Nurse Education Today 34 (2014) 999–1004

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/nedt

Caring for ethnic minority patients: A mixed method study of nurses' self-assessment of cultural competency

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ARTICLE INFO

Article history:
Accepted 9 December 2013

Keywords:
Ethnic minority patients
Cultural competency
Pain assessment

SUMMARY

Background: Research shows that nurses tend to be lacking cultural competence, which may influence treatment and care for ethnic minority patients negatively.
Purpose: To investigate how Medical Unit nurses and Psychiatric Unit nurses assess their own competency concerning patients with minority backgrounds. The topics covered are: intercultural knowledge, knowledge of medical traditions and differences in illness etiology, symptom assessment, and in-service education and availability of advice. These topics are seen in relation to the nurses' years of work experience.
Methods: Three focus group interviews were conducted before the development of a Likert-type questionnaire containing six topics and a total of 35 statements. 145 Medical Unit nurses (90%) and 100 Psychiatric Unit nurses (81%) returned the questionnaire. SPSS was used to analyze the quantitative data; hermeneutic thematic analysis was used for the qualitative data.
Results: Both the Medical Unit nurses and the Psychiatric Unit nurses indicated that knowledge about illness and treatment philosophies other than Western biomedicine was inadequate. The respondents also found symptom assessment difficult, and they were offered little, if any, in-service education. Work experience added little substantive knowledge.
Conclusion: Experience alone does not equip nurses with adequate knowledge for intercultural symptom assessment and culturally competent treatment and care. Formal education, in-service classes, courses, feedback and access to relevant information are needed together with reflection upon clinical practice.

Introduction

Cultural competency is a many-faceted phenomenon which California Endowment (2003) defines as the attitudes, knowledge and skills necessary for providing quality care to diverse populations. This constitutes a growing challenge in nurse education as many societies become ever more culturally diverse.

In previous studies we have found only very limited discussions on how nurses themselves assess their intercultural competency in relation to specific clinical issues, and we have not found any studies comparing nurses working in medical and psychiatric units. We therefore conducted a study of Medical Unit (MU) registered nurses' and all levels of Psychiatric Unit (PU) healthcare workers' self-assessed cultural competency in a hospital with a 30–40% ethnic minority patient population in Oslo, the capital of Norway. In this city 30% of the 624,000 inhabitants are immigrants or have immigrant parents. On a national basis it is 14.1% (Statistics Norway, 2013). In this paper the nurses' self-assessed general intercultural knowledge, knowledge of non-biomedical illness philosophies, symptom assessment ability, and availability and need of in-service programs and support are discussed.

Cultural Competency – A Brief Review

The research question was *How do Medical Unit nurses and Psychiatric Unit nurses assess their competency concerning patients with non-Western minority backgrounds*? Cultural competency means incorporating 'culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs' (Betancourt et al., 2003, p. 294). Several authors report inequality in health between ethnic minority and majority populations (Blom, 2010; Culley and Dyson, 2001), and that ethnic minority patients often receive lower quality treatment and care than the majority population (Monsivais and McNeill, 2007; Moore and Butow, 2004). According to Smedley et al. (2003), this disparity in healthcare also persists when studied in light of, for instance, socioeconomic status, age, place of treatment, and kind and stage of disease.

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0260-6917/$ – see front matter © 2013 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.nedt.2013.12.004

One of the most important tools to eliminate the disparities is integrating 'cross-cultural education' into the training of current and future healthcare providers (Smedley et al., 2003). Several nursing theorists (e.g. Gerrish and Papadopoulos, 1999; Leininger, 1994; Papps and Ramsden, 1996) point to the importance of cultural competency in nursing and the lack thereof. Benner et al. (2010) found that student nurses, in general, are poorly prepared to work with people with different ethnic, class or religious backgrounds from their own. This is supported by a study of curricula and intercultural education in Norwegian nursing colleges (Magelssen, 2012) and the necessity of curricular modification and development in British nurse education (Narayanasamy et al., 2013).

Many authors of studies referred to in this paper use the concepts of 'culture' and 'ethnicity' as synonyms. Our basic view in this paper, however, is that within any 'cultural' or 'ethnic' group one will find considerable diversity. While a person's values, beliefs and customs may be culture based, they will also be unique to that individual. According to Howard (1996, p. 14)

> [c]ulture is the customary, learned manner in which human groups organize their behavior and thought in relation to their environment. Defined in this manner, culture has two principle aspects: behavioral and cognitive. The *behavioral* component refers to how people act, and especially interact, with one another. … *Cognition* involves how people perceive, classify, and interpret their world.

Ethnicity relates to people who look upon themselves – and are seen by others – as belonging to a distinct ethnic minority group. This may or may not be related to race, religion, and/or culture (Jenkins, 1997).

Research Methods

An exploratory mixed method design (Creswell, 2008) was chosen, a "procedure of first gathering qualitative data to explore a phenomenon, and then collecting quantitative data to explain relationships found in the qualitative data" (Creswell, 2008, p. 561). Only findings from the participating nurses are reported here.

Instrument Development

Three focus group interviews were conducted with healthcare staff working in the two fields (6 + 5 MU RNs and 7 PU health professionals) as the first step in the development of a questionnaire (Halkier, 2010) to learn about the participants' hands-on experiences working with ethnic minority patients.

The participants were asked which questions would be pertinent for a questionnaire specifically developed for their respective units. These interviews supported the themes anticipated from a previous study (Hanssen, 2010).

Some instruments mapping healthcare personnel's self-assessment concerning cultural competency already existed (e.g. Campinha-Bacote, 2007; Sargent et al., 2005), but no instrument was found to correspond with what our interviews indicated were clinically relevant in these hospital contexts. A Likert-type questionnaire was developed based on the focus group interview findings and the previous study. 35 statements were designed to operationalize cultural competency, divided into six main topics: 1. Experience and knowledge, 2. Illness, health behavior and pain, 3. Collaboration, attitudes and conduct, 4. Communication and collaboration with interpreters, 5. Death and dying/suicide, 6. Culture, religion, and diet. In this paper the focus is on issues within topics 1 and 2, nurses' general intercultural knowledge, knowledge of non-biomedical illness philosophies, symptom assessment, and the availability and need of in-service programs and/or support system.

Each statement was given six response alternatives: 1–2: I strongly agree/agree, 3: I neither agree nor disagree, 4–5: I disagree/strongly disagree, 6: I don't know. There were four open-ended questions.

Reliability

The method triangulation of this mixed method study augments reliability (Halkier, 2010). Furthermore, Fernandez et al. (2004), among others, have found that self-assessed competency studies are relatively trustworthy.

Validity

Based on the focus group interviews and a previous study (Hanssen, 2010), we produced a questionnaire reflecting as closely as possible the nurses' real life experiences working with non-Western patients. Comments from two experienced researchers and two clinical nurses made us reduce the number of statements and make the wording clearer. A small pilot study was then carried out. This caused further refinement of the questions. A quantitative research expert scrutinized this third draft. After some further linguistic refinement, the actual study was commenced.

Respondents

All RNs working in the two units, independent of age and whether having completed any post-bachelor education, were included in the study. Both units have adult patients.

Medical Unit: N = 145, 90% of registered staff nurses (12% men, 88% women). Years of nursing experience: 0–10+.

Psychiatric Unit: N = 100, 81% of registered staff nurses (19% men, 81% women). Years of psychiatric nursing experience: 0–10+.

Data Analyses

Quantitative Data

The electronic analytical tool SPSS was utilized for the quantitative data with the questionnaire statements as analytic categories. Several statistical tests were applied. None of the tables show significant differences. One explanation may be the limited number of respondents.

Qualitative Data

The recorded focus group interviews and the comments found in the questionnaires' open-ended questions and in the margins were meticulously transcribed. The questionnaire statements were used as analytic categories also for the qualitative data where applicable. The qualitative texts were analyzed together according to a hermeneutic tradition (Gadamer, 1989). Focus group interviews, answers to open questions and other written comment texts were read, re-read and discussed to re-evaluate our conceptions, deepen our understanding and as far as possible avoid bias.

Ethical Considerations

The study was approved by a hospital Privacy Ombudsman for Research and the respective unit heads. The focus group interviewees and the questionnaire respondents were informed orally and in writing about the study and its purpose. Neither group signed a consent form but all were informed that participation was voluntary and that they were free to withdraw at any time.

Respondents put their unmarked, anonymous questionnaires into a communal envelope on the respective wards, which were then collected. No names were written down or mentioned during the focus group interviews. The interview recordings were deleted after transcription. The interviewees' and the respondents' confidentiality have been ensured throughout the entire research process, from data collection to publication.