Nurse Education Today 35 (2015) 1062–1068

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/nedt

A constructivist theoretical proposition of cultural competence development in nursing

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ARTICLE INFO

Article history:
Accepted 25 May 2015

Keywords:
Cultural competence
Competence development model
Nursing education
Constructivism
Grounded theory
Qualitative data analysis

SUMMARY

Cultural competence development in healthcare professions is considered an essential condition to promote quality and equity in healthcare. Even if cultural competence has been recognized as continuous, evolutionary, dynamic, and developmental by most researchers, current models of cultural competence fail to present developmental levels of this competence. These models have also been criticized for their essentialist perspective of culture and their limited application to competency-based approach programs. To our knowledge, there have been no published studies, from a constructivist perspective, of the processes involved in the development of cultural competence among nurses and undergraduate student nurses. The purpose of this study was to develop a theoretical proposition of cultural competence development in nursing from a constructivist perspective.

We used a grounded theory design to study cultural competence development among nurses and student nurses in a healthcare center located in a culturally diverse urban area. Data collection involved participant observation and semi-structured interviews with 24 participants (13 nurses and 11 students) working in three community health settings.

The core category, 'learning to bring the different realities together to provide effective care in a culturally diverse context', was constructed using inductive qualitative data analysis. This core category encompasses three dimensions of cultural competence: 'building a relationship with the other', 'working outside the usual practice framework', and 'reinventing practice in action.' The resulting model describes the concurrent evolution of these three dimensions at three different levels of cultural competence development. This study reveals that clinical experience and interactions between students or nurses and their environment both contribute significantly to cultural competence development. The resulting theoretical proposition of cultural competence development could be used not only to guide initial and continuing nursing education, but also to help redefine quality of care in a culturally diverse context.

Introduction

The development of cultural competence among healthcare professionals and students is considered one of a series of solutions to improve quality of care in a culturally diverse context and to reduce health inequities (Calvillo et al., 2009). Many studies have explored cultural competence and its inclusion in nursing education programs. The vast majority of these studies are based on Leininger's conceptions of culture and culturally congruent care (Leininger and McFarland, 2006). Studies have also presented teaching strategies that foster the development of this competence and their effects on student learning (Kokko, 2011; Long, 2012). Most of these strategies are based on acquiring specific knowledge about given cultural groups, which denotes an essentialist understanding of the concept of culture and leaves little room for diversity within any one culture (Blanchet Garneau and Pepin, 2015). From a constructivist perspective, the concept of culture is considered to be fluid, dynamic, and constantly evolving in relation to historical, political, and social conditions. In this sense, culture is a relational process. A culturally diverse context thus encompasses diversity that can assume many forms in society—such as age, gender, sexual orientation or socioeconomic status—and is not limited to race and ethnicity. Moreover, even the notion of competence itself becomes problematic when it refers to know-how or behaviors to be adopted. Competence, understood from a constructivist perspective, refers rather to a systemic and holistic conception of learning (Tardif, 2006). Developing a competence involves challenging one's prior knowledge and developing new knowledge in a dialectic manner through an iterative cycling of reflection and action (Duke et al., 2009). Hence, the development of a competence requires long-term work and continues throughout life.

Even if cultural competence has been recognized as continuous, evolutionary, dynamic, and developmental by most researchers (e.g. Andrews and Boyle, 2012; Campinha-Bacote, 2002; Jeffreys, 2010; Giger and Davidhizar, 2008; Papadopoulos, 2006; Purnell and Paulanka,

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http://dx.doi.org/10.1016/j.nedt.2015.05.019
0260-6917/

2003), current models of cultural competence fail to present developmental levels of this competence. Most models focus on cultural competence domains such as cultural sensitivity, awareness, skill, knowledge, and encounter (Shen, 2014) without presenting the learning processes involved in the concurrent evolution of these domains. Hence, they do not depict a profile of the progression of this competence that could be used in a competency-based approach to education. Thus, it becomes difficult to assess a progression in the development of this competence among students and nurses from another point of view than the one of the learner. Most models have also been criticized for their focus on ethnicity, on popular and stereotypical representations of cultural groups, and on cultural differences (Williamson and Harrison, 2010). Williamson and Harrison (2010) point out that emphasizing differences can reinforce ethnocentric approaches to care. Even though authors have recognized the systemic nature of cultural competence, models still focus on individual actions, thereby obscuring the influence of organizational and societal structures.

Some recent studies have described the relation of cultural competence with the environment at a personal, organizational and global level (Soulé, 2014). However, these studies have not moved from a descriptive perspective to the integration of the resulting categories or concepts described into a unified theoretical proposition.

Drawing from both the nursing (Calvillo et al., 2009; Duke et al., 2009; Goudreau et al., 2009; Lynam et al., 2007) and the education sciences literature (NRC, 2001; Tardif, 2006), Blanchet Garneau and Pepin (2015) have defined cultural competence as a "complex know-act[3] grounded in critical reflection and action, which the healthcare professional draws upon to provide culturally safe, congruent, and effective care in partnership with individuals, families, and communities living health experiences, and which takes into account the social and political dimensions of care". This definition highlights the interactional, dialogical, dynamic, contextual and evolutionary nature of cultural competence. The development of cultural competence is then understood as a lifelong ongoing process.

While there is an abundance of literature on cultural competence and its domains in various health fields, there is little data on the learning processes involved in the development of this competence from a constructivist perspective. The aim of this study was to develop a constructivist theoretical proposition of the development of cultural competence in nursing. We wanted to answer the following research question: how do nurses develop their cultural competence in their learning and practicing environments?

Methods

Methodologically, this research was informed by the constructivist perspective described by Guba and Lincoln (2005), who proposed a relativist ontology and a subjectivist and transactional epistemology. A constructivist perspective provides a theoretical lens to consider the development of cultural competence as a process that situates actors engaged in learning in constant interaction with their environment. We used Corbin and Strauss' (2008) grounded theory to document the process of cultural competence development among nurses and students in a health and social services center serving an urban population presenting substantial cultural and social diversity. The research project received ethical approval from the study setting and university of affiliation of the authors. Carrying out this study in the natural setting of the actors involved in the phenomenon allowed us to examine in detail the actual experience of people interacting with each other in their own social environments. The first author was the principal investigator of this research and undertook each step of sampling, data collection and analysis (Blanchet Garneau, 2013). The second author advised on the research process and participated in the validation of data analysis and theoretical proposition.

Sample

The participants were nurses (n = 13) and students (n = 11) in the final year of a baccalaureate nursing program, all working in the study setting (encompassing three community health settings and home care) during the data collection period. According to Morse (2000), 20 to 30 participants are sufficient for theoretical saturation in grounded theory. Including both nurses and students offered the potential to understand cultural competence development through the various stages of learning.

A purposive sampling strategy allowed recruiting nurses recognized by their peers as having a high level of proficiency in cultural competence, as well as nurses that were interested by culturally competent practice and senior undergraduate level students. Most of the participants were recruited at the beginning of data collection (n = 22). Two nurses were recruited during data collection to explore more deeply certain dimensions of the theoretical proposition under construction. The sampling, data collection, and analysis were only partially concurrent and were conducted from October 2011 to August 2012. Corbin and Strauss (2008) state that it is still possible to aim for theoretical saturation when most participants are selected at the start of data collection rather than over the course of developing the theoretical proposition. In such cases, it is important to remain attentive to variations in the participants and in the data collected (Corbin and Strauss, 2008). Thus, diversification and theoretical saturation principles guided the sampling in this study. The 24 participants' sociodemographic characteristics are presented in Table 1. It should be noted that by sharing their experience retrospectively, nurses identified by their peers as having a high level of development contributed to define not only the higher level of cultural competence development, but also the previous ones. Similarly, some students contributed to define not only the lower level of development but also the next levels.

Data Collection

A semi-structured interview was conducted with each of the 24 participants. Periods of participant observation (29 h) preceded the semi-structured interviews of 16 of the 24 participants (13 nurses and three students). Observations focused on the physical environment of the participants, the different actors, actions and interactions taking place, the aims pursued and the feelings expressed by these actors. As the data collection progressed, observations became more specific to refine the theoretical proposition. Observational data provided a means of triangulating interview data, adding to the methodological rigor. Interviews focused on participants' experience with people from diverse cultures, situations in which they thought they expressed or witnessed cultural competence, and significant moments in their personal or

Table 1
Sociodemographic characteristics of the participants.

Characteristics		Number of participants		
		Students	Nurses	Total
Age (Years)	21 to 30	8	3	11
	31 to 40	0	6	6
	41 to 60	3	4	7
Country of birth	Canada	4	8	12
	Canada — 2nd generation immigrant	2	2	4
	Outside Canada	5	3	8
Nursing experience (Years)	0 to 1	11	0	11
	1 to 3	0	3	3
	4 to 9	0	5	5
	10+	0	5	5

[3] Translation of French "savoir-agir" that goes beyond know-how.