Ethics and Cross-Cultural Nursing

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This article examines how cultural misunderstandings and language differences generate ethical dilemmas in cross-cultural nursing. It explores the consequences of actions that result when health care providers lack an awareness of the value systems of patients that differ from their own. Described are the principles arising from ethical theory, their application to nursing, and incorporation into professional codes of ethics. Two case studies illustrate the close relationship between culture, health, and communication, with language barriers a significant factor in predicting the outcomes of care. Recommendations are offered for cultural competency training for health care institutions, nursing administrators, and nursing educators.

Cultural diversity has been an integral part of American life for decades, enriching society with the traditions, practices, and contributions of people from other lands. Most of America’s early settlers emigrated from European countries, but the newest wave of immigrants to reach Western shores has come primarily from Asia and Latin America, a trend expected to intensify in the 21st century. Kabagarama (1993) predicts that non-Caucasian minorities will represent one third of the population in the United States.

The influx of individuals and groups of different ethnic and racial origins has become a challenge to nurses in their goal to provide safe, effective, and culturally congruent care. To do so requires knowledge and understanding of a patient’s cultural orientation, including language, patterns of interaction, and attitudes toward health and illness. These elements must be incorporated into proposed interventions. When nurses are unaware of the value systems of people in their care, as well as family expectations about roles and relationships, a disconnect can occur, creating serious ethical dilemmas with deleterious outcomes.

Leininger (1991) has defined nursing as a transcultural care phenomenon: “Nurses without preparation in transcultural nursing would be handicapped when working with people from a diverse culture” (p. 16). In Eliason’s (1993) view, “Nursing practice cannot be ethical unless the culture and beliefs of the client are taken into consideration” (p. 225). Culture, health, and nursing are closely interrelated and interdependent. When nurses are not culturally competent, an undermining occurs in the provision of health services, creating misdiagnosis, unnecessary suffering, and potentially harmful complications (Villarruel, 1995).

Because the aim of every society should be to support its members and help them to survive, some type of social organization has to be instituted to protect the people. Across various cultures, a kinship system serves this purpose in that it defines the rights and responsibilities of the individual. Dilemmas arise, however, when moral practices based on cultural values are not always congruent with ethical definitions of human rights and obligations. Curtin and Flaherty (1982) clearly illustrate this point when stating that “unreflected prescriptions about right and wrong conduct infer action without choice, in contrast to the ethical premise that choice of the right action follows a mental process of rational problem solving” (pp. 106-107).

Among some ethical relativists, there is no universal determination of right and wrong because values systems are relative to the particular individual or cultural group (Bandman & Bandman, 1995). One advantage of this view is that it does not require an absolute standard of morality to be observed without question. Also, relativism promotes tolerance of alternate behaviors and practices.

The downside is that limitations can arise when one assumes that all actions of a specific group are right, and any deviation is viewed as wrong. Bandman and Bandman (1995) clarify this point: “Since there is no transcultural justification of any moral practice, each culture is the supreme moral lawgiver unto itself, and there is then no higher moral court of
appeal” (p. 83). Curtin and Flaherty (1982) claim that “cultural relativism places personal conscience in an inferior position to tradition and social custom” (p. 46).

THE ETHICAL IMPERATIVE

Derived from the Greek ethos, meaning character, the term ethical often appears interchangeably with moral from the Latin moralis, meaning manners (Thompson & Thompson, 1992). Both terms are concerned with distinguishing right from wrong in attitude or behavior, with ethics characterized as the reasoning aspect of the moral-ethical continuum. Philosophically, ethics seek the reason behind the moral rule or standard.

Bioethics is the term applied in the health field, and thus bioethics in nursing connotes the uniqueness of the moral problems that nurses face in their practice (Veatch, 1987). According to Ray (1994), transcultural ethics reflect how people ought to live “when subjectively sharing a common world” (p. 252). Applying this same concept to nursing would seem to suggest that in the patient care setting a therapeutic relationship would be highly desirable.

In cross-cultural nursing, interaction takes place between specific cultures in the process of providing care. It consists of two components—one within the diverse nursing profession, and the other between nurses as caregivers and culturally diverse people as care receivers. For the purpose of investigating ethical concerns in the caring process, cross-cultural nursing ethics between nurses and patients will be explored in this article.

The link between ethics and cross-cultural nursing is grounded in nurses’ obligation to provide good nursing care and the patient’s opportunity to receive appropriate nursing care. This is intertwined with culture. Culture is a way of life and provides the basic cognitive road map for understanding the world and unwritten rules for living, which include ethical guidelines (Eliaison, 1993).

Ethical theory relates to a system encompassing various principles applicable to all walks of life. Among the oldest and most traditional philosophies are the deontological theories, in which an action is perceived as right or wrong and follows certain prescribed guidelines (Curtin & Flaherty, 1982). Here, the ethical imperative has to be the absolute importance of human life, requiring duty-based ties to oaths, laws, and truths. In other words, as long as people do their duty, they are acting ethically. According to Benjamin and Curtis (1992), duties apply to the individual. They note that “within a particular framework, a person has a duty to carry out or refrain from a certain action if and only if the framework includes a rule or principle requiring or forbidding that type of action” (p. 30). The framework, they add, is duty-based if it includes some duties that ought to be performed, even if certain larger goals acknowledged by the system would not be advanced.

As an advocate of the deontological school of thought, Immanuel Kant, the great 18th-century philosopher, supported such beliefs as individual rights and worth, autonomy/self-determination, promise keeping, privacy, personal responsibility, and the sanctity of life. The principle of justice in deontological ethics represent a critical element. Whereas legal justice is in accordance with the law, ethical justice deals with fairness or impartiality (Thompson & Thompson, 1992).

In contrast to deontology are the teleological ethical theories, which purport that the criteria for what is good or bad do not concern the motive before an action but rather the consequences that follow (Thompson & Thompson, 1992). To put it simply, the end justifies the means. Within this category, utilitarian ethics emerge, connoting the greatest good for the greatest number. In this approach, individual rights and benefits are often compromised to the utilitarian good. Actions are perceived as right when they tend to generate happiness and, conversely, wrong when producing the opposite effect of pain or deprivation of pleasure (Munson, 1992). People who believe that the maximization of goals takes precedence over all other considerations when deciding what has to be done are perceived as following a goal-based ethical framework (Benjamin & Curtis, 1992).

Proponents of the utilitarian school contend that an action is right if it conforms to a rule of conduct validated by the principle of utility (Munson, 1992). On the other hand, some skeptics (Dyer, 1986; Flew, 1984) have noted the difficulty in predicting consequences accurately and measuring the value of happiness, because it depends on the individual’s subjective worldview—weltanschauung. Bandman and Bandman (1995) report that in light of advances in science and technology, it is not unusual for health professionals to apply utilitarian principles. “Questions of just allocation of health care resources and nursing services are frequently given a utilitarian approach,” they declare, citing the use of triage as an example. “One sorts patients out into those who can essentially recover on their own, those who are expected to die, and those to whom the care can make a difference” (p. 82).

INFLUENCE OF CODES

As a profession, nursing is distinguished by its philosophy of care, commitment to humane well-being, a specific blend of knowledge and skill, and its service to the community (Curtin & Flaherty, 1982). The link between nursing and ethical behavior is based on the belief that nurses follow certain principles of conduct relating to rules, obligations, and responsibility. In situations requiring cross-cultural nursing, sensitivity to the patient’s value system is of paramount importance because it may differ markedly from that of the caregiver. By learning the reality of the person’s culture, including attitudes toward illness, appropriate interventions can be introduced.
Ethical nursing practice is an essential part of the social contract of professional nurses. The present American Nurses Association (ANA) Code for Nurses with Interpretive Statements (ANA, 1985) serves as a guide to validate the trust and responsibility expected of nurses by the public. The principle of respect for people is viewed as the most important statement in the document, which expresses the moral concerns and goals of nurses and aims to justify ethical decisions. The code also defines the nurse’s relationship to the patient as an advocate. Furthermore, it acts as a means of self-regulation by the profession.

Through the years, the ANA Code has undergone refinement and interpretation, but its inclusive ethical principles remain steadfast. Although the ANA addressed ethical concerns from its beginnings, the first code did not appear until 1950. The last revision speaks to collaborative relationships with members of the health professions and other citizens, emphasizing professional responsibility and accountability (ANA, 1985). A new ANA Code of Ethics, which will include culture, human rights, and principles, is currently in draft form.

Another important ethical guide is the International Council of Nurses (ICN, 1973) Code, which recognizes that nursing practice must reflect and respect cultural and religious differences. This statement has particular significance for American health care providers, who increasingly service clients and families from other cultures. Within the code, however, seeds of conflict can surface if professional caregivers question or challenge the health care practices of a patient from a different cultural group or minority (Bandman & Bandman, 1995). The dilemma facing nurses is whether to respect harmful values or attempt to move toward change.

Nursing educators and practitioners need to be aware of other codes that have relevance for their work. Almost two decades ago, the American Medical Association (AMA) adopted a revised and shorter version of its Principles of Medical Ethics (AMA, 1980). This latest code is of some interest because it indicates for the first time the responsibility of the physician to respect the rights of patients, families, colleagues, and other health professionals (previously the term was allied professionals) (AMA, 1980). The principles have also eliminated the sexist use of he (Bandman & Bandman, 1995, p. 34). Of marked import is the description of the physician’s obligation to the public to expose incompetent fraudulent colleagues, to respect the law and change it to help patients, to make pertinent information available, to employ the talents of other health professionals, and to contribute to community improvement.

The Patient’s Bill of Rights, adopted in 1972 by the American Hospital Association, contains valuable information for both nurses and patients. Stated therein is the principle of informed consent, which highlights information concerning diagnosis, prognosis, and treatment proposed, with its risks and alternatives explained in language understood by the patient. Informed consent represents both an ethical and legal principle. It relates to Kant’s concern for the dignity of all people, the principles of self-determination, autonomy, and the legal concept of the inviolability of the individual.

**PATTERNS OF CARE: ETHICAL IMPLICATIONS**

The legacy of Hippocrates to the medical profession appears prominently in the Hippocratic Oath, which contains ethical principles adopted later by modern nursing in the Florence Nightingale Pledge. From Hippocrates have come two influential principles associated with deontological bioethics: nonmaleficence and beneficence. Whereas nonmaleficence stresses the imperative to do no harm, beneficence holds the view that the right action generates the greater good for the patient and is understood by the profession (Thompson & Thompson, 1992). When beneficence is strictly followed, the person’s well-being becomes the sole criterion for a positive outcome, despite any cost to the family or society.

In philosophical terms, the two principles emphasize the importance of cooperation with the care-providing network. They identify physician as the bearer of moral agency, or the people having the right and power to make ethical decisions about a patient’s care. In this paternalistic approach, nurses urge the patient to select treatment plans based on the physician’s view of what is best for the individual. In other words, professionals know better and can act accordingly, even if the patient does not agree (Gadow, 1990). Directly opposite to paternalism is consumerism, in which nurses act as guides, informing patients about the facts of their condition and the treatment options. The decision of how to proceed is left entirely to the patient while the nurse withdraws.

A beginning shift has occurred, however, in delivery approaches, with the practice of advocacy viewed as a compromise between paternalism and consumerism. Gadow (1990) elaborates,

[Advocacy nursing] is the active assistance to patients in their self-determination concerning health alternatives. It is the effort to help patients to become clear about what they want in a situation, to assist them in discerning and classifying their values and examining available options. (p. 53)

In their attempts to develop an ethical system to help patients become more involved in decisions about their health, nurses employ autonomy as a guiding principle. Of Greek origin, the word means independence or self-governing status. Legally, however, if a person is judged incompetent, mentally ill, senile, or in some other adverse condition, autonomy is limited or even denied (Thompson & Thompson, 1992).

In recent times, feminist perceptions about the holistic nature of nursing have generated the movement behind the ethics of caring. What emerges is the sharing of beliefs about
life and health between nurses and patients. Through the process of advocacy nursing, nurses illustrate how to make ethical decisions by applying their own ethical principles, which must be understood and placed within a proper perspective; nurses must avoid being judgmental when their views differ from those of others. In the interchange, a dialogue can occur, facilitating human and holistic decisions to be made by the patient (Crowley, 1991).

Within this context, the role of the nurse assumes a newer and more complex dimension, requiring an informed and empathetic caregiver, particularly in cross-cultural nursing. The following two case studies provide a realistic description of situations occurring in the patient care setting when problems surface with a mismatching of nurses and patients espousing different ethical systems of behavior.

CASE STUDIES

Description of the Problem: Case 1

Mrs. S. Lu, a 43-year-old Asian female, was admitted to the psychiatric department of a large general hospital. She had first become ill 7 years earlier and had been receiving treatment from an Asian nurse therapist in an outpatient clinic. Her only relative was a married, self-employed sister who spoke English, which Mrs. Lu did not.

When the patient immigrated to the United States 10 years earlier, she was separated from her husband, whom she left behind with her two children. Shortly before her hospitalization, her two daughters, ages 13 and 15, had come to live with her. During the Christmas holidays, she decided to fast and had her own family to look after. Yet, it is questionable whether the nursing, medical, or social service staff contacted the sister after the patient’s admission. Mrs. Lu’s sudden departure should not have come as a surprise to the staff, if the patients’ language problem was compounded by the staff’s failure to locate employees in the institution of similar cultural background who could interpret Mrs. Lu’s concerns. Asian nurses and physicians were known to work in some of the other departments. By not seeking out translators (internal and external to the hospital), the nurses neglected their duty and responsibility to assess the patient’s problems and human responses accurately to provide appropriate and congruent nursing care.

Although the patient’s sister spoke English, she apparently did not visit her sister in the hospital. She worked full-time and had her own family to look after. Yet, it is questionable whether the nursing, medical, or social service staff contacted the sister after the patient’s admission. Mrs. Lu’s sudden departure should not have come as a surprise to the staff, if the nurses had an awareness of the patient’s cultural value system. In Asian society, it was not unusual for people to view the hospital as a prison. It was quite remarkable that the patient immediately sought out her nurse therapist, which showed that she wanted to be helped. She was then able to share her unpleasant hospital experience. Mrs. Lu had been in the care of the same nurse therapist for some time; it was unfortunate that her psychotic episode occurred at the time when the clinic was closed and the therapist was away over the holidays. Thus, if the sister tried to reach her, it would not have been possible.

Description of the Problem: Case 2

Mrs. Hwa, a 65-year-old woman who spoke only her native Korean language, came to the United States on a 6-month visitor’s visa to be with her daughter, a graduate nursing student at a local university. She had no previous psychiatric history.

Shortly after her arrival, she complained of severe abdominal pain. Concerned that it might be an appendicitis attack, her daughter admitted her to the medical unit of a large teaching hospital. During the next few days, the patient was subjected to a variety of tests, including blood work, to determine
her diagnosis. When repeated blood samples had to be taken, the patient became frightened and began to scream. The staff nurse tried to hold her down while the blood was being withdrawn, but that only intensified her agitation. After that, the patient did not want the nurse to come near her and continued to yell. A psychiatric consultation was ordered, which resulted in Mrs. Hwa being medicated with Haldol, a powerful psychotropic drug. The following morning, when her daughter came to visit her, she was stunned to see her mother’s condition. The drug had produced serious side effects, causing slurred speech and a rigidity of the hands. The daughter immediately arranged for her mother to be discharged from the hospital because of the treatment inflicted on her. Also, by that time, Mrs. Hwa’s earlier gastric problem seemed to have ceased.

**Analysis of the Case 2**

**Situation: Ethical Implications**

Serious ethical issues surfaced in the patient care setting related to Mrs. Hwa’s inability to speak English and the insensitivity of the nursing and medical staff in failing to recognize the potential consequences of this communication problem. The staff showed a lack of awareness as to why the patient reacted so strongly to having the blood tests done. In her culture, it is inconceivable that the wishes of an elderly person would be ignored. If they had contacted her daughter as soon as the problem arose, the nurses would have acquired some understanding of the situation, and the daughter, in turn, could have explained to her mother why the tests were necessary.

In the goal-oriented approach of the nurses, aiming to have the tests take precedence over everything else, they ignored the basic ethical principle of the patient’s right to information about her treatment and the need for consent. In this case, the utilitarian focus that was applied did not achieve its purpose but rather exacerbated the difficulty. The request for psychiatric intervention appeared precipitous, reflecting poor judgment, because no proper cultural nursing assessment was performed. Because of Mrs. Hwa’s age and the fact that she could not communicate in English, the staff arrived at wrong assumptions, believing the cause of her behavior to be of a psychotic or organic-based nature. Their observations were formed. Because of Mrs. Hwa’s age and the fact that she could not communicate in English to the hospital staff due to language barriers. The nurses in this situation were unable to alleviate the suffering or safeguard their interpretation. Misunderstanding the patient’s behavior (continuous crying and yelling) overrode the patient’s right to information for treatment and consent.

**THE NURSES’ POINT OF VIEW**

Duty-based ethical theory states that individual rights and duties can be presented in a goal-based framework because certain duties engender certain rights, and some duties ought to be performed even if a certain larger goals are not to be accomplished (Munson, 1992). The nurses were faced with certain dilemmas in trying to calm the patients down because their behavior was disturbing other patients and disrupting their own treatment. Not getting a translator for these two patients was the wrong judgment because the nurses neglected their duty and responsibility to assess the patients’ problems correctly. Furthermore, the nurses failed to respect the patients’ human dignity and the uniqueness of each individual patient.

The fundamental responsibility of the nurse, according to the ICN (1973) Code, is fourfold: “to promote health, to prevent illness, to restore health, and to alleviate suffering.” The code for nurses is a public statement of belief expressing moral concern, the values, and the goal of nursing. Both of these patients were unable to communicate in English to the hospital staff due to language barriers. The nurses in this situation were unable to alleviate the suffering or safeguard these patients (ANA, 1985).

Another important observation is that the nurses had no awareness of the ethics of caring. Empathy, nurturing, and commitment appeared to be singularly lacking in the nurses’ relationship to Mrs. Lu and Mrs. Hwa. For example, the nurses did not demonstrate any understanding of Mrs. Lu’s crying. It could be concluded that the nursing staff did not function as patient advocates.

JCAHO (1997) advocates the participation of the family in decisions regarding care to improve the outcomes (RI.2.2). Patients being treated for emotional or behavioral disorders have special needs related to the assessment process (PE.6).
But no family members or translators participated in the treatment of these Asian patients. Therefore, the nurses violated ICAHO standards of patients’ right to treatment or family intervention and participation. Special assessment, in this case cultural assessment, was ignored. Above all, the nurses misunderstood the cultural meaning of the patients’ crying and yelling.

**SUMMARY**

Communication is the most important tool in any organization, but in the health care setting, it takes on special meaning because of the diversity of cultures in American life. Certainly, ethical issues become more prominent when a lack of communication occurs. Andrews and Boyle (1995) allude to the elements of transcultural communication skills and communication barriers, particularly miscommunication between a patient and nurse in a different culture. Language differences may cause longer treatment for culturally diverse people than for English-speaking patients (Andrews & Boyle, 1995).

In cross-cultural communication, Bernstein (1991) refers to the process of incommensurability, in which various views meet and interact through argument and dialogue based on the participant’s willingness to enter into a new shared reality. Such willingness or unwillingness is essential and reflects ethical acts between people. In the case of Mrs. Lu, the nursing staff appeared to lack the knowledge and skills to develop a shared nurse-client relationship. The nurses failed to demonstrate their caring and compassion as empathic caregivers and their commitment to determining the basis of patients’ crying.

**RECOMMENDATIONS FOR CULTURAL COMPETENCE TRAINING**

Cultural competency in nursing means “the capability to provide nursing care effectively in cross-cultural situations regardless of personal values and beliefs that differ from those of the patient” (Villarruel, 1995, p. 18). Culturally competent care is defined as knowing, recognizing, and demonstrating sensitivity to individual differences (Meleis, 1999). Cultural differences involve issues that can affect the entire health care organization. An individual’s culture influences his or her understanding of illness, attitudes toward health, and help-seeking behaviors (Marsella, 1982). Culturally congruent care means “to provide care that is meaningful and fits with cultural beliefs and life ways” (Leininger, 1999, p. 9).

Cultural congruency occurs when health care professionals’ cultural beliefs and worldviews match those of the clients in the treatment process (Donnelly, 1998). As Lipson (1999) stated, cross-cultural nursing is “a complex and interacting combination of knowledge, attitudes, and skills” (p. 6).

Some models have evolved that can guide nurses in implementing transcultural nursing care. Leininger (1995) described her Sunrise Model as a cognitive map that depicts a rising sun, symbolizing the integration of social and physical sciences. Included are concepts of cultural and spiritual values in addition to socioeconomic issues, communication, and environmental factors. Leininger proposes three modes of action. First, culture care preservation and maintenance incorporate traditional folk care knowledge and skills. Second, culture care accommodation and negotiation provide culture-specific or spiritual needs of care from the clients’ worldview. Third, culture care repatterning and restructuring refer to designing a new and healthier lifestyle for the well-being of clients (Leininger & Reynolds, 1993).

In another model, developed by Geiger and Davidhizar (1995), the authors explain how to perform individualized nursing and intervention by applying six essential cultural phenomena in the clinical setting:

- **Communication.** Different languages have different meaning;
- **Space.** Various cultures have different concepts about social, personal space, and territoriality;
- **Social Organization.** Family systems and religious and other organizational groups vary among cultures;
- **Time.** Each culture has its own conception and orientation regarding time;
- **Environmental Control.** The values, beliefs, and concepts of health practices vary widely among cultural groups;
- **Biological Variations.** Constitutional endowment and vulnerability differ among people representing different cultures. (p. 4)

To be effective, cultural competency training requires the participation of the entire health care community, including nurses and other health care providers. In the patient care setting, an interdisciplinary approach is essential to meeting the goals of the training or educational program. The following suggests an approach to meeting this aim.

1. **Health Care Institutions**

Health care organizations should provide supports internally and encourage collaborative arrangements with ethnic resources in the community. Institutional administrative support is crucial to the success of efforts to foster culturally competent care, with provisions for adequate staffing and financial resources. Cultural competency training is incorporated into grand rounds to enhance awareness of the care required for culturally diverse patients (Spicer, Ripple, Louie, Baj, & Keating, 1994). Encouraged are interdisciplinary programs for staff, sponsorship of seminars, attendance at continuing education programs on transcultural health care, and arrangements with agencies in the community to bring in consultants. Among these are translators (via a language bank) and other appropriate experts who can contribute to a positive cultural climate in the facility.
2. Nursing Service Administration in the Health Care Setting

Nursing administration should implement and strengthen cultural competency training in the work setting through hospital orientation by promoting knowledge and understanding of the ANA Code of Ethics and the Patient’s Bill of Rights.

Orientation of new employees. From the outset of employment, the nursing department incorporates concepts of cultural competency (Villarruel, 1995) into the initial orientation. This segment of the program includes demographic information about the patient population. Descriptions of cultural competency are presented, underscoring its importance in providing safe, effective, and culturally congruent care. Also included are the ethical-legal consequences that may arise when the cultural value systems of patients differ from those of their caregivers. Appropriate resources are provided, such as audiovisuals and readings, to enhance the nurse’s knowledge of cross-cultural nursing.

Ongoing staff development. At regularly scheduled in-service programs for staff, opportunity is provided to discuss the concerns of nurses regarding the care of patients from multicultural groups, particularly those with communication problems. Certain basic concepts are addressed, such as recognizing the uniqueness of the patient, the importance of cultural assessment, and the need for cultural evaluation tools (Wilkins, 1993).

Interdisciplinary programs are planned periodically involving case studies with a problem-solving focus. This forum invites the participation of representatives from medicine, social service, and other disciplines. Outside experts in cultural anthropology, communication, and other relevant areas can provide valuable information in resolving ethical dilemmas facing health care providers.

3. Nursing Education in Academic Settings

Nurse educators need to design curricula that will prepare students to practice in the new millennium and provide the health care needs of the future.

Undergraduate level. Transcultural nursing courses belong in the core curriculum, or transcultural concepts should be integrated into other courses (Donnelly, 1998). Faculty members should reinforce the information when students begin their clinical experience and discuss cultural-ethical issues on the patient care unit.

Graduate level. Core transcultural nursing concepts, such as professional issues and ethical or legal aspects of nursing, should be integrated into the curriculum, including courses in the student’s area of specialization. Student objectives can be developed to show application of ethical principles on specialty units housing clients from other cultures. In addition, student projects and research in transcultural nursing can be encouraged.

Without question, culture is inextricably interwoven with communication. The understanding of culture requires language. According to Munhall (1994), different language systems reflect different perceptions of the same reality, and language does not exist apart from thought. Culture, nursing, and ethics are closely interrelated and interdependent.

REFERENCES


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