Northwest University

Recommendation:
Extended Cultural Immersion Experience
As a Required Program
In Baccalaureate Nursing Programs

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Practicum V: Thesis Project II

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Imagine that you have just wakened in the hospital to discover you have been critically injured in a horrible accident. Born and raised in Kenya, you are in the US on a study visa, living your dream to study abroad, and the unthinkable has happened to you. Having just started school, you know no one well enough to call them to your bedside where you are recovering from multiple injuries. Your English language skills are satisfactory, but the people around you speak quickly, abruptly, and in bio-scientific terms. You are trying to make sense of your bandages and stitches, your leg is in some kind of traction, and countless beeping machines and tubes run in and out of your body. If only someone would slow down, tell you what happened, and ask you what you're feeling. You hope someone will ask what you need. You want to feel confident in the care plan in progress for you, but you do not understand all that is happening. Your family would comfort, feed, and mediate for you, but they cannot fly out from Kenya. You need an advocate, someone who sees you as a human and not a task-driven project. You are afraid and feel helpless, which no doubt exacerbates your pain.

Recently in Seattle, a charter bus of international college students suffered a tragic collision, sending dozens to Harborview Medical Center. Those students possibly felt as lost and fearful as the hypothetical patient described above; however, anyone can potentially require healthcare on foreign soil, as a visitor or as a resident. Furthermore, it doesn't require international travel to encounter diversity; the world has become a much "smaller place." But while early globalization was marked by people's tendencies to assimilate into what Lechner calls a "monoculture" (114), today people maintain individual cultural identities. Hamelink asserts that "there is local cultural differentiation" not one global culture (Lechner and Boli 30). It is imperative, then, in this increasingly globalized society, that nurses have cultural educational training that adequately prepares them to offer holistic and compassionate care to diverse, local neighborhood communities and to foreign visitors. In most every US healthcare setting, nurses

can expect to treat patients from many different ethnicities, cultures, races, and nationalities People in general, hold specific and varied cultural belief systems, special interests, religions, and differing cultural frames of reference. Because of this diversity, the American Associate of Colleges of Nursing (AACN) expects baccalaureate nursing education to include cultural education.

The AACN expects cultural education to occur in nursing programs, yet while different theories and strategies for cultural education have been integrated into Bachelor of Nursing (BSN) programs, no consistent, standardized strategies have been enforced. Strategies range from cultural immersion as a stand-alone elective, to different levels of integrated ideas and experiences. Either way, cultural education must be experiential to be efficient and successful in the long run. Education that brings lasting impact influences students' hearts, their senses, their awareness, and their perspectives far into their professional careers. An immersion experience ensures that education is "not just transactional but rather transformational" learning (Ihrig). This transformation awakens a reconnection to the values that once brought students to pursue nursing in the first place (Adamshick et al.). Studies by Evanson and Zust, and by Levine show that students can develop a heart and mind for social justice and patient advocacy that persists for years after their cultural immersion (qtd. in Adamshick et al.). For a balanced cultural competency, nursing students must learn cultural knowledge, gain a desire to understand "others," master skills, and practice awareness and sensitivity (Campinha-Bacote "Model of Cultural Competency" 2005). Most important, nursing students must experience cultural encounters, (Campinha-Bacote "Transcultural Care" 2005).

Ultimately, to best learn these constructs, all baccalaureate nursing programs should include extended, overseas immersion in a different culture as a requirement for graduation from

a Bachelor of Science in Nursing (BSN) program. This thesis is a case study of the Buntain School of Nursing at Northwest University where just such an extended immersion experience is required. Through integrated, qualitative research in the form of program research, observations, individual surveys and interviews, this study illustrates the impact that the four-week trips have had on the BSON students at Northwest University: first, the students gained significant cultural awareness, and second, the feedback proves that this specific model for education is imperative for holistic healthcare.

Context

In light of the growing diversity, world travel, internet exposure, and other opportunities for multi-cultural exposure, nurses must be ready to minister with sensitivity and diplomacy to all patients. Diplomacy and humility are the needed responses to global tensions created by international terrorism and refugee crises. These responses make up the basis for the necessary cultural sensitivity that this thesis will address. In the context of this project, culture refers to any people group's traditions, perspectives, beliefs, and general ways of thinking. These traditions and perspectives are shared in common and passed along to those who live in a specific people group. Cultural sensitivity, often called cultural humility, is a thoughtful stance that comes from a self-awareness of our own personal perspectives. Armed with this awareness, we can practice tolerance and empathy for other people groups' differing cultural perspectives. Tolerance and cultural humility come from experiential understanding. When we set aside pre-conceived notions about people's values and expectations, we effectively individualize and humanize others. This practice shows cultural competence.

Within healthcare settings, this process of cultural competence and humility benefits all patients' care. Within all BSN (Bachelor of Science in Nursing) educational programs, requiring

nurses' to experience diverse cultures is the best way to strengthen their self-awareness and cultural humility. Literature shows that the correct response to the challenges globalization is cultural competency. Cultural, or more specifically, trans-cultural education, fulfills American AACN expectations toward cultural competence which, in turn, provides nurses with the holistic nursing skills that facilitate their work with diverse patient populations. Holistic care considers the patients' physical needs in context of their spiritual, emotional, and psychological states. Patients dealing with illness or injury often feel scared and vulnerable. Consequently, holistic nursing includes compassionate, empathetic care that is void of prejudice or ethnocentric assumptions. Holistic care requires valuing a person's cultural context. In fact, Taylor states that "nonrecognition or misrecognition [of culture] can inflict harm" (qtd. in Volf 19). Literature shows that immersion, a saturation in transcultural experiences, is vital for learning the elements of cultural sensitivity for competent and just care. For this reason, the AACN must reexamine its standards for cultural education in baccalaureate nursing programs.

In addition to previously published literature, this case study of the Buntain School of Nursing (BSON) at Northwest University in Kirkland, WA, will show that an immersion element profoundly affects the process of learning cultural competence. The BSON requires a month-long immersion experience as a senior year capstone class which places nursing students in a cross-cultural engagement outside the mainland US. Because each of us has an ethnocentric viewpoint, we can best consider other's viewpoints when we step outside our own perspectives (Volf 251). Volf contends that "we can try to see the 'other' concretely, rather than abstractly" (251) by surrounding ourselves in differing contexts that challenge our usual ways of thinking. That is the premise for relocating nursing students for one month abroad in a different cultural environment. This model for cultural education is imperative for holistic education in cultural

competence. This thesis will show why cultural education in nursing education matters, how cultural competence acts its part, and how it is best taught.

Baccalaureate Nursing Education

Cultural Immersion is Key

Immersion in a culture very different from one's own provides a life-changing experience unmatched by any other educational method of transcultural education. Immersion allows nursing students to grow rapidly, deeply, and in lasting ways. While research, cultural assessment training, anthropology, coursework, and cultural studies do form a theoretical understanding of cultural sensitivity, none takes the place of the dimensional experience of cultural immersion. However, literature review and queries to the AACN about cultural immersion in nursing programs did not yield any records of other programs that require an extensive study-abroad program of immersion such as the one in the Buntain School of Nursing.

The BSON integrates didactic coursework around an immersion experience. Dr. Campinha-Bacote similarly believes that cultural encounters are central to learning cultural competence. Coursework learning combined with an immersion experience, work synergistically to shape true cultural competence. The immersion experience affords students the opportunity to integrate what they have already been taught about cultural diversity and cultural sensitivity in a place where it is imperative they use this knowledge. As illustrated below, cultural encounters facilitate cultural competence learning. Each "e" represents encounters that lead to increased need for cultural knowledge or skillful assessment. Each encounter potentially increases awareness of bias and desire for knowledge. These increased needs, in turn, build more skill and more desire for additional awareness, ad infinitum. Ongoing cultural encounters exponentially expand the layers of sensitivity and skills that in turn develop cultural competence.

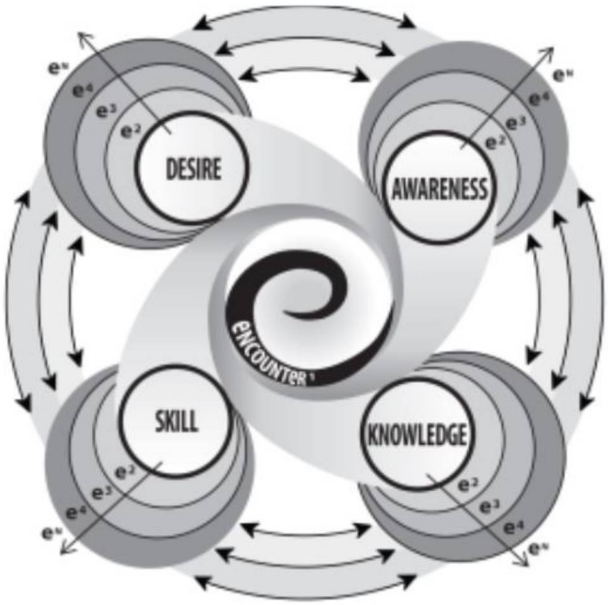

Fig. 1 The Process of Cultural Competence in the Delivery of Healthcare Services

A Case Study of a Baccalaureate Nursing Program

The BSON stresses a cultural-sensitivity distinctive important for equipping its student nurses in cultural awareness and competency. As a member of the administrative staff with this program for over a decade, I formally meet with prospective students who want information about our program. Quite often this distinctive of cultural sensitivity is what compels a student to inquire about the BSON, indicating that the student's element of *desire* for cultural competence pre-exists at some level. These students express a desire to learn about other cultures, and they believe our cultural immersion experience will give them the insight and knowledge they need to

offer compassionate, competent care. Many students express a personal interest in gaining universally marketable skills in a helping profession so they can serve on the mission field, in developing countries, work on the *Mercy Ships* hospital ships, or serve with any other global medical missions and charity works. When students and I discuss the requirement for one-month study abroad, students often identify that element as the most important criteria of the program.

During their senior year, all BSON students must complete this one month of clinical work in a cross-cultural immersion experience. It is also essential for students to leave mainland America to completely engage themselves in one of Northwest University's pre-determined clinical sites abroad. The one-month stay reflects the school's view that students must experience a time span longer than that of typical vacations, and a month-long experience pushes students beyond the adrenaline rush of adventure. They need that time to overcome challenges and to depend on open-mindedness, observations, communication skills, and tolerance so that they learn with endurance. The course's lead professor describes the four weeks as the perfect trip length to cycle students through differing viewpoints: Week one feels like vacation, and week two becomes more productive. Week three becomes a hardship, demanding focus and endurance, and by week four, the students are saddened that it is almost time to leave (Barsness). The overall impact of the experience on the students, and their subsequent nursing careers, is an enormous advantage: awareness of the unique cultural framework of their patients and awareness of their own previously held assumptions about others.

US bacchalaureate nursing programs use various methods for teaching transcultural education acceptable to the AACN. Those models will be explored below. Currently, my research shows that the BSON nursing school is unique in its required, extended, overseas immersion experience. All other baccalaureate prepared nurses across the nation will benefit in

the same way from a similar immersion component in their education toward cultural competence. The BSON uniquely provides a compelling argument that endorses the benefits of cultural immersion. I interviewed registered nurses (RNs), alumni from the BSON's graduating classes between 2002 and 2015. I focused on their trans-cultural education which included their study abroad experiences and its possible influence or resulting long-term impact. I reassured them that they could speak freely as their identities are not revealed. For the sake of their identification, I cite them using assigned pseudonyms and otherwise reference them as interviewees, nurses, graduates or respondents. Their feedback supports the far reaching effects their extended cross-cultural immersion experiences have had on their cultural awareness and sensitivity. The findings show why this model of cultural education is so important for holistic nursing.

Using qualitative research methods, I created a survey to collect data from BSON alumni. I interviewed twenty five graduates from the BSON and found that their study abroad experiences helped them espouse and integrate their formal trans-cultural education. Their experiences increased their own self-awareness, which is foundational for cultural sensitivity. All but one of the respondents in my interviews had international experiences before coming to the BSON. They all believed they began nursing school with an adequate level of cultural competence. However, looking back after their BSON experience, they all admitted that they started the BSON program with little cultural competence at all. They realized that there is no end to learning about many cultures, but what they could learn is that every one has his or her own unique cultural framework. They learned they cannot over-generalize or stereo-type even within the culture they have visited for a month during school. So while they gained new cultural connections, they also realized they cannot generalize their experiences in one culture to all people of that culture.

Many of the BSON grads also report increased understanding, and therefore tolerance, of those whose cultures and healthcare perspectives differ from their own. One nurse, Brenda[1], remarked that the trip helped her to recognize her personal assumptions about what health means to different cultures. She now understands that she has to ask many questions about her patients' expectations rather than making generalizations based on stereotypical cultural backgrounds. Another nurse related that her trip brought her unexpected insight about "negotiating" cultural differences. Consequently, Brenda has gained the courage to advocate for patients who do not agree with their recommended treatments. She deeply respects her patients' decisions, even when they contradict the general expectations of the Western world.

This same nurse was surprised to see for herself that "conditions there [at her overseas site] were worse than here at home and treatment looks different" (Brenda) However, after getting to see how the system works, Brenda realized "the heart of nursing is the same across cultures…things there were more similar than different, and [patients were] getting the treatment they needed". She learned not to judge quickly or negatively because her professors taught her that "different is not wrong, it is just different." She recommends students should go somewhere very different from any cultural experience they have already undergone so that they learn not to make any assumptions. Brenda also wishes everyone could spend time in a location they know nothing about so they can see the difference between general information found on the web about a site, versus what a person learns when he or she gets there. "It's an eye-opening balance between assumptions and valid knowledge [about a cross-cultural site]. And even then, you can not assume the same framework for everyone in that culture" (Brenda). These nurses learned

[1] All RN interviewees' identities are protected with assigned pseudonyms.

self-awareness about stereo-typing. They gained cultural insights not only from academic learning, but also from the powerful influence of life-changing experiences.

Why Cultural Education in Nursing Matters

Cultural sensitivity is a vital element of holistic healthcare. Requisite transcultural education in higher education has gained firm footing in healthcare education as an area that cannot be minimalized. The students at the BSON understand that their study abroad requirement uniquely prepares nurses for sensitive, holistic caregiving. Our hypothetical injured Kenyan student paints a picture of how patients are directly affected by healthcare workers who may or may not practice cultural sensitivity. Increasing market globalization, worldwide immigration, and international study drive the demand to include multicultural education- hich in turn results in cultural understanding that influences evolving cultural education models. This ongoing reform necessitates that the AACN reexamine standard cultural education in baccalaureate nursing programs to better determine what cultural competence looks like, how it is best taught, and how it is evaluated.

When treating a patient, a culturally competent caregiver must serve with openness and empathy. Openness brings understanding, and empathy brings acceptance. Nurses cannot assume that their patients share their own understanding or expectations for healthcare. Beyond the communication gap often created by differing languages as well as medical terminology, nurses and their patients can suffer gaps in cultural understanding. These differences affect a patient's healthcare expectations and the patient's resulting compliance. Culley rightly points out that even the term "non-compliance" is a negative judgment of a patiet because it suggests that the patient's cultural difference is abnormal or inappropriate (qtd. in Andrews and Boyle 9). Calling a patient "non-compliant" may stem from a caretaker's poor understanding of his or her

own personal bias or of the patient's differing cultural context. It is important for healthcare workers to understand that simple awareness of cultural differences is not enough. Nurses must also have the humility to understand differing contexts in order to alleviate prevailing prejudices, microaggressions, and other cultural conflicts resulting from generalized stereotypes.

Understanding cultural frameworks helps nurses effectively treat their patients from any culture or clime. Kim-Goodwin, Clarke, and Barton, authors of the 2001 model for *Culturally Competent Community Care* (CCCC), specifically explain how culture defines boundaries for ethnically diverse populations and show that these boundaries drive their healthcare expectations (919). Though globalization has opened doors to diverse cultures, it has not universally blurred all cultures into a mono-culture, or as Barber calls it, the "McWorld culture" (qtd. in Lechner and Boli 32). Kim-Goodwin et al., further explain that even locally, many US subcultures maintain their original culture's traditional health beliefs and practices. Therefore, US medical caregivers must explore differing beliefs and practices with each individual patient involved. They must extend the practice of critical thinking beyond only the clinical aspects of their patients to include also the cultural aspects of their patients. When a nurse uses critical thinking, he or she quickly assesses a medical situation and the options for response. In the same way, a nurse using critical thinking about a patient's perspectives offers more culturally appropriate approaches to each individual.

Patients who have relocated from their homeland or have learned alternative healthcare perspectives from their families, bring different conventional thinking to their health and its needs. Such patients' cultural traditions are crucially important regardless of the patient's current home (Hofstede et al. 202). Globalization, then, also happens at home. It includes increasing cross-cultural, local contacts besides the much touted American involvement in international healthcare capacities. So, at home or in a foreign culture, healthcare workers must understand

their patients' cultural diversity. Nurses specifically must acknowledge the stressors and conflicts between themselves and their patients and understand and estimate how these stressors may relate to the patient's cultural context (Afaf Amin 9). Madeleine Leininger of *Transcultural Health Care Issues and Conditions* states similarly that "… nursing education must provide the learners with knowledge, experience and awareness of diverse cultures so to enable them to become effective deliverers of health care to individuals of different cultural orientations at home or in any nation of the globe" (qtd in Amin 9).

We cannot surgically remove culture from healthcare. According to Rumay Alexander, director of multicultural affairs at the UNC School of Nursing, nurses must be educated in emerging societal expectations and social interactions because "diversity is directly woven into…healthcare setting[s]" (415). Nurses need to build and preserve every patient's trust. Alexander emphasizes that cultural competency links specifically with patient safety, healthcare disparity, and any resulting feelings of "microaggression" the patient feels while under the care of a dominant, culturally insensitive, healthcare provider (416). Kim-Goodwin et al. attribute misdiagnoses, misunderstandings, and other barriers to mutual trust between patient and caregiver to a lack of relevant transcultural care (919). The patient, unfortunately, often extends this distrust to the whole healthcare system. It is crucial that nurses gain both the sensitivity and the resulting cultural humility from exposure to cross-cultural experiences such as those required by the Buntain School of Nursing.

Without cultural sensitivity, healthcare workers can put barriers between themselves and their patients. Even worse, misunderstandings can cause unintended disparity and harm. An example of this consequence is the story of a Hmong refugee family raising their epileptic daughter Lia Lee in Merced County, CA (Fadiman). Due to language barriers and mutual cultural ignorance, whenever their little girl needed prescriptions or emergency care, the Lees did

not follow through, which their doctors judged as non-compliance. In reality, the Lees could not read, did not speak English, and could not understand the prescribed care plan. Additionally, their medical staff distrusted and misunderstood the family's cultural expectations for treatment by a Shaman in their home. Therefore, treatment outcomes were unsatisfactory for both parties, even dangerous for their daughter, leading to the family's reluctance to seek or trust help from the Western doctors. In turn, Western doctors, frustrated with the communication barriers and the extended time with interpreters, were impatient and unwilling to engage in compassionate, equitable care. This little girl's health deteriorated quickly through multiple health crises that might have been avoided had their been more mediation services available for the family. Lia is now in a permanent vegetative state. Ironically, while Western doctors wish they could have done more, the Lees cherish and care for Lia without regret or demands. They accept her condition as ancestrally determined and care for her at home now without complaint. The differing responses further show a disconnect in expectations based on cultural beliefs. Fortunately since then, cross-cultural training and translators are now part of the protocol at Merced County Hospital and most other US hospitals.

Another unintended consequence of cultural insensitivity is the potential for widespread social injustice. Often people groups receive different qualities of healthcare accessibility and treatment based on stereotypical perceptions of racial or ethinic backgrounds (Dilworth-Anderson, Pierred, and Hilliard 26). A minority culture perceived as inferior may not receive the same expedient, patient, compassionate healthcare as majority populations do. Nurses should always be sensitive to each patients' cultural framework and through cultural sensitivity, provide equitable care as well as become more proactive in advocating for equitable healthcare for their patients.

Because, as Dilworth-Anderson et al. and Rumay contend, cultural aptitude can lead to

healthcare disparity, and it highlights a cautionary relationship between available transcultural care, advocacy, and social justice. Social awareness exposes the inequities in healthcare service. To foster this awareness, Evelyn Clingerman recommends a standard of social justice skills and research as a framework for educating healthcare workers in cultural sensitivity (334). For example, there is social injustice when minority groups suffer discrimination in employment or healthcare benefits resulting in inaccessibility to healthcare. Also, some culture groups come to expect miscommunications, impatience, and disrespect from the medical community. These expectations cause them to stay away from doctors, and this stance leads to higher incidence of treatable illnesses left unattended. This results in commonly treated problems becoming worse afflictions than they need have. Reluctance to use medical care can lead to higher infant mortality, or death from treatable diseases. All of these scenarios, repeated throughout minority cultures lead to statistics that show disparity in health for our minority populations. Groody reminds us that "justice involves institutional change and transforming unjust social structures" (96). Multiple authors correlate cultural aptitude and positive health outcomes as important for reducing the injustices of healthcare disparitities (Kim-Goodwin et al. 924; Mobula et al. 10). Dr. Campinha-Bacote concurs stating "cultural competence is based on a commitment to social justice" (2011).

Martinez describes an example of health care providers' cultural ineptitude that led to emotional harm. It was the case of a "Mexican woman who arrived at the emergency room of a hospital, believing that she was still pregnant. The woman kept asking in Spanish, 'Wasn't her unborn child growing?' Tragically, she did not comprehend that she had actually miscarried two months earlier during an emergency visit to another hospital" (qtd. in Kim-Goodwin et al.). A Spanish speaking healthcare worker, or access to a translator-via-phone at the previous hospital, would have informed her of her miscarriage when it had happened. Cultural aptitude should

include skills such as culturologic assessments, critical thinking, and native-language communication that bring advocacy. In return, patients feel empowerment, trust, and satisfaction in healthcare services. These results lead to positive outcomes for community health of diverse populations.

An important aspect of cultural humility and respect involves the sensitivity to avoid ethnocentric approaches. In his memoirs about his healthcare work abroad, Daniel Fountain writes of learning that in many cultures, relationships carry a higher priority than does precision, so nurses must learn to respect, to correct without shaming, and to gain trust, language skills, and respectful relationships (25). He believes that "the key to value is trust" (197); healthcare workers need to genuinely know the people they serve (209) and build mutual trust to be able to help them. He gives the example of trying to convince the Congolese that using latrines was important in reducing illness and parasite transmission. The Congolese had "logical, coherent, internally consistent" rationale for how disease spreads, and he did, too (63). When Fountain first questioned them about their resistance to helping him build latrines, the villagers feared the Western doctor's judgment, and they felt shamed for their own ancestral, spiritual beliefs in curses. Soon Fountain found a way to acknowledge and link their beliefs to reasons for using better hygiene. As an example of "participatory development and empowerment" (Bornstein 125), the locals agreed with his respectful logic, complied with latrine building, and all took ownership for prevention and healthcare.

Part of cultural sensitivity also includes taking the time to learn about one's patients rather than using a one-size-fits-all approach to assessments. Mary Narayan's study supports this approach to ensure safe and acceptable care for individuals. Using culturally relevant assessments and home health care plans, this relationality ensures care that relates to and respects the patient's beliefs and practices. Healthcare workers offering holistic care must

understand and work within culturally defined and supported healthcare plans if they are to help their patients of diverse cultural populations (612). For example, culturally competent nurses must recognize their own bias and not impose this bias on their patients (612). Instead, these nurses make time to question their patients and build trust. Narayan uses the acronym LEARN to express the need to *listen, explain, acknowledge, recommend* and *negotiate* (618). By taking the time to learn about each individual, nurses both reduce their own potential for cultural imposition and also learn effective ways to ensure safe and acceptable care for them.

Other findings emphasize this need for cultural resources that teach meaningful communication between nurse and patient (Heineken and McCoy 45). As in Fountain's assertion, Heineken's stresses that careful and respectful questions and assessments can build essential trust with the patient. (51). For example. Heineken and McCoy site a case study of a patient, recently arrived in the states from rural Cambodia, who failed to keep doctor's appointments for her rheumatoid arthritis (47). She did not understand her meds or reasons for a recommended hip replacement. This case is similar to the Hmong family's experience with CA doctors. Even when a translator was available for the Cambodian woman, she resisted treatment because surgery back home is limited to emergency intervention. Her distrust was alleviated when her son, clinical staff, and a home health nurse worked together to understand her cultural perspectives, and she ultimately agreed to the surgery. Unlike the case with the Lee family, sensitive follow up with competent communication led to positive outcomes for this woman.

In like manner, Wikberg and Eriksson's study asserts that transcultural caring as part of holistic nursing – treatment of the whole person – will always benefit the patient. They insist on commitment to "body, mind and spiritual and sociocultural interconnectedness…but also [with a] comparative view of cultural differences and similarities" (489). They, too, stress cultural competence as the definitive means to ensure the best holistic outcomes for patients (494). In the

case of our hypothetical, injured Kenyan student, we can hope her caretakers will use cultural awareness and holistic healthcare goals to better understand her specific family dynamics, her healthcare perspectives, and her specific needs.

Besides encouraging compliance, reducing bias and conflict, respecting diversity, learning trust, and offering relevant, holistic care, this evolution of cultural education comes as a response to changing global perspectives. Today's global perspective should accept equality in diversity that, in turn, should respect and acknowledge differences without stereotyping a population (Banks 293). Otherwise, minorities and other marginalized populations can perceive a bias and lack of competency in their healthcare (Johnson 106). Humane and sensitive services promote feelings of empowerment, satisfaction, and trust. Another case study by Heineken and McCoy (48) follow a male Filipino, Alzheimer's patient who needed post-op wound care. He was extremely agitated with his nurse, so she was replaced. When the second nurse was replaced with a Filipino nurse, the patient's countenance changed significantly. He was less agitated and more compliant. The nurse learned that the presence of Caucasian nurses triggered the patient's WWII post-traumatic stress and confusion. When the family concerns brought new nursing sensitivity and dynamics, the situation was resolved. These examples help show the significance of the healthcare community's proactive intentions in sensitive healthcare.

Cultural Competence Defined

The "Tool Kit of Resources for Cultural Competent Education for Baccalaureate Nurses" describes the five essential elements underlying cultural competence in nursing care: nursing grads must be professionally trained to apply cultural knowledge in various contexts, to use best practices to provide culturally competent care, to promote quality outcomes for diverse populations, to become social justice advocates for vulnerable populations, and to participate in cultural competence healthcare development (AACN resource 2). In an article about cultural

competency, transcultural nurse educator Josepha Campinha-Bacote notes there is yet no universally accepted definition of cultural competency that provides a designated template or goal ("Cultural Competency in Graduating Nursing Students" 38).

However, Campinha-Bacote herself defines cultural competency as a "*process* in which the healthcare provider continuously strives to achieve the ability to work effectively within the cultural context of a client, individual or community" (38 emphasis mine). The US Department of Health and Human Services (HRSA) (http://www.hrsa.gov/index.html), the AACN, and the *Online Journal of Cultural Competence in Nursing Healthcare* (http://www.ojccnh.org/project/faq.shtml) agree that cultural competence is an ongoing process requiring continual commitment. Merrell et al. also support this contention; in their exploratory study with nurse educators in Wales, they state that preparing "pre-registration nursing students" [pre-licensure nurses] for work with ethnically diverse populations is a "work in progress" (490). They believe nursing curriculum alone is not enough to prepare nurses to engage with the Welsh social justice agenda and ethnically diverse patient populations (490).

Likewise, this process of cultural competency includes elements of cultural knowledge, skills, awareness, desire, and encounters ("Tool Kit" 5). As an additional resource published by the AACN, "The Essentials of Baccalaureate Education for Professional Nursing Practice" explains that *cultural humility* should be a high priority in the ongoing process of cultural competency. Tervalon & Murray-Garcia (1998) describe cultural humility as a process that "incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-clinician dynamic, and to developing mutually beneficial…partnerships with communities…as a more suitable goal than cultural competence" (qtd. in "Essentials of Baccalaureate Education" 36). With input from stakeholders in healthcare, this document of essentials reflects BSN programs' expectation that their graduates will exhibit flexibility and

compassion from a holistic framework of competency. Going back to our hypothetical, international student at Harborview, the AACN educated nurse would be expected to show the patient compassion and to use sensitive, culturally appropriate communication, to use a translator for the patient's non-English speaking family, and to consider the patient's understanding of the care plan. This approach comes from a heart of cultural humility, and that heart comes from ongoing cultural encounters.

Another standard for defining cultural competence is an ability to work constructively with patients' cultural elements and to regard the treatment interventions in context of their values and beliefs ("Tool Kit" 13). This kind of care is reflected in more than just knowledge and skills, but also in practicing culturally relevant health assessments, acknowledging differences in expectations, and then adapting care plans accordingly (13). Fadiman's story of Lia Lee's family is a good example of what happens when caretakers fail to consider the patient's cultural context. The ability to understand cultural expectations and then negotiate for the patient's systems of care remains a clear expectation for the culturally competent nurse.

In the case of our hypothetical Kenyan student at Harborview, a culturally competent nurse would ask the patient about her comfort, her expectations and perspectives about care, diet, and family involvement. If the patient was unclear or uncomfortable with her care plan, an equally sensitive conversation with her doctor or a translator would occur as quickly as possible. Together they would create a care plan that respected the patient's values and expectations. One of the BSON graduates who works in cardiac telemetry cites this perspective as crucial to patient care. Along with inquiring into her patients' healthcare expectations, she also inquires about their spiritual values. If a patient indicates that having a spiritual healer or representative from his or her faith would be a comfort or, she tries to arrange the meeting. She admits, "I love how my [cultural] education fit with my own heart for missions and cultural understanding, and now I

know how important it is to see things throught the eyes of the patient and his/her culture if I can" (Sarah).

Several constructs help form cultural competence. Creators of the CCCC (Kim-Goodwin et al.) assert that elements of culturally proficient healthcare include caring, cultural sensitivity, knowledge, and skills (918). Campinha-Bacote agrees with the foci of sensitivity, knowledge, and skills, but would also add two more qualities. She states that nurses need both to practice cultural *desire* and to experience cultural *encounters*. She describes this desire as a virtue of "teachableness, love, caring, and humility" ("Biblically Based Model" 20). She argues that cultural competency is more about "the motivation of the healthcare provider to 'want to' engage in the process of becoming culturally competent; not the 'have to'" ("The Process of Cultural Competence in the Delivery Healthcare Services"). In 2002, she taught that this *desire* was a key element to cultural competence. Yet after evidence-based research in 2010, she amended her emphasis to name *cultural encounters* as the central requirement and recommends those encounters must be ongoing (ibid).

Though cultural *competence* has yet no firm definition, educators agree that human compassion and all the aforementioned skills are basic to transcultural expertise. Also, this competency is dynamic, ever changing, and ever challenging. No two situations call for the exact same competency application. However, Alexander asserts that nurses and other healthcare providers should see cultural competency itself not as an end goal but as both an outcome and also a journey toward an outcome (417). The universal contention is that cultural competency is an ongoing process, driven by desire and sensitivity, and not necessarily one that can or should ever be thought of as complete. Dr. Campinha-Bacote describes it as an unending journey of transformation which concerns perpetual human growth, glacial but ever present cultural change, and a challenging topic for life time learning ("Cultural Competence in Nursing Curricula").

Cultural understanding begins with increased *self*-awareness because when that happens, nurses increasingly recognize the need for their own sensitivity when treating those of diverse populations. This self-awareness competence is one of the most commonly referenced takeaways of the BSON cultural immersion experience. Nurses need to recognize their own biases, but more important, recognize how these biases might affect their assumptions, prejudices, and healthcare service. For instance, in earlier decades, US patients of color have been treated in separate buildings from white patients, US healthcare workers have expected foreign-born people to master the English language and fit in with US culture, and US healthcare workers have stereotyped minority patients rather than individualized them. Prejudices linger even when nurses and doctors believe them gone, so Stacks and Holmes rightly maintain that until we are aware of our own biases and how they affect our actions, we cannot begin to understand the values of those who are different from us (5). Adamshick et al. describe Welsh nursing students' feedback after a one-week immersion in Honduras as bringing "bittersweet knowledge" of their own awareness of fear, anger, and ignorance. The students report gaining understanding and sensitivity that persists for years after their immersion experience. This case study of the BSON will also reiterate the self-awareness gained in its integrated coursework and cross-cultural immersion.

It is important to understand the difference between cultural awareness, cultural sensitivity, and cultural humility. Cultural *awareness*, both globally and personally, is not the same as cultural *sensitivity* because one can be aware of cultural differences or even personal ethnocentrism yet still not respond with value and respect. General cultural awareness sharpens when we see one culture stand in stark contrast to another. Our self-awareness comes when ours is the culture that contrasts with the "other"cultural context. Our cultural sensitivity comes from experiencing cultural encounters wherein we are the ones who are different from those of the

majority culture. These experiences give us empathy as we learn what it is like to stand out as different or foreign. It is this empathy that leads to our cultural humility, and we learn not to make assumptions but to be curious and questioning. Immersion in a different culture gives us opportunities to learn individual personalities and stories and to treat all people as individuals.

Beyond the learned cultural postures, nursing students must acquire cultural *skills.* These skills include "the ability to conduct a culturologic assessment…and to determine health care needs within the cultural context" of the patient (Kim-Goodwin 923). Cultural *knowledge* includes the understanding of different cultures without stereotyping, and knowing how to ask the patient about his or her values. Cultural *encounters* include intentional interaction and observations of others from diverse cultural contexts. These encounters are central to the process of cultural competence as the means for learning awareness, sensitivity, and humility. This process for learning should be ongoing. Encounters are foundational to motivating patient-centered care.

Current Models of Cultural Education in Baccalaureate Nursing Programs

In the same way that cultural competence has multiple definitions, its skills can be taught through many different models or through an integration of more than one teaching model. The AACN "Tool Kit" recognizes a number of specific teaching models that emphasize different priorities. For instance, the *Campinha-Bacote Model of Cultural Competence* emphasizes individualized assessments for every patient so as to better understand each client's personal context and expectations. This approach discourages tendencies for general assumptions about a person's ethnic group (5). So a caregiver must deliberately engage in cultural learning and also possess a desire to set aside personal bias. Nurses must seek to know and understand each individual patient. Dr. Campinha-Bacote's model was the original groundwork of the cultural education strategy at the Buntain School of Nursing.

A different perspective for cross-cultural education in nursing is the well-known *Leininger's Cultural Care Diversity and Universality Theory/model*. Leininger's model emphasizes cultural anthropology as the background for broader understanding. Anthropology combined with the patients' personalized context is a popular integration model for teaching cultural sensitivity. Similarly, the BSON includes a prerequisite course in Cultural Anthropology as part of its coursework. *Spector's Health Traditions Model* represents a combination of three theories that concentrate on a person's tribal lifestyle and his or her traditional cultures. This theory stresses caring, transcultural knowledge, understanding ways cultural values affect worldview and spirituality, and discerning how culture embeds itself in a patient's health behaviors (7).

Another model mentioned in the AACN "Tool Kit" is the *Giger and Davidhizar's Model of Transcultural Nursing*. This particular text is required for the *Global and Intercultural Nursing* course in the Buntain School of Nursing. The model covers the different ways people groups communicate, how they orient themselves socially as well as how they orient thesmselves to space, time, environment, and biological dimensions (ibid.5). Using this model, a nurse learns to assess a patient for flexible and congruent care plans. These examples of cultural education models are not comprehensive, but they do represent the variety of approaches for teaching nursing students the tools for a broader and more specific understanding of culturally diverse patients. The AACN strongly cautions cultural educators to stress that cultural diversity includes more than simply recognizing ethnic groups (5); it also includes group-categories such as age – the elderly, teens, juveniles – family status, caste groups, socio-economic groups, refugees, disabled, and others.

Literature by transcultural education experts also suggests a variety of hands-on teaching

strategies for practicing cultural competence. For instance, students should practice cultural assessments on themselves and other populations ("Tool Kit" 9). Heineken and McCoy's "Establishing a Bond with Clients of Different Cultures" promotes efficient cultural assessments using hypothetical positive and negative scenarios of health situations. This case study approach teaches students that understanding cultural norms mitigates the tension of misunderstandings from both caregiver and patient. Studying these scenarios teaches the student that building a bond with the patient comes with respectful, appropriate communication, and that appropriate communication comes from understanding the patient's culture (49). For instance, asking patients what they call their illness, what they believe caused it, and how they have been dealing with it, gives the caretaker the patients' frame of reference and insight into relevant vocabulary. Practicing this approach could have saved the Hmong family in Fadiman's story much unnecessary grief and misunderstanding.

In support of this hands-on practice, Narayan's "Cultural Assessment and Care Planning" emphasizes the importance of individualized assessment skills and care to ensure that the patient's care plan is congruent with his or her beliefs and practices (611). This is another perspective that was absent in the Hmong family care at the Merced County hospital. Culturally competent nurses ask their patients questions both about their healthcare awareness and about their cultural norms (Narayan 612). Narayan's previously mentioned "LEARN" model (618) perfectly reflects this assessment model. Students need to consider consulting a cultural broker, or translator, as the most caring and vigilant way to communicate with patients. These teaching strategies help students learn that trust begins with mutual understanding that is based on careful and respectful questions and assessments.

Another AACN recommendation for cultural education is to offer opportunities for students to learn insightful viewpoints from guest lecturers such as transcultural nurses, cultural healers, patient advocates, or community health nurses. The BSON also believes that these lecturers offer insightful, differing perspectives for consideration. Political advocates, plus community and spiritual leaders can also speak to specific, culturally appropriate needs. Students should also research case studies, journals, and create ethnographies to become more sensitive to perspectives of culturally motivated discrimination, oppression, and inequities that are not related only to healthcare ("Tool Kit" 10). Yet, even doing research on a destination site does not give an all-encompassing understanding about a community or its culture. Actively experiencing the culture in a day-by-day way that requires all their senses, nurses still get only a glimpse of understanding but enough to realize that they cannot generalize all people within that culture (nurse #5). Other recommended exercises include simulation and role-play as a context for self-awareness and a chance to recognize stereotyping, misunderstanding, and conflict. Ting-Toomey contends that students must learn "mindful intercultural communication," (qtd. in "Biblically Based Model" 61) so their patients feel personally and individually known rather than stereotyped.

Baccalaureate programs such as the BSON, consistently offer *Community Health* courses that bring about the cultural encounters that Campinha-Bacote argues are an important element of cultural competence ("Biblically Based Model" 20). *Community Health* curricula include visits to multi-ethnic neighborhoods or clinics, homeless encampments and shelters, and correctional centers. These visits and others present opportunities for exposure to unconventional healing practices. Working with diverse populations exposes students to alternative therapies, immersion in diversity, and orientation to different cultural contexts. Here cultural encounters and immersion become the foundation for new awareness and cultural sensitivity.

Ference and Bell's strategy for "Changing Preservice Teacher Attitudes" (2004) offers a two-week local (US) immersion for healthcare educators. Its goal is to increase self-awareness and teacher misconceptions regarding Latino students. These teachers increase their cultural skills and knowledge, and they learn better empathy for ESOL (English for Speakers of Other Languages) patient perspectives. Then, in turn, the instructors gain tools for addressing diversity issues and social justice issues with their own students (343). A nurse prepared in cultural sensitivity can better recognize issues of healthcare disparity or other issues related to cultural diversity. Again, cultural immersion is one of the most important ways to gain these insights.

In their narrative *Transforming Lives*, Kottler and Marrin disclose ways that service-learning and altruism make a difference for those who serve, as well as for those they assist. The transformation for those immersed in another's culture shows in their reduced ethnocentrism as students become "citizens of the world" (78). As in this thesis, the authors argue that training requires hands-on application because "book learning provide[s] a foundation of knowledge, but then you must invest the hard work to make the content part of you" (100). The immersion experience brings compassion and empathy through active engagement with people in the real world. Cynthia Moe-Lobeda emphasizes this same contention because she sees too much tendency for learning "about" different people, rather than learning "from" them (120). Immersion is the opportunity to learn differing perspectives in experiential and lasting ways.

A final example of learning by immersion comes from Fountain's previously cited *Health for All*. Fountain turned his own memoirs of his time in the Congo fifty years ago into an instructional model of community health education. He admittedly entered the Congo with a Western perspective of treating diseases rather than people (8) using the biomedical model of Western medicine. Fountain, today, discourages the scientific vocabulary that alienates different

cultures that rely on tradition, not medicine. Since values drive behavior, and those values come from deeper beliefs, assumptions, and worldviews (75), health education must be culturally relevant (77). Immersion is the best way to understand cultures in their complexities. Because he immersed himself in the Congolese culture, he became self-aware and now understands how to teach healthcare in the context of the locals' priorities and understanding. His text reminds healthcare community developers that they must immerse themselves in differing cultures to set aside ethnocentrism.

The BSON is unique in its required, extended overseas immersion experience. In their description of the Illinois Wesleyan University's study abroad program, Folse et al. identify only sixteen other undergraduate nursing programs that include extensive cultural immersion experiences (235). Yet of those listed, the immersion experience is either didactic *or* clinical, is usually an *option* rather than a requirement, often takes place during the Sophomore year or on summer break, and frequently *extends* the length of the program for cohorts that choose the study abroad plan (235-237). In contrast, the BSON's month-long study abroad is specifically designed to satisfy part of the semester's clinical hours required for accreditation. It does not further extend the program length, there is no *alternative* tract that excludes the trip, and all learning is face-to-face with faculty on site, rather than through video-or tele-conferencing to faculty back in the states.

This thesis maintains the unconditional necessity of requiring experiential immersion in a setting different from the student's culture. In the case of the Buntain School of Nursing, that is accomplished with the required course *Nursing Practice as Ministry*. As described above, multi-cultural populations bring diversity to healthcare needs, and they require cultural competency from their healthcare providers. Such competency as described by transcultural nurse Josepha

Campinha-Bacote, PhD, includes ongoing learning in cultural awareness, knowledge, skill, encounters, and desire (1999, 2005, 2011, 2015, 2016). Interviews with BSON graduates confirm that the cross-cultural immersion program satisfies their desire for building competency and ultimately anchors them in all the cultural competency components. They each describe gratitude for the exposure to transcultural encounters.

However, not only do the students benefit from an immersion course, the faculty do as well, especially those who will teach transcultural education coursework. Many faculty teach cultural know-how based more on a foundation of desire than on formal training. When Kardong-Edgren studied the cultural competency of baccalaureate nursing faculty, she found that nursing faculty members who were exposed to diverse community service-learning, expressed that these face-to-face encounters were the best way to learn transcultural healthcare skills previous to teaching them (365). Just as with their students who experience a cultural immersion, faculty also see improvement in their own cultural awareness and knowledge. This model of service learning uniquely enriches and enlightens nursing students and faculty by removing their learning opportunities from the classroom and taking them into the community (Hart 76).

Service-learning also facilitates awareness of the relationship between diversity, social justice, and healthcare disparity (Groh 400). As previously cited, Clingerman, Kottler, Fountain, and the AACN all emphasize the correlations between cultural respect, sensitivity, and social justice issues in healthcare equity. When a patient is non-compliance, it is often because his or her health care workers lack the content or desire for sensitive and effective communication. As beforestated, the term "non-compliant" is negative, and healthcare workers should understand that it implies an imbalance of power and sensitivity (Andrews and Boyle 9) Non-compliance

may not equal defiance and obstinance; it may simply meant that a patient thinks differently, and these differences are judged to be wrong. Consequently, statistics of poor health among some sub-cultures can be correlated to perceived disrespect and impatience that makes some patients reluctant even to seek needed healthcare. It follows that "by understanding a group's values, belief systems, and ways of thinking and behaving,… care providers… can be better equipped to identify the cultural influences that serve as barriers and facilitators to eliminating health disparities" (Dilworth-Anderson 31).

Diverse cultural encounters help bring that understanding and equipping. Immersions increase self-awareness of personal and professional biases and assumptions as well as the sensitivities that bring cultural competence. These sensitivities are foundational to the journey of cultural competence in nursing care. Rumay Alexander summarizes the benefits of cultural training in healthcare:

> Because all knowledge is about the past and all decisions are about the future, mental models suggest that the quest to be the best requires continuous learning. When one puts culture and competence together (cultural competence), the result is both a process (series of events) and an outcome (a synthesis of different perspectives). Mastering the skill set of cultural competence is a win-win for all involved. In health care, this understanding is what is needed for the demands of today's unique patient and workforce. (420)

In sum, cultural competence is a developmental process learned through integrated theories and strategies. Without question, holistic care requires nurses to seek personal and specific assessment of their patients' understanding and expectations. To neglect these cultural

assessments and the resulting need for accommodations and understanding, invites tension and even conflict as the patient responds with fear or perceived non-compliance. Nursing students and professional nurses alike must learn ongoing awareness of others' diversity by first gaining self-awareness. They must desire to set aside their own biases to learn the personal context of each individual patient in their care. Research and experience have proven that *immersion* in differing cultures is the most influential way to gain that awareness and understanding. Understanding culture remains the key to every patient's emotional and psychological well-being as he or she partners with nurses to follow an agreeable health care plan. Implementing this approach, nurses can learn to administer more effective, holistic health care for each of their patients.

Coursework in the BSON

When I surveyed twenty-five BSON alumni about their cultural education, I asked them which courses they believed most affected their cultural education. The chart below shows the frequency of commonly named BSON coursework. Alumni specifically mentioned six courses as impactful to their cultural education in nursing school. Of the six courses referenced, only *Community Health* and *Psychology* are common to most baccalaureate nursing programs. *Faith Integration, Global Health, Cultural Anthropology* and the Cross-cultural immersion (*Nursing Practice as Ministry*) reflect Northwest University's missional ideals for engaging the world. Based on the data collected from the nurse interviews, these courses work together to prepare nursing students for compassionate, holistic, culturally sensitive nursing skills. The correlation will be explained further in the forthcoming sections of **Coursework Progression** and **Alumni Responses**.

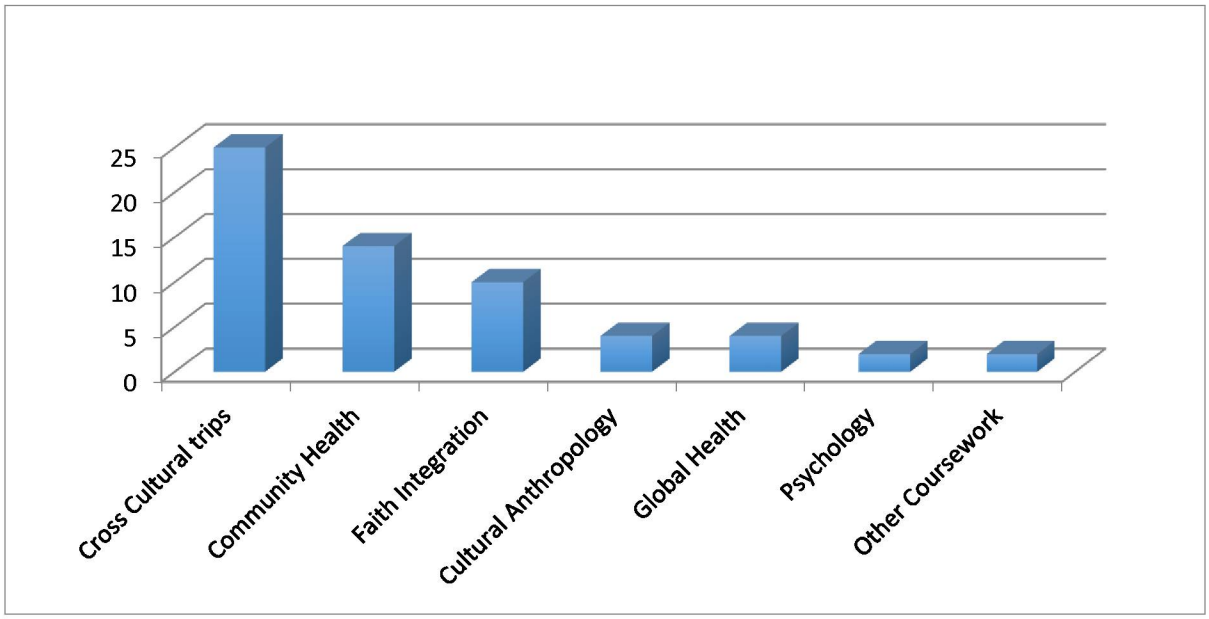

Fig. 2 References to Cultural Education Courses Alumni Considered Helpful

History of BSON Coursework

The coursework named above, is intentionally required as part of the overall trans-cultural education at the BSON. Befitting the school's strong commitment to cultural sensitivity, its foundations of cultural education model include integrating various coursework, projects, and Josepha Campinha-Bacote's theories and processes. At the inception of the BSON, clinical knowledge and skills made up the primary focus of program curriculum, but cultural education was a strong priority as well. The school is named after missionaries Mark and Huldah Buntain who left the US to minister to the poor in Calcutta. The Buntains started a church, school, feeding program, and hospital, and they often collaborated with Mother Teresa in caring for the poor. Their ministries represent many of the aspects of cross-cultural care that require cultural humility.

In 1999, when Dr. Annalee Oakes agreed to develop the curriculum for the BSON program, she already had extensive experience and collaboration with baccalaureate nursing

program development overseas in Japan and Taiwan. She had learned firsthand how to cultivate self-awareness, to respect cultural differences, and to accept different spiritual tenents while collaborating on a cross-cultural project. With existing ties to Taiwan, she developed cross-cultural clinical opportunities with colleagues in Taipei. She arranged immersion experiences for BSON nursing students and, in turn, she offered Taiwanese nurses a transcultural immersion in the US each summer. That exchange is still ongoing annually between locations. Dr. Oakes' hope has always been that "just as our students are profoundly affected by their immersion and learn things not found in books, that the Taiwanese students also would go home with that same sense of learning by seeing and feeling what books don't teach." To educate students in cultural skills before their immersion, Dr. Oakes included the other coursework listed above that students identified as helpful for learning cultural competence. Integrated and espoused in the cross-cultural trip, those courses still make up the groundwork to prepare students for the capstone clinical, study-abroad class called *Nursing Practice as Ministry*.

Coursework Progression

The nursing students at the BSON formally begin their cultural education even before being accepted into the actual nursing program. They must take *Cultural Anthropology* as a prerequisite. The BSON program incorporates this blending of anthropological concepts in its transcultural education model. To explore diverse populations and their complexities, in *Cultural Anthropology*, students learn cultural differences within various ethnographic contexts (Clark 1). This course includes an ethnographic fieldwork project and an opportunity for a community cultural event, both occasions for additional cultural encounters. Four of the interviewees mentioned that this course helps them clarify their values and to practice unconditional compassion. One nurse, Sandy, commented that *Cultural Anthropology* reminded her of the

value of an individual's story and helped her remember that "there is whole lot more under the surface of [her] patients". Another nurse, Sarah, commented on how this course even helped her understand her own multi-cultural, family background.

Besides *Cultural Anthropology*, our students also must complete courses in *Global and Intercultural Nursing, Faith Integration,* and *Community Health* as part of their cultural education before entrance into the program. Three interviewees specifically referenced the importance of the *Global and Intercultural Nursing* class. Graduates recalled that the guest speakers shared extremely memorable insights into working within different cultural contexts and with diverse colleagues. Alumni shared relevant anecdotes about exercising tolerance and understanding in their daily personal and business relationships. Nurses Sarah, Nate, Cheri, and Mary shared that these stories, coupled with windshield surveys and other research, help them respect their patients and even their own colleagues from different cultural backgrounds.

The Buntain School of Nursing asserts that its nursing program "will uniquely prepare you to meet human need with compassion and competence" (Northwest University View book 3) with a faith-based commitment to service. Many graduates reference their *Integration of Faith* course as pivotal to understanding their patients as valuable individuals with whom they had a chance to connect in a vulnerable time of their patients' lives. Reflecting the belief that all people are made in the image of God, and therefore valued and worthy of respect, the BSON encourages its nursing students to clarify their calling for compassionate service via the course *Integration of Faith, Service, and Nursing*.

This course guides students to understand that nursing comes from understanding "Imago Dei" (people are made in the image of God). One interviewee, Wayne, specifically expressed that his patients' value comes from God the Creator. He articulated how this affects his approach

to each patient. He stated that "the patient is in one of their most horrible times…and I want to bless them, so I have to be culturally aware" (Wayne). Students form a personal philosophy of nursing in their *Integration of Faith* course. They articulate their intended use of professional nursing to reach a needy world (Sterciuc 1). They create a personal mission statement that defines how they wish to serve people in their calling including those of other faiths. Students learn that God is "the God of all cultures" (Volf 40), and, therefore, other cultures and faiths are not a threat; instead, getting to know these faiths enriches their own Christian faith. Alumni remark that the comprehensive integration of this and other courses give them tools for understanding different spiritual beliefs and traditions. One graduate remarked, "The most important aspect is that it [nursing] is done in…celebration of God's created genius of God's diversity. That's what makes it ok to be different, because we are all the same regardless of language or faith or culture" (Wayne).

Another graduate, Jim, reflected on the holistic approach to healthcare as being sensitive to faith values. Several of the interviewees mentioned appreciation for the emphasis of this coursework on treating everyone with dignity, and with respect for the value that all people have. Jim stated that "all people includes patients, coworkers, and managers, as they all deserve appreciation and respect". As a reflection of her faith values, one nurse remarked how important it is to take the time to learn a person's story so that she can build relationships, trust, and mutual respect (Brandy).

As previously stated, early in the program, students create a personal mission statement. They then revisit their mission statement at the end of the program. I asked each nurse if his or her mission statement had changed from its original draft, if it had changed after their cross-cultural trip, or even if it had changed in the years since they have been licensed RNs since

graduation. All twenty-five nurses state that, fundamentally, their mission statements have not changed. Most recognized, however, that their statements became more specific and better clarified after their trips. Interviewees remark that this course ultimately taught them to care with empathy and to show compassion without judgment.

Another crucial element of transcultural healthcare learning is the *Global and Intercultural Healthcare* course. This course includes guest speakers from different cultures who navigate cross-cultural business models, or who work with refugees through *World Relief*, for example. Students also complete a semester-long study of a cultural group and develop a care plan for a common health condition specific the group they study. Graduates recall that the course introduced them to experts in their various fields of cross cultural service. Brenda shared that her cross-cultural experiences were provocative and influential. The importance of cultural sensitivity was reinforced by the people who "were great cultural brokers and advocates" on her cross-cultural trip (Brenda) . In this course, students choose and research a specific healthcare concern as it relates to a specific nation. Then they make recommendations for alleviating these contextual healthcare problems. From these projects and from the professor who teaches the course, the students learn the "intrinsic value of all people and cultures, [that] they are worthy of utmost dignity and respect. I loved this aspect [of our education] from the get go" (Brenda).

Besides naming the study abroad course, students chose the *Community Health* course as the second most influential learning experience in the program. This fact further asserts that immersion is highly important for learning because cultural immersion is also a large part of the *Community Health* course. In taking this course, students encounter people from differing cultures and settings, including a staged disaster relief plus visits to several locations: a local correctional center, in-home health care patients, homeless shelters, and a refugee support center.

Almost half of the respondents specifically referenced participating in *World Relief*'s "Refugee Project" as deeply meaningful.

For this experiential project, the students are assigned a foreign ethnicity, culture, and costume, and they must adhere to the role-playing exercise as they walk the streets of Seattle. The students receive immigration paperwork and verbal instructions, neither of which is comprehensible because of contrived language barriers. They must suffer the reactions of passersby who stare or avoid them due to their unusual dress and inability to communicate. Such practical exercises teach the perspective of the refugee. Many of the grads relay the unforgettable, emotional upheaval plus the learned empathy this exercise in "forced reality" gave them (Nate). To this day, Karen recalls the hostility she felt from passersby. Walking in the shoes of a refugee gave her a perspective that would be otherwise hard to achieve. Her awareness and empathy cause her now to help anyone she encounters, personally or professionally, who seems confused by language barriers. Although it is a manufactured experience, this exercise supports the importance of immersion in creating lasting sensitivities and compassion for differing cultures.

Many of the nurses I interviewed, though not all, express some additional, post-graduation experiences in multi-cultural encounters and a desire for more. This did not surprise me, as the cultural sensitivity aspect of our program is a common draw to those who already have this interest. Including American and international students, the students' cultural experiences ranged from multi-ethnic family dynamics, to multi-cultural neighborhood living, to travelling nationally and internationally, and to living overseas.

Alumni Responses

Across the board, graduates shared very similar comments that reflect the basic principles taught in BSON cultural education. The most universal response from the alumni regarding their cultural education in the BSON is their heightened cultural *awareness*. They express this as both *self*-awareness and *global* awareness. The nurses found that they recognized their need to be sensitive to differences and commonalities alike. Furthermore, many graduates express gratitude for the cultural skills and knowledge they learned and for the opportunity to experience multiple cultural encounters. They specified how they integrated their academic skills with their cross-cultural immersion. All of these positives became pivotal in deepening their desire to learn and practice cultural competence.

Beginning with *self*-awareness, alumni describe their BSON cultural education as eye-opening and humbling. Justin, an international student, now a registered nurse, brought with him his own culture to the US, and then he visited yet another country for his cross-cultural trip which opened his eyes to his prejudices at home, and abroad. When he left the US for a third culture, he realized that people around the world are all looking for commonalities and acceptance. He became aware of his own biases and learned to be open-minded, to make no assumptions about what people should expect from each other. I asked each registered nurse (RN) to rate his or her cultural competence when each of them began the program, and each admitted they had over-estimated their competence, especially regarding their cultural awareness. Every one of them humbly acknowledged that they really had not known as much as they had thought they had. Interestingly, all twenty-five alumni had either lived or travelled internationally, or lived in diverse communities before coming to the BSON. So while they had some awareness of diversity before the program, they all graduated with a deeper realization that

they could never generalize their cultural knowledge about cultures different from their own. This self-awareness is a secondary result of the academic and experiential coursework.

One interviewee put it in a nutshell, "We have to remember that you don't know what you don't know" (Karen). This statement equally represents personal self-awareness as well as global awareness. Another RN, Sarah, found that her trip to Taiwan makes her own mother's Korean culture more personally relevant and comprehensible. She has gained a greater appreciation and context for things her mom says and does. While in Taiwan, she added considerable insight into her own cultural identity and gained a deeper compassion for Asian culture and Eastern medicine than she had known before. Sarah believes she has found her own family ties in her personal journey of cultural immersion. Like other alumni, this nurse expressed that the experience gave her even more self-awareness than cultural awareness.

Today, in her work with cardiac patients, Sarah applies her insight toward understanding her patients' spiritual needs, family involvement, and healthcare expectations even as they face possible death. She has a heightened awareness regarding how certain Asian cultures handle death; often they are more at peace with end-of-life stages than are members of other cultures. Yet, she remembers that she cannot assume that perspective based on ethnicity. So while Sarah expected her cultural education to bring greater insight into her culturally diverse patients, she also gained self-discovery as well as a deeper compassion for diverse patient groups. In turn, she has encouraged her coworkers to employ cultural sensitivity when they care for ethnically diverse patients who might face end-of-life concerns.

As stated by Kim-Goodwin et al., cultural *sensitivity*, or respect and value for another's culture, must feed our responses in working with patients of diverse cultures (922). For example, a hospital nurse might ask for an interpreter or for a translator phone if he or she has a patient

who speaks no English. Some of the BSON alumni commented that they are grateful for access to translator phones when they communicate with scared and vulnerable patients in the emergency room, for example. Having been in countries where they did not speak the language, graduates Nate and Laurie remember that this communication gap is frustrating when there was no access to an interpreter or a "double-use" phone. As in the case of the hypothetical Kenya patient, our own graduates have found themselves sick or injured during their studies abroad. One nurse (Marcia) recounted that her stay in the Taiwanese hospital was immensely affecting:

> The thing that made the biggest impact was being in the hospital and not understanding anything they're saying, their diagnoses, what they could see or understand…the big pictures; being helpless and not understanding anything because it's not Latin-based…So when we have patients that don't understand English, it's easy to get into a huddle and talk around and about them, but it gave me a perspective of how frustrating and scary it is to not know what your caretakers are saying, just like the aid car and administrative staff don't. We use the translator phones, but for non-English speaking patients, I understand how scary that can be!

Language barriers are difficult to bridge, but language, ethnicity and, race are not the only defining characteristics of culture. Others include socioeconomic class, physical attributes, age, gender, shared experience, faith, special interests, and other descriptors of any lens through which one sees the world. (Alexander 417). Dan learned to correlate cultural awareness skills to working with generational cultures. He had not previously considered the cultural differences between his generation and those in the youth or elderly patients he sees. He acknowledges that he cannot assume perspectives and must ask questions. This is why, globally, educators commit

to curricular reforms that promote understanding the world, participating in cultural life, and becoming more informed about issues that present differing beliefs and values (Morley and Forde 3). These emphases are crucial to compassionate understanding as well as to strong community building.

Respondents shared ways in which the encounters in *Community Health* locations such as the women's shelter, the homeless camps, and the refugee shelters, gave them opportunities to practice skills for cultural assessments. Those skills include reading body language and other non-verbal communication and carefully asking sensitive questions instead of assuming perspectives or knowledge. These and the study abroad encounters integrated with course work and research provide students the opportunities to practice sensitive communication with diverse patient populations. The nurses' learned humility and ongoing self-awareness continually builds additional layers of cultural competence.

Awareness of different social backgrounds brings respectful engagement and trust that patients need in healthcare settings (3). Taking the time to learn a patient's individuality and humanizing patients by learning their history, expectations, and understanding – these acts facilitate understanding and mutual respect between patients and their caregivers. Alumni stress that they can neither learn everything about every culture, nor assume generalizations about the people in the nation-states they have visited. They are eager to learn generally about a homeland culture, but they know they cannot stereo-type even those cultures they have witnessed.

Having been to Taiwan or India, for instance, some say they have connections with their Chinese and East Indian patients, yet they do not presume their patients' expectations. Kelsey, a Mother-Baby nurse, recounted how her experiences with post-partum tradition in Taipei, Taiwan, helped a new Chinese mother relax and trust in her care. The young mother was

comfortable with Western medicine, but the nurse found out that the patient's own mother expects Eastern approaches and was nervous about the care her daughter and grandbaby were receiving. When the new grandmother's visit was imminent, the patient asked for water with ice. Kelsey suggested using an opaque cup so her mother would not see the ice. The young mother relaxed in good humor, appreciative of the respectful insight and accommodation. The nurse remembered that in Taipei, post-partum mothers are not allowed icy drinks as they may be harmful to mother and baby. Kelsey had just enough experience to ask about this potential expectation of a new grandmother. Without making assumptions, she let the patient know that she wanted to help ease anxiety in any way she could.

Another Mother-Baby nurse, Mary, likes to share with her Indian patients her own school experiences in Calcutta, building bonds of trust with her patients as well. She knows she cannot claim proficiency about Indian culture, but simply sharing her Indian experience with her patients does build bridges. Sometimes her patients have healthcare expectations that cannot be met in the US system, but making connections with her patients allows her an opportunity to educate them about what they can expect here in the US At times, she remembers being frustrated with patients' seemingly unrealistic demands, but she remembers to practice what she had learned in nursing school 13 years ago. Mary learned that each of us can have misguided expectations, yet we can learn from each other if we will take the time to talk and listen respectfully.

While abroad, students learn both the overall context of a people group and also that within that context, each individual's needs will vary. They experience the prevailing cultural norms in general, but they also understand that these norms represent only a localized area. They see for themselves the existing diversity within every culture. For example, in the American

culture, we might contrast and compare the politics, culture, diet, and spirit of the deep South with the same elements in the Midwest or the Pacific Northwest. BSON graduates see that every person is a unique individual, someone who may not espouse all the same perspectives and history of other people of their society. Therefore, immersion in cross-cultural encounters does not make us experts in others, but it can bring connections and awareness. It can remind us to be inquisitive and and open to what each of us brings to an encounter.

Cultural education in baccalaureate nursing programs includes various formats for integrating cultural coursework, but central to cultural education must be the cultural immersion. A month-long, cultural immersion abroad such as the BSON course is unique and highly recommended. The experience allows nursing students to pool all of their learning in cultural education and practice it in challenging, personal experiences. Interviews with alumni supported the positive outcomes of all transcultural education coursework in the BSON. Yet no other course has as much impact as the *Nursing Practice as Ministry* course, the overseas immersion experience.

Opposition

A few specific arguments stand against this immersion experience. As mentioned earlier, Folse et al. identified only sixteen other BSN programs that have an extensive immersion course, and they are not a required, month long experience. It is difficult to find faculty who can leave their families for one month. Similarly, one month can pose to be a hardship for many students as well. Therefore, students are informed of this requirement before applying to the program and after acceptance to the program. Faculty and staff alike are still drawn to the cross-cultural aspect of this required course. Faculty who believe in the effectiveness of the BSON model of cross-cultural education are drawn to the vision and teaching positions as well. Another argument

against this immersion experience is that baccalaureate nursing programs are already pressed for time. The depth and breadth of the program leaves little room for time away. As a result, many programs that offer an extensive immersion offer it only as an elective so the student is not required to extend program attendance.

In addition, cost can be prohibitive, but the BSON divides its cross-cultural immersion course fee into increments paid each semester. This division allows the students to cover the fee in smaller payments or to cover it with financial aid packages. The final argument against immersion comes from an interview with Dr. Campinha-Bacote herself. She has noticed that some students come back from cross-cultural immersions feeling traumatized by the disparity and suffering (phone interview). She notes that some nurses decide against returning to developing countries because the needs there are too dire or too overwhelming. However, she also admits the studies she has reviewed did not include long-term ones and wonders if, in time, nurses do recover and return overseas to offer needed healthcare services where they can.

Cultural Competence Evaluation

BSON grads understand that cultural competence is a life-long pursuit, one at which it they never completely accomplish. There are, however, a few formal measurements for assessing cultural competence in nursing care. In general, the assessments are self-reports. Besides checking for awareness of globalization and cultural sensitivity, the test surveys essentially measure self-awareness. As evidenced by the interviewees in this thesis project, graduates from the BSON gain self-awareness. They learn it when they stand in contrast to the locals in their site of immersion. They learn firsthand that people of all cultures are unique and valuable. They learn that different environments and resource pools mean different approaches to healthcare and that those approaches are effective in their contexts (Erin). They continually discover that

"different" is acceptable, and as a result, they become more and more aware of ethnocentrism. Awareness gives them the tools to practice cultural humility and sensitivity with their patients.

Conclusion

Cultural education in baccalaureate nursing is keeping up with the demands of a progressively globalized world. As world trade, travel, disaster relief, international study abroad and other reasons bring people together across national boundaries, cultures must learn to coexist. Mixing and melding culture populations requires the need for sensitivity and understanding as we navigate people's differing values and traditions. Also, as concerns for international unrest and refugee displacement add to the tensions, society must do all it can to promote respect and peace between people groups wherever they associate with one another. In the context of healthcare, nurses enter into some of the most vulnerable situations people must endure. That is the time when compassion and consideration for each person is of utmost importance. When people are sick or in pain and feel compromised, nurses are in a position to respond to their patients' needs with genuine holistic care. Cultural competent nurses can help meet this challenge. With cultural sensitivity, nurses can bridge social interactions, reduce fear, alleviate misunderstandings, and produce better health outcomes for diverse populations. Cultural competence is best defined as an ongoing process, a place at which one never fully arrives. It should be an open-ended mission for all in response to our globalized society, but for nurses, it is essential.

My interviewee RNs all report that their immersion experiences gave them self-awareness and global awareness. They also admitt that they had overestimated their levels of cultural competence before experiencing these trips abroad. Since having worked as RNs for as many as thirteen years, they now correlate their immersion experience with cultural sensitivity in

their careers and in their relationships. Today, they desire ongoing encounters with and better understanding of their international neighbors, coworkers, and patients because they know that cultural competency is a process. The progress they have made toward cultural competence is palpable to them, and they desire more. Many graduates of the BSON have gone on to enjoy cross-cultural healthcare missions in African, South American, European, and Asian countries. Many have returned to remote areas of Alaska to live and work with the Yup'ik Native tribe. These nurses' immersion experiences have given them a desire to return to distant worlds and embrace a foreign cultural context and its people.

Globalization brings diversity of thought and expression. If we allow it, these differences in cultures can greatly enrich our own ethnocentric experiences. We know cultural competence is not static or ever truly achieved; it is an ongoing process of learning by exposure to different cultural encounters. These encounters provide nursing students deeply felt insights that academic research alone cannot offer. They learn that their own discomfort at being the "other" helps them face their fears and ignorance so that they can become culturally sensitive to their patients. They see first hand that sick and hurting patients' vulnerabilities and fears grow when there are also language barriers and cultural differences. Through being the "stranger," they understand that the only way to really gain self-awareness and sensitivity is to stand in contrast to a culture different from their own; in other words, they must walk in the shoes of the "other" (Volf 251).

We must seek the experience of the foreigner in the midst of the locals, strangers in a strange land. We must be changed forever by the experience, and act on it with sensitivity and open-mindedness as well as with medical knowledge. Extended cross-cultural immersion in baccalaureate nursing programs must be the vehicle by which nurses gain the needed skills to offer holistic care to every patient. For our hypothetical Kenyan patient, that means her nurses

will do their best to explain what is happening and respect her concerns. Her nurses will reassure her, offer her resources, read her body language, and value her with great care all because they know she needs this holistic care before she can trust them. As she is immersed in this frightening, very foreign scenario, she will be grateful for nurses who have a foundation of cultural insight because of their own challenging immersion experiences. This injured student represents one of many who may well experience a positive cross-cultural encounter specifically because of her culturally sensitive nurses and their holistic care.

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