Intercultural Competence in Nursing Education: Integrating Theory, Practice, and Didactics in Higher Education

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Abstract

The increasing cultural diversity of European healthcare systems means nurses need to develop competencies that go beyond clinical expertise. This article examines the relevance of intercultural competence in nursing practice and education. Using theoretical approaches such as Campinha-Bacote's Process Model of Cultural Competence as a basis, the paper analyses three case studies addressing intimate care and gender roles, family involvement in decision-making, and culturally shaped understandings of pain and medication adherence. The analysis reveals that intercultural competence encompasses cognitive knowledge, reflective awareness, empathy, communication skills, and the capacity to negotiate culturally sensitive solutions within institutional constraints. The article also discusses implications for the didactic approach in higher nursing education, emphasising case-based learning, reflective practice, simulation-based training and the systematic integration of intercultural learning into curricula. It concludes that intercultural competence should be considered a cross-cutting professional competence, developed throughout nursing curricula rather than as an isolated teaching topic. The findings emphasise the necessity of providing structured learning opportunities, employing qualified educators, and implementing valid assessment methods to prepare future nurses to deliver culturally sensitive, patient-centred care in an increasingly diverse healthcare landscape.

Keywords: *Intercultural competence, Nursing education, Cultural diversity in healthcare*

1. Introdution

The increasing cultural diversity in European healthcare systems presents nursing professionals with complex demands that go beyond purely clinical expertise. Migration, demographic change, and globalization mean that patients with different cultural backgrounds, value systems, and concepts of health encounter one another in healthcare settings. This diversity affects not only communication processes, but also expectations of nursing care, decision-making, and approaches to illness and therapy [1]. For nursing professionals, this means that they must be able to recognize culturally shaped needs and respond to them appropriately. Intercultural competence is therefore increasingly understood as a key qualification in professional nursing. In addition to communication skills, it includes reflection on one's own cultural influences as well as the ability to adapt nursing practice in a context-sensitive manner [2]. Despite the high relevance of intercultural competence, nursing education often shows insufficient systematic integration of corresponding content into curricula [3]. Teaching offerings often remain selective and are not sufficiently linked to practical experience. This creates the need to develop didactic concepts that convey theoretical foundations while also promoting their application in realistic situations [4].

Against this background, the present paper pursues three objectives: First, the significance of intercultural competence for nursing practice is examined using concrete case examples. Second, these cases are analyzed with reference to established theoretical models of interculturality. Third, didactic approaches are discussed that enable the sustainable integration of intercultural learning into university-based nursing education.

2. Theoretical Background

Various theoretical models exist for the conceptual classification of intercultural competence, describing different dimensions of cultural sensitivity and practical competence. The following section presents selected approaches that are particularly suitable for analyzing nursing interaction situations.

2.1 Intercultural Competences in Nursing

In the health sciences discourse, intercultural competence is understood as a multidimensional construct that comprises cognitive, affective, and action-related components [5]. It describes the ability of nursing professionals to act effectively and appropriately in intercultural situations. In addition to knowledge about cultural differences, intercultural competence particularly includes reflection on one's own values and the ability to adapt nursing interventions to different cultural contexts [6].
In nursing science, intercultural competence is often linked to the concept of cultural competence, which aims at patient-centered and culturally sensitive care. The focus is not on attributing static cultural characteristics, but rather on a dynamic understanding of culture as situationally and individually shaped [4]. In nursing, intercultural competence is understood as the ability to act reflectively, appropriately to the situation, and with consideration of patient-specific needs in intercultural care situations [7].

2.2 Models of Intercultural Competence Development

To further conceptualize intercultural competence in nursing, various developmental models can be used that focus on learning and professionalization processes. One internationally widely received model is Campinha-Bacote's "Process of Cultural Competence in the Delivery of Healthcare Services," which describes cultural competence as a dynamic and never fully completed process. The model comprises the dimensions of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire, thereby emphasizing that both conscious self-reflection and repeated intercultural encounters are central prerequisites for competent action. From a nursing education perspective, this implies creating learning opportunities in which students can question their own assumptions, build knowledge about diversity, and test concrete action strategies in protected settings [8].
In addition to process-oriented models, approaches to cultural sensitivity and transcultural competence play an important role. These distinguish between ethnorelative and ethnocentric orientations and thereby describe developmental stages of intercultural attitudes. Nursing literature also emphasizes that intercultural competence is always embedded in institutional frameworks and organizational cultures and therefore must not be understood solely as an individual characteristic of nursing staff [6]; [7]. For university-based nursing education, this has two consequences: First, curricula should provide progressive learning opportunities along these developmental dimensions; second, opportunities for realistic, practice-oriented experience are essential in order to support the transition from cognitive knowledge to situational, action-related ability [4]; [3].

3. Analysis of the Case Examples in Relation to the Theoretical Framework

The following case vignettes are now analyzed with regard to the theoretical concepts of intercultural competence explained above. The aim is to systematically identify the demands on nursing action that become visible in these situations and to relate them to the dimensions of cultural competence, particularly cultural awareness, cultural knowledge, and cultural skill. On this basis, concrete reflection and learning potentials for university-based nursing education are subsequently derived. The analysis is carried out exemplarily using the first case vignette and can be applied analogously to the other cases.

Case 1 – Linguistic and Cultural Barriers in Intimate Care
On a surgical ward in an acute hospital, a female patient is on the second postoperative day following a lobectomy. The nursing care plan provides for her to be supported with personal hygiene and mobilized that morning in order to prevent postoperative complications. Due to the staffing situation, however, only a male nurse is on duty on the relevant side of the ward, while several patients requiring extensive and time-intensive care need to be attended to on the opposite side. The patient, who has a Muslim background, firmly refuses support with personal hygiene from the male nurse and justifies this with religious and cultural ideas of intimacy and gender roles. The male nurse faces the challenge of reconciling the nursing requirements of postoperative care with the patient's culturally and religiously grounded wishes, as well as with the organizational conditions.

Case 2 – Family Involvement and Decision-Making in Nursing Care
On an oncology ward, an older male patient is being cared for after chemotherapy. The treating physician plans an informational discussion about the further course of therapy and possible palliative options, since the previous treatment has not achieved the hoped-for success. The responsible nurse prepares the conversation and asks the patient whether he has any questions in advance or whether

she can organize anything for him. The patient responds hesitantly and asks for his entire family (his wife, adult children, and a brother-in-law) to be present during the discussion. He also expresses the wish that important decisions be made jointly with the family and not by him alone. The nurse is unsettled, as she assumes a patient-centered model in which the patient himself is at the center as the autonomous decision-making authority. She faces the challenge of reconciling the culturally shaped expectation of collective decision-making and family involvement with the principles of informed consent and individual autonomy, without disregarding the patient's needs or excluding the family.

Case 3 – Understanding of Pain and Adherence to Medication Intake
In a geriatric care facility, a resident with chronic back pain is being cared for. Despite a physician's prescription for regular pain medication, the resident frequently refuses to take it and states that pain "is part of life" and that one "has to endure it." In conversations, it becomes clear that the resident comes from a cultural environment in which expressing pain is considered a sign of weakness and in which taking strong medication is viewed with mistrust. The nurse observes that the resident is becoming increasingly immobile and is avoiding social activities, which indicates insufficiently treated pain. The nurse faces the task of building a trusting relationship, understanding culturally shaped ideas about pain and medication, and working together with the resident to find ways that both respect her values and enable appropriate pain therapy. In doing so, the nurse must navigate between the duty of nursing care, respect for autonomy, and consideration of culturally shaped patterns of interpretation.

3.1 Identified Competence Requirements

The three case vignettes presented illustrate that intercultural competence in nursing practice must be understood as a complex interplay of knowledge, attitude, and ability to act. At the cognitive level, all three situations require an understanding of culturally and religiously shaped ideas that significantly influence health behavior and interaction. In the first case, nursing professionals must recognize concepts of intimacy, gender roles, and professional distance as relevant influencing factors instead of interpreting them merely as "special requests." In the second case, knowledge of different concepts of autonomy and collective decision-making is necessary in order to understand family involvement not as a restriction of patient autonomy, but as a culturally embedded form of self-determination. The third case shows that culturally shaped concepts of pain and ideas about medication can influence adherence and that nursing professionals must be aware of these interpretive patterns and incorporate them into their care planning.
At the reflective and affective level, the ability for self-reflection and empathy becomes particularly evident in all three cases. Nursing professionals are required to critically question their own ideas of efficiency, professionalism, autonomy, and pain management and not to judge prematurely why patients reject certain offers or express different expectations. This also includes recognizing power asymmetries in the nursing situation: patients are in vulnerable positions, while nursing professionals possess institutional interpretive authority as well as temporal and organizational resources. Intercultural competence is shown here in the willingness to adopt the perspectives of patients and relatives and to take their reasons seriously, without negating one's own nursing responsibilities. This reflective attitude is particularly relevant in the second case, where Western-influenced concepts of individual autonomy come into tension with collective decision-making models, as well as in the third case, where the duty of care and respect for culturally shaped coping strategies must be balanced.
At the action-related level, several concrete competence requirements can be identified. These include the ability to shape negotiation processes with patients and relatives in which nursing requirements and cultural or religious needs are made transparent and shared solutions are developed. In the first case, this may mean actively shaping organizational conditions and seeking interprofessional or team-based support, for example through reorganizing task distribution or making temporal adjustments. In the second case, this requires communicative competence in order to involve the family without overriding the patient's voice, as well as the ability to sensitize the interdisciplinary team — for example physicians and social workers — to culturally sensitive discussion formats. In the third case, nursing professionals must be able to develop alternative approaches to pain therapy that take culturally shaped reservations into account, for example through gradual education, involvement of trusted persons, or adjustment of the form of administration. The case vignettes thus demonstrate exemplarily that intercultural competence includes both individual and organizational dimensions of action.

3.2 Reflection and Learning Potentials for Students

For university-based nursing education, the three case vignettes offer diverse potential for stimulating reflection processes among students and specifically promoting the development of intercultural competence. At a first level, students can be invited to view the situations from different perspectives: from the perspective of the patients, the relatives, the nursing professionals, and the organization. Such perspective-taking supports the development of empathy and helps to relativize premature judgments — such as “the patient is uncooperative,” “the family is interfering,” or “the resident is non-compliant” — in favor of a more differentiated understanding of reasons for action and contextual conditions. In guided reflection sessions, students can also address their own reactions, irritations, or defensive attitudes and thereby contribute to the development of cultural awareness.

Furthermore, the cases are suitable for integrating theoretical models of intercultural competence development into didactic work. Students can, for example, systematically work through the process of managing the situation using models such as the process of cultural competence — for example cultural awareness, knowledge, skill, encounters, and desire — and examine which dimensions are particularly required in the respective case constellations. In the first case, cultural awareness, meaning self-reflection on one’s own norms, is central; in the second case, cultural knowledge, meaning understanding collective decision-making models; and in the third case, cultural skill, meaning communicative negotiation in the context of adherence problems. In this way, theoretical knowledge is not treated abstractly, but is concretely linked to realistic nursing situations. At the same time, it is possible to discuss which additional competences — for example in the area of organizational negotiation or interprofessional collaboration — have so far been insufficiently represented in classic competence models.

Finally, the vignettes open up possibilities for action-oriented forms of learning, for example through role plays, simulation-based scenarios, or case-based discussions. Students can try out different communication strategies, develop alternative solutions, and reflect together on their effects. Through feedback from teachers and peers, they can experience how word choice, nonverbal communication, timing, and the way nursing measures are justified affect trust and willingness to cooperate. This makes clear that intercultural competence does not arise solely through cognitive learning, but above all through repeated, guided practice and reflection in complex, ambiguous situations. Such learning arrangements lay the foundation for students to later be able not only to theoretically justify culturally sensitive decisions in their professional practice, but also to implement them responsibly in practice.

4. Didactic Implications for Nursing Education

The analysis of the three case vignettes has shown that intercultural competence in nursing comprises cognitive, reflective, and action-related dimensions that must not be developed in isolation from one another, but rather integrated into complex practical situations. This results in concrete requirements for the design of university-based nursing education. The following section discusses three central didactic approaches that enable the systematic and practice-oriented integration of intercultural learning into curricula: case-based learning and reflective practice, simulation-based learning formats, and intercultural training modules and their curricular anchoring.

4.1 Case-Based Learning and Reflective Practice

Case-based learning is particularly suitable for depicting the complexity of intercultural nursing situations and encouraging students to analytically engage with real problems. The case vignettes presented can be used in various teaching formats, such as seminar discussions, small-group work, or portfolio assignments. What is essential is that the cases are not presented as examples of “right” or “wrong” solutions, but rather as starting points for differentiated engagement with competing values, institutional conditions, and professional scope for action. Students can be guided to adopt different perspectives, develop alternative courses of action, and evaluate them with regard to nursing, ethical, and cultural dimensions. Current reviews show that case-based learning contributes to competence development particularly when it is linked to guided reflection phases in which students can address their own assumptions, uncertainties, and affective reactions [4],[2].

A central element of reflective practice is the systematic promotion of cultural awareness, that is, conscious engagement with one’s own cultural influences, normative assumptions, and positions of power [8]; [6]. This can be supported through structured reflection tasks, such as keeping learning journals, guided self-reflection exercises, or peer-feedback formats. Teachers should create a protected space in which students may also articulate irritations, uncertainties, or internal resistance without having to fear being judged as “intolerant.” Especially the confrontation with one’s own blind spots and

assumptions is an essential component of intercultural learning processes and can be specifically initiated through case-based work (Dimitrova & Sehouli, 2023; [6].

4.2 Simulation-Based Learning Formats

In addition to case-based discussion formats, simulation-based learning environments offer the opportunity to experience and practice intercultural nursing situations in an action-oriented way. In role plays or with simulated patients, students can reenact the situations described in the case vignettes and try out different communication strategies, forms of argumentation, and nonverbal behaviors. Within the protected framework of simulation, students can make mistakes, experience uncertainty, and learn from these experiences without real patients being affected. International studies show that simulation-based training can contribute to the development of cultural competence, particularly when it is combined with structured debriefing phases in which the experience is jointly reflected upon and theoretically contextualized [4].
Concrete simulation scenarios can be developed for the three case vignettes presented. In the first case, concerning intimate care and gender roles, students can practice how to conduct a respectful conversation with the patient within a limited timeframe, negotiate organizational solutions, and at the same time make nursing necessities transparent. In the second case, concerning family involvement and decision-making, it can be simulated how an informational discussion can be structured in a way that both recognizes the patient as an autonomous subject and involves the family without perceiving their presence as a “disruption.” In the third case, concerning understanding of pain and adherence, students can practice how to build a trusting relationship, address culturally shaped reservations, and develop viable compromises together with the resident. Such simulations make it possible to specifically train cultural skill, that is, the concrete application of intercultural competences in interaction, and to deepen it through repetition and variation [2];[8].

4.3 Intercultural Training Modules and Curricular Anchoring

In addition to selective teaching and learning arrangements, systematic curricular anchoring of intercultural competences is necessary in order to achieve sustainable learning effects. This means that intercultural content should not be addressed only in individual elective modules or projects, but must be integrated as a cross-cutting theme in various modules and across several years of study [3]; [4]. The integration of cultural competence into nursing education can take different forms: through the design of independent cultural competence courses, through the embedding of cultural content into existing theoretical and clinical courses, or through the continuous consideration of cultural diversity in all learning opportunities. Studies show that continuous development of cultural competence throughout the entire nursing program, both in theory and practice, is more effective than isolated individual measures [4].
A particular challenge lies in the assessment and evaluation of intercultural competence development. While cognitive knowledge can be assessed through traditional examination formats, reflective and action-related dimensions are more difficult to measure. Regular assessment of students’ competence development is considered necessary in order to monitor learning progress. Alternative examination formats such as OSCEs — Objective Structured Clinical Examinations — with standardized patients can be used for this purpose, enabling feedback on professionalism, communication skills, and culturally sensitive behavior [4].
Moreover, the qualification and continuing education of university lecturers themselves is a central prerequisite for successful cultural education [9]; [10]; [3]. Lecturers should possess intercultural competences and receive continuous training in culturally and linguistically appropriate care [4]; [9]. Studies show that lecturers with international education, multilingual abilities, and participation in cultural training are better able to engage students in discussions about cultural diversity. The importance of age, multilingualism, and continuing education for the development of cultural competence among lecturers is emphasized by current research. Therefore, targeted interventions such as language support programs, cultural competence training, and the promotion of reflective practices should be implemented in order to improve the cultural competence and transcultural teaching behavior of nursing educators [9].
Finally, the involvement of external partners, such as intercultural trainers, self-organizations, or patient representatives, is valuable. Through guest lectures or joint workshops, students can gain insights into different perspectives. Such participatory approaches help to avoid essentialist notions of culture and promote a dynamic, context-related understanding of diversity [3]; [4].

5. Discussion and Conclusion

In light of increasing social diversity, the development of intercultural competence in nursing education represents a central educational policy and professional challenge. The present analysis shows that a theoretically grounded understanding of culture and cultural competence, as offered by Campinha-Bacote's Process Model [8], is a necessary but not sufficient prerequisite for practice. Sustainable competence development can only succeed through the combination of theoretical grounding with evidence-based didactic strategies.

The examined teaching and learning strategies, such as case-based learning, simulation training with standardized patients, cultural immersion experiences, and curricular integration, prove effective when they build systematically upon one another and are implemented throughout the entire course of study [4]; [3]. Particular emphasis should be placed on the importance of reflective learning processes that enable students to recognize and critically question their own cultural influences [1]; [2]. Without this self-reflection, there is a risk that cultural knowledge leads to stereotypical attributions rather than to differentiated, context-sensitive nursing practice.

A central finding is that intercultural competence must not be understood as an additive curriculum element, but as a cross-cutting competence embedded in all modules. However, this also requires university lecturers themselves to possess the corresponding competences and to receive continuous professional development [9], [10]. The qualification of lecturers, particularly with regard to their cultural sensitivity, language competence, and didactic skills, is therefore an essential institutional task.

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