DWHITE (NON-HISPANIC) NURSE PRACTITIONER STUDENT PERCEPTIONS
OF HISPANIC PATIENTS

by

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White (Non-Hispanic) Nurse Practitioner Student Perceptions of Hispanic Patients

A dissertation proposal submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Nursing at George Mason University

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DEDICATION

I dedicate this work first and foremost to my family, who have persevered through this journey with me and have always provided me with love and encouragement. To my daughter Liana for supporting me through my continuous quest for achievement and urging me to reach for the stars; to my son Joseph who has taught me to believe in and stand up for myself, and not to be afraid of taking risks; to my sister Celia, who has always blazed new trails and because of that, opened the door to higher education and allowed me to create a new world of possibilities for me and my children; to my sister Carmen, who always provided me with unconditional love and encouraged me to explore, play, laugh, and dream; and to Mami, whose unfailing love, faith, and courage taught me that nothing is impossible and that I am never alone. I thank them all for their endless support, patience, and, most of all, love.

Finally, I also dedicate this work to the people of my race/ethnicity, Hispanics: Puerto Ricans, Nuyoricans, Cubans, Mexicans, South Americans, Central Americans, in hopes that a time will come when we will be embraced for the beauty and value we bring to this life and that as a people, we can one day all receive a more culturally competent, linguistically appropriate, respectful, effective, and efficient quality of health care services.
Buscando America

Estoy buscando America
Y temo no encontrarte
Tus huellas se han perdido
Entre la oscuridad

Estoy llamando America
Pero no me respondes
Se han desaparecido
Los que temen a la verdad

Envueltos entre sombras
Negamos los que es cierto
Mientras no haya justicia
Jamas tendremos paz

Viviendo dictaduras
Te busco y no te encuentro
Tu torturado cuerpo
No saben donde esta
Si el sueño de uno
Es sueño de todos
Romper la cadena
Y echarnos andar

Tengamos confianza
Pa lante mi raza
A salvar el tiempo
Por los que vendran

Te han secuestrado America
Y amordazao tu boca
Ya nosotros nostoca
Ponerte en libertad

Te estoy llamado America
Nuestro futuro espera
Y antes que se nos muera
Te vamos a encontrar

Estoy buscando America
Estoy llamando America
Luchando por la raza
Y nuestra identidad

Estoy buscando America
(Esta es mi casa)
Estoy llamando America
Y vamos a encontrate
Entre la oscuridad

Estoy buscando America
Estoy llamando America
Se desaparecidi
Lo quien niegan la verdad

Estoy Buscando America
Estoy llamando America
Ya nosotros nostoc, hoy
Ponerte en libertad

Lyrics by Ruben Blades
As recorded 1983
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ABSTRACT

WHITE (NON-HISPANIC) NURSE PRACTITIONER STUDENT PERCEPTIONS OF HISPANIC PATIENTS

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Thesis Director: Dr. Charlene Douglas

As the United States continues to become increasingly more diverse, the health care industry must adjust and develop improved strategies for the effective provision of health care services to all. The Hispanic population is the fastest growing minority group in the United States. This population (ethnic group) faces many challenges to receiving adequate health care including: stereotyping by health professionals; language and cultural barriers; limited access to health care; and a lack of trust in the current health care system. Hispanic patients are frequently met by predominantly White (non-Hispanic) health care practitioners, who bring their own set of biases and stereotypes to the encounter. This study explores White (non-Hispanic) nurse practitioner (NP) student perceptions of Hispanic patients and how these perceptions may influence their provider/patient clinical encounter. Furthermore, the study assesses White (non-Hispanic) NP students’ perceived cultural self-efficacy regarding Hispanic patients and investigates whether there is a relationship between their perceptions of Hispanic patients and their
perceived cultural self-efficacy. A mixed methods research approach was used to investigate White (non-Hispanic) NP student perceptions of Hispanic patients. A modified version of the Cultural Self-Efficacy Scale (CSES) was used to assess the White (non-Hispanic) NP students’ perceived Hispanic cultural self-efficacy. Strategies to enhance White (non-Hispanic) NP provider/patient clinical interactions as well as mechanisms to improve the development of a therapeutic relationship with Hispanic patients are discussed.
CHAPTER I
INTRODUCTION

. . . when you change the way you look at things, the things you look at change. (Dyer, 2004, p. 183)

Background
With the growing ethnic/racial distribution of the population of the United States, the lack of cultural diversity in the U.S. registered nurse (RN) population (U.S. Department of Health and Human Services [USDHHS] and Health Resources and Services Administration [HRSA], 2006) and the racial and ethnic disparity that continues to plague our health care system (Pfizer, 2004; Reyes, Van de Putte, Falcon, & Levy, 2004; U.S. Department of Health and Human Services [USDHHS] and National Institutes of Health [NIH], 2004), it becomes increasingly more important to assess the impact that care provided by White (non-Hispanic) RNs may have on racial and ethnic health care disparities. According to the 2004 National Sample Survey of Registered Nurses (NSSRN) (USDHHS & HRSA, 2006), the nursing profession remains a predominantly White female profession with a population of 81.8% estimated to be White (non-Hispanic) and 7.5% of the population not declaring a specific racial/ethnic background. Of those RNs who elected to indicate a racial/ethnic background, an
estimated 10.7% designated themselves as non-White (USDHHS & HRSA, 2006). In the 2008 NSSRN (USDHHS & HRSA, 2010), it was reported that 16.8% of all nurses in the United States were from a minority racial and ethnic group.

The 2004 NSSRN (USDHHS & HRSA, 2006) also highlights the fact that the delivery of nursing care is trending away from the hospital setting to more of a community and public health care environment. These alternate settings include: physician-based practices, nurse-based practices, and health maintenance organizations. Frequently, RNs who have attained increased education and certification then serve as advanced practice registered nurses (APRNs) and find themselves providing primary health care services in these settings. The category of advanced practice registered nurses (APRNs) includes: nurse practitioners (NPs), clinical nurse specialists (CNSs), nurse midwives (CNMs), and nurse anesthetists (NAs), and they represent approximately 240,461 or 8.3% of the total RN population. The March 2004 NSSRN APRN category of NP showed an almost 38% increase since the 2000 RN sample survey. Some of these NPs may establish their own nurse-managed clinics where they will be responsible for providing primary care services to a variety of patients. The almost 38% growth in the NP category, as well as the movement of nursing care services to a more ambulatory environment, demonstrates that this group of providers could well be responsible for providing an increased share of primary care services to an increasingly diverse population. A recent surge in the number of retail clinics staffed by NPs is evidence of the increasing need for primary care services that are convenient and provide quality care for patients in need. “In 2008, an estimated 158,348 nurses had preparation as nurse
practitioners (NPs). NPs represent the largest group of advanced practice registered nurses (APRNs)” (USDHHS & HRSA, 2010, p. xxx).

The 2003 Institute of Medicine (IOM) report Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care stated: “Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients’ insurance status and income, are controlled” (Smedley, Stith, & Nelson, 2003, p. 1). This report further states that the sources of these health care disparities are “rooted in historic and contemporary inequities” (Smedley et al., 2003, p. 1). The report, which includes information regarding clinical encounters, specifically referred to studies focused on race factors (black or white) and physician recommendations or decision making, which inferred that clinical decision making may be influenced by the physician’s perception of race rather than objective data (Schulman et al. 1999; Schwartz, Woloshin, & Welch 1999; Smedley et al., 2003).

A 2005 Washington Post article, “See No Bias” (Vedantam, 2005), discussed a psychological test which could help individuals examine implicit attitudes through words and images or concepts. According to Banaji, one of the researchers who helped develop “The Implicit Association Test” (Project Implicit, n.d.), this research challenges the notion that discrimination is a thing of the past.

The implicit system is likely a part of the ‘primitive’ brain, designed to be reactive rather than reasoned. It specializes in quick generalizations, not subtle distinctions. Such mental shortcuts helped our ancestors survive . . . . The same mental shortcuts . . . are what cause people to form unwelcome stereotypes about other people. (Vedantam, 2005, p. 15)
According to Banaji, the test measures race bias, rather than racism, and unfortunately implicit biases are a strong predictor of how an individual will actually behave (Vedantam, 2005). Greenwald and Banaji’s (1995) research, which was the foundation for Vendantam’s 2005 article, tested the belief that social behavior was conscious and provided evidence that social behavior frequently operates in an unconscious manner.

Derrick Bell (1991), a professor at New York University’s Law School, stated, “we live in a society in which racism has been internalized and institutionalized to the point of being an essential and inherently functioning component of that society—a culture from whose inception racial discrimination has been a regulative force for maintaining stability and growth and for maximizing other cultural values” (pp. 88–89).

Malcolm Gladwell (2005), in his book *Blink: The Power of Thinking without Thinking*, shared the story of how his life changed when he made the decision to grow his hair long and wild. His experience led him to study first impressions, gain a better understanding of the power that they yield, and then write about them. A study referred to in *Blink* and done by Aronson and Steele (as cited in Gladwell, 2005) led them to opine that “much of the time, we are simply operating on automatic pilot, and the way we think and act—how well we think and act on the spur of the moment—are a lot more susceptible to outside influences than we realize” (p. 58).

If we accept the premise that racism is endemic in today’s society and if research illuminates the fact that physicians will at times make clinical decisions on African-Americans or black patients based on race factors, rather than clinical indications, then
could a patient’s name, color of skin, physical characteristics, language, accent, etc., impact a provider’s approach to patient care? Could the results of these studies shed some light on the impact of race/ethnicity on the quality of care provided to other populations, in particular, Hispanics? (Auerbach et al., 2000; East & Peterson, 2000).

The literature review demonstrates that a majority of the studies related to race and health care disparities have focused on the African-American population (Lillie-Blanton & Lewis, 2005). The 2003 IOM report Unequal Treatment urged researchers to study other health care providers and other racial/ethnic groups. The U.S. Hispanic growth rate of 3.6% as compared to the overall U.S. population growth, which was 1% over the 12 months starting in July 2003 (Associated Press, 2005), provides justification for focusing research on the Hispanic racial/ethnic group. A March 2011 release of a U.S. Census report reflects the continued growth of the Hispanic population in the United States.

In 2010, there were 50.5 million Hispanics in the United States; composing 16% of the total population (see Table 1). Between 2000 and 2010, the Hispanic population grew by 43%—rising from 35.3 million in 2000, when this group made up 13% of the total population. The Hispanic population increased by 15.2 million between 2000 and 2010, accounting for over half of the 27.3 million increase in the total population of the United States. (Humes, Jones, & Ramirez, 2011, p. 3)
Statement of the Problem

What makes institutionalized racism so pernicious and difficult to eradicate is that racist practices are often invisible because they are accepted as standard operating procedures within our institutions. (Berlak, 2001, p. 14)

Findings from the Commonwealth Fund 2001 Health Care Quality Survey and other studies reveal that on a wide range of health care quality measures, minority Americans do not fare as well as Whites. African-Americans, Asian-Americans, and Hispanics are more likely than Whites to experience difficulty communicating with their physician, to feel that they are treated with disrespect when receiving health care services, and to experience barriers to care, including lack of insurance or a regular doctor (Collins et al., 2002; Hicks et al., 2005; Langwell & Moser, 2002; Lillie-Blanton & Hoffman, 2005; Lillie-Blanton & Lewis, 2005). Moreover, a substantial proportion of minorities feel they would receive better care if they were of a different race or ethnicity. Hispanics and Asian-Americans frequently stand out as the least-well-served by the health care system (Collins et al., 2002, p. v). The 2003 IOM report Unequal Treatment exposed that “A large body of published research reveals that racial and ethnic minorities experience a lower quality of health services, and are less likely to receive even routine medical procedures than are white Americans” (Smedley et al., 2003, p. 2). Other studies have arrived at similar conclusions (U.S. Department of Health and Human Services [USDHHS] & Agency for Healthcare Research and Quality [AHRQ], 2004; Langwell & Moser, 2002; Rust et al., 2004).
Racism and discrimination frequently lead to decreased access and quality of care. For instance, as noted in the 2002–2006 Strategic Plan for Health Disparities Research, racial bias can play a significant role in whether a cardiac catheterization will be recommended for patients presenting with chest pain (U.S. Department of Health and Human Services [USDHHS], National Institutes of Health [NIH], & Office of Behavioral and Social Sciences Research [OBSSR], n.d.). Additionally, the 2003 IOM report Unequal Treatment also stated that racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors such as patient insurance status and income are taken into account (Smedley et al., 2003). Thus, the OBSSR in its 2002–2006 Strategic Plan for Health Disparities Research emphasizes the need to engage in research whose aim is to better understand the degree to which racial bias could influence minority health (USDHHS, NIH, & OBSSR, n.d.).

Hispanics and/or Spanish-speaking individuals are one of several ethnic groups who experience the barriers to health care which racism and discrimination create. Unfortunately, a lack of knowledge remains regarding the extent of these barriers on other ethnic racial populations (in particular, Hispanics) due to the fact that most of the existing data in this area predominantly concerns African-Americans. The Kaiser Family Foundation report emphasizes the need for further studies and information regarding the role of bias as a possible cause of health care disparities (Epstein & Ayanian, 2001; Lillie-Blanton & Lewis, 2005).
**Statement of the Purpose**

The purpose of the study was to examine White (non-Hispanic) NP student perceptions of Hispanic patients and how these perceptions may impact the provider/patient clinical encounter. It also sought to explore the relationship between the perceived cultural self-efficacy of White (non-Hispanic) NP students and their perceptions of Hispanic patients.

**Significance of the Study**

Recent studies in health care disparities have been geared toward bias, physician/patient communication (U.S. General Accounting Office, 2003), and barriers to care, but there has been limited information regarding the RN’s role in provider/patient interaction and communication with Hispanics and how bias/racism may influence this provider/patient clinical encounter (Eliason, 1998, 1999; Harris & Cummings, 1996; Puzan, 2003; Tullmann, 1992).

Additionally, although there are some nursing studies related to cultural competence and attitudes, these studies have focused predominantly on African-American patients (Castillo & Torres, 1995; Eliason, 1999; Vaughan, 1997). There have been limited studies regarding White (non-Hispanic) RNs, Hispanic patients, and latent racial biases and perceptions. Therefore, since the distribution of RNs by racial/ethnic background, according to the 2004 NSSRN, demonstrates that this population is predominantly White (non-Hispanic) at 88.4% (p. 6), as well as the 2008 NSSRN which shows a White (non-Hispanic) population of 83.2% (USDHHS & HRSA, 2010), then how could racial, ethnic, cultural, and language differences between the White (non-
Hispanic) RN population influence the provider/patient interaction? Should subconscious/unconscious racial biases exist, could they and/or how would they influence the provider/patient clinical encounter?

Furthermore, because the RN category of NP has demonstrated a 38% growth rate since 2000 and nursing care services show movement away from acute care toward ambulatory care settings, it is quite likely that this subset RN population will also be predominantly White (non-Hispanic) and will most probably function in a more autonomous manner. Thus, it would be important to gain additional insight regarding this population and more importantly those currently seeking this status. For these reasons, research into the White (non-Hispanic) NP students’ perception of Hispanic patients is needed and could provide new information regarding its potential impact on the clinical encounter.

**Research Questions**

- What are the White (non-Hispanic) NP students’ perceptions of Hispanic patients?
- In what way does the Hispanic patient influence the White (non-Hispanic) NP student provider/patient clinical encounter?
- What are the White (non-Hispanic) NP student expectations of Hispanic patients?
- What is the perceived Hispanic cultural self-efficacy of the White (non-Hispanic) NP student?
- Is there a relationship between the White (non-Hispanic) NP students’ perceived cultural self-efficacy related to Hispanics and their responses to the qualitative interview questions?
Is there a relationship between the White (non-Hispanic) NP students’ demographic factors and their perceived Hispanic cultural self-efficacy?

**Definition of Terms**

*Theoretical*

Aversive racism: “The inherent contradiction that exists when the denial of personal prejudice co-exists with the underlying *unconscious* negative feelings and beliefs” (Dovidio & Gaertner, 2002, p. 24).

Cultural competence: “Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities” (Meadows, 2000, p. 1).

Discrimination: “The act of denying rights, benefits, justice, equitable treatment, or access to facilities available to all others, to an individual or group of people because of their race, age, gender, handicap or other defining characteristic” (discrimination, n.d.).

Ethnocentrism: “Ethnocentrism is a nearly universal syndrome of discriminatory attitudes and behaviors (Sumner 1906; LeVine and Campbell 1972). The attitudes
include seeing one’s own group (the in-group) as virtuous and superior, one’s
own standards of value as universal, and out-groups as contemptible and inferior.
Behaviors associated with ethnocentrism include cooperative relations within the
group and the absence of cooperative relations with out-groups (LeVine and
Campbell 1972). Ethnocentric behaviors are based on group boundaries that are
typically defined by one or more observable characteristics (such as language,
accent, physical features, or religion) regarded as indicating common descent
(Sumner 1906; Hirschfeld 1996; Kurzban, Tooby, and Cosmides 2001)”
(Hammond and Axelrod, 2006, p. 926).

Eurocentrism: “The consideration of events and people exclusively from the perspective
of whites [sic.] who came to the United States from Europe” (Byrne, Weddle,

Institutional racism: Racial prejudice supported by institutional power and authority used
to the advantage of one race over others (Anti-Defamation League, 1999).

Racism: “Refers to institutional and individual practices that create and reinforce
oppressive systems of race relations whereby people and institutions engaging in
discrimination adversely restrict, by judgment and action, the lives of those
against whom they discriminate” (Krieger, 2003, p. 195).

Stereotypes: “Rigid preconceptions held about all people who are members of a particular
group” frequently based on a lack of knowledge and based on preconceived
notions (Harris, 2002, p. 120).
White privilege: “A right, advantage, or immunity granted to or enjoyed by white persons beyond the common advantage of all others, an exemption in many particular cases from certain burdens or liabilities . . . . The possession of an advantage white persons enjoy over non-white persons” (Clark, 2011).

**Operational**

Advanced practice registered nurse (APRN): A registered nurse who has completed an advanced program of study which enables him/her to gain certification and practice as a nurse practitioner, nurse mid-wife, clinical nurse specialist, or nurse anesthetist.

Communication: Communication that occurs in such a manner that builds a relationship where patient and nurse are equal partners in the consultation and where effective treatment is the outcome that both are seeking (Anonymous, 2002).

Encounter: A meeting with a person (patient) in a health care environment such as a hospital, clinic, health care provider’s office, etc. A meeting taking place between a patient and a registered nurse will be considered a clinical encounter for the purposes of this research.

Hispanics: The term used by the federal government to identify individuals with Spanish surnames or whose heritage is linked with individuals from Spain. For the purposes of this research Hispanics will be the primary term used to describe all Latino/Hispanic populations.

Latino/a: Used to signify persons with nationalities or ancestries derived from countries with “Hispanic” cultures, currently in the United States, these persons or groups
are primarily (but not exclusively) Mexican Americans, Central Americans, Puerto Ricans, and Cuban Americans.

Nurse practitioner (NP): Nurse practitioners (NPs) are registered nurses who have graduate-level nursing preparation at the master’s or doctoral level as a nurse practitioner. NPs perform comprehensive assessments, and promote health and the prevention of illness and injury. These advanced practice registered nurses diagnose; develop differential diagnoses; order, conduct, supervise, and interpret diagnostic and laboratory tests; and prescribe pharmacologic and non-pharmacologic treatments in the direct management of acute and chronic illness and disease. Nurse practitioners provide health and medical care in primary, acute, and long-term care settings. NPs may specialize in areas such as family, geriatric, pediatric, primary, or acute care. Nurse practitioners practice autonomously and in collaboration with other health care professionals to treat and manage patients’ health problems, and serve in various settings as researchers, consultants, and patient advocates for individuals, families, groups, and communities (American Nurses Association, 2010, p. 114).

NP student: A registered nurse who is enrolled in a program leading to an advanced degree, which will enable him/her to become a nurse practitioner.

**Theoretical Framework**

The investigator used Critical Race theory (CRT) as a theoretical framework that represents a wide body of legal and political research that critically examines the role of race as a social construct that organizes political interactions. CRT argues that racism is
endemic to American culture and that discrimination is a product of stereotyping and psychological prejudices as well as “institutional structures and practices through which individual attitudes and behavior play out” (Blasi, 2002, p. 280).

CRT examines the role of race as a social construct that organizes political interactions and builds on insights of critical legal studies and radical feminism. The intellectual father of CRT is Derrick Bell, a professor of law at New York University. CRT draws from American radical tradition exemplified by figures such as Sojourner Truth, Frederick Douglass, W. E. B. DuBois, Cesar Chaves, and Martin Luther King, Jr. The late Alan Freeman, who taught at SUNY Buffalo law school, wrote a number of foundational articles (Delgado & Stefancic, 2001).

The basic tenets of CRT include:

- Racism is ordinary, not aberrational.
- White-over-color ascendancy serves important purposes, both psychic and material.
- Racism advances the interests of white elites (materially)—large segments of society have little incentive to eradicate it (Delgado & Stefancic, 2001, p. 7).
- “Race and races are products of social thought and relations. Categories that society invents, manipulates, or retires when convenient” (Delgado & Stefancic, 2001, p. 7).

CRT has two schools of thought:

- Idealists—racism and discrimination are matters of thinking, mental categorization, attitude, and discourse. Race is a social construction, not a biological reality.
- Realists—racism is much more than having an unfavorable impression of members of other groups. Racism is a means by which society allocates privilege and status.
LatCrit theory is complementary to CRT and is focused on Latino issues such as immigration, culture, and language, to name a few. LatCrit theory posits that race and racism intersect with other Latino issues, including language, class, sexuality, generation status, and gender, and that these forms of oppression have a way of impacting one another. “LatCrit is especially conscious of accounting for how additional dimensions of identity might also be subjected to additional or different forms of discrimination or marginalization in the case of Latinos” (Villalpando, 2004, p. 43).

As stated by Powell (2002), “disparities are rooted in laws that disadvantage people of color and overadvantage whites” (p. 8). Powell (2002) further states, “Persistent racial disparities are not dependent upon racial animus or ill will; this is why they are termed ‘structural.’ This is the racism that is built into all of our structures, it is the status quo, and will only be undone in a lasting way when structures are reformed” (p. 8).

Therefore, in this study, the investigator examined White (non-Hispanic) NP student perceptions of Hispanic patients through the analysis of the interview responses for potential examples of provider/patient interactions that may manifest themselves in language, attitudes, and/or behaviors that exemplify CRT.

In reference to cultural competence, the investigator referred to the model developed by Campinha-Bacote (2003), who views cultural competence as a process which includes cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters. In this model, cultural desire is defined as the motivation that prompts the nurse to engage in the process of becoming culturally aware.
Campinha-Bacote (2003) depicted her cultural competence model as a volcano, emphasizing that it is cultural desire that incites one to achieve cultural competence. As previously stated, this model has the following constructs: cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters. They are defined as follows:

- Cultural desire is framed as the nurse’s motivation to initiate the process toward cultural competency and includes a passion and willingness to learn from others.
- Cultural awareness is the ability of the nurse to engage in self-examination and involves the examination of one’s assumptions, biases, and prejudices about people who are different.
- Cultural knowledge is the course one takes to secure sound cultural knowledge regarding diverse ethnic and cultural groups.
- Cultural skill is the ability of the individual to perform a cultural assessment and collect the appropriate information in a culturally appropriate manner.
- Cultural encounter is the means by which the nurse is encouraged to engage in interactions with patients from diverse backgrounds.

To incorporate this model into one’s practice, Campinha-Bacote (2003) urged the use of the mnemonic “ASKED”, which corresponds with questions to prompt a nurse to reflect and engage in assessing one’s ability to engage in a culturally appropriate patient encounter.

Therefore, regarding cultural competence, the research participants were selected on the premise that they have engaged in patient/provider encounters with Hispanic
patients, and their responses were analyzed for evidence of where they may be placed on this cultural competence continuum based on this model.

**Assumptions**

1. Institutional forms of racism are embedded in American society in both visible and invisible ways (Berlak, 2001; West, 1993).

2. The White majority population is unaware of their latent and inherent racist practices or behaviors. “. . . people are ignorant of the things that affect their actions, yet they rarely feel ignorant” (Gladwell, 2005, p. 71).

3. It is assumed that the qualitative research process will be an appropriate method for the researcher to employ in order to investigate White (non-Hispanic) NP student perceptions of Hispanic patients.

4. It is assumed that White (non-Hispanic) NP students will provide primary care services to Hispanic patients.

**Limitations**

1. The investigator is an RN who is of Puerto Rican descent. She therefore does not share the same frame of reference as the respondents she researched. Her frame of reference growing up in the South Bronx, in a Puerto Rican household and an extremely diverse neighborhood, may influence how she interprets the responses to the questions posed.

2. The investigator comes to the research experience with her unique set of conscious and subconscious biases. To address this issue, the researcher sought
clarification to unclear responses in order to avoid inappropriate assumptions and, during the interview process, validated information with participants.

3. The participants may have provided responses during the interview process that are socially correct and not genuine responses that would typically be used in their interactions with Hispanic patients. This situation may have limited the study’s ability to discover the true essence of the provider/patient experience and issue being explored.

4. The participants were all enrolled in NP programs in educational institutions that are rooted in the Catholic faith. The spirituality factor may have greatly influenced the manner in which these nurses practice nursing overall and the responses to the questions posed. Although the participants represented different faiths, under another setting the context and results may have been different.

5. The cultural self-efficacy scale may have influenced the participants’ response during the interview process by providing participants with a preview of what knowledge regarding these patients should include and used terms such as ethnocentrism, discrimination, ethnicity, and culture.

6. The NP students may have possessed different levels of RN experiences or education and may have been at different stages of their NP educational process. Therefore, this group will not be totally homogeneous.

7. Participation in this study was voluntary, and the nurses who agreed to participate may be individuals who, for the most part, have a more positive attitude towards the Hispanic population.
Figure 1 depicts the researcher’s (Rose Iris Gonzalez) thoughts regarding how racial bias and cultural stereotypes could impact patient care. The model uses underlying White privilege and cultural bias as the lens we typically view others with, which, according to the researcher’s perspective and literature cited, is always present in our daily communication and interactions with others. The upper section of the model attempts to depict the encounter between a White (non-Hispanic) health care provider and a white patient. It assumes there will be mutual respect, caring, and non-bias interaction as well as non-discrimination. This in turn would lead to a strong provider/patient interaction and communication as well as a good exchange of health care information. Under these circumstances there is a greater opportunity for the development of a therapeutic relationship that leads to an increased potential for positive health care outcomes.

In the lower section of the model, the White (non-Hispanic) health care provider views the patient through the lens of White privilege and cultural bias. Racial and cultural differences between health care providers and patients could lead to discrimination and incorrect health assumptions as well as weak provider/patient communication. Ultimately, this could lead to an increased potential for negative outcomes in the health care encounter. By studying the
identified populations of White (non-Hispanic) NP students and Hispanic patients, the research will attempt to test the model.
Figure 1. Rose Iris Gonzalez’s Conceptual Model. Effects of Underlying White HCP Privilege and Hispanic Cultural Bias on Patient Outcomes.
CHAPTER II
REVIEW OF THE LITERATURE

We still live in a society that is separate and unequal. To achieve social and economic justice, the goal of the 21st century must become the elimination of institutionalized racism in all sectors of social, economic, cultural, and political life—in business, housing, employment law enforcement, the courts, health care institutions, and, of course schools. (Berlak, 2001, p. 14)

Most recently, the 2003 IOM report Unequal Treatment stated that even when access-related factors such as insurance status and income are taken into account, racial and ethnic minorities tend to receive a lower quality of health care than non-minorities. This fact alone accentuates the importance of identifying and addressing variables that may negatively impact the provision of quality medical care, including factors such as effective patient/provider communication and the need to overcome cultural and linguistic barriers in the provider/patient relationship (Collins et al., 2002).

Today’s RN population unfortunately does not mirror this country’s population. As cited in the Registered Nurse Population: Findings from the 2008 National Sample Survey of Registered Nurses (USDHHS & HRSA, 2010), racial/ethnic minority representation among the total RN population of approximately 3.1 million U.S. RNs remained low and was reported at only 16.8%. With the disparity in the ethnic/racial distribution of our population and the population of RNs, it becomes increasingly more
important to assess an RN’s competency and confidence to work with such a diverse patient population. Thus, there is a strong need to understand this population’s perception of Hispanics and their patterns of interaction, which could be based on their conscious/unconscious perceptions. It is also important to assess the nurse’s perceived cultural self-efficacy to understand how it might influence a nurse’s provider/patient clinical encounter and the development of a therapeutic relationship.

**Demographics**

Hispanics are the most rapidly growing racial/ethnic group. According to the U.S. Census Bureau, in 2005, out of a country total of 296.4 million, 33% or 98 million were part of a group that was identified as other than non-Hispanic white (U.S. Census Bureau Public Information Office, 2006). This report further stated that Hispanics continue to be the largest minority group, numbering 42.7 million, and demonstrated a 3.3% increase in population from July 1, 2004 to July 1, 2005. In 2000, the Census reported 35.3 million or approximately 13% of the entire U.S. population are Hispanic/Latino (Grieco & Cassidy, 2001, p. 3).

The 2006 Census report further stated that Hispanics accounted for almost half (49%) of the country’s population growth between July 1, 2004 and July 1, 2005, and this growth was due in part to a natural increase (births minus deaths) and immigration (500,000). Another important fact demonstrated that the 2005 Hispanic population was much younger than the national average with a third of the Hispanic population under 18. According to the U.S. Census Bureau, nationally one-fourth of the total U.S. population is under 18 (U.S. Census Bureau Public Information Office, 2006).
Additionally, the U.S. Census Bureau reported (U.S. Census Bureau, 2003) that 47 million or nearly 1 in 5 U.S. residents age 5 and older in 2000 spoke a language other than English at home. This data demonstrates that Spanish is the second highest language spoken in the home, showing a 62% increase from 17.3 million in 1990 to 28.1 million in 2000, 11 million additional Spanish speakers (U.S. Census Bureau, 2003).

**Historical Context**

Discrimination and disparity in health care services provided to persons of color have existed for a long time. “Prior to passage of the Civil Rights Act of 1964, health care facilities in both the southern and northern United States were segregated as were medical schools and nursing programs” (U.S. Commission on Civil Rights, 1999a, p. 1). In 1946, Congress passed the Hospital Survey and Construction Act, known as the Hill-Burton Act, which established federal funding for the construction and modernization of hospitals and other health care facilities. The act stated that each State “shall provide for adequate hospital facilities . . . without discrimination on account of race, creed, or color.” Unfortunately, that same section of the Hill-Burton Act exempted racially segregated hospitals from this requirement, so long as they provided “facilities and services of like quality” (U.S. Commission on Civil Rights, 1999a, p. 2).

In 1963, the exemption in the Hill-Burton Act for segregated facilities was successfully challenged and overturned. The Civil Rights Act of 1964 further clarified the prohibition of discrimination in federally funded programs.

As previously stated, Congress enacted the Civil Rights Act in 1964. Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d *et. seq.* states “No
person in the United States shall on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance” (Title VI, Civil Rights Act of 1964, 1964).

The objective of Title VI is to prohibit recipients of federal funds from discriminating against the intended recipients, participants, or beneficiaries of federal monies. As applied to the U.S. Department of Health and Human Services (USDHHS),

Title VI requires HHS (the Federal agency with primary responsibility for enforcement of Title VI in the health care context) to administer and enforce Title VI through the issuance of rules, regulatory or orders establishing the standards for compliance . . . Title VI empowers HHS with the authority to conduct pre-award reviews, compliance reviews, complaint investigations, conciliations, sanctions, mediations, and settlements, and to refuse funding to, or terminate funding for, any recipient found in violation of Title VI regulations, after an opportunity for an administrative hearing and voluntary compliance. (U.S. Commission on Civil Rights, 1999a, p. 2)

As cited in the U.S. Commission on Civil Rights report,

Enactment of Title VI ended the most blatant forms of health care discrimination. But Title VI has proved ineffective in ending the less obvious inequities caused by policies and practices that disproportionately adversely impact on racial minorities. Title VI’s deficiencies are inherent in the structure of the statute: it relies on administrative enforcement; it fails to define statutorily prohibited discrimination and the evidentiary burdens in a case alleging discrimination because of disparate racial impact, it relies on voluntary receipt of federal funds; and it lacks monetary remedies in a private enforcement action. (U.S. Commission on Civil Rights, 1999b, p. 13)

Thus, Title VI’s statutory reliance on administrative enforcement has proved misplaced, at least as regards to federally funded health services. No administration has placed a high priority on minority health needs or the troubling inequities in health care delivery. The result has been, at best, inadequate and, at worst, a complete lack of health
In the 1980s, the following discriminatory practices continued: “Segregated waiting rooms particularly in the South; Minority patients, regardless of income were more likely than white patients to be treated by trainees rather than staff physicians; Minorities’ symptoms were treated in isolation, without taking into consideration other health conditions” (U.S. Commission on Civil Rights, 1999b, p. 7).

In 1982, the Commission on Civil Rights reviewed the health service programs funded by the Older Americans Act and found that racial and ethnic disparities existed. “The Commission report revealed that older minorities faced barriers to participation due to a variety of factors including language and cultural barriers” (U.S. Commission on Civil Rights, 1999b, p. 9). In the 1990s, “Thirty five years after the passage of Title VI unequal access to health care remains a reality for many women and members of minority groups. There is still evidence of discrimination based on race, national origin, color and gender in health care and health related programs” (U.S. Commission on Civil Rights, 1999b, p. 10).

“Discrimination may be observed in the practice of racial medical redlining, . . . national origin related issues such as treatment of patients with limited English proficiency . . . and unequal access to health care financing programs such as medicare and medicaid” (U.S. Commission on Civil Rights, 1999b). “In 1994 – the National Institutes of Health (NIH) adopted a new policy on the inclusion of minorities and women in health research” (U.S. Commission on Civil Rights, 1999b, p. 11).
The 1996 U.S. Commission on Civil Rights’ report, . . . Federal Title VI Enforcement to Ensure Nondiscrimination in Federally Assisted Programs, found that the HHS Office for Civil Rights had an inadequate civil rights implementation, compliance and enforcement program. There was strong evidence that HHS was not enforcing Title VI or ensuring those health care entities receiving billions of Federal dollars were carrying out Title VI, Title IX and other Federal civil rights laws. (U.S. Commission on Civil Rights, 1999b, pp. 11–12)

Therefore, although these laws and regulations have been enacted and implemented, due to a lack of enforcement by these agencies, discriminatory practices continue to exist.

**Cultural Competency**

Since RN education regarding care of Hispanic patients has been focused on cultural competency and cultural self-efficacy, a review of the literature was done to identify research accomplished in the areas of cultural competency and cultural self-efficacy. Donnelly (2000) examined the consequences of cultural misunderstandings and language differences in cross-cultural nursing through two case studies which illustrate the close relationship between culture, health, communication, and outcomes of care. In this case study, due to language barriers and a lack of knowledge regarding the patients’ cultural values and behaviors, the patients’ rights to treatment or family participation were violated. Leonard (2001) speaks of the shift in thought process by the biomedical community to accommodate diverse cultures and systems of care rather than these cultures assimilating into the dominate culture. Leonard challenges nurses to shape the reform, which includes the use of complementary and alternative treatments. Wood (2001) refers to the growing number of schools who are implementing cultural
competency programs, and Dreher and MacNaughton (2002) contend that cultural competence is nursing competence. They recommend the clinician become culturally competent in the provider/patient encounter as well as the knowledge base regarding culture, lifestyles, health beliefs, and behaviors. Winn and Riehl (2001) identified transcultural competent care as a necessary curricular component and an important clinical skill for health care workers.

In order to achieve these skills, nursing educators have recently engaged in mechanisms to enhance a student’s cultural competency by providing her/him with international and/or cultural clinical immersion experiences (Anderko & Kinion, 2001; Kollar & Ailinger, 2002; Walsh & DeJoseph, 2003). Ottani (2002) provided a framework that enabled nurses to focus on global phenomena. However, according to Black (2001), inconsistencies in health professions education programs regarding multicultural content in curricula continue and a strong need remains to evaluate these skills and a nursing student’s perceived cultural competence. Indicators and instruments to assess, measure, and enhance a student’s and nurses’ cultural competency are being developed and evaluated (Black & Purnell, 2002; DiCicco-Bloom, 2000; Napholz, 1999; Salimbene, 1999).

A study done by Kardong-Edgren (2004) regarding cultural competency and nursing faculty noted that faculty in health education and nursing programs were not adequately prepared to teach cultural content. Faculty in this study reported that their comfort level increased when they worked with people from other cultures either in the
classroom or at their workplace. They also agreed that cultural immersion influenced their comfort level.

Regarding cultural competence and NPs, a literature review provided insight directly related to cultural competence education in NP programs as well as NPs’ own measure of cultural competency.

Mahoney, Carlson, and Engebretson (2006) provided a theoretical approach to assist students in meeting the elements of cultural competence as outlined in recommendations provided by the National Organization of Nurse Practitioner Faculties. Ciesielka, Schumacher, Conway, and Penrose (2005) provided a multifaceted approach to integrate cultural competence in an NP program. Rutledge, Garzon, Scott, and Karlowicz (2004) used culturally enhanced standardized patient scenarios to help NP students develop cultural competency skills and knowledge in a safe environment. And Green-Hernandez, Quinn, Denman-Vitale, Falkenstern, and Judge-Ellis (2004) addressed the creation of a culturally competent interdisciplinary practice that fosters community caring. Some articles focused on the need to increase the cultural competency of NPs (Dunn, 2002; Rexroth & Davidhizar, 2002) and provided examples of educational programs and strategies to address this issue (Denman-Vitale, 1999; Thomas, Brandt, & O’Connor, 1999). O’Brien, Anslow, Begay, Pereira, and Sullivan (2002) discussed the need for cultural sensitivity and cultural competency when working with diverse communities and provide suggestions for coping in this changing environment.

Magary and Brandt (2005) identified cultural competence as an essential component of leaders who expect to build partnerships with diverse communities.
Carol (2006) focused on increasing the number of minority nurses while McGinnis, Moore, and Continelli (2006) focused on studying the practice patterns of minority NPs as compared to non-minority NPs. McGinnis et al. (2006) found that minority NPs were more likely to work in a federally designated health profession shortage area, in a hospital, community health center, and school, but less likely to work in physician offices or NP practices.

Finally, in an attempt to assess cultural competency in NPs, Benkert, Tanner, Guthrie, Oakley, and Pohl (2005) used an instrument to assess the cultural competence of NP students and provided an overview of predictors of culturally competent behaviors in clinical practice. Benkert et al. (2005) recommended that NP programs concentrate on increasing a student’s comfort with diverse client groups and cultural knowledge in clinical practice. Smith-Campbell (2005) assessed the cultural competence of health professional students (physicians, physician assistants, social workers, and NPs) who participated in the National Health Service Corps (NHSC) clinical experience. According to the study, there was no change in students’ cultural competence after their clinical experience. However, many of the students expressed a greater interest in providing health care services in an underserved community.

**Cultural Self-Efficacy**

According to Bandura (1977), self-efficacy is frequently viewed as a person’s confidence level that a particular behavior can be executed. Bernal and Froman (1993) posited that:
According to Self-efficacy theory, community health nurses will develop an increased sense of self-confidence in caring for culturally diverse clients if they have the opportunity to work with these clients, are provided with appropriate transcultural nursing role models, are given praise and encouragement for working with culturally diverse clients, and are in physical and mental readiness to care for these clients. This increased self-confidence in the provision of culturally competent nursing care is termed “cultural self-efficacy.” (p. 25)

Regarding cultural self-efficacy, the literature review yielded a mixture of published research studies and dissertations aimed at assessing cultural self-efficacy of nursing students as well as practicing RNs. Bernal and Froman’s (1987, 1993) instrument, the Cultural Self-Efficacy Scale (CSES), was referred to in many of the studies. This instrument was developed to measure cross-cultural self-efficacy of nurses working in a variety of settings. Joseph (2001) used the CSES and measured the cultural self-efficacy of nurses caring for patients at three U.S. Army hospitals. Nurses in this study expressed a positive attitude toward African-American patients and a least positive attitude toward the Latino-American patient, yet expressed a fairly high degree of confidence in knowledge of cultural concepts and patterns for African-Americans and Latinos. Kulwicki and Bolonik’s (1996) research, which measured graduate baccalaureate nursing students using the CSES, demonstrated that the students had little self-confidence in their ability to provide culturally competent care. This supported previous studies that nursing students are not provided with the experiences needed to provide culturally competent care. In fact, in a study done by Alpers and Zoucha (1996), when students who were and were not provided with cultural content were compared using the CSES, findings suggested that those who had received some cultural course content felt less competent than those who had not received any. However, in studies
done by Hagman (2001), St. Clair and McKenry (1999), Talley (2002), and Williamson and Stecchi (1996), both formal and continuing education including short-term clinical immersion experiences did move nursing students as well as nurses toward cultural self-efficacy. Talley’s findings suggest that cross-cultural experiences, cultural diversity education that includes positive faculty performance feedback, and role modeling by culturally competent nurses are factors which positively influence RN cultural self-efficacy. A follow-up literature review using the terms “cultural self-efficacy” and “Hispanics” resulted in articles that dealt with the testing of an instrument to assess students’ cultural self-efficacy in caring for elders who are ethnically diverse (Shellman, 2006), and articles related to the investigation of cultural attitudes, knowledge, and skills of either nurses, faculty, or the health workforce (Jones, Cason, & Bond, 2004; Joseph, 2004; Kardong-Edgren et al., 2005). Kardong-Edgren et al. (2005) suggested that exposure to people from other cultures enhances confidence in knowledge and attitudes. The research from Jones et al. (2004) demonstrated gaps in workers’ knowledge of other cultures which could benefit from educational interventions, although this study stated it remains unclear whether increased cultural knowledge improves patient outcomes. Joseph’s (2004) study revealed that nurses reflected more positive attitudes toward patients of similar ethnic backgrounds and expressed a high degree of confidence in their cultural self-efficacy toward African-Americans and Hispanics and low confidence in Asian-Americans. Coffman, Shellman, and Bernal (2004) opine, after a literature review of the use of the CSES, that specific conclusions regarding the tool could not be reached due to data inconsistencies.
A literature review using the CINAHL, MEDLINE, and CINHAL Plus Full Text databases with the keywords “cultural self-efficacy” and “nurse practitioners” yielded no results. It is therefore evident that more research is needed in this area in order to identify and implement a model of nursing education and practice which will assure RNs and NPs are prepared and can function with a higher level of cultural self-efficacy.

**Language and Health Care Findings**

Language and culture play a large role in patient/provider interactions. Regarding language, Peterson (2001) stated that:

... nearly thirty-two million people presently living in the United States speak a language other than English. Almost fourteen million of these individuals lack good English-language skills, and the United States Government has designated them as individuals with ‘Limited English Proficiency’ (LEP). An LEP individual is someone who cannot communicate in English, either through writing or speech, at a level necessary to interact effectively with English-speaking service providers. (pp. 1437–1438)

An individual’s language can be used to identify one’s national origin. In response to this finding, the Equal Employment Opportunity Commission (EEOC) addressed language as a form of national origin discrimination. As stated in Colon’s (2002) article regarding English only workplace rules:

... the EEOC published the first Guidelines on Discrimination Because of National Origin in 1970. The Guidelines define national origin broadly, as including, but not limited to, the denial of equal employment opportunity because of an individual’s or his or her ancestor’s, place of origin; or because an individual has the physical, cultural or linguistic characteristics of a national origin group. ... The primary language of an individual is often an essential national origin characteristic. (p. 235)

Therefore, language, because it is perceived and defined as a national origin characteristic, often solicits a response or interaction that is discriminatory in nature.
In reference to quality of health care services, findings from the 2001 Commonwealth Fund Health Quality Survey state: regardless of language skills, Hispanics are more likely than the rest of the population to report having difficulty communicating with and understanding their doctor. “One of three Hispanics and one of four Asian Americans have problems communicating with their doctor” (Collins et al., 2002, p. v). Furthermore, Hispanics who primarily speak Spanish at home report even greater difficulties: more than two of five (43%) Spanish-speaking Hispanics report problems communicating with or understanding their doctor. These language barriers are likely to influence the quality of care Hispanic patients receive.

**Discrimination and Racism**

To be effective health care providers, registered nurses should learn to deal with an increasingly diverse patient population. Although many nurses have engaged in cultural competency training, stereotypical views of people of color still exist.

Overall, white persons viewed African-Americans more negatively than any other group, and Hispanics were viewed twice as negatively as Asians. A large body of psychological research indicates that an individual who holds a negative stereotype will discriminate against someone who fits the stereotype. Strikingly, this research reveals that stereotype-linked bias is both automatic and unconscious, even among persons who are not prejudiced.

. . . discriminatory behavior that is unconscious, unthinking, and unintentional may be a routine part of service delivery by persons who do not endorse racism. (Caesar & Williams, 2002, p. 8)

According to Becker (2004):

Access to medical treatment is not simply about being uninsured, however—it is a class-and color-based phenomenon (D. Williams 1999). Racism is structured into the health care system in pervasive and sometimes invisible ways (Byrd and Clayton, 2002). Actions of the state may cloak racialized policies that are aimed primarily at ethnic minorities and can be seen as forms of discrimination (Goode
and Maskovsky 2001). Solomos and Back (2000) observe that the language of culture and nation invokes a hidden racial narrative and that racisms are coded within a cultural logic that makes it possible to deny that they are racisms. Omi and Winant (1994) suggest that the state is itself increasingly the preeminent site of racial conflict, emerging out of the process of racial formation, defined as the sociohistorical process by which racial categories are created, inhabited, transformed and destroyed. (p. 259)

Dovidio and Gaertner (2002) have used the term “aversive racism” to describe the contradiction which exists when an individual denies being prejudiced but harbors “unconscious negative feelings and beliefs. Unfortunately, the negative feelings and beliefs that underlie aversive racism are rooted in normal, often adaptive psychological processes” (p. 24). These individuals realize that being prejudiced is bad but they do not recognize themselves as being prejudiced (Dovidio & Gaertner, 2002). Therefore, these unconscious thoughts, which can influence behaviors and attitudes, should be exposed prior to the nurses’ engagement in a provider/patient relationship with an individual from a different culture. According to Barbee (1993), one can characterize racism in nursing by identifying its three forms. These include denial, aversive racism, and the color-blind perspective. Barbee is of the opinion that racism is denied in nursing. It is as if the term “nurse” can transcend racism.

One model of cultural competence as developed by Campinha-Bacote, 1999, includes personal awareness, knowledge, skill, encounters, and desire. Cultural awareness as it relates to nursing is defined as: “... the deliberate, cognitive process in which health care providers become appreciative and sensitive to the values, beliefs, lifeways, practices and problem solving strategies of clients’ cultures.” An individual must examine his/her own’s prejudice and bias which enables one to understand and move closer to the goal of cultural competence. (Byrne et al., 2003, p. 277)

There is a body of work published that specifically addresses NPs and racism. Harris and Cummings (1996) acknowledged that nurses have been relatively quiet on the
topic of racist and ethnocentric behaviors. Therefore, in order to facilitate culturally competent care, advanced practice nurses must understand these behaviors in order to fully overcome them. Dunn (2002) goes further, stating culturally competent care requires a change of world view for both the client and the provider in addition to stating that competency is a continuous process. Other researchers focused on strategies to overcome systemic barriers (Van Zandt, D’Lugoff, & Kelley, 2002) or designing culturally appropriate, user-friendly screening programs (Jennings, 1996) in order to improve the health care outcomes of diverse communities. Another potential modification to the current system to address these unacknowledged racist or ethnocentric behaviors would be to institute changes in the educational structure and curriculum of advanced practice nurses. Foolchand (1995) proposed that students explore their own stereotypes, views, values, and attitudes and prejudices with the context of race and ethnicity. Such exploration may result in anger, resentment, and frustration, so these sessions must be facilitated by someone skilled in this area who is able to be both sensitive and supportive. Further awareness can be developed through the examination of critical incidents, and the collection of direct observations of interactions with minority clients, visitors, and staff. These observations could then form the basis of further exploration of stereotypes and their effect on communication, which could lead to NPs who are better able to respond to the health care needs of a diverse population.

The early work of Thiederman (1986) explored the issue of ethnocentrism and health care behaviors. He discussed the tendency of health care professionals to project their own culturally specific values and behaviors to foreign-born patients, and how this
contributes to non-compliance in patients. As previously discussed, Harris and Cummings (1996) urged NPs to understand their own ethnocentric and racist behaviors in order to develop strategies to provide culturally competent care.

Patient/Provider Communication

“Researchers have known for more than 25 years that patient satisfaction, adherence to treatment and appropriate utilization of health care services depend largely on the quality of communication between doctors and patients during office visits” (Gibson, 1994, p. 14). “Communicating well means building a relationship where patient and nurse are equal partners in the consultation (DoH, 2001) and where effective treatment is the outcome that both are seeking” (Anonymous, 2002, p. 1).

“Studies converge to show that when primary care physicians are more relationship-centered (versus physician-centered) patients are likely to display higher satisfaction, better adherence to prescriptions, more maintained behavior change, better physical and psychological health . . .” (Williams, Frankel, Campbell, & Deci, 2000, p. 79).

Studies regarding patient/provider communication offer some valuable insights regarding how communication impacts the health care encounter. Some research focused on techniques or instruments to improve this communication process while other studies examined how patient/provider communication impacts health care outcomes and health care disparities.

Research focused on instrument development and measurement, which are important in the study of the health care encounter, included Smith et al. (2006), which
evaluated the psychometric properties of a modified version of the Perceived Involvement in Care scale (M-PICS) and concluded that it is a valid measure of perceived patient/provider communication related to persistent pain. Chumbler et al. (2007) examined a Cancer Care Dialogue Model through a patient care coordinator’s use of a home messaging device. They found that the use of this device improved the patient’s score on the health-related quality of life scale. Skinner et al. (2004) focused on testing the internal consistency and construct validity of the Asthma Therapy Assessment Questionnaire and found that it appeared to have satisfactory measurement properties and could be used to identify patients who could benefit from improved disease management efforts. Katz, Nissan, and Moyer (2004) performed a randomized controlled trial of a web-based patient/provider communication system which showed that patients, physicians, and staff had positive attitudes toward on-line communication, and Lewis and Abell (2002) developed and pilot-tested an instrument which included patient/provider communication as one of its constructs.

Kilbourne, Switzer, Hyman, Crowley-Matoka, and Fine (2006) provided a framework to guide future health disparities research, which included effective patient/provider communication. The article also suggested that provider factors, including bias and attitudes, influence health care disparities. In addition, in busy health care settings, providers could be subject to subconscious processes such as bias and stereotyping, which could negatively impact care. Powe, Daniels, and Finnie (2005) found that a provider’s belief of their perception of a patient’s cancer fatalism may influence patient/provider communication.
There are specific interventions that can improve care through improved patient/provider communication. Cintron and Morrison (2006) conducted a meta-analysis of ethnic groups, pain, and analgesia and concluded that ethnic disparities exist and educational interventions should aim to improve patient/provider communication. Reilly and Lambrecht (2001) discussed the cognitive model as a framework to understand the patient’s perspective and a way to improve patient/provider interaction. McCauley, Bixby, and Naylor (2006) focused on vulnerable elders with heart failure and found that strategies to strengthen APRNs patient/provider relationship and communication yielded positive results. Fehringer et al. (2006) concluded that the increased use of open-ended questions and non-judgmental dialogue by providers would improve patient/provider communication and adherence to HIV/AIDS treatment and therapy. Lloyd, Ammary, Epstein, Johnson, and Rhee (2006) suggested that a transdisciplinary approach to care as well as improved health literacy skills contribute to effective patient/provider communication. Hays et al. (2006) concluded that pediatric palliative care services that include a focus on effective communication can improve quality of life and patient satisfaction. Arar, Wang, and Pugh (2006) found that the use of an electronic medical record as a tool improved patient/provider communication, concerning self-care, during the medical encounter. Other studies that identified patient/provider communication as part of an intervention which could yield or yielded positive health outcomes include: Kuhajda et al. (2006); Ellington et al. (2006); Clayton, Mishel, and Belyea (2006); Aikens, Bingham, and Piette (2005); Mitoff, Wesolowski, Abramson, and Grace (2005); Rodriguez and Young (2005); Amaoako (2004); Kerner et al. (2003); Kerr, Smith,
Kaplan, and Hayward (2003); Saltz (2003); Mishel et al. (2003); Ricci et al. (2001); Durso (2001); Burton, Schultz, Connerty, Chen, and Edington (2001); Ciechanowski, Katon, Russo, and Walker (2001); Richardson, Sanders, Palmer, Greisinger, and Singletary (2000); and Garfield and Caro (2000).

Kinney et al. (2006) found that patient/provider communication regarding cancer genetic test counseling and testing of African-American patients was suboptimal. Savasta (2004) also found that insufficient patient/provider communication may increase HIV/AIDS transmission in older adults. Kroll, Beatty, and Bingham (2003) concluded that individuals with certain physical disabilities may be placed at greater risk for lack of appropriate care due to poor patient/provider communication.

In reference to communication and language barriers, Cohen, Rivara, Marcuse, McPhillips, and Davis (2005) found that Spanish-speaking patients whose families have a language barrier appear to be at greater risk for medical events with serious consequences as compared with patients who do not have a language barrier. Hablamos Juntos, a program of the Robert Wood Johnson Foundation (National Center for Farmworker Health, 2005) is working to seek solutions to the language and health care issue for Latinos. Their plan focuses on the availability and quality of interpreters, developing health care materials in Spanish, and developing mechanisms for patients to navigate health care facilities.

Some articles urged increased research regarding patient/provider communication. Wissow and Kimmel (2002) believe studies related to patient/provider communication could be undertaken in the emergency room and could yield useful data. Ortega et al.
(2001), in a study regarding the use of an emergency room by asthmatic children on Medicaid, recommended further studies to include the patient/provider communication factor. Clayton et al. (2006) found that increased provider/patient communications unfortunately led to increased thoughts about breast cancer recurrence for breast cancer survivors. Clayton recommends future research to identify how the patient/provider communication influences these negative thoughts. Makoul (2003) discussed models and concepts of communication and suggested that the context of cancer offers a promising area for study in order to enhance research regarding patient/provider communication. Wissow (2005) examined physicians’ and patient socioeconomic status (SES) and found that physicians were less likely to encourage participation of patients from low SES in care.

Demiris, Patrick, Mitchell, and Waldren (2004) focused their research on telemedicine and shared their concerns regarding the increased risks of patient/provider communication failures and errors and suggest the development of standards to address this patient safety issue. Moyer, Stern, Dobias, Cox, and Katz (2002) studied patient/provider communication via e-mail and concluded that patients and providers would need additional education to promote these technologies as well as assurances regarding its efficiency and effectiveness. On a more positive note, Nobel and Boissonnas (2000) suggested that the Internet offers a way to improve patient/provider communication.

Kabakian-Khasholian, Campbell, Shediae-Rikallah, and Ghorayeb (2000) studied Lebanese women and medical management of their pregnancy and delivery and
identified that women valued good patient/provider interactions in these health care encounters.

In reference to patient/provider communication and NPs, a literature review yielded only three articles. Alexander and Moore’s (2007) study regarding menopause and vasomotor symptom management options suggested that increased patient/provider communication about treatment options requires improvements in patient/provider communication. The study by McCauley et al. (2006) regarding health outcomes of vulnerable elders with heart failure demonstrated that focusing on improved patient/provider relationships improved patient/provider communication. Turnbull’s (1992) dissertation focused on the patient/provider communication process among students and found that provider gender greatly influenced the student/provider communication process.

Finally, an investigation regarding Hispanics, NPs, and communication also yielded limited results. Martyn, Reifsnider, and Murray (2006) found that the use of an Event History Calendar (which provides a sexual risk assessment) with Latina adolescents was useful for improving communications. Shaffer (2002) in a study of Hispanic migrant pregnant women found that Hispanic women were more likely to access prenatal care if the health care providers were culturally sensitive and were able to communicate in Spanish. Poss and Gamez (2003) suggested that NPs may want to acquire additional language skills to work with patients of diverse cultural backgrounds. Araiza, Klopf, and Kelley (2005) developed a web-based tool to assist providers in learning some Spanish medical terminology to be used during primary health care
encounters with Hispanic/Latino patients. And finally, Barron, Hunter, Mayo, and Willoughby (2004) studied care provided to clients of Mexican origin. They identified six key points to consider related to cultural marginality, acculturation, and adherence in order to improve this health care provider/client relationship. It is clear that more research is needed in this area.
CHAPTER III
METHODOLOGY

This chapter includes a statement of the purpose; the study approach; participants and setting; and data collection and procedure for analysis. It also describes the methods used to conduct this study.

**Purpose of the Study**
This study was designed to examine White (non-Hispanic) NP student perceptions of Hispanic patients and how these perceptions may impact the provider/patient clinical encounter. It also explores the relationship between the perceived cultural self-efficacy of White (non-Hispanic) NP students and their perceptions of Hispanic patients.

**Study Approach**
The researcher conducted a mixed methods (qualitative & quantitative) research study to explore the perceptions of White (non-Hispanic) NP students of Hispanic patients. According to McQueen and Zimmerman (2006), qualitative research tends to focus on “behavior, attitudes, and motivations . . . to examine information about a specific context” (p. 475). According to Maxwell (1996), the five particular research purposes for qualitative studies include: understanding meaning, understanding context,
identifying unanticipated phenomena, understanding the process, and the development of causal explanations.

“Transformative mixed methods procedures are those in which the researcher uses a theoretical lens . . . as an overarching perspective within a design that contains both qualitative and quantitative data.” (Creswell, 2009, p.15).

Institutional Review Board Approval and Consents

The Human Subject Review Boards or Institutional Review Boards (IRBs) of all universities involved were provided a protocol that outlined the methodology and process for the study. Additions to the proposed protocol included the process for student recruitment as well as a detailed recruitment script that was read to each class in order to recruit participants. One particular university required two consent forms, which were provided to each student prior to the commencement of the study. A process to maintain the confidentiality of the data obtained during this investigation was also outlined in the protocol and adhered to throughout the study.

Research Ethical Considerations

Prior to data collection, an application for Human Subjects Research Review was completed and submitted to George Mason University’s Office of Research Subject Protections (ORSP). This application included the proposed informed consent document, the demographic survey, the modified version of the CSES, and the proposed interview questions. Additional approval from the universities where the participants were enrolled for classes was also secured.
There were no foreseeable risks with this study, however, at times the participants could have experienced some discomfort with questions posed or with the sensitivity of the topic of discussion. During the study, participants were provided with an opportunity to share negative consequences regarding the process but none of the participants verbalized any negative impact. Participation in this study was solely voluntary. Individuals chose to participate and could withdraw from the study at any time without penalty, however, none of them did. A $25 Target gift card was used as a recruitment incentive and was provided to each participant at the completion of the survey, CSES, and qualitative interview.

Participants and Setting

A purposive sampling procedure was used for this study. Theoretical sampling (purposive sampling) aims to construct a sample that is meaningful theoretically because it includes certain criteria which could help to develop or test a theory or argument (Mason, 2002). Twelve White (non-Hispanic) NP students, from universities rooted in the Catholic tradition, located in a large metropolitan area (with NP programs), were recruited for this study. The sole recruitment from these schools rooted in the Catholic faith and traditions was done to equalize the potential impact of the faith variable on this study. The NP students were also required to be enrolled in an NP program in one of theses nursing schools. The NP students were selected because they were already licensed RNs who had some nursing experience, and because of the diversity of the U.S. population, most probably had been exposed to Hispanic patients or had previously provided care to Hispanic patients during their nursing career. They were also selected
because it was understood that the degree they were seeking would ultimately lead them into primary care environments where they would function more independently and, therefore, in future practice could possibly place them in environments that would increase their exposure to Hispanic patients.

All participants for this study were required to be White and non-Hispanic, which was explained during the recruitment process and further validated in the demographic survey. Thus, the study sought to identify the White (non-Hispanic) NP students’ baseline perceptions of Hispanics as well as their cultural self-efficacy related to caring for Hispanic patients in order to gain a better understanding of these perceptions and how they could possibly impact provider/patient encounters.

The recruitment process took place after IRB approval was achieved. NP students were recruited and interviewed during the spring, summer, and fall of 2010. In order to recruit NP students for this study, the researcher contacted the deans of the identified schools, via email, to seek permission to recruit students and to assist the researcher in identifying the most appropriate professors to approach who might be willing to allow access to their classes. After review of the IRB protocol and approval forms, the respective deans referred the researcher to the most appropriate professors. The research protocol was then shared with these identified professors, and once an understanding of the research goals and protocol was achieved, the professors allowed the researcher to attend the beginning of their respective classes to read the recruitment script. The researcher read the recruitment script to the identified classes and handed out contact information to all students. Once the students expressed their interest either during the
class after the script was read, or via email or telephone after the class, they were contacted by the researcher, via email or phone, and were again provided with a brief overview of the study to assess their interest and availability for participation. Once the NP students agreed to participate, a date, time, and location was identified and mutually agreed upon for the interview to take place.

Participants were interviewed in various locations that ranged from a library conference room located either on or off the university campus, to vacant clinic offices or conference rooms located either on or off the university campus. Empty classrooms were also used when available or convenient. Again, these locations were mutually agreed upon by the researcher and the participant. After meeting at the designated time and place, formal introductions were made, another scripted overview of the study was provided, and then an informed consent was provided to each participant, which they each signed. After the informed consent was signed, each participant was provided with a written demographic survey as well as a modified Cultural Self-Efficacy Scale (CSES), which they were asked to complete prior to the commencement of the qualitative interview. These items were not discussed in order to limit their influence on the interview process. While the participant was completing the survey and CSES, the researcher began to set up and test the tape recorder for the qualitative interview. All participants were informed that the qualitative interview would be tape recorded and transcribed, and all granted permission to tape the interview. Each participant was asked if he or she would be willing to review the transcript post-interview and all responded that it was not necessary. Many of the participants were interviewed during peak paper
and exam time and were not interested in reviewing the script because of their tight schedules and responsibilities. Many were also working and going to school so they viewed a review of the transcript as just an additional piece of work and burden that they did not want to take on.

**Data Collection**

The participants in this study remain confidential. All efforts to ensure this confidentiality is maintained were implemented, including providing each participant with a number and an alias which was used throughout the study.

*Demographic survey*

The researcher developed a demographic survey to capture some initial participant data. The survey provided information on the participant’s age, gender, race, marital status, cultural identification, cultural diversity exposure, nursing educational background and experience, language, and cultural competence education.

*The Cultural Self-Efficacy Scale*

The Cultural Self-Efficacy Scale (CSES) is a 26-item, Likert-type instrument that was designed and tested by Bernal and Froman in 1987. It was originally used “to measure the perceived sense of self-efficacy of community health nurses caring for culturally diverse clients. The scale items were grouped in three sections according to: (a) knowledge of cultural concepts, (b) cultural patterns, and (c) skills in performing transcultural nursing functions” (Coffman et al., 2004, p. 180).
A reported high rating on the scale could be interpreted as having a high level of confidence in one’s ability to provide culturally appropriate care to that ethnic population and a greater likelihood of engaging in the provision of services with that ethnic population. A low rating on the CSES could identify a low level of confidence as well as possible avoidance behavior in working with that particular ethnic population.

According to Bernal and Froman, in a document attached to the CSES when permission was granted for its use in this study, the items in the scale were developed from anthropology and transcultural nursing literature (H. Bernal, personal communication, September 29, 2003). The explanatory document further states that the alpha internal consistency estimates for the entire scale were found to be .97.

Bernal and Froman (1993) conducted a more extensive study to further test the reliability and validity of the CSES. The original sample population in 1987 was nurses who worked with an inner city population in Connecticut. This study included a national sample of community health nurses. For this original sample, “Alpha internal consistency for the CSES was calculated at .97. . . . Further analysis showed a significant positive relationship (r = .55, p < .005) between ethnicity, interactions with diverse clients within undergraduate experiences, and levels of general cultural self-efficacy” (Coffman et al., 2004, p. 181).

The CSES used by this researcher and for this particular study was modified in order to measure the NP student participants’ level of confidence in caring for a specific subset of patients, that of Hispanic patients. As originally administered by Bernal and
Froman in 1987 and 1993, the CSES sought to identify cultural self-efficacy of three specific ethnic/racial groups (Blacks, Latino/Hispanics, and South East Asians).

**Participant interviews**

Once the demographic questionnaire and the CSES were completed, the participants were interviewed using open-ended questions. “Your research questions formulate what you want to understand; your interview questions are what you ask people in order to gain that understanding” (Maxwell, 1996, p. 74). The interviews lasted approximately 60 minutes.

Table 1 provides an overview of the objectives and goals of the interview questions, the actual list of open-ended questions posed, as well as potential prompt questions.
<table>
<thead>
<tr>
<th>Objective/Goal</th>
<th>Actual Question</th>
<th>Potential Prompt Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elicit White (non-Hispanic) perceptions of Hispanic patients.</td>
<td>What things come to mind or what do you think of when you first encounter a Hispanic patient?</td>
<td>You said that…</td>
</tr>
<tr>
<td>Elicit information pertaining to Hispanic patient impact on patient care.</td>
<td>How would you say the Hispanic patient influences your patient/provider clinical encounter?</td>
<td>Describe your most recent encounter with a Hispanic patient. Tell me more. What did you mean by that?</td>
</tr>
<tr>
<td>Elicit information pertaining to specific behaviors/interventions with Hispanic patients.</td>
<td>What types of behaviors/interventions do you most frequently engage in during your clinical encounters with Hispanic patients?</td>
<td>How would you compare these behaviors/interventions with patients who are not Hispanic? What would you do differently, if anything? What did you mean by that?</td>
</tr>
<tr>
<td>Elicit information related to Hispanics and White (non-Hispanic) nurses perceptions of follow-up patient care.</td>
<td>What is your experience with clinical follow-up with the Hispanic patient?</td>
<td>Can you recall the last time you cared for the same Hispanic patient more than once? What were the results? How did that make you feel?</td>
</tr>
<tr>
<td>Elicit responses related to White (non-Hispanic) nurse expectations of Hispanic patients.</td>
<td>When you work with Hispanic/Latino patients, what is your expectation of their adherence to treatment regimens?</td>
<td>Were prescriptions and other treatments ordered?. Tell me more. What led to this decision? Can you give me an example?</td>
</tr>
<tr>
<td>Open-ended question to provide opportunity to speak out about other issues related to Hispanics.</td>
<td>Are there any other major concerns specific to Hispanic patients?</td>
<td></td>
</tr>
</tbody>
</table>
The researcher provided a non-judgmental environment and used good eye contact, appropriate gestures, and a comfortable rate of speech during the interviews. At times the researcher sought further clarification through the use of phrases, seeking interpretation, repetition, and verification. Some additional questions that were used during the interview process to probe for deeper meanings included:

- What does this mean to you?
- What led to this?
- What were the results?
- How did you feel?
- What did you mean by that?
- You said that . . . .
- Can you give me an example?

Interviews were recorded, and then transcribed verbatim.

**Bracketing**

Phenomenology requires that the researcher state his or her assumptions about the phenomena under investigation (Creswell, 1998). The researcher is of the opinion that racism is endemic in our society and is largely not visible to the majority (White) population. According to West (1993), racist practices directed against people of color have been an important element of U.S. history, culture, and society.

My mother, Epifania Olivieri Gonzalez, who is almost 99 years old, tells me stories about when the United States took possession of the island of Puerto Rico and how U.S. soldiers (Whites) tied the natives to horses, dragged them through town until
they were dead, and treated them as if they were ignorant and inferior. Hispanics on the island of Puerto Rico in this situation were treated as animals and beings that had to be dominated and controlled. They were thought of as less human than Whites. This is just one memory but it could be replicated in many ways through the eyes of African-Americans, Native Americans, Hispanics, and all those individuals who suffered because they did not look White. “Institutional forms of racism are embedded in American society in both visible and invisible ways” (West, 1993, p. 107). Although this memory and recollection recalls a time past, these incidents shaped perspectives and imbedded a subconscious frame of reference that is difficult to erase.

This analysis also reveals how the oppression and cultural domination of Native Americans, Chicanos, Puerto Ricans, and other colonized people differ significantly (while sharing many common features) from that of Afro-Americans. Analyses of internal colonialism, national oppression, and cultural imperialism have particular significance in explaining the territorial displacement and domination that confront these peoples. (West, 1993, p. 104)

More frequently than not, the White majority population is unaware of their latent and inherent racist practices or behaviors based on a history of unspeakable atrocities committed to those who were different and misunderstood.

Data collection and analysis process
The CSES and demographic surveys were collected and coded appropriately to maintain confidentiality and then analyzed. Through an identification key, only the researcher will be able to link the two forms and the qualitative interview results. All coded data and the informed consents were kept separate from the identification key, and both were kept in separate secured areas.
The interviews were completed, transcribed verbatim, and analyzed. “Data analysis requires that researchers dwell with or become immersed in the data” (Speziale & Carpenter, 2003, p. 69). Inductive analysis was used. “Inductive analysis means that the patterns, themes, and categories of analysis come from the data; they emerge out of the data rather than being decided prior to data collection and analysis” (Patton, 1987, p. 150). Data analysis modeled Miles and Huberman’s (1994) three-phase process of data reduction, data display, and conclusion drawing/verification. To assist with the qualitative data analysis, the researcher also engaged in the use of a software program such as NVivo.

“Data reduction refers to the process of selecting, focusing, simplifying, abstracting, and transforming the data that appear in written-up filed notes or transcriptions. As we see it, data reduction occurs continuously throughout the life of any qualitatively oriented project” (Miles & Huberman, 1994, p. 10).

“Data reduction is a form of analysis that sharpens, sorts, focuses, discards, and organizes data in such a way that “final” conclusions can be drawn and verified” (Miles & Huberman, 1994, p. 11).

“Generically, a display is an organized, compressed assembly of information that permits conclusion drawing and action . . . . The most frequent form of display for qualitative data in the past has been extended text” (Miles & Huberman, 1994, p. 11).

Thus, as referenced in Miles and Huberman (1994), data was analyzed and clustered into themes. Themes that emerged include language barriers, racial bias, stereotypes, cultural differences, quality of provider/patient communication, and
therapeutic caring relationships. Data was displayed in extended text by providing excerpts of the participants’ own words (Fig. 2).

Figure 2. Components of Data Analysis: Interactive Model as Illustrated in Miles and Huberman (1994, p. 12).

A statistical analysis of the demographic surveys and the CSESs was done using descriptive statistics. The responses were analyzed to assess whether there is a relationship between the responses to the interview questions and the NP students’ responses to their perceived CSES and the demographic survey.
Ethical Considerations in Nursing

The Code of Ethics for Nursing adopted by the American Nurses Association (ANA) establishes the ethical standards for the nursing profession (American Nurses Association, 2001). The Code states that the nurse practice with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems. It also urges respect for human dignity and for the inherent worth, dignity, and human rights of every individual. According to the ANA Code of Ethics, nurses are to consider the individual needs and values of all persons in all professional relationships and should deliver nursing services with respect for patient needs and values, and without prejudice. Above all, the Code urges that the nurse respect the patient as a person (American Nurses Association, 2001).

The Code clearly identifies the need for nurses to provide health care services to all without prejudice and with respect for the patient’s values and needs. Roberts (1996), as cited in Sorrell (2003), stated that those who dominate by ethnicity, age, class, and gender may be “unaware of the invisibility of privilege within our society” (2003, para. 5). This lack of awareness can lead to interactions which could negatively impact the health care services provided to individuals and which do not reflect the standards endorsed by the ANA Code of Ethics. Sorrell (2003) suggested that we listen to stories of diversity in order to better “understand the potential for oppression built into the structure of our language, our social institutions and, especially, our healthcare systems” (2003, para. 3). Sorrell also suggested that we “explore the thin places where suffering lies
hidden.” My goal throughout this study was to explore those thin places to see what may lie within.
CHAPTER IV
PRESENTATION OF THE FINDINGS AND ANALYSIS OF DATA

This study aims to describe White (non-Hispanic) NP students’ perceptions of Hispanic patients and how these perceptions may influence their clinical encounters. This study also assesses the White (non-Hispanic) NP students’ perceived cultural self-efficacy of Hispanic patients. The findings of this study are reported in this chapter.

Once the interviews were completed, the surveys were analyzed and the qualitative interviews were transcribed by a firm specializing in transcription services. All surveys, tapes, and transcribed data were maintained in a secured area, and confidentiality of participants was maintained. The qualitative transcripts underwent line-by-line data coding in NVivo 9 (NVivo qualitative data analysis software, 2010) in order to identify some overarching themes. I also engaged in data analysis by hand coding the data utilizing the Miles and Huberman (1994) approach of data collection, data display, data reduction, and conclusions.

The coding of data, for example (data reduction), leads to new ideas on what should go into a matrix (data display). Entering the data requires further data reduction. As the matrix fills up, preliminary conclusions are drawn, but they lead to the decision, for example, to add another column to the matrix to test the conclusion.

In this view, qualitative data analysis is a continuous, iterative enterprise. Issues of data reduction, of display, and of conclusion drawing/verification come into figure successively as analysis episodes follow each other. (p. 12)
The research data and analysis is presented in this chapter and includes results of the demographic survey, the Cultural Self-Efficacy Scale (CSES) and the qualitative interviews. The demographic data, CSES, and results of the qualitative interviews are used to answer the following research questions:

- What are the White (non-Hispanic) NP students’ perceptions of Hispanic patients?
- In what way does the Hispanic patient influence the White (non-Hispanic) NP student provider/patient clinical encounter?
- What are the White (non-Hispanic) NP students’ expectations of Hispanic patients?
- What is the perceived Hispanic cultural self-efficacy of the White (non-Hispanic) NP student?
- Is there a relationship between the White (non-Hispanic) NP students’ perceived cultural-self efficacy related to Hispanics and their responses to the qualitative interview questions?
- Is there a relationship between the White (non-Hispanic) NP students’ demographic factors and their perceived Hispanic cultural self-efficacy?

**Demographic Survey Results**

All participants in this study completed the demographic survey provided at the beginning of the research encounter. There were a total of 12 participants in this study (Fig. 3). Six participants (50%) were age 30 or below with another three participants (25%) ranging from 31 to 35 years of age. Three of the participants (25%) were between the ages of 36 and 60. The mean age of this sample population was 37.6, with the greater percentage of the students being 35 and under.
The average age of these participants is much lower than the average age of licensed RNs in the United States, which is 46, according to the findings of the 2008 National Sample Survey of Registered Nurses (USDHHS & HRSA, 2010). However, it was noted that a plateau in the aging trend of the RN workforce appears to be a result of an increase in the number of employed RNs under the age of 30, which is more reflective of my sample (USDHHS & HRSA, 2010). All participants were female and self-identified as White (non-Hispanic). This is very typical of the U.S. RN population. According to NSSRN, 83.2% of the RN population is identified as White (non-Hispanic) (USDHHS & HRSA, 2010).
In reference to marital status, nine (75%) of the participants were single. Only one participant in this group stated that she was either in an inter-racial marriage or inter-racial relationship.

All participants responded affirmatively that they were born in the United States (12 = 100%). However, one participant stated she had dual citizenship. This citizenship, however, was not connected to a predominantly Spanish-speaking country. Most participants, nine (75%), stated they grew up in a predominantly White neighborhood (Fig. 4).

Figure 4. Participants’ Neighborhood of Origin, n = 12.

Of those participants, three (25%) responded they grew up in a neighborhood that was not predominantly White, one individual grew up a predominantly African-American
neighborhood, one in a White/African-American or mixed neighborhood, and the last individual just marked other. When participants were asked if they moved frequently, many responded by either leaving this item blank or by writing “not applicable”, so it is safe to say the majority of these participants grew up in neighborhoods that were predominantly White. Of those who responded that they had moved frequently (five or 42%) it remained evident that the predominant culture/race/ethnicity that influenced them the most was the White (non-Hispanic) race and culture.

All participants responded that English was their primary language, with six participants or 50% checking that they did not speak another language. Of the remaining six that did declare knowledge of a second language, four (33%) checked that they spoke Spanish, one participant spoke French, and one participant spoke Danish (Fig. 5).

In question number 12, participants were asked to self-identify the color of their skin and they all identified themselves as either being white, Caucasian, pale white, or fair. It is safe to say that all (100%) of the participants in this study self-identified as White.
In reference to their education and work setting, participants were asked about their RN education and all responded that they received a BSN, which represents a shift in entry-level education of RNs. According to the NSSRN 2010, an associate degree in nursing is the most commonly reported initial education for nurses (45.4%). Bachelor’s or graduate degrees were achieved by 34.2% of RNs in 2008, which represents almost twice as many as graduated at this level in 1980 (USDHHS & HRSA, 2010, p. xxvii). This research group reflects the shift in entry-level nursing education currently being advanced on the national level.

Regarding employment/work setting, of those nurses who were employed, more than half (seven or 58.3%) worked in a hospital setting and four (33%) worked in a clinic.
This work facility data is very representative of the current U.S. RN population.

“Hospitals remain the most common employment setting for RNs in the United States, with 62.2% of employed RNs reporting that they worked in hospitals in 2008 . . .” (USDHHS & HRSA, 2010, pp. 3–8). These NP student participants’ clinical specialty areas included critical care (25%), pediatric care (25%), adult medical/surgical (8.3%), and the remaining (41.7%) worked in some form of a primary care setting.

In this study, I wanted to gain a better understanding of the White (non-Hispanic) NP students’ encounters with racially/ethnically, diverse patients as well as their encounters with Hispanic patients as compared to their overall total patient encounters. The study was aimed at investigating individuals who were already licensed RNs and studying to become NPs because there was an expectation that these nurses had engaged in some form of nursing clinical practice and had some experience in caring for patients prior to their entry into their master’s NP program. Regarding their perceived percentage of encounters with racially/ethnically diverse patients as demonstrated in Fig. 6, according to their responses on the demographic survey, all participants had clinical encounters with racially/ethnically diverse patients; five of the participants responded that their encounters with this patient population ranged over 25% and some as high as 75% as compared with their overall total patient clinical encounters.
Regarding encounters specifically with Hispanic patients, six (>50%) of the participants responded that their encounters with Hispanic patients related to total patient encounters within the last year ranged anywhere between 25–49% of the time, demonstrating that these participants had some exposure in their practice to racially/ethnically diverse populations, including encounters with Hispanic patients (Fig. 7). They affirmed that previous experience in clinical encounters with diverse patients, including Hispanic patients, was not foreign to them.

From this data we know that these nurses were White, grew up in predominantly White neighborhoods, had a BSN, and had engaged in clinical encounters with Hispanic patients. What does the data show related to their exposure to cultural competency education?
The demographic survey responses show that ten (83.3%) of these respondents had at least a college class on cultural competency. The other two participants (16.7%) had completed only cultural competency training. Cultural competency training typically takes place in a clinical environment such as a hospital and/or clinic and is provided to employees of an institution. It typically incorporates organizational and cultural and linguistic competence and can be more focused on the communities that institution serves. Training “is a learning process that involves the acquisition of knowledge, sharpening of skills, concepts, rules, or changing of attitudes and behaviors to enhance the performance of employees. Training is activity leading to skilled behavior” (“Introduction of Training,” 2007).
Figure 8. Cultural Competency Coursework and Training on Diverse and Hispanic Patients.
Half of the participants responded that they had a college class as well as cultural competency training. The length of a college class focused on cultural competency noted by the participants ranged anywhere from 1 to 120 hours. The typical length of a cultural competency college class ranged most frequently between 1 and 3 hours with 3 hours being the most frequently cited number of hours for duration of a cultural competency class. According to the responses on the survey, cultural competency training ranged from 2 to 3 hours.

Related to the perceived outcomes of the total participants who had either the cultural competency class or the cultural competency training, ten (83.3%) of the participants stated the coursework/training was helpful with racially/ethnically diverse patients, but only six (50%) of all the participants checked that the cultural competency education/training was helpful with Hispanic patients. The following is an interesting perspective from one of the participants who I have identified here as Camryn:

But now I’m like reflecting on it . . . because I’m going to graduate school here and you have clinical work and everything but it is kind of interesting because while I’ve had some of the culture competency like training and things like that, it almost seems like Hispanic—like the Hispanic, like that culture because it’s so common is falling out of our cultural—like our competency, like out of that training, you know.

They are kind are like—you know, we learn a lot about Native Americans and some of the other like, you know, Eastern cultures and things like that but with Hispanics, like I’m kind of trying to think of some of the—like I have like—you know, your kind of like ingrained stereotypes and things like that.

But like I don’t really know much about how—what their beliefs—like as a culture . . .

Some, such as Heidi, shared that their university did try to provide culturally competency education.
I mean . . . was always very good about trying to do, you know, some cultural competence and some—a lot of it was based on religion competence because it was . . . University but I mean with that you kind of end up talking about cultural competence and things like that. And so I mean I think that it was something that I was sensitized to at that point.

Finally, Edith, a participant who did her undergraduate work as well as graduate work in the same institution provided the following: “Cultural competency is huge, at least it was really stressed at . . .”

**Modified Cultural Self-Efficacy Scale Results**

This section covers the results of the modified CSES, which focused on the Hispanic population and the participants’ perceived Hispanic cultural self-efficacy. The following research question will be addressed in this section: What is the perceived Hispanic cultural self-efficacy of the White (non-Hispanic) NP student?

The results of the CSES follow. The overall mean for this administration of the CSES for all 12 participants was 3.3 on a 5-point Likert scale, which falls between neutral and some level of confidence.

The first section of the CSES, which measures level of confidence in knowledge of cultural concepts, seven (58%) of the respondents reported they had some or quite a lot of confidence (3.6–5.0 CSES score) with their knowledge of cultural concepts. It was also interesting to note that in this category, eight (66%) of the respondents reported a moderate to “quite a lot of confidence” (4–5 CSES score) in being able to distinguish between ethnocentrism and discrimination. The overall mean value for this section of questions was 3.4.
Regarding the second section of the CSES instrument, which measures level of confidence in knowledge of cultural patterns related to Hispanics, eight (66%) of the respondents reported they had between slightly above neutral and a high level of confidence (3.2–4.8 CSES score) in this skill set. Nine (75%) of the respondents reported that they have between a lot and quite a lot of confidence in their knowledge of cultural patterns of Hispanics related to family organization (4–5 CSES score). The overall group mean value for this section of questions was 3.175, which is only slightly above neutral.

Regarding section 3 of the CSES, which measures the NP students’ overall level of confidence with specific nursing skills, six (50%) of the respondents reported they had between a moderate and quite a lot of confidence in this skill set (3.6–4.8 CSES score). Approximately nine (75%) of the respondents reported having a high level of confidence to “quite a lot of confidence” related to their use of an interpreter, advocacy, and taking a life history. It was clear during the qualitative interview process that many of these nurses had used an interpreter throughout their nursing career. The overall group mean value for this set of questions was 3.6, which was the highest value as compared to all the groups and demonstrated moderate confidence in this skill set.

The reliability analysis done on the CSES for this administration (12 cases) (Table 2) was reported at the alpha internal consistency coefficient of .945 level, which was slightly lower than what was reported for other administrations of similar scales but still remained high.
Table 2. Reliability Statistics.

<table>
<thead>
<tr>
<th>Cronbach’s Alpha</th>
<th>No. of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.945</td>
<td>26</td>
</tr>
</tbody>
</table>

“Cronbach’s alpha is an index of the degree to which all of the different items in a scale are measuring the same attribute . . . . it is basically an index that summarizes the correlation between all items in a scale and the scale total considered simultaneously” (Polit, 1996, p. 249). Previous administrations of reliability with alpha internal consistency were reported at the .97 level. These studies (Bernal & Froman, 1987, 1993) were done with larger populations: 190, 315, both with larger samples.

Kulwicki and Bolonik (1996) administered the CSES to graduating students. Their reported results of those graduating students demonstrated minimal confidence in their ability to provide culturally competent care.

This current study’s administration reflects some participants reporting minimal to at least some confidence with their perceived cultural self-efficacy of Hispanic patients. In a few areas, some NP students actually reported a higher level of confidence in their perceived self-efficacy to provide culturally competent care to Hispanics. This could reflect these NP students’ increased exposure to the Hispanic population from the time they graduated from nursing school including their current NP student clinical experience, which increased their perceived cultural self-efficacy.

Individual student results (Table 3) were as follows:
### Table 3. Participant Statistics.

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Median</th>
<th>Mode</th>
<th>Std. Deviation</th>
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<td>4.0</td>
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<td>3.0</td>
<td>0.70602</td>
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<td>3.0</td>
<td>3.0</td>
<td>0.66216</td>
</tr>
<tr>
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<td>2.5385</td>
<td>3.0</td>
<td>3.0</td>
<td>0.98917</td>
</tr>
<tr>
<td>Edith</td>
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<td>4.0</td>
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<td>Heidi</td>
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<tr>
<td>Justin</td>
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<tr>
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</table>

*Multiple modes exist. The smallest value is shown.

### Qualitative Data Analysis

The qualitative data in this study were analyzed utilizing two distinct methods. Miles and Huberman’s (1994) process of data collection, data reduction, data display, and conclusion was used to arrive at common themes/patterns (p. 12).

According to Miles and Huberman (1994),

Data reduction is not something separate from analysis. It is *part* of analysis. The researcher’s decisions—which data chunks to code and which to pull out, which patterns best summarize a number of chunks, which evolving story to tell—*are all analytic choices*. Data reduction is a form of analysis that sharpens, sorts, focuses, discards, and organizes data in such a way that “final” conclusions can be drawn and verified. As Tesch (1990), points out, it also can be seen as “data condensation.” (p. 11)

In order to respond to the research questions posed I also utilized Miles and Huberman’s “Conceptually Clustered Matrix” (1994) “A conceptually clustered matrix
has its rows and columns arranged to bring together items that ‘belong together’” (p. 127). This provided me with a framework to identify how each of the concepts related to each other.

Line-by-line coding using NVivo (NVivo qualitative data analysis software, 2010) was also done on the interview data. Participants’ words created approximate codes (300) and identified some potential major themes. The following provides the results of my analysis arranged according to the questions posed. In order to protect the identity of the participants of this study, each participant was provided with an alias. Therefore, the names used in this study are all fictitious and are not in any way related to the participants’ real names.

What are the White (non-Hispanic) NP students’ perceptions of Hispanic patients?

The interviews provided a wealth of information not only about the White (non-Hispanic) NP students’ perceptions of Hispanic patients but also provided information related to how each nurse assessed, or made a judgment, about their patient’s culture and/or ethnicity. How did they know their patient was Hispanic? Information related to their personal assessment or knowledge of this information centered around three major themes/patterns. These themes/patterns are: physical characteristics, language, and patient chart. The following section provides a glimpse into the way these NP students assessed or formed their opinions that their patient was Hispanic clustered into these identified themes.
Physical characteristics

When interviewing Blanche, she told me that she knew her patient was Hispanic by saying the following:

Well, I mean kind of—kind of right off the bat I mean it’s so superficial and it seems silly but a lot of times it’s the way they look. Like their complexion, just their skin tones and, you know, the color of the hair, the color of their eyes, just other certain physical characteristics but (PAUSE) also kind of the way they would have the room arranged like how much stuff they would bring to them—with them to the hospital.

So I guess I don’t—I don’t really know. I guess it’s pretty judgmental. Just some people I was kind like, oh, they’re Hispanic but I mean I also had a situation once where a patient assumed that I was Hispanic for the same reasons and it’s absolutely not true so . . .

Edith stated, “I mean I guess walking into the room anyone obviously speaking Spanish, you figure they’re Hispanic. Also you could sort of tell with skin coloring and hair type if they’re Hispanic.”

Camryn reported,

By how they look, I mean—and so yeah, so there’s your initial like, you know, stereotype but I guess I immediately will look at them. But no, I guess I generally assume ID based on how they look like, that right there they’re Hispanic.

So I guess (unintelligible) American or, you know, born and raised and everything here and—but usually I mean if you see the dark hair, and the dark skin, and the dark eyes, you know, like that’s kind of the first perception and then after you talk to them for a little bit—or based on the name and things like that, so I guess that’s—like very initially how you kind of like ingrained stereotypes and things like that. The shorter stature, the color of their skin, (PAUSE) the color of their skin, the color—you know, they have a certain type of hair. Basically physical features and (PAUSE) then their name, if they have a—if they have a Hispanic-sounding name.

As evidenced by their own words, some of these NP student nurses made assumptions about their patients based on physical characteristics. They even used the term “ingrained stereotypes” when they discussed their frame of reference or perception of appearance. The physical characteristics they most often focused on were facial
features, skin tone, color of hair (dark), color of eyes (dark), complexion, darker skin, shorter statute, and “a certain type of hair.” These NP students frequently used the phrase, “if they appear Hispanic.”

Faith summed it up by saying, “if I’m getting a new patient and they have a last name that sounds Hispanic I might think so—they might be Hispanic, but many times that’s not true so I try to wait until I actually see the patient and if they appear Hispanic, maybe with darker hair or darker skin, that’s a clue for me.”

Language
Another recurring theme regarding this issue of Hispanic identification was language. Many of the nurses knew their patient was Hispanic either through his/her Hispanic-sounding last name or if they overheard people speaking Spanish before they entered the patient’s room.

Dahlia stated, “Basically physical features and (PAUSE) then their name, if they have a—if they have a Hispanic-sounding name.”

Edith said, “I mean I guess walking into the room anyone obviously speaking Spanish, you figure they’re Hispanic.”

Grace stated, “They’d be triaged and they’d come in and then I always introduce myself, Hi, my name is . . . . I’m a nurse. And if they appear Spanish speaking I’ll say do you speak any English and I say it like that, like I budge this much and it’s my fault but I’m just—zero part of me wants to learn a language right now.”

Addison reported,

I know they’re Hispanic because they speak Spanish and I work at a place in the city that—that is for Hispanic patients, but even so I mean I sometimes assume
that they don’t speak English so I speak Spanish with them and then you can tease out that they . . .

I sometimes forget to give them the option of speaking English and some do opt to speak English and I guess that first assumption is oh, well, they’re going to speak Spanish if they come here.

Blanche said, “And a lot of times too when I said hello, just the way they would say hello back like if there was any kind of accent or, you know, maybe a hesitation with speaking English, for some patients, not for all. Some people you couldn’t tell at all that way. They would have, you know, virtually no Hispanic inflections at all.”

Lacy said, “So name, maybe their language, whether they can speak the language.”

To summarize this feedback, frequently an individual’s name as a function of language and then the verbal affirmation of hearing another person speaking the Spanish language led the NP students to identify their patients as being Hispanic.

**Patient chart**

Some of the nurses thought their patient might be Hispanic by reviewing the chart and seeing the patient’s last name.

An example of this was shared by Heidi:

We get referrals here so I don’t see the patients immediately. So my first idea that the patient may be Hispanic is when I get a referral and the name sounds like something that is possibly Hispanic. And then I take it from there. Usually if I’m looking at the referral paperwork it usually has the patient’s race and ethnicity written on the referral paperwork.

Edith stated, “Well, sometimes you can tell by their names or it’s also—I look at each chart before I see a patient and I look at sort of their background and it says what
nationality they are, what race they are. So I sort of know going into the room what they are.”

In these scenarios, the NP student has reviewed the patient’s chart and used information gleaned through either the documented history or physical, or intake data already charted, to gain a better understanding of who the patient is and what his/her background might be. While some might make an assumption based on last name, these nurses looked at other objective data charted to arrive at their assessment.

To summarize, regarding Hispanic identification, many of the participants made a reference to the fact that they made assumptions that their patient was Hispanic based on physical characteristics and language. Name identification played a strong role in how these NP students arrived at the Hispanic patient determination. Physical and primary language characteristics are often considered national origin characteristics (Colon, 2002). Others used less subjective data and reviewed the chart. If the chart had a Hispanic-sounding name, they would search for notations on the patient’s background and ethnicity to validate.

These nurses’ voices have provided us a glimpse into the human process used to identify individuals as Hispanics. The next question this study aims to answer is: What are the White (non-Hispanic) NP student perceptions of Hispanic patients?

The NP students’ perceptions of Hispanic patients clustered around the following themes:

- Personality/behavioral characteristics
- Language
Many of the NP students viewed Hispanics as being kind, timid, reserved, well-mannered, patient, grateful, and genuine people. At times they used the work stoic and believed they were “frequent nodders”, which provided the perception that they understood what was being communicated to them even though that may not have been the case. The NP students shared that they also viewed Hispanics as loyal, hardworking, tired people who were friendly, open, and fun. Some shared that Hispanics from their perspective had a more fluid idea of time.

As a visual, Grace said, “They are clean and well put together. Well mannered and appropriate.”

Grace added, “But, you know, there are things that you pick up on based on just interacting with people and the Hispanic culture like normal—. . . .—stuff like this pregnant couple and the (unintelligible) there have been just really kind, genuine people and religious, a lot of times ask for chaplains.”

Blanche said, “And a lot of times I really thought my Hispanic patients were the most fun to take care of so usually I was pretty excited (PAUSE) just because they’re—these families are from a very different structure than some of the other patients I would take care of.”
Dahlia stated,

I can tell you nine times out of ten it was the Hispanic people who were so grateful that we were there. They were very grateful.

Now I don’t know where that came, if they didn’t get the same level of care, the same standard back home wherever home was, but they—they were always very grateful.

Justine said,

I do have a perception that there might be some more anxiety among Spanish speaking patients, maybe that’s a cultural level or—so if you cannot (unintelligible) from integrated some—I don’t know where that stress comes from.

I still have the perception that sometimes it carries some more anxiety . . .

An overview of the personal/behavioral characteristics of Hispanics as shared by these students led me to believe that these NP students for the most part had a positive perspective of Hispanic patients. One phrase that was slightly suspect was the following shared by Grace: “They are clean and well put together. Well mannered and appropriate.”

This almost appears as code for the expectation or the preconceived notion that Hispanics are expected to be dirty, rude, and inappropriate. This is a phrase that could have been explored further to get at the root meaning or subconscious/unconscious perspectives.

One could wonder as to what could be the root of this phrase. According to Dovidio and Gaertner (2002), “Unfortunately, the negative feelings and beliefs that underlie aversive racism are rooted in normal, often adaptive psychological processes” (p. 24).

Language
Language was another one of those themes that arose from the data in the NP students’ perceptions of Hispanic patients. Most were concerned about communicating with their patient and if they identified their patient as Hispanic, there was an immediate concern
about potential language barriers and one NP student in particular quickly assumed that
her patients only spoke Spanish and approached them by initially speaking in Spanish to
them.

Dahlia said, “Am I going to be able to communicate with them, is there going to
be adequate language understanding (PAUSE) yes . . . . The language barriers greatly
affect how I perceive patients and how they perceive me . . .”

Edith stated, “Usually my first concern is do they speak English and if they do
speak English is it their primary language? Do I need to get an interpreter, can they
effectively communicate their child’s needs to me?”

Grace said that she was “nervous because I can’t understand them, so discomfort
because I feel like I’m not going to be able to convey or understand what they are there
for.”

Addison said, “I know they’re Hispanic because they speak Spanish and I work at
a place in the city that—that is for Hispanic patients, but even so I mean I sometimes
assume that they don’t speak English so I speak Spanish with them and then you can
tease out that they . . .”

Faith stated, “Well, when I first talk to them I (PAUSE) try to know—understand
if they understand English or not.”

As evidenced by these conversations, most of these nurses viewed Hispanic
patients as individuals who speak in Spanish. NP students conveyed a strong
need/urgency to identify their ability to communicate with their patient as soon as
possible. One NP student acted on her assumption about Hispanics speaking only in
Spanish and automatically conversed in that language with her patients because she was bilingual. She did work in a predominantly Spanish-serving clinic which could lead her to quickly adapt her behavior to address all patients in Spanish. However, there were also other perspectives related to language which were expressed, such as Kelby’s, who stated:

But it’s more along the lines of, you know, I mean why don’t you have the decency to speak my language, why can’t you connect with me, why isn’t there this bond and I think that is a problem in the U.S., is that feeling of you have to speak English that a lot of Americans have whereas the rest of the world thinks it’s sort of just polite to be able to speak at least one other language.

Addison shared, “You know, there’s already a stigma that, I don’t speak Spanish, you need to learn English. You’re in America now, that kind of finger shaking.”

This perspective can lead one to believe that some nurses much like other individuals could have a bias regarding English language proficiency and that language bias could be passed on to the patient in subtle, nonverbal ways which could negatively impact that patient/provider relationship.

**Education/employment**

This theme focused on the Hispanic patients’ education and employment status. Some of these NP students were working in low-income clinics that may have influenced the following perceptions based on their encounters in those workplace settings.

According to Heidi, “A lot of my patients and I don’t think this is necessarily specific to the entire Hispanic population in general . . . you know . . . not necessarily jobs that are extremely flexible . . .”
Ivory stated, “I have a great sympathy for the Latinos that I do work with. They are often low-income . . . ”

Justine said, “I think I might have a higher expectation on educational level from people that are more culturally like me . . . ”

Ivory stated, “. . . particularly your Latino people because education is not put an important thing on. Latinos they have these low income jobs. They sure as heck can’t take time off from McDonald’s; McDonald’s is not going to let them.”

Addison shared, “They’re the poor, they are the uneducated or undereducated, they’re the illiterate, they’re the people that are exposed to the worst environment that have just moved to look for something better and I don’t think that there’s a real clear understanding.”

“The racial/ethnic disparity in both income and education, compared with non-Hispanic whites, was greatest for Hispanics and non-Hispanic American Indians/Alaska Natives. It was the lowest for non-Hispanic mixed races and Asian/Pacific Islanders, and intermediate for non-Hispanic blacks” (Centers for Disease Control and Prevention [CDC], 2011).

Many of these NP students viewed Hispanics as low-income, less-educated individuals with little autonomy in their work settings. The low income coupled with inflexibility with their work environment at times negatively impacted their ability to access care. Many of these individuals sought care in local clinics for the underserved.
Family
As the interviews progressed most of the NP students I spoke with frequently mentioned the Hispanic family. Here is what they had to say about their perceptions of Hispanic patients and the role of family.

Heidi said, “I feel like they are going to prioritize their children as long as I make it so that it’s possible for them to do it, I mean then I feel like they’re very dedicated to their families perhaps more so than others.”

Ivory stated,
Well, I might possibly put a little influence, a little more emphasis on the family with the Latinos . . . . And then the macho, you have the famous macho thing where in some way yeah, they’re very macho in some way but in other ways they can be very, very sweet, sweeter than, you know, white people, the white men, and so I often times see that and try to build on that strength of you’ve got to be here for your family . . .

In this scenario, as I interpret it from my perspective, Ivory integrates her perception of the Hispanic patient’s cultural value regarding family in her interactions with her Latino male patients and tries to build on that value and link it to the improvement and maintenance of health in her provider/patient communications.

Lacy said, “I think that they’re usually family oriented and dedicated so I try to do whatever I can to assist them and help them . . . . always family oriented, hard working, most of the time very religious, Catholic religion. I find that they definitely care about their family members and I enjoy taking care of people . . .”

It is also safe to conclude from these interviews and according to this data, some nurses perceive that Hispanic patients will have family support—like it’s almost a given.
Blanche stated, “I feel like I spend a lot more time talking with them about their families and like family support structure, probably because I assumed it was there.”

Camryn shared the following:

When you are working with the Hispanic patient you think of—a lot of times I think of like the family and like how much their family’s involved, not only involved in their care but how much their family is just there. I feel like Hispanic patients have more family than the other—than the other cultures, like definitely.

Finally, Faith shared, “I feel like Hispanic patients tend to have more family involvement. There’s multiple generations and (PAUSE) like sisters and brothers and aunts and uncles all living together . . . lots of family support.”

It’s clear that the nurses in this study expressed awareness and shared their experiences which emphasized that Hispanics valued family and that their family, frequently large and multi-generational, was typically part of the health care encounter and something they had to consider when caring for Hispanic patients.

Legal status

The last theme that arose from the data was the issue regarding the legal status of the Hispanic patient. There were various references to this issue during the interviews.

Heidi stated, “A lot of my patients, and I don’t think this is necessarily specific to the entire Hispanic population in general, but a lot of my patients are not necessarily here legally . . .”

Justine said, “And as a nurse I made the decision for myself. You know, whether they’re here legally, not here legally, that’s not my job. That’s INS’s job. They are here now. It’s just my job to take care of them . . .”

Kelby shared,
I think the issue of status is something that is prevalent especially in going to seek care because a lot of them don’t understand when they’re just in this country that this isn’t like most countries where you have to show your card to get service.

This is you show up, we take care of you. Yes, you may get bumped to another hospital once you’re stable, you know, if you show up in a for-profit hospital but you will be seen and you will be cared for.

And I think there is a great concern especially in the great debate over what do we do with our total illegal immigrant population, which I think is sort of ridiculous that we put that all on the Hispanic population. We do have other illegals. Let’s be honest. We were all illegal at one point in time unless you’re a Native American. I mean what do you think Ellis Island was?

Kelby continued and responded to a follow-up question whether she thought nurses in general viewed Hispanic patients differently. To this Kelby responded,

I think some of them do, absolutely. I think some of them think that, you know, I hate to use the phrase, but they’re “wetbacks”. I mean I’ve heard it said about them and I cannot believe that someone would actually say that about their patients.

It’s a horrible thing. It’s a horrible thing to imply that because I mean how many English speaking Hispanics have been in this country for generations, a lot. I mean look at the comparison. There’s a lot of Hispanics here whose families have been here since the Spanish American War. How many—that was 100 and whatever years ago.

Well, you’re treating them and comparing them to someone that just crossed the border, who knows, legally, illegally, who cares. You’re putting them all in one pot and I really—I don’t like that. I really don’t like that.

The following provides information regarding the term “wetback”:

Operation Wetback was a repatriation project of the United States Immigration and Naturalization Service to remove illegal Mexican immigrants (“wetbacks”) from the Southwest. During the first decades of the twentieth century, the majority of migrant workers who crossed the border illegally did not have adequate protection against exploitation by American farmers. As a result of the Good Neighbor Policy, Mexico and the United States began negotiating an accord to protect the rights of Mexican agricultural workers (Koestler, n.d.)

The NP students also viewed Hispanics from a legal/illegal status. From their perspectives, some viewed them mostly as individuals who are here illegally; some did not care about their legal status and felt that it was just important to provide health care
services. One provided information regarding the use of a slang term by other nurses she works with to define Hispanics related to their legal status and expressed her shock and distain for its use.

In summary, the White (non-Hispanic) NP students’ overall perceptions of the Hispanic patient focused on five major themes which included personality/behavioral characteristics, language, education/employment, family, and legal status. Most of the perceptions shared led me to believe that for the most part, these NP students viewed Hispanics in a favorable light. There were some responses that shared an unfavorable perception of Hispanics especially when focused on language, education/employment, and legal status. Some of these perceptions, especially in the type of verbiage that was used to convey this information, I interpreted as having negative racial undertones in their perspectives of Hispanics and evidence of tones of aversive or covert racism.

The second question posed during the qualitative interview was: In what way does the Hispanic patient influence the White (non-Hispanic) NP student provider/patient encounter?

The themes that emerged from these interactions include:

- Language/communication
- Time
- Relationship/interaction dynamics
- Nursing issues/concerns

As I read through the transcripts and engaged in data reduction, it was clear throughout many of the interviews that language and communication really played a
major role in the provider/patient encounter and was something that preoccupied almost all, if not all of the participants in some way or another. “Intercultural communication is an essential and necessary skill to learn to manage the emotional and psychological challenges of operating outside one’s cultural comfort zone” (Tate, 2003, p. 214). Some of these NP students were bilingual but most of them had to depend on other nurses, health care workers, colleagues, or institutional support systems to maneuver around this impediment to patient care. The following, in their own words, provides a glimpse into these NP student nurses’ encounters with Hispanic patients and what types of issues influence their interactions and ultimately patient care.

**Language/communication**
Grace stated,

I can’t—I mean I can barely understand what they’re saying—so much of what you say is how you say it and I don’t even know what they’re saying.

I only work at one hospital I mean usually bilingual nurse there, there’s a nurse there so I’ll grab them and most of the time they’ll take over the care and I will completely step aside because I know they are going to take better care of them.

Heidi shared,

I guess the first thing I think of is am I going to be able to communicate with this patient and with this patient’s family.

I mean obviously a lot of Hispanic patients speak English but my population, most of my Hispanic patients do not speak English and so it adds an extra level of complication to the situation.

But when I call if I feel like there’s any sort of communication I usually ask if it’s okay if I connect us with an interpreter . . .

Ivory stated, “I try to do a lot of open-ended questions and I try not to assume things. Like with the Latinos I try to have—like I have that subtext in my mind and I’m sure I do jump to more conclusions with the Hispanics.”

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Kelby reported,

Well, the first thing I’m concerned about is whether or not they have enough English to be able to participate in the conversation without an interpreter.

And for me it’s just sort of—you know, I go up, I introduce myself and then I always ask (Spanish) or if it’s no or si (unintelligible) then I just, you know, ask if they want an interpreter and if they do great, if not I run and I grab one of the nurses that I know speaks Spanish because the thing is I have to make sure when I’m doing my assessment before I take them back that I know about their allergies, I know about the site, I know that they’re prepared.

So for me, you know, first thing I want to know, can you understand what I’m saying, if you can great, if you can’t we’ll figure a way.

Addison shared,

I know they’re Hispanic because they speak Spanish and I work at a place in the city that—that is for Hispanic patients, but even so I mean I sometimes assume that they don’t speak English so I speak Spanish with them and then you can tease out that they . . .

Blanche reported,

Sometimes first thought like when I would walk into a room with a Hispanic patient I would already be assessing how much English they could speak honestly, just so I would know how I needed to communicate with them and make sure that they understood what was going to go on and what was going to happen, and make sure that I could meet their needs."

I mean for me that was the biggest thing when I was taking care of Hispanic patients just—I really want to make sure that I’m going to be providing them the best care I can and if I’m not communicating with them well then already there’s a problem because I mean aside from me trying to get information to them, a lot of times I would have trouble getting, you know, information back.

So—I mean and it’s not too bad because my Spanish is not fluent by any means but I can understand a lot more than I can speak so I sound—a lot of times with patients who have very little or no English a lot of communication was non-verbal and so it felt like I spent a lot of time developing those skills.”

Camryn stated,

And then sometimes I think of—and then often the immediate thing I think of is like the language—language barrier and how many barriers to care there is with Hispanic patients because a lot of times while there is interpreting services and things like that, it ends up being a child or a family member who does the interpreting, and I feel like that kind of is short sighting the patients a little bit.
And I think that—that happens in clinics too. Like now where I’m working in a clinic like we have—rather than having an interpreter in my outpatient clinic we have, you know, one of our receptionists that speaks Spanish but she’s not actually like educated as an interpreter. So I think of that a lot of times.

Dahlia shared,

If they speak English it doesn’t encounter it all, it doesn’t change—I would treat—I treat everyone the same way regardless—irregardless [sic] of socio-economic status, regardless of (PAUSE) history, medical history, if they’re sick, if they’re not sick, if they’re generally well.

I treat them the same way as I would treat someone who is chronically ill as far basic human kindness; you know what I mean, and medical knowledge. Everyone deserves the same level of medical care regardless of who they are.

But if they don’t speak Spanish—if they don’t speak English the same is still true but I rely—if I don’t—if I have an interpreter versus if I do not have an interpreter or a family member, I still provide the same level of care but the history isn’t there, you can’t take an adequate history. Do you understand? So you’re basically going off what you’re seeing in front of you and not this story that comes with a sick person.

Edith shared,

Language barriers, huge.

The communication I find especially with people who can effectively communicate in English, I want to also make sure that they understand what I’m saying because effectively communicating doesn’t always—they’re not always grasping the full picture of what I’m trying to explain.

So I always want to make sure that I can either have them repeat instructions back to me or that they can do it in their on words and then I always provide handouts and I always ask whether they want it in English, or in Spanish, or in both, whether they want to take it home, maybe their husband who only speaks Spanish wants to read it.

If the patient doesn’t speak English I—my Spanish skills are not very strong. I—I can communicate but not efficiently to provide care so we have a television that brings in—and the interpreter comes on the television. And I always use a Spanish interpreter if they don’t speak English well enough to communicate their child’s needs or their own needs.

Faith stated,

Well, when I first talk to them I (PAUSE) try to know—understand if they understand English or not. That’s probably the first thing and then I move on—if
they don’t—if they understand English how much, and if they don’t understand English then what I can do next to communicate.

They come to the floor and if they do not speak any English I call interpreter services for the initial interview and they’ll bring us a language line that we can use as well.

I think that the language barrier is hard. I think it’s hard to not be able to communicate well with the patient even not—if there is an interpreter, even a language line, they’re great. I’d rather a real person be there and that’s just not always feasible.

So I think sometimes that clinically it’s hard and I don’t know a ton about Hispanic culture so sometimes I don’t understand where they’re coming from or—and I’m sure they don’t understand where I’m coming from so I think that can be hard.

I trust like an interpreter service and a language line just because like that’s their job but I try really hard not to use other medical personnel that I don’t necessarily trust.

Yes, I mean normally somebody—the report that the other nurse will give me will say that they’re Hispanic and if I walk into the room and I see like if a patient sort of just is nodding all the time, is not really saying anything, I get the impression that they’re not understanding what I’m saying. They just continue to just nod and not say anything.

In summary, language and communication plays a central role in the patient/provider encounter. There were many concerns expressed about NP students’ inability to speak the Spanish language and communicate effectively with their patients.

This added a level of complication to the encounter. One NP student fluent in Spanish assumed her patients who “appeared Hispanic” or had a Hispanic surname, automatically spoke Spanish with her patients. Some NP students quickly asked the patient’s permission to use an interpreter, some used nonverbal skills to facilitate communication, and some responded by transferring the patient to another nurse’s care. For example, Grace reported,

And fortunately it ends up me being like okay, it’s your patient. Like if I’m—we work in teams like from A, B, and C, two nurses to each, and I’m on team two, and they find a Spanish speaking patient and . . . on my service, I’m like that’s
you because no part of me wants to try to understand right now, I’m overwhelmed.

Some NP students stated they spend less time with their patients, and others shared that they frequently jump to conclusions regarding patients and care. Another NP student shared she felt like the inability to communicate on a one-to-one level desensitized the nurse from the patient.

Camryn stated, “I think sometimes that like desensitizes you like to that patient a little bit just because you can’t like interact with them directly sometimes.”

Those NP students who frequently used an interpreter believed that they had to have trust in the communication that was being facilitated by the interpreter. However, there still exists translation/interpretation facilitated by family and children as shared below.

Camryn reported, “A lot of times while there is interpreting services and things like that, it ends up being a child or a family member who does the interpreting, and I feel like that kind of is short sighting the patients a little bit.”

Finally, there was concern expressed regarding continuity of care. Camryn said, “that there’s a break in the continuity, you know what I mean?”

As shared by these NP students, it is evident that the language barrier brought another level of complication to the patient/provider encounter and definitely impacted patient care services. Some NP students made it clear that nonverbal behavior such as nodding did not equate with understanding and could in fact be misleading when dealing with this population. It provided a false sense of effective communication.
Time

Time was another theme that arose from the conversations when the NP students were asked how the Hispanic patient influenced their encounter.

Grace said, “I spend less time with my Spanish-speaking patients . . .”

Heidi reported,

Well, I mean obviously we have to be more timely about scheduling interpreters or things like that. We have to be—you know, stay more on schedule. I guess for—I mean yet I have to admit—I don’t know if I want—this on tape.

Yet I found that a lot of my patients who are Hispanic have a more fluid idea of time and so I usually try and build in a little bit more wiggle room for arrival time and things like that just because otherwise my interpreter is going to be gone and my providers are going to be gone and things like that. So I feel like if I have a patient who has a more fluid concept of time I try and build in more wiggle room into the schedule.

Heidi continued,

But with my patients who tend to run a little bit behind on time I try to build in more time. And then of course you end up building in a little bit more time just for like the translation process and making sure that people really truly understand what you’re saying . . .

Justine reported, “I may be more predisposed to give them more time which as a student I can afford that, on the clock billing my own stuff, I don’t know. But as a student I’ve been able to afford—if I need to take a little bit longer, go for it.”

Kelby stated, “It’s more of a, I don’t want to spend the time, I don’t want to do the effort to find someone, or I don’t want to use the phone. I mean it’s not that hard to do a three way phone call with an interpreter but the answer is they don’t want you to do that.”

While working in a clinic that primarily serves the Hispanic community, Addison said about that time, “So I think that, you know, I—I really try in all my patient
encounters to get to the heart and I have the luxury because I’m a student so I can indulge
them in more time then probably I ever will to (unintelligible).”

Blanche reported,

... it takes a lot more time and with that inherently it takes more patience then to
even be willing to spend that kind of time because I’ve actually—you know,
sometimes you have a bad night and you’re just like I don’t have time for this and
I mean I hate to admit that I’m guilty of sometimes not taking care of patients the
way I should but I mean I am, like sometimes I would get patients and be like I
don’t even know—I kind of have to tough it out.

Yeah, then it’s like your patient care the whole rest of the day just suffers
because you get stuck somewhere and that takes a toll very quickly.

Blanche added, “I feel like I spend a lot more time talking with them about their
families and like family support structure, probably because I assumed it was there.”

Camryn stated, “And then, you know, also like it can be difficult like if you’re an
inpatient and you do need an interpreter or something like that—to when if you are
diligent about using that interpreter or not you know, using a family member or
something like that, that also adds, you know, time and strain to an already busy day.”

Faith stated, “I think maybe with Hispanic patients sometimes I’ll maybe not go
in depth as much if they understand or have questions because of a time constraint but
with my other patients even if I go in depth I’m not sure if they technically understand
what I’m saying.”

Faith added, “so it just takes way more time then planning and when someone—I
feel like when a patient can’t speak English it just—it takes a lot more time because—or
there’s going to be—they’re going to be—like a disservice because they’re not going to
understand what’s going on.”
The Hispanic patient, therefore, impacts the patient/provider encounter from a time factor sometimes due to the way they view time from a more fluid concept, to the extra time needed in order to communicate and provide translation services. Some stated that if they use an interpreter, they actually spend less time with the patient. It almost conveys a sense of distance, as if the interpreter is there; the relationship with the patient is just one of understanding the language, but not really establishing a therapeutic relationship. However, many shared the perspective that patient care did take a lot more time, especially with a patient who did not speak English, and that the nurse needed much more patience during these encounters. Finally, some shared that patient care did suffer and that the Hispanic patient, especially one who did not speak English, added additional strain to an already busy day and workload.

Relationship and interaction dynamics
The building of a relationship with your patient is a necessity in order to provide quality patient care. The nurse/patient interaction/relationship is one that can profoundly impact patient care outcomes. Many of these NP students shared their challenges and their perspectives related to caring for a Hispanic patient, especially one who does not speak English. These NP students also shared experiences related to their relationships with these patients as well as some of the dynamics involved with their interactions.

These interviews provide a glimpse into their Hispanic patient encounters and relationships with Hispanic patients.
Grace stated, “I spend less time with my Spanish speaking patients because if I do have an interpreter they’ll go in and then come back and tell me what they said. So it is a different relationship.”

Kelby reported,

I think being able to be aware of what your patient is saying is literally the most important thing that you can do because the patient knows themselves the best and getting that person to really have a connection with you even though it’s through another person is really, really important because I’m able to glean information that sometimes the doctor and sometimes the anesthesiologist really isn’t able to get out . . .

Kelby added,

And I’m sort of like just calm down, just breathe, just get that human interaction, that human patient interaction between you and the nurse and just getting it all together.

It’s the basics of nursing, having connections, getting that trust and, you know, sometimes it has to go through a third party but as long as you have that connection you’ll be able to do what you need to do for the benefit of your patient.

Lacy stated, “So that’s—I guess the point I’m trying to get in is if they have a problem, whatever it is, whether they don’t have the money to come back, whether they don’t have transportation to come back, they’re not necessarily going to tell you unless they feel close to you.”

Addison shared,

I mean it’s really a give and take and so the way I like to perceive it is you tell me about your culture, you tell me about—what—what works for you in terms of how you can make change, how you can improve your health, how you can improve your family’s health. You tell me what you think you’re capable of doing and then I’m going to input my professional—not even professional, my academic—my expertise onto this.

And that’s where it’s a relationship and it’s a building and it’s a long process . . .
So if I can establish that relationship in a primary care setting with a patient that is really my—my goal . . .

Blanche stated,

As far as (PAUSE) like my clinical experience and as a nurse practitioner student, that’s been really hard too because you’re—you have a very specific timeframe of time to take care of patients and so I found that it’s even harder in a clinical setting to take care of patients that you seem to not be connecting with on even the most basic, you know, language level.

Camryn reported,

. . . because it’s just harder to build a relationship with a patient if you’re not actually—like you can’t—you can’t communicate with like one—so I think—and I think sometimes that like desensitizes you like to that patient a little bit just because you can’t like interact with them directly sometimes.

And then, you know, also like it can be difficult like if you’re an inpatient and you do need an interpreter or something like that—to when if you are diligent about using that interpreter or not you know, using a family member or something like that, that also adds, you know, time and strain to an already busy day.

So I think sometimes, you know, that can kind of comes into play in that—in that nurse/patient relationship, not—and it’s something that, you know, not the patient’s fault by any means it’s just—it’s an added (unintelligible).

I just notice in general, like if I had to generalize, it’s harder to build like a real caring like nurturing relationship with that patient because of that. So I think that’s the main thing, the main thing that I would say.

And then sometimes it can be difficult if they do have their entire family there as well. It’s already difficult not to communicate but with everybody speaking a different language and then you walk in and then you’re the minority, that can be also kind of difficult and frustrating too because you’re not only trying to—because the family’s involved in the care but you’re having a hard time communicating with everybody and not just them.

So like that can be kind of frustrating but—but the thing --that’s like really the biggest thing that comes to mind for me.

Camryn continued,

. . . and when I think you’re initially going to like have a break in your—like in the patient/provider relationship because even if you can try, like the fact is, you know, you learn how to kind of like therapeutically communicate with a patient and things like that and it’s just not possible with an interpreter.

Like you can—you know, you can be empathetic and be caring and nurturing in your tone but everything goes through, you know, a phone or an interpreter and
things like that and then there’s just that odd—that there’s a break in the continuity, you know what I mean?

It’s like getting the information—giving and getting—getting and giving the information so like I think I feel like with my Hispanic patients I haven’t really developed like the rapport with the Hispanic patients that I have with other patients because you have that immediate—that barrier already. So I think that is—and that’s kind of challenge in and of itself . . .

Dahlia said,

But there was a huge level of mistrust.

I don’t need to change what I’m doing. I’m just as respectful with them as I am with someone else.

Um, it was very awkward, (PAUSE) it was very awkward because I had no idea if the interpreter—we had AHAC which stands for something, I don’t know what it stands for. AHAC—they would have AHAC interpreters there so I knew that they were competent interpreters but I had no idea what they were saying.

Faith stated, “So I think sometimes that clinically it’s hard and I don’t know a ton about Hispanic culture so sometimes I don’t understand where they’re coming from or—and I’m sure they don’t understand where I’m coming from so I think that can be hard.”

From these NP student voices, nurses stressed that it’s important to establish a good relationship with one’s patient. Sometimes with Hispanic patients, especially if they do not speak English, and an interpreter is used, it becomes a different relationship.

Another NP student viewed the establishment of the nursing relationship as the “basics of nursing, having connections getting the trust,” which is needed for continuity of care.

Another NP student viewed relationship building as a “long process” and a “goal.” Lack of time and language barriers and the influx of patient family during the patient/provider encounter appeared to have a negative impact on their ability to establish a therapeutic patient/provider relationship. One NP student shared that it could be frustrating to feel
like you are the minority and not able to comfortably communicate not only with the patient, but also with the family.

Although I viewed the patient relationship as well as the interaction dynamics as a connected theme—I wanted to highlight some of the differences within this category. One could say that interaction dynamics play off of the relationship or influences/impacts the relationship as well as is dependent on the perceived relationship and the comfort level of those interacting. What follows is what these NP students shared about their interactions with the Hispanic patient and, at times, with Hispanics in general. They also shared some of their feelings about this ethnic group.

Ivory stated,

Because I do have lots of familiarity with Hispanic patients, particularly the Mexicans and Central Americans because of the Central Americans we have here in the D.C. area and because I’ve lived in Mexico, I have a certain kind of joking style with them, kind of a very relaxed style that I might not have with everybody, particularly even the South Americans, or white people, or black people, or Asian people.

And in the non-diabetes situation once again I would say it’s that I have a great sympathy for the Latinos that I do work with.

I’m afraid off the top of my head I can’t think of much other things that I do except for I’m a little warmer with Latinos, you know, perhaps just reverse discrimination but I’m probably just a little warmer I think. That’s what I think.

Regarding her ability to speak to the patient in Spanish and also joke with them

Ivory said,

From my perspective they enjoy it. It makes them feel more comfortable from my perspective and people, like I said when I do encounter people who are a little more serious because there are certainly serious Latinos as well, like I said I tone it down. You know, I try to modify if they’re serious people. I don’t want to be annoying them.

But for most part the Hispanics, people of Central American and the Mexican people because I have such a strong affinity for those particular groups, they
especially—I do perceive that they really, really, really enjoy it. It makes them feel more comfortable.

Lacy stated, “And Hispanic people tend to be stoic and so if they need help they won’t ask you, they won’t let you know.”

Lacy continued,

I find that my interactions with the Hispanic families and the patients are much more enjoyable for me.

They’re fun people to me. They laugh. I enjoy being around—so from a personal perspective it’s an enjoyable encounter for me.”

Yes, I have to be totally honest. I feel like I probably would smile more. I probably would be more open, maybe easier to joke with, maybe know certain things that they would even find funny . . .

Lacy also shared another side of the Hispanic and non-Hispanic relationship as well as the Hispanic patient and White (non-Hispanic) nurse dynamics that she has observed.

Lacy reported,

I think that there’s definitely challenges. I think that—I can perceive that there’s—especially in certain parts of the country, there’s bias against Hispanic people. I don’t—you know, it’s all self centered, ignorance mostly. All prejudice (unintelligible) but, you know, (unintelligible) but it’s true (unintelligible).

Have I observed it in the healthcare arena? To be honest with you when—I’ve worked in military hospitals and I’ve worked in civilian hospitals. I think (unintelligible) in the military hospitals where you never see it in the military hospitals or there’s such a large proportion of Hispanic people that serve in the military.

In other words you have a Hispanic patient but you’d also have a Hispanic doctor or Hispanic nurse that you work with so that—I don’t see it in the military

Do I see it in the civilian sector, I do. I used to work in, you know, rural hospitals and you definitely will see it.

When asked how this plays out, Lacy responded,

Ignoring the patient’s calls for help, treating them like they’re dirty, you know, stupid.
It makes me very angry when I see (unintelligible) and I see prejudice and discrimination against the Hispanic patient and it makes me very, very angry because usually the people that are discriminating, they’re doing it out of total ignorance, total fear, and it’s unnecessary and (unintelligible) for help because it’s a crisis in their life and the last thing that they need is someone else to make it even worse for them and if I will see it I will (unintelligible).

Addison shared, “A pleasant encounter generally. It is—I don’t know that as opposed to another but it’s typically a very pleasant encounter.”

Blanche reported, “it takes a lot more time and with that inherently it takes more patience . . .”

Blanche continued,

With my Hispanic patients I found I was a lot more touchy with in terms of I spent a lot more time like holding their hands, like reassuring them through touches to their arm and stuff, you know, things like that.”

And with some of my Hispanic patients and it wasn’t even always me that would initiate—like you walk in the room and they’re already holding out their hands like oh, come over to the bed and hold my hand while we talk.

And I found that I was much more interactive sometimes—not—interactive is not exactly the right word but definitely more physical with some of my Hispanic patients because I mean I—they—they were that way with me and so I would respond in kind.

And then I found the more patients I took care of that were Hispanic, the more I would start to initiate kind of like—if they seemed comfortable with it, the more I’d be like oh, okay well, I’ll touch your arm while we’re talking, you know, things like that.

Camryn shared,

It was just kind of like, you know, you try to manage their pain and things like that but you assume that they want all the hospital treatment and everything that we’re—that we’re saying that they need and so I didn’t—I don’t think I was really as sensitive enough as maybe I—as maybe I should have been as far as like assessing for that and seeing if like if that might be some of the reason that they were being more quiet is like they didn’t want some of the things, or they wanted something different, or they wanted to be treated different or, you know, something like that.

Edith said,
And if they are I always ask about cultural needs and what type of cultural background they’re from and that sort of helps me get a sense—I try never to assume because you—you don’t ever know.

I guess when a mother and a father come in, it took me a while to realize that the dad is primarily going to speak for the family, (PAUSE) and usually to address the father first, but that was really it.

In summary, as these NP students shared, there were common threads related to their interaction dynamics. Some NP students, typically those who demonstrated some increased familiarity with Hispanics, used a more relaxed, joking style and even smiled more with the Hispanic patient. Some said they had a warmer, even more open approach with their interactions. And some said they had pleasant encounters and even enjoyed the encounter and looked forward to encounters with Hispanic patients. They said Hispanics were fun and that they laugh. One NP student viewed Hispanics as stoic and shared that they may not overtly ask for help. This is certainly something to consider if the patient remains quiet while another patient in a similar situation would more than likely complain. I can validate that I have seen this take place with a personal family member who had a fractured shoulder and was not given any pain medicine because she, the patient, did not ask for it. Not one nurse entered her room and asked her if she had pain from a total fractured shoulder. Incredible! Another nurse said patience and time was required for successful interactions, especially if an interpreter was used. The use of touch was another way that an NP student interacted with her Hispanic patients. Hand holding during difficult times was typically prompted by the patient and then integrated into the nurse’s pattern of communication with Hispanics. She believed that these patients found the use of touch more comforting including while engaged in verbal interactions. One NP student shared that it was important to identify early on in the
encounter, who would be speaking on behalf of the family in order to address them appropriately and respectfully and facilitate the encounter. An additional concern raised was that at times, perhaps there was a lack of sensitivity to the patient’s needs and nurses could be reading patient cues incorrectly. This could certainly impact the effectiveness of the patient care encounter as well as patient care outcomes. Lastly, a concern was shared through personal observation, that prejudice and discrimination still exist today toward Hispanic patients and that in the clinical arena it is expressed or manifested through ignored patient calls for help and as Lacy shared, “treating them like they are dirty, stupid.”

Blanche added, “I mean honestly I’ve probably thought it at least once a shift where I’d see somebody who was like oh, I don’t want that patient. I know that it goes on for sure.”

Although privilege is attached to social categories and not to individuals, people are the ones who make it happen through what they do and don’t do in relation to others. This almost always involves some form of discrimination—in other words, treating people unequally simply because they belong to a particular social category. Whether it’s done consciously or not, discrimination helps maintain systems of privilege. (Johnson, 2006, p. 54)

Because nursing is based on concepts of empathy and labor, nurses believe that they see all people the same. The implicit assumption is that racism does not affect the type of nursing care given. Morgan (1984) however refutes this view. She found that while Euro-American nursing students perceived Black patients more favorably than Black people, they perceived Euro-American patients more favorably than any other group (Morgan 1984). Because illness episodes involve unequal power relations between patients and providers, a sense of power on the part of the students may have influenced the students’ responses in regard to the Black patients. (Barbee, 1993, p. 349)
Nursing issues/concerns

During the analysis of the data, it became evident that there was another theme that sometimes touched on issues previously discussed but in other ways had a more clinical, health care focus to it. I thought it was important to include these perspectives in this analysis and labeled them nursing issues/concerns.

Ivory said,

My typical behaviors when I’m working with Latinos, well, certainly one typical behavior is in my conversation with them, acknowledging things that particularly with the Central American population and some Mexicans that I work with, kind of acknowledging where they are coming from and how that may affect their ability for example to pay for their medicines.

Camryn stated,

Well, I think as far as like any—if I was in like a clinic setting I’d say a lot of times with your Hispanic patient, you know, there’s more—more commonly the financial concern and the insurance concerns which is—well, which, you know, may change now with the health care (unintelligible) underway but nonetheless there is like that financial concern and things like that.

Blanche said, “. . . so I would say economics is a big deal.”

Justine shared,

. . . I feel very strongly that it makes me really angry to see people who work just as hard as I do can’t get access to care. It always ticks me off.

Well, they’ll come back with—let’s give an example of a kid that has maybe a mild asthma or even a moderate or a severe asthma (unintelligible), they’ll come back if the kid is exacerbated again and you start getting into the history and have they been doing the controller medicine, no, they haven’t been doing the controller medicine. Why not? It just costs so much.

. . . and I understand every clinic can’t have an interpreter on board but if institutionally it could be more saturated, have translators more available, less delay, it’s helpful.

Addison reported,

. . . like I see a lot female,—women, Hispanic women who—what I’ve gathered from probably the two years just in the clinical—two semesters in a clinical
setting, but I’ve also worked with Hispanic mostly women in the past so I have a fair amount of exposure.

I think that sometimes, especially if they’ve recently migrated that there’s a lot of loneliness and I think loneliness plays a huge impact or has a huge impact on your physical health.

And so I see a lot of those things like lower back pain and vaginal pain or some of the things where there’s not a real clear link between the actual physical health problems and a solution to it and often times it requires a lot of psycho-social support and me referring out. That’s just with women.

And by contrast I would say that with men it’s very quickly—it’s—it’s like a muscular skeletal injury. It’s something that happened at work. It’s a back pain that—not sure if it’s in his chest or in his back, it’s hypertension, it’s diabetes, it’s a very delineated health problem that can—can get prescriptions if you will.

Camryn reported,

And then a lot of times I think of—as far as my inpatient experience, I think of kind of the pain management because it seems like I’ve had—with my Hispanic patients that I’ve had a lot of times there seems to be issues—that I can recall that there’s been a lot of issues with managing with pain in the Hispanic patients and that can be difficult.

Edith shared,

So talking about food groups, it’s really important to know what these Hispanic parents want to give their children and what they don’t want to give their children.

Typically the Hispanic population that I have doesn’t give herbal supplements but I always make sure—it’s really important to ask about any herbal supplements because (PAUSE) I want to stress, I want to make that I’m not getting any interactions with medications.

And that’s a really sensitive subject because I guess about 75% of my patients, Hispanic patients are co-sleeping with their children so it’s just really important to emphasis the dangers of co-sleeping and the high risk of SIDS and how you could roll over and smother your baby.

But you sort of have to take a sensitive approach to it because it’s something that’s been practiced in I guess their families for so long, well, I did it with my mom and I’m fine so why I can’t I do it with my child. And then it’s sort just important to talk about the increase in SIDS and what we can do to prevent it and . . .

Faith said, “I don’t think that they get the teaching education and explanations that other patients that speak English all get. Not on purpose but . . .”
Blanche shared, “if English isn’t their first language try to have like pamphlets or information that I can print out and hand to them and I’ve done that a lot of times.”

Addison reported, “so I think that the very unique thing about the Hispanic patients by and large that I see is their struggle to navigate the health care system. And there is a real difference if there is, you know if citizenship is—is void or not there, I don’t ever ask about that, ever.”

In summary, nursing issues/concerns focused on overall access to health care services including resources for services needed and financial concerns related to medications. Some NP students shared that Hispanic women needed much more psychosocial support, which required referrals. One NP student believed that if there were more translators available across sites it would facilitate patient care with non-English-speaking patients. Some admitted that there was a lot less patient education taking place with this population, and some found it helpful to provide the patient materials to assist with their education of their disease process so that these materials could be shared with their extended family. NP students expressed a need to help Hispanics navigate the health care system in general whether they were legal citizens or not. These issues are concerns that should be taken seriously by future practitioners in order to improve the overall provision of quality health care services to Hispanics.

What are the White (non-Hispanic) NP student expectations of Hispanic patients? The following provides an overview of NP students’ responses to this question. The responses are grouped into three categories. It is my opinion that these categories from my perspective are very much inter-related. The categories are:
- **Relationship**
- **Expectations**
- **Follow-up**

As I reviewed the transcripts, there was an overall expectation from these NP students that most Hispanic patients are not bilingual and that Spanish is their primary language. This frame of reference could have been acquired from either the geographic location of their employment/work setting or clinical practicum experience. Some said they worked in a clinic which was geared toward providing low-income Hispanics with health care services. As Grace said, “Very few are bilingual. Sometimes they will have a family interpreter.”

*Relationship*

Heidi reported,

> I have found that if I do my part of the job and schedule their appointments when they tell me they can come because they are off of work and things, that my patients are very good at follow-up. And if I schedule something they will come as long as I don’t do it—as long as I give them enough notice so that they can either schedule time off from work or schedule it on days when they don’t have to work.

Kelby stated, “And so it’s a successful program because they cater but it’s not given willingly. It’s a partnership. They establish a partnership with that patient and commitment, and enforce that commitment.”

Lacy shared,

> So that’s—I guess the point I’m trying to get in is if they have a problem, whatever it is, whether they don’t have the money to come back, whether they don’t have transportation to come back, they’re not necessarily going to tell you unless they feel close to you.
But if you can understand that ahead of time and you can communicate with as many people in that family as you can, you can find out and make sure that the patient has the resources he needs to come back and if you do that then you’ll be successful. But I don’t think that they miss an appointment because they just don’t think it’s important. I think that there are other factors involved that we just need to know about.

Faith stated, “And I don’t think that maybe always that they feel comfortable with saying that because sometimes I found out through other—like a social worker that oh, actually that we’re going to set up like a cab for them to get to and from.”

It is clear from these responses that it is important to establish a relationship with the Hispanic patient. If the Hispanic patient does feel comfortable with the provider, then they will be able to share their concerns and need for additional resources, which will ultimately impact their overall ability to be a partner in care and can lead to more successful health care interactions and outcomes.

*Expectations*
What are these NP students’ expectations?

Ivory reported, “My expectation of their adherence to regimen. Well, like I said, I expect them to have the same challenges of adherence of everybody else.”

Justine said, “In children that are covered by Medicaid my expectation is 100% adherence. That’s been my experience. In children who are not on Medicaid because they were not born in the United States I expect some non-compliance because of the cost of medications.”

Kelby stated,

Well, it depends because we have a lot of ones that are illegal immigrants and if they’re part of (Spanish) I can’t pronounce that right. They’ll—we have a lot of
federal funding so a lot of the meds and stuff are covered so I’m not concerned about them.

If they’re just coming in and through and out, I’m not as sure but I would say that about any set of patients when it comes to money because the question is, is it food or is it medication, well, I need food to live and I might need the medication. So I choose food, or I’m choosing housing or gas so I can go to work.

So I think for me it really is can I find the resources to make it easier for those that don’t have the resources, and if they do they have better patient outcomes but I’d say that’s true for anybody.

Kelby continued to talk about the clinic which provides prenatal care at a minimum cost. These patients are expected to sign a contract and adhere to the contract in order to obtain the services. If they miss three visits they are removed from the program and the three visit rule is enforced. So this provides a clear expectation that these women will comply with care requirements or suffer a consequence.

Kelby reported,

I know this—you have a row of them waiting for the bus or a row of them come in one car like five or six women all of them pregnant at different stages, and they all come together and they do it specifically because, you know, you get the care, you get the delivery, and you get the follow-up.

And it’s very, very strict and it—but it works and I think because it’s so strict and because so much is covered and so much is given to them, that it sort—they understand and they’re willing to work within the rules.

Lacy stated,

I think it’s the one thing that I can say. I don’t know if it’s a cultural bias or if it’s true but when you treat or take care of, when you manage a Hispanic patient, you manage a group of people because they’re all—their family is connected, they’re very family oriented.

A lot of times when you see a Hispanic person, they don’t ever come by themselves. They come with their family members and so I find that’s fine, great, and I’m used to it so I just work with everybody.

But I think other nurses, that if they don’t recognize that they may have less compliance and less follow through because they don’t understand the whole family dynamics.

Addison shared,
I think my expectation is that they’ll adhere, that they’ll take it. I have seen one gentleman who we diagnosed him with diabetes and he was like (unintelligible).

He was one of my first days of my clinical time at this clinic and sort of interesting because the primary that I was working with just said oh, well, you have diabetes and then put him on a bunch of meds and at the end of the visit—he was Spanish speaking but was—she was speaking English and I wasn’t intercepting to—to interpret because I hadn’t been asked to.

And he was moving along with the conversation, giving some decent context clues that he was understanding most of it but at the end of it he said so how long will I have to be on this—these medications and she just said oh, forever, you have diabetes and no—I mean no thought to the fact that you just told somebody that their life is going to now be different. They have a disease that’s not ever going to go away.

And he came back and had been compliant with those meds in spite of the fact she had started him on like two or three different meds and that he by all sort of symptoms that he had described had probably gone into bouts of hypoglycemia by taking the meds wrong and was on Metformin and had massive GI upset. None of that had been given to him in terms of information.

He was scheduled for a diabetes educational appointment which he for some reason—I don’t know if he didn’t go or somehow it got cancelled or there was some sort of miscommunication.

I mean it was the classic example of poor language communication and—and there is—I mean I’ve in Hispanic—I’ve been in Spanish speaking countries and you don’t want to be the person that doesn’t understand and you don’t want to be the person that—you know, there’s already such a stigma that, I don’t speak Spanish, you need to learn English. You’re in America now, that kind of finger shaking.

I think—talk about walk a mile in his shoes, I don’t—wouldn’t want to speak up if I didn’t understand something but his last effort was to say so how long am I going to have to be on this, you know. It was very obvious to me—but the poor guy, I mean he has just been miserable for three months and—or I guess it was actually six weeks, but he’s just been miserable and came back and—and clearly compliant and probably too compliant.

But I always have the expectation that patients that I follow will be compliant and I think that if you have the expectation of anything else then you already set the bar a little lower.

Blanche reported,

I would honestly say about the same as I have for other patients. I mean I don’t expect them to adhere more or less based on them being Hispanic. Again I feel like I kind of more assess (PAUSE) their own background and their social structures and stuff like that and then I can usually guess whether or not they’re
really going to stick with the program or not but I really do that with any of my patients, not necessarily specific to Hispanics.

Camryn stated,

Okay, (PAUSE), okay, I can be honest and say with—you know, that I—I would—would probably say being completely honest that I have like lower expectations for the Hispanic and Latino patients because-- to adhere and I can’t really necessarily say why, for like all the reasons why or whatever, but I can’t—I mean I think part of the reason is because sometimes they sit there and they say yeah, yeah, yeah, like I understand, I understand and they don’t, they don’t understand.

They’re not using their medications the right way. They’re not taking the full course, like they’re not—and so—not that they don’t want to, it’s that they never understood in the first place but just because you have that culture—that language barrier you think they understood and like you think that they’re telling you they understood and they don’t.

And so like—so I didn’t follow this—my preceptor was just telling me on Monday when I was in clinical that she had this, you know, Spanish speaking patient and she was like in—basically found out that she like, you know, hadn’t taken her medication correctly and she’s still getting sick.

So I have—and so I don’t know—and like I know that is a big part of the reason—I think it’s because a lot of times you think you’re understanding each other and you’re not. But I think that as a rule (PAUSE) I would say I have lower expectations of—of Hispanics than like—than a white, than a Caucasian, like English speaking American. Yeah, I do.

Blanche continued,

But I think it’s different with your Hispanic patients. They don’t know—like we have kind of these like stairs of care and like things that we see as a simple like okay, like, you know, here’s your Z Pack and you kind of assume and yeah—and you just give it to them assuming like okay, this is—it’s obvious they’re going to know how to do it and they don’t, or, you know, you haven’t really like you said become partners, like establish an understanding like you need to take—this is how you need to take it, okay, you know.

Rather than taking the time to have them repeat, okay, tell me what you need to—yes.

Dahlia shared,

I was inexperienced. I honestly—I had a very skewed view of life at that point that, you know, they don’t want to do it, then they don’t let them do it, you know. You know what I mean?
So in that part of my life, in that situation in that emergency department I didn’t—I honestly didn’t think people were going to do what they were going to do. Like if we gave them antibiotics they would take the antibiotics as much as we gave to them but they weren’t going to go out and get them if they couldn’t afford it.

So, you know, I mean you do what you can do and if you don’t provide 100% of something some people just aren’t going to finish the course of antibiotics. They’re not going to go to the physical therapist unless you give it to them for free.

It was a very indigent population there too, Hispanics, African-Americans, Asian—I mean, all—all comers, you know, came to—walked into the emergency department there.”

Edith said,

Typically, yeah. I feel like they adhere to what we’re saying. If I’m giving a patient a medication or giving a patient an idea to do like a food diary or something, I feel like they typically do it but it’s very important to stress the importance of doing it.

I feel like if I’m not stressing the importance of doing it, it’s sort of like oh, it didn’t seem that important and it’s not necessary to do it. But I do feel like if I stress how important it was that they would absolutely do it. They would finish their medications. They would do the food diary.

Faith shared,

I feel like they do—they should adhere but I feel like unless they properly understand then they’re not going to and I feel like sometimes resources are a bigger problem because if they can’t get the medication they need then they’re not going to be able to adhere anyway.

**Follow-up**

The following provides a glimpse into the perspectives/experience of the NP students with Hispanics and patient care follow-up.

Heidi reported,

Uh-huh, I mean I feel the further out it gets the less devoted to follow-up people are but I have to say that really I would say that my Hispanic patients are really excellent about follow-up, I mean more so to be honest with you than my non-Hispanic patients that live 20 miles away. I mean I’ve never had any sort of—my patients are great at following up.
Heidi continued,

But if they’re able to get the medication and they’re able to understand the instructions with the medication, and again we’re really lucky because a lot of our medication information sheets here we can print out in Spanish and things like that, so then I feel like that the adherence is—I think that sometimes the children become a little stubborn and the adherence is a little bit more challenging for the families but I definitely think that the parents are putting forth every effort to make sure that they receive whatever treatment it is that they need to receive.

Justine said, “Largely—largely very positive experiences, most of the patients followed-up but they also had the very unique circumstance of most of (unintelligible).”

Justine continued, “I’m thinking about the specialty clinics that I was with here for about 45 clinical hours and (unintelligible) nurse practitioner had the perception that they didn’t have very good follow-up but I’m convinced it wasn’t—they never got the message clearly in the first place. They didn’t get their questions answered.”

Lacy, regarding Hispanics and follow-up care, stated,

That is definitely dependent upon the family support. In other words if you have—if they have a soldier and he needs to follow-up, a lot of times the follow-up is a group effort and so if I want to ensure success I would definitely communicate with the other person, or the wife, or the mother, or the friend of the patient that I’m working with.

I think it’s the one thing that I can say. I don’t know if it’s a cultural bias or if it’s true but when you treat or take care of, when you manage a Hispanic patient, you manage a group of people because they’re all—their family is connected, they’re very family oriented.

Lacy continued, “But I think other nurses, that if they don’t recognize that they may have less compliance and less follow through because they don’t understand the whole family dynamics.”

Blanche stated,

But I mean that’s of course not across the board with Hispanics, that’s one specific case but a lot of times with (PAUSE) the Hispanic heart failure patients it
felt like they weren’t really being followed up in the community very well at all (PAUSE) and a lot of times it would be they wouldn’t tell me that they don’t have a primary care provider, or that they didn’t have the time, or they didn’t have the resources, that they ran out of their meds and just didn’t fill the prescription or, you know whatever.

A lot of—(PAUSE) I mean there was always a lot of excuses for why they weren’t being taken care of, and maybe not excuses but valid reasons. I mean it’s just for some reason I felt like they were having a harder time being managed by the community.

Blanche continued regarding patient care discharge instructions,

I think in general we do a terrible job with discharge instructions, I mean everywhere, I mean in any specialty. I’ve never really been impressed with how discharge instructions are done and I mean that there’s different time constraints, and just a general failure.

It’s hard for patients. Like they want to go home, they don’t want to sit there and listen to you go on and on about their discharge instructions. Like they don’t care, they just want to get out the door—not that they don’t even care but it’s just hard to retain information when you’re like, my car is downstairs and I want to leave and eat real food.

I mean I really don’t think we do a good job making sure patients understand the diagnosis, how they can manage it, and how to lead better lives. I really feel like we just slap band-aids on them and we’re like good luck and send them off so . . .

Edith stated,

I would say it’s split 50-50. I have my Hispanic patients that follow-up regularly. I tell them to be back in two weeks, they’re scheduling at two weeks. They’re on time. They’re ready to go.

And then I’d say my other 50% of Hispanic population, if there’s not—if it’s just for like a weight check I would say they don’t come back and their feeling—as long as I feel my child’s healthy they don’t need to come back.

And that’s a lot of the problem even with missing checkups because you come in so often until the age of two years old. I mean they’re coming at birth, and then at two weeks, one month, two months, four months, six months, and they’re coming so frequently that often I have Hispanic patients skipping some visits saying oh, well, we were just here, my baby’s fine, I don’t have any concerns. We’ll just catch up on shots later.

Edith continued,
It’s very patient dependent. I guess most typically in Hispanics if they feel better they don’t necessarily want to follow back up from what I personally have seen from the emergency room.

And then in more severe cases if they had a really big scare like if they had seizure then I would see them following up but less concerning for them, maybe a cellulitis, they take their medication, it would better. They still should call back—and come back in two weeks for a follow-up appointment, you wouldn’t see them.

Faith shared,

Yeah, I don’t have a ton of follow-up except when patients come—when they come back for the hospital. Sometimes I’ll have a lot of patients that come back because they, you know, get sick again or have to come for follow-up. I guess in my (unintelligible) I have some follow-up patients. (PAUSE)

I think when patients come back—I think the thing about—I mean I had a lot of frequent patients that come back so they seem to get the drill a little more, you know. I think we do try to do a good job of teaching them but sometimes I feel like it’s a (PAUSE) lack of understanding little things about maybe like the duration of how long they’re supposed to take an antibiotic, or how many times, or just simple teaching things we might take for granted.

In summary, according to these NP students there are mixed opinions regarding their expectations of Hispanic patients and in their experiences with follow-up care. It appeared there was greater success with follow-up care if a therapeutic relationship was established where a patient felt comfortable expressing his/her needs and concerns. Some believed that because Hispanics are very family-oriented, there was an increased likelihood of success if the family was included in follow-up plans of care. There was also great emphasis on resources, not only financial resources but social supports to decrease barriers to care. For instance, in the case of the well-baby check-ups it was the cost of the visit and the fact that the baby appeared to be fine that they chose not to bring the baby in for a follow-up. The interview discussion could lead one to believe this could be the case. So the cost factor again had an impact on care. Finally, a greater emphasis on patient education and discharge instructions was needed not only for Hispanics but, in
reality, for all patients. Many said that if the patient understood the diagnosis and treatment regimen, and there was some validation of that understanding, there was a greater opportunity for success in adherence to treatment and follow-up care.

Is there a relationship between the White (non-Hispanic) NP students’ perceived cultural self-efficacy related to Hispanics and their responses to the qualitative interview questions?

After careful analysis of the data, for the most part, there is a direct relationship between the individual participants’ perceived cultural self-efficacy related to Hispanics and their responses to the qualitative interview questions. Those who scored low in the range of neutral to little confidence (3 or <3) all had responses which either provided a glimpse into their anxiety, expressed their limited knowledge of Hispanics and their culture, or sometimes provided an example of their avoidance behavior or distance with this culture.

Grace (CSES 2.1) stated,

Well, I just don’t have a lot of experience with Hispanic culture other than the health system. Nervous because I can’t understand them, so discomfort because I feel like I’m not going to be able to converse or understand what they are there for.

Like all of the questions I answered on the survey, I’m like not competent, not competent because I’m not there to, you know, quite (unintelligible) I’m not there to learn about their culture.

Camryn, who had an overall score of 3.0 on her CSES, stated,

It’s like getting the information—giving and getting—getting and giving the information so like I think I feel like with my Hispanic patients I haven’t really developed like the rapport with the Hispanic patients that I have with other patients because you have that immediate—that barrier already. But like I don’t really know much about how—what their beliefs—like as a culture so . . .
Dahlia (CSES 2.5) reported, “I’m just as respectful with them as I am with someone else. I hope that I would treat people the same way no matter who they were and not just because I had a connection with her (referring to her nanny).”

Faith (CSES 2.4) said, “So I think sometimes that clinically it’s hard and I don’t know a ton about Hispanic culture so sometimes I don’t understand where they’re coming from or—and I’m sure they don’t understand where I’m coming from so I think that can be hard.”

Those whose CSES scores fell above the neutral and between the range of confidence and quite a lot of confidence had responses which spoke of cultural competence and the need to understand where the patient is coming from. Many stated that they enjoyed these encounters and spoke of ways they made their clinical encounters more effective.

Edith (CSES 4.0) stated, “And if they are, I always ask about cultural needs and what type of cultural background they’re from and that sort of helps me get a sense—I try never to assume because you—you don’t ever know.”

Heidi (CSES 3.3),

So I think that it’s been a process. I mean, you know, I certainly don’t think that I was as sensitive hopefully when I was a new nurse versus having now done this for a while, but I’m certain that in ten years if you asked me the same questions I’m going to laugh at what I said now.

Addison (CSES 3.7) expressed her confidence in the provision of culturally competent care,

It’s not so pie in the sky anymore, it’s not so, cultural diversity and—and cultural competency is XY and Z. I think that—that I’ve learned in practice and am
always learning and hope I’ll always continue that, is that being culturally 
competent there’s not a set of—of check marked boxes that make you competent. 
It’s about understanding how to relate to other human beings, whether you’re 
from Ethiopia, or Latin America, or next door.

In summary, there is a relationship between the qualitative interview questions 
and the NP students’ perceived cultural self-efficacy. Those who were less confident 
expressed that there was discomfort and lack of knowledge regarding the Hispanic 
culture. Those whose scores leaned in the direction of a greater sense of confidence were 
more likely to express comfort and enjoyment with their Hispanic patient clinical 
encounters. They also showed evidence of progression in the cultural competence 
continuum.

Is there a relationship between the White (non-Hispanic) NP students’ 
demographic factors and their perceived Hispanic cultural self-efficacy?

The NP students’ demographic responses were compared to the results of their 
CSES. Factors used in this comparison included: neighborhood they grew up in; 
secondary language, percentage of encounters with Hispanic patients, college class on 
cultural competency with number of hours; cultural competency training with number of 
hours; and, finally, whether they find the cultural competency education/training helpful 
with Hispanic patients. It was interesting to note that two out of the three NP students 
who had the lowest scores on the CSES (Grace and Faith), indicating little confidence to 
deliver culturally appropriate care, at times shared they engaged in avoidance behavior 
with these patients and demonstrated through their responses that they had little exposure 
to Hispanic patients. Faith had limited if any exposure to Hispanic patients, and the other 
NP student, Dahlia, only specified 10% exposure during the last year as compared with
the total patient population she cared for. The other NP student whose scores demonstrated little confidence and whose qualitative interview provided some insight into avoidance behavior, Grace, actually had encounters with Hispanic patients about 30% of the time during the last year, however, she was working with a homeless and alcoholic population so this might have influenced her avoidance behavior and her lack of interest in learning more about this culture. Prior to her recent exposure she had limited exposure to Hispanics so this was a very new experience for her.

The number of hours these individuals were exposed to cultural competency education or training did not appear to have a direct relationship on their CSES scores. These three NP students’ total hours of cultural competency education/training ranged from a 3 hour class to 6 hours mixed (3/3) and 10 hours (2/8) of total education and training. Other students with high CSES had similar exposure to this amount of cultural competency education and training. In fact, 50% of the students who had taken a cultural competency class/training stated that it did not help them in caring for Hispanic patients. One NP student, Camryn, felt that because the Hispanic culture is becoming so common today it appears to be “falling out of our cultural competency, like out of our training.”

Those with high scores on the CSES, signifying a greater degree of confidence in their ability to work with Hispanic patients, had different responses to these particular demographic factors. Some of these participants stated that they grew up in a neighborhood with a different race/ethnic culture so had exposure to different cultures and ideas early on in their development. Some of those with higher CSES scores also spoke Spanish, which then enabled them to decrease or greatly diminish the language
barrier which so many of these NP students stated negatively impacted their patient/provider encounters and frequently required translators/interpreters.

Finally, it appears the strongest association with their total CSES score was the percentage of encounters with Hispanic patients or immersion in that culture. One NP student, who had a high degree of confidence, spoke Spanish, and only had about a 20% encounter rate with Hispanics during the last year, shared during the qualitative interview that she had previously worked (actually her first job out of nursing school) in a predominantly Hispanic clinic where most of the providers were Hispanic. Justine shared, “I felt like I was an outsider in my own country but it was a fabulous opportunity.” Others who demonstrated a higher degree of confidence as demonstrated by their CSES scores had shared that they had done missions in Latin American countries, studied in Mexico or Central America, or had close friends who were of Hispanic descent and had developed close relationships with their friend’s families. So it appears that language and a greater exposure to this culture and people increases the NP students’ perceived cultural self-efficacy as noted by the CSES results in comparison with their demographic data as well as some additional qualitative data.

One NP student who had engaged in church missions in Latin American countries traveled to Africa to better understand what it would feel like to be in a place where you were physically and culturally totally different from the population at large.

Camryn shared,

But then when I went to Africa I went—I went on my own and I went with like one other nurse from Chicago so there’s like me and one other white person basically and that was really intimidating.
And we would like walk to our clinic that we worked at and we would walk home and it was just—it was very intimidating. Like I don’t know if I could done it if I wouldn’t have had even one other White person with me because it was that intimidating and—which was kind of what I wanted, like I wanted to kind of understand like that . . . What it felt like to be like that minority and then like get—immerse myself in like another culture as opposed to like within a large, large group of my own culture. So it’s kind of what I wanted but like I didn’t think it would be as difficult as it was even though I feel like . . .

You know, a lot of Africa, even more so than even places in Europe, despite the fact that like, you know, there’s these—in Europe they’re like white but like in Africa they—they are—they have kind of—make their like culture—not culture but like a lot of things are conducive to English speaking people. It’s like a lot of people in the schools and everything there are in English and a lot of things are in English.

So it’s not like—you know, you can’t communicate even, but it’s so intimidating because you’re the only white—like we’re the only white people where we—where we were and it was very intimidating and it was much harder to be like—you know, and you had to be safe too. You had to take that into account.

But like it was much harder to like be very outgoing and it was hard because like, you know, a lot more people—people had different expectation of you and, you know—so this is a different dynamic from like us being the minority of, you know, Africans versus—versus Americans. And then they expected because you’re—you’re white—you know, basically a white person that, you know, their expectation is like oh, you have—you have money and you’re rich, you’re from America and blah, blah, and blah so you have like a lot of like—you know, a lot of that kind of cultural like dynamic . . . Yeah. So that was really interesting.

And it was very hard like and intimidating to like interact and everything for a long time because like I was just so like oh my gosh, it’s like too overwhelming because this is not my culture and this is not my—these aren’t, you know, like my people and I don’t—I don’t know what to do, like I don’t know how to adapt to it. So that was really interesting.

I think this experience clearly demonstrates what another of the NP students said regarding cultural competency. Addison said, “It’s about understanding how to relate to other human beings whether you’re from Ethiopia, or Latin America or next door . . . respect for and understanding . . . where that person comes from and lots of walk a mile in their shoes . . .”
Roberts (1996), as cited in Sorrel (2003), states that those who dominate by ethnicity, age, class, and gender may be “unaware of the invisibility of privilege within our society” (2003). I believe the NP student’s experiences as shared through these interviews have begun to unveil what I had hoped to explore in this study. Addison’s closing words reflect the perspective I hope each nurse can one day achieve so that all nurses can truly provide culturally competent, linguistically appropriate care for all.
CHAPTER V
DISCUSSION OF FINDINGS AND CONCLUSIONS

You must be the change you want to see in the world.
–Mahatma Gandhi, Indian political and spiritual leader (1869–1948)

According to the 2003 Institute of Medicine (IOM) report Unequal Treatment, “Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients’ insurance status and income, are controlled” (Smedley et al., 2003, p. 1). This 2003 IOM report further states that the sources of these health care disparities are “rooted in historic and contemporary inequities” (p. 1). The report, which includes information regarding clinical encounters, specifically refers to studies focused on race factors (black or white) and physician recommendations or decision making, which inferred that clinical decision making may be influenced by the physician’s perception of race rather than objective data (Schulman et al., 1999; Schwartz et al., 1999; Smedley et al., 2003).

According to a (2008) Commonwealth Fund study, Racial and Ethnic Disparities in U.S. Healthcare: A Chartbook, Hispanics continue to have difficulty accessing the health care system and are not likely to have a routine provider. This study shares that
Hispanics tend to access health care services through community or public health clinics and report their general health status as fair or poor.

Racial and ethnic minorities experience disparities across a significant number of health status measures and health outcomes. These racial and ethnic differences are driven by issues such as income, education, and work status, as well as by issues such as poor housing, neighborhood segregation and other environmental factors within communities. But disparities in health status and outcomes may also result from failures within the health care system. Problems accessing services and lower quality of care for minority patients clearly impact the health of these populations. (Mead et al., 2008, p. 19)

The March 2008 Commonwealth Fund Chartbook report further states that, “According to the Institute of Medicine (IOM), health care should exhibit six key characteristics in order to be deemed high-quality care; it should be safe, timely, effective, efficient, patient-centered, and equitable” (Mead et al., 2008, p. 61).

This report notes: “Differences in quality may be the result of differential treatment of patients by individual providers, but emerging evidence also points to variation in quality among providers depending on the race or ethnicity of their patients” (Mead et al., 2008, p. 61).

Therefore, as evidenced by Mead et al. (2008), health care disparities continue to exist for Hispanics, the fastest growing minority in the United States, and it is clear that more information is still needed to understand the dynamics of this disparity especially as it pertains to nursing care and Hispanic patient interactions with registered nurses.

As previously cited (Mead et al., 2008), Hispanics tend to receive much of their health care services in community health care settings as well as public health clinics. As reported, these settings tend to be more local, flexible, and economically suitable for this population. Frequently, these settings are staffed by primary care providers such as
physicians, physician assistants, and advanced practice nurses, typically, nurse practitioners and nurse midwives, further validating the need to study this population of health care practitioners in relation to the Hispanic patient. Some of these providers may have taken a course in cultural competency, which may or may not have provided them with sufficient information to enable them to be culturally sensitive and appropriate in their encounters with Hispanic patients. Some enter these settings with limited exposure to racial/ethnic diversity, which could render them less confident to engage in a therapeutic relationship.

**Summary**

The purpose of this study was to examine White (non-Hispanic) NP student perceptions of Hispanic patients and how these perceptions may impact the provider/patient clinical encounter. It also sought to explore the relationship between the perceived cultural self-efficacy of White (non-Hispanic) NP students and their perceptions of Hispanic patients.

A mixed methods research study was conducted during the spring, summer, and fall of 2010. Twelve White (non-Hispanic) NP students were recruited from two universities that had NP programs. These two universities were also rooted in the Catholic faith. These participants completed a demographic survey, a modified Cultural Self-Efficacy Scale (CSES), and then engaged in an audiotaped qualitative interview. All were provided consent forms, and confidentiality was maintained throughout the process. The audiotaped interviews were transcribed, and the demographic surveys and CSESs were scored and analyzed. All participants were given an alias in order to maintain their
confidentiality. The results of the demographic data and CSES were reported in Chapter IV. The transcribed interviews were initially coded in NVivo, then analyzed using Miles and Huberman’s data reduction process. Themes emerged from the data and were used to answer the research questions posed in this study.

Discussion of the Findings

A synopsis of the research findings related to the major questions posed follows.

Research Question #1: What are the White (non-Hispanic) NP students’ perceptions of Hispanic patients?

The NP students’ overall perceptions of Hispanic patients clustered around five major themes that included personality/behavioral characteristics, language, education/employment, family, and legal status. Many of the perceptions shared could be viewed as favorable. When these NP students spoke of Hispanics they used the following words: kind, timid, reserved, well-mannered, patient, grateful, and genuine people. The NP students also reported that they viewed Hispanics as loyal, hardworking, tired people who were friendly, open, and fun. Some shared that Hispanics had a more fluid idea of time and incorporated this factor in their patient care planning. However, there were some responses that focused on language, education/employment, and legal status, which appeared to be somewhat of concern.

Most of the nurses viewed Hispanic patients as individuals who spoke Spanish and shared their concerns related to effective communication and the need for institutional supports such as on-site interpreters, translation lines/computers, and bilingual colleagues. Some nurses shared information related to English-only bias that
currently exists in this country. Addison said, “You know, there’s already a stigma that, I don’t speak Spanish, you need to learn English. You’re in America now, that kind of finger shaking.” This perspective led me to believe that like other individuals, some nurses could have a bias regarding English language proficiency and that language bias could be passed on to the patient in subtle, nonverbal ways which could negatively impact that provider/patient relationship. “Adults whose primary language is not English are more likely to report that their providers sometimes or never listened carefully, explained things clearly, respected what they said, and spent enough time with them...” (Mead et al., 2008, p. 64).

Related to the Hispanic patient’s educational level, one NP student, Justine, shared, “I think I might have a higher expectation on educational level from people that are more culturally like me...” “Allport observed that people universally and spontaneously separate themselves into homogenous groups, into us and them categories” (Dovidio, Glick, & Rudman, 2005, p. 37). Many of these NP students viewed Hispanics as low-income, less educated individuals with little autonomy in their work settings. Their low income coupled with inflexibility in their work environment at times negatively impacted their ability to access care. Many of these individuals sought care in local clinics for the underserved.

Hispanics are the least likely of the racial and ethnic groups examined to use private physicians as their place of care and the most likely to use community health centers (CHC). Hispanics’ high usage of CHCs may be explained by the facilities’ support services (e.g., interpreter services, off-peak hours, and transportation), willingness to provide care despite patients’ inability to pay, and convenient locations, often in low-income areas (Rosenbaum & Shin, 2006). (Mead et al., 2008, p. 44)
Related to the NP students’ perception of Hispanic patients, family was another theme that emerged from the data. These NP students were aware of and shared their experiences which emphasized that Hispanics valued family and that their family, frequently large and multigenerational, was typically part of the health care encounter and something they had to consider and incorporate into their patient plan of care. Some found the integration of family helpful in assisting the patient to adopt care regimens or move them toward adherence to medications and treatment therapies. Other NP students found them challenging especially when they were not fluent in Spanish and felt like they (the individual nurse) were in the minority. This created stress and decreased comfort in their (NP students’) communication with the patients themselves.

Legal status was the last theme that emerged related to perceptions of Hispanics. Many of the nurses made references to this issue and shared that they viewed Hispanics mostly as individuals who are here illegally. Others shared that they did not care about their legal status and felt that it was just important to provide these patients with health care services. One individual provided information regarding the use of the slang term “wetbacks” used by other nurses she works with to define Hispanics related to their legal status and expressed her shock and disdain for its use. “The trouble around diversity, then, isn’t just that people differ from one another. The trouble is produced by a world organized in ways that encourage people to use difference to include or exclude, reward or punish, credit or discredit, elevate or oppress, value or devalue, leave alone or harass” (Johnson, 2006, p. 16).
One other particular statement about Hispanics warranted further investigation and could be viewed as suspect. According to Dovidio and Gaertner (2002),

“Unfortunately, the negative feelings and beliefs that underlie aversive racism are rooted in normal, often adaptive psychological processes” (p. 24). Grace shared this statement, “They are clean and well put together. Well mannered and appropriate.” This almost appears to be code for the expectation or the preconceived notion that Hispanics are expected to be dirty, rude, and inappropriate.

Allport anticipated the rapid, thoughtless, even automatic nature of categorization, and its link to prejudices: . . . Social psychologists and their lay audiences have been shocked by how rapidly categories cue ingroup advantages to us and match out group stereotypes to them. For example (Gaertner & McLaughlin, 1983), white participants, primed with the words “whites” or blacks,” then had to distinguish words from nonwords. Compared to “blacks,” the prime “whites” speeded decisions about white stereotypic words (ambitious, smart, clean). This result and others like it showed the rapid, apparently unavoidable impact of race, age, gender, and even literal “us-them” categories on prejudgment . . . (Dovidio et al., 2005, pp. 38–39)

*Research question #2: In what way does the Hispanic patient influence the White (non-Hispanic) NP student provider/patient encounter?*

Themes that emerged from the interviews included: language/communication, time, relationship/interaction dynamics, and nursing issues/concerns.

Language/communication
The overarching theme of language/communication related to patient care was prevalent in nearly all of the interviews. This issue really preoccupied almost all, if not all of the participants in some way or another. “Intercultural communication is an essential and necessary skill to learn to manage the emotional and psychological challenges of operating outside one’s cultural comfort zone” (Tate, 2003, p. 214). Some of these NP
students were bilingual but a good number of them had to depend on other nurses, health
care workers, colleagues, or institutional support systems to maneuver around this
impediment to interaction and quality patient care. Most of them shared their experiences
with interpreters, telephone lines, computers, and other health personnel who assisted
them with communication for the non-English-speaking Hispanic. A few stated that
family and nonmedical interpreters were also used in these patient care interactions if
nothing else was readily available. One NP student, Kelby, shared: “It’s more of a, I
don’t want to spend the time, I don’t want to do the effort to find someone, or I don’t
want to use the phone. I mean it’s not that hard to do a three-way phone call with an
interpreter but the answer is they don’t want you to do that.”

Some nurses also shared that the use of either language lines or computers could
be a generational issue with those who were younger and more recently educated/trained,
expressing greater comfort and dependence in the use of these devices and the
observation that older nurses were less likely to use these resources. “Adults whose
primary language is not English are more likely to report that their providers sometimes
or never listened carefully, explained things clearly, respected what they said, and spent
enough time with them . . . ” (Mead et al., 2008, p. 64). “Language barriers, for example,
pose a problem for many patients where health systems lack the resources, knowledge, or
institutional priority to provide interpretation and translation services” (Smedley et al.,
2003, p. 8). As stated in the Agency for Healthcare and Research Quality 2010 National
Healthcare Disparities Report, poor communication with nurses was reported by
Hispanics as compared with non-Hispanic Whites (USDHHS &AHRQ, 2010).
Time
According to these NP students, the Hispanic patient impacts the provider/patient encounter from a time perspective in various ways. One NP student said that in her encounters with Hispanic patients, Hispanics had a more fluid concept of time, and she then incorporated that information into her patient care planning and scheduling of appointments. Other nurses spoke of the increased time commitment needed with these patients, especially if they were predominantly Spanish-speaking. The use of an interpreter increased the time needed for communication and translation services. Some said that if they used an interpreter they actually spent less time with the patient because it creates a different type of relationship. Most of these NP students, however, shared the perspective that patient care did take a lot more time, and that the nurse needed much more patience during these encounters. Finally, the Hispanic patient, especially one who did not speak English, did add additional strain to an already busy day and workload. Blanche stated, “It takes a lot more time and with that inherently it takes more patience then to even be willing to spend that kind of time because I’ve actually—you know, sometimes you have a bad night and you’re just like I don’t have time for this and I mean I hate to admit that I’m guilty of sometimes not taking care of patients the way I should but I mean I am, like sometimes I would get patients and be like I don’t even know—I kind of have to tough it out.”

Relationship and interaction dynamics
The nurse/patient relationship/interaction is one that can profoundly impact patient care outcomes. These NP student voices stressed that sometimes with Hispanic patients,
especially if they do not speak English, and an interpreter is used, it becomes a different relationship. Some felt that they had difficulty establishing the kind of rapport they establish with other patients. Some believe there is mistrust, which also impedes the development of a therapeutic relationship. “Besides language factors, distrust of the medical community may also prevent the delivery of truly patient-centered care. Black and Hispanic patients reported lower confidence and less trust in their specialist than white patients . . .” (Mead et al., 2008, p. 65). Another NP student viewed relationship building as a “long process” and a “goal”. In this study, lack of time, language barriers, and the influx of patient family during the provider/patient encounter had a negative impact on the NP students’ ability to establish a therapeutic provider/patient relationship.

In addition to the aforementioned NP student provider/patient relationship issues, there were common themes to their interaction dynamics. Many of the NP students, those with increased familiarity with Hispanics, used a relaxed joking style and even said that they smiled more with these patients. Some said they had a warmer, even more open approach with their interactions, and a few stated they looked forward to these interactions. One NP student viewed Hispanics as stoic and shared that they may not overtly ask for help. This is certainly something to be sensitive to in clinical practice and could require an increased need to probe further during patient/provider interactions. Another stated that perhaps there was a lack of sensitivity to the patient’s needs and nurses could be reading patient cues incorrectly. Finally, a concern was shared by a couple of NP students that through personal observation, prejudice and discrimination
today exist toward Hispanic patients and in the clinical arena is at times expressed through ignored patient calls for help and treating patients poorly.

Although privilege is attached to social categories and not to individuals, people are the ones who make it happen through what they do or don’t do in relation to others. This almost always involves some form of discrimination—in other words, treating people unequally simply because they belong to a particular social category (Dovidio and Gaertner, 1986). Whether it is done consciously or not, discrimination helps maintain systems of privilege. (Johnson, 2006, p. 54)

Finally, these NP students shared that Hispanic patients overall, in their opinion, struggled to navigate the health care system especially if citizenship was an issue. Additionally, they illuminated concerns pertaining to the Hispanic patients’ ability to have the financial resources necessary to pay for medications and other health care needs and services.

*Research Question #3: What are the White (non-Hispanic) NP student expectations of Hispanic patients?*

The NP student expectations of Hispanic patients focused on three areas: relationship, expectations, and follow-up. According to these NP students, there is an overall expectation that most Hispanic patients are not bilingual and that for most of them, Spanish is their primary language. As Grace said, “Very few are bilingual.” This frame of reference could have been acquired from either the geographic location of their employment/work setting or where they are currently doing their clinical rotations. This expectation may lead nurses to believe that all Hispanic patients need interpreters to communicate with them effectively. This assumption could possibly lead a nurse to transfer the patient to another’s care or to wait until an interpreter is available before actually meeting with or assessing the patient, resulting in delayed care. Some NP
students who had higher scores on the CSES stated they validated their patient’s language competence during their first interaction and often utilized a more patient-centered approach to care.

In reference to the issue of relationship, the interviews brought to light the need to establish a therapeutic relationship with the Hispanic patient. According to some of the interview responses, if the Hispanic patient does feel comfortable with the provider, then the patient will be able to share his/her concerns, which will ultimately impact the outcomes. One NP student nurse shared a success story of a maternal-child health clinic that does a great job of enrolling women and ensuring they obtain prenatal care, leading to better birth outcomes. These women sign a contract, agree to fulfill their clinic appointments, and then their prenatal care and delivery costs are all covered for a small predetermined fee. Both parties are aware of the expectations and enter into a contractual relationship, and most of the women fulfill their obligations. The contract is enforced, and that knowledge is shared with the community. The success of the program is gauged by delivery of healthy babies, healthy moms, and the continued influx of new patients based on word-of-mouth advertising.

In reference to expectations of Hispanic patients and their experiences with follow-up care, there were mixed opinions. As identified through the responses it appears that some nurses believe there is greater success with follow-up care if the family is included in follow-up plans. There also appears to be increased success if the financial resources and social supports are addressed. This validates the need to develop a therapeutic relationship early on in the encounter where the patient again could express
his or her concerns and needs so that these barriers to care can be addressed and the patient can become an active participant in his or her care.

According to the Registered Nurse Association of Ontario (2002), a therapeutic relationship is defined as being “grounded in an interpersonal process that occurs between the nurse and the patient. It is a purposeful, goal-directed relationship that is directed at advancing the best interest and outcome of the patient” (Foster & Hawkins, 2005, p. 698). A term that is being used more frequently today is “patient-centered care”, referring to a system of care where the patient and family are key components of health care decisions and the delivery of care (Hughes, 2011).

A greater emphasis on patient education and discharge instructions was also stressed not only for Hispanic patients, but for all patients in general. Some students referred to the fact that discharge instructions were handed to the patient after they were briefly discussed and then the patients were asked to sign the discharge instruction sheet. The patient’s signature documents that he/she was provided with this information. However, it remains unclear how much the patient or the family really understands from this interaction. Many of these NP students said that if the patient truly understands his/her diagnosis and treatment regimen, and if there is some validation to the provider that the patient has achieved this understanding, then there is a greater opportunity for success in adherence to treatment and follow-up care.

*Research Question #4: What is the perceived Hispanic cultural self-efficacy of the White (non-Hispanic) NP student?*

A summary of the perceived Hispanic cultural self-efficacy of the White (non-Hispanic) NP students, which includes the results of the CSES, follows. In reference to the first
section of the CSES, which measures level of confidence in knowledge of cultural
concepts, seven (58%) of the respondents reported they had confidence and some
respondents had quite a lot of confidence in their knowledge of cultural concepts. This
section included questions that referenced ethnocentrism, discrimination, ethnicity, and
culture. In the second section of the CSES instrument, which measures level of
confidence in knowledge of cultural patterns related to Hispanics and is the largest
section of the scale, eight (66%) of the respondents reported that they had between
slightly above neutral and a high level of confidence in this skill set. Thus, a larger
number of these students had more confidence in their knowledge of Hispanic cultural
patterns, which includes family organization, role differentiation, patterns of
disease/illness, and utilization of the health care system, as well as religious beliefs and
patterns. When you compare this with the results of the demographic survey related to
cultural competency courses/training and whether these courses had helped or not helped
with information related to Hispanics, six (50%) of these NP students stated that cultural
competency courses/training did not help, yet eight (66%) of them had a higher level of
confidence with this section of the scale (Fig. 9). This is an interesting outcome which
signifies different levels of confidence based on basic overall knowledge and different
skill sets. There is a difference between the acquisition of knowledge vs. an individual’s
confidence in the implementation and use of that knowledge in a clinical environment.
This might explain the dissimilarity in this category. Regarding section 3 of the CSES,
which measures the NP students’ overall level of confidence with specific nursing skills,
50% of the respondents reported they had between a moderate and quite a lot of confidence in this skill set.

Approximately nine (75%) of the respondents reported having a “high level of confidence” to “quite a lot of confidence” related to their use of an interpreter. During the qualitative interview process many of these NP students shared their experiences related to the use of devices or working with interpreters. One can assume that owing to the increased availability of interpreters or devices such as phone lines or computers, and these NP students’ increased experience with these techniques as shared during these interviews, many of these NP students demonstrated an increased confidence in this area.

To summarize, only three (25%) of these students had little confidence in their perceived cultural self-efficacy of the Hispanic patient. One student rated herself in the neutral category, with the remaining eight (66%) of these NP students rating themselves with some confidence in their cultural self-efficacy of Hispanics and about six (50%) of these NP students with moderate (score above 3.5) self-efficacy and two (16%) of these

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Figure 9. Helpfulness of Combined Coursework and Training When Working with (A) Racially/Ethnically Diverse Patients and (B) Hispanic Patients.
students declaring a very high degree of Hispanic cultural self-efficacy. One NP student, in particular, with a high degree of Hispanic cultural self-efficacy was a new graduate who stated that her Hispanic patient encounter rate last year was about 35% and that she had previously been involved in coursework related to international studies. She also stated that her undergraduate and graduate programs both had a greater focus on and stressed cultural competency and that it was woven throughout her entire program. Another NP student who scored an overall high rate on cultural self-efficacy (4.8) had lived in Mexico and visited other Latin American countries. She viewed herself as bicultural, was bilingual, and really enjoyed working with the Hispanic population and exhibited a great deal of confidence with this population during the qualitative interview process, frequently speaking in Spanish to make her points.

In an article written by Ciesielka, Schumacher, Conway, and Penrose (2005), the authors discussed how they went about addressing the need to integrate cultural competence in order to address health care disparities. Although they were attempting to provide diverse experiences for their students, not all were afforded the opportunity. The faculty had identified “a disconnection between the classroom curriculum and opportunities provided in the clinical setting” (p. 8). They decided to enhance the clinical experience for NPs by including a cultural immersion experience in the Dominican Republic. Students returned and “verbalized awareness that differences between cultures and people were most relevant when trying to practice in a culture outside one’s own” (p. 8).
Research Question #5: Is there a relationship between the White (non-Hispanic) NP students’ perceived cultural self-efficacy related to Hispanics and their responses to the qualitative interview questions?

A comparison of the results of the CSES and the responses to the qualitative interviews demonstrates that there does appear to be a relationship between the responses to the qualitative interview questions and the NP students’ perceived cultural self-efficacy. Those NP students, whose CSES scores were neutral to less confident, expressed that there was discomfort and lack of knowledge regarding the Hispanic culture. Those NP students, whose scores ranged from above neutral, which was 3.0, and in the direction of a greater sense of confidence, were more likely to express comfort and enjoyment with their Hispanic patient clinical encounters. They also showed evidence of progression in the cultural competence continuum. While interviewing these NP students it was clear that some had increased exposure to the Hispanic population through work with missions. Some had traveled to Latin American countries with other health care providers. The results of those NP students’ increased exposure to this population reflected increased confidence with a few areas in the CSES scores, demonstrating NP students reporting a higher level of confidence in their perceived cultural self-efficacy to provide culturally competent care to Hispanics. One nurse in this group stated that although she had gone on missions in Latin America, the experience and patient/provider relationship was still different because the providers had a greater sense of power in this relationship and there was a large group of providers servicing patients, which provided these practitioners a safety net and a comfort zone even though they were in another country and of a different culture. In addition to their own personal encounters and work with missions, it was clear
that their current clinical experience was also providing these NP students with increased exposure to this population, thereby helping to increase their cultural self-efficacy.

Finally, related to those NP students who demonstrated a greater level of cultural self-efficacy related to Hispanics, these were the individuals who were the most forthcoming and freely shared some less than optimal behavior exhibited by some of their nurse colleagues and peers. They were more open in their use of terms such as “stereotypes” and “discrimination” and openly discussed these issues with me. Others in this cohort with lower CSES scores were much more guarded during the conversations as observed through their body language, volume used during the conversation, and pregnant pauses when in search of a more politically/socially acceptable response to the questions posed.

Research Question #6: Is there a relationship between the White (non-Hispanic) NP students’ demographic factors and their perceived Hispanic cultural self-efficacy?

In reference to this question, overall there appears to be a relationship between the NP students’ demographic factors and their perceived Hispanic cultural self-efficacy. Factors used to respond to this question included: neighborhood they grew up in; secondary language; percentage of encounters with Hispanic patients; college class on cultural competency with number of hours; cultural competency training with number of hours; and, finally, whether they found the cultural competency education/training helpful with Hispanic patients. Two out of three NP students who had the lowest scores on the CSES, which indicates little confidence to deliver culturally appropriate care, affirmed this lack of confidence by sharing at times they engage in avoidance behavior with these patients, and demonstrated through their responses that they had little exposure to Hispanic
patients. However, the number of hours these individuals were exposed to cultural competency either through education or training did not appear to have a direct relationship to their CSES scores.

Fifty percent of the students who had completed cultural competency class/training stated that it did not help them in caring for Hispanic patients. Those with high scores on the CSES, signifying a greater degree of confidence in their ability to work with Hispanic patients, had different responses to these particular demographic factors. Some of these participants stated that they had grown up in a neighborhood with a different race/ethnic culture so they had exposure to different cultures and ideas early on in their development. Some of those with higher CSES scores also spoke Spanish, which then enabled them to decrease or greatly diminish the language barrier. Finally, it appears the greatest factor that influenced their total CSES score is their percentage of encounters with Hispanic patients or immersion in that culture. Some shared that they had done missions in Latin American countries, had studied in Mexico or Costa Rica, or had close friends who were of Hispanic descent and had developed close relationships with their friends’ families. The increased exposure to the Hispanic population through either increased number of encounters or total immersion in a culture different from their own did increase the individuals’ overall cultural self-efficacy.

**Conclusion**

This study provided an opportunity to interview White (non-Hispanic) NP students to learn more about their perceptions and interactions with Hispanic patients, including their confidence in providing care to this growing segment of our population.
According to the results of the CSES, about 50% of these nurses had some confidence to quite a lot of confidence in their cultural self-efficacy related to Hispanics. However, when asked how they knew their patients were Hispanic many of them responded in a way that led me to believe it was automatic based on facial features, color of skin, dark hair and eyes, shorter stature, and a Hispanic-sounding last name. Camryn said, “By how they look, I mean—and so yeah, so there’s your initial like, you know, stereotype but I guess I immediately will look at them. But no, I guess I generally assume ID based on how they look like, that right there they’re Hispanic . . . . like very initially how you kind of like ingrained stereotypes and things like that.” “ . . . much of the time we are simply operating on automatic pilot, and the way we think and act - how well we think and act on the spur of the moment - are a lot more susceptible to outside influences than we realize” (Gladwell, 2005, p. 58).

Although the majority of these NP students held positive perceptions of Hispanic patients, some NP students shared that after they had made an assumption that their patient was Hispanic they either opted to avoid taking the patient assignment or quickly transferred the patient to someone else’s care. Others revealed that some nurse colleagues had less positive perceptions of this population and at times engaged in discriminatory behaviors toward Hispanics.

As stated by Powell (2002),

. . . disparities are rooted in laws that disadvantage people of color and overadvantage whites . . . . Persistent racial disparities are not dependent upon racial animus or ill will; this is why they are termed “structural.” This is the racism that is built into all of our structures, it is the status quo, and will only be undone in a lasting way when structures are reformed. (p. 8)
In reference to cultural self-efficacy, nurses who had low scores in cultural self-efficacy engaged in avoidance behaviors and readily shared their lack of knowledge of this culture and its belief systems and their discomfort in the provision of health care services to Hispanics because of this discomfort and lack of knowledge. Those NP students whose CSES scores reported a higher level of cultural self-efficacy expressed a sense of comfort, and even enjoyed these patient/provider encounters. Some who fell in this category shared that they had increased exposure to this population, which increased their comfort and understanding of Hispanics and allowed them to develop a better provider/patient relationship. Finally, exposure to cultural competency courses/training alone did not increase these NP students’ cultural self-efficacy, in fact, 50% of these nurses stated that their courses did not help them with their care of the Hispanic patients.

Limitations
The first and foremost limitation is that my last name is Gonzalez, which is a well-known Hispanic surname and could have influenced the way the participants interacted with me. In the discussions with these NP students, they shared that frequently they used the patient’s name to identify their culture/ethnicity. Many may have assumed that I was Hispanic but no one ever asked me that question directly. One NP nurse in particular asked me if I believed the nurses would be honest with me during the interviews owing to my last name. I just responded that I hoped so.

A second limitation was that I used two schools located in a large multicultural metropolitan area that is racially and ethnically diverse. Many individuals who attend schools in this area are exposed to a diverse population, especially in the clinical arena,
even if they had never been exposed to it prior to their arrival here. For many of them, these increased exposures to diverse populations may have influenced their responses and comfort level with Hispanics. Many shared that they were doing clinical rotations in settings that served predominantly low-income Hispanic patients. Third, these two schools are rooted in the Catholic faith, which focuses on education of the whole person through exposure to different faiths, beliefs, and cultures and has a greater emphasis on spirituality. One NP student in particular shared that caring for the whole person included culture and faith and it was something that was taught in her current nursing program. Fourth, there were some questions on the demographic survey which could have been posed in a clearer fashion, although I do not believe this had a significant impact on the responses. Fifth, most of these interviews took place at the end of the semester when these students were struggling with time and multiple commitments. This limitation did not allow for a follow-up review of the audiotaped transcripts as well as the responses to the demographic survey and the CSES with the participants.

Finally, many of the individuals who agreed to participate in this study appeared to have an interest in the Hispanic population. Some had traveled to Latin American countries to gain additional experience and improve their comfort level and skill in working with Hispanics. Thus, many of the nurses in this study had a certain affinity for the Hispanic patient and were willing to contribute their time to this study because they already held an interest in improving care to this population.
Reflection on Rose Iris Gonzalez’s Conceptual Model

As I reflect on the model and the effects of White health care provider privilege and cultural bias on patient outcomes, the results of the qualitative interview only revealed a couple of students, in particular, those with decreased Hispanic cultural self-efficacy who spoke of behaviors in the clinical arena that led me to believe that they acted on their stereotypical views about Hispanic especially when it focused on language. Many identified Hispanics by their last name, but I was unable to explore many of their actions related to their assumption that their patient was Hispanic based on last name only.

However, during the interview process some nurses shared less than desirable behavior by their colleagues, including unanswered call bells and their English-only attitudes. Those nurses who acted on these biases often failed to provide adequate care to the patient thereby giving credence to the model that acting on racial bias and stereotypes does lead to poor communication and interaction and negatively impacts care.

Implications for further research

There is a strong need to replicate this study to a broader nursing population in order to better assess nursing’s cultural self-efficacy with Hispanic patients and how that influences the provider/patient relationship. A future study could potentially uncover any unconscious, subconscious bias toward this ethnic/racial group and then provide the support needed to develop mechanisms to address it both in education and clinical practice. Also, it would be helpful to gain a better understanding, from the patient’s perspective, of how increased cultural self-efficacy impacts the provider/patient encounter. Studies that could observe these nurse/patient interactions or assess Hispanic
patients’ reactions to their patient care could prove enlightening and beneficial. Research should also be done on nurse educators themselves to better understand where they fall on the cultural competency continuum. They are the ones responsible for developing a strong cadre of practitioners with the education, experiences, and skills to enable future NPs to practice independently in these community health centers and public health clinics in order to provide quality primary care services to all. One student in particular shared that she would not want to emulate the behavior of her preceptor and that the way this preceptor interacted with Hispanic patients provided her good information related to behaviors and types of interactions to avoid. A study done by Kardong-Edgren (2004) regarding cultural competency and nursing faculty noted that faculty in health education and nursing programs were not adequately prepared to teach cultural content. Some younger students shared that they believed some of the disparity in cultural competency was generational. Studies to explore this potential generational gap could also prove beneficial on numerous fronts.

*Implications for clinical practice*

This study does appear to demonstrate that cultural competency courses/training alone do not significantly impact the perceived cultural self-efficacy of nurses. Two things should occur in order to more positively influence the nurses’ journey on the cultural competency continuum. First and foremost, because nursing remains a predominantly White female profession and the United States is moving toward a more multicultural population, nurses need to increase their awareness of their own personal beliefs, attitudes, and biases. The model of cultural competence as developed by Campinha-
Bacote (2003) stresses the need for cultural desire and awareness. Each individual should engage in self-examination and must become appreciative and sensitive to the values and beliefs of his/her patients and other cultures. “An individual must examine his/her own prejudice and bias which enables one to understand and move closer to the goal of cultural competence” (Byrne et al., 2003, p. 277). One might encourage all to gain a better understanding of white privilege and at least some exposure to critical race theory itself. NP students, in fact all student nurses, could be urged to take “The Implicit Association Test” (Project Implicit, n.d.), which may possibly help individuals examine implicit attitudes and measure their individual race bias, which are strong predictors of how an individual will actually behave.

Nurses need to be exposed to and immersed in different cultures and populations in order to increase their competency with diverse individuals. In studies done by Talley (2002), Hagman (2001), Williamson & Stecchi (1996), and St. Clair & McKenry (1999), both formal and continuing education, including short-term clinical immersion experiences, do move nursing students as well as nurses toward cultural self-efficacy. Talley’s findings suggest that cross-cultural experiences, cultural diversity education, which includes positive faculty performance feedback, and role modeling by culturally competent nurses are factors that positively influence RN cultural self-efficacy.

As nurses increase their cultural self-efficacy and become more culturally competent in their provision of nursing care services, it becomes incumbent on the institution or workplace setting to provide an environment that would facilitate quality patient care to diverse populations. This study identified the need for more time for
patient care, which could equate to increased nurse staffing and allowing nurses to have more input into the development of their nurse/patient staffing requirements. Nurses would then have the time needed for interpreters and the development of a therapeutic relationship with their patients. Secondly, the institution needs to provide resources such as translators/interpreters and materials in multiple languages to assist with patient education and discharge planning. One nurse who I interviewed spoke highly of her facility, stating that they provided all the right resources and made it an institutional requirement to provide culturally competent care. This facility is in comparison to a different institution that conducted post-op calls to racially/ethnically diverse patients and was aware that many of their patients had diverse language needs yet did not provide interpreters for follow-up post-op calls to non-English-speaking patients. This dichotomy sends a mixed message to the nurses required to make these calls regarding their support for culturally competent, linguistically appropriate care. The nurses at times did not even call individuals with Hispanic-sounding surnames because they believed these individuals did not speak English and they would not be able to communicate with them, therefore, these patients received a lower quality of care or at the very least disparate care. It is incumbent upon the institution/facility to foster culturally competent linguistically appropriate care, which is ultimately quality patient care for all. Without that kind of support, nurses will encounter increased barriers to care and could ultimately, in spite of their best intentions, provide less than adequate care.

According to the National Alliance for Hispanic Health,

Culturally competent agencies are characterized by acceptance of and respect for difference, continuing self-assessment regarding culture, careful attention to the
dynamics of differences, continuous expansion of cultural knowledge and resources and adaptations of service models in order to better meet the needs of different racial and/or ethnic groups. Such agencies recognize and value groups as distinctly different from one another and as having numerous subgroups, each with important cultural characteristics. (Reyes et al. 2004, p. 12)

Finally, a patient-centered approach to care, or as some call it a relationship-centered or a therapeutic patient care relationship, is what all providers need to strive to achieve with their patients. This is where the practitioner and patient work together to achieve agreed upon goals and ultimately develop a partnership (Williams et al., 2000).

This was something that was referred to by one of the NP students who was doing her clinical rotation in one of the maternal child clinics. The NP student shared that these mothers agreed to abide by the rules of a contract to make their prenatal visits and participate in care routines that would allow their pregnancy and birth costs to be covered by the clinic. The mothers received prenatal care services throughout their pregnancy, and their health care costs were completely covered for a small fee. It was an enforceable contract that carried more weight and held the patients accountable. It may not have been the ideal therapeutic relationship but it was an agreed-upon, negotiated relationship. According to Williams et al. (2000), “The relationship-centered approach involves physicians understanding the patients’ perspectives, being responsive to the needs of patients (and in some cases their families), and sharing treatment-relevant power with patients and their families” (p. 79). In order to achieve quality health care outcomes, a therapeutic patient-centered relationship must occur. More information related to this aspect of patient care, especially for NP students, would be extremely valuable and beneficial for them and the patients they will ultimately care for.


Recommendations

It is clear that there is a great need for more education regarding the ANA Code of Ethics and what it really means in relation to patient care and treating people with respect. One of the more culturally competent nurses said it this way: “It’s about understanding how to relate to other human beings whether you’re from Ethiopia or Latin America or next door . . . respect for and understanding . . . where that person comes from and lots of walk a mile in their shoes.” This should be highlighted to a greater extent in nursing curricula. Additionally, faculty should aim to be good role models and set standards for quality care to racially/ethnically diverse patients. They must emulate what cultural self-efficacy and cultural competency/proficiency should look like for their students and inculcate it into teaching and clinical practice experiences.

This study further demonstrates that immersion experiences appear to have a positive influence on RN cultural self-efficacy regarding Hispanic patients. NP students’ increased exposure to diversity in their clinical experiences as well as the tools to work with diverse populations does appear to positively impact their comfort level and competence to work with diverse patients. However, included with this increased exposure must be an evaluation process so they can learn more than just clinical skills during these experiences but more of how they can really provide culturally competent quality care to all patients and obtain instant feedback in order to move them toward the development of a therapeutic provider/patient relationship.

While on the cultural proficiency journey, the RN should engage in self-reflection to discover underlying biases and better understand what he/she brings during the clinical
encounter. “Thus far, being White has given one the luxury of not having to examine one’s own race critically” (Dodd & Irving, 2006, p. 235). Each one of us brings a briefcase filled with baggage that includes race, culture, generation, geographic location of birth and upbringing, dominant culture of experience, city or country living, socioeconomic status, etc. All of that influences who we are and how we act toward others, not to mention how history or societal norms overall influence how we view others. Becoming more aware of ourselves and experiencing otherness is the first step toward cultural proficiency, and all nurses should be sensitized to this process.

Additionally, nurses should develop an increased sensitivity to patient care issues and needs in order to incorporate these needs into their patient care planning. Patient care should not take place in isolation. This could be as simple as being sensitive to incorporating patient needs in treatment, and in their scheduling of follow-up services and care. As identified in this study, nurses need to become more aware and sensitive to their own nonverbal behaviors, which may be inadvertently sending mixed messages to their patients and other care providers. They must also become more sensitive and aware of the patient’s nonverbal behavior. This study illuminated that patient nodding does not always equate with understanding. A re-familiarization with good communication techniques as well as more effective teaching and learning strategies would be beneficial.

Related to patient discharge, more information needs to be provided to the patient prior to his/her release. It was clear throughout this study that patients are frequently shortchanged during the discharge process even though instructions may be adequately documented. There is much lost in the translation. Patients who speak a different
language than their nurse are then left to cope with lack of language proficiency as well as limited health literacy. This is a recipe for failure. Verbal verification of understanding, including urging patients to repeat the instructions, could help to ensure confirmation of their understanding and ultimately adherence to discharge instructions and better outcomes.

Today, it is safe to say that physical characteristics, race/ethnicity, and language (racial bias/white privilege) do in many arenas negatively influence the patient/provider clinical encounter and, ultimately, health care outcomes. The road to cultural proficiency and a quality, effective, therapeutic patient-centered relationship is a journey that all health care providers need to embark on. It is a journey that takes some personal desire, self-reflection, knowledge, and patience. If registered nurses and other health care practitioners engage in this journey, we can, as a nation, decrease and ultimately one day eliminate health care disparities based solely on the color of one’s skin, hair, and eyes or language that we speak.
APPENDIX A

White (non-Hispanic) NP Student Perceptions of Hispanic Patients

INFORMED CONSENT FORM

RESEARCH PROCEDURES
This research is being conducted to study to identify white (non-Hispanic) NP student perceptions of Hispanic patients in order to gain a better understanding of these perceptions and how they may impact nursing interactions and/or the patient/provider encounter. If you agree to participate, you will be asked to complete a demographic survey and the Cultural Self-Efficacy Scale which will take approximately 15-30 minutes to fill out. You will also be asked to participate in an interview which will take about 60-90 minutes. The interview will be tape recorded and transcribed. A copy of the transcribed interview will be provided to you for verification. The tapes will be analyzed and once the analysis is complete, the tapes will be destroyed. In the transcribed notes the interviewees will be given aliases in order to ensure confidentiality. The tapes will be used only for the purpose of this study.

RISKS
There are no foreseeable risks for participating in this research. However, at times there could be some discomfort with questions asked or the sensitivity of the discussion.

BENEFITS
There are no benefits to you as a participant other than to further research in the understanding of white (non-Hispanic) NP student and Hispanic patient encounters

CONFIDENTIALITY
The data in this study will remain confidential. The surveys will be coded with a number and the individuals will use the same number with the taped interviews. Fictitious (alias) names will be used to hide identity of interviewees. Participants’ names and other identifiers will not be placed on surveys or other research data. Since the identifiable data will be coded, (1) your name will not be included on the surveys and other collected data; (2) a code will be placed on the survey and other collected data; (3) through the use of an
identification key, the researcher will be able to link your survey to your identity; and (4) only the researcher will have access to the identification key.

PARTICIPATION
Your participation is voluntary, and you may withdraw from the study at any time and for any reason. If you decide not to participate or if you withdraw from the study, there is no penalty or loss of benefits to which you are otherwise entitled. There are no costs to you or any other party. As an incentive for your complete participation in the study you will be provided with $25.00 Target gift card. This gift card will be provided to you after you have completed all parts of the participation which includes a survey and interview questions.

CONTACT
This research is being conducted by Rose Gonzalez, MPS, RN, nursing doctoral candidate at George Mason University. She may be reached at [Contact Information] for questions or to report a research-related problem. Her faculty advisor is Charlene Douglas, PhD, RN and she can be reached at [Contact Information] or [Contact Information]. You may contact the George Mason University Office of Research Subject Protections at [Contact Information] if you have questions or comments regarding your rights as a participant in the research.

This research has been reviewed according to George Mason University procedures governing your participation in this research.

CONSENT
I have read this form and agree to participate in this study.

__________________________  __________________________
Name                        Date of Signature

Version date: January 6, 2010
APPENDIX B

DEMOGRAPHIC SURVEY
WHITE (NON-HISPANIC) NP STUDENT PERCEPTIONS OF HISPANIC PATIENTS

Please check or write-in answers to questions as appropriate.

1. Age in years: ________

2. Gender: Male______Female_____

3. Race - White _____ Black_______ Asian___ Other_______

4. Hispanic: Yes _______ No_______

5. Married ____ Single_____ Divorced ____

6. Inter-racial Marriage/Inter-racial relationship? Yes _____ No_____

7. Were you born in the United States? Yes ____ No ______

8. What was the predominant racial/ethnic composition of the neighborhood/town in which you grew up? ____ White _______African American _____Latino/Hispanic _____ Asian _____ Native American. _____Other

9. If you moved frequently, what was the predominant culture/race/ethnicity in the neighborhood which influenced you the most?

   ___________________________________________________.

10. Primary language: ______________

11. Secondary language: ____________

12. How would you self-identify color of skin? ______________

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13. RN Education: _____ Diploma _____ Associate Degree _______
    _____ Masters _____ Other - please list ____________________

    _____ Critical Care _____ Long Term Care _____ Other (List)

15. How would you characterize **the percent** of your encounters with racially or
ethnically diverse patients related to your total patient encounters within the last year?
    ______%  Percent of encounters with Hispanic patients in the last year? ________ ___

16. Have you had a college class on cultural competency? _____ Yes _____ No.

17. If so – approximately how long was the class? ____________ hours

18. If not, have you completed cultural competency training? ___ Yes _____ No.

19. If so – approximately how long was the training? ____________ hours

20. Do you believe the cultural competency education/training you completed helped
to improve your clinical interactions with culturally diverse patients?  Yes ____
    No______.  With Hispanic patients?  Yes ________ No__________.

21. Please describe the type of facility you work in:
    _____ Hospital _____ Clinic _____ Nursing Home _____ Home Care _____ Hospice
    __________________ MD Office ________________ Other (Please identify)

Thank you for completing this survey.
APPENDIX C

THE CULTURAL SELF EFFICACY SCALE (modified)

Directions: Your responses are confidential and will help us to plan better services for Hispanics. Indicate how much confidence you have about doing each of the behaviors listed below.

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<tr>
<th>1</th>
<th>2</th>
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<tbody>
<tr>
<td>Very little confidence</td>
<td>Quite a lot of confidence</td>
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CONFIDENCE IN MY KNOWLEDGE OF CULTURAL CONCEPTS

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<th>Distinguishing between inter and intra cultural diversity.</th>
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<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
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<tr>
<th>Distinguishing between ethnocentrism and discrimination.</th>
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<th>2</th>
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<tr>
<th>Distinguishing between ethnicity and culture.</th>
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</table>

CONFIDENCE IN MY KNOWLEDGE OF CULTURAL PATTERNS OF HISPANICS

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<tr>
<th>Family organization</th>
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<th>Role differentiation</th>
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<th>Child care practices</th>
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<tr>
<th>Utilization of health system</th>
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<th>2</th>
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</thead>
<tbody>
<tr>
<td>Types of social supports</td>
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<tr>
<td>Utilization of traditional folk health practices</td>
<td>1</td>
<td>2</td>
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<td>Nutritional patterns</td>
<td>1</td>
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<tr>
<td>Economic style of living</td>
<td>1</td>
<td>2</td>
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<td>Migration patterns</td>
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<td>Class structure</td>
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<td>Beliefs about health and illness</td>
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### CONFIDENCE IN THE FOLLOWING SPECIFIC NURSING SKILLS

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<tr>
<td>Advocacy</td>
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<tr>
<td>Activity</td>
<td>Little Confidence</td>
<td>Quite a lot of Confidence</td>
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<tr>
<td>Performing a 24 hour diet review</td>
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<tr>
<td>Participant observation</td>
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<tr>
<td>Taking a life history</td>
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<td>Developing a geneogram</td>
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APPENDIX D

RECRUITMENT SCRIPT

Hello, my name is Rose Gonzalez, MPS, RN and I am a nursing doctoral candidate at George Mason University. My dissertation thesis is “White (non-Hispanic) nurse practitioner student’s perception of Hispanic patients.” My research proposal aims to identify nurse practitioner student perceptions of Hispanic patients and how that might impact the clinical encounter by engaging in a small qualitative study. It also aims to assess nurse practitioner students’ perceived cultural self-efficacy regarding Hispanic patients. My goal is to recruit 6 nurse practitioner students from . . . and 6 nurse practitioner students from . . .

This study is a non-experimental study which involves a demographic survey, a cultural self-efficacy scale and then a 60-90 minute audio taped qualitative interview. This process should take between 1.5-2.0 hours in total. If you are interested in participating in this study, please contact me at [contact information] or [contact information]. To compensate each participant for their time, upon completion the participant will receive a $25.00 Target gift card. Thank you for the opportunity to address this class.

You can also e-mail me at [email] or text me on my cell phone. Thank you.
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U.S. Department of Health and Human Service [USDHHS], Health Resources and Services Administration [HRSA]. (2010). The registered nurse population: Initial findings from the


Rose Gonzalez has been a registered professional nurse since 1980. Ms. Gonzalez received a Bachelor of Science in Nursing, Magna Cum Laude, from Mount Saint Mary College, in Newburgh, NY. She was awarded a Master of Professional Studies with a concentration in Health Care Administration from the State University of New York at New Paltz in 1987 and in 1991 was inducted into the Sigma Theta Tau International Honor Society of Nursing.

Prior to her arrival in Washington, DC, she served the New York State Board of Regents, and the New York State Education Department, as the first Latina and nurse to serve as the Acting Executive Secretary to the State Boards for Optometry and Veterinary Medicine. She assisted both Boards in executing their responsibilities for professional credentialing, practice and discipline.

Currently she serves as the Director of Government Affairs for the American Nurses Association, where she is called upon to oversee the department that lobbies both the Executive Branch and Congress on issues important to nursing. She coordinates the work of the ANA-PAC, which provides funding for candidates running for political office on the federal level, and N-STAT, which is ANA’s grassroots program. Another component of ANA’s Government Affairs program, which she oversees, is State Government Affairs, which serves as a resource and provides strategy to ANA’s state nurses organizations. This allows for an integrated approach to federal and state legislative activities.

Throughout her professional career, Ms. Gonzalez has remained actively involved in her community. She served as Vice President of the National Association of Hispanic Nurses (NAHN) and continues to work to promote the professional, educational, and political advancement of all registered nurses.