I am both intrigued and annoyed by the term cultural competence. The term seems to imply that a person can achieve competence when it comes to knowing and understanding the beliefs, traditions, and values of people from a plurality of cultures and with that knowledge provide care accordingly.

In fairness to scholars who write about cultural competence in nursing, I recognize that most do not claim that someone can know everything necessary about even one culture different from his/her own in order to provide good nursing care. Yet I often read and hear nurses speak about characteristics of Hispanics, Asians, and other cultural groups as if they were homogeneous, when in fact they are not.1

I am a naturalized American citizen, born in Cuba of Cuban parents. I came to the United States when I was 8 years old and was raised in a home where Spanish was always spoken, Cuban food was served for dinner, and family friends were other Cuban immigrants. I have traveled to other Latin American countries and have extended family members who live in several Central and South American countries. Although I speak Spanish and share some of their Hispanic characteristics, our cultural values and practices differ. Hispanic cultures of different countries may have appropriated influences from European cultures, African cultures, or indigenous Indian cultures. Our foods are different, the ways we practice Christianity may be different, and the ways we make healthcare decisions and view end-of-life care may be very different. My ability and motivation to adopt American ways as my own also have been influenced by the fact that I came to the US as a political refugee and did not have the option of returning to Cuba, even for a visit.

If age, gender, education, socioeconomic status, and the length of time one has lived in the US are considerations, significant differences in values and lifestyles become evident even among people from the same country of origin. For example, Grossman and Purnell2 summarize characteristics of “People of Cuban Heritage,” but much of what they say about bereavement practices, expressions of pain, the African Cuban religion of Santeria, and folk beliefs about pregnancy are not familiar to me.

Today, my 85-year-old father continues to cling to the Cuban values and traditions with which he was raised, although living in the US has inevitably led to some changes that influence his daily routines and the decisions he makes. He has trouble accepting that I am so Americanized and that my children consider themselves to be of Cuban descent but fully American. We are three generations from the same family with different views on how our common culture influences how we live our lives, experience illness, and view healthcare. Our interpretation and experience of Cuban culture continues to change and evolve with each generation.

My point is that we need to be careful with our interpretation of what it means to be culturally competent. Too often, we talk about cultural competence as becoming knowledgeable about a laundry list of cultural characteristics attributed to a group.3 Such a perspective fosters stereotyping, can contribute to patient alienation and inadequate treatment, and ultimately hinders nursing care.4

Certainly it is beneficial to know about common characteristics relevant to specific cultures. However, I prefer the term cultural sensitivity, which implies being open to and respectful of another’s beliefs, traditions, and values and being aware of factors such as immigration status, education, spirituality, family influences, and social class.1 It requires being self-aware of one’s own culture and presuppositions. Being culturally sensitive requires approaching patients, not with preconceived ideas or ethnocentric biases, but with a sincere interest in learning how others interpret their cultural traditions and are influenced by them. Being culturally sensitive is a relational process, not a goal to be achieved.

**References**