to training culturally competent family therapists. *Journal of Marital and Family Therapy* 1995; 21(3):227-237.

110. Harris SH, Cummings SH. Reflections on ethnocentrism and racism: a challenge for advanced practice nurses. *Advanced Practice Nursing Quarterly* 1996; 2(2):70-74.

111. Hart A, Hall V, Henwood F. Helping health a social care professionals to develop an 'inequalities imagination': a model for use in education and practice. *Journal of Advanced Nursing* 2003; 41(5): 480-489.

112. Hartman CR. The nurse-patient relationship and victims of violence. Scholarly Inquiry for Nursing Practice. 1995; 9(2):175-192.

113. Hassouneh-Phillips D, Beckett A. An Education in Racism. *Journal of Nursing Education* 2003; 42(6):258-265.

114. Hautman MA. Folk health & illness beliefs. *Nurse Practitioner* 1979; 4:24-34.

115. Health Resources and Services Administration—U.S. Department of Health and Human Services. Cultural Competence Works: Using Cultural Competence To Improve the Quality of Health Care for Diverse Populations and Add Value to Managed Care Arrangements. Washington, D.C., 2001 (http://www.hrsa.gov/financeMC/ftp/culturalcompetence.pdf , Accessed 9/10/03).

116. Henderson A. Power and knowledge in nursing practice: the contribution of Foucault. *Journal of Advanced Nursing* 1994; 20(5):935-939.

117. Henry GB. *Cultural Diversity Awareness Inventory*. Hampton, VA: Hampton University, 1985.

118. Henry W. Idiopathic Health Systems. *Second Opinion* 1999; (September):11-19.

119. Hewison A. Nurses' power in interactions with patients. Journal of Advanced Nursing. 1995; 21(1):75-82.

120. Imes S, Landry D. Don't underestimate the power of culture. *Scientific Nursing* 2002; 19(4):172-176.

121. Hupcey JE. Establishing the nurse-family relationship in the intensive care unit. *Western Journal of Nursing Research* 1998; 20(2):180-194.

122. Ironside PM. "Covering content" and teaching thinking: deconstructing the additive curriculum. *Journal of Nursing Education* 2004; 43(1):5-12.

123. Ironside PM. New pedagogies for teaching thinking: the lived experiences of students and teachers enacting narrative pedagogy. *Journal of Nursing Education* 2003; 42(11):509-516.

124. Jackson B. The Other Kind of Doctor: Conjure and Magic in Black American Folk Medicine. In *African-American Religion: Interpretive Essays in History and Culture*, ed. TE Fulop, AJ Raboteau. Pp. 417-431. New York: Routledge, 1997.

125. Jackson LE. Understanding, Eliciting and Negotiating Clients' Multicultural Health Beliefs. *Nurse Practitioner* 1993; 18(4):30-43.

126. Johnson DW, Johnson RT, Smith KA. *Active Learning: Cooperation in the College Classroom*. Edina, MN: Interaction Book Company, 1991.

127. Johnson M, Webb C. The power of social judgement: struggle and negotiation in the nursing process. *Nurse Education Today* 1995; 15(2):83-89.

128. Johnson PB, Malgady R. Cultural/Ethnic Comparisons: A Research Agenda. *Journal of Gender, Culture, and Health*

1999; 4(3):171-185.
129. Jones PR. Hindsight bias in reflective practice: an empirical investigation. *Journal of Advanced Nursing* 1995; 21(4):783-788.
130. Jordan J. Rethinking race and attrition in nursing programs: A hermeneutic inquiry. *Journal of Professional Nursing* 1996; 12:382-390.
131. Kagawa-Singer M. Addressing issues for early detection and screening in ethnic populations. *Oncology Nursing Forum*
1997; 24(10):1705-1711.
132. Kagawa-Singer M, Kassim-Lakkha S. A Strategy to Reduce Cross-cultural Miscommunication and Increase the Likelihood of Improving Health Outcomes. *Academic Medicine* 2003; 78(6):577-587.
133. Kaptchuk TJ, Eisenberg DM. Varieties of Healing. 1: Medical Pluralism in the United States. *Annals of Internal Medicine* 2001a; 135(3):189-195.
134. Kaptchuk TJ, Eisenberg DM. Varieties of Healing. 2: A Taxonomy of Unconventional Healing Practices. *Annals of Internal Medicine* 2001b; 135(3):196-204.
135. Kemper KJ, Barnes LL. Considering Culture, Complementary Medicine, and Spirituality in Pediatrics. *Clinical Pediatrics* 2003; (April):205-208.
136. Kincheloe J, McLaren P. Rethinking critical theory and qualitative research. In *Handbook of Qualitative Research*, N. Denzin, Y. Lincoln, ed. Pp. 279-313. Thousand Oaks, CA: Sage, 2000.
137. Kingma M. *The Emerging Global Nursing Shortage*. Geneva, Switzerland: International Council of Nurses, 2001.
138. Kirkham SR, Anderson JM. Postcolonial Nursing Scholarship: From Epistemology to Method. *Advanced Nursing Science* 2002; 25(1):1-17.
139. Kitson A. The essence of nursing. *Nursing Standard* 1999; 13(23):42-46.
140. Kleinman A. Clinically applied medical anthropology: the view from the clinic. *Advances in Medical Social Science* 1984; 2:269-288.
141. Kleinman A. *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books, 1988.
142. Kleinman A. *Writing at the Margins: Discourse Between Anthropology and Medicine*. Berkeley: University of California Press, 1994.
143. Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine* 1978; 88:251-258.
144. Krumeich A, Weijts W, Reddy P, Meijer-Weitz A. The benefits of anthropological approaches for health promotion research and practice. Health Education Research. 2001; 16(2):121-130.
145. Landau R. Locus of control and socioeconomic status: does internal locus of control reflect real resources and opportunities or personal coping abilities? *Social Science & Medicine* 1995; 41:1499-1505.
146. Lang F, Floyd MR, Beine KL. Clues to patients' explanations and concerns about their illnesses. A call for active listening. *Archives of Family Medicine* 2000; 9(3):222-227.
147. Leininger M. Culture Care Theory: A Major Contribution to Advance Transcultural Nursing Knowledge and Practices. *Journal of Transcultural Nursing* 2002; 13(3):189-192.
148. Leininger M. Changing foci in American nursing education: primary and transcultural nursing care. *Journal of Advanced Nursing* 1978; 3(2):155-166.
149. Leininger M. *Transcultural nursing: Concepts, theories, research and practice*. New York: McGraw-Hill, 1995.

150. Lemmer C. Teaching the spiritual dimension of nursing care: a survey of U.S. baccalaureate nursing programs. *Journal of Nursing Education* 2002; 41(11):482-490.

151. Lengacher CA, Bennett MP, Kip KE, Keller R, LaVance MS, Smith LS, Cox CE. Frequency of use of complementary and alternative medicine in women with breast cancer. *Oncology Nursing Forum* 2002; 29(10):1445-1452.

152. Leonard BJ. Quality Nursing Care Celebrates Diversity. *Online Journal of Issues in Nursing* 2001; 6(#2, Mss 3). (http://www.nursingworld.org/ojin/topic15/tpc_3.htm, Accessed 3/10/04).

153. Leonard BJ. Plotnikoff GA. Awareness: the heart of cultural competence. *AACN Clinical Issues* 2000; 11(1):51-59.

154. Leppert PC, Partner SF, Thompson A. Learning from the community about barriers to health care. *Obstetric Gynecology* 1996; 87(1):140-141.

155. Leuning CL, Swiggum PD, Barmore Wiegert HM, McCullough-Zander K. Proposed Standards for Transcultural Nursing. *Journal of Transcultural Nursing* 2002; 13(1):40-46.

156. Liaison Committee on Medical Education. Accreditation Standards (http://www.lcme.org/standard.htm#culturaldiversity, Accessed 3/07/03).

157. Liaison Committee on Medical Education. Full text of LCME Accreditation standards, from Functions & structures of a medical school, part two (http://www.lcme.org/stndtext.htm#educationalprogram, Accessed 1/16/04).

158. Lichstein PR, Young G. “My most meaningful patient”. Reflective learning on a general medicine service. *Journal of General Internal Medicine* 1996; 11(7):406-409.

159. Lin Y, Rancer AS. Sex differences in intercultural communication apprehension, ethnocentrism, and intercultural willingness to communicate. *Psychological Reports* 2003; 92(1):195-200.

160. Louie K. Cultural competence. In *Nursing care of the addicted client*, K. Allen, ed. Pp. 222-237. Philadelphia: Lippincott-Raven, 1996.

161. Lowenberg JS. The nurse-patient relationship reconsidered: an expanded research agenda. Scholarly Inquiry for Nursing Practice. 1994; 8(2):167-184; discussion 185-190.

162. Luckmann J. *Transcultural communication in nursing*. Albany, NY: Delmar Publications, 1999.

163. Luker KA, Austin L, Caress A, Hallett CE. The importance of 'knowing the patient': community nurses' constructions of quality in providing palliative care. *Journal of Advanced Nursing* 2000; 31(4):775-782.

164. Lupton D. Perspectives on power, communication and the medical encounter: implications for nursing theory and practice. *Nursing Inquiry* 1995; 2(3):157-163.

165. Lutz K, Jones K, Kendall J. Expanding the praxis debate: Contributions to clinical inquiry. *Advances in Nursing Science* 1997; 20(2):23-31.

166. Machado GA. Cultural Sensitivity and Stereotypes. *Journal of Multicultural Nursing & Health* 2001; 7(2):13-15.

167. Mackenzie ER, Taylor L, Bloom BS, Hufford DJ, Johnson JC. Ethnic Minority Use of Complementary and Alternative Medicine (CAM): A National Probability Survey of CAM Utilizers. *Alternative Therapies* 2003; 9(4):50-56.

168. Mahoney JS, Engebretson J. The interface of anthropology and nursing guiding culturally competent care in psychiatric nursing. *Archives of Psychiatric Nursing* 2000; 14(4):183-190.

169. Mallik M. Advocacy in nursing—perceptions of practising nurses. *Journal of Clinical Nursing* 1997;6(4):303-313.

170. Mathews HF. Rootwork: Description of an Ethnomedical System in the American South. *Southern Medical Journal* 1987; 80(7):885-891.

171. Matthews DA, McCullough ME, Larson DB, Koenig HG, Swyers JP, Milano MG. Religious commitment and health

status: a review of the research and implications for family medicine. *Archives of Family Medicine* 1998; 7:118-24.

172. McAllister G, Farquhar M. Health beliefs: a cultural division? *Journal of Advanced Nursing* 1992; 17(12):1447-1454.

173. McIntosh P. White Privilege and Male Privilege: A Personal Account of Coming to See Correspondences through Work in Women's Studies. Working Paper Series No. 189, Wellesley College, 1988.

174. Meleis A, Hall J, Stevens P. Scholarly caring in doctoral nursing education: Promoting diversity and collaborative mentorship. *Image* 1994; 26:177-180.

175. Mendias EP, Guevara EB. Assessing Culturally Competent Scholarship. *Journal of Professional Nursing* 2001; 17(5):256-266.

176. Mendyka BE. Exploring Culture in Nursing: A Theory-Driven Practice. Holistic Nursing Practice 2000; 15(1):32-41.

177. Meyer CL. How effectively are nurse educators preparing students to provide spiritual care? *Nurse Educator* 2003; 28(4):185-190.

178. Miller NL. Haitian Ethnomedical Systems and Biomedical Practitioners: Directions for Clinicians. *Journal of Transcultural Nursing* 2000; 11(3):204-211.

179. Mishler EG, Clark JA, Ingelfinger J, Simon MP. The language of attentive patient care: A comparison of two medical interviews. *Journal of General Internal Medicine* 1989; 4(4):325-335.

180. Morse GG. Reframing women's health in nursing education: a feminist approach. *Nursing Outlook* 1995; 43(6):273-277.

181. Najm W, Reinsch S, Hoehler F, Tobis J. Use of Complementary and Alternative Medicine Among the Ethnic Elderly. *Alternative Therapies* 2003; 9(3):50-57.

182. Narayanasama A. ASSET: a model for actioning spirituality and spiritual care education and training in nursing. *Nurse Education Today* 1999; 19(4):274-285.

183. Nehls N. Narrative pedagogy: rethinking nursing education. *Journal of Nursing Education* 1995; 34(5):204-210.

184. Nolan P, Crawford P. Towards a rhetoric of spirituality in mental health care. *Journal of Advanced Nursing* 1997; 26(2):289-294.

185. Norris J. Teaching communication skills: effects of two methods of instruction and selected learner characteristics. Journal of Nursing Education. 1986; 25(3):102-106.

186. Núñez Molina MA. Community Healing Among Puerto Ricans: *Espiritismo* as a Therapy for the Soul. In *Healing Cultures: Art and Religion as Curative Practices in the Caribbean and Its Diaspora*, Pp. 115-227. New York: Palgrave, 2001.

187. Nunnelee JD, Spaner SD. Explanatory model of chronic venous disease in the rural Midwest—a factor analysis. *Journal of Vascular Nursing* 2000; 18(1):6-12.

188. Nursing Practice and Education Consortium. Vision 2020 for Nursing. (http://www.nursingsociety.org/programs/vision2020.rtf, Accessed 3/9/04).

189. Office of Minority Health—U.S. Department of Health and Human Services. National Standards for Culturally and Linguistically Appropriate Services [CLAS] in Health Care: Executive Summary. Washington, D.C., March 2001 (http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf, Accessed 9/10/03).

190. Office of Minority Health—U.S. Department of Health and Human Services. Teaching Cultural Competence in Health Care: A Review of Current Concepts, Policies and Practices (Contract Number: 282-98-0029, Task Order #41, Task 2: Synthesis Report), Washington, D.C.: Office of Minority Health, U.S. Department of Health and Human Services,

March 12, 2002.

191. Owen MJ, Holmes CA. 'Holism' in the discourse of nursing. *Journal of Advanced Nursing*. 1993; 18:1688-1695.

192. Oxford University Press. *The Compact Edition of the Oxford English Dictionary*, II:3343. New York: Oxford University Press, 1977.

193. Pachter LM. Culture and clinical care. Folk illness beliefs and behaviors and implications for health care delivery. *JAMA* 1994; 271:690-694.

194. Papadopoulos I, Lees S. Developing culturally competent researchers. *Journal of Advanced Nursing* 2002; 37(3):258-
264.

195. Peña Dolhun E, Muñoz C, Grumbach K. Cross-cultural Education in U.S. Medical Schools: Development of an Assessment Tool. *Academic Medicine* 2003; 78(6):615-622.

196. Pesut B. Developing spirituality in the curriculum: worldviews, intrapersonal connectedness, interpersonal connectedness. *Nursing Education Perspectives* 2003; 24(6):290-294.

197. Pesut B. The development of nursing students' spirituality and spiritual care-giving. *Nurse Education Today* 2002; 22(2):128-135.

198. Peters M. Does constructivist epistemology have a place in nurse education? *Journal of Nursing Education* 2000; 39(4):166-172.

199. Peterson R, Smith J. A Patient Care Team Approach to Multicultural Patient Care Issues. *Journal of Nursing Care Quality* 1996; 10(3):75-79.

200. Pinderhughes E. *Understanding Race, Ethnicity and Power—The Key to Efficacy in Clinical Practice*. New York: The Free Press, 1989.

201. Plotkin SR, Post R. Folk Remedy Use in the Inner City. *Southern Medical Journal* 1999; 92(8):795-798.

202. Pluralism Project. Website. Harvard University .

203. Prochaska JO, Velicer WF. The transtheoretical model of health behavior change. *American Journal of Health Promotion* 1997; 12(1):38-48.

204. Purnell L. The Purnell Model for Cultural Competence. *Journal of Transcultural Nursing* 2002; 13(3):193-196.

205. Purnell L, Paulanka BJ. *Transcultural health care: A culturally competent approach*. Philadelphia: F. A. Davis, 1998.

206. Rabowitz S, Kushnir T, Ribak J. Preventing burnout: increasing professional self efficacy in primary care nurses in a Balint Group. *AAOHN Journal* 1996; 44(1):28-32.

207. Rafael AR. Advocacy and empowerment: dichotomous or synchronous concepts? *Advances in Nursing Science* 1995; 18(2):25-32.

208. Ramos MC. The nurse-patient relationship: theme and variations. *Journal of Advanced Nursing* 1992; 17(4):496-506.

209. Rew L, Becker H, Cookston J, Khosropour S, Martinez S. Measuring Cultural Awareness in Nursing Students. *Journal of Nursing Education* 2003; 42(6):249-257.

210. Richardson SF. Complementary Health and Healing in Nursing Education. *Journal of Holistic Nursing* 2003; 21(1):20- 35.

211. Ridley C. *Overcoming unintentional racism in counseling and therapy*. Thousand Oaks, CA: Sage, 1995.

212. Risser AL, Mazur LJ. Use of Folk Remedies in a Hispanic Population. *Archives of Pediatrics & Adolescent Medicine* 1995; 149(9): 978-981.

213. Rivera JO, Ortiz M, Lawson ME, Verma KM. Evaluation of the Use of Complementary and Alternative Medicine in the Largest United States-Mexico Border City. *Pharmacotherapy* 2002; 22(2):256-264.

214. Root M. Experiences and Processes Affecting Racial Identity Development: Preliminary Results from the Biracial Sibling Project. *Cultural Diversity and Mental Health* 1998; 4(3):237-247.

215. Rorie JA, Paine LL, Barger MK. Primary care for women. Cultural competence in primary care services. *Journal of Nurse-Midwifery* 1996; 41(2):92-100.

216. Salimbene S, Gerace LM. Cultural Competence for Today's Nurses—Part One—Culture and Women's Health. *Nursing Spectrum*).

217. Salimbene S, Gerace LM. Cultural Competence for Today's Nurses—Part Three—The Cultural Factor in Pain Management. *Nursing Spectrum*.

218.

219. Schmieding NJ. Minority Nurses in Leadership Positions: A Call for Action. *Nursing Outlook* 2000; 48:120-127.

220. Schön D. *Educating the Reflective Practitioner: Toward a New Design for Teaching and Learning in the Professions*. New York: Basic Books, 1987.

221. Shearer R, Davidhizar R. Using Role Play to Develop Cultural Competence. *Journal of Nursing Education* 2003; 42(6):273-276.

222. Singer M, Clair S. Syndemics and public health: reconceptualizing disease in bio-social context. *Medical Anthropology Quarterly* 2003; 17(4):423-441.

223. Smith LS. Cultural competence for nurses: canonical correlation of two culture scales. *Journal of Cultural Diversity* 1998; 5(4):120-126.

224. Smith RC, Hoppe RB. The patient's story: Integrating the patient- and physician-centered approaches to interviewing.

Annals of Internal Medicine 1991; 115(6):470-477.

225. Snyder M, Lindquist R. Issues in Complementary Therapies: How We Got to Where We Are. *Online Journal of Issues in Nursing* 6(2).

226. Sorrel J. The Ethics of Diversity: A Call for Intimate Listening in Thin Places. *Online Journal of Issues in Nursing*.

227. Spector RE. Cultural Diversity in Health and Illness. *Journal of Transcultural Nursing* 2002; 13(3):197-199.

228. Spector RE. *Cultural diversity in health and illness* (5th ed.) Upper Saddle River, NJ: Prentice Hall Health, 2000.

229. St Clair A, McKenry L. Preparing culturally competent practitioners. *Journal of Nursing Education* 1999; 38(5):228-234.

230. Steering Committee, Call to the Nursing Profession and Nursing's Agenda for the Future. Nursing's Agenda for the Future: The Future Vision for Nursing.

231. Sturch E. Assessment of learning in the cross-cultural domain: Reflection leads to learning for the teacher. *Journal of Advanced Nursing* 1994; 19:749-754.

232. Sutherland LL. Ethnocentrism in a Pluralistic Society: A Concept Analysis. *Journal of Transcultural Nursing* 2002; 13(4):274-281.

233. Tatum BD. Talking about Race, Learning about Racism: The Application of Racial Identity Development Theory in the Classroom. *Harvard Educational Review* 1992; 62(1):1-24.

234. Taylor JS. Confronting "Culture" in Medicine's "Culture of No Culture." *Academic Medicine* 2003a; 78(6):555-559.

235. Taylor JS. The story catches you and you fall down: tragedy, ethnography, and "cultural competence." *Medical Anthropology Quarterly* 2003b; 17:159-181.

236. Tervalon M. Components of Culture in Health for Medical Students' Education. *Academic Medicine* 2003; 78(6):570-

594.
237. Tervalon M, Murray-García J. Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. *Journal of Health Care for the Poor and Underserved* 1998; 9(2):117-125.
238. Thandeka. *Learning to Be White: Money, Race, and God in America*. New York: Continuum, 1999.
239. Thiederman SB. Ethnocentrism: a barrier to effective health care. *Nurse Practitioner* 1986; 11(8):52, 54, 59.
240. Tovey P. Adams J. Towards a sociology of CAM and nursing. *Complementary Therapies in Nursing & Midwifery* 2002; 8(1):12-16.
241. Vasquez M. Reflections on unearned advantages, unearned disadvantages, and empowering experiences. In *Handbook of Multicultural Counseling*, JG Ponderotto, JM Casas, LA Suzuki, CM Alexander ed. Pp. 387-414. Thousand Oaks, CA: Sage, 2000.
242. Ventres W, Gordon P. Communication strategies in caring for the underserved. *Journal of Health Care for the Poor and Underserved* 1990; 1(3):305-314.
243. Vermeire E, Hearnshaw H, Van Royen P, Denekens J. Patient adherence to treatment: three decades of research. A comprehensive review. *Journal of Clinical Pharmacy & Therapeutics* 2001; 26(5):331-342.
244. Walker M. Analysing qualitative data: Ethnography and the evaluation of medical education. *Medical Education* 1989; 23(6):498-503.
245. Ward SL. Caring and healing in the 21st century. *MCN, American Journal of Maternal Child Nursing* 1998; 23(4):210-215.
246. Warner JR. Cultural Competence Immersion Experiences: Public Health Among the Navajo. *Nurse Educator* 2002; 27(4):187-190.
247. Watson J. Watson's philosophy and theory of human caring in nursing. In *Conceptual Models For Nursing Practice*, JP Reihl-Sisca, ed. Pp. 219-235. Norwalk, CT: Appleton & Lange, 1989.
248. Wear D. Insurgent Multiculturalism: Rethinking How and Why We Teach Culture in Medical Education. *Academic Medicine* 2003; 78(6):549-554.
249. Weidman HH. Research strategies, structural alterations and clinically applied anthropology. In *Clinically Applied Anthropology*, NJ Chrisman, TW Maretzki, ed. Pp. 201-241. Dordrecht, The Netherlands: D. Reidel, 1982.
250. Welch M. Concept Paper: Culturally Competent Care. National Advisory Committee, Office of Minority Health/Office of Public Health and Sciences, Department of Health and Human Services, March 18-19, 2002.
251. Wells M. Beyond Cultural Competence: A Model for Individual and Institutional Cultural Development. *Journal of Community Health Nursing* 2000; 17(4):189-199.
252. Wendler MC, Struthers R. Bridging Culture On-Line: Strategies for Teaching Cultural Sensitivity. *Journal of Professional Nursing* 2002; 18(6):320-327.
253. Wilkinson S, Bailey K, Aldridge J, Roberts A. A longitudinal evaluation of a communication skills programme. *Palliative Medicine* 1999; 13(4):341-348.
254. Wright SM, Carrese JA. Serving as Physician Role Model for a Diverse Population of Medical Learners. *Academic Medicine* 78(6):623-628.
255. Yoder MK. Instructional Responses to Ethnically Diverse Nursing Students. *Journal of Nursing Education* 1996; 35(7):315-321.