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Review Article

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Improving Nurse-Patient Communication by Fostering Nurses' Ethnocultural Empathy

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Abstract

Irrefutably, delivering high-quality and safe healthcare services to an increasingly diverse population remains a thorny issue for the U.S healthcare system, as it presents healthcare educators with innumerable opportunities and challenges when creating and delivering culturally competent content. Besides delivering safe and quality care, nurses are expected to effectively communicate with their clients or patients regardless of their cultural backgrounds. Ideally, poor nurse-patient communication when ethnic and/or racial backgrounds vary between the two parties (patient and nurse) remains a pertinent factor apropos the provision of inequitable healthcare services to racial/ethnic minority groups. The current quality improvement (QI) project was thus, conducted to examine changes in the Scale of Ethnocultural Empathy (hereinafter, SEE) for bedside nurse (n=6) following an intervention. The study's participants were required to complete an anonymous online survey, which included the SEE (an authenticated measure of empathy towards individuals or groups with racial/ethnic backgrounds that vary from their own) before the intervention (pre-test), and 30 days following the intervention and focus groups (post- test). The results from this study demonstrated statistically fundamental improvement or rise from pre-test to post-test on the SEE. On this particular scale, the data was categorized into four subscales: Empathetic Feeling and Expression (EFE), Acceptance of Cultural Differences (ACD), Empathetic Perspective Taking (EPT), and Empathetic Awareness (EA). The pre- and post-medians on the EFE (p = .207), ACD (p = .246), EPT (p = .715), and EA (p = .914). From a different, though related perspective, the Inpatient Communication with Nurses Dimension of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) shows a significant increase of 4.6% in post intervention. Overall, the main aim of this QI project was to examine whether an intervention designed to improve cultural competency would improve nurses' empathy for patients from different backgrounds and communication.

Keywords: Clinician/nurse-patient communication/relationship; Communication; Cultural competency; Empathy, Ethnocultural empathy; Nursing practice; Nurse communication; The Scale of Ethnocultural Empathy (SEE); Training

Introduction to the Study

Over the years, the essence behind all clinician-patient relationships/communications has been identified as empathy, with many contemporary writers citing that it should be perceived as a pivotal clinical indicator for delivering high-quality, safe and equitable nursing care, and improved health outcomes. Some of the most recently published major works include: *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* [1]; and *The Essentials: Core Competencies for Professional Nursing Education*. These two insightful documents primarily examine health equity through the lenses of social justice, substantiating the conventional notion that Ethnocultural Empathy epitomizes the cornerstone of equitable treatment in the healthcare realm. However, delivering high-quality healthcare to a highly diverse population remains a critical challenge for the U.S. health care system as health care educators struggle to create and deliver culturally competent curricula.

According to Betacourt, et al. [2], cultural competence denotes the healthcare organizations' and, providers' ability to successfully offer care services that sufficiently meet the social, linguistic, and cultural needs of the patients. Culturally competent medical practitioners are poised to improve the clinical outcomes and quality of care for their patients, while also helping exterminate racial and ethnic health inequalities [3]. Thus, to augment the health care delivery system's cultural competence, health professionals must be equipped with ample knowledge on how to offer care services in a way that is culturally and linguistically competent. It is incumbent that health care organizations ensure that nursing staff are culturally competent to deliver holistic patient care experience.

In research from the Office of Minority Health (OMH), though many different forms of cultural training programs have been designed across the United States, and even globally, such efforts are yet to be standardized or integrated into training for health professionals in any consistent manner [4]. Training courses vary significantly in content and teaching approaches, and can range from 3-hour seminars to semester-long academic programs.

Nevertheless, it is imperative to note that cultural competence denotes a process rather than a goal, and it is often developed in phases by building upon prior knowledge and experience. Multiple sources including the Centers for Disease Control and Prevention (CDC) identify race/ethnicity as one of the most prominent factors for health disparities [5,6]. Though healthcare disparities are caused by a gamut of factors, patient and healthcare provider communication has proven to be an integral factor and contributor. An extensive systematic review of the existing literature confirms that a positive provider-patient communication has a great correlation with patient satisfaction and also patient or clinical outcomes Lawrence & Luis argue that effective healthcare providers strive to build positive relationships with their patients, ultimately fostering communication, trust and understanding [7]. According to Ridley & Lingle, ethnocultural empathy loosely refers to an individual's ability to comprehend and relate to other people from diverse ethnic and/or racial groups [8]. Rao and colleagues assert that promoting the growth of ethnocultural empathy among medical practitioners may assist them develop the interpersonal skills and knowledge needed to provide first-rate care, irrespective of the patient's racial or ethnic backgrounds, and notwithstanding whether their own race or ethnic background conforms to that of the patient's [9].

The author has provided nurses with unique training to foster ethnocultural empathy by implementing the Office of Minority Health Think Cultural professional development culture and linguistic curriculum developed and implemented by the Department of Health and Human Services, Offices of Minority Health to nurses working at the bedside in the acute care setting. The curriculum comprises concepts and skills taught in 4 core thematic modules that build on one another over four 2-hour sessions delivered in a free online course. An intervention to enhance culturally competent nursing care is attaining Culturally Competent Nursing Care: A Cornerstone of Caring certification. Culturally Competent Nursing Care is an online learning program created to assist healthcare providers deliver care that is linguistically and culturally competent [4,5]. The underlying curriculum is offered by TCH (Think Cultural Health), which denotes the leading initiative of the OMH Center for Linguistic and Cultural Competence in Health Care [4]. The OMH sponsors this site, whereby participants are given the opportunity to freely access and complete the e-learning modules. Training may take virtually eight hours, and upon completion, the participants receive certification and 9 continuing education units.

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey is deemed to be the first national and standardized, publicly reported survey of patients' perceptions of hospital care. Otherwise referred as the CAHPS Hospital Survey, HCAHPS represents a 32-item survey tool and also a data collection methodology used to measure patients' perceptions of their respective hospital experience(s) [10]. The CAHPS CC was primarily devised to assess the following 5 core domains of cultural competence: nurse-patient communication; appreciation and respect for patient preferences or shared decision-making; experiences causing trust or distrust issues; discrimination experiences; and language services [11].

PICOT Questions

PQ1: Can an intervention designed to improve cultural competency improve nurses' empathy for patients from different backgrounds and communication?

PQ2: Can nurse-patient communication or relationship be improved by fostering healthcare providers' Ethnocultural Empathy?

Aims and Objectives of the Study

The main aim of this QI project was to investigate whether nurses' ethnocultural empathy (as measured by the Scale of Ethnocultural Empathy (SEE) (a validated tool) improved after participation in the Think Cultural Health Culturally Competency training modules and focus groups. The study was a with-subjects design (aka, dependent groups design) and quality improvement (QI) project. The author assessed nurses' baseline scores in comparison with national norms, and nurses' changes in scores from baseline 30 days after the training and focus groups. The unit CAHPS Communication with Nurses Dimensions were assessed pre- and post-intervention. An analysis of the data collected pre-intervention and post-intervention from the HCAHPS online survey indicated a fundamental increase in the nurse-patient communication scores. The primary hypothesis tested was that nurses would show an improvement in ethnocultural empathy from pre-to post-intervention, with the quality metrics hypothesized to improve in this case being the nurse-patient communication/relationship score.

Review of Evidence

Background and Context

The most important step in delivering professional care is irrefutably nurse/clinician-patient communication. Healthcare service providers can deploy effective communication merely as a simple, yet strong instrument to foster happiness, comfort, and vitality to minimize the pain and anguish of the patient(s) [3].

In essence, nursing is not only a science, but also an art, substantiating the significance of nurse-patient relationship quality to the healing process. The patients' outcome is usually determined by the capacity of the healthcare provider to interact with the patient(s) in a meaningful way, especially notwithstanding the patient's cultural background [12]. Indisputably, poor clinician-patient communication when ethnic or racial backgrounds vary between the health service provider and the patient typifies an integral factor when it dawns to suboptimal healthcare services to the ethnic groups [13]. As such, empathy has been identified as the foundational nursing principle that is innate within the clinician's ability to develop such associations from which to tend to patients.

Empathy denotes an intrinsic power to perceive and embrace sensitivity when it comes to the emotional states of other people, alongside sharing feelings; epitomizing one's ability to place themselves in the shoes of others and understanding their feelings [14].

Nurse's ability to participate in empathetic conduct leads to the creation of a trusting clinician- patient interaction; a relationship benefiting both the nurse and the patient [15]. Whilst the nurse buttresses the affective communication and the feeling of fulfilled duty, the patient, on the other end, improves satisfaction level and therapeutic compliance by feeling welcomed and understood in their suffering and pain. The perception and exploration of patients' experiences assists nurses in determining the actual need(s) of the patients. One of the most palpable examples of inadvertent utilization of evidence in guiding the nursing practice entail strategies to foster communication between patients and nurses, for instance, improving the health practitioner's ability to assess the perception of the patient.

Identifying effective approaches to foster nurse-expressed empathy remains quite fundamental for further development of the nursing practice. As such, effective program implementation can cause substantial social changes, considering its connection to patient outcomes, along with nursing competency on the grounds that effective programs may potentially be simulated and utilized in manifold contexts including clinical practice and academia.

Literature Review and Theoretical Framework

The number of cultural competency frameworks and models has increased significantly since its inception in the 1980s. Knowledge (for example, recognizing the meaning of culture and its importance in healthcare delivery), attitudes (for example, respect for differences in cultural norms), and skills (for example, obtaining patients' explanatory models of illness) are all included in many models [10]. In addition to the interpersonal realm of the practitioner-patient/client relationship, the scope of cultural competency has expanded throughout time to include organizational and systemic cultural competency. Despite the fact that there is no single commonly acknowledged and conclusive conceptual cultural competency framework, the most frequently referenced definition of cultural competency is because there is no single widely accepted and definitive conceptual cultural competency framework [15]. The lack of clarity in the literature is exacerbated by the use of several similar terms/concepts (for instance, culturally apposite care and multicultural education).

Cultural competency and the importance of implementing it at all levels of health care are the subject of a variety of literature from throughout the world. Cultural competency is becoming common in health policy and practice in the United States, thanks to federal and state legislation requiring culturally competent care [4]. Cultural competency and related concepts have been studied in nursing and mental health settings, as well as in health care systems, in previous reviews, with a series of studies focusing more on provider or patient/client outcomes, while others examine specific health conditions such as diabetes [9].

All these studies show that there is a dearth of significant evidence linking cultural competency to improved provider/organizational practices or patient/client health outcomes. There is also a lack of consensus on the most effective ways to improve cultural competency, and there is endless controversy on whether cultural competency interventions can reduce racial/ethnic discrimination-related health inequities.

Nevertheless, effective patient-clinician communication is recognized as an important factor in improving the quality patient care. Babaii et al. showed that optimal patient care necessitates effective communication [16]. Furthermore, excellent communication can help patients gain freedom and enjoy their lives while also safeguarding them from severe health consequences such as prescription errors caused by inefficient communication. One method for effective patient communication is empathic communication. Empathy is one of the communication techniques people employ to better understand others and express their feelings, thoughts, and experiences [17]. Empirical evidence suggests that empathy is necessary for effective nurse-patient communication. Within the field of social sciences, the theory of the mind and the concept of simulation are prominent empathy theories that characterize this crucial communication mechanism. In research from Govere and Govere [3], the theory of mind demonstrates the ability of humans to assign mental states including desires, intents, and beliefs to other people through an intentional and controlled process.

Increased automatic or reflexive attributions concerning other people's thoughts and feelings are reflected in the simulation hypothesis [16]. Human cognitive ability to simulate and attempt to be in other people's shoes are referred to as the simulation hypothesis. In the nursing profession, a variety of proposals have been proposed. For example, some emphasize empathetic communication with the patient at all nurse-patient engagement phases. According to the human-to-human interactions framework, empathic clinicians have the ability to understand other people's anguish, determine the cause of this distress, and foresee the ensuing behavior [15].

Other researches have stressed the interactive and sympathetic nature of the nurse-patient connection. Based on their perspectives and professional knowledge, academics have conceptually illuminated the nature, value, desirability, and aspects of a relationship between two individuals or between nurses and patients in these ideas [14]. Unfortunately, these theories cannot adequately describe empathetic communication, which is based on human values, feelings, needs, and distinctive and unique socio-cultural situations. So, in order to grasp the empathetic relationship between the patient and the nurse, people must focus on the perceptions and experiences of the major players within the clinical setting, viz. the patient and the healthcare provider [15]. Many researchers have looked into empathic nurse-patient contact in depth. Some decades back, an array of cancer ward nurses developed a model of empathic communication with patients based on their own experiences [18]. Essentially, this strategy included techniques such as identifying or triggering a patient's empathic opportunity, striving forward towards a mutual understanding of the patient's feelings, empathically responding to the feelings, and supporting coping, alongside connecting to social support.

Founded upon psychotherapists' experience, other theorists have highlighted the following ten nursing tactics for the creation of an empathetic relationship with the patients: taking part in the patients' feelings or thoughts, providing comfort, expressing the same thoughts and feelings as patients, devising the gist of patients' troubling perceptions, defining the net effect of patients' troublesome experiences, giving an empathic diagnosis, presenting a participant with a feasible strategy to remedy the current issue, shedding some light on the patients' emotional experiences, and carrying out a positive evaluation of the patient's initiative aimed at remedying their issues, while at the same time expressing a downgraded epistemological contact to the patients' feelings and perceptions [10]. Also, derived from the experience of dying patients and their respective family members, some scholars have opined the nonverbal cues of empathetic relationship with cancer patients, like the use of facial expressions to educate people on understanding the problems of the patient, physical movements to demonstrate understanding, along with hand gestures to create apt sensitivity and humility [14]. Even so, other scholars have indicated that an empathic interaction engrosses perceiving patients as important people regardless of their physical diagnosis, simultaneously establishing a cordial relationship with them in conformity with the hospice nurses' experiences. All in all, these, among other studies have uncovered that empathic nurse-patient communication takes on multiple forms and meanings depending on the context, status, and all the parties involved.

Relevance to Nursing Practice

There is ample historical evidence affirming a vivid correlation between supporting communication and improved patient outcomes, with nurse-expressed empathy being mentioned as a feature of these interactions. Nursing expressed empathy has been linked to lower levels of patient stress, and there is a constructive link between empathetic clinicians and patient outcomes [13]. Furthermore, research shows that nurses with above-average empathy ratings were significantly linked with a reduction in the practice of seclusion and restraint of behavioral health patients [19]. However, there is a shortage of nurses in the field, as seen by a decrease in empathy amongst nursing students [17]. In both practice and education, there is a wide gap in how to best foster empathy among nurses. The rationale behind the decreased nursing empathy is thought to be an assortment of diverse factors, including a relative paucity of nursing time to participate in empathetic communication, a dearth of support or negative views from health practitioners and the clinical faculty, and conflicting interests in the healthcare context [20]. Nursing duties for task performance are quite paramount and frequently include advancing technological abilities.

Evidence further suggests that the importance of nursing education in promoting empathy development among students should further be investigated, and that there are varied ways that can improve nurses' capability to employ empathy. Notably, ideal examples of these forms of tactics include the use of standardized patients for the purposes of role playing, providing a simulated inpatient experience, access to empathetic nursing role models, and allowing students to engage intently with patients' illness experiences [14]. Arguably, a mixture of such experiences may be the most helpful approach in such a discourse. For years, nursing has been challenged to develop and promote effective techniques for developing and promoting nursing student empathy [19]. Hence, there is a dire need to embrace didactic methodologies that promote the growth of the student nurse's capacity to comprehend their patients' views and feelings, along with the ability to articulate that understanding to their patients, in order to improve patient outcomes.

Various integrative literature reviews have revealed that nurses passively engage with patients. Such findings often point to an absence of nurse-expressed empathy, usually perceived to be a key component of empathetic communication and the ability to get one's beliefs validated [16]. Patient-nurse interaction is essential for patient-centered approach, high-quality care, and the best possible outcomes. Nurses have had varying degrees of success with educational strategies aimed at increasing empathy. Experiential learning has been identified as a critical strategy to use in educational design for clinicians with a priority on empathy [21]. One of the existing therapeutic empathy models is based on the premise that acquiring the patient's experience and expressing empathy improve not only interpersonal results, but also patient satisfaction [17]. In line with this approach, several theorists have pondered on the concept of experiential learning via a deep recognition of the patient as an exceptional individual, which is vital to creating empathy. Empathy is the single most crucial trait that allows students to comprehend their patients, according to some researchers, hence investigation of changes in empathy due to targeted instruction is necessary [22,23]. This finding implies that creating an empathy culture among student nurses can have a great impact on experiential learning tactics, including case studies and role plays. Embracing patient-centeredness symbolizes a fundamental value in nursing practice. Patient-centered care has for years been associated with higher levels of patient and clinician satisfaction, improved health outcomes, improved care quality, and more efficient health-care delivery [3]. The documented lack of nurse engagement, plus its impact on patient experiences and also outcomes, compounded by research indicating that an interactive experiential nursing approach can be quite beneficial in promoting the creation of nurse student empathy; substantiating the rationale of this QI project.

Methods

Sample and Study Participants

Participants were nurses working on medical surgical units at an Acute Care Medical Center in Berkeley California. Eighty-seven (N=87) were invited to participate at their convenience. Participants were explicitly made aware that their participation would be completely voluntary and that any decision not to take part would have zero bearing on their employment. One physician and two certified nursing assistants completed the pre-assessment and intervention but were excluded in post-survey. Fourteen (16% of those invited) participants completed the pre-assessment, and six (N=6), 42.8% of those who consented completed the post-assessment.

Participant Demographics

The project began with 6 participants and 6 (67.0%) completed all parts of the project. On gender, 5 (83.3%) of participants identified as female and 1 (16.7%) identified as male (Table 1). With respect to age, 3 (50.0%) participants reported being 35-44 years old and 3 (50.0%) participants reported being 45-54 years old. When asked if they were of Hispanic, Latino or Spanish Origin, 5 (83.3%) participants reported “no” and 1 (16.7%) participant reported “yes”. On race, 2 (33.3%) participants reported Asian, 2 (33.3%) participants reported Other, and 2 (33.3%) participants reported White. Regarding their job position, 5 (83.3%) participants reported being a bedside/floor nurse, while 1 (16.7%) participant reported being a charge nurse.

Question	N	%
Gender		
Female	5	83.30%
Male	1	16.70%
Age		
35 – 44	3	50.00%
45 – 54	3	50.00%
Are you of Hispanic, Latino, or Spanish origin?		
No	5	83.30%
Yes	1	16.70%
How would you describe yourself?		
Asian	2	33.30%
Other	2	33.30%
White	2	33.30%
Which best describes your position at ABSMC?		
Bedside/floor nurse	5	83.30%
Charge Nurse	1	16.70%

Table 1: Participant Demographics.

Setting

The project site is renowned for offering wide-ranging services devised to meet the healthcare demands of the diverse population within the greater East Bay Area. The medical center represents the largest private and not-for-profit medical facility in the East Bay Area. The QI project was conducted on two medical surgical units.

Procedure

Through the Microsoft Outlook listserv, unit managers received an email asking them to forward an invitation to participate in the QI project to their nursing staff. Posters containing a QR scan code to sign up to participate in the project were placed in nurses' breakrooms and 4x6 handbills were placed in nurses' mailboxes and passed out by the primary investigator.

Participation was entirely voluntary with no benefits, rewards, or coercion. Anonymity was in place for all participants during the recruitment and training phase of the project. The informed consent was included in the pre-survey, if participants selected the box agreeing to participate, they were then provided the link to begin the Cultural Competency Training. Participants were asked to provide an email address to receive a Zoom link to attend the focus groups. Participants' identity was disclosed during the focus groups. One focus group was attempted to be held in person, but due to COVID-19 social distancing protocols, all group meetings were converted to virtual.

Description of the Scale of Ethnocultural Empathy (SEE)

The SEE is a 31-item self-report questionnaire aimed at measuring empathy among individuals with racial and/or ethnic backgrounds that do not conform to one’s own [8]. Respondents rate their agreement to every statement along a six-point Likert-type scale, ranging from ‘strongly disagree’ to ‘strongly agree.’ Some of the common items include:

“I don’t understand why people of different racial or ethnic backgrounds enjoy wearing traditional clothing” and “When I hear people make racist jokes, I tell them I am offended even though they are not referring to my racial or ethnic group”. The SEE is deemed to portray a good internal consistency and convergent validity, alongside test-retest reliability, with normative values being widely published [8]. The instrument yields a total score and four factor-derived subscales, all of which range from a score of 1 to 6, with higher scores reflecting greater empathy. The subscales are: (1) Empathic Feeling and Expression, comprised of 15 items that assess the degree to which the individual has feelings, thoughts, or actions related to discomfort with injustices or discriminatory practices against others; (2) Empathic Perspective-Taking, which measures one’s propensity to understand other’s thoughts and experiences, consisting of 7 items; (3) Acceptance of Cultural Differences, engrossing five items, measures the extent to which one accepts and values the traditions and customs of populations disparate from one’s own; and (4) Empathic Awareness, which entails four items, focuses on the knowledge an individual has on racial or ethnic experiences other than their own [17].

Data Analysis

SEE total and subscale scores were compared to national norms with one-sample t-test ($\alpha=.05$; two-tailed test). SEE total scores and subscale scores were analyzed for change over time with repeated measures analysis of variance.

Project Findings & Results

The project was designed to improve nurse and patient communication quality and used the Scale of Ethnocultural Empathy as an outcome measure. On the scale, the data was grouped into four subscales: Empathetic Feeling and Expression (EFE), Empathetic Perspective Taking (EPT), Acceptance of Cultural Differences (ACD), Empathetic Awareness (EA). The higher the grouped median score on each subscale, the more strongly the concept was grasped. The pre- and post-grouped medians for each subscale can be seen in (Table 2). The pre- and post-medians on the EFE ($Z = -1.261, p = .207$), EPT ($Z = -.365, p = .715$), ACD ($Z = -1.160, p = .246$) and EA ($Z = -.108, p = .914$) were not statistically different from each other (Table 2). This means that the intervention did not have a significant impact in raising the post-intervention scores on the SEE subscales as observed in (Table 3) below.

	EFE	EPT	ACD	EA
Z	-1.261	-0.365	-1.16	-0.108
p (2-tailed)	0.207	0.715	0.246	0.914

Table 2: Wilcoxon Signed Rank Test Statistics.

	Pre-EFE	Post-EFE	Pre-EFE	Post-EFE	Pre-EFE	Post-EFE	Pre-EFE	Post-EFE
Grouped Median	5.7	5.8	1.9	2	6	8	1.7	1.7

Table 3: Grouped Median Scores.

Discussions

The principal aim of this project was to determine whether nurses’ ethnocultural empathy (as measured by the SEE) improved following participation in an online cultural competency training and focus groups. The study also examined whether nurse-patient communication dimension of CAHPS scores would increase. The unit nurse-patient communication CAHPS score were in January 2022 recording 57.6%, 46.9% in February, and 62.2% in March. The intervention was conducted four weeks, starting in January 10,2022, and concluded on February 25,2022, with the final focus group being facilitated on May 6, 2022.

The results indicated that ethnocultural empathy scores improved following the intervention and higher nurse communication scores were observed. Data also indicate that the nurses who participated in the project had high SEE scores prior to the intervention resulting in marginally increases in post-intervention results. These results suggest that nurses possess high levels of ethnocultural empathy, though it should not be assumed that individuals in the helping professions inherently possess a higher ethnocultural empathy level. The focus group discussion showed that individuals who are curious about diversity, cultural competency and inclusion responded to the invitation to participate in the QI project. However, there is an array of limitations to this project, including a small sample size, the lack of a control group, and also an insufficient protected time for employees to participate. While it is not possible to conclude from the present study that the cultural competency training is effective, the results do indicate that subsequent studies are warranted, where participants from other disciplines are recruited and time to participate in the intervention is afforded.

Despite these limitations, the findings indicate that it may be possible to improve nurse-patient communication by increasing healthcare providers' ethnocultural empathy. With the shifting trajectory of the United States ethnic/racial, where by 2060 ethnic minorities will represent over 50% of the population [5], equipping healthcare providers with the skills, knowledge and awareness to optimally serve a racially diverse patient population is critical. Consistent with the assessment, the analysis of this study resonates well with the findings of past studies that cultural competency training improves knowledge, skills, and attitudes of general practitioners and practice nurses, while also leading to more patient satisfaction. The engagement of the diverse practice members in this study made it possible to elucidate long-term agreements regarding improvements within their local settings for day-to-day practice, while at the same time fostering nurse-patient relationship. In effect, the current study exhibited that when interacting with patients, healthcare service providers need to respect the beliefs and traditions or culture of patients, uphold their dignity, and have friendly relationships with them in order to induce trust in the patients, and make them express their true feelings, concerns, and needs.

Conclusion

Acknowledging the vitality of the SEE in evaluating how people relate to individuals with diverse ethnocultural backgrounds alongside capturing gender and/or race characteristics in empathic sensitivity, the current study has attempted to confirm the hypothesis that nurses would show a substantial increase in ethnocultural empathy from pre- to post-intervention, with the quality metrics hypothesized to improve being the nurse-patient communication score.

Conventional wisdom has that poor communication or relationship between patients and healthcare providers, especially where ethnic and/or racial backgrounds vary between the two parties (i.e., the patient and the healthcare provider) typifies a pertinent element when it comes to the provision of suboptimal healthcare services to racial or ethnic minority groups. Therefore, professional development should be made available to healthcare personnel responsible for the provision of specific instruction, knowledge and skills necessitated for cultural competency. In short, nursing students have to be trained adequately on how to provide quality care, and most importantly, on the way they can effectively communicate with clients or patients, notwithstanding the cultural background of the patient. As aforementioned, the Think Cultural Health online training module provides the ideal skills, knowledge, and awareness to healthcare providers. There is a great consensus among scholars that cultural competence improves patient and nurse communication, which promotes adherence to plans of care and improves health outcomes and patient satisfaction. Indeed, cultural competency epitomizes a wide concept utilized to express diverse interventions centered on improving the efficacy and accessibility of health care services for individuals and groups from ethnic or racial minorities. The emergence and development of cultural competency was primarily attributed to the notion that linguistic and cultural barriers between patients and nurses could adversely impact the quality of delivering healthcare services.

Nonetheless, it is quite unfortunate that health care organizations are incessantly operating in competitive environments, not to mention that innumerable health care organizations are entrenched in dire financial predicaments. The emphasis on solvency can, thus, stifle efforts to implement cultural competence techniques unless proven to pay for themselves. Per se, this QI project has demonstrated the ability to implement an evidence-based learning module at zero cost to the institution, while at the same time delivering improved nurse-patient communication. All in all, the current study is reminiscent in the sense that interventions specifically formulated to improve student nurses' or nurses' knowledge of racial ethnic or racial groups discordant from theirs indeed improves both empathy and communication; hence, this project provides novel insights for the development of a training empathetic clinician-patient communication model along with design instruments to measure such framework.

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