Critical Cultural Awareness and Diversity in Nursing: *A Minority Perspective*

Chenit Ong-Flaherty, DNP, CNL, APHN-BC

With the advent of globalization and migration, the significance of culture in our daily lives has become more acute. Cross-cultural interactions have grown exponentially; from multinational corporations to aviation, people from different cultures interact, some interactions more successful than others. These interactions have resultant outcomes, be they in the form of an efficient and successful business or the sentinel event of an aviation accident. A quick survey of any hospital in the San Francisco Bay Area alone will find great diversity, with more than 110 languages spoken.[1] The increase in multicultural interactions in healthcare has made care provision more complicated. There has been much attention given to organizational culture, team development, and effective communication. Similarly, there is the call for patient-centered care, which must incorporate cultural needs and respect for patient wishes; providers must work on becoming "culturally competent." Indeed, there is much attention given to the importance of culture. Yet, too frequently, one still encounters the reality of cultural ethnocentrism. It is especially disturbing when ethnocentrism rears its ugly head in healthcare.

More than 2 decades of educating healthcare providers on cultural competency begets the question of why culturally insensitive care and care disparities, as well as the protracted struggle for better communication and teamwork in healthcare, still persist. The first problem lies in the outdated application of "cultural competency" based on the didactic approach to teaching ethnic-based information without developing critical understanding and appreciation of cultural dimensions. The second, and possibly the more important, factor may lie in the profession itself. Nursing is populated largely by white women; the schema of thought of a dominant culture has significant implications on how culture is addressed.[2] Critical cultural awareness and diversity go hand-in-hand; solutions for one must include the other.

Cross-cultural training must be readdressed and move away from limiting, ethnic-based information to a comprehensive program entailing experiential and reflective learning. It should incorporate cultural concepts or dimensions such as individualism versus collectivism and power distance, integrating the lived experience of people from historical and sociological contexts. This training should start with nursing leaders, and for that matter, all leaders in healthcare. For this to happen, it will take great leadership; this change calls for ethical leadership with foresight, courage, and the ability to

see beyond the "norm," a leader who understands the importance of diversity in closing the provider-patient gap.[2,3] Addressing critical cultural awareness may encourage minorities to be more inclined to join the profession, both as clinicians and educators.

THE CULTURAL DIMENSION OF COLLECTIVISM VERSUS INDIVIDUALISM

The social psychologist, Geert Hofstede, began his work in the 1960s on the premise that individuals are influenced by the culture in which they are nurtured. Culture is defined as the norm or the schema of thought in which we are programed, or as Hofstede calls it, the "software of the mind."[4] In childhood, the culture in which we are nurtured influences our perspectives, morals, beliefs, thoughts, and behaviors. At professional school, we are programed by professional expectations. At work, organizational culture adds another layer of complexity to the cultural stage on which we act. The norm is an expectation that is not challenged until cross-cultural interaction occurs. Understanding other cultures does not automatically occur; it takes guidance and the ability to critically reflect that individuals can move away from judgment and to be open to new ideas and realities. Ultimately, a person can develop cultural awareness to the level at which a culture can be switched on and off depending the environment and situation, a level of sophistication analogous to emotional intelligence.[4-6]

Hofstede's survey of hundreds of thousands of people all over the world brought him to develop cultural dimensions. His original four are individualism–collectivism (addressed in this paper); power distance; masculinity–femininity; and uncertainty avoidance. His earliest works have been replicated for validity and reliability, widely cited, and adopted by the business world, multinational corporations and various industries, including the critical work by Robert Helmreich, who co-created the Cockpit Resource Management for aeronautical and aviation safety.[4-10]

The dimension of collectivism–individualism may have the most significant influence on perspectives and behaviors.[3,5,10-12] The dichotomy of "us versus them" is accentuated by the very different worldviews of "self" in collectivism and individualism. In the collectivist mind, the "self" is connected to a group. This connection to others is imperative in how the "self" functions. Actions reflect not just one individual, but everyone connected to that individual. Priorities lie in maintaining the good standing of the group; harmony is emphasized, with the understanding to avoid shaming anyone. Individual successes are celebrated as group successes. Communication is high-context, indirect with subtleties in meaning for the purpose of maintaining harmonious relationships. Goals are similarly group oriented.

On the opposite end is individualism. As the word implies, the "self" in individualism is about the autonomous individual, separate from everyone else. "I" and "me" matters most, as in the principles of individual rights and autonomy. Actions reflect just 1 individual, as well as the consequences of actions. In other words, how does an action affect "me"? Individual success is celebrated. Language is low context in nature, direct, with little concern for its impact on others.[4,5,10]

This cultural dimension has been found to critically affect communication and safety.[5-7] Most profound is misinterpretation in communication, and the assumptions that come with the misinterpretation. For example, in addressing a problem, a simple and direct "You need to," said by a person from an individualist perspective is simply relaying a need. Said to a collectivist, the statement can be easily misconstrued as rude, disrespectful, or shaming. In addressing the same problem, a person from a collectivist background may ask, "What can we do to" in relaying the same message of need with the goal of maintaining harmony and respecting the working relationship. The same question can be misconstrued by the individualist coworker as a sign of incompetence or avoidance of truth.

IMPLICATIONS IN NURSING

The worldview of "self" in the contexts of collectivism and individualism affect nursing clinically in provider–patient and provider–provider relationships, and in education in educator–student and educator–educator relationships. In the provider–patient relationship, for example, it is known that many cultures make decisions collectively, usually as a family unit. Group decision making can be complex and time consuming, frustrating a provider from the individualist perspective to whom individual rights and autonomy are key to decision making. This is a common phenomenon observed by collectivists in which providers have made comments along the lines of "You have the right to make your own decision." Attempts to communicate rights with good intentions can backfire, as the directness in language is perceived as disrespectful and blame-oriented, which causes shame. Such misunderstandings have safety implications. Patients are known to sign out against medical advice or, in perceiving judgment, opt to withhold information critical to care. The opportunity for trust to develop is gone, possibly with long-term consequences where healthcare is avoided, with poor outcomes for the patients.

An example of this common cultural misunderstanding is demonstrated in the case of a young woman from the Middle East. She had just arrived with her engineer husband to the Bay Area. Being a devout Muslim, she was brought in by her husband for vaginal bleeding and abdominal pain. She needed a pelvic examination, which, in her culture, has to be performed by a female physician. There were only male physicians on duty that night at the emergency department. As the team was trying to decide how best to care for her, a nurse went into the room and proceeded to lecture the patient and her husband that "They are in America now" and told the patient that, as a woman, she has the right to make her own decision regarding being examined by a male physician. Crying, the patient left the department with her husband. The offending nurse informed the team of what she had done and commented it was "good riddance" that the patient and her husband had left. There were no concerns for patient safety: what if the patient had had an ectopic pregnancy? Why could she not be kept for observation for another 3