Journal of Transcultural Nursing
22(1) 7–14

DOI: 10.1177/1043659610387147
http://tcn.sagepub.com
SAGE

A Guide to Developing a Culturally Competent Organization

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Abstract

The journey to organizational cultural competence for a health care organization, educational setting, freestanding clinic, or long-term-care organization is a process that requires the collaborative efforts from people at all levels in every department as well as external consumers such as public policy officials, students, and community leaders. Broadly speaking, four main but overlapping areas must be considered in institute activities and strategies to accomplish a comprehensive culturally competent organization. These four areas are (a) administration and governance, (b) orientation and education, (c) language, and (d) staff competencies. This article presents key content areas and activities to consider on the journey to cultural competence. Tables with suggested departmental responsibilities for implementation are included. In some cases, the journey may best be facilitated by a consultant who is well versed in cultural competence and organizational dynamics.

Keywords

organizational culture, workforce diversity, transcultural health

Introduction

The journey to cultural competence for an organization, whether it is a health care establishment, educational concern, freestanding clinic, or long-term-care organization, is a process that involves every department. Organizational cultural insensitivity can pervade all aspects of the organization, requiring the collaborative efforts of the organization's key players and stakeholders with inclusion of personnel at all levels. Resources must be dedicated for achieving organizational cultural competence. Seemingly, this journey also involves the organization's consumers, which include patients, students, community members, and policy makers.

Attention to cultural competence is a topic of paramount interest as it is a frequent topic in the business literature, particularly among international settings, because diverse groups must relate effectively to have positive outcomes (Rijamampianina & Carmichael, 2005). For example, Graen (2006) describes the need to develop groups to identify cross-cultural conflicts and ways to cope with insensitivities by building on the third-culture bonding approach to the GLOBE movement fathered by Robert House (Graen, Hui, & Gu, 2004; Gupta & House, 2004; House, Hanges, Janidan, Dorfman, & Gupta, 2004; Javidan, Dorfman, Sully de Luque, & House, 2006). The GLOBE approach is a research methodology that builds best practice norms to leadership and development by studying cultures rated to Anglo-American cultural management issues and constructs. Fox (2006) noted that managers need diverse cultural information to deal with foreign counterparts. McFarland (2006) noted the importance of cultural adaptation and that the inability to adjust to the host culture was a major stress for 40% of expatriates who failed during their foreign assignments. Those who experienced the most stress reported being culturally "unprepared" and that their cross-cultural preparation program was too brief and did not prepare them for differences. They also reported a lack of support for adjusting to ongoing cultural

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diversity. In contrast to an abundant literature on adjusting to diversity in organizational business situations, there is a dearth of literature on attaining organizational competence in health care settings.

Because of the different meanings people attach to the word *diversity*, the journey to cultural competence begins by broadly describing ethnocultural diversity and being inclusive of age, gender, socioeconomic, educational, and religious backgrounds of patients and staff. Although this broad description is commendable, some cultural and subcultural groups, either consciously or unconsciously, will be victims of cultural insensitivity. For others, overt discrimination and racism may occur. Because the majority group(s) usually holds the power and creates the dominant organizational culture, extreme care must be exercised to assure that no one group is forgotten. Otherwise, the organization might unknowingly engage in cultural imperialism, the practice of extending the policies and practices of one group (usually the dominant one) to disenfranchised and minority groups, and cultural imposition, the intrusive application of the majority group's cultural view on individuals and families (Purnell, 2001; Universal Declaration of Human Rights, 2001).

Cultural competence in a care setting is defined as having the knowledge, understanding, and skills about a diverse cultural group that allows the health care provider to provide acceptable cultural care. Competence is "an ongoing process that involves accepting and respecting differences and not letting one's personal beliefs have an undue influence on those whose worldview is different from one's own" (Purnell & Paulanka, 2008, p. 10). Cultural competence may be defined in a variety of ways. According to Giger and Davidhizar (2008), cultural competence is "a dynamic, fluid, continuous process, whereby an individual, system, or healthcare organization finds meaningful and useful care-delivery strategies based on knowledge of the cultural heritage, beliefs, attitudes, and behaviors of those to whom they deliver care" (p. 8.). Cultural competence is a continuous and conscious process, which is not necessarily linear and includes having general as well as specific information about a culture so the health care provider knows what questions to ask (Purnell & Paulanka, 2008). The expert panel on cultural competence of the American Academy of Nursing further synthesizes these various definitions:

> Cultural competence is having the knowledge, understanding, and skills about a diverse cultural group that allows the healthcare provider to provide acceptable cultural care. Competence is an ongoing process that involves accepting and respecting differences and not letting one's personal beliefs have an undue influence on those whose worldview is different from one's own. Cultural competence includes having cultural general as well as cultural specific information so the healthcare provider knows what questions to ask. (Giger et al., 2007, p. 100)

According to Giger and Davidhizar (2008), culturally sensitive environments are important in the delivery of culturally competent health care. When cultural competency is considered from an organizational point of view, four key components are included: (a) administration and governance, (b) orientation and education, (c) language services, and (d) staff competencies. These four components are much broader than just hiring a certain percentage of staff who reflect a racially diverse community and attaining the common fallacy when hiring minorities that suggests, "We'll take you in but you will have to be like us."

Assessing an Organization's Cultural Competence

The first step in organizational cultural competence is an assessment of the organization's strengths, weakness, and capacity in each of the aforementioned areas. Bean (2006) believes that every organization should have its own research for the evaluation of cross-cultural competence. A variety of strategies may be identified and activities implemented to accomplish organizational competence.

Administration and Governance

The administration and governance of the organization are primarily responsible for assuring that organizational cultural competence occurs. From the perspective of this article, *administration* includes all department heads, and *governance* includes the Board of Trustees. Board members are usually selected for their economic status or expertise; however, the Board must also reflect the ethnic diversity of the community served. Although many activities will be delegated to individuals and committees, these areas are responsible for the overall organization's journey to cultural competence.

An organization must distinguish between policies on cultural sensitivity and competence and patient and staff safety issues. For example, one organization whose administrators found tattoos objectionable added to the dress code "tattoos need to be covered." Obviously, this example has potential for additional discord in the organization because many of the younger generation as well as others have small tattoos on their neck, ankle, and other places and would not present a safety concern for patients or staff. Management personnel were concerned and fearful of their rights to enforce professional standards when confronted with a rationale that the practice was based on culture. The only legally restricting parameter relates to protective groups, that is, race, gender, age, nationality, disability, and religion. If "nobody can do it, it isn't discrimination." Staff and administration need to feel secure in their actions and not be overly sensitive if there is a complaint that is related to "culture."

One must appreciate that the census definitions of race are very limiting and make it difficult to compare current

data with previous census data. According to anthropology, only three races exist: mongoloid, Caucasoid, and negroid (Haney-Lopez, 1994). Discrimination and different definitions of race, ethnicity, and culture can be both subtle and overt. The U.S. Bureau of the Census allows individuals to make selections that include both race and ethnicity.

To be inclusive, the board of governance must include members of the ethnicity of the community it serves as does the ethics committee. Administration is responsible for developing a mission statement and philosophy that address diversity. To demonstrate community responsiveness, the organization should engage in community diversity fairs and help organize wellness days with health screenings. The organization must network and partner with ethnic community agencies. In networking, the organization meets with people who can be of help to each other. In partnering, a mutually beneficial business-to-business relationship exists and is based on a commitment that enhances the capabilities of both (Investment Dictionary, 2006). When both internal and external stockholders participate, programs are more likely to reflect the needs of the community. Otherwise, maternal child services may be increased but what is really needed might be geriatric, HIV, or oncology services to name a few.

Administration's strategic plan must reflect the needs of the community. A Diversity Committee for cultural competence should include staff, managers, chaplains, and members who are representative of the community. One fallacy is that an organization must have a minority member to head the Diversity Committee. In reality, the best person to head this committee is someone who has proven leadership abilities to reach consensus in diversity and inclusion issues (Peabody Institute, 2006).

Internal human and financial resources must be allocated to diversity training. Some organizations need to seek fiscal resources from federal, state, and private agencies to assure organizational cultural competence. Human resources may also be helpful, especially consultants who are generally available at no cost to organizations if they come from state or federal organizations.

To help determine if the organization is reaching ethnocultural groups in their catchment area, administrators need to ask some salient questions (a) are the organization's programs advertised in community newspapers and on the radio and television in the languages of the community and (b) do pictures and posters reflect the client population? If ethnic groups do not see pictures and posters reflective of their group, they may not feel welcome. For example, if the organization sees large numbers of Native Americans, then pictures that portray Native American populations should be displayed. Advertising programs in a major English newspaper may not be helpful if the ethnic community does not have a high literacy rate in English.

If staff is used for interpretation, here should be a written plan in place to address coverage of their regular job duties while interpreting for patients and staff, which is a requirement of the Joint Commission on Accreditation of Healthcare Organizations. Frequently, members of the staff are called from one unit to another to interpret and conduct intake assessments, leaving their units inadequately covered.

The human resources department, as a major part of administration, frequently has the oversight responsibility for organizational wide policies and procedure. Recruitment and hiring activities should reflect the diversity of the community along with active recruitment of bilingual staff with consideration of higher pay if they are certified. Position descriptions and performance evaluations must reflect cultural competence. This department must ensure that policies address bias and prejudices of staff and clients. Some questions that Human Resources should ask are the following: (a) Do conflict and grievance procedures reflect the languages of the staff? (b) Is there a holiday calendar representing the client and staff population base? (c) Is there a mentoring program to entice recruitment into the health professions, which is one area where ethnic matching may be highly desirable.

An organization needs to determine what type of data to collect. Should the data collection process include race, ethnicity, culture, and language preferences? For example, if data collection centers only on race such as African American/Black, then populations such as Nigerians, Haitians, and others may be missed. This information is important even for the dietary department to determine if food choices reflect the staff and patient preferences. If pediatric patients are seen, culturally appropriate toys should be made available, for example, Hispanic and Black Santas and Black, Jewish, and Muslim dolls (see Table 1).

Orientation and Education

Every organization has a responsibility to orient new employees and provide in-service and continuing education. In most places, orientation and in-service education are shared between a centralized department responsible for the overall organization and for department-specific activities. The following are questions and content areas for assessing the journey to organizational cultural competence.

Orientation and education activities must be present at all levels of the organization to help assure that the staff is culturally sensitive and competent: this includes the chief executive officer, physicians and other professional staff, unlicensed assistive care providers, and maintenance and housekeeping staff. Insight related to general self-efficacy to cope with cultural diversity must be included (Luszczynska, Scholz, & Schwarzer, 2005).

In addition to orientation, mentoring programs should exist for diverse student and staff populations. A mentor knows the dominant culture and system and is also familiar with the cultural of the new employee. The diversity of heath

Table 1. Assessment Guide: Administration and Board of Governance Responsibilities

Activity	Yes	No	Comments
Mission and Philosophy include statements on diversity and inclusion.			
Board of Trustees is reflective of the diversity of the community.			
Ethics committee exists and reflects the patients and staff.			
Fiscal resources are allocated to diversity training.			
Policies address discrimination, bias, and prejudice of staff.			
Data collection includes patient race, ethnicity, culture, and language preferences.			
The organization engages in community diversity fairs that address health promotion and wellness; illness, disease, and injury prevention; and health maintenance and restoration.			
The organization networks and partners with community ethnic and faith-based organizations.			
Strategic plan reflects the needs of the community.			
Organization's programs are advertised in community newspapers, on the radio and television, in grocery stores, and at bus stops and other transportation centers.			
The community is surveyed to determine programs and services that are needed.			
The organization seeks local, state, and federal funds for diversity initiatives as needed.			
Videos are representative of the diversity and languages of the patients.			
Research priorities reflect the needs of the community.			
Satisfaction surveys are in the languages of the populations served.			

Table 2. Assessment Guide: Human Resources Responsibilities

Activity	Yes	No	Comments
Pictures, posters, and calendars representing the diversity of the patient and staff are posted throughout the organization.			
Cultural resources reflect the patient population and are available to staff.			
Recruitment and hiring activities are reflective of the community.			
Culturally diverse holidays reflective of the patients and staff are celebrated.			
Bilingual staff is recruited.			
Diversity classes are initiated for administrators, professionals, and other care providers.			
Issues related to autonomy and culture are addressed in orientation and with current employees if needed.			
Mentoring programs are initiated for culturally diverse staff.			
Positions descriptions and performance evaluations include statements on diversity and inclusion.			
Conflict and grievance procedures reflect the languages and ethnicity of the staff.			
The organization engages in activities that address health literacy of the populations served.			
English as a second language classes are held for employees.			
Written documents undergo a cultural-sensitivity review to assure neutral language.			
Staff surveys are in the languages of the populations employed.			

professions should be included in orientation. Not all staff are familiar with the diversity of health professions seen in the United States, such as occupational therapist, physical therapists, and radiology technicians, to name a few. Issues related to culture and workforce autonomy should be discussed in orientation and adequate time allotted to cover what is important. Although all groups exercise assertiveness to some degree, the manner in which assertiveness is displayed can be quite different.

With globalization and the increased use of foreign-educated employees who are unfamiliar with the U.S. insurance system, this is a necessity. Nursing care delivery systems should be explained during orientation. With many professionals from foreign countries working in the United States, it is likely that not all of them are familiar with the defensive U.S. charting system and nursing care delivery systems. The role of health insurance reimbursement needs to be explained during orientation. Certification for cultural competence should also be offered.

If the organization engages in clinical research, input on research priorities should be sought from consumers and staff. An attempt needs to be made to obtain researchers who are reflective of staff, clients, and the community (see Table 2).

Language

A third component to assess on the journey to cultural competence is language. Research has demonstrated that language

is the biggest barrier to quality health care (U.S. Department of Human Services Office of Minority Health, 2004). In culturally competent organizations, there are several areas to assess with regard to language, which overlaps with other components. For example, sometimes organizations are misguided and spend money on items that do not result in increasing cultural competence, such as posters proclaiming "we are all one race" and "lose your accent." They may be well intended and make an organization feel sensitive, but this is misguided.

Staff must acknowledge and realize when there is lack of congruency between the languages of staff and patients, especially with the use of colloquialisms and slang as well as the use of homonyms and other similar-sounding words or phrases. An example follows: An immigrant nurse from India was at work and told her supervisor that she had a headache. The supervisor suggested that she take Aleve. The nurse did not report to work the next day because she was not familiar with trade name drugs and thought her supervisor suggested "a leave" from work. Other examples of misguided language competency are signs posted in the admission office stating, "If you can read this sign (sign in English), you do not need an interpreter." In this example, if the patient cannot read, no other opportunity is available. Patients' rights documents should be translated into the major languages in the community. Interpretation and translation resources are a federal mandate, not elective. Interpretation is verbal; translation is written.

Waiting areas should have literature in the languages of the populations served and directions to referral facilities in the languages of the populations served. The authors recognize that it may not be possible to have literature in the languages of all groups seen in the organization, but the major language groups should be available, depending on the population it serves—for example, Spanish, Russian, French, and so on. Mechanisms should be in place for translation and interpretation, and staff should know about them. In addition, policies addressing interpretation should be available along with resources for translation of educational materials in the languages of the populations served. The organization should also engage in activities that address health literacy of the populations served and have written documents undergo a cultural sensitivity review, which is something for the Diversity Committee to explore. This may be an exceptionally difficult task to accomplish because agreement on neutral language is difficult within ethnocultural groups, some of which is based on educational and socioeconomic status and the stigma that may be attached to mental health and other issues. Consent and procedure forms should be translated into the languages of the population served. Obviously, this is an ongoing process and one that might be ever expanding.

English as a second language classes could be held for staff. If an organization hires people who find English difficult, it has an obligation to help them learn English in order to decrease communication barriers. Videos could have pictures of and be in the languages (including sign language) of the populations served. The need for an interpreter should be determined ahead of time. The telephone system should have a menu for diverse languages. Some of the satisfaction surveys should be in the languages spoken in the communities. If surveys are only in English and 40% of the population served does not speak English, the survey results are not valid and cannot be used well for long-range planning. Staff surveys should also be in the dominant languages spoken by staff. In addition, wellness and health promotion classes should be offered in the languages of the client base.

If staff engages in behavior that is insensitive, lacks cultural understanding, or reflects prejudice, it should never be tolerated. Moreover, some individuals are not aware that their comments are racially, ethnically, or stereotypically offensive or negative. Staff should also discourage racial and ethnic slurs among their coworkers (see Table 3).

Staff Competencies

The fourth component of organizational cultural competence to assess is staff competencies. Staff can never learn all the diverse cultures of the world. However, direct-care staff should be provided a general cultural framework for assessment as well as having culture-specific knowledge about clients to whom they provide care—Russian, Hispanic, Bosnian, and so on (Giger & Davidhizar, 2008; Purnell, 2009). The more knowledge staff has about specific cultures, the better the assessment. Pharmacists, nurses, and physicians should be educated in ethnopharmacology. The professional literature is sparse in this area; however, professionals must be alert to unproven "designer drugs" for specific ethic and racial populations. A "lunch and learn" series related to the specific cultural groups of patients and staff might be helpful. Intake forms of each discipline should reflect a cultural assessment and include pain scales in the diverse languages of the population served. The Culturally and Linguistic Appropriate Services are a starting point to guide language services throughout the organization.

Staff must accept responsibility for their own education by attending conferences, reading research literature, observing cultural practices, and so on. As professionals, staff are responsible for their own continuing education, although clinical department heads and mangers need to encourage and provide financial resources for attendance at cultural conferences.

One of the best ways for staff to learn about culture is to have an understanding of their own culture and worldview and avoid letting it have an undue influence on those from other backgrounds (Purnell, 2009). They must (a) not assume that their culture is the same as the client's culture, (b) demonstrate acceptance and respect for cultural differences,

Table 3. Assessment Guide: Hospital Education Responsibilities

Activity	Yes	No	Comments
Role of health insurance reimbursement is addressed in orientation.			
Diversity of the health professions is included in orientation.			
Organizational diversity is addressed in orientation.			
Staff is offered classes that provide general cultural as well as culture-specific knowledge.			
Interpretation services are available and staff is aware of them.			
Major patient documents are translated into the languages of the clients served.			
Cultural references such as books, articles, and web-based resources are available on patient units and in the library.			
Teaching materials are in languages of the staff and patients and are on the organization's internal television system.			
Cultural and Linguistic Appropriate Standards are used.			
A system is in place that assesses the need for an interpreter for elective surgery and scheduled admissions.			
The telephone system has a menu for diverse languages.			
A cultural brokering/mentoring program is initiated for new employees.			
Pharmacists, physicians, and nurses are educated in ethnopharmacology.			
Researchers are reflective of the staff, clients, and community.			
Certification is offered in cultural competence and at different levels.			
Staff take responsibility for their own education in culture by attending outside conferences, reading literature, and observing cultural practices.			

Table 4. Assessment Guide: Nursing Department Responsibilities

Activity	Yes	No	Comments
Culturally appropriate toys are available on pediatric units, in the emergency department, and in reception areas where children are likely to be.			
Pain scales are in the languages and ethnicity of patients.			
Intake forms reflect cultural assessment.			
Nursing care delivery systems are described during orientation.			
Videos that are representative of the diversity and languages of the patients are available.			

Table 5. Assessment Guide: Dietary Department Responsibilities

Activity	Yes	No	Comments
Food pyramids are available and reflective of the patients' languages and ethnicity.			
Food selections are available in the ethnicity of the staff and patients.			

(c) resist judgmental attitudes such as "different is not as good" (Giger and Davidhizar, 2008; Purnell, 2009; Purnell & Paulanka, 2008), and (d) be open to cultural encounters (Campinha-Bacote, 2006). Staff must continue to learn about the cultures of clients to whom they provide care (McFarland, 2006) and demonstrate knowledge of the health beliefs and meanings of health and illness of diverse clients (Giger & Davidhizar, 2008).

For culture-specific information, staff should have knowledge of practices to maintain health and wellness and respond to illness and death and dying, the rituals around which vary across culture and religions (Davidhizar, Bechtel, & Juratovac, 2000; Dowd, Poole, Davidhizar, & Giger, 1998; Giger & Davidhizar, 2008; Purnell, 2009; Purnell & Paulanka, 2008; see Table 4).

Staff must avoid stereotyping by recognizing that the primary and secondary characteristics of culture determine the degree of adherence to one's dominant culture. Primary characteristics of culture are age, generation, nationality, race, color, gender, and religion. Secondary characteristics of culture are educational status, socioeconomic status, occupation, military status, marital status, parental status, gender issues, urban versus rural residence, physical characteristics, sexual orientation, and reason for migration (sojourner, immigrant, or undocumented status; Purnell & Paulanka, 2005; Purnell, 2009; see Table 5).

Identify Strengths and Weaknesses

The journey to cultural competence includes identifying strengths and weaknesses and the capacity for increasing organizational cultural competence. An organization with a financially robust status may need less outside help and be able to make the journey faster than a smaller or less fiscally robust organization. The strengths, weaknesses, and capacity emerge from the organization's self-assessment. Strengths are used as assets on which to build. Moreover, staff should be recognized and commended for their assets and strengths rather than be criticized for their weaknesses. Whenever possible, administrators and managers should personally give positive affirmation in newsletters, posting notes on staff bulletin boards, and place memos in the personnel files of staff.

The weaknesses identified in the organizational assessment can be used to design strategies and activities for increasing organizational cultural competency. Carefully selecting activities and departments, persons, or committees responsible for their implementation with a cost/benefit ratio is important.

The first activities and strategies can be implemented with minimal financial, time, and personnel resources. The second round of activities and strategies that are selected can be accomplished in 1 or 2 years. Finally, long-range activities that require significant outlay in human and fiscal resources can be undertaken. The overall plan must have administrative support with identification of goals, the department(s) or individual(s) responsible for implementation, and a plan to measure their success.

Ongoing Evaluation

Regardless of the activities and strategies to ensure cultural competence, ongoing evaluation is essential to the success of the plan. It is important to determine initially what and who should be evaluated. The evaluation should be tailored to the strategies that are being implemented or to the core measures that are identified at the beginning of the process. The evaluation plan should include both qualitative and quantitative measures. Evaluation data must be communicated to all those involved in the process so that ongoing feedback can be obtained.

Summary

As cultural competency has become the buzzword of the day, and personnel and agencies report they have cultural competence, it is important to carefully assess to what degree competency is present. What can be done to decrease the lack of competency that may permeate the organization is also important. A resource of websites, journals, books, and articles for additional reading is provided in the appendix at http://tcn.sagepub.com/supplemental. An attempt was made to obtain resources from several countries.

Authors' Note

This article is the work of the Expert Panel on Cultural Competence of the American Academy of Nursing. Some of the panel members are listed as primary authors.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interests with respect to the authorship and/or publication of this article.

Funding

The author(s) received no financial support for the research and/or authorship of this article.

References

Bean, R. (2006). Cross-cultural competence and training in Australia. *Diversity Factor, 14*, 14-22.

Campinha-Bacote, J. (2006). *The process of cultural competence in the delivery of healthcare services*. Retrieved from http://www.transculturalcare.net/Cultural_Competence_Model.htm

Davidhizar, R., Bechtel, G., & Juratovac, A. (2000). Responding to the cultural and spiritual needs of clients. *Journal of Practical Nursing, 50*(4), 20-24.

Dowd, S., Poole, V., Davidhizar, R., & Giger, J. (1998). Death, dying, and grief in a transcultural context: Application of the Giger and Davidhizar assessment model. *The Hospice Journal, 13*(4), 33-47.

Fox, C. (2006). International business negotiator. *British Journal of Administrative Management, 53*, 20-22.

Giger, J., & Davidhizar,R. (2008). *Transcultural nursing: Assessment and intervention*. St. Louis, MO: Mosby.

Giger, J., Davidhizar, R., Purnell, L., Harden, J., Phillips, J., & Strickland, O. (2007). American Academy of Nursing Expert Panel Report: Developing cultural competence to eliminate health disparities in ethnic minorities and other vulnerable populations. *Journal of Transcultural Nursing, 18*, 95-102.

Graen, G. B. (2006). In the eye of the beholder: Cross-cultural lesson in leadership from project Globe: A response viewed from the third culture bonding (TCB) model of cross-cultural leadership. *Academy of Management Perspectives, 20*(4), 95-101.

Graen, G., Hui, C., & Gu, Q. (2004). A new approach to intercultural cooperation. In G. B. Graen (Ed.), *New frontiers in leadership* (pp. 225-246). Greenwich, CT: Information Age.

Gupta, W., & House, R. (2004). Understanding leadership in diverse cultures. In D. Tjosvold & K. Lueng (Eds.), *Leading in high growth Asia* (pp. 13-54). Singapore: World Scientific.

Haney-Lopez, I. F. (1994). The social construction of race: Some observations on illusion, fabrication, and choice. *Harvard Civil Rights-Civil Liberties Law Review, Winter.* Retrieved from http://academic.udayton.edu/race/01race/race.htm

House, R., Hanges, P., Janidan, M., Dorfman, P., & Gupta, V. (Eds.). (2004). *Leadership, cultures, and organizations: The Globe study*. Thousand Oaks, CA: Sage.

Investment dictionary. (2006). Retrieved from http://www.investordictionary.com/definition/partnering.aspx

Javidan, J., Dorfman, P., Sully de Luque, M., & House, R. J. (2006). In the eye of the beholder: Cross cultural lessons in leadership from project GLOBE. *Academy of Management Perspectives, 20*(1), 67-89.

Luszczynska, A., Scholz, U., & Schwarzer, R. (2005). The general self-efficacy scale: Multicultural validation studies. *Journal of Psychology, 139*, 439-457.

McFarland, J. (2006, January). Culture shock. *Benefits Canada, 30*(1), 31.

Peabody Institute. (2006). *Diversity home page*. Retrieved from http://www.peabody.jhu.edu/diversity

Purnell, L. (2001). Cultural competence in a changing health-care environment. In N. L. Chaska (Ed.), *The nursing profession: Tomorrow and beyond* (pp. 451-461). Thousand Oaks, CA: Sage.

Purnell, L. (2009). *Guide to culturally competent health care*. Philadelphia, PA: F. A. Davis.

Purnell, L., & Paulanka, B. (2008). *Transcultural health care: A culturally competent approach* (3rd ed.). Philadelphia, PA: F. A. Davis.

Rijamampianina, R., & Carmichael, T. (2005). A framework for effective cross-cultural co-opetition between organizations. *Problems and Perspectives in Management, 4*, 92-103.

Universal Declaration of Human Rights. (2001). Retrieved from http://www.amnesty.org/en/universal-declaration-human-rights-anniversary

U.S. Department of Human Services, Office of Minority Health. (2004). *Physician Toolkit and Curriculum*. Retrieved from http://minorityhealth.hhs.gov/assets/pdf/checked/toolkit.pdf