

Cultural Diversity: The Intention of Nursing

John Lowe, RN, PhD, FAAN, and Cynthia Archibald, RN, PhD

Nursing in the United States has expressed its intention of being a professional discipline that is culturally diverse. However, after examining the progress in this area, it is evident that nursing's movement toward cultural diversity has been slow and episodic. This article addresses cultural diversity progress in nursing and explores behaviors and actions that could enhance the cultural diversity of nursing.

Search terms: *Culture, diversity, intention, transcultural nursing*

John Lowe, RN, PhD, FAAN, is an Associate Professor; and Cynthia Archibald, RN, PhD, is an Assistant Professor, Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL.

Introduction

The culture of the United States has been developing since long before it became a country (Hickey, 2005), and today the nation's culture has components derived from cultures all over the world. Clearly, this makes cultural diversity within health care a highly complex issue that cannot be mastered overnight. Instead, many have found it to be "a career-long endeavor that may initially seem to be characterized more by frustration than by satisfaction" (McGee, 2001, p. 105). In 1986, the American Nurses Association (ANA) issued its first intention to strengthen cultural diversity programs in nursing. Needless to say, there has been much discussion regarding culture in nursing and questions of willingness to go beyond the rhetoric of intention (ANA, 1986).

In 1986, the American Nurses Association issued its first intention to strengthen cultural diversity programs in nursing.

According to the theory of reasoned action (Fishbein & Ajzen, 1975), intention and intentionality are determined by the attitude toward behaviors(s) and subjective norms for behavior(s). Attitude toward behavior is seen as the function of beliefs concerning the consequences of performing the behavior and evaluation of each of these consequences as either positive or negative. Subjective norm is seen as the function of what others expect and the motivation to comply with those expectations. Jemmott, Jemmott, and

Cultural Diversity: The Intention of Nursing

Villaruel (2002) explained subjective norms to be people's beliefs of referents' (people, groups, or organizations) approval or disapproval of behavior which is also conceptualized as perceived social pressure to perform or not to perform the behavior. Malle and Knobe (1997) defined intention and intentionality as comprising the five components of (a) a desire for an outcome; (b) a belief that the action will lead to an outcome; (c) a desire to perform the action; (d) skill to perform the action; and (e) awareness while performing it.

Attitude toward behavior is seen as the function of beliefs concerning the consequences of performing the behavior and evaluation of each of these consequences as either positive or negative.

The intention of nursing being a discipline that embraces, integrates, and permeates cultural diversity is continually challenged and evaluated. The changes in the ethnic and cultural composition of the U.S. population constantly challenge nurses daily to incorporate the diverse needs of their clients into the provision of quality nursing care while facing a shortage of adequate qualified staff to meet these needs. Research findings indicate that without the attention to diversity, healthcare practices of clients and quality of health care will diminish and health disparities will increase (Cook, 2003). Eliminating health disparities is one of two primary goals set by the U.S. Department of Health and Human Services (U.S. DHHS) Healthy People 2010. The goals set within the Healthy People 2010 is firmly dedicated to the principle that every

person in every community across the nation regardless of age, gender, race or ethnicity, income, education, geographical location, disability, or sexual orientation deserves equal access to comprehensive, culturally competent, community-based health care (www.health.gov/healthypeople). Nursing also has an expressed commitment to assist with the resolution of problems in society particularly as related to health care, and simultaneously be cognizant of the need to be culturally diverse.

The changes in the ethnic and cultural composition of the U.S. population constantly challenge nurses daily to incorporate the diverse needs of their clients into the provision of quality nursing care while facing a shortage of adequate qualified staff to meet these needs.

Society expects nursing to be culturally competent in response to the increasing prevalence of diverse people in the United States. According to the U.S. Census Bureau (2007), the minority population within the United States has reached a high of over 100 million, and one third of the total U.S. population is of minority descent. In addition, every 27 sec, there is one international migrant. It is predicted that the population that belongs to the four minority groups counted by the U.S. Census Bureau will increase from 25% in 1990 to 32% by 2010 and to 48% by 2050 (Servonsky & Gibbons, 2005, p. 52), thereby switching places with the majority population in the

United States by the year 2050, and representing 50% of the labor force (U.S. Census Bureau, 1999).

Every 27 sec, there is one international migrant.

Advancement of Cultural Diversity in Nursing

Much advancement has been made since the conception of becoming culturally diverse in nursing. A hallmark behavior and action that focused on cultural diversity within nursing gave rise to the transcultural nursing movement. The early focus of the transcultural nursing movement was to bring sensitivity to the differences between nurses' own culture and that of the people to whom they were providing care (Leininger, 1979). Transcultural nursing also became known as a way to combine the concept of culture into all aspects of nursing while providing health care (Desantis, 1988; Giger & Davidhizar, 2004). Successes of the transcultural nursing movement included incorporating culture to the nursing curricula and to the licensure and certification exams. In addition, organizations that promote the integration of culture into all aspects of nursing have been developed.

The advancement of cultural diversity is clear in the goal and mission of the ANA (1986, 1991), which is a commitment to serve the health needs of all people. In addition, the ANA has included cultural diversity as a priority in its strategic plans. Historically, cultural issues were addressed through the ANA's interaction with minority organizations and minority leadership within the ANA. For example, when the National Association of Colored Graduate Nurses dissolved in 1950, the ANA attempted to absorb their functions and responsibilities (Carnegie, 1994). Since that time,

cultural diversity issues have been addressed through ANA groups, such as the Committee on Intergroup Relations, Affirmative Action Task Force, and the Council of Cultural Diversity. In 1974, the ANA responded to an invitation by the Center for Minority Health and the National Institute of Mental Health to submit a grant proposal to support doctoral-level preparation in the area of mental health for ethnic and racial minority healthcare providers. Thus, the Ethnic Minority Fellowship program of the ANA has been a consistent and focused program for the doctoral preparation of ethnic minority nurses in the area of substance abuse and mental health disorders. Additionally, issues relating to cultural diversity have been voiced through amendment ratification, position papers, and other statements made by the ANA.

The U.S. DHHS Division of Nursing Leadership Invitational Congresses' focus on caring for the emerging majority is another example of the advancement of cultural diversity in the nursing profession (1997). The overall purpose of the congresses was to enhance racial and ethnic diversity and cultural competency in the nursing workforce. The congresses invited minority nurse leaders to move a nursing action agenda forward in order to enhance the health care of the emerging majority populations of the nation.

Additionally, the Workforce Diversity Grants within the Nursing Workforce Development programs were developed to increase opportunities for individuals who are from disadvantaged backgrounds, including economically disadvantaged families, as well as racial and ethnic minorities underrepresented in the nursing profession (ANA, 2007). These programs are funded by Title VIII of the *Public Health Service Act* and administered by the Health Resources Services Administration of the U.S. DHHS.

Current Status of Cultural Diversity in Nursing

As the United States anticipates a rapid growth in minority/ethnic populations in the near future,

Cultural Diversity: The Intention of Nursing

nursing will need to consider how to operationalize cultural diversity characteristics in process, reflection, and practice. Although a continued challenge, the necessity in preparing and assisting nurse researchers and clinicians to be able to meet the health needs of a culturally diverse population takes on a sense of urgency. Despite an approximate 25% increase in the minority/ethnic population of the United States over the last decade, the ethnic composition of nursing has remained virtually unchanged. The U.S. Census Bureau (2004) reported just 11.6% of registered nurses are racial or ethnic minorities. Of this number, 4.6% were non-Hispanic African American, 3.3% were Asian or Pacific Islander, 1.8% were Hispanic, 0.4% were American Indian/Alaskan Native, and 1.5% were from two or more racial backgrounds. It seems as if an additional 500,000 nurses of ethnic or minority groups are needed just to reflect percentages of these groups in relation to the total population. These figures represent imperceptible changes since the 1970s. These data strongly suggest that nursing is not providing sufficient numbers of minority nurses to create a critical mass. A minority nursing critical mass is needed to guide the profession through research, education, healthcare services, and the sharing of information with nonminority nurses and other healthcare professionals.

Millions of Americans who are of minority and culturally diverse ethnicities are living lives that do not reflect the progress in medical technology and research in the world's most advanced democracy. The ethnic minority population in the United States faces separate, unequal health, and many health disparity issues. Even the well-educated, well-insured middle-class minorities are more likely to have difficult births, higher rates of certain cancers, more deaths from diabetes, and far less adequate health care than their White counterparts. Ethnic minority groups die younger and faster than Whites in almost every type of illness and cause of preventable death with the exception of suicide. For example, fewer African

American women get breast cancer than White women, but African American women experience higher mortality rates from breast cancer. African American men have the highest rate of prostate cancer in the world. Also, while many presume drugs and homicide to be the major cause of death among African Americans, it is severe high blood pressure that leads to stroke and cardiovascular and renal diseases (Agency for Healthcare Research and Quality, 2005; American Medical Association, 1997). Compared to Whites, Hispanics and Native Americans have two to three times the rate of diabetes, and Vietnamese American women contract cervical cancer five times as often (Spector, 2004). HIV/AIDS among the African American population in the United States continues to challenge the healthcare community. While risk behaviors may be decreasing in some target populations, other groups (such as African American youth) appear to be at ever-increasing risk for being infected with HIV (Valleroy et al., 2001).

The necessity in preparing and assisting nurse researchers and clinicians to be able to meet the health needs of a culturally diverse population takes on a sense of urgency.

Alarming, the number of ethnic and culturally diverse people with these and other conditions that create high nursing and healthcare demands will increase through this century. Therefore, nursing will need to serve this population with increased culturally diverse knowledge, information, and resources. The intention of nursing to be culturally diverse will be greatly enhanced when a culturally competent nursing

workforce is developed through education, product and resource development, and community outreach.

Nursing as a profession and discipline can conceptualize cultural diversity as more than just an awareness of diverse cultures through basic nursing curricula. The curricula need to go beyond simply teaching categories of cultural content where categories of beliefs and practices of cultural characteristics are developed and implemented for nursing assessment and intervention purposes.

The Future

To evaluate the movement of nursing's cultural diversity intention, the attitudes and beliefs about cultural diversity should be examined for its impact on behavior and actions that have resulted in the operational definition and actualization of cultural diversity. In process, reflection, and practice, nursing science should embody characteristics of cultural diversity; in that way, the science would serve as a process for understanding all aspects of cultural diversity. Nursing as a profession and discipline can conceptualize cultural diversity as more than just an awareness of diverse cultures through basic nursing curricula. The curricula need to go beyond simply teaching categories of cultural content where categories of beliefs and practices of cultural characteristics are developed and

implemented for nursing assessment and intervention purposes. Members within a cultural group must be seen as individuals experiencing human dimensions of health and illness. According to Zoucha and Housted: "the health care provider ought to treat a patient who happens to be from a particular culture, as an individual from a particular culture rather than, in effect, to treat the culture through the patient" (2000, p. 326). In this way, the ability to use diversity in a competent manner will become second nature for each nurse.

Future nurses need to be taught how to apply culture and diversity in the clinical setting. This will begin when nursing faculty are prepared in the cultural diversity dimension and are fully persuaded/passionate about the cause. Nursing academia must confront the critical shortage of diversity among its faculty. Increasing the diversity among nursing faculty within nursing's educational programs is needed so that students have diverse role models. Diversity among nursing faculty can also help to disseminate and interpret cultural knowledge and needs of diverse nursing students. Additionally, nursing curricula need to reflect culturally diverse learning styles (Crow, 1993; Lowe, 2002). Nursing as a culture transmits its survival through education that continues to use a mainstream Anglo-culture-based curriculum. This often creates great demands on culturally diverse students (Bruyere, 1991). More curricular time and integration of cultural diversity concepts and content need to be considered. For instance, the anthropological perspectives of both emic (insider's) and etic (outsider's) viewpoints in patient care should be integrated to nursing curriculum, theory, and practice. Incorporating an emic-etic approach in patient care allows nurses to adhere to a culturally diverse approach that puts them in a culture-brokering position (DeSantis, 1991). Chalanda (1995) described culture brokering as "the act of bridging, linking, or mediating between groups or persons through the process of reducing conflict or producing change" (p. 19). Through culture brokering, patients will be able to mediate between their beliefs and practices and the beliefs and practices promoted

Cultural Diversity: The Intention of Nursing

by Western biomedicine about how they should resolve their particular health or illness situation.

Diversity among nursing faculty can also help to disseminate and interpret cultural knowledge and needs of diverse nursing students. Additionally, nursing curricula need to reflect culturally diverse learning styles.

Nurses in clinical practice have been expected to use a recipe or formula approach to delivering culturally competent patient care. Often, this approach does not adequately address cultural diversity because of preconceived and prescribed stereotypical notions and assumptions. Patients must be viewed as individuals outside of stereotypical characteristics and categorized to a particular cultural group. In this way, it would become clear that there are views and practices that conceptualize diversity between and within cultures. In addition, individual differences are evident even within cultural groups. Through a comparative focus, commonalities among cultures that can be readily detected can begin to be used to develop theories and generalizations across cultural groups. Models that guide and give direction for managing multicultural nursing staff are limited.

Nursing as a professional discipline needs to operationalize a culturally informed clinical practice that emanates from research and theory that has been tested in practice. Assessment methods need to be developed that can generate rules for individual nursing interventions. For example, the Conceptual

Framework of Nursing in the Native American Culture informs and guides nurses and other healthcare professionals in ways to apply Native American culture to care being provided to Native Americans (Lowe & Struthers, 2001). This conceptual framework was developed from research conducted to depict the phenomena of nursing in the Native American culture. More frameworks need to be developed that go beyond just being descriptive and become prescriptive for culturally competent practice. A knowledge base to use as a foundation to perform culturally competent scholarship needs to be developed (Meleis, 1996).

Culture brokering as “the act of bridging, linking, or mediating between groups or persons through the process of reducing conflict or producing change.” Through culture brokering, patients will be able to mediate between their beliefs and practices and the beliefs and practices promoted by Western biomedicine about how they should resolve their particular health or illness situation.

Nursing, from a cultural diversity approach and perspective, has been more descriptive in nature. Research approaches need to move from descriptive research to applied, programmatic, or biocultural in nature. The dynamics of culture on patient responses

to health and illness and on physiological factors, cost of care, length of stay, and rates of compliance/adherence need to be studied. The effects of the application of culture to patient care needs should be studied. For example, the physiological outcome effects of Native American patients who have received care guided by the Conceptual Framework of Nursing in the Native American Culture can be studied. Through a comparative focus, commonalities among cultures could be readily detected and used to develop theories and generalizations across cultural groups.

To enhance cultural diversity, nursing needs to study the effects of using culture on physiological, psychological, spiritual, and social factors. Nursing care could then be based upon a culturally informed nursing science. Outcome measures of the effects of culture on health-seeking behavior and the response to illness could be developed. Findings from research that identify the effectiveness of various intervention strategies with cultural groups can be integrated with the clinical functions of assessment, diagnosis, and intervention.

To enhance cultural diversity, nursing needs to study the effects of using culture on physiological, psychological, spiritual, and social factors. Nursing care could then be based upon a culturally informed nursing science.

Summary

Nursing has expressed the intention of being a culturally diverse profession. Therefore, nursing

behaviors and actions should be experiencing positive outcomes as a result of having a culturally diverse workforce and the provision of culturally competent care as the standard and norm. Competence in the use of culture involves behaviors and actions by nurses that use culture-specific knowledge in developing interventions that are culturally appropriate (Lowe, 1994). Culturally specific interventions should be acceptable to both healthcare providers and patients and should be mutually derived. Nursing as a culturally diverse profession and discipline could also effect constructive changes in the healthcare delivery system, making it responsive to the cultural dimension within healthcare needs. Health disparities could also be impacted by a culturally diverse nursing profession.

Despite the intentions and the efforts made by nursing, progress in the area of cultural diversity has been slow, sporadic, and overdue. The lack of progress is evident in the poor representation of ethnic and cultural minorities in the profession of nursing, the ability to respond to increased nursing care demands, and the need to build coalitions between national, state, and local professional nursing associations/organizations and the ethnic minority and cultural communities. Additionally, an increase in the ethnic and cultural diversity of nurses in the profession may help with the pervasive and increasing nursing shortage. Cultural diversity in nursing could become a unifying theme and strength factor. Nursing must move its intentions forward to behaviors and actions that produce outcomes that reflect a culturally diverse profession and discipline.

Author contact: jlowe@fau.edu, with a copy to the Editor: nursingforum@gmail.com

References

- Agency for Healthcare Research and Quality. (2005). *National health-care quality report* (Full report). Rockville, MD: Author.
- American Medical Association. (1997). Council on ethical and judicial affairs. Black/White disparities in health care. In *Code of medical ethics: Current opinions with annotations* (pp. 91-95). Chicago: Author.
- American Nurses Association. (1986). *Cultural diversity in nursing*. Silver Spring, MD: ANA House of Delegates.

Cultural Diversity: The Intention of Nursing

- American Nurses Association. (1991). *Nursing's Agenda for Health Care Reform*. Washington, DC: Author.
- American Nurses Association. (2007). *Nursing's legislative and regulatory initiatives for the 110th congress: Nursing shortage*. Silver Spring, MD: Author.
- Bruyere, J. (1991). Personal growth and the minority student. *Journal of Nursing Education, 30*, 278–279.
- Carnegie, E. (1994). *The path we tread: Blacks in nursing worldwide* (3rd ed.). Sudbury, MA: Jones and Bartlett Publishers.
- Chalanda, M. (1995). Brokerage in multicultural nursing. *International Nursing Review, 42*(1), 19–22, 26.
- Cook, C. (2003, January 31). The many faces of diversity: Overview and summary. *Online Journal of Issues in Nursing, 8*(1). Retrieved 1 October, 2007, from <http://nursingworld.org/ojin>
- Crow, K. (1993). Multiculturalism and pluralistic thought in nursing education: Native American world view and the nursing academic world view. *Journal of Nursing Education, 32*(5), 198–204.
- DeSantis, L. (1988). The relevance of transcultural nursing to international nursing. *International Nursing Review, 35*, 110–116.
- DeSantis, L. (1991). Developing faculty expertise in culturally focused care and research. *Journal of Professional Nursing, 7*(1), 300–309.
- Fishbein, M., & Ajzen, I. (1975). *Belief, attitude, intention and behavior: An introduction to theory and research*. Reading, MA: Addison-Wesley Publishing.
- Giger, J. N., & Davidhizar, R. E. (2004). *Transcultural nursing assessment and intervention* (4th ed.). St. Louis, MO: Mosby.
- Hickey, J. (2005). *Society in focus*. Boston: Pearson.
- Jemmott, L. S., Jemmott, J. B., & Villaruel, A. M. (2002). Predicting intentions and condom use among Latino college students. *Journal of the Association of Nurses in AIDS Care, 13*(2), 59–69.
- Leininger, M. (1979). *Transcultural nursing*. New York: Mason International.
- Lowe, J., & Struthers, R. (2001). A conceptual framework of nursing in the Native American culture. *Journal of Nursing Scholarship, 33*(3), 279–283.
- Lowe, J. (1994). Developing cultural competence. *Florida Nurse, 42*(2), 16.
- Lowe, J. (2002). Balance and harmony through connectedness: The intention of Native American nurses. *Holistic Nursing Practice, 16*(4), 4–11.
- Malle, B. F., & Knobe, J. (1997). The folk concept of intentionality. *Journal of Experimental Social Psychology, 33*, 101–121.
- McGee, C. (2001). When the golden rule does not apply: Starting nurses on the journey toward cultural competence. *Journal for Nurses in Staff Development, 17*(3), 105–112.
- Meleis, A. (1996). Culturally competent scholarship: Substance and rigor. *Advances in Nursing Science, 19*(2), 1–16.
- Servonsky, E. J., & Gibbons, M. E. (2005). Family nursing: Assessment strategies for implementing culturally competent care. *Journal of Multicultural Nursing & Health, 11*(3), 51–56.
- Spector, R. (2004). *Culture and diversity in health and illness* (6th ed.). Upper Saddle River, NJ: Prentice-Hall.
- U.S. Census Bureau (1999), (2007). *Population estimates program, population division*. Washington, DC: U.S. Government Printing Office.
- U.S. Census Bureau. (2004). *National sample survey of registered nurses and the American Community Survey*. Washington, DC: US Government Printing Office.
- U.S. Department of Health and Human Services, Division of Nursing. (1997). *Invitational congress of minority nurse leaders: Caring for the emerging majority*. Washington, DC: Author.
- Valleroy, L. A., Mackellar, D. A., Karron, J. M., Rosen, D. H., McFarland, W., Shehan, D. A., et al. (2001). *High HIV and risk behavior prevalence among 23- to 29-year-old men who have sex with men in 6 US cities*. Paper presented at the 8th Conference on Retrovirus and Opportunistic Infections, Chicago.
- Zoucha, R., & Housted, G. L. (2000). The ethical dimensions of delivering culturally congruent nursing health care. *Issues in Mental Health Nursing, 21*, 325–340.