Cultural Competence in Clinical Nursing: A Qualitative Study

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Abstract

Aims: Given the wide cultural diversity of patients in the current world, nurses need to have great cultural competence. This study aimed to explore the concept of cultural competence in Iranian nurses. **Materials and Methods:** This qualitative study was conducted in 2017–2018 using Graneheim and Lundman's approach to qualitative content analysis. A purposeful sample of eighteen clinical nurses was recruited with maximum variation from hospitals of Isfahan and Ahvaz, Iran. Data were collected through eighteen semistructured interviews and simultaneously analyzed through directed content analysis. **Findings:** Data analysis resulted in the formation of thirteen subcategories which were respectively grouped into the four categories of cultural cognition (cultural awareness, cultural knowledge, and cultural insight), cultural care intention (cultural encounter, cultural desire, and cultural eagerness), cultural flexibility (cultural attitude, cultural sensitivity, and resolving cultural conflicts), and cultural care skills (communication skills, cultural evaluation skills, behavioral skills, and skills to get feedback about cultural care). **Conclusion:** Iran has many ethnic and religious groups which have a variety of subcultures, so Iranian nurses need to be sensitive about cultural diversity in health-care settings and have the cultural competence to facilitate the delivery of quality culturally competent care to the patients of different cultures.

Keywords: Clinical nursing, cultural competency, nursing care, qualitative research

Introduction

Cultural diversity is one of the striking characteristics of the current world.[1] Culture, defined as thoughts, relationships, actions, rituals, beliefs, and values of a group of people,[2] significantly affects social behaviors, health-related habits and behaviors, and response to illnesses and treatments.[3] The Islamic Republic of Iran has many ethnic and religious groups which have a variety of subcultures, languages, lifestyles, customs, traditions, and different modes of livelihood.[4] Research in the Islamic Republic of Iran shows that beliefs about health care and people's perceptions of illness and health vary across ethnic and religious groups.[4,5]

Cultural diversity also affects nursing practice. Currently, nurses need to provide care to patients of different cultures.[6] Compared with other health-care professionals, nurses spend a greater amount of time with patients.[7] They need not only to provide holistic care to their clients but also to establish effective and respectful communication with them.[8] However, cultural diversity can be a major challenge to quality nursing care delivery because nurses' lack of knowledge about how to deal with patients' different cultural beliefs and values can impair nurse–patient communication and, thereby, negatively affect nursing care.[9] Therefore, nurses need to be sensitive about cultural diversity in health-care settings and adopt strategies to effectively manage it.[10]

Cultural competence is a complex multidimensional concept.[7] Its most widely accepted definition of cultural competence provided by Chun quotes from Cross *et al*.: "a set of behaviors,

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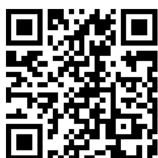

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attitudes, and policies that come together in a system, agency, or among professionals, enabling that system, agency, or those professionals to work effectively in cross-cultural situations."[11]

The available conceptual and theoretical models in the area of cultural competence have been developed in certain historical, sociocultural, and political contexts.[12] Although various studies have been conducted about the concept of cultural competence in nursing focusing on specific domains or tools of cultural competence,[2,13-18] this concept has not extensively been explored in the context of Iran,[4] especially in clinical nursing. Qualitative approaches are exploratory and enable researchers to explore the complexity of the phenomena affecting health-care providers, receivers, and policymakers.[19] Therefore, this study was conducted to explore the concept of cultural competence in clinical nursing and its dimensions based on Iranian nurses' experiences of care delivery to patients of different cultures based on Suh's Cultural Competence Model.

Materials and Methods

This qualitative content analysis study was conducted from April 2017 to July 2018 using Graneheim and Lundman's approach to qualitative content analysis. The main study participants were eighteen clinical nurses recruited from different wards of public and private hospitals in Isfahan and Ahvaz, Iran. Sampling was performed purposefully, and with maximum variation in terms of nurses' age, gender, work experience, workplace, and place of residence. In order to enrich the study data, participants were recruited from different ethnic groups in Iran, namely *Kurds*, *Turks*, *Persians*, *Armenians*, and *Lurs*. Inclusion criteria including Iranian nurses who had at least 25-year-old and had a bachelor's degree or higher. They being able to speak in Persian language and agreement for participation in the study. They also should have nursing experience in hospital for 2 years and more. Accordingly, we referred to the hospitals (Isfahan and Ahvaz, Iran) and created a list of nurses who had inclusion criteria. Then, we telephoned the nurses in the list and invited them to the study. If agreed, they were asked to determine the preferred time and place for interview.

Data were collected through in-depth semistructured interviews. All interviews were conducted in the Persian language. Each interview was started by greeting the intended participant. They were informed about the aims and the methods of the study and then the questions about demographic characteristics and open-ended questions about participants' experiences of care delivery to the patients of different cultures were asked. The interviews were mainly started by asking this questions, "Can you please explain your experiences of care delivery to patients of other cultures?" and "Which challenges did you experience in care delivery to patients of other cultures?" Considering that the approach of this study is directed content analysis, Suh's model of cultural competence was used in designing the interview's questions. It is a simple and brief applicable theoretical model for cultural competence in nursing.[20] Among other models of cultural competence, the Suh's model is accessible, complete, and relatively new.[21] Examples of these questions were the following: The cultural awareness domain: "What do you know about the principles of your own culture?" and "How do you obtain cultural information?" The cultural knowledge domain: "How do you obtain information about other cultures, their ideologies, and cultural differences? "The cultural skill domain: "How do you provide care to a patient of a different culture? "Probing questions were also used to add to the depth of the study data. Examples of these questions were, "Can you provide an example?" and "Can you explain more about this?" All interviews were held with appointment and in a quiet room at the participants' preferred place and time. The mean length of the interview was 26 min and ranging from 24 to 65 min. Data collection was continued up to data saturation.

Data were analyzed using directed content analysis. The aim of directed content analysis is to validate or implicitly develop an existing theory or conceptual framework. The theory used in directed content analysis helps predict the relationships among variables.[22] The three phases of directed content analysis are preparation, organization, and reporting.[23] In the preparation phase, each interview was transcribed and the transcript was perused several times to immerse the researcher in the data. In the organization phase, an unconstrained matrix was created to allow the development of possible new categories. Unconstrained matrix allows the development of some categories inductively in steps of "grouping," "categorization," and "abstraction." Next, the data were reviewed to find meaning units relevant to the predetermined categories. The meaning units were coded. Moreover, meaning units which were relevant to the cultural competence concept but not to the predetermined categories were also identified and coded. Finally, the generated codes were allocated to the predetermined categories in the matrix or grouped into new categories [Table 1].

The credibility of the findings was ensured through prolonged engagement with participants and the data and also through asking several participants to review some interview transcripts and the generated codes. Moreover, data

Table 1: An example of data coding and categorization

Quotation	Code	Subcategory	Category
It was difficult for me to communicate with patients who did not understand my language. I attempted to convey what I meant using body language	Communication through body language Get help from a translator to communicate	Establishing communication	Cultural care skills
	Using a common language	Patient assessment skills culturally	

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triangulation was applied by interviewing nurses at different times. In addition, data were independently analyzed by the authors and they generated codes and categories were compared and combined with each other. Confirmability was ensured through peer-checking. Labeling and sorting the data and checking the coding process were used by the research team and other relevant experts for agreement among researchers. Dependability was ensured through providing detailed explanations about the different phases of the study. In addition, the transferability of the findings was established through sampling with maximum variation and providing thick descriptions of participants' characteristics and experiences.

The Ethics Committee approved this study (code: IR.AJUMS. REC.1396.832).

Results

Participants in this study were 18 patients (male = 11, female = 7). The mean and the range of their ages were respectively 28.4 and 25–61 and their work experience varied from 4 to 36 years.

During the process of data analysis, the dimensions of cultural competence included four categories: Cultural cognition, cultural care intention, cultural flexibility, and cultural care skills [Table 2].

The subcategories of cultural care intention were cultural encounter, cultural desire, and cultural eagerness. In cultural encounter, nurse exposure to patients from different cultures is one of the factors in gaining cultural competence. A 42-year-old male nurse from Ahvaz said in this regard: "*Many patients come here from countries like Iraq and Afghanistan. Sometimes the passenger comes from other cities such as Tehran, Tabriz or elsewhere. We are in contact with all kinds of cultures" (p. 2)*. The next subcategory of cultural care intention was cultural desire. The nurse's desire to care for patients from different cultures plays an important role in the formation of cultural competence. Some nurses love caring for these patients. A 28-year-old male nurse said in this regard: "*I was very surprised when I came to the ward and hear that we have a German patient. It was very interesting for me.!" (p. 9)*. In cultural eagerness, some nurses describe their strong desire to encounter, communicate, and care for patients with different cultures, which seems to be largely due to their personality; For example, one of the experienced participants states in this regard: "*In cases where the patient is foreign or from another culture, I volunteer to take care of him and pay attention more" (p. 17)*.

Table 2: Categories and themes of cultural competence

Theme	Category
Cultural care intention	Cultural encounter
	Cultural desire
	Cultural eagerness
Cultural flexibility	Cultural attitude
	Cultural sensitivity
	Resolving cultural conflicts
Cultural cognition	Cultural awareness
	Cultural knowledge
	Cultural insight
Cultural care skills	Communication skills
	Cultural evaluation skills
	Behavioral skills
	Skills to get feedback about cultural care

The subcategories of cultural flexibility were cultural attitude, cultural sensitivity, and resolving cultural conflicts. In cultural attitudes, acceptance and respect for cultural differences between patient and nurse and having a positive view of patients from other cultures are important. Experienced female nurse with a doctorate degree said: "*The patient should not be disrespected even if we have a negative view of his religion or ethnicity; I respect the patient's beliefs. The patient is primarily a human and has rights…" (p. 11)*. The next subcategory of cultural flexibility was cultural sensitivity. The nurse's attention to the culture of the patient is one of the important issues that must be considered in nursing care. The 33-year-old nurse said about one of the ethnicities: "*They are very sensitive to privacy issues. So we tried to attention to the patient's privacy in bed, especially in women" (p. 5)*. The third subcategory of cultural flexibility was resolving cultural conflicts. In the process of caring for a patient with a different culture, sometimes there are challenges that participants have mentioned some of these cases. One of the female nurses from Chaharmahal Bakhtiari said in this regard: "*The patient's companions insisted that we add torbat soil to the patient's food (via NGT (and we cannot accept it. They said this soil can heal our patient!." (p. 18)*.

The subcategories of cultural cognition were cultural awareness, cultural knowledge, and cultural insights. In cultural awareness, nurses need to know their culture and understand the cultural differences between themselves and the patient and consequently not having prejudice in cultural matters. A 25-year-old male nurse said in this regard: "*I knew that their culture was different from ours and I did not have a positive view of them, but I took care of him like other patients" (p. 14)*. Cultural information and issues of different national and religious ethnicities are components of cultural knowledge. This knowledge, help the nurse to learn how to care appropriately and effectively for patients from different cultures. An experienced male nurse from Khuzestan said in this regard: "*. In some cultures, respect for people is very important; For example, in Khuzestan, the Arab people likes to be greeted warmly and to be highly respected." (p. 2)*. During working years, nurses gradually gain a cultural insight by cultural awareness and knowledge that can help them manage possible problems in caring for patients from different cultures. One of the young nurses from Isfahan who also worked in Khuzestan said: "*Patients from. Do not eat hospital food and do not like Muslims to touch them. So we did not insist on this. We allowed their families to bring them food from home" (p. 10)*.

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The subcategories of cultural care skills were communication skills, cultural evaluation skills, behavioral skills and skills to get feedback about cultural care. In the first stage of patient care, communication between the patient and the nurse is very important, so that if effective communication is not established, the care and treatment process will be disrupted. One of the participants with 15 years of work experience said: "*We try to communicate with the patient in any way. Talk English or get help from a translator or other colleague…" (p. 1)*. The second sub category of cultural care skills was cultural evaluation skills. For cultural care, it is necessary for the nurse to assess the patient's cultural needs. A 35-year-old nurse from Tehran said in this regard: "*When a patient is admitted, we should know their needs such as physical, cultural, and religious needs. We can take care better of the patient in this way…" (p. 12)*. The next subcategory of cultural care skills was behavioral skills. Cultural competence requires certain behavioral skills such as work commitment, respectful behavior, patience and compassion. One of the female nurses experienced in caring for an Indian patient Said: "*I tried to take care of the patient in a friendly and respectful way. Of course, I take care of all the patients in this way, but I had this feeling more to that patient…" (p. 11)*. The last subcategory of cultural care skills was skills to get feedback about cultural care. The nurses need to receive feedback on their culturally care, which is usually obtained through the patient, his companions or relevant officials. One of the male nurses with 37 years of experience in this regard said: *"satisfaction and happiness of the patient and his companions at the time of discharge were valuable to me. I made sure I did my job right" (p. 17).*

Discussion

The main dimensions of cultural competence are cultural cognition, cultural care intention, cultural flexibility, and cultural care skills.

Cultural cognition was one of the main dimensions of cultural competence in the present study. Findings revealed that through developing awareness of their own cultures, of differences between their own cultures and their patients' cultures, and of cultural differences among patients, nurses can employ effective strategies for care delivery to the patients of different cultures. Such awareness is developed through obtaining cultural knowledge from different sources and results in a cultural insight which guides nurses in their next encounters with patients of different cultures. The models of cultural competence shows that cultural cognition is an essential component of cultural competence and includes cultural awareness and cultural knowledge and are in line with result of this study.[24-28]

Cultural care intention was the second main dimension of cultural competence in this study.[26] Cultural motivation or desire denotes that a nurse does not automatically achieve cultural competence; rather, he/she needs to have desire and make deliberate attempts for understanding patients' needs.[25] Iranian nurses' desire to provide culturally-appropriate care to the patients of other cultures was affected by different factors such as their ability to establish effective communication with patients, their familiarity with their cultures, and their eagerness to learn about their cultural issues. Yet, an earlier review study reported that nurses have limited cultural knowledge, do not effectively use cultural knowledge in practice, and face barriers in establishing effective communication with patients.[6]

The third main dimension of cultural competence in the present study was cultural flexibility. This study's participants faced different challenges in providing care to the patients of different cultures. These challenges were mainly related to those cultural needs of patients that contradicted the principles of medical sciences or the principles of nurses' own cultures. In order to provide culturally-appropriate care, nurses need to be sensitive about these challenges and conflicts, foster positive attitudes toward them, and employ appropriate strategies to resolve them. As a facilitator of achieving cultural competence in nursing, cultural sensitivity is also a main dimension in the cultural competence models.[20,25,27,29]

Study findings also revealed cultural care skills as the other main dimension of cultural competence in clinical nursing. Cultural care skill in other cultural competence models is defined as the ability to collect cultural information about clients' health.[25,29,30] Effective communication with the patients of different cultures is the most essential component of cultural care skills.[31,32] The participants of this study attempted to communicate with the patients of different cultures through body language, bilingual speakers, colleagues, patients' companions, and a second language.

Conclusion

Iranian nurses are in contact with patients from different cultures, so to improve the quality of nursing care, it is necessary to have cultural competence, and policymakers and nursing managers should pay attention to this issue and plan for that. This study reveals the dimensions of cultural competence and can guide nurses in acquiring cultural competence. In addition, the findings of the study can be used in the nursing curriculum to enhance the cultural competence of nursing students and graduate nurses.

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Conflicts of interest

There are no conflicts of interest.

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