African Americans are one of the largest ethnic groups in the United States. Data from the U.S. Department of Commerce, Bureau of the Census (2001) reveal that there are approximately 34,333,000 African Americans residing in the United States, representing 12.1% of the total population. The African-American population is expected to increase to 40.2 million by 2010 (American Demographics, Inc., 1991). Health disparities among the African-American population include life expectancy, heart disease, hypertension, infant mortality and morbidity rates, cancer, HIV/AIDS, violence, type 2 diabetes mellitus, and asthma. The purpose of this article is to address the issue of health disparities among African Americans by providing nurses with a practice model of cultural competence.

**Key Words:** African Americans, health disparities, cultural assessment, cultural competence, culture, diversity, inequality, cultural awareness, racism.

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**A Model of Cultural Competence**

The Process of Cultural Competence in the Delivery of Healthcare Services is a practice model of cultural competence that defines cultural competence as the ongoing process in which the nurse continuously strives to achieve the ability and availability to work effectively within the cultural context of the patient (individual, family, community) (Campinha-Bacote, 2007). This practice model requires nurses to see themselves as becoming culturally competent rather than being culturally competent, and it involves the integration of cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters (see Figure 1). Each of these constructs will be applied to caring for the African-American patient.

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**Cultural Desire**

Cultural desire is defined as the motivation of the nurse to “want to” engage in the process of becoming culturally competent with African-American patients; not the “have to” (Campinha-Bacote, 1998). Cultural desire is the pivotal construct of cultural competence that provides the energy source and foundation for one’s journey toward cultural competence. Humility is a key factor in addressing one’s cultural desire. Nurses who are humble have a genuine desire to discover how their patients think and feel differently from them. Cultural humility is a quality of seeing the greatness in others and coming into the realization of the dignity and worth of others. As health care professionals, nurses do not have to accept the patient’s belief.
system; however, nurses must treat each person as a unique human being worthy and deserving of love and care. In this sense, cultural desire is expressed in terms of human dignity, human rights, social justice, and equity (Campinha-Bacote, 2005). Research continues to demonstrate a direct correlation between inequality and negative health outcomes, and it is because of this link that nurses must consciously connect cultural competence partners with social justice. Stacks, Salgado, and Holmes (2004) contend that when cultural competence partners with social justice, equality in health outcomes can finally be achieved for all, regardless of race/ethnicity, language, gender, religion, or sexual orientation.

Cultural Awareness

Cultural awareness is the conscious self-examination and in-depth exploration of our personal biases, stereotypes, prejudices, and assumptions that we hold about individuals who are different from us. In addressing cultural awareness, nurses must ask the question, “Am I aware of any biases or prejudices that I may have toward African-American patients?” An example of one unconscious area of bias may be the African-American dialect.

Although the dominant language spoken among African Americans is English, there is a way of speaking among some African Americans that sociolinguists refer to as African American English (AAE). These terms include Black English, Ebonics, Black Vernacular English (BEV), and African American Vernacular English (AAVE) (Bland-Stewart, 2005). The major problem that AAE speakers face is prejudice. Most people believe that AAE is inferior to Standard American English. At times, African Americans who use AAE are misinterpreted as being uneducated.

A nurse’s personal beliefs and biases about African Americans may lead to unequal treatment, misdiagnosis, and over-medication (Levy, 1993; Smedley, Stith, & Nelson, 2002). For example, African Americans are at a higher risk of misdiagnosis for psychiatric disorders, and therefore, may be treated inappropriately with drugs. Studies have found that African Americans are more likely to be over-diagnosed with having a psychotic disorder and more liable to be treated with antipsychotic drugs, regardless of diagnosis (DelBello, Soutullo, & Strakowski, 2000; Lawson, 1999; Strakoski, McElroy, Keck, & West, 1996; Strickland, Lin, Fu, Anderson, & Zheng, 1995). While there are several possible explanations, DelBello et al. (2000) contend that one plausible explanation is that clinicians perceived African Americans to be more aggressive and more psychotic, and as a result, were prescribed the antipsychotics.

In examining the construct of cultural awareness, nurses must also examine the possibility of racism and ask the question, “Is there racism in health care?” While previous research attributed the problem of health disparities among African Americans and other minority groups to access-related factors, income, age, comorbib conditions, insurance coverage, socioeconomic status, and expressions of symptoms; the Institute of Medicine (IOM) cites racial prejudice and differences in the quality of health as possible reasons for increased disparities (Burrells, Maxey, & Levy, 2002; Smedley et al., 2002; Stolberg, 2001).

Cultural Knowledge

Cultural knowledge is the process of seeking and obtaining a sound educational base about African Americans (Campinha-Bacote, 2007). In acquiring this knowledge, nurses must focus on the integration of three specific
issues: health-related beliefs about practices and cultural values, disease incidence and prevalence, and treatment efficacy (Lavizzo-Mourey, 1996). Because most African Americans tend to be suspicious of health care professionals, they tend to see a physician or nurse only when absolutely necessary and may use home remedies to maintain their health and treat specific health conditions. Some African Americans, particularly of Haitian background, may believe in sympathetic magic. Sympathetic magic assumes everything is interconnected and includes the practice of imitative and contagious magic. Contagious magic entails the belief that once an entity is physically connected to another, it can never be separated; what is done to a specific part is also done to the whole. This type of belief is seen in the practice of voodoo, when an individual will take a piece of the victim’s hair or finger nail and place it on a hex, which they believe will cause the person to become ill (voodoo illness) (Campinha-Bacote, 1992).

Imitative magic assumes the belief that “like follows like.” For example, a pregnant woman may sleep with a knife under her pillow to “cut” the pains of labor. African Americans consider themselves spiritual beings, and God is thought to be the supreme healer. Spiritual beliefs strongly direct many African Americans as they cope with illness and the end of life. In a review of the literature on spiritual beliefs and practices of African Americans, Johnson, Elbert-Avila, and Tulsry (2005) noted that “spiritual beliefs and practices are a source of comfort, coping, and support, and are the most effective way to influence healing; God is responsible for physical and spiritual health, and the doctor is God’s instrument” (p. 711).

In regard to disease incidence and prevalence, Underwood and colleagues (2005) assert that African Americans experience an “excessive burden of disease.” When examining the relationship of social characteristics, such as education, income, and occupation to health indicators, African Americans have worse indicators when compared to Caucasians (Navarro, 1997). African Americans are at greater risk for many diseases, especially those associated with low income, stressful life conditions, lack of access to primary health care, and negating health behaviors.

Hypertension is the single greatest risk factor for cardiovascular disease and heart attacks among African Americans. Compared with hypertension in other ethnic groups, hypertension among African Americans is more severe, more resistant to treatment, and begins at a younger age, and the consequence is significantly worse, including organ damage (Brewster, van Montfrans, & Kleijn, 2004; Moore, 2005). African Americans also experience higher overall cancer incidence and mortality rates, and less than 5-year survival rates when compared to non-Hispanic Caucasian, Native American, Hispanic, Alaskan Native, Asian American, and Pacific Islander population groups (Underwood & Powell, 2006). Because African Americans are concentrated in large inner cities, they are at risk for being victims of violence. Death due to violence is the sixth leading cause of death among African Americans (National Center for Health Statistics, 2002). It is also noted that African Americans have a disproportionally higher rate of poor asthma outcomes, including hospitalizations and deaths. Deaths due to asthma are three times more common among African Americans than among Caucasians (Asthma and Allergy Foundation of America and the National Pharmaceutical Council, 2006).

African Americans suffer from certain genetic conditions. Sickle cell disease is the most common genetic disorder among the African-American population, affecting one in every 500 African Americans. In addition to sickle cell disease, glucose-6-phosphate dehydrogenase deficiency, which interferes with glucose metabolism, is another genetic disease found among African Americans. Finally, AIDS contributes to the lower life expectancy of African Americans compared to European Americans. In 2003, African Americans, who make up approximately 12% of the U.S. population, accounted for half of the HIV/AIDS cases diagnosed. Treatment efficacy, especially the field of ethnic pharmacology, is important to address when obtaining cultural knowledge. Examples of drugs that African Americans respond to or metabolize differently are psychotropic drugs, immunosuppressants, antihypertensives, cardiovascular drugs, and antiretroviral medications (Burroughs et al., 2002; Campinha-Bacote, 2007; Dirks, Huth, Yates, & Melbohm, 2004; Glazer, Mogantern, & Doucette, 1993). For example, Dirks et al. (2004) found that the oral bioavailability of specific immunosuppressants in African Americans was 20 and 50% lower than in non-African Americans.

In obtaining cultural knowledge of health-related beliefs practices and cultural values, disease incidence and prevalence, and treatment efficacy among African Americans, it is critical for nurses to remember the concept of intra-cultural variation. There are marked differences within as well as across cultural groups (Campinha-Bacote, 2007). African Americans are not a homogenous group, but rather, reflect a very heterogeneous group composed of a gene pool of over 100 racial strains. Therefore, nurses must develop the skill to conduct a cultural assessment with each African-American patient.

**Cultural Skill**

Cultural skill is the ability to collect relevant cultural data regarding the patient’s presenting problem, as well as accurately perform a culturally based, physical assessment in a culturally sensitive manner (Campinha-Bacote, 2007). The goal of a cultural assessment is to explore the
patient’s explanation of his or her illness. Kleinman (1980, p. 106) finds it useful to ask the following open-ended questions in eliciting the details of the patient’s explanatory model:

- What do you call your problem? What name does it have?
- What do you think has caused your problem?
- Why do you think it started when it did?
- What do you think your sickness does to you? How does it work?
- How severe is it? Will it have a short or long course?
- What do you fear the most about your sickness?
- What are the chief problems your sickness has caused for you?
- What kind of treatment do you think you should receive? What are the most important results you hope to receive from this treatment?

Nurses also need to develop cultural skill when performing a physical assessment with African-American patients. In performing a culturally based physical assessment, Bloch (1983) encourages nurses to internally ask questions such as, “How does skin color variation influence assessment of skin color changes and its relationship to the disease process?” This question raises important concerns for the African-American patient. Nurses are trained in the art of using alterations in skin color and deviations from an individual’s normal skin tone to aid with diagnoses. For example, yellow jaundice is a sign of a liver disorder; pink and blue skin changes are associated with pulmonary disease; and ash or gray color signals cardiac disease (Salcido, 2002). However, these acquired assessment skills are based on a Eurocentric rather than a melanocentric approach to skin assessment. Assessing the skin of most African-American clients requires different clinical skills from those for assessing people with white skin (Campinha-Bacote, 2008). For example, pallor in dark-skinned African Americans can be observed by the absence of the underlying red tones that give the brown and black skin its “glow” or “living color.” Lighter-skinned African Americans appear more yellowish brown, whereas darker-skinned African Americans appear ashen. Cyanosis and blood oxygenation levels may present differently in dark-skinned clients than in light-skinned clients. For example, some dark-skinned African-American patients may have very blue lips, which may give a false impression of cyanosis. In striving toward a melanocentric approach to assessing the skin of culturally diverse patients, Purnell and Paulanka (2003) offer the following guidelines for assessing skin variations:

1. Establish a baseline color (ask a family member),
2. Use direct sunlight, if possible,
3. Observe areas with the least amount of pigment,
4. Palpate for rashes, and
5. Compare skin in corresponding areas.

**Cultural Encounters**

Cultural encounter is the deliberate seeking of face-to-face interactions with African-American patients. Ting-Toomey (1999) contends that effective cultural encounters should consist of “mindful intercultural communications” and argues that the opposite of mindful cross-cultural communication is “mindless stereotyping” (p. 16), which is a closed-ended, exaggerated over-generalization of a group of people based on little or no external validity. Negative encounters from health care professionals can greatly affect African Americans’ decision to seek medical attention (McNeil, Campinha-Bacote, Tapscott, & Vample, 2002). One study reported that 12% of African Americans, compared to 1% of Caucasians, felt that health care practitioners treated them unfairly or with disrespect because of their race (Kaiser Family Foundation, 2001). Because most African Americans tend to be suspicious of health care professionals, effective cultural encounters are key in establishing a trusting relationship. The case study in Figure 2 presents a communication gap between the nurse and an African-American patient.

When interacting with African Africans, it is important to know that most prefer to be greeted formally, such as Doctor, Reverend, Pastor, Mr., Mrs., Ms., or Miss. They prefer their surname because the “family name” is highly respected and connotes pride in their family heritage. African-American communication has been described as high-context (Cokley, Cooke, & Nobles, 2005). They tend to rely on fewer words and use more non-verbal messages than what is actually spoken. The volume of African Americans’ voices is often louder than those in some other cultures; therefore, nurses must not misunderstand this attribute and automatically assume this increase in tone reflects anger. African-American speech is dynamic and expressive. They are also reported to be comfortable with a closer personal space than other cultural groups.

Health literacy must also be addressed during the cultural encounter with African Americans; research shows that health literacy is the single best predictor of health status. Healthy People 2010 defines health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (U.S. Department of Health and Human Resources, 2002). Low health literacy affects 40% of African Americans and is considered a barrier to receiving optimal health care.

**Conclusion**

The Process of Cultural Competence in the Delivery of Healthcare Services model (Campinha-Bacote, 2007) provides nurses with a model of practice to render culturally competent and culturally responsive health care to African Americans. In applying this practice model of cultural compen-
The patient presents at a local urologic group as a referral from a community clinic. The nurse reviews the chart prior to entering the examination room. The nurse notes that the next patient is LaShawn, a 24-year-old African-American female with a chief complaint of low pelvic pain and burning during voiding for 2 to 3 weeks. The nurse sees that the chart has been flagged, noting that LaShawn is not employed, has no insurance, and lives in subsidized income housing. The nurse sighs and rolls her eyes, and enters the room to collect the initial assessment information.

Nurse: (enters the room, looking through the chart) “Why are you here?”
LaShawn: (sitting on the end of the examination table) “I told the other nurse, why she didn’t tell you?”
Nurse: (rolls eyes) “Well, just tell me again.”
LaShawn: “It hurts to go to the bathroom.”
Nurse: (sighs) “How long have you had this problem?”
LaShawn: “About 2 weeks. It got better because I drank baking soda like my Grandma told me. Then I took a bath in Epsom salts, and that helped too.”
Nurse: “Well, those things might have made things worse, and you should have come right away.”
LaShawn: “I don’t have insurance, and I was trying to fix myself. I don’t know how I will be able to pay the bill, lettin’ on getting the medicine for this.”
Nurse: “OK.” (Turns and walks out of the room.)

The nurse gives a report to the physician as follows: “This patient will not be compliant. She is using home remedies of drinking baking soda water and using Epsom salts. She said she won’t get the prescription filled. She also is challenging authority, so I am not sure how well she will listen to you.”

As you consider The Process of Cultural Competence in the Delivery of Healthcare Services model of culturally competent care and above case study, identify:
- Potential and actual barriers to communication.
- Issues relative to cultural desire.
- Issues relative to cultural awareness.
- Implications of cultural knowledge as it relates to self care.
- The impact of cultural skill on the outcome of care.
- The impact of cultural encounters on the outcome of care.

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**Additional Reading**