Achieving Cultural Competency with Lesbian, Gay, Bisexual, and Transgender (LGBT) Patients through Application of Carper's Fundamental Patterns of Knowing in Nursing

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Vulnerable Groups

Vulnerable groups with respect to health care are those susceptible to heightened adverse physical, psychological, or sociological health because of their particular status within society (De Chesnay & Anderson, 2008). Nurses and other health care professionals who work with non-institutionalized patients regularly provide care for members of vulnerable groups (Bailey, 2010). "Vulnerable populations include individuals living in poverty, those having immigrant status, people of color, and people who are marginalized by their sexual preference and/or religion" (Bailey, 2010, p. 55). The United Nations Committee on Economic, Social and Cultural Rights (CESCR) identifies additional societal states that generate vulnerability, such as disability, nationality, marital and family status, place of residence, and economic condition (Chapman & Carbonetti, 2011). Women and children are vulnerable to a myriad of vulnerabilities, predominantly violence, as are the chemically dependent and the mentally ill (De Chesnay & Anderson, 2008). Vulnerable groups experience higher morbidity and mortality rates compared with other groups in the community (Bailey, 2010). Health disparities are common among vulnerable groups, including disproportions involving cancer screening and treatment, infant mortality rate, diabetes, cardiovascular disease, and HIV or AIDS infection (Brusin, 2012). Known marginalized groups are particularly susceptible to such disparities within health care settings. "Marginalized people experience discrimination, poor access to health care, and resultant illnesses and traumas from environmental dangers or violence that make them vulnerable to a wide range of health problems" (De Chesnay & Anderson, 2008, p. 25).

Cultural Competency

It is essential that nurses acquire cultural competency to provide quality nursing care to vulnerable patients. The term "culture" implies a communal conditioning of a person's attitudes, knowledge, beliefs, experiences, values, gender roles, family roles, and general worldview

(Brusin, 2012). "Cultural competency" has many definitions. De Chesnay and Anderson (2008) describe it as a means of professional practice that requires sensitivity and respect for a client's cultural differences (p. 25). Cultural competency is the ongoing engagement of a client that requires the assimilation of knowledge and awareness regarding the diversity of the client's unique life experience (Munoz, DoBroka, & Mohammad, 2009). Brusin (2012) describes it as the ability to provide care to diverse clients that satisfies their linguistic, social, and cultural needs (p. 130). Leininger and McFarland developed the concept known as "transcultural nursing," which demands sensitivity toward the client's perceptions of illness and treatment to provide appropriate interventions (Munoz, et al., 2009, p. 496). According to Bailey (2010), cultural competency involves the "biogenic mode" of Hallorsdottir's Theory, *i.e.*, the process whereby "one affirms the personhood of the other by connecting with the true center of the other in a life-giving way" (p. 55). Each of these definitions is valid.

Cultural competency requires the nurse to provide "patient-centered care" (Brusin, 2012, p. 130). Nurses acquire an ethical motivation to promote culturally competent care when they achieve an understanding of a client's culture (De Chesnay & Anderson, 2008). Nurses who practice with empathy, support, and assume a non-biased position positively affect patient outcomes (De Chesnay & Anderson, 2008). As simple as the concept appears, it requires the nurse to do more than just smile and approach the patient in a friendly fashion. Rather, it involves internal self-reflection and the acquisition of specific skills. The achievement of cultural competency mandates that the nurse must distinguish the singular, unique characteristics of each individual client through exploration of the client's needs, values, preferences, and beliefs (Brusin, 2012). The nurse can act accordingly only after he or she becomes aware of his or her own perfunctory assumptions and personal biases (Brusin, 2012). We as human beings process a myriad of thoughts within microseconds, the majority of which often are oblivious to us. Within

the psychiatric or chemically dependent rehabilitation settings, often the recidivism of a client elicits the thought: "He stopped taking his medication again," or "She just doesn't want to help herself." As quickly as the thought arises, the nurse internalizes it, often without conscious awareness that this assumption will negatively affect his or her provision of nursing care to that client.

Personal bias is a form of ethnocentricity (Munoz, et al., 2009). A nurse unaware of a particular diverse culture, perhaps because of non-exposure to it, tends to respond to a client from that culture with either stereotyping or "superficial declarations of tolerance for everyone" upon initial contact (Munoz, et al., 2009, p. 498). This generally progresses to a negative evaluation of that culture and elevation of the nurse's own culture as superior (Munoz, et al., 2009). Support exists for the contention that evidence-based knowledge can overcome conscious bias (Brusin, 2012). Conquering unconscious bias, however, requires the active accomplishment of specific goals (Brusin, 2012). Unconscious, per definition, denotes a legitimate lack of awareness that the bias exists within oneself. Nonetheless, its effects are objectively observable. A nurse may avoid a patient entirely or avoid eye contact with that patient (Brusin, 2012). His or her communication with that patient may reflect incongruences among pitch, tone, or expressed affect (Brusin, 2012). Posture or body language can convey non-verbal negative attitudes or feelings (Brusin, 2012). Such behaviors tend to communicate feelings of dislike, disgust, or apathy.

Homophobia and Heterosexism

The lesbian, gay, bisexual, and transgender (LGBT) group is vulnerable within a variety of areas, notwithstanding the health care arena, because of homophobia and heterosexism. "Homophobia is defined as the irrational fear or hatred of one who is homosexual, being in close contact with that individual, displaying anti-homosexual attitudes and behaviors, as well as

feeling that discrimination toward homosexuals is justified" (Dinkel, Patzel, McGuire, Rolfs, & Purcell, 2007, p. 1). "Heterosexism is defined as the assumption that another person is heterosexual and is viewed as normative in the United States" (Dinkel, et al., 2007, p. 1). Homophobia itself tends to translate into one's "fear of homosexuality in oneself," fear of confrontation with sexual propositions, or fear of one's already accepted sexual orientation (Christensen, 2005, p. 62). Homophobia and heterosexism are often the causes of discrimination in the housing market, within the legal system, and in the workplace (Brown & Henriquez, 2008). All too frequently they cause hate crimes, such as the barbaric murder of Mathew Shepard, and adolescent suicide (Brown & Henriquez, 2008). Families, friends, and churches often reject LGBT individuals, leaving them isolated and without social supports (Green & Feinstein, 2011). This usually occurs in conjunction with verbal and physical abuse (Dysart-Gale, 2010). Such situations inevitably cause LGBT individuals to experience greater degrees of mental health problems than their heterosexual counterparts (Fingerhut, Peplau, & Gable, 2010). Negative attitudes toward LGBT individuals directly correlate with conservative political beliefs (Brown & Henriquez, 2008). Discrimination of LGBT individuals also directly correlates with high degrees of religiosity (Brown & Henriquez, 2008). The simple fact is that LGBT individuals constitute a "socially stigmatized minority group" (Fingerhut, et al., 2010, p. 101). Stigmatization contains much broader negative implications than marginalization. Where marginalization produces apathy, stigmatization engenders hatred.

Health and Health Care Inequities

Well-documented evidence shows that LGBT patients "experience significant health inequities…that include increased risks for chronic disease and mental health concerns" (Daley & MacDonnell, 2011, p. 1). Stigmatization greatly increases the reluctance of LGBT members to seek needed health care (Dinkel, et al., 2007, p. 2). It also precipitates poorer general health in

LGBT patients because they fail to access preventive health care programs (Irwin, 2007). LGBT patients also experience worse health outcomes than heterosexual patients (Garnero, 2010). Within the health care setting, heterosexuality is the perceived norm by default (Dysart-Gale, 2010). In most health care facilities, assessments contain questions regarding whether the patient is single, married, divorced, or widowed (Dysart-Gale, 2010). Such assessment questions effectively eliminate the possibility that the patient is a member of the LGBT community, thus discouraging this self-revelation. A health care provider's lack of knowledge in this regard frequently results in non-adherence to therapies and treatments by LGBT individuals (Neville & Henrickson, 2006). LGBT individuals tend to respond to assessments and treatment only to the extent they believe their needs will be understood and respected (Neville & Henrickson, 2006). The majority of LGBT patients fail to reveal their sexual orientation because they fear a "lack of absolute confidentiality and family conflicts, rejection, social isolation and other consequences of invisibility" (Rondahl, Innala, & Carlsson, 2006, p. 374). Older LGBT patients are more secretive regarding their sexual orientation than younger patients (Rondahl, et al., 2006). Nurses must acquire cultural competency with LGBT patients to ensure the provision of quality patient care.

Fundamental Patterns of Knowing in Nursing

This writer views the concept of cultural competency with the purity and beauty of simplicity: Cultural competency, while retaining the professional boundaries inherent in the nurse-patient relationship, is “knowing another as I would want another to know me.” Knowing is the acquisition of factual, exclusive, intuitive, and creative knowledge by interfacing with the environment on each level of human perception. Knowing in nursing is "an artful and fluid process requiring creative thinking and a beauty of coordinated actions that should directly benefit the patient" (Billay, Myrick, Luhanga, & Yonge, 2007, p. 149). In her pioneering article

"Fundamental Patterns of Knowing in Nursing," Barbara A. Carper identified four symbiotic components of knowing: Empirics, aesthetics, personal, and ethics (Carper, 1978). These four "patterns" of knowing involve "critical attention to the question of what it means to know and what kinds of knowledge are held to be of most value in the discipline of nursing" (Carper, 1978, p. 13). Knowing in nursing is "a dynamic interweaving of various patterns of knowing that evolves as individuals live and interact with the world" (Bonis, 2009, p. 1337). It is acquired from experience, reflection, and discovery of meaning (Bonis, 2009). "Understanding four fundamental patterns of knowing makes possible an increased awareness of the complexity and diversity of nursing knowledge" (Carper, 1978, p. 21). Consequently, knowing enables a nurse to provide substantially superior culturally competent care.

Empirical Knowing

Empirical knowing is "knowledge that is systematically organized into general laws and theories for the purpose of describing, explaining and predicting phenomena of special concern to the discipline of nursing" (Carper, 1978, p. 14). It proceeds from the rationalistic belief that reason is the only font of knowledge (Mantzorou & Mastrogiannis, 2011). Usually, it is the result of empirical research (Fawcett, Watson, Neuman, Walker, & Fitzpatrick, 2001). One may discover, observe, verify, and replicate empirical knowledge (Billay, et al., 2007). It is objective, measureable, and generalizable to other significances (Billay, et al., 2007). Empirical knowing includes "facts, organized descriptions, conceptual models and theories which explain and predict relationships" (Mantzorou & Mastrogiannis, 2011, p. 253). The scientific processes of assessment, reasoning, and research glean empirical knowledge and determine its representative meanings (Mantzorou & Mastrogiannis, 2011). Empirical knowing is the “science” of nursing.

Much relevant empirical knowledge exists regarding the LGBT group. The group maintains the highest prevalence of cigarette smoking, which ranges from 38 to 59% among

youth and from 11 to 50% among adults (Garnero, 2010). The prevalence of polycystic ovarian syndrome is 38% among lesbian women compared to 14% among heterosexual women (Garnero, 2010). LGBT African American adults possess the highest rates of diabetes (Garnero, 2010). Lesbian women have higher obesity rates than heterosexual women (Garnero, 2010). Lesbian and bisexual women along with gay, bisexual, and transgender Latino adults most frequently have no health care insurance and experience greater difficulty accessing medical care (Garnero, 2010). African-American LGBT members maintain the highest rates of delay or non-compliance in filling prescription medications (Garnero, 2010). Anti-LGBT prejudice, discrimination, and violence generate stress that directly correlates with deficient mental health outcomes (Fingerhut, et al., 2010). Suicide rates for LGBT youth range from 20 to 42%; gay men are six times more likely and lesbian women are two times more likely to attempt suicide than their heterosexual counterparts (Garnero, 2010). LGBT Asian members are most likely to experience psychological distress (Garnero, 2010). Male gay, bisexual, and transgender individuals have a significantly higher prevalence of eating disorders (Garnero, 2010). The LGBT group experiences substantially higher substance abuse, alcohol binge drinking and heavy alcohol use (Garnero, 2010). The risks of HIV and STD acquisition and transmission are greater for gay and bisexual men than heterosexual men (Garnero, 2010). Approximately 40% of homeless youth are LGBT individuals (Garnero, 2010).

Knowing these empirical facts directs the nurse when implementing a plan of care for an LGBT patient. Nursing assessments should contain "gender neutral terms" regarding the patient and his or her family (Rondahl, et al., 2006, p. 378). Non-threatening questions include: "Do you live alone or with someone?" and "Who do you live with?" (Rondahl, et al., 2006, p. 378). If the patient is willing to disclose his or her LGBT status, nurses need to inquire about the patient's relationships, family, community, and supportive environment. Suggested questions are

"How open are you? Would you be comfortable in a room with another patient if your partner visits you? Do you have the support of friends and family? Does your partner communicate with your parents and siblings?" (Rondahl, et al., 2006, p. 378). Nurses should ask LGBT patients how to address and document their partners (Rondahl, et al., 2006). Nurses should ask transgender patients if they prefer the identity "He" or "She" (Garnero, 2010, p. 181). Nurses must not refer LGBT patients to mental health providers solely because of their sexual orientation (Garnero, 2010). Nurses need to educate LGBT patients regarding HIV, AIDS, and STDs (Neville & Henrickson, 2006). However, they also need to provide education regarding the patient's primary illnesses and the health risks LGBT patients more prevalently experience. Significantly, nurses must take into account the patient's individual lifestyle and resources when planning for discharge.

Aesthetic Knowing

Aesthetic knowing "involves the creation and/or appreciation of a singular, particular, subjective expression of imagined possibilities or equivalent realities" (Carper, 1978, p. 16). It is the ability to perceive beyond the empirical information and comprehend the patient's own desired vision of reality (Mantzorou & Mastrogiannis, 2011). "Through awareness and reflection on experience, nurses are better able to understand the uniqueness of individual patients and plan therapeutic interventions accordingly" (Bonis, 2009, p. 1334). This entails the envisioning of realistic possibilities (Fawcett, et al., 2001). Simply stated, aesthetic knowing is a form of perception that determines the particular need the patient is conveying by his or her behavior, rather than classifies the patient's behavior with a conventional label (Carper, 1978). Through reflection upon empirical observation a nurse comprehends aesthetic meaning (Bonis, 2009). Aesthetic knowing requires empathy-the ability to experience the feelings of another (Carper, 1978). It also necessitates the exhibition of genuine caring. Caring creates for the

patient a bond with humanity (Mantzorou & Mastrogiannis, 2011). Aesthetic knowing transforms the subjective experience into creative nursing care (Billay, et al., 2007). It is the "art" of nursing.

Hostility from health care providers toward members of the LGBT group is commonplace (Garnero, 2010). LGBT people of color experience a higher degree of health disparities and thus have greater degrees of negative health outcomes (Garnero, 2010). LGBT members are far less likely to access needed health care services because they fear or have experienced bigotry within the health care system (Garnero, 2010). LGBT youth report that 90% of them have been called gay in a derogatory fashion, 85% have been verbally harassed, and 44% have been physically assaulted because of sexual orientation (Russell, Ryan, Toomey, Diaz, & Sanchez, 2011). Studies support the conclusion that family members inflict 60% of the violence upon LGBT youth (Dysart-Gale, 2010). The primary health care needs of LGBT members are largely ignored because health care workers overwhelmingly focus on HIV, AIDS, and STD issues (Neville & Henrickson, 2006). Heterosexual society in general isolates same-sex families, which deprives them of social support, personal wellbeing, and full human rights and citizenship (Weber, 2008).

For the patient experiencing any such situations, aesthetic knowing beckons the nurse to reflect upon the personal realities that define who that patient truly is. Reflection upon the past abuses suffered by the LGBT patient causes the nurse to comprehend with greater depth the patient's behavior. Subsequent empathy generates identification of the patient's unique individuality yet concomitant inclusion within the human community. Consequently, aesthetic knowing permits the nurse to perceive that patient's desired vision of reality. Once this level of understanding is achieved, the nurse is more capable of forging a professional human bond and, with patient participation, creating an artistic, specialized nursing plan of care based upon

realistic possibilities. Additionally, nurses must inquire regarding the health perceptions, practices, values, and worldviews of LGBT patients (Munoz, et al., 2009). Aesthetic knowing for purposes of providing culturally competent care requires nursing interventions that improve health, provide comfort and support, enhance patient wellbeing, and primarily endorse human dignity (Bailey, 2010).

Personal Knowing

Personal knowing "is concerned with the knowing, encountering and actualizing of the concrete, individual self" (Carper, 1978, p. 18). It encourages total unity and true revelation in the engagement between self and patient, seeking awareness for the purpose of supplanting ignorance (Carper, 1978). "The assessment of personal knowing involves examining the congruity of the expressed self with the authentic self" (Mantzorou & Mastrogiannis, 2011, p. 254). When congruity is achieved, the nurse connects sincerely with the patient, revealing his or her genuine identity for the patient's benefit (Mantzorou & Mastrogiannis, 2011). Personal knowing involves discovering one's own method of acquiring authenticity (Fawcett, et al., 2001). Receiving and reflecting upon the feedback from others assists in this discovery process (Fawcett, et al., 2001). The goal of personal knowing is the establishment of the therapeutic nurse-patient relationship. "Providing care to vulnerable groups is contingent upon nurses' ability and willingness to establish a climate where clients perceive themselves as persons of value" (Bailey, 2010, p. 57).

Studies have shown that many nurses consider homosexual men "sick, perverted, promiscuous, and child molester[s]" (Christensen, 2005, pp. 60-61). Reasons for these beliefs include the fiction that homosexuality is merely sexual activity, lacking emotional, psychological, and cultural aspects (Kean, 2006). The majority of nurses assume the heterosexuality of their patients (Rondahl, et al., 2006). This assumption negatively affects the

provision of quality nursing care because honest communication is not established (Rondahl, et al., 2006). Studies also support the contention that homophobia and heterosexism contribute to substandard, inappropriate, and rough nursing care for LGBT individuals (Neville & Henrickson, 2006). Many LGBT patients report increased suffering inflicted by insensitive and incompetent nurses in acute care settings (McCarthy, 2010). Significant others, such as monogamous partners of LGBT patients, are predominantly ignored or treated with hostility by nurses and other health care staff (Rondahl, et al., 2006). Nurses frequently deny significant others visitation rights although the patient has no other family members (Irwin, 2007). "Cultural stereotypes attribute abnormality and immorality to sexual minorities, which in turn leads to marginalization, self-destructive behavior, self-loathing, and self-harm" (Weber, 2008, p. 613). Historically, programs designed to teach nurses and other health care providers culturally competent patient care techniques only marginally, if ever, include the LGBT group of patients (Daley & MacDonnell, 2011).

Acquiring evidence-based knowledge provides a nurse with the means to overcome conscious bias (Brusin, 2012). Studies support the contention that unconscious bias may be countered by seeking commonalities with the patient (Brusin, 2012). A patient's sexual orientation should be contemplated only when it is necessary to formulate appropriate medical or nursing interventions (Brusin, 2012). "Imagining the difficult situation faced by racial minorities and stigmatized ethnic groups helps decrease the activation of even unconscious stereotypes" (Brusin, 2012, p. 138). Such imagining is similarly effective for the nurse who treats LGBT patients. Studies also indicate that an increase in contact with LGBT patients directly correlates with a decrease in negative stereotypes and biases with respect to them (Brown & Henriquez, 2008; Dinkel, et al., 2007). Personal knowing mandates that culturally competent nurses maintain an "open mind" concerning LGBT issues (Rondahl, et al., 2006, p. 379). It also

imposes upon nurses a duty to acquire continuing education that enhances awareness of LGBT issues, challenges stereotypes and biases, expands their perspectives, and fuels critical thinking (Munoz, et al., 2009). A nurse who cannot view an LGBT patient as one who possesses inherent human value consequently cannot create a culturally competent patient care environment.

Ethical Knowing

Ethical knowing "requires an understanding of different philosophical positions regarding what is good, what ought to be desired, what is right; of different ethical frameworks devised for dealing with the complexities of moral judgments; and of various orientations to the notion of obligation" (Carper, 1978, p. 21). The concept of morality extends beyond the norms or nursing ethical codes (Carper, 1978). Rather, a moral decision must be the result of considering each situation as specific and unique (Carper, 1978). Ethical knowing requires the nurse to "understand the different ethical frameworks designed for addressing complex moral and ethical dilemmas and judgments" (Billay, et al., 2007, p. 151). Ethical knowing also encompasses assisting patients to discover their own meanings regarding life and living (Mantzorou & Mastrogiannis, 2011). This involves inquiring into and justifying a patient's values and beliefs (Fawcett, et al., 2001). Ethical knowing requires nurses to advocate for their patients. The World Health Organization mandate of social justice "requires nurses to move beyond the clinical context and look at society as a whole to offset the social factors undermining the health and wellbeing of all LGBT [individuals]" (Dysart-Gale, 2010, p. 25).

LGBT patients experience health care disparities and the consequential negative effects in a variety of ways. These life-destructive situations inevitably involve ethical issues. The Code of Professional Practice of the Nursing and Midwifery Council declares a patient's right to receive professional, compassionate, and dignified nursing care at all times (Christensen, 2005). Even so, many health care providers including nurses continue to provide deficient quantities and

qualities of patient care to LGBT patients based upon their personal political, religious, or gender role beliefs. Wellbeing for LGBT patients frequently depends upon creating their own families by forming romantic relationships and including children in their families (Weber, 2008). Although some states permit same-sex marriages, often the laws continue to deny parental rights to both parents of adopted children (Brown, Smalling, Groza, & Ryan, 2009). When this occurs, "the whole family structure is minimized and vulnerable" (Brown, et al. 2009, p. 231). Older LGBT patients are more likely to have long-term, monogamous relationships (Kean, 2006). However, many nurses continue to ignore their partners when providing patient care, and partners are often excluded from consulting sessions where discussions occur involving life-changing medical decisions for the patient.

Ethical knowing demands that nurses refrain from discussing their own negative religious, political, and gender role beliefs with LGBT patients. These topics, although appropriate in other forums, are unacceptable within the health care setting. Ethical knowing also requires that nurses must show respect for the LGBT patient and the family structure (Garnero, 2010). Medical staff should include the partners of LGBT patients in consultations and decision-making processes, and inform partners with critical information when necessary (Irwin, 2007). All staff must ensure the confidentiality of the LGBT patient (Irwin, 2007). Health care personnel also should obtain permission from the LGBT patient to reveal necessary information to other health care professionals who become involved in the plan of care. Obtaining this permission spares the LGBT patient the stress of having to constantly "come out" to every health care provider who comes into their room (Neville & Henrickson, 2006). Most significant, ethical knowing obliges the nursing profession to challenge the disparate health care services often provided LGBT patients and the homophobia prevalent among all health care providers (Neville & Henrickson, 2006). Nurses must not tolerate disparities in health care for

any patient. On the contrary, it is a moral imperative that nurses do all within their power to oppose such practices. Achieving cultural competency with LGBT patients, and with other vulnerable groups, means nothing if the nurse is unwilling to include that competency within his or her practice.

Conclusion

Concepts that promote cultural competency include reflection upon one's personal stereotypes and biases, the substitution of acceptance of the inherent value of every world culture in place of ethnocentricity, and the continual striving for social justice (De Chesnay & Anderson, 2008). The acquisition of cultural competency with respect to the LGBT patient is the most promising means of defeating homophobia in nursing (Dinkel, et al., 2007). Carper's Fundamental Patterns of Knowing in Nursing provide a comprehensive means to achieve competency with any culture. Conjoining empirical knowing with aesthetic, personal, and ethical knowing creates a four-pronged hybrid singularity of nursing science, art, caring, and morality. Consequently, this writer reiterates his previous contention: Cultural competency, while retaining the professional boundaries inherent in the nurse-patient relationship, simply is "knowing another as I would want another to know me."

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