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Cultural Competency in the Medical Workplace: A Look at Outpatient Clinic Nurses at a Children's Hospital in New England

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Cultural Competency in the Medical Workplace: A Look at Outpatient
Clinic Nurses at a Children's Hospital in New England

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Honors Thesis in Anthropology

Advisor: Dr. Pamela Erickson

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I. Abstract

This paper analyzes the current state of progress toward cultural competency in the medical workplace, specifically in the hospital setting. It compares the current writing on the topic to research done at a large New England children's hospital. The nurses are all individuals who work in an out patient setting so they often see the same patients regularly for longer periods of time. This differs from the in-patient or floor nurses who only spend limited time with a constantly changing population of patients. The research involved one-on-one interviews and a focus group with nurses at the hospital. The focus group participants also took a survey before and after the one-hour discussion. In the interviews the nurses were asked about their experience with diverse patients, any cultural conflicts that have come up with their patients including issues of "non-adherence", how they themselves and the hospital as a whole responded to those cultural conflicts, and their exposure to and knowledge about Complementary and Alternative Medicines. The focus group involved a presentation that provided some background information on cultural competency followed by hypothetical cultural conflict scenarios. The nurses discussed how they would respond to these scenarios. The surveys before and after the focus group asked similar questions to the interviews but they can be analyzed quantitatively and they allow the tracking of any changes in responses after the focus group. This research offers an interesting look into the current state of cultural competency in one example medical workplace.

II. Introduction to Cultural Competency in the Medical Setting

Applied medical anthropology in the clinical setting has a lot to offer both anthropologists and medical practitioners. The course of an illness can illuminate key features of the patient's culture, the medical practitioner's culture, and the culture of the medical system in which they come together and interact. Arthur Kleinman made an excellent assessment of the discipline in his 1985 contribution to *Medical Anthropology Quarterly*. He outlined everything that can be learned from clinical medical anthropology from the role of the family in illness episodes, to the cultural significance of illness and the associated norms, to the impact of disease at a societal level. He explains how illness exists in two realms; the biomedical realm where illness is narrowly defined and the whole experience boxed in to strict categories and the social realm where the experiences and confines of the biomedical realm are altered and redefined by relevant cultural construct. This can also be understood as the "dialectical interaction between social structure and physiology" (Kleinman, 69). The anthropological perspective allows the added depth of understanding not only the medical system but also the cultural construction of that system. This adds a layer of analysis that allows medical anthropologists to investigate the relationships between disease and other important factors like race, class, and gender among other questions.

Kleinman also explains the importance of respect, which is so crucial in this field. In order to properly study and critique the biomedical system, there needs to exist a respect for the practitioners and what they accomplish. Applied medical anthropology can bring so much to the clinical setting. It incorporates the studies of "primary care, medical specialty, public health, health policy, and research settings" along with a cultural understanding that is so often missing

from the discussion of clinical practice (Kleinman, 70). While this is certainly a very important field of study, Kleinman noted a few concerns. With all these lofty goals, he questioned whether or not they were being accomplished and whether anthropologists were doing their part to influence medicine and health policy in a positive way. He did not believe that enough was being done, and now, almost thirty years later, some of the issues he raised are still relevant. There has been some progress made, for example in terms of cultural education in medical and nursing school, but there is still a long way to go within this discipline. That is why studies like this one are so important, because they help to establish the state of the biomedical community so applied medical anthropologists can determine how best to promote cultural competency in the medical workplace (Kleinman).

Another article written in the same year was similarly critical of the discipline, but Dr. Michael Phillips was focusing more on issues within clinically applied anthropology. He identified three main problems that were stopping meaningful progress. The first is that clinically applied anthropological theory is not relevant to real-world clinicians. In many ways this is reminiscent of the typical discord between the hard sciences and the social sciences. The hard scientists want data and action while the social scientists value theory. While this is a broad generalization, it holds true in this case where the doctors are not interested in anthropological theory but rather want to know what they can do. Without an action plan they are unlikely to change their behavior. The second issue is that anthropologists are severely limited in their roles as observers. They are not care providers and they are generally considered to be outside the system so they are stuck with accepting the “physical reductionism and Cartesianism of biomedicine” of which they as anthropologists are critical (Phillips, 31). There are many more

holistic approaches such as the bio-psycho-social model that clinically applied anthropologists prefer, but they have no power to implement any such model within medicine. This is unfortunate since anthropologists have insight that would help clinicians better treat their patients, such as an understanding of the difference between the clinician's understanding of a sickness episode and the way that same episode is understood and experienced by the patient.

Finally, Phillips noted that there is no clear role for clinically applied anthropologists in the medical system. They are not necessarily valued or used to their full potential by clinicians. One way anthropologists could help clinicians is in care negotiations. When biomedical care providers dispense a treatment plan they expect it to be followed, even when the patient may have other ideas. The patient might not use a particular treatment or they might use their own treatment in addition that could interfere with the medical treatment plan, and the medical care provider may never know. When providers do find out the patient is often labeled as non-adherent without any sort of compromise being attempted. Clinically applied anthropologists can help raise the level of communication between patients and providers, allowing them to have an open discussion about treatment options. Basically, the resolution of any cultural conflict, whether the care providers are aware of it or not, could be aided by clinically applied anthropologists. When they are available they are often isolated from rather than integrated into the medical setting, which is unfortunate as they could help raise the level of cultural competency. Once again, even thirty years later, Phillips' concerns are still present. The discipline is still looking for a way to integrate academic anthropology into the clinical setting. Once that is achieved, anthropologists will be able to implement more of their ideas and move toward real progress on the goals of clinically applied anthropology (Phillips).

Another important aspect of applied medical anthropology is the realm of information collection, data analysis, and the transforming of that analysis into practical applications. This is discussed thoroughly in Pelto and Pelto's 1997 article "Studying Knowledge, Culture, and Behavior in Applied Medical Anthropology". To some extent, this area of study can help to explain the conflicts described earlier. Anthropologists have a different perspective from medical practitioners or even public health workers in that they focus on the cultural meaning imbued in illness. The importance of understanding a patient's or population's cultural beliefs is often forgotten, and while medical practitioners and public health workers may identify their patients as having significant beliefs, they view their own western biomedical background as a knowledge system that is more relevant to the immediate health problem. Medical anthropologists see biomedicine as just another system of cultural belief and study it as such. Even the term belief can be belittling when it is used to describe folk models in a derogatory way. "Often beliefs is used to connote ideas that are erroneous from the perspective of biomedicine and that constitute obstacles to appropriate behavior" when it is contrasted with the term "knowledge" which is used for what are considered scientific facts and universal truths (Pelto and Pelto, 148). Anthropologists do not necessarily make a distinction between those two terms and certainly do not view beliefs as somehow less "true". This is evident in the anthropological understanding of pluralistic health care practices. In industrializing countries and even industrialized ones like the United States it is common for people to integrate their medicine by seeking out both western biomedicine and their own traditional remedies during sickness episodes. This directly contrasts with the idea that there has to be one true or right system. If patients seek out multiple health systems it would make sense for those systems to be

open to cooperation and mutual respect with each other. The isolation of different systems can also have an impact on people's medical decision making that can in turn affect their health and well-being (Pelto and Pelto).

Once the difference in perspective is perceived, medical anthropology studies can be understood and placed in their context within the medical setting. Pelto and Pelto highlight focused ethnographic studies with both quantitative and qualitative components. These consist of several components including a specifically focused illness category (for example HIV/AIDS among men in Hartford, CT), a series of specific questions, and the gathering of emic data. The data collection begins with understanding the vocabulary of the domain and moving on to more structured operations looking at illness beliefs, knowledge, and specific accounts of illness episodes. The first step is always interviews with key informants. This gives the researchers a general understanding of the domain they are investigating as well as the proper vocabulary to use in data collection moving forward. Once they have this information the researcher will develop a structure of the domain by having informants complete ranking and ordering tasks. Next the researchers can conduct semi-structured interviews with informants to learn details of their illness experience. These interviews can be analyzed with the structure that has been established and through that the information can be placed into an explanatory model. Such focused ethnographic studies add a lot of depth to the understanding of illness experience beyond what is gained from public health workers. Most importantly they look at culturally framed illness experience with an emphasis on personal accounts of illness episodes. They are also very narrowly focused which allows for a thorough understanding of a specific illness domain. This can be much more valuable than a simple general health profile of a population because it allows

for the formation of action plans that should be unique for every illness category and cultural group. The ethnographic perspective although often overlooked in the clinical setting can be extremely valuable for improving health outcomes (Pelto and Pelto).

This particular hospital has a significant proportion of Latino patients, who are primarily Puerto Rican, so it is worthwhile to look into the specific needs of that population. With the increasing Latino population in the United States there has been an increasing interest in their health and the differences in their traditional medical cultures. While they do have a higher life expectancy on the whole, “Latinos are at particular risk for diabetes mellitus, tuberculosis, hypertension, HIV/AIDS, alcoholism, cirrhosis, and death from violence” (Peterson-Iyer). What makes this even more concerning is the fact that Latinos are less likely to seek out healthcare whether that is for financial reasons such as a lack of health insurance or cultural reasons such as not wanting to medicalize pregnancy. It is also possible that Latinos do not seek western medicine because they are not receiving the highest quality of care. There are not many Latino healthcare professionals compared to other groups so Latino cultural competence is an important factor in many hospitals including the one where I conducted my research (Peterson-Iyer).

Language is the biggest concern as communication is key in providing medical care. Even if the patient speaks some English, it is very difficult to understand a medical discourse in a second language. This communication barrier goes both ways as “Latinos generally report feeling less listened to and understood by their doctors, as well as less able themselves to understand their doctors” (Peterson-Iyer). In this case a non-English speaking patient is not receiving the same quality of care as someone who fully understands their diagnosis and care plan, can communicate their questions and concerns to their care providers, and has options if

they feel that they are being treated unfairly. Another important consideration is patient's use of Complementary and Alternative Medicines (CAMs). Many Latino Americans still use traditional remedies from their home country, often in conjunction with western medicine. Herbal remedies are common and there are many curanderos, espiritistas, and other folk healers working in the U.S. These therapies are often not respected in biomedicine regardless of their effectiveness and as there is the possibility of herbal remedies and pharmaceuticals interfering with pharmaceutical drugs prescribed by the physician it is important that patients feel that they can disclose everything they are using to their care providers. There are also "folk illnesses" such as susto (fright sickness) that are not recognized by western biomedicine and other cultural barriers to seeking western healthcare. While traditions vary greatly, there are several cultural trends that emerge in the Latino population that are relevant to health. These include "personalismo" or putting a value on personal interaction, which could be a conflict in our fast-paced medical system, and "respeto" or respecting authority figures which could prevent patients from questioning their physicians. There is also a strong value placed on family and the involvement of relatives in a patient's care can be discordant with the individualized nature of the biomedical system. While these are generalizations, it is important for medical care providers to be familiar with these things when treating their Latino patients. In general the key to reducing cultural conflict is to be open to learning about an individual patient's cultural background and taking that background into account in their care, but it is helpful to be familiar with some general cultural concepts that may come up with large populations of patients (Peterson-Iyer).

III. Research Setting and Population

This study took place at a large children's hospital in New England. Within the hospital there are several outpatient clinics where patients come to visit specialists on an appointment basis. The population for this study consisted of the nurses from these outpatient clinics. These nurses have a unique perspective in that they often see patients over a longer period of time. While emergency or floor nurses see patients for a limited period of time, outpatient clinic nurses have the ability to build relationships with patients and families as they come in for their regular appointments. This makes the issue of cultural competency even more important as these nurses have the time and ability to thoroughly understand the cultural background of their patients and how it impacts their care.

The interviews were conducted with twelve registered nurses (RNs) coming from a range of departments; the Orthopedic, Pulmonary, Urology, Neurology, Infectious Disease and Immunology, Cardiology, Neurosurgery, Otolaryngology, and Gastroenterology clinics were represented. All of the nurses were female but their ages and years of experience varied greatly. The interviews were conducted in a small meeting room in a different outpatient clinic from the one in which any of the nurses worked.

The survey and focus group presentation were completed with six nurses. Three of those nurses had also been interviewed and three were new to the study. Once again they were all female RNs of varying years of experience. The surveys were administered in a conference room in the same clinic as the interviews where the nurses were able to sit around a table. The presentation about cultural competence was completed in the same location immediately following the survey administration.

IV. Research Methods

This study took place over two separate days and contained three parts. The first part consisted of a day of one-on-one semi-structured interviews with nurses about their own understanding of cultural competence and their experience with cultural conflict. The starter questions were as follows:

1. What is your role at this hospital?
2. Describe a typical patient interaction.
3. Have you had patients that come from a different culture than yourself?
Can you identify any of these different cultures?
4. What are some conflicts that come up with patients in general? (e.g., noncompliance)
5. Have you experienced any conflicts that have arisen as a result of the patient's culture?
If so describe some of those experiences and how you or other hospital personnel responded to them.
6. Do any of your patients use any complementary and/or alternative medicines (CAMs) in addition to the care they receive here? (explain CAMs if necessary). If so, do you feel this enhances or interferes with their care?
7. Have you come across patients that refuse an aspect or form of care? If so, have any of these situations arisen as a result of the patient's culture? Describe some examples and how you or other hospital personnel responded to them.
8. In general how well do you feel you as a medical professional respond to cultural conflict?
9. In general how well do you feel the hospital as a whole responds to cultural conflict?
10. What is the best way to deal with cultural conflict?
11. Is there anything that is not currently being done that would help the hospital better deal with cultural conflict?

Throughout the interviews follow up questions were asked as things came up. Hand written notes were taken during the twelve interviews that were completed.

The second part of the study was a survey that was administered on the second day of the study. Participants were asked to answer each question on a Likert scale of strongly disagree, disagree, slightly disagree, neither agree nor disagree, slightly agree, agree, and strongly agree.

The survey questions are as follows:

1. I see a diverse group of patients.
2. In general I am able to identify the cultural background of my patients.
3. The cultural background of my patients is an important factor in their care.
4. I am open to learning about the cultural background of my patients.
5. The cultural background of a patient can be a source of conflict with their care (e.g., noncompliance)
6. I have a good understanding of commonly used Complementary and Alternative Medicines.
7. Many patients use Complementary and Alternative Medicines in addition to the care they receive here.
8. The use of Complementary and Alternative Medicines interferes with the patient's care.
9. In my role as a medical professional, I am generally able to deal with cultural conflict well.
10. In general, this hospital deals with cultural conflict well.

These paper surveys were collected before the focus group from the six participants.

The third and final part was a focus group and presentation completed on the second day after the survey was administered. It started with a short introduction and a presentation covering some of the basic aspects of cultural competence. This presentation was in the form of a power point containing slides covering the topics of cultural conflict, cultural competency, different medical practices and beliefs, and complementary and alternative medicines. This was followed by five hypothetical cultural conflict situations. The nurses discussed how they would handle these situations if they came up at the hospital and what resources they would seek out. They talked about different approaches to dealing with the situations and hand written notes were taken on their responses. After the hypothetical situations, the nurses started a discussion of general cultural competency issues and different real-life situations they had come across in their nursing experience. Once again hand written notes were taken on their conversation.

The research was approved by the Human Subjects Protection committees at the University of Connecticut and the hospital. All participants were given an information sheet and gave verbal consent.

V. Research Questions and Goals

The main question I addressed in this study is how culturally competent the nurses are at this one example of a medical workplace. Other minor questions included how familiar the nurses are with Complementary and Alternative Medicines, what strategies and resources do nurses use to deal with cultural conflict, and “what improvements could be made to improve cultural competency in the medical workplace.

The interview portion of this study sought to identify cultural conflicts that have arisen at this particular children’s hospital and to understand how the nurses see these cultural conflicts and respond to cultural conflict situations. I also wanted to learn about the nurses' familiarity with Complementary and Alternative Medicines, especially in reference to how their patients use them. The surveys were used to collect some quantitative data about the overall cultural competence of the nurses. The focus group added more of an educational component to the study. The goal of the presentation portion was to familiarize the nurses with basic cultural competence ideas and the discussion portion sought to understand the nurses’ thought process as they worked through a cultural conflict situation. The discussion also allowed the nurses to learn from each other as they provided different solutions to the hypothetical situations. The goal of this discussion was to bring the topic of cultural competency to the nurses’ attention so they can continue to discuss it in their workplace. The broad goal of this study is to add knowledge of the

about the current state of medical cultural competency so medical anthropologists can better implement programs that will be maximally effective.

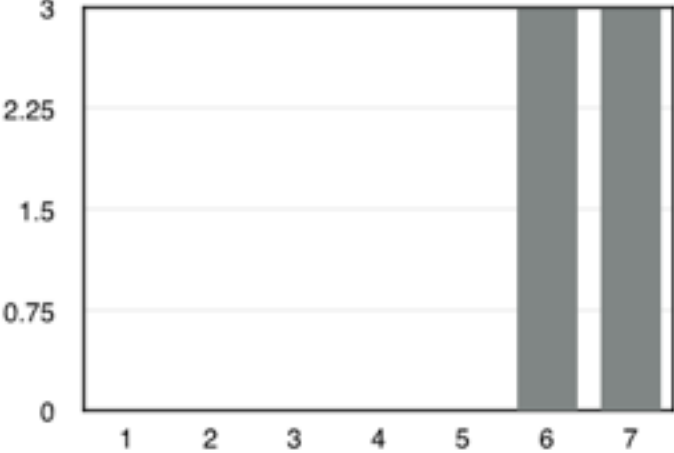
VI. Presentation of Data

In the survey, I used a seven point Likert scale for the questions above, from 1 strongly disagree to 7 strongly agree, as indicated below, to assess knowledge and attitudes about the study questions:

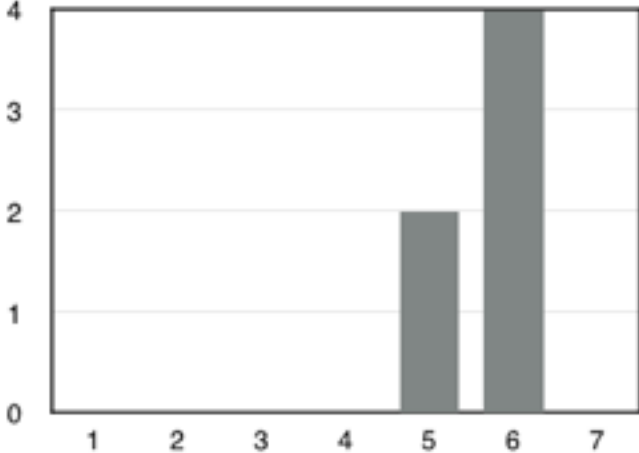
1. Strongly Disagree
 2. Disagree
 3. Slightly Disagree
 4. Neither Agree nor Disagree
 5. Slightly Agree
 6. Agree
 7. Strongly Agree
- DNR. Did Not Respond (Left Blank)

The responses of the six nurses are displayed in the following graphs. The category of “Did Not Respond” is only included when there were respondents who left the question blank, all other questions were answered by all six nurses.

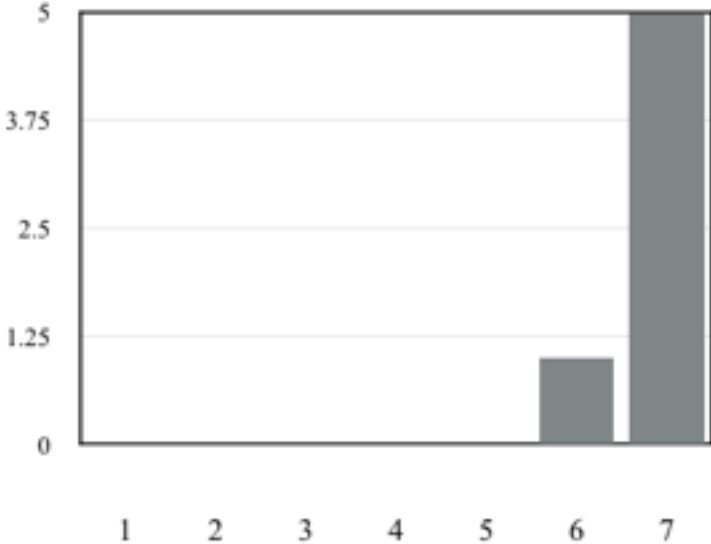
I see a diverse group of patients:



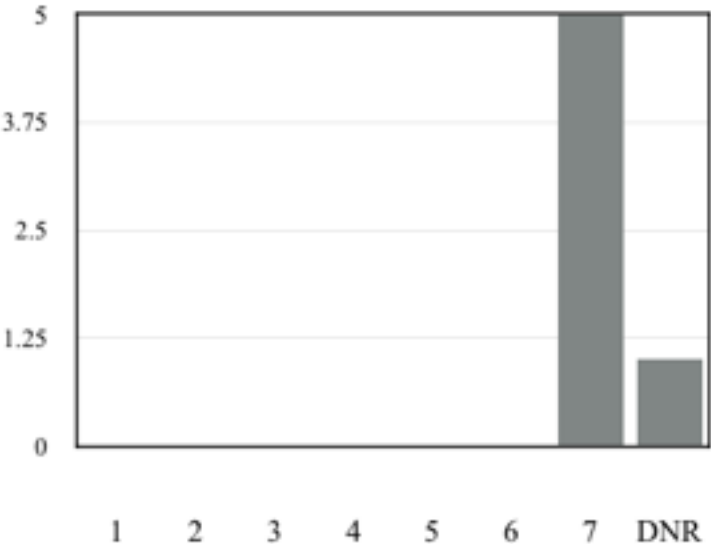
In general I am able to identify the cultural background of my patients:



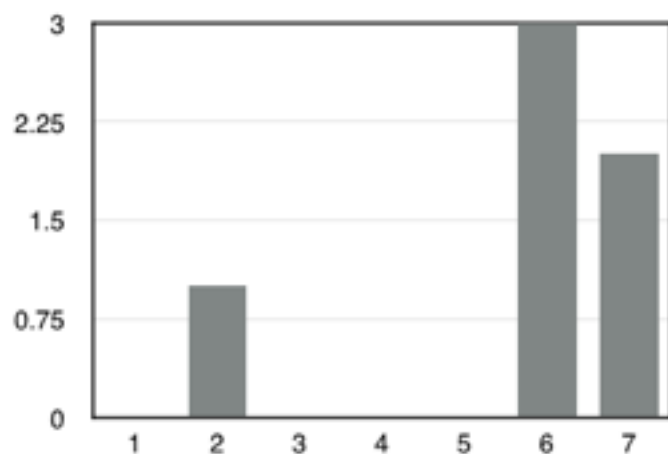
The cultural background of my patients is an important factor in their care:



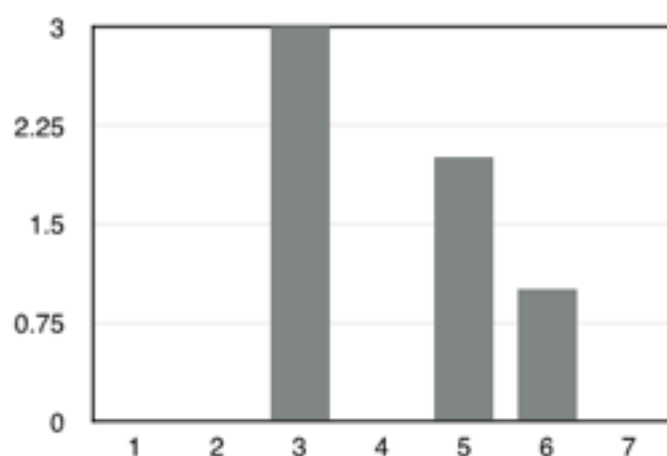
I am open to learning about the cultural background of my patients:



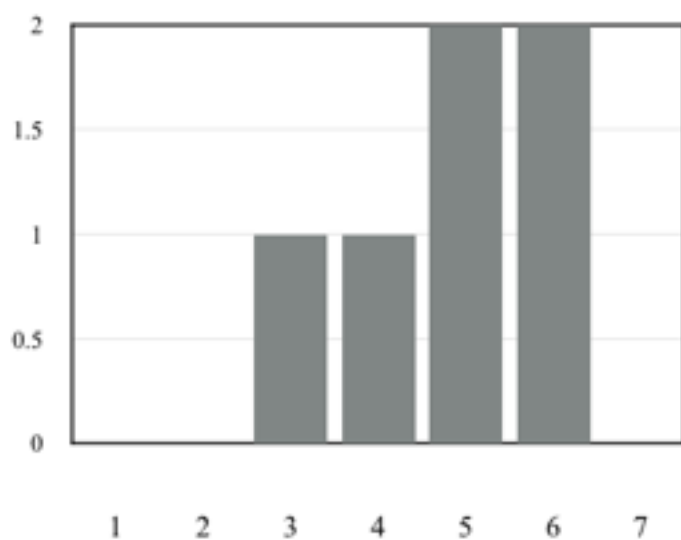
The cultural background of a patient can be a source of conflict with their care (e.g., noncompliance):



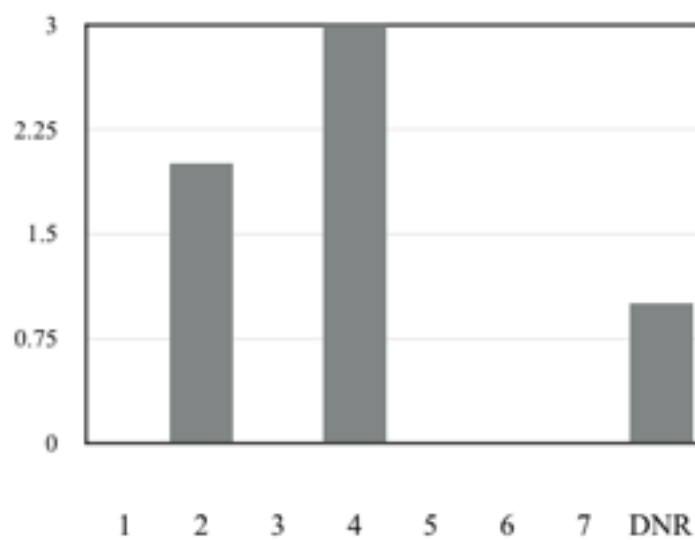
I have a good understanding of commonly used Complementary and Alternative Medicines:

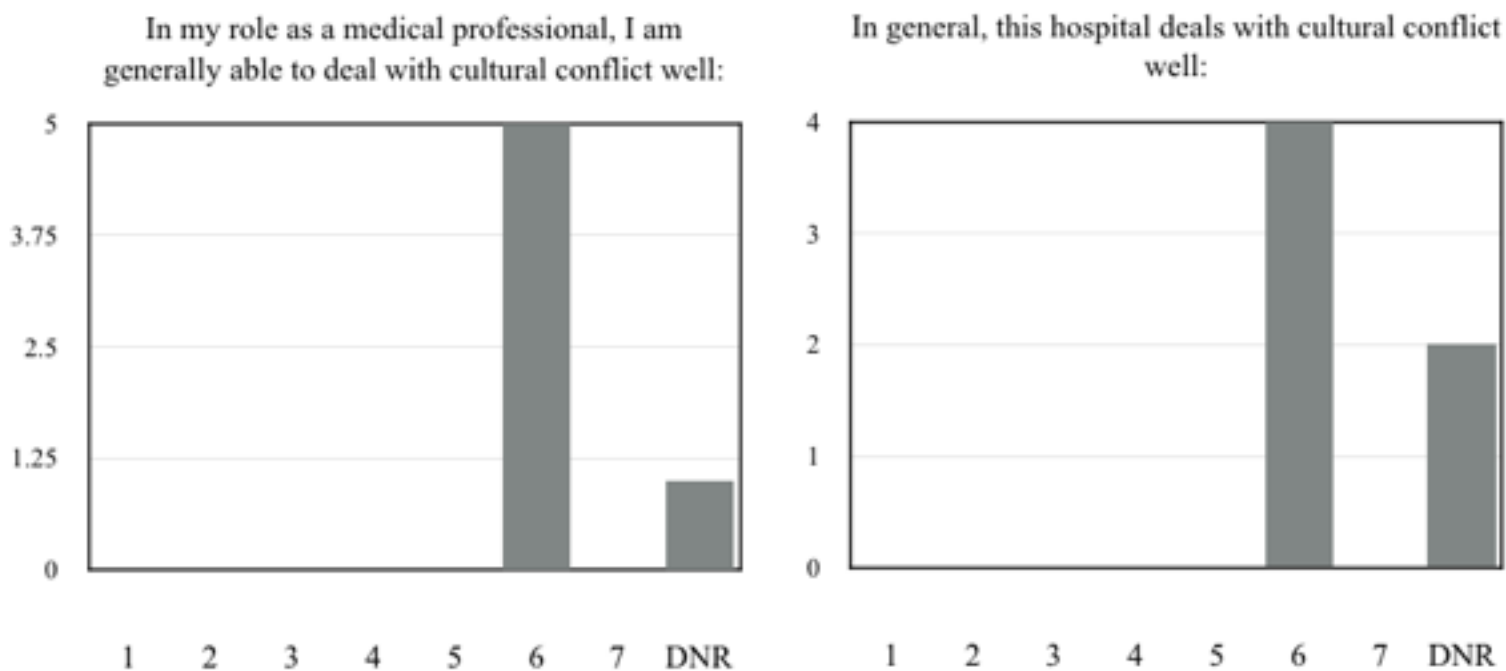


Many patients use Complementary and Alternative Medicines in addition to the care they receive here:



The use of Complementary and Alternative Medicines interferes with the patient's care:





There were two surveys that were responsible for the four "Did not respond" answers.

The first one, survey U, left the last two questions blank. This could be because the last two questions were on the third page and it is possible that she did not see that there was a third page and therefore skipped it altogether or did not have time to complete the last two questions. The other was survey V where the respondent wrote notes by the questions she left blank. For the question "the use of complementary and alternative medicines interferes with the patient care", she wrote "unsure, but I hope it does not interfere" in place of a response. For the final question, "in general, [this hospital] deals with cultural conflict well", she wrote "unsure, but I would hope we avoid conflict".

For the statement "I see a diverse group of patients", three nurses answered agree and three answered strongly agree so overall they felt they see a diverse group of patients. They also felt somewhat able to identify the cultural background of their patients with two nurses saying

they slightly agreed with and four nurses saying they agreed with the statement “in general I am able to identify the cultural background of my patients”. The nurses also understand the importance of a patient’s cultural background with all of the nurses that responded either agreeing or strongly agreeing with the statements “the cultural background of my patients is an important factor in their care” and “I am open to learning about the cultural background of my patients”. The next few questions received more mixed responses. To the statement “the cultural background of a patient can be a source of conflict with their care (e.g., noncompliance)”, one nurse responded disagree, three responded agree, and two responded strongly agree. To the statement “I have a good understanding of commonly used Complementary and Alternative Medicines”, three nurses said slightly disagree, two said slightly agree, and one said agree. Similarly to the statement “many patients use Complementary and Alternative Medicines in addition to the care they receive here”, one nurse responded slightly disagree, one responded neither agree nor disagree, two responded slightly agree, and two responded agree. Two nurses disagreed with the statement “the use of Complementary and Alternative Medicines interferes with the patient’s care” while three said they neither agreed nor disagreed and one nurse did not respond. In general the nurses believe that both they themselves and the hospital as a whole deal with cultural conflict well with all the nurses that responded saying they agreed with the statements “in my role as a medical professional, I am generally able to deal with cultural conflict well” and “in general, this hospital deals with cultural conflict well”.

Informal Interviews

In this section I provide a summary of each of the twelve interviews I did with the nurses and describe the major issues they raised about dealing with cultural competence issues within the clinical setting.

Nurse A was a female who has been a nurse for about nine years. She has worked in Chicago and Alaska but has been at her current position in the orthopedic clinic for around four months. She mainly interacts with parents over the phone answering questions about triage. She has had experience with patients from all continents but specifically talked about working with the native Alaskan population. She has experienced conflict and non-adherence across all patient populations but spoke of one specific incident with an adult Saudi Arabian patient at a previous hospital. He took issue with her, as a female nurse, treating him and the situation escalated ending with him popping his colostomy bag in her face. Security was called and dealt with the situation like an assault. In general the most common cultural conflict she experiences here is a language barrier, usually with Spanish-speaking patients and families. For this she brings in an interpreter if one is available. Otherwise she uses the phone line which also has many less common languages. In terms of Complementary and Alternative Medicines (CAMs), she had a lot of experience in Alaska with patients using traditional herbal remedies and massage, which she felt enhanced their care. She wasn't sure if it actually worked but felt that there was at least a psychological advantage when the patient feels that it is helping them. For patients that have refused care A has experienced adult Jehovah's Witness patients that refuse blood products. In those situations they would give them fluids and iron to try and manage the condition without a transfusion but when the situation became life threatening she would appeal to the patient to

accept the life saving transfusion. Overall she feels that her diverse nursing school education in Chicago has prepared her well to deal with cultural conflict and that this hospital is equipped to treat a diverse group of patients although more multilingual staff would be helpful. Her general approach to dealing with cultural conflict is to deescalate the situation, make sure the patient feels understood by trying to see it from their point of view, and most importantly listening.

Nurse B is a female who has been a nurse for almost six years and works in the orthopedic clinic. She mostly interacts with patients by triaging over the phone and getting them started in the room at their appointments. In terms of patients with different cultural backgrounds than herself she identified patients with different religions, particularly Muslim patients with whom there had been conflicts with showing skin when taking medical photographs. In general she has experienced noncompliance with patients not keeping up with things like dressing changes at home and patients skipping appointments or arriving late. Some of the cultural backgrounds that she has experienced conflict with are younger parents and single mothers. As B works in orthopedics, a lot of her patients use physical therapy for their multiple sclerosis but in terms of CAMs she has patients that see chiropractors and use vitamins. She believes that these CAMs have a neutral effect, that they do not interfere with their care but that they do not help either. She has never experienced a patient refusing an aspect or form of care. Overall she feels decently prepared to deal with cultural conflict but relies on her coworkers for help in those situations. On the whole she feels the hospital is very diverse and manages cultural conflict well although they could use more Spanish translators. Her general strategies for dealing with cultural conflict are to understand "where the patient is coming from" and what is important to them.

Nurse C has been a nurse for ten years and currently works in the pulmonary outpatient clinic. She interacts with parents of patients on the phone and in the clinic giving treatment plans and taking medical histories. She identified “Spanish” and “Indian” as the main patient cultural groups that she encounters. In general, the most common patient conflicts and noncompliance issues that she comes across are due to parents not understanding what they are supposed to do. This includes misunderstanding medication doses, trying to overcome a language barrier, and other such problems. C specifically mentioned the language barrier as a more common cultural conflict because, as she says, the patient care plans are very confusing, even for native English speakers. She does not know if her patients use CAMs but she did have a cystic fibrosis patient who also went to a naturopath. This interfered with the patient’s care in the clinic because the family only wanted to follow the care plan of the naturopath. C has had a Jehovah’s Witness refuse a blood transfusion for her grandchild who was a patient. As the child’s legal guardian she was legally able to do this so they treated the patient with alternative means which were successful. In general she does not feel well prepared to deal with cultural conflict. It was not covered when she went to nursing school and it is not something she really thinks about. She does not feel educated about cultural competency issues and feels the hospital could offer more classes and presentations on the topic. Her overall strategy for dealing with cultural conflict is to ask someone such as a patient care advocate or a social worker for help.

Nurse D works in this hospital’s urology clinic and has been a nurse for six and a half years. A typical patient interaction for her is visiting with patients in the room with the doctor. In her current position she has many Hispanic patients as well as a significant Laotian population and at her previous hospital she worked with a lot of patients from the United Arab Emirates,

Egypt, and other Arabic speaking countries. In general the patient conflicts she comes across are noncompliance issues arising from two main causes. The first is parents not following treatment plans which causes their children to be noncompliant at no fault of their own and the second is teenage patients who do not want to follow treatment instructions for whatever reason. She experienced more cultural conflict at her previous hospital where she experienced gender issues with her Middle Eastern patients. There were instances of male patients disrespecting female nurses and husbands making decisions for their wives' care but this particular hospital had an international department to help educate the nurses on such cultural conflict issues. She is very familiar with CAMs and has had patients who used acupuncture, massage, and herbs. She always asks when taking medical histories as herbs can interfere with pharmaceuticals but in general she believes they are helpful, specifically she has seen acupuncture help chemotherapy patients. D has had Jehovah's Witness patients refuse blood products and in these situations she explains the pros and cons to the patient and if they still refuse tries to treat with alternative methods. In general she feels well prepared to deal with cultural conflict as it was covered in her nursing school education but feels that her previous hospital was better equipped to deal with cultural conflict issues and it really helped to have international resources beyond just translators. She suggested that this hospital should make educational and written materials readily available in many languages and have more translators available. Her overall strategy for dealing with cultural conflict is to advocate for the patient, respect their choice and autonomy, and to separate her personal opinions from the situation.

Nurse E has been a nurse for thirty years and currently works in the pulmonary clinic at this children's hospital. Her patient interactions in her current role are very brief and she mainly

gets histories and does post teaching where she instructs patients and their families how to administer the medication and complete the procedures that they will have to do at home. She sees a diverse group of patients, specifically a lot of Hispanic patients. In terms of noncompliance, she has patients forget to take their medication when they feel good and patients with different levels of education who may not understand their care plans. She also identified patients who speak other languages as a source of cultural conflict as it is difficult to fully explain care plans to them with the language barrier. In terms of CAMs, E has experienced a few patients who use naturopaths and she is respectful of that choice and works with them. In these cases she worries about overmedication with two different care providers but is open to non-prescription interventions. She has had patients worried about giving their children steroids but could not identify any cultural barriers to accepting care. In general she feels well equipped to handle cultural conflict because she is an open-minded and nonjudgmental person, although she has learned diversity later in life because it was not covered when she was in nursing school. E also feels that the hospital is well equipped to deal with cultural conflict because they have interpreters available, although she did complain about having limited time with patients. Overall her strategy for dealing with cultural conflict is to seek out her supervisors for support.

Nurse F has been a nurse for four years and currently works in the neurology clinic. She mainly interacts with patients over the phone with a little work in the clinic and she always deals with her patients through their parents. She has worked with Portuguese, Hassidic Jewish, Sikh, African American, and Hispanic patient populations. In general she has experienced noncompliance with patients not taking medications, failing to follow a prescribed diet, and forgetting to check their blood sugar. Cultural conflict has come up with patients of different

income and education levels that put them at a higher risk for noncompliance. She is familiar with CAMs and has had patients use acupuncture, biofeedback, and supplements, some of which have been prescribed by their doctor in the clinic. This had never interfered with her patient's care and she has seen it help in some cases. F has also experienced a Jehovah's Witness patient refuse a blood transfusion but in this case it was not absolutely necessary and they just monitored the patient. In general she feels comfortable dealing with cultural conflict because she is an open and respectful person and had classes on the subject in nursing school. She also tries to educate herself further on her own time. F also feels the hospital deals with cultural conflict well because she has not seen any problems although her exposure is limited as she has only worked at this hospital for four months. Her overall strategy for dealing with cultural conflict is to make accommodations if it is not harmful to the patient and to get the ethics committee involved if it is.

Nurse G has been a nurse for 20 years and currently is a coordinator in the infectious disease and immunology clinic. She has specifically worked with HIV patients for much of her career. In her current role she works with patients both in the clinic and on the floors. Some cultures she has worked with include impoverished women and children, drug and alcohol abusers, Puerto Ricans, South Americans, gay young men (especially of color), African Americans, Jamaicans, Africans (especially from Ghana), Haitians, Vietnamese, Chinese, Eastern European, and Southeast Asian patients. She does not like to use the term noncompliance but has experienced "adherence problems" including patients not taking medications, missing appointments, not getting tests done, and not following diet and lifestyle recommendations. Within the culture of the HIV populations she has worked with, she has observed an "I don't like

to take pills” attitude whether patients feel they are strong enough without medicine, have a distrust of doctors because the medicine makes them feel sick, or don't see the need for pills when they aren't presenting symptoms. She also recognized that due to the sensitive nature of her work some of her minority patients might not feel comfortable sharing certain things with her as a white woman because of that inherent power dynamic. G has also noticed that some of her Hispanic patients use traditional medicine but may not disclose that because they feel Americans are very anti-traditional medicine. She is very familiar with CAMs and has patients that use prayer/spirituality, diet, and supplements to help manage their conditions. Some supplements can interfere with the patient's medications and some supplements are bad for patients with HIV so it is important for her to get an accurate medical history. She has also experienced teenage patients refusing aspects or forms of care because they do not want to identify with their disease. In general, she feels that she is able to deal with cultural conflict well. She looks at a situation and if it will do good or be neutral for the patient then she makes that accommodation. She is unaware of the hospital's official policies but knows that they do not always ask specific questions about CAMs and feels that the patients would benefit from the doctors asking more of these types of questions. She also suggested including a cultural assessment as part of their care. Overall her approach to dealing with cultural conflict is to first identify the problem, decide if what they want would be harmful separating one's own cultural beliefs, and finally not telling the patient what to do but merely offering a care option.

Nurse H has been a nurse for ten years and currently works in the cardiology clinic. She interacts with patients and families over the phone, checks on patients on the floors when they have been admitted, and does clinic work. She identified Hispanic, African American, Hindu,

and “Arabian” as cultures she has worked with. The biggest noncompliance issue she deals with is patients not getting their blood levels checked, which can be very serious but she has never experienced a cultural conflict as far as she could identify. She also does not know of any of her patients using CAMs. Overall she feels comfortable dealing with cultural conflict because it was covered in nursing school. H feels that the hospital is well equipped to handle cultural conflict although they could use more in person translators especially for Spanish. Overall her strategy for dealing with cultural conflict is to ask for the patient’s reasoning and dig deeper into why they are experiencing a conflict and then to ask for help if she doesn’t understand their reasons.

Nurse I has been a nurse for over thirty years and currently works in the neurosurgery clinic. She interacts with patients in pre and post-operative care as well as regular office visits and helps arrange referrals and follow up appointments. She has experience with Hispanic, Puerto Rican, Central American, South American, and Mexican patients including first generation individuals. The main noncompliance issue she experiences is patients missing appointments, but she could not identify any instances of cultural conflict. She says that she avoids cultural conflict by being kind, calm, and gentle and asking patients about their culture. She also speaks a little Spanish, which comes in handy. In terms of CAMs, I suggests that patients use yoga, massage, and acupuncture and she always asks if they are taking any supplements. She believes these CAMs enhance their care and do not interfere. She has also experienced Jehovah's Witness patients that refuse blood products and in these cases she has access to resource people who will come and talk to the family and they have always been able to accommodate these patients. At first she said she did not feel well equipped to deal with cultural conflict but eventually decided that she is because she is open and able to seek out

resources. She believes the hospital does not have enough resources but they do the best they can and it would help to have more human interpreters. Overall her strategy for dealing with cultural conflict is to try and identify how to best interact with that patient.

Nurse J has been a nurse for about six years total, three years as an LPN and three years as an RN. She currently works in the ear, nose, and throat clinic. She works with parents over the phone and with the patients directly in clinic, on the floors when they are admitted, and in post-op. She has had patients who are African including one country that they could not find a translator for, "Spanish", "Arabic", Portuguese, and French. In general the noncompliance issues she encounters are patients missing the follow-up appointments, not changing their trachea tubes, and not getting the proper supply refills. The cultural conflicts that she has experienced are with Jehovah's Witness patients who refuse blood products or want to wait for surgery. In these cases she tries to find alternatives and ultimately respects the wishes of the children's guardians. In terms of CAMs she is most familiar with her patients using herbal remedies. She is unsure if they actually help but is concerned because they can interfere with surgery. In general she feels that she is able to deal with cultural conflicts because she is willing to look things up and try to better understand the situation. She feels the hospital is also very well equipped with good patient advocates that are themselves diverse and are therefore able to deal with a diverse group of patients although she notes that more in person interpreters would help. Overall J's strategy for dealing with cultural conflict is to understand the patients concern, get all the facts, learn more about their culture, and alternately try and accommodate them.

Nurse K has been a nurse for 34 years and currently works in the ear, nose, and throat clinic. She deals with parents over the phone addressing their concerns, making assessments,

and educating them about their care. There is also a clinical aspect to her role where she takes patient histories and coordinates their home care. She has worked with African, Indian, Hispanic, and hearing-impaired patients. In general the noncompliance issues she deals with are when patients don't show up for appointments. In these cases she starts by calling the family and trying to find out why they are being non-adherent so that if there is an underlying issue it can be addressed. Otherwise it will be treated as an ethical issue and DCF may get involved. She has also experienced many culturally specific conflicts. With her Indian patients she recognizes that she mostly interacts through the males, usually the father of the family. She also notes that they have a lot of respect for doctors and require a lot of reassurance so they often want her, as a nurse, to check with or talk with the doctor before accepting her advice. In these cases she will try and talk to the mother if the father is not available but overall it does not affect the child's care because the parents in her experience are very concerned and motivated to help their child and are polite, respectful, and appreciative. She has also had a family from Africa that spoke a dialect for which she was not able to get a translator even on the computer system. In this case they had to get creative and translate for the mother through the father who spoke a little English. K is quite familiar with CAMs and has patients that use herbal remedies for ear drops and pain management, naturopathy, and diet. Some supplements can interfere with anesthesia but overall she feels these CAMs are helpful to her patients. She even tries to personalize her post-operative diet instructions to the culturally specific foods the patient eats at home. She has experienced patients refuse care, specifically refusing blood products for religious beliefs. There used to be a point person who specifically dealt with these issues but that position no longer exists so she tries to make a clear plan and accommodate the family. She has also had Indian families question the

need for certain procedures and in these cases she takes the extra time to explain the procedure and its rationale in detail to the family. She also notes that it is very important to give people time to make their decision. In general she feels very well equipped to deal with cultural conflict. She is experienced, always willing to learn, and not afraid to ask for help. She also feels that the hospital as a whole has the resources, is respectful, and is willing to accommodate a diverse group of patients. One improvement suggestion that K offered was to have a welcome brochure at each floor and clinic that explains to new patients what they do there. Overall her strategy for dealing with cultural conflict is to find out what the problem is, listen and validate the patient, and ask "how would you like us to handle it?". Then you can either accommodate them or explain why you cannot. In some cases she would seek the help of social services or try to find other alternatives to make the families happy, all the time remaining sensitive to the parent's wishes when dealing with their children.

Nurse L has been a nurse for 30 years and currently works in the gastroenterology clinic. She works with patients in the clinic where she provides care instruction as well as on the phone where she will talk with parents or patients themselves if they are old enough. She mostly has experience with Spanish-speaking patients has also had some Indian patients and families. In general she experiences cultural conflict when her patients don't understand the care plans or don't understand the importance of following through with those plans. She has not experienced very much cultural conflict as far as she could identify but did recall several instances with Spanish-speaking families misunderstanding or needing extra clarification due to the language barrier. In these cases she seeks out a Spanish-speaking secretaries for their help. In terms of CAMs, L has patients that use naturopathy, vitamins, and supplements, which she believes help

but need to be from a reputable source and the doctor needs to be made aware of their use. She has experienced Jehovah's Witness patients refusing blood products which she said was more of an issue for the doctors to deal with, but that they did have people come talk to the families and try to find alternatives in those situations. In general she feels that she deals with cultural conflict well and that she has improved as time has gone on because of increased training within the hospital. She also feels the hospital has the resources to deal with conflict well although they could use more translators, social workers, and Spanish-speaking social workers. Overall her strategy for dealing with cultural conflict is to observe and have the patient "teach me so I can do the right thing".

In summary, all of the nurses I interviewed spoke about experiencing cultural differences in their work, especially those related to language difficulties and gender norms during patient care. They seemed to prefer live interpreters to the telephone interpreters and appreciated any help they could get from hospital or outside resources. They also felt they were competent to deal with conflict situations by keeping an open attitude, understanding the patient's point of view, and working to tailor treatment plans to cultural customs when possible. Many would welcome further instruction or in-hospital assistance with cultural differences, especially when facing a new cultural or ethnic group. Most of them were aware of CAMs, but they were evenly split on whether or not they thought CAMs were effective or not.

In the focus group presentation, five hypothetical situations were proposed to the nurses and they discussed how they would handle these situations. Situation 1A stated "a two year old patient comes in for her regular appointment with her parents, both of whom only speak Spanish. What accommodations, if any, do you have in place for this appointment?" The nurses agreed

that while ideally they would get a live interpreter, that would be difficult as they are very limited. Next they would try to use the “MARTI” which is a computer-based translator. This is a service the hospital pays to use that allows the nurses to access medical interpreters for a wide variety of languages on a computer screen that can be wheeled into the patient’s room. They also have access to a Language Line phone interpreter service although they generally said they prefer the computer. Whatever type of translator they would be using, they agreed that they would set it up ahead of time if they knew that such an accommodation was needed.

Situation 1B was, “A thirteen year old male patient comes in for his first appointment. He speaks English as his second language but he is accompanied by his mother who only speaks Tamil. What special accommodations, if any, do you make for this appointment? What accommodations, if any, do you put in place for his future appointments?”. In this case with a less widely known language the nurses would check to see if it was available on MARTI or the Language Line. They were pretty confident that Tamil would be available on MARTI as it has a wide range of available languages although one of the nurses said that she had encountered a family who spoke a language they could not find on the MARTI or the Language Line. If a medical translator is not available, they would check with family support to see what options they have. The nurses also noted that often these patients will have a relationship with an interpreter established ahead of time who will accompany the family to their appointments. As a last resort they will have someone from their community come and translate.

Situation 2 stated “A fifteen year old female patient comes in for her first appointment. She is scheduled with a male doctor and there are only male doctors in this particular department. When she realizes this she explains that she is uncomfortable having a male doctor

examine her because of her faith. What accommodations, if any, do you make for this appointment? What accommodations, if any, do you put in place for her future appointments?”

The nurses stated that they would have no problem switching the patient to a female doctor because there are no clinics in their hospital without a female doctor. However, if as the prompt states no female doctors were available they would offer to have a female nurse in the room and ask if that would be okay. Otherwise they would try and arrange to have a female nurse practitioner or physician’s assistant come to examine the patient and pass the information on to the doctor.

Situation 3A was, “A five year-old comes in for his regular appointment accompanied by his parents. His parents mention that they are using traditional herbal remedies to aid their son’s condition. What accommodations, if any, do you make for this patient?” The nurses agreed that they would get the specifics of what the patient is using, how long they have been using these herbs, and whether a health provider is monitoring their use and add this information to the patient’s medical history. Then they would also enter the names of herbs on Lexi-Comp, an online information system on drugs, where they can check drug interactions to make sure none of the herbs are interfering with their prescriptions from their doctor. They would also check whether the herbs were coming from a “reputable source”. If there were any drug interactions between the herbs or supplements and the biomedical pharmaceutical treatment, they would try to understand what the parent understands about the CAM products they are using and try to seek a compromise for use. In these negotiations they would encourage the parents to pick a plan of care, either the doctor’s recommendations or whatever CAM is interfering with that care plan.

Situation 3B states “A seventeen year old comes in for her first appointment accompanied by her parents. You inform them that you want to draw some blood for a routine CBC. Her parents refuse on religious grounds. What special accommodations, if any, do you make for this appointment? What accommodations, if any, do you put in place for his future appointments?” The nurses agreed that they would determine how urgent the CBC was for whatever procedure was planned to see if they could just accommodate the parents by not doing that procedure. If the procedure was necessary, they would then try and negotiate with the family getting family support and possibly spiritual advisors involved. If they still refused the procedure, they would next see if not doing it would harm the patient. If it would they would have to waive the parent’s rights for a 96-hour period in which the hospital would gain custody. They stressed that this is a worst case scenario and they do not want to do this but that parents are often okay with being “overridden” if it in the best interest of their child. Some of the nurses also would want to check with the patient herself since she is seventeen to see what her wishes are.

After they finished discussing these situations the nurses brought up a few real-life cultural conflict situations that they and experienced. One nurse described an encounter on an elevator where she came across a Middle Eastern couple that did not have the required visitor stickers. The woman was in “full dress” and only her eyes were visible. This nurse talked to the man who was a bit argumentative at first but eventually went with her to go get their stickers. It turns out they did have the proper identification and the couple ended up thanking this nurse for taking security seriously. Another nurse described a toddler who was septic and had a clotted femoral line, which required a life-saving amputation. The boy was Hindu and his family believed that you have to die whole. So at first they were against this procedure but eventually

they were able to compromise by cremating the amputated leg to be recombined with his remains when he dies. Finally a third nurse described a family where the child required surgery but the family wanted to take the child to their home country first to visit with family. They were able to accommodate this with scheduling and the nurse showed interest by asking the family about their culture and having them bring in pictures from their home.

Overall, the nurses attending the focus groups were very aware of the need for culturally appropriate care and made use of the resources available to them to enhance this.

VII. Data Analysis

Throughout the interviews there were several things that kept coming up. First of all, despite varying levels of experience all of the nurses had similar roles. Eight of them discussed phone triage as a primary patient interaction many tasks were performed by several of the nurses, such as taking patient's medical history and distributing care plans. They also largely agreed about the need for more translators. When asked if there was anything the hospital to do to deal with cultural conflict better, seven of the nurses specifically mentioned more translators or more multilingual staff. Spanish was highlighted as the most needed language and while they have access to online translators many agreed that they would prefer that more in-person interpreters were available. One nurse even had suggested that it would be a great idea to have Spanish-speaking social workers available. Another trend was the common experience of having Jehovah's Witness patients refuse blood products. Seven of the nurses I interviewed told me this as their first answer when I asked if she had ever experienced a patient refuse an aspect of

therapeutic care, which leads me to believe it is a fairly common conflict, or if not common at least memorable.

While many of the nurses had similar experiences, they varied in their approaches to handling the conflict. Nurse A said that she would first use alternatives like fluids and iron and if that did not work then she would appeal to the patient. Similarly nurse C and nurse J just mentioned using alternative treatments. Nurse D said that she would appeal to the family/patient first and then if that did not work try alternatives. While the difference between A's and D's answers may seem subtle, there is an important distinction. In the cases where alternatives can be effective, it would avoid conflict to start with those therapies as soon as the patient/family voiced their objections to receiving blood products rather than to start with trying to convince them to go against their religious beliefs. Nurse I and nurse L both made the great point of having a social worker or someone else come talk to the family. This is another great way to avoid cultural conflict because instead of trying to deal with the issue on their own, they recognized that they do not know the nuances of the issue and bringing in someone who is more familiar with it could avoid cultural conflict and get the patient the best care possible. Overall however this was a conflict where the nurses show a good level of cultural competency.

There is more variation in the nurses' familiarity with Complementary and Alternative Medicines (CAMs). Almost all of the nurses had patients that used CAMs, although some of them did not initially label them as such. This was also the most divisive section of the survey with three respondents answering that they slightly disagreed with the statement "I have a good understanding of commonly used Complementary and Alternative Medicines" and an interesting spread of responses on the questions "many patients use Complementary and Alternative

Medicines in addition to the care they receive here” and “the use of Complementary and Alternative Medicines interferes with the patient’s care”. This was also the question in the interviews that I provoked the most questions from the nurses, It was also interesting to see what the nurses thought of the CAMs their patients were using. Some of the nurses did not believe they helped, at least not medically, and had an overall skeptical tone when discussing them. Although I framed the question as “Complementary and Alternative Medicines”, I was really referring to complementary because if they are patients in the clinic then they are already using biomedicine making any other therapies they use complementary rather than alternative. However, every nurse discussed the CAMs their patients use as “alternative” medicines which speaks to how they view them. While some nurses such as D, E, G, and K showed an extremely high level of cultural competence in this area, other nurses would benefit from a deeper understanding of the CAMs their patients are using, especially those that are well established and shown to be effective.

The most discussed cultural conflicts were related to patient’s language or ethnic background, including religion. Other areas of cultural conflict were not mentioned, perhaps because the nurses were not identifying these factors as aspects of culture. One of these is gender, which was not widely discussed and the three nurses who did bring it up had different experiences. They range from nurse K who was impressively willing to respect her patient’s culturally significant gender roles and adjust her behavior to nurse A who had a gender conflict get out of control to the point where security had to be called. When the gender conflict hypothetical situation came up in the focus group, the nurses struggled a little bit trying to figure out how to accommodate that patient. They quickly identified that this was something that could

come up with the young Muslim women in their clinics, but their first instinct was to offer to have a female nurse in the room during the appointment. While this may help some young women who feel uncomfortable with a male doctor, per the prompt it would not solve the situation where the female patient was uncomfortable with a male doctor examining her at all. They eventually agreed that under extreme circumstances they could have a female nurse or physician's assistant examine the patient instead and report to the doctor. While this was their final solution, it seems more temporary because it is likely that sooner or later the patient would have to see a doctor. Although I am not surprised, no one suggested referring the patient to another clinic that had a female doctor. That would have been the ideal solution. Thus, in terms of gender the nurses showed mixed levels of cultural competency from mediocre to excellent.

The nurses I interviewed identified Hispanic or Latino as the largest ethnic population with whom they work, which means they should be more familiar with the needs of that population. I have already outlined many of the specific cultural conflict areas that can arise with the Latino American community and those were reinforced by the nurses' experience. The primary concern for most of the nurses in general was language barriers, particularly with Spanish. It came up in almost every interview and the nurses in the focus group fully understood the importance of the issue and knew exactly how to handle the situation including what resources the hospital should improve upon. Other cultural aspects like the high level of family involvement were noted and treated as neutral issues, while there was another category that was met with lower levels of cultural competence such as their patients' use of CAMs and understanding of traditional medical (TM) practices among Puerto Ricans. Once again the nurses ranged from moderate to excellent cultural competence in this area but overall they would

benefit from more in-service training specifically addressing the needs of their many Latino patients. As well, they would benefit from understanding that there is great cultural variability in TM among Latinos of different geographical heritage.

The nurses' own background can also impact their cultural competence. I initially hypothesized that the greatest determinant of this would be how long the individuals had been working as a nurse because the younger nurses or at least the nurses that had graduated more recently would have been exposed to cultural competence training in nursing school while the older nurses presumably would not have had that type of education. While there were certainly some nurses who struggled with cultural competence because they had not been exposed to it in nursing school, I found that experience was far more important in a nurses' cultural competence than courses in school. Nurse K is the perfect example of this. She has been a nurse for thirty-four years, the longest of any of the nurses I interviewed, and she was also the most culturally competent. She was able to draw on her many years of experience to identify and deal with cultural conflict effectively and respectfully, always keeping the patient's best interest at heart. This is in contrast to many of the more recently graduated nurses such as nurse F who has only been a nurse for four years. She is familiar with the issues "on paper" because she had cultural competency classes in nursing school, but with less experience she was much more tentative. Well education both in the form of nursing school classes and in-service training helped these nurses, practical experience proved to be a key factor in their ability to be culturally competent..

While the nurses showed an acceptable level of cultural competence overall, there were a few areas that could be improved. For example, it was difficult for some of the nurses to identify a conflict they had experienced specifically as a cultural conflict. Some nurses, such as nurse I,

said she had never experienced any cultural conflicts but then proceeded to give examples of cultural conflicts that she had not recognized stemmed from the patient's cultural background. In the one on one interviews I got the sense that some nurses did not feel comfortable identifying conflicts as cultural, perhaps because they were trying to be politically correct. However all of the nurses in the survey said that they either agreed or strongly agreed with the statement "the cultural background of a patient can be a source of conflict with their care (e.g., noncompliance)". There was an overall tone to the interviews that some nurses had when discussing cultural conflict. Some of the language used suggested that the nurses were focusing on the individual patients as the source of conflict without truly recognizing the larger cultural forces at play. One example is nurse D who described the gender roles with her Middle Eastern patients as disrespecting her role as a health care provider due to her gender as contrasted with nurse K who discussed a similar gender dynamic with her Indian patients and how she respected the father's role in the family. There were other comments peppered throughout the interviews such as "de-escalate the situation", "respect the patient's choices", and the skepticism around CAMs discussed earlier that suggest some nurses did not recognize fully appreciate or value the importance of a patient's culture in his/her life and just how avoidable cultural conflict is. With an increased level of cultural competence, cultural conflict would not need to be a major issue and accommodations could be made to assure consensus between patient and provider on treatment plans. This is a much more realistic approach than trying to get patients to abandon deep-seated cultural traditions like societal gender roles.

With any cultural conflict addressed there was a range of cultural competency exhibited by the nurses. Here I highlight the specific "red flags" that led to that conclusion. Nurse A had a

few small issues, mainly around focusing on cultural conflict as inherently confrontational. Her approach was to de-escalate the situation and make the patient feel understood, but she did not seem as willing as other nurses to adjust her care to the patient's cultural expectations. She was also reluctant to identify conflict as cultural. Thus, overall nurse A showed a moderate level of cultural competence with room for personal development. Nurse C seemed very confused on the whole subject of cultural competency. From CAMs to how a patient's cultural background can impact their care she admitted that she did not know much about the subject and did not feel well equipped to handle these situations. She showed a moderate level of cultural competency in the few situations she has dealt with, but there is a lot of room for improvement. Nurse H was unfamiliar with many of the issues I asked her about. Since it is unlikely she has never experienced cultural conflict in her ten years as a nurse, she may be failing to label conflicts as having a cultural source so it was difficult to identify her level of cultural competence. Nurse I also had trouble identifying cultural conflict and initially answered "no" or "I don't know" to a lot of questions before thinking of examples, but overall she showed a high level of cultural competence. Overall there was nothing seriously concerning that came up at any point in this study. While there is definitely room for improvement, it is happily more to move this hospital from acceptable to exceptional cultural competence.

It is also important to highlight those nurses that showed an exceptional level of cultural competence as a positive example. Nurse G is one such example. She is able to identify a wide range of patient cultural backgrounds including cultures no one else thought of like injection drug users, understands the cultural roots of medical conflict. She even corrected me that she uses the term "non-adherence" because she does not like the connotation of "non-compliance".

She is not only familiar with CAMs but encourages their use as part of a holistic care plan and even pointed out her own racial and educational privilege as a factor in her patient relations. Overall she has an excellent approach to dealing with cultural conflict and is a great role model for her fellow nurses. Another excellent role model is nurse K. She is also able to identify a diverse range of cultural backgrounds and goes above and beyond to accommodate her patients. Instead of simply labeling her patients as non-compliant she seeks to understand the root of the problem going beyond her stated job role. She is willing to adjust her care to a patient's cultural background and has taken it upon herself to learn more about the cultures she commonly encounters on her own time including familiarizing herself with CAMs. Overall she has an excellent strategy for dealing with cultural conflict, starting by asking patients "how would you like us to handle it?" She is very open, respectful, and still willing to learn and grow even after thirty-four years as a nurse. Her peers could learn a lot from her. Hopefully now that the topic has been introduced they will continue to discuss cultural competence issues and all of the nurses will be able to learn from each other and increase the hospital's level of cultural competence.

VIII. Conclusion

Overall this children's hospital in New England showed a fairly good level of cultural competence among their nurses. While there is room for improvement, there were no issues and some of their nurses are exceptional examples of cultural competency in the modern medical workplace. Some of the best specific improvement suggestions came from the nurses themselves. They saw the importance of having an adequate number of in-person translators and a more diverse hospital staff. Some focused on written materials being clear and available in

different languages. They also recognized that in-service training is helpful and one nurse suggested a cultural assessment tool. In addition to these suggestions, the nurses at this particular hospital could benefit from education programs both around general cultural competence and cultural training about the specific cultures that they come across most often. If nothing else the nurses can educate each other, and thus it is important to make cultural conflict a subject they feel comfortable discussing with each other and with other health care providers. That does not just apply to the nurses at this one children's hospital, however, this kind of study should be undertaken with other health care providers in other hospitals. Moreover, the suggestions for improvement from the nurses themselves and from my findings are widely applicable. The main objective of this study was aimed at the medical community in general in order to raise the issue of cultural competence as something health care providers should evaluate, improve, and prioritize in order to optimize good patient outcomes. Having spent time with these nurses, talked to them, questioned them about cultural competence, I have to admit I admire the overall empathy and compassion they display towards their patients and their constant struggle to accommodate cultural differences within biomedicine. In a sense, they play the role of anthropologist translating cultural beliefs and accommodating them to bring about the best patient care possible. Their openness, courage, and largely uncompensated work on cultural competence should renew our faith in the spirit of the healing professions.

IX. Works Cited

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