Cultural Competency and Cultural Humility in Simulation-Based Education: An Integrative Review
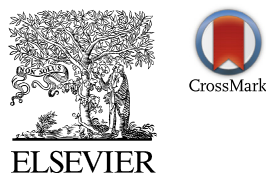
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Review Article

Cultural Competency and Cultural Humility in Simulation-Based Education: An Integrative Review

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KEYWORDS
cultural humility;
cultural competence;
cultural sensitivity;
simulation;
culture;
diversity;
nursing education

Abstract
Background: Cultural humility is endorsed; yet, the state of the science of cultural humility in simulation-based education is unknown. The aim of this integrative review is to provide what is known about cultural competence and cultural humility in simulation-based education to base future efforts in education, research, and policy.
Methods: Sixteen studies were reviewed and appraised in this integrative review.
Results: Four themes of learning outcomes from simulation emerged from the studies: (a) cultural sensitivity and cultural competence, (b) insight and understanding, (c) communication, and (d) confidence and comfort. There were no studies that mentioned cultural humility.
Conclusions: Cultural humility in simulation-based education is lacking, signifying a need for educational reform and research.

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"Understanding and eliminating health disparities requires a close examination of our past work and future focus in health care research across settings" (Yeager & Bauer-Wu, 2013, p. 1). As the science of simulation continues to expand and is increasingly accepted as a mechanism to improve patient safety, educational researchers will benefit from examining what is known about best practices in simulation and the directions to move forward. Current research suggests a gap in knowledge related to best simulation

practices for underrepresented students (Fuselier, Baldwin, & Townsend-Chambers, 2016; Graham & Atz, 2015). To improve diversity in workforce representation and prepare nursing students to aptly care for a multicultural population to reduce health disparities, improved education and research regarding cultural humility in simulation is essential.

Studies have indicated that students of minority backgrounds appreciate integration of race and culture in simulation (Fuselier et al., 2016; Graham & Atz, 2015). However, current international simulation standards lack an emphasis on diversity and cultural humility; thus, simulation curricula may be missing this essential component. The aim of this article is to provide the state of the science or what is known about cultural competence and cultural humility in simulation-based education to provide direction for simulation education, research, and policy development.

Key Points
- Current research suggests a gap in knowledge related to best simulation practices for underrepresented students.
- Not one study was located that described the use of simulation to teach cultural humility.
- We recommend a diverse simulation curriculum and cultural humility training.
- Adding cultural humility as a standard will serve as the impetus to transform simulation environments globally.

Background

The Merriam Webster (2017) dictionary defines "diversity" as "the condition of having or being composed of differing elements; the inclusion of different types of people (such as people of different races or cultures) in a group or organization" (para 1). According to the National League for Nursing (2016):

> Diversity signifies that each individual is unique and recognizes individual differences — race, ethnicity, gender, sexual orientation and gender identity, socio-economic status, age, physical abilities, religious beliefs, political beliefs, or other attributes. It encourages self-awareness and respect for all persons, embracing and celebrating the richness of each individual. It also encompasses organizational, institutional, and system-wide behaviors in nursing, nursing education, and health care (NLN, 2016, p. 2).

In the presence of increased globalization, increased diversity within the student body, inadequate minority workforce representation, and in the midst of global health disparities, "diversity and quality health care are inseparable"

(NLN, 2016, p. 2). For these reasons, faculty and administrators of schools of nursing and health sciences are working to improve efforts to foster diversity and enact cultural humility.

In their seminal article, Tervalon and Murray-Garcia (1998) distinguished cultural humility from cultural competency. The authors indicated that "cultural humility incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations" (p. 123). In the context of medical education, they suggested a movement from cultural competence to cultural humility. Chang, Simon, and Dong (2012) created the QIAN model to describe cultural humility. QIAN, the Chinese word for "humbleness," summarized the core values of cultural humility. The Q for self-questioning and critique, the I for bidirectional cultural immersion, the A for active listening, and the N for the flexibility of negotiation. Foronda, Baptiste, Ousman, and Reinholdt (2016) performed a concept analysis of the term "cultural humility" and arrived at the following definition:

> In a multicultural world where power imbalances exist, cultural humility is a process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with diverse individuals. The results of achieving cultural humility are mutual empowerment, respect, partnerships, optimal care, and lifelong learning (p. 213).

The goal of achieving cultural competence implies a sense of expertise or a skill that can be mastered, the notion of cultural humility suggests a more flexible and humble endpoint (Yeager & Bauer-Wu, 2013). Therefore, it is suggested that nurse educators shift away from cultural competence and help students develop a foundation for the life process of working toward cultural humility.

Methods

Whittemore and Knafl's (2005) method of integrative review was applied. This type of review involves five steps: (a) problem identification, (b) literature search, (c) data evaluation, (d) data analysis, and (e) presentation. We searched the databases of PubMed, CINAHL, EMBASE, and ERIC for articles describing cultural competence or cultural humility in simulation with the assistance of a Johns Hopkins Welch Medical Library Informationist and applied the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (PRISMA, 2015) (Figure). The guiding question was "What is the state of the science of cultural humility in simulation-based education in the health professions?" All methods (high-fidelity, low-fidelity, etc.) of simulation were included. The date parameters were from January 1, 2010 to June 19, 2015. Search terms included cultural competence,
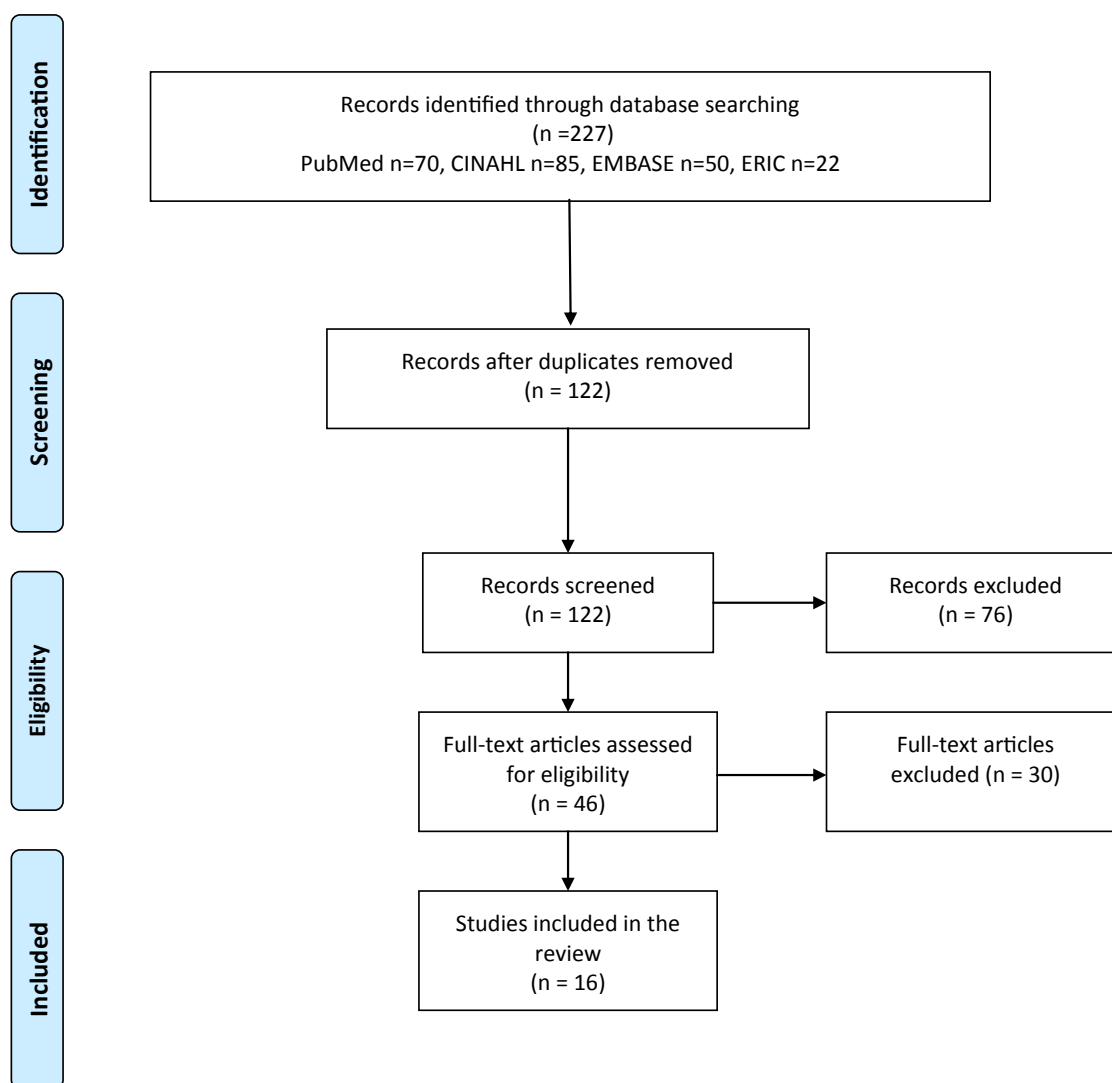
Figure   Flowchart.

cultural, culturally, humble, humility, competence, competent, and simulation. The preliminary search yielded 227 documents. Case studies, abstracts, vignettes, and articles that were not written in English were excluded. One hundred twenty-two article abstracts were read through for relevance to the topic yielding 46 articles. A team of seven nurse researchers read through the 46 articles and used summary tables to extract key points. After limiting to full-text research studies, inclusive of quantitative and qualitative research, 16 studies were identified and included in this review.

Articles were read, and key data were extracted and placed in a summary table (Table). Data were reduced by "extracting and coding data from primary sources to simplify, abstract, focus, and organize data into a manageable framework" (Whittemore & Knafl, 2005, p. 550). Key concepts/constructs were recorded and tabulated for frequency. The most frequently occurring concepts informed the development of themes. Methodological quality was assessed applying the Melnyk levels of evidence (Melnyk &

Fineout-Overholt, 2015). In this hierarchy ranging from 1 to 7, a level 1 is the highest form of evidence with a level 7 being the lowest form of evidence.

Results

After reviewing and synthesizing the data of the simulation studies, four overarching themes of learning outcomes emerged from the review: (a) cultural sensitivity and cultural competence, (b) insight and understanding, (c) communication, and (d) confidence and comfort. The content, methods, and focus of the articles reviewed varied widely encompassing a breadth of topics within simulation including: different types of learners, simulated patient populations, cultural concepts, context, and methods of simulation. Fourteen studies were completed in the United States, one was completed in Australia, and the other study was completed in Canada.

Table Summary

Authors/Year	County of Study Origin	Objective	Study Design and Sample	Key Results or Recommendations	Limitations	Appraisal Level
Grossman (2013)	United States	Develop teaching strategies to facilitate learning experiences with diverse critically ill geriatric patients.	Descriptive, pre—post test design with 35 senior nursing students	After completing the high-fidelity simulations and case studies, students' fears and anxieties about working with diverse critically ill older adults decreased.	It is hard to deduce the effect of the simulation as the surveys were evaluated pre- and postcourse; thus, the case study, pre-assigned readings and Powerpoints may have contributed. No reliability or validity data were provided for the survey. No statistical significance was reported.	Level 6
Jeffery et al. (2014)	Australia	To provide a detailed analysis of the value of BPGs used in the development, teaching and learning, and evaluation of OSCEs in a rural and remote postgraduate course for remote area nurses.	Mixed methods with student surveys, focus groups, and staff interviews. Student surveys (n = 15) and focus groups (n = 13) and staff interviews (n = 5) Descriptive statistics were used to describe the student sample. The narrative data were transcribed verbatim and analyzed using content analysis. Triangulation was achieved with the convergence of the separate data sources focusing on themes and patterns within and between students and tutors.	The majority of student participants had limited experience in working in remote area nursing prior to participation and therefore the opportunities that availed themselves were critical in adequately equipping them with the requisite knowledge, skills, and abilities. Three themes emerged from the data: (a) value of common and significant events in OSCE, (b) power of deliberate actions, and (c) learning cultural sensitivity. OSCEs in this setting proved to be a good way for students to learn the skills required by remote area nurses.	Student and staff data were aggregated instead of analyzed separately. No reliability or validity data were provided for the survey. No statistical significance was reported.	Level 6

Table (*continued*)

Authors/Year	County of Study Origin	Objective	Study Design and Sample	Key Results or Recommendations	Limitations	Appraisal Level
				Overwhelmingly, the modifications using the BPGs were highly valued by students and staff. Further use of BPGs is recommended.		
Kamau-Small et al. (2015)	United States	The objectives were to evaluate identified barriers to change in health behavior and to evaluate behavior change over the span of the semester of nursing students learning about diversity and social justice.	Mixed methods with 149 senior level nursing students enrolled in community and public health nursing course. Posttest design with a posttest, open-ended online surveys at two and eight weeks (postintervention) and a CAR after the intervention. Each CAR was audited qualitatively. Intervention was a six-hour workshop that consisted of content, theater presentation, and simulation. Role play was involved.	100% Of the students earned either an 11 or 12 on a 12-item quiz about diversity. In regards to the survey data, students found the theater piece the most valuable, along with other interactive activities (where they learned about diversity and social justice). There was a decrease in awareness from week 2 (83%) to week 8 (58%). Behavior change increased from week 2 (4%) to week 8 (28%). This could be indicative of a contemplation about the issue to action about the change behavior. Barriers to change appeared to be more present at the two-week mark and decreased at the eight-week mark. Thirty-one percentage were determined to make change based on material they learned in class. Making change in health care involves information and the change process is slow. This study attempted to use a guiding theory to understand the change process of nursing	The sample was a convenience sample. There were no pretest data on the students' understanding of diversity and social justice. No reliability or validity data were provided for the CAR. No statistical significance was reported.	Level 6

Table (*continued*)

Authors/Year	County of Study Origin	Objective	Study Design and Sample	Key Results or Recommendations	Limitations	Appraisal Level
				students in being with self-awareness of issues and making change.		
Leake et al. (2010)	United States	The purpose of the project was to grapple with the challenge of increasing culturally responsive practice in a context of safety and permanency that is defined by American political and cultural values. The learning of cultural competence in the context of a Latino population was evaluated.	Mixed methods design using surveys, focus groups, and structured interviews with professional observers. Convenience sample of 114 child welfare professionals, 51 evaluators, and 15 participants (child welfare agency staff and community partners) in the focus groups. Fifteen interviews with the project team.	Knowledge, attitude, and skills improved; 90% reported learning in all key competency areas targeted; and 82% strongly agree training would make them more effective in their practice. The study findings found that the simulation "opened the eyes" of the participants experiencing a simulation of Latino families and immigrant families in the child welfare system. The simulation increased awareness of the language barriers and challenges faced by immigrant families, helped them gain new knowledge, and helped to break down community barriers.	Evaluation via participant self-report. No reliability or validity data were provided for the instrument. No statistical significance was reported. No qualitative analysis method reported.	Level 6
Mager and Grossman (2013)	United States	To increase cultural awareness in nursing students caring for diverse older adults in home care	Qualitative surveys were distributed before and after the interventions of case studies and high-fidelity simulation. Convenience sample of Junior nursing students (n = 59) and senior nursing students (n = 55).	Both groups demonstrated an enhanced depth and breadth of cultural competence. Participants indicated that, "reaching competency is a lifelong, continuously evolving journey; and I need an awareness of my own beliefs and values before I can be totally competent." They stated cultural competency involved, "being able to identify people's needs and implement best practices in	Limitations of this study included the lack of generalizability due to the study population (convenience sample of nursing students). This was a classroom assignment	Level 6

Table (*continued*)

Authors/Year	County of Study Origin	Objective	Study Design and Sample	Key Results or Recommendations	Limitations	Appraisal Level
				providing care." Most realized they were not culturally competent. Seniors appeared to have a greater understanding of cultural competence. Yet, the seniors participated in simulations, whereas juniors participated in small group case studies.	and hence all participants needed to complete this assignment to attain a grade. There was no control of other activities that might influence the student perceptions (i.e., other classes). This study did not use a tool to measure cultural competency. No formal qualitative analysis method was reported.	
Murphy and Nimmagadda (2015)	United States	Explore how IPS affected nursing and social work students' perceptions of readiness to learn together.	Quasi-experimental design with pre/post measures using the RIPLS, an 18-item questionnaire with three constructs: teamwork and collaboration, patient centeredness, and sense of professional identity. Survey included open-ended questions that asked students to self-identify strengths and challenges connected to their interprofessional learning. Forty-three senior nursing students and 45 social	Both student groups showed significant ($p < .05$) changes in attitudes toward interprofessional learning, with attitudes becoming more positive after simulations. (significant changes were noted in concepts of teamwork and collaboration, sense of professional identity, and patient-centeredness). Themes identified were communication, ability to work as a team, attitudes, listening skills, and	Susceptible to Type-II errors due to posttest score loss of response (posttest response rate was 48.8% for nursing and 57.7% for social work students). Also there was an inability to match the	Level 3

Table (*continued*)

Authors/Year	County of Study Origin	Objective	Study Design and Sample	Key Results or Recommendations	Limitations	Appraisal Level
			work graduate students participated. Summative content analysis was used to determine frequency of themes.	leadership skills. The most frequently reported challenge by both groups was interprofessional role uncertainty, and this was reduced by over two-thirds on the posttest.	individual responses pre and posttest IPS.	
Ndiwane et al. (2014)	United States	To introduce an OSCE with culturally diverse standardized patients to graduate nursing students.	A one-group pre–post test design with surveys, 29 first-year graduate nursing students in accelerated master's degree program. Learning experience implemented in three phases: (a) pretest, (b) didactic introduction to culturally sensitive issues, and (c) video-recorded OSCE with two ethnically diverse, standardized patients. Followed by posttest and final evaluation of experience. The Cultural Assessment Survey and adapted student satisfaction survey was used.	Use of OSCE provided a positive learning experience for students' comfort in cross-cultural skills and diverse patient background. Students were satisfied with the experience. Data indicated that most of the students agreed the OSCE experience helped them gain insight into skills need for thinking critically about cultural competence and enabled them to ask culturally appropriate questions. Critical thinking skills were improved by reviewing the video-recorded encounters and reflecting. Cultural Assessment Survey showed significant ($p \leq .01$) findings in five of seven areas after the exposure to OSCE culturally sensitive interactive experiences.	Small sample size, convenience sample, no control group, no reliability, or validity data reported on the instruments used; one survey was adapted.	Level 3
Ruth-Sahd et al. (2011)	United States	To use simulated patient scenarios to foster cultural sensitivity, interdisciplinary awareness, and encourage the application of class content using low-tech simulation experiences in a fundamentals nursing course.	Descriptive design using input and reflections from 73 baccalaureate nursing students The first low-tech simulation was regarding vital signs assessment; the second simulation at the end of semester was comprehensive assessment and clinical reasoning skills.	After the first simulation, students reported their biggest concerns: 1. Not knowing what to do if the patient had a problem. 2. Not doing the right thing/ hurting the patient. 3. 68% Never worked in health care and were fearful. 4. Those with experience expressed nervousness about doing something wrong 100%.	Small sample size. No reliability or validity data was reported on the tool. No statistical significance reported. No qualitative methods used to analyze	Level 6

Table (*continued*)

Authors/Year	County of Study Origin	Objective	Study Design and Sample	Key Results or Recommendations	Limitations	Appraisal Level
				5. Not knowing where to go in clinical 53%. 6. Difficulty with care plan 98%. 7. Unable to answer questions 72%. 8. Documenting incorrectly 43%. 9. Not knowing how to deal with different patients 69%. After the second simulation, 1. 91% Agreed simulation helped them prioritize. 2. Use clinical reasoning 91%. 3. Explain assessment skills 84%. 4. Improve communication skills 69%. 5. Enhance scope of knowledge regarding scope of practice 68%. 6. Provide confidence in decision making 87%. 7. All agreed debriefing was helpful. The use of simulation with beginning nursing students fostered cultural sensitivity and an awareness of interdisciplinary teamwork while promoting safe patient care.	open-ended questions.	
Sales et al. (2013)	United States	To compare three educational interventions (a cultural competence lecture, two written case scenarios, and a simulated patient exercise) to determine the extent to which each intervention enhanced cultural competency.	Pre–post test design with surveys. 84 second-year pharmacy students. Validated Cultural Assessment Survey—investigator-developed tool	Each of the three interventions showed improvement in at least one of the cultural competency domain of students' ability to verbalize awareness. Students in the simulation ($p = .008$) and lecture ($p = .037$) group showed greater improvement than those in case scenario group in the cultural skills statement.	Sample size, no reliability, or validity data on the tool. Potential for response bias in those who are more culturally competent and volunteer.	Level 3

Table (*continued*)

Authors/Year	County of Study Origin	Objective	Study Design and Sample	Key Results or Recommendations	Limitations	Appraisal Level
				Comparison of pre- and postintervention responses in simulation group—students were more likely to agree or strongly agree with the cultural desires question indicating they would like to learn about different cultures and ethnic groups ($p = .037$). Case scenario group had significant change in cultural awareness mastery of cultural competency ($p = .041$). Significant changes in lecture group cultural skills question ($p = .001$) and cultural empathy ($p = .032$). None of the activities raised survey scores for all domains. They suggest a combination of three interventions to increase cultural competency.	Lack of incentive to complete the survey instrument or provide expected answers could have skewed responses.	
Simonelli and Gennaro (2012)	United States	To emphasize the need for newer educational strategies such as simulation in a childbearing clinical course to educate nurses to become culturally competent providers for women who are waiting longer to have babies are not necessarily part of a nuclear family and who are likely to experience an increased level of technology during the birthing process.	Descriptive study with surveys. 142 RN students. Gathered student evaluation data of their simulation experience for childbearing clinical course.	>92% Agreed that simulation enhanced their theory development. >95% Indicated simulation enhanced their clinical experience. >94% Reported that simulation was an effective way to learn. There is a need for more active pedagogies that mirror students' learning needs and the needs of the diverse health care system.	No reliability or validity data on the tool. No statistical significance reported.	Level 6
Simones et al. (2010)	United States	To develop a five bed simulation project to enable nursing students to practice and apply	Observational analysis using evaluation rubrics of team performance and individual	Students' perceptions strongly supported learning by "hands on" method. They did not have	Small sample. No reliability or validity	Level 6

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Table (*continued*)

Authors/Year	County of Study Origin	Objective	Study Design and Sample	Key Results or Recommendations	Limitations	Appraisal Level
		principles related to delegation, supervision, scope of practice, and culturally competent care to enhance students' cultural awareness and sensitivity in the clinical setting.	student performance. Two RN and two LPN students from different sites worked in teams to care for five individualized patient scenarios from different racial and ethnic groups. Used online learning modules, with several practice runs over four to six months. Team was allowed 30 minutes. to receive morning report on five patients, make assignments, and complete care worksheets.	comfort working together. Students reported it felt different to "think on their feet." Individual performance varied greatly. Team members performed their duties within their scope of practice. RN students felt they were able to do a good job of delegating and prioritizing. LPN students efficient in completing the tasks. The simulation exercise validated the benefit of more comprehensive threading of delegation and supervision and other leadership principles throughout students' nursing education. Enhanced understanding and appreciation for the different nursing education programs and the importance for continuing to work together. Provided a unique opportunity to work collaboratively on important issues in education that transfer to nursing practice.	data on the tool. No statistics reported.	
Smith and Silk (2011)	United States	To investigate the impact of simulation involving an Arab American Muslim patient on medical students' knowledge, skills, and attitudes regarding culturally competent health care to Arab American Muslim patients.	Randomized Controlled Trial. 199 Second-year Osteopathic Medicine students. Control group (n = 102), experimental group (n = 97) received an online, 30- to 60-minute interactive patient simulation featuring an Arab American Muslim patient. Both groups completed a modified Clinical Cultural Competence Questionnaire.	Experimental group reported more knowledge about Arab Americans and greater self-efficacy in being able to communicate with Arab Americans. Main effect for bilingual status on five of the outcome measures including knowledge of diversity ($p = .001$), knowledge of Arab Americans ($p = .001$), overall cultural sensitivity ($p = .036$), cultural sensitivity skill level with Arab Americans ($p = .003$),	Only immediate effects of the intervention were studied: self-report measure. More objective assessment may be possible with observed patient interaction.	Level 2

Table (*continued*)

Authors/Year	County of Study Origin	Objective	Study Design and Sample	Key Results or Recommendations	Limitations	Appraisal Level
				and cross cultural comfort with Arab Americans ($p = .028$). Bilingual students scored higher than English speaking only participants on all measures and it was strongest predictor of success.		
Strasser et al. (2013)	United States	To evaluate the impacts of poverty simulation for students and professionals of public health regarding their attitudes toward people living in poverty.	Mixed methods design using a pre–post test with surveys and an open-ended question about new insights or knowledge with 99 public health students and professionals.	Participants indicated increased empathy, understanding, and knowledge of the barriers faced by low-income populations and increased confidence in their ability to identify issues contributing to poverty and positively impact those living in poverty. Change in participant confidence in ability to (a) understand obstacles faced ($p < .01$), (b) ability to identify key issues that affect this population ($p < .01$), and (c) ability to positively impact poor people in their communities ($p < .01$). Participants were significantly more likely to view people living in poverty differently in order to better serve their needs and to seek out information to address poverty issues ($p \leq .001$). 69.8% of participants felt simulation was useful. Three themes were expressed: (a) increased empathy and understanding, (b) simulation increased understanding of barriers and stressors that are faced with poverty, and	The survey instrument was not piloted for validity or reliability. Results are not generalizable because the participants were volunteers. There was possible response bias. Results may be conservative because the participants already have knowledge about the issues faced with poverty.	Level 3

Table (*continued*)

Authors/Year	County of Study Origin	Objective	Study Design and Sample	Key Results or Recommendations	Limitations	Appraisal Level
				(c) insight into the system of social services encountered by those of limited resources.		
Walker et al. (2011)	Canada	The purpose is to describe and evaluate the use of VLP for teaching medical communication in English for health care professionals.	Pre–post test design using questionnaires. Five female French native-speaking junior college nursing students at a French language learning college in Quebec. Four areas were evaluated: (a) importance of English in the workplace, (b) ease of operability, (c) effect of VLP use on pronunciation, and (d) learner confidence.	Learners reported learning English would be "very useful" (n = 4) or "somewhat useful" (n = 1). They indicated the module was easy to operate and it addressed their anticipated language learning needs. Analysis of data generated by the modules revealed improvements in acceptability of the nurses' pronunciation of the medical interview questions. The VLP Increased learner confidence in pronunciation by 7%. Findings suggest the module can be effective in language training for health care professionals.	Self-report, small sample, no reliability, or validity data. VLP needs to be tested in other types of professionals.	Level 6
Xu et al. (2010)	United States	To examine sociocultural competence regarding communication in a sample of international nurses working in two community hospitals in southern Nevada.	Quasi-experimental using pre- and postassessment with 28 international nurses (defined as receiving basic nursing education outside the United States) (18 in the intervention group, 10 in the control group). Intervention: four workshops on sociocultural dimensions of communication. Standardized patients were used.	No statistically significant differences were identified between the intervention or control groups. They suspected that no differences were found because the nurses in the study were highly acculturated. The nurses had a mean of 13.8 years of living in the United States.	Small sample size. No reliability or validity data reported on the tool. The international participants were already acculturated. Fatigue from participating in the 16-week study could have affected motivation and participation.	Level 3

Table (*continued*)

Authors/Year	County of Study Origin	Objective	Study Design and Sample	Key Results or Recommendations	Limitations	Appraisal Level
Yang et al. (2014)	United States	Evaluated the effectiveness of a poverty simulation in increasing understanding of and attitudes toward poverty and resulting in changes in clinical practice among nursing seniors.	Pre–post test design using surveys and open-ended questions. 3 Cohorts of senior community health nursing students (n = 233). 21-Item Attitude Toward Poverty Scale was used.	Significant increase understanding of financial pressures (mean ± SD: 2.89 ± 0.84 vs. 4.15 ± 0.58); feelings of stigma (mean ± SD: 24.9 ± 5.2 vs. 27.0 ± 4.8; $p < .001$); challenges in improving situation (mean ± SD: 2.75 ± 0.88 vs. 4.10 ± 0.66), and emotional stresses (mean ± SD: 2.89 ± 0.99 vs. 4.24 ± 0.70). The most frequently reported feelings about poverty were frustration, stress, worthlessness, anxiety, and helplessness. Students reported the simulation was an eye-opening experience, that they become more empathetic and sympathetic, and influenced their nursing practice. Authors recommend that poverty simulation occur earlier in nursing programs. These simulations provided an opportunity to increase awareness and culturally sensitive practice among students.	The reliability of the tool was not reported. Students may have had slightly different experiences due to the nature of simulation. There was no randomization or control group.	Level 3

Note. BPG = Best Practice Guidelines; CAR = clinical application report; IPS = interprofessional simulation; OSCE = objective-structured clinical examination; RIPLS = Readiness for Interprofessional Learning Scale; VLP = virtual language patient.

Learners

Of the 16 studies reviewed, there was a diverse pool of learners. The identified learners encompassed students in both pre-licensure and graduate programs as well as current health care professionals. The following learners were selected as participants in the studies: nursing students, nurses, medical students, global health students, pharmacy students, public health students, international nurses, child welfare professionals, and French-speaking English-as-a-second-language students.

Simulated Patient Populations

The studies involved simulated patients from diverse patient populations. The simulated patients were identified as portraying Latino families, an Arab American Muslim patient, older adults, individuals who live in rural areas, native English speakers, individuals and communities who live in poverty, and obstetric patients.

Cultural Concepts

The studies addressed various cultural concepts as a learning objective of the simulation. Concepts taught included geriatric/elderly care (Grossman, 2013; Mager & Grossman, 2013), diversity and social justice (Kamau-Small, Joyce, Bermingham, Roberts, & Robbins, 2015), cultural sensitivity or cultural competence (Leake, Holt, Potter, & Ortega, 2010; Ndiwane, Koul, & Theroux, 2014; Sales, Jonkman, Connor, & Hall, 2013; Simonelli & Gennaro, 2012; Xu, Shen, Bolstad, Covelli, & Torpey, 2010), cultural awareness (Ruth-Sahd, Schneider, & Strouse, 2011; Simones et al., 2010), interprofessional learning (Murphy & Nimmagadda, 2015), knowledge, skills, and attitudes (Jeffery et al., 2014; Smith & Silk, 2011; Strasser, Smith, Pendrick Denney, Jackson, & Buckmaster, 2013), and English as a second language (Walker, Trofimovich, Cedergren, & Gatbonton, 2011).

Contexts

The contexts of the simulations included a range of settings and situations. Environments included the clinical setting, critical care, remote areas, communities, community hospitals, general health care, home care, birthing, and impoverished settings.

Methods of Simulation

The following methods of simulation were used: role-play, standardized patients, manikin-based simulation, and virtual simulation.

Learning Outcomes

As a result of the simulations incorporating a diversity component, the synthesized data revealed the following themes of learning outcomes: (a) cultural sensitivity and cultural competence, (b) insight and understanding, (c) communication, and (d) confidence and comfort.

Cultural Sensitivity and Cultural Competence

The learning outcomes of cultural sensitivity and cultural competence clearly emerged as a result of simulation. Simulation helped to achieve "cultural sensitivity" in five studies (Jeffery et al., 2014; Ndiwane et al., 2014; Ruth-Sahd et al., 2011; Smith & Silk, 2011; Yang, Woomer, Agbemenu, & Williams, 2014) and "cultural competence" in three studies (Mager & Grossman, 2013; Ndiwane et al., 2014; Sales et al., 2013). Similar concepts that were included under this theme included "cultural empathy" (Sales et al., 2013; Strasser et al., 2013), "diversity" (Kamau-Small et al., 2015; Smith & Silk, 2011), "social justice" (Kamau-Small et al., 2015), and "cross-cultural skills" (Ndiwane et al., 2014).

Jeffrey et al. (2014) used mixed methods to analyze Best Practice Guidelines used in the development, teaching, learning, and evaluation of objective-structured clinical examinations (OSCEs) in a rural and remote postgraduate course for remote area nurses. Learners expressed "learning cultural sensitivity." Ndiwane et al. (2014) conducted a study with 29 first-year graduate nursing students using OSCEs with two ethnically diverse standardized patients. Data indicated that most students agreed the experience helped them gain insight about cultural competence and enabled them to ask culturally appropriate questions. The Cultural Assessment Survey showed significant findings in five of seven areas after the interactive experiences. In a study evaluating the effectiveness of a poverty simulation with 233 nursing students, students noted a significant increase in understanding financial pressures, feelings of stigma, challenges, and emotional stresses (Yang et al., 2014). The authors concluded that the simulations provided an opportunity to increase awareness and culturally sensitive practice among students.

Smith and Silk (2011) provided compelling evidence of the effectiveness of simulation to improve medical students' knowledge, skills, and attitudes regarding culturally competent health care. With 199 second-year osteopathic medicine students, the experimental group received an online, 30- to 60-minute interactive patient simulation. After participating in a simulation featuring an Arab American Muslim patient, students in the experimental group demonstrated a statistically significant improvement in knowledge of diversity ($p = .001$), knowledge of Arab Americans ($p = .001$), overall cultural sensitivity ($p = .036$), and culturally sensitivity skill level with Arab Americans ($p = .003$).

Insight and Understanding

The second theme that emerged as an outcome from simulation in this context was "insight and understanding." The simulation created "insight" (Strasser et al., 2013) and "awareness" (Kamau-Small et al., 2015; Leake et al., 2010; Sales et al., 2013; Yang et al., 2014). Learners expressed an increase in "understanding" and "appreciation" (Simones et al., 2010; Strasser et al., 2013; Yang et al., 2014). Additional outcomes encompassed under this theme included a positive "learning experience" (Ndiwane et al., 2014; Simonelli & Gennaro, 2012; Strasser et al., 2013), increase in "critical thinking" (Ndiwane et al., 2014), "perception change" (Strasser et al., 2013), and that it "opened the eyes" of participants (Leake et al., 2010).

In a poverty simulation with 99 public health students and professionals, a pre−post test survey was used to evaluate the impact of the simulation (Strasser et al., 2013). Three themes were expressed: (a) increased empathy and understanding, (b) simulation increased understanding of barriers and stressors that are faced with poverty, and (c) insight into the system of social services encountered by those of limited resources. Simonelli and Gennaro (2012) conducted a descriptive study with 142 nursing students gathering data about their simulation experience for a child-bearing course. The simulation was about a woman who was waiting longer than average to have a baby and was not necessarily part of a nuclear family. Over 95% of students indicated the simulation enhanced their clinical experience, and over 94% reported that simulation was an effective way to learn.

Communication

Simulation was used with success to improve communication skills (Murphy & Nimmagadda, 2015; Ruth-Sahd et al., 2011; Smith & Silk, 2011). When nursing and social worker students completed an interprofessional simulation together, findings demonstrated improved communication in the context of working as a team (Murphy & Nimmagadda, 2015). Similarly, when 73 nursing students simulated interdisciplinary awareness by working in groups to play a nurse, pharmacist, physical therapist, physician, dietician, and family member, 69% of the students indicated an improvement in communication skills (Ruth-Sahd et al., 2011). Smith and Silk (2011) investigated the impact of simulation involving an Arab American Muslim patient on medical students' knowledge, skills, and attitudes regarding culturally competent health care to Arab American Muslim patients. In this study evaluating second-year osteopathic medicine students (n = 199), the experimental group who received a patient simulation featuring an Arab American Muslim patient reported more knowledge about Arab Americans and being better able to communicate with Arab Americans. Of note, bilingual students scored higher than only English-speaking participants on all measures of the modified Clinical Cultural Competence Questionnaire. In fact, being bilingual was the strongest predictor of success in this study (Smith & Silk, 2011).

Comfort and Confidence

The final theme that emerged from the studies was that simulation in a culturally diverse context lead to increased "comfort" (Ndiwane et al., 2014; Smith & Silk, 2011) and "confidence" (Ruth-Sahd et al., 2011; Strasser et al., 2013; Walker et al., 2011). After performing an OSCE with culturally diverse standardized patients, nursing students noted more comfort in their cross-cultural skills (Ndiwane et al., 2014). Medical and global health students were placed in simulations to provide cultural competency training before their fieldwork. Eighty percent of participants felt better prepared for their fieldwork, and simulation was noted to have had a "positive impact on perceived cultural view and comfort in fieldwork settings" (p. 1126). In the Smith and Silk (2011) study involving 199 medical students using simulation to care for the Arab American Muslim patient, the experimental group demonstrated a statistically significant increase in cross cultural comfort ($p = .028$).

In a study using simulation to foster cultural sensitivity and interdisciplinary awareness, 87% of participants indicated the simulation provided confidence in decision making (Ruth-Sahd et al., 2011). Strasser et al. (2013) led a poverty simulation with public health students and professionals (n = 99). The simulation lead to a change in participant confidence in the ability to (a) understand obstacles faced, (b) ability to identify key issues that affect the population, and (c) ability to positively impact poor people in their communities (Strasser et al., 2013). Using a "virtual language patient" with five French native-speaking nursing students in Canada, the simulation was noted to have increased learner confidence in pronunciation of English by 7% (Walker et al., 2011).

Methodological Quality

When appraising the studies for methodological quality using the evidence hierarchy, nine studies were rated as level six evidence and five studies at level four evidence. Only 2 of the 16 studies were rated as level two or three evidence. The majority of studies located were lower in the hierarchy of evidence.

Discussion

This review provides a foundation of what is known and lacking regarding the use of simulation in a culturally diverse context. The preponderance of the existing research suggested that simulation has been used successfully with

learners to improve their cultural sensitivity and cultural competence, insight and understanding, communication, and comfort and confidence when dealing with diverse individuals. The wide range of contexts for the use of simulation, while exciting, limits the depth and rigor of this synthesis. Not one study was located that described the use of simulation to teach cultural humility. Cultural humility in simulation is lacking, signifying a need for educational reform and research.

Research Gaps

Through conducting this intgrative review, a number of gaps became visible. The majority of the studies were conducted in the United States; thus, it is important to consider this skew. Although we suspect this work may exist, there were no studies found from outside of the United States that described training health professionals about cultural practices of the American patient (American customs, beliefs, practices); although, it is plausible this research was not located due to language restriction of English and the search strategy employed. Further, there is a slant in these data as most studies incorporated an unspoken American-based majority perspective.

The authors noted a wide variety in the types of simulations used from poverty simulations, to interprofessional simulations, to care of the Arab American Muslim patient. It is important to note that cultural diversity may occur in the context of working in diverse professions as well as culturally diverse patients. The differences in learners, types of patients, simulation methods used, and outcome variables made this review difficult to synthesize. This breadth also signifies a lack of depth into what is known regarding best practices in teaching cultural humility.

The term diversity encompasses many veins. There was a gap in the literature of research that examined use of simulation to improve care for the following diverse populations: ethnically diverse, underrepresented minority, religious differences, difference in sexual orientation, gender identity, obese individuals, disabled, and racially diverse. It is possible that these studies were not discovered as the search strategy was not targeted to these populations; although, there is a limited amount of research in simulation related to these unique populations (Ozkara San, 2015; Ruth-Sahd et al., 2011).

Communication was evaluated in two contexts: communication within the team and provider-to-patient communication. These types of communication are highly different and warrant different teaching approaches. However, we advocate that both types of communication skills are necessary and require special attention in nursing education.

Although cultural competence was clearly evident, no studies using the terminology of cultural humility were located in the context of simulation. In light of the search strategy undertaken in this review that was inclusive of the terms humble and humility, this finding suggests a large gap. Further development and incorporation of this concept in simulation-based education and research is suggested.

The majority of studies were rated low in terms of their design and quality of evidence. Many of the studies reviewed were only descriptive in nature with limited studies employing an intervention and control group with a robust sample size. There was a noted lack of reliable and valid assessment tools used to evaluate the constructs of cultural sensitivity and cultural competence in most studies. The lack of rigor as well as the diversity of methods employed in the studies present educators an opportunity to rethink development of a simulation curriculum as well as apply new simulation standards moving forward (Chang et al., 2012).

Recommendations

Diversify the Simulation Curriculum
To attend to the needs of a diverse student population, diverse interprofessional teams, and diverse patient populations, we suggest movement to better address diversity and more carefully diversify the simulation curriculum. Culture must be interpreted in the broadest sense and simulation curricula must be examined to assure that students are exposed to a wide variety of cultural contexts. To strategically evaluate the simulation curriculum assuring representativeness of various cultures, we suggest using a grid to plot out the existing and desired diversity components (Foronda, Swoboda, Bahreman, & Foisy-Doll, 2017). The simulation environment should be examined regarding culturally diverse signage and assure presence of racially diverse manikins. Instead of having two or three simulations with a diverse patient, we suggest threading diversity throughout the curriculum and include a discussion on the complexities of potential cultural differences during each debriefing session.

Cultural Humility Training
In addition to having a simulation curriculum infused with culturally diverse scenarios, we suggest that facilitators and students receive cultural humility training. This training shifts away from the notion of cultural competence and is designed to teach learners the fundamental concepts of cultural humility, reinforcing that it is a life-long process of learning. With the vision of creating more open-minded and flexible practitioners among diverse professions, educators should emphasize the need for self-reflection and the ability to view situations from multiple perspectives and lenses.

Future Research

Based on the findings of this review, we suggest that future research evaluate student learning outcomes related to integration of select cultural components in simulation. We need more robust research using experimental designs

with adequate sample sizes, diverse patients/manikins, and valid and reliable measures in the context of evaluating cultural humility. Further, we recommend assessing the presence of cultural humility in simulation centers and curricula internationally. The absence of research in this area suggests that diversity and cultural humility efforts in simulation are lacking. First, we must attempt to identify best practices in simulation for diversity and cultural humility and then expand to evaluate effectiveness of simulation curricula.

Policy Change

We recommend that diversity and cultural humility be added as a standard to the International Nursing Association for Clinical Simulation and Learning (INACSL) Standards of Best Practice: Simulation[SM]. The newly revised 2016 INACSL Standards were currently released, and there is now mention of ''race and culture'' under the Design Standard (INACSL Standards Committee, 2016, p. S7). This is an improvement from previous iterations of this living document. To truly impact simulation centers across the globe, we recommend and advocate for a full standard to delineate and guide simulation facilitators to create more diverse and inclusive learning environments. Adding cultural humility to the standards will serve as the impetus to transform simulation curricula and environments globally.

Limitations

This review has several limitations. First, this review was limited to full-length studies published in the English language. Research abstracts were excluded. Second, we suspect there are simulation studies that exist to address diverse patients or communities; however, because of the search strategy employed designed to focus on cultural humility, these studies did not emerge but likely could be located with a different search strategy. Further, this review is a compilation of research from various disciplines and types of learners using different methods of simulation. Thus, it is difficult to formulate best practices from this review. However, the breadth of databases and learners captured is considered a strength. This review contributes to the literature by identifying the gap of cultural humility in simulation and the need to improve education in this area.

Conclusion

This review serves as a starting point to emphasize the need for progress in simulation related to cultural humility. Cultural humility is a perspective and process that applies universally throughout one's daily interactions and communications; yet, it is a relatively new focus in education. Diversity and cultural humility should transcend the confines of the classroom and

extend to the simulation center to improve student learning, student retention, and ultimately, improve provider-to-patient communications, relationships, and patient outcomes. It is important that we examine our current simulation programs and guiding standards to improve simulation practices and better prepare learners.

Acknowledgments

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Using Simulation With Nursing Students to Promote Affirmative Practice Toward the Lesbian, Gay, Bisexual, and Transgender Population: A Multisite Study

Annette T. Maruca, Desiree A. Diaz, Cherrill Stockmann, and Laura Gonzalez

Abstract

AIM The aim of this research was to evaluate the impact of a transgender simulation on nursing students' affirmative practice when caring for a transgender person.
BACKGROUND There is a paucity of research that assesses the attitudes of nursing students toward lesbian, gay, bisexual, and transgender (LGBT) persons and a deficit in nursing curricula regarding LGBT content.
METHOD A nonexperimental, pretest-posttest design was used to evaluate nursing students' affirmative practice when caring for a transgender patient using the Gay Affirmative Practice Scale.
RESULTS A Wilcoxon signed-rank test revealed a statistical significance in Gay Affirmative Practice scores after the simulation with a small effect size. These results suggest that the transgender simulation supported nursing students' attitudes and affirmative practice when providing nursing care to a transgender person.
CONCLUSION Experiential learning in nursing education is an effective approach to teach cultural competence and sensitivity in caring for vulnerable populations.

KEY WORDS Bias – LGBT – Nursing Student Attitudes – Simulation – Transgender

The health care needs of the lesbian, gay, bisexual, and transgender (LGBT) population are beginning to receive significant attention from health care providers, legislators, policy makers, and educators (Lim, Brown, & Justin Kim, 2014; Lim & Hsu, 2016). A study by the National Gay and Lesbian Task Force (Grant et al., 2010) highlighted the importance of addressing the health care needs of transgender persons and their access to health care.

The current evidence reveals that there is still a need for research to better understand the unique, individualized health care needs of the LGBT population. Health care providers have described feeling uncomfortable when providing services to LGBT patients, which may attribute to health disparate outcomes. Factors that may attribute to this issue include the following: a) medical and nursing schools curricula contain little content on lesbian, gay, bisexual, health and "even less about transgender health" (Lim et al., 2014, p. 25; Office of Disease Prevention and Health Promotion [ODPHP], 2016); b) social and sexual stigma continues (Kirkpatrick, Esterhuizen, Jesse, & Brown, 2015); and c) providers typically do not inquire about LGBT identity during health assessments (Bosse, Nesteby, & Randall, 2015).

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As members of the health care team, nurses need to be aware of these health disparities and be part of the solution to provide equal care to all people, regardless of race, gender, sexual orientation, gender identity, and religious beliefs (Agency for Healthcare Research and Quality [AHRQ], 2015). Nurses have a significant role in improving the health of patients and providing evidence-based, compassionate, and nonjudgmental care. One approach to address this need in health care delivery is by incorporating education, particularly in nursing curricula, about health disparities and the distinct health care needs of LGBT persons (Brennan, Barnsteiner, Siantz, Cotter, & Everett, 2012; Keepnews, 2011; Lim et al., 2014).

A study by Obedin-Maliver et al. (2011) showed that only five hours of instruction were devoted to this population as part of undergraduate medical education in the United States and Canada (Lim, Brown, & Jones, 2013). The amount of attention and time nursing programs allotted to the health care needs and concern of the LGBT population was examined by Lim, Johnson, and Eliason (2015); results showed that the "median time devoted to teaching LGBT health was 2.12 hours" (p. 144). Experts "generally agree that essential content appears to be limited or lacking in the majority of nursing programs" (Brennan et al., 2012; Lim, 2013, p 93).

Walsh and Hendrickson (2015) surveyed 113 nursing programs for the existence of LGBT education. Of 21 respondents, 10 (47.62 percent) addressed transgender or transsexual individuals; 15 (71.43 percent) reported an average of 1.6 hours spent on LGBT content. Findings indicate a need to incorporate content related to LGBT health, particularly transgender concerns, in nursing education curricula. There is a deficit in nursing curricula regarding LGBT content (Strong & Folse, 2015; Walsh & Hendrickson, 2015).

Nurse graduates are expected to competently conduct a comprehensive assessment and address health disparities that meet the needs of vulnerable populations. It would stand to reason that lack

of adequate education on LGBT content can foster nursing students' lack of comfort in discussing specific health care concerns with LGBT persons more than with the general population. The American Association of Colleges of Nursing's (2008) *Essentials of Baccalaureate Education* describes the competencies necessary for baccalaureate-prepared nurses, including respectful, patient-centered care and a holistic, caring framework that guides practice (p. 8). The knowledge gap in competencies for practicing nurses is important to address given that Healthy People 2020 (U.S. Department of Health and Human Services, 2010), the Institute of Medicine (2011), and the Agency for Healthcare Research & Quality (2015) have focused their attention on health disparities and best practices in health care delivery for the LGBT community (Lim & Hsu, 2016).

Nurse faculty are challenged to incorporate LGBT education into the curricula in order to prepare nurses to provide knowledgeable care, to skillfully employ assessment skills, to be proficient in empathetic therapeutic communication, and to address the considerable health disparities faced by this community (Belluardo-Crosby & Lillis, 2012; Johnson & Amella, 2014; Lim, 2013). "Nursing as a profession needs to support efforts in academia and clinical settings to ensure a knowledgeable and culturally competent nursing workforce while removing health disparities for vulnerable populations, including the LGBT community" (Strong & Folse, 2015, p. 46).

LITERATURE REVIEW

A review of the literature revealed that the inclusion of LGBT health care concerns in nursing curricula is inadequate to address the needs of LGBT persons (Eliason, Dibble, & Robertson, 2011, p. 243), that there are notable gaps on the extent to which LGBT content is woven in the curricula (Lim et al., 2014), and that core concepts related to LGBT experience need to be identified and addressed (Brennan et al., 2012). Some efforts have been made to provide LGBT content in nursing curricula. Strong and Folse (2015) developed an educational intervention that consisted of a PowerPoint presentation (40 to 45 minutes) covering the care of LGBT clients. The educational intervention focused on knowledge of key terminology, health disparities, medical care of transgender patients, and culturally competent communication skills. The brief educational intervention was found to be useful in improving knowledge and attitudes toward LGBT patient care.

Another example of integration in the curriculum is provided by Carabez et al. (2015). They used a course assignment where nursing students were given educational readings, a two-hour presentation on LGBT health issues, and an assignment to conduct a scripted interview with practicing nurses about their experiences with this population. Nearly 40 percent of the nursing students who participated in the study reported feeling unprepared to provide nursing care to LGBT patients; through interviews with practicing nurses, they recognized the existence of "nursing silence," which they had learned about during their readings. Brennan et al. (2012) suggested nurse faculty consider using a variety of pedagogical strategies (e.g., films, case studies, ethics courses, clinical experiences, simulation) to help nursing students grasp the complexities of the LGBT community.

Simulation has been shown to be an effective educational strategy for teaching nursing skills, knowledge, and assessing attitudes (Brown, 2015). Simulation provides students with the opportunity to apply and evaluate their ability to competently perform a health assessment, to apply knowledge, and to appraise their performance while practicing in a safe learning environment. Based on this review of the literature, simulation has not been used as a pedagogical strategy to educate nursing students on LGBT health care needs and culturally sensitive care.

METHOD

The aims of this study are to promote nursing students' knowledge, skills, and attitude in caring for LGBT persons and to determine if they demonstrate affirmative practice after a simulation. The research question is: Do nursing students' affirmative practice in caring for LGBT persons improve after experiencing a transgender simulation? The hypothesis is that the transgender simulation will enhance attitudes and beliefs and support affirmative practice related to LGBT patients.

A descriptive pretest-posttest, nonexperimental research design was used to answer the research question. This multisite study recruited undergraduate, prelicensure BSN nursing students from two different state university systems, one in Connecticut and one in Florida. A convenience sample of students in their psychiatric mental health didactic and clinical course was recruited. A transgender simulation was created to provide students with the opportunity to establish therapeutic communication and to assess anxiety levels while providing safe care. The simulation lab participation is already incorporated into the nursing curricula at both universities so all students were involved in the simulation. Participation in the study was completely voluntary. Institutional review board approval was obtained at both universities.

Out of 170 eligible undergraduate nursing students representing all sites (one in Connecticut and two in Florida), 159 students voluntarily participated in the study; only 48 nursing students completed both the pretest and posttest survey or had valid data ($n = 48$). Regardless of participation, all students enrolled in the course with its associated practicum engaged in the simulation experience in their home institutions in familiar simulation labs. The simulation lab is credited to the student as clinical hours.

Procedure

Prior to participation in the simulation, students received LGBT content during the didactic portion of their nursing course via lecture. A faculty member, who was not the course instructor, introduced the study, administered it, and collected the surveys to eliminate personal bias and remove any suggestion of pressure to participate. All nursing students were handed an information sheet, demographic sheet, and the Gay Affirmative Practice (GAP) survey after they received an explanation about the proposed study. Only students who volunteered to participate completed the demographic sheet and the survey prior to partaking in the simulation. Students were told they could opt out of the study or discontinue involvement at any point in time without consequence or effect on their grade.

The posttest survey was completed after all students (participants and nonparticipants) had gone through the simulation experience. This meant there was a delay of one to four weeks in data collection after the simulation. The posttest survey was completed in the classroom following the same process as the pretest survey.

Simulation

The rationale for designing the simulation specific to a transgender patient is that transgender persons are more likely to a) experience lack of access to health care providers and discrimination than lesbians, gays, and bisexuals (Carabez et al., 2015; Lim et al., 2014);

b) experience a higher prevalence of HIV, sexually transmitted diseases, victimization, mental health issues, and suicide (Institute of Medicine, 2011; Suicide Prevention Resource Center, 2009); and c) are less likely than lesbian, gray, and bisexual individuals to have health insurance (Carabez et al., 2015).

Adhering to NLN Jeffries Simulation Theory (Jeffries, Rodgers, & Adamson, 2015), the simulation was designed by faculty with expertise in psychiatric mental health nursing and reviewed for theoretical content. All components of the simulation were appraised by two certified health care simulation educators. An RN, who is also a PharmD, verified the type of medications and the appropriate dosages typically prescribed to transgender persons who are in transition.

This was a high-fidelity simulation using a manikin; a faculty member with expertise in this area was the voice of the patient. The client was transitioning from male to female and still in the early stages of transformation. She was seeking health care related to her experiencing extreme nervousness and a migraine headache. As the scenario unfolded, the client became more anxious, agitated, and evasive in answering questions, demanding to leave the emergency room.

The learning objectives were: a) establish and maintain therapeutic communication in a culturally sensitive manner with a transgender patient, b) identify signs and symptoms of anxiety, and c) safely manage a client experiencing anxiety. Facilitators had a form that identified the physical characteristics, perceptions, and learning ability of the client at each level of anxiety — mild, moderate, severe, and panic (Varcarolis & Halter, 2014). Outcomes were evaluated using a checklist to yield consistency in evaluating learner performance and reliable grading. Some outcomes were ability to establish honest and open therapeutic communication assessed by use of therapeutic communication techniques and ability to a) accurately perform a mental status exam and physical exam; b) recognize early signs and symptoms of anxiety; c) determine escalation of anxiety level and assess potential harm; and d) maintain a safe environment. Consistency of objectives, outcome evaluation, and simulation best practices were ensured at both universities.

All facilitators were trained in Debriefing for Meaningful Learning methodology (Dreifurst, 2015). Questions were asked of the learner during the debriefing that promoted recall of events during the scenario. This allowed students an opportunity to appraise their role in the scenario; to consider how the role of the nurse impacted their sense of well-being; and to examine feelings, beliefs, assumptions, or motives related to learner's actions.

Instrument

The GAP survey was used for several reasons (Crisp, 2006). This 30-item self-report survey, developed for social workers but used with nursing and medical students for the same population, is designed to assess the health care practitioner's affirmative practice with the LGBT community. It examines attitudes and beliefs to evaluate affirmative practice that models culturally competent care to gay, lesbian, and bisexual populations. Chapman et al. (2012) used it to assess medical and nursing students' attitudes, knowledge, beliefs, and gay-affirmative practices related to LGBT parents seeking health care for their children. Although the authors designed the simulation scenario specific to a transgender person, the GAP survey examines both beliefs and practice toward the LGBT community and fits with the aims of our study.

Reliability was tested using Cronbach's alpha: belief domain = .93, behavior domain = .94. Evidence of convergent construct validity

using Pearson's r correlations was .624 (p = .000) between the belief and behavior domains (Crisp, 2006). The GAP uses a Likert scale to assess the degree to which students' beliefs about clinical practice are consistent with gay affirmative action, with higher scores indicating practice beliefs that are more consistent with gay affirmative action principles. Questions 1 to 15 measure a practitioner's beliefs and attitudes about treatment; questions 16 to 30 measure a practitioner's behaviors in the clinical settings. Responses are "strongly agree" (5) to "strongly disagree" (1) for the first 15 questions and "always" (5) to "never" (1) for the second group of questions. For the total GAP, scores range from range 30 to 150; the possible range for subscales is 15 to 75. Higher scores reflect more affirmative practice with LGBT clients.

RESULTS

Descriptive statistics were done using Statistical Package for the Social Science (SPSS) version 23 to provide a summary of the sample. Of the 47 students who completed the study, 41 were female (87 percent) and 6 were male. Ethnicity was similar across the three sites. The ethnic breakdown was Caucasian (n = 35, 74 percent) and black and Hispanic (11 percent each); one student was Asian, and one was Native Hawaiian/Pacific Islander. The mean age was 21 years old. Of this sample, 70 percent reported some religious affiliation, with 53 percent identifying as Catholic and 13 percent as Christian; 30 percent reported no religion.

To examine the hypothesis that a transgender simulation will enhance attitudes and beliefs related to LGBT patients and support affirmative practice, a Wilcoxon signed-rank test, a nonparametric test, was done to examine any differences between the paired samples. A two-tailed paired t-test could not be conducted to compare GAP scores before and after the simulation because parametric assumptions were not satisfied. The data were nonnormally distributed. A Wilcoxon signed-rank test revealed a statistically significant increase in GAP scores after the simulation (see Table 1). The median score on the overall GAP scale increased from 114 before to 125 after the simulation. These results suggest that, overall, the simulation supported nursing students' interactions and affirmative practice when providing nursing care to a transgender person.

Further analysis was performed on the subscales, Beliefs/Attitudes and Practice. The results showed a statistically significant difference in median scores between pretest and posttest related to practice behaviors (see Table 1). There was minimal change in median scores for beliefs/attitude, which was not statistically significant (see Table 1). The results suggest a significant positive change in affirmative practice after the simulation but no significant difference in attitudes and beliefs from pretest to posttest.

DISCUSSION

The evidence shows that with nursing curricula lacking in content that addresses LGBT health care needs, nurse educators are encouraged to identify ways to include this content in their respective nursing programs (Keepnews, 2011). Although integrating specific LGBT-related content in nursing education has begun, there is great room for improvement, especially noting the total number of hours spent on this content throughout the entire program (Walsh & Hendrickson, 2015). This transgender simulation was part of nursing students' psychiatric mental health nursing course and addressed issues for which transgender persons are at higher risk, such as depression, generalized anxiety disorder, panic attacks, and risk of harm by others (Brennan et al., 2012).

Table 1: Descriptive Statistics

Total Scores	n	Mean	SD	Percentiles 25th	50th (Median)	75th
Pre-GAP	48	112	25.99	100	113	128
Post-GAP	48	117	29.85	106	125	137
Preattitude	48	61	13.77	58	64	72
Postattitude	48	61	17.28	60	66	73
Prepractice	44	50	15.66	38	52	61
Postpractice	46	54	15.90	45	57	66

Note. Range for total GAP scores is 30-150; for subscales (attitude and practice), possible range is 15-75. Higher scores reflect more affirmative practice. GAP = Gay Affirmative Practice.

Test Statistics[a]	Total GAP Score	Subscale Attitude	Subscale Practice
	Post-GAP – Pre-GAP	Postattitude – Preattitude	Postpractice – Prepractice
z	–3.716[b]	–1.844[b]	–3.003
Asymp. Sig. (2-tailed)	.000*	.065	.003*

[a]Wilcoxon signed-ranks test; [b]Based on negative ranks; *p < .05, two-tailed.

As nursing students may not encounter patients who identify as LGBT during their clinical rotations, this simulation offered the opportunity to build their competencies. Students practiced skills in health assessment and communication and learned about the associated complexities of care when an individual is in the transition process. Just becoming comfortable asking questions with dignity and respect takes time. It is not uncommon for health care professionals to stumble on the correct use of pronouns as an individual transitions from female to male or male to female. It is important to ask clients how they would like to be addressed and then use the preferred term.

There is also a paucity of understanding of trans terminology such as gender role, gender identity, transsexual, or transgender. Defining each term is necessary to understand the LGBT culture and distinguish the diversity present in this community. Another challenge that nursing students may encounter is the social reaction clients often experience from family, friends, and coworkers, who may react to the transition negatively and treat the person differently. Nursing students were exposed to a few of the many challenges faced by LGBT individuals during the transgender simulation. The results revealed improvement in affirmative practice.

Self-awareness is an essential first step in developing a sensitivity and understanding for diverse populations such as LGBT. The debriefing for meaningful learning helped bring about a conscious awareness of potentially unknown biases and stigma — similar to not knowing what one does not know. This study noted that based on their median pretest/posttest GAP scores relating to attitude, with minimal change after involvement in the simulation and debriefing (64 versus 66), nursing students identify themselves as accepting of all cultures, races, ethnicities, and diversity, including the LGBT population.

Lim and Hsu (2016) reported in their integrative review that "nursing students may feel the need to state that they are capable of treating everyone alike" to invoke a socially desirable response (p. 151). Nursing students in this study were young (mean age 21) and may have exhibited a similar phenomenon. An article by Shaddock (2016), published in the *Hartford Courant,* classified this phenomenon as being "transfriendly" or accepting of this lifestyle while lacking sensitivity to the unique needs of this population and education specific to their health status. Lack of exposure to the LGBT population and lack of education on their health care needs in nursing programs may lead to a false sense of cultural competence by nursing students.

Limitations

There were several limitations in this study. Despite the potentially large number of students for recruitment, there was a large dropout rate. The final sample was small for a number of reasons. The delay in administering the posttest survey (one to four weeks) may have interfered with continued participation. Participants may have lost interest and did not see continued participation as relevant.

The administration of the instrument proved arduous to track at the regional campus sites due to distance at multiple campuses, resulting in a significant number of participants who did not complete the posttest survey. The GAP instrument could have presented limitations with nursing students with only two semesters of clinical practice and minimal exposure to the LGBT population. This became evident by the large numbers of incomplete data for the "practice" questions (16-30) leading to invalid data and 62 percent of the sample missing the posttest survey. Although the GAP survey was used previously to examine attitudes and beliefs of nursing students, an instrument specific to transgender persons and their unique health care issues might have been more applicable.

Although the use of multiple settings improved generalizability, it is important to acknowledge the small sample size, the use of a convenience sample, and the lack of randomization. Multisite studies can present challenges with data across all campuses.

Implications for Nursing Education

Lim and Hsu (2016) noted that most of the studies on nursing students' attitudes toward the LGBT population were done in single-site university settings, and there is a need for outcome research on LGBT affirmative practice. This multisite study adds to nursing education by integrating LGBT education in the nursing mental health syllabus and translating knowledge into affirmative practice through simulation. Further research across multiple sites with larger populations will continue to advance the knowledge gained from this study.

It would be beneficial to repeat this simulation with senior-level BSN students to examine if skills translate into affirmative practice over time. Lim et al. (2015) reported in their survey of nurse faculty that "one third indicated limited awareness of LGBT health issues" and the majority seldom or never taught content related to this topic. Therefore, training faculty is as important as educating students. Using this simulation with nurse faculty can be easily operationalized and important step to ensure they are supportive and engage in integrating LGBT education in other nursing courses. Creating different scenarios that cover issues across the lifespan, such as LGBT youths, and to address the complexities of health care needs such as surgeries for a transgender person who is in the process of transition are other ways to further advance this study.

CONCLUSION

This study demonstrated that simulation is an effective teaching strategy that can be readily incorporated into the nursing curriculum. Experiential learning is an effective approach to teach cultural competence and sensitivity in caring for vulnerable populations. It is only a beginning step to introducing the topic of health care needs for the LGBT population; threading this education throughout all nursing courses and future translational research should be done to determine the sustainability of affirmative practice over time. The benefit of simulation and debriefing for meaningful learning is to encourage self-examination and self-awareness of one's possible biases and knowledge deficits, vital steps to developing cultural competence and patient-sensitive care. It will also be important to examine faculty perceptions and knowledge base with this population to promote better learning for nursing students.

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A Concept Analysis of Cultural Sensitivity

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What is This?

A Concept Analysis of Cultural Sensitivity

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Cultural sensitivity is used ubiquitously, yet different meanings are constructed. An improved understanding of the term as described within health care and in general would enhance nurses' understanding and communication with professionals and clients. To uncover the current meaning of cultural sensitivity, a concept analysis was performed. Findings included the attributes of knowledge, consideration, understanding, respect, and tailoring. Necessary antecedents were diversity, awareness, and an encounter. The consequences were effective communication, effective intervention, and satisfaction. A definition of cultural sensitivity was proposed. Providers may benefit from recognizing and addressing the identified antecedents and attributes to obtain the positive consequences of employing cultural sensitivity.

Keywords: cultural sensitivity; concept analysis

The concept of cultural sensitivity has proliferated into a buzzword. By definition, buzzwords are "stock phrases that have become nonsense through endless repetition" (*WordNet*, 2001). *Cultural sensitivity* is utilized ubiquitously within multiple contexts from health care to business to education. An improved understanding of the term as described within health care and in general would enhance nurses' understanding and communication with professionals and clients. To uncover the current meaning of cultural sensitivity, a concept analysis was performed using Rodgers and Knafl's (2000) techniques.

Method

To "bridge the gap" between health care providers and recipients of care, a literature search across multiple disciplines should be performed, including popular media (Rodgers & Knafl, 2000, p. 87). In other words, examining literature outside of the discipline of nursing, such as education, psychology, or business, is helpful to find out how the term is used and interpreted globally. Therefore, the researcher performed an electronic search using several scholarly and popular databases. The term *cultural sensitivity* was chosen over the words *cultural competence* or *cultural care*, terms commonly used within nursing, to embrace the broadest audience possible. The decision was made to look for the term within the titles of articles as some databases have more refined search capabilities than others allowing for a systematic search

approach across disciplines. When the keyword *cultural sensitivity* was entered with a date range of 2000 to 2005, the Academic Search Elite database revealed 300 matches. All articles with the words *cultural sensitivity* or *culturally sensitive* in the title were pulled, yielding 18 articles for inclusion. In addition, the Cumulative Index to Nursing & Allied Health Literature (CINAHL) database was searched using *cultural sensitivity* as a keyword only for the year 2000, producing 20 articles with *cultural sensitivity* or *culturally sensitive* in the title. Further searches with a date range of 2000 to 2005 were completed in the Education Resourses Information Center (ERIC) database, Social Sciences in ProQuest, and Public Affairs Information Service (PAIS) International database by entering *cultural sensitivity* as a keyword only and selecting articles with *cultural sensitivity* or *culturally sensitive* in the title. Abstracts and headings of these articles were subsequently scanned for substantiality prior to selection. Google was searched using *cultural sensitivity* as a keyword, but with no date range; 7 articles listed within the first four display pages were chosen at random. After these recent literature searches were completed, ERIC and PsychInfo were examined for the earliest uses of the term *cultural sensitivity*, finding six

Table 1
Summary Table

Database Searched	Number of Articles Reviewed
Academic Search Elite	18
CINAHL	20
ERIC	13
Social Sciences in ProQuest	2
PAIS International	1
PsychInfo	2
Google	7

documents published in the 1960s and 1970s. In this ancestral search, *cultural sensitivity* was required as a keyword only. The combined searches lead to the review and analysis of 63 documents (see Table 1).

Rodgers and Knafl's (2000) techniques of concept analysis were utilized to guide the process. According to Rodgers, the purpose of analysis is "to define the concept of interest in terms of its critical attributes or 'essence'" (Rodgers & Knafl, 2000, p. 77). Rodgers provided the following evolutionary method of concept analysis, noting that the listed activities should not be interpreted as specific steps, as they often occur simultaneously:

1. Identify the concept of interest and associated expressions (including surrogate terms).
2. Identify and select an appropriate realm (setting and sample) for data collection.
3. Collect data relevant to identify
   a. the attributes of the concept; and
   b. the contextual basis of the concept, including interdisciplinary, sociocultural, and temporal (antecedent and consequential occurrences) variations.
4. Analyze data regarding the above characteristics of the concept.
5. Identify an exemplar of the concept, if appropriate.
6. Identify implications, hypotheses, and implications for further development of the concept (Rodgers & Knafl, 2000, p. 85).

The nature of the process is heuristic and inductive and should serve as a "foundation for further inquiry and development" (Rodgers & Knafl, 2000, p. 84).

More specifically, in conjunction with Rodgers's method (Rodgers & Knafl, 2000), each article was read and specific keywords and phrases that related to cultural sensitivity were highlighted. These keywords and phrases were placed on a grid with the headings of antecedents, attributes, or consequences. After completion of data entry, the grids were evaluated and words,

phrases, or themes that repeated across the disciplines were clustered together. The clustered words, phrases, and themes were analyzed and consolidated in the development of categories revealing the antecedents, attributes, and consequences.

Findings

Attributes

After synthesizing the data, five major headings that encompassed the attributes were formulated. "Identification of the attributes of the concept represents the primary accomplishment of concept analysis" (Rodgers & Knafl, 2000, p. 91). The following concepts emerged as attributes of cultural sensitivity: knowledge, consideration, understanding, respect, and tailoring.

Knowledge. To achieve cultural sensitivity, one must have knowledge of cultural differences and values (Center for Effective Collaboration and Practice, n.d.; Guidry, 2000; Josipovic, 2000; Kane, 2000; Parfitt, 2004; Percival & Black; 2000; Wasson & Jackson, 2002; Wilson, Baker, Brown-Syed, & Gollup, 2000; Zoucha, 2000). Knowledge is defined as "the range of one's information" (*Merriam-Webster's Dictionary of Law*, 1996). This knowledge can be acquired through training, education, or experience with a culture in a variety of contexts (Chan, Haynes, O'Donnell, Bachino, & Vernon, 2003; Godwin, 2001; Impink, 2002; Lasch, 2000; Morse, 2001; Mugeere, 2000; Murdaugh, Russell, & Sowell, 2000; Sallady, 2004; Warren, Henson, Turner, & O'Neill, 2004). In mental health, "it is important for the counselor to have knowledge of the norms, values, and attitudes of minority clients" (Scorzelli & Reinke-Scorzelli, 2001, p. 91). In reference to special education, one parent notes that if teachers and administrators were properly trained about culture, religion, and communication, children would receive quality education (Zionts, Zionts, Harrison, & Bellinger, 2003). In health care, "nurses need to know and respect the culturally grounded values, beliefs, and practices of clients to ensure safe, quality care and appropriate use of the health care system" (Raines & Morgan, 2000, p. 168). The importance of adequate physician knowledge in relation to cultural sensitivity has led to the imposition of legal mandates ("Institute for International Research," 2005). In the military field, it has been recommended that cultural sensitivity training be added to the basic training curriculum (Holt, 2002). Additionally, in the market of business, cultural training is linked as the key to success ("Local Relationships," 2003).

Consideration. A second attribute, consideration, is defined as "careful thought, deliberation, or taking into account; having concern or caring for others" (*The American Heritage Dictionary of the English Language*, 2000). One's background, language, and beliefs must be considered initially in order for cultural sensitivity to follow (Al-Krenawi & Graham, 2000; Armstrong, 2003; Cheng, 2000; Skelly et al., 2000; Tobin, Chen, Edwards, & Chan, 2000; Wilson et al., 2000). Parental perceptions of cultural sensitivity are related to the level of consideration of cultural beliefs and values by service providers (Zionts et al., 2003). This theme of consideration and caring is especially prominent in the health care setting. In approaching patients, "the first rule is to avoid cultural stereotyping and to be open, authentic, sensitive, and caring" (Lasch, 2000, p. 20). Considerations of diet, customs and traditions assist in culturally sensitive nursing care (Josipovic, 2000). When working with Hispanic clientele, personalized caring is important (Chan et al., 2003). To medically interview patients, the practitioner should express compassion (Dowdy, 2000). Social workers need to consider acculturation and its effect on families when working with the ethnic Arab client (Al-Krenawi & Graham, 2000). Physical therapists should take into consideration the personal beliefs, practices and needs of patients to provide cultural sensitivity (Bender, 2000). Throughout various perspectives, cultural sensitivity necessitates taking an individual or group's identity into consideration.

Understanding. A third essential attribute is understanding, and it is defined as "perceiving and comprehending the nature and significance of, or grasping" (*The American Heritage Dictionary of the English Language*, 2000). To provide cultural sensitivity, an individual must understand the effects and importance of another's values or experiences (Australian Flexible Learning Framework, n.d.; Guberman & Maheu, 2004; Josipovic, 2000; Percival & Black, 2000). Clinicians must attempt to understand their patients as well as convey understanding to them (Ganzer & Ornstein, 2002). "Trying to understand the world without ethnocentric glasses is not easy" (Parfitt, 2004, p. 1.), but necessary. A desire for understanding is a key ingredient in cultural sensitivity (Ethnic Harvest, 2004). "To succeed, one must be understanding of caregiving practices that are different or unfamiliar and be willing to give them a try" (Klinker, n.d., para. 1). Health care providers need to understand their patients' cultures to tailor their interventions to the patients' needs (Guidry, 2000). Cultural sensitivity involves understanding from both parents and teachers (Yang & McMullen, 2003). American teachers who do not have sufficient knowledge

about cultural backgrounds may end up misunderstanding students and parents (Yang, McMullen, & Benson, 2003).

Respect. The fourth attribute and a fundamental component of cultural sensitivity is respect (Holt, 2002; Hyun, 2002; Neill, 2000; Raines & Morgan, 2000; Zionts et al., 2003). In this analysis, respect is defined as "willingness to show appreciation or regard" (*The American Heritage Dictionary of the English Language*, 2000). In one study, parents' perceived level of respect was directly related to how well the school respected one's cultural beliefs and values (Zionts et al., 2003). Elementary school and college educators are urged to respect the cultural richness of students and incorporate culturally sensitive curricula (Percival & Black, 2000). In addition, "nurses must have an understanding and appreciation of the client's cultural expectations, [and] respect the client's needs" (Raines & Morgan, 2000). In dealing with the public, listening respectfully (Klinker, n.d.), and showing respect for one's culture and language are critical in integrating cultural sensitivity (Ethnic Harvest, 2004). "By developing both respect and acceptance . . . a social and cultural foundation is established for the creation of a unified society" (Godwin, 2001, para. 2).

Tailoring. The fifth and final attribute of cultural sensitivity is tailoring. Tailoring is defined as "to make, alter, or adapt for an individual or group" (*The American Heritage Dictionary of the English Language*, 2000). Along with having the knowledge, consideration, understanding, and respect for an individual, a tailoring or adaptation must take place in an attempt to meet one's needs and demonstrate cultural sensitivity. The altering or adapting can occur at two levels. First, the individual providing cultural sensitivity must "alter one's own perspective first, taking into account the perspective of others" (Van Hook, 2000, p. 70). The similar theme of tailoring occurred at the practice level, whereas an intervention is tailored to a client (Harris et al., 2001; Resnicow, Soler, Braithwaite, Ahluwalia, & Butler, 2000; Scorzelli & Reinke-Scorzelli, 2001). Many studies have indicated that tailored interventions are more efficacious than nontailored interventions (Harris et al., 2001). Tailoring can occur through a method of teaching, a way of approaching patients, selecting a treatment, a manner of providing care, the chosen content of military training, or in business planning (Holt, 2002; Jibaja, Sebastian, Kingery, & Holcomb, 2000; Kallstrom, 2000; "Local Relationships," 2003; Raines & Morgan 2000; Van Hook, 2000; Zoucha, 2000). Across various settings, cultural sensitivity involves tailoring a mindset or action to fit or match the recipient.

Antecedents and Consequences

Additional relevant data to the attributes of cultural sensitivity are the identification of the antecedents and consequences (Rodgers & Knafl, 2000). The antecedents are particularly important as they set the stage for the possibility of employing cultural sensitivity. The first group heading of the antecedents is diversity. Diversity means the differences of individuals from one another and encompasses belief systems, culture, language, religions, values, attitudes, norms, traditions, and barriers (Hugo, 2000; International Federation of Red Cross and Red Crescent Societies, 2005; Ulrey & Amason, 2001; Warren et al., 2004; Zoucha, 2000). The second antecedent is awareness. One needs to first be aware of one's own culture (Lu, Organista, Manzo, Wong, & Phung, 2001; Seibert, Stridh-Igo, & Zimmerman, 2002; Wasson & Jackson, 2002; Zoucha, 2000) and then be aware of differing cultural perspectives (Josipovic, 2000; Van Hook, 2000). The third antecedent is an encounter. To experience cultural sensitivity, one must come into contact with or have an experience with an individual of cultural difference (Akiba & Miller, 2004; Chan et al., 2003; Lasch, 2000).

The consequences of cultural sensitivity are constructive or positive in nature, demonstrating its importance in any discipline. The first consequence is effective communication. When cultural sensitivity takes place, the result is effective interaction with the client (Australian Flexible Learning Framework, n.d.; Bauer & Wayne, 2005; Yang & McMullen, 2003; Wasson & Jackson; 2002). Another consequence is that an effective intervention transpires after cultural sensitivity is incorporated. Interventions range from teaching methods to patient care to customer service (Guidry, 2000; Tobin et al., 2000). The third and final consequence is satisfaction. Parents, students, teachers, nurses, and patients alike feel satisfaction when cultural sensitivity is integrated (Raines & Morgan, 2000; Zions et al., 2003).

Based on the above analysis, the following definition of cultural sensitivity is provided: Cultural sensitivity is employing one's knowledge, consideration, understanding, respect, and tailoring after realizing awareness of self and others and encountering a diverse group or individual. Cultural sensitivity results in effective communications, effective interventions, and satisfaction (see Figure 1).

Limitations

Although this analysis sheds light onto the current meaning of cultural sensitivity, several limitations exist. First, rigor was compromised by varying search strategies across the disciplines, leading to some inconsistencies procedurally. The researcher did not impose date

Figure 1
Concept Analysis of Cultural Sensitivity.
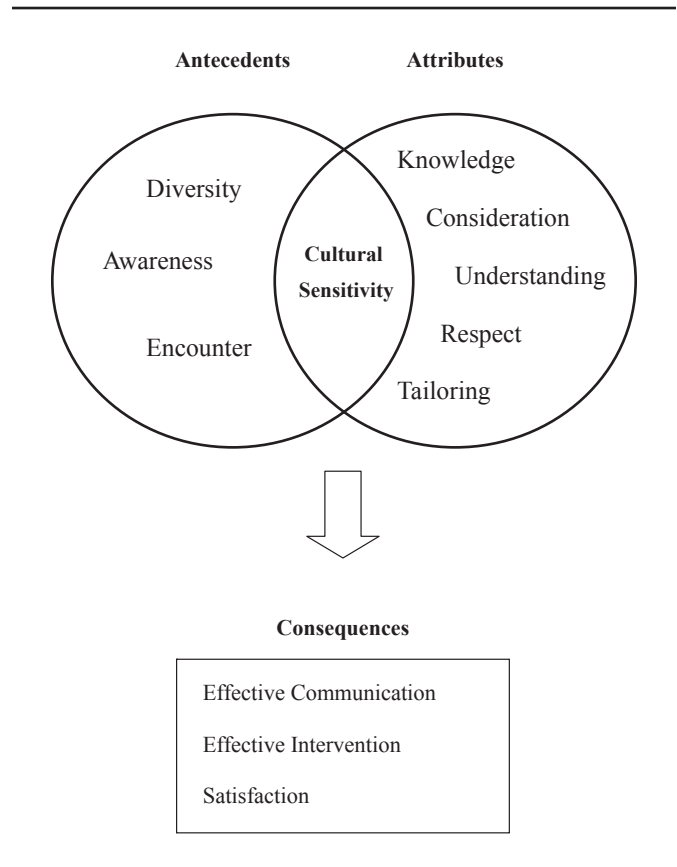
restrictions to documents found on Google but placed more stringent date restrictions on other databases. Incidentally, most articles pulled from Google were within a 5-year context. Second, some articles were included with the words *culturally sensitive* as opposed to *cultural sensitivity*, which may or may not influence meaning. After the literature was examined, a chasm in business literature was evident. It may have been more representative to search more business-related databases to elicit additional information.

Conclusion

Performing a concept analysis is a genuine and surprising exploration to discover meaning. Language is trendy, and select words and definitions can lend multiple interpretations and, hence, confusion. Concept analyses help us to maintain a grip of clarity and understanding of words, the primary elements of our communication framework. Studying the use of concepts in nursing as well as across various disciplines is worthwhile to understand what we say to each other as nurses, as well as understand

the public perception of the word. The findings of this analysis, including the figure and proposed definition of cultural sensitivity, may serve as an underpinning for theory generation, education, and practice in a multicultural society. In preparing for any culturally sensitive intervention, providers may benefit from recognizing and addressing the identified antecedents and attributes to obtain the positive consequences of cultural sensitivity.

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