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UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

CULTURAL COMPETENCE AND RACIST ATTITUDES OF
DIRECT PATIENT CARE REGISTERED NURSES
IN A MIDWESTERN STATE

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy

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College of Natural and Health Sciences
School of Nursing
Nursing Education

May, 2011

This Dissertation by Linda K. Hardy

Entitled: *Cultural Competence and Racist Attitudes of Direct Patient Care Registered Nurses in a Midwestern State*

has been approved as meeting the requirement for the Degree of Doctor of Philosophy in College of Natural and Health Sciences in the School of Nursing, Program of Nursing Education

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ABSTRACT

Hardy, Linda K. *Cultural Competence and Racist Attitudes of Direct Patient Care Registered Nurses in a Midwestern State*. Published Doctor of Philosophy dissertation, University of Northern Colorado, 2011.

Racism has been implicated as one of the causes of health disparities in non-White population groups in the United States. The purpose of this study was to explore and describe cultural competence and racist attitudes of direct patient care registered nurses (DPC RNs) in a Midwestern state. The researcher hypothesized that racist attitudes impacted cultural competence, compromised the nurse-patient interaction, and potentially led to less than optimal patient outcomes.

Critical Social Theory and Leininger's Theory of Culture Care Diversity and Universality served as the framework for this quantitative, descriptive correlational research. Cultural competence was measured with the Cultural Competence Assessment (CCA) instrument and racist attitudes were measured with two subscales of the Quick Discrimination Index (QDI). These instruments, with the Marlowe-Crowne Social Desirability Scale-C, were administered to participants using Survey Monkey, a secure, web-based survey site.

Results suggest that DPC RNs in this sample possess a less than optimal level of cultural competence and that racist attitudes are present at a level that requires acknowledgement and attention by the discipline of nursing, particularly nursing education. Further, as age of the RN increased, cultural competence increased as did

racist attitudes. These older RNs displayed cultural competence but with underlying racist attitudes. Cultural competence education alone has not addressed the issue of racism in nursing. Results demonstrated a weak correlation between cultural competence and racist attitudes; over the complete sample of RNs, as cultural competence increased, racist attitudes decreased. This finding implies that cultural competence education has some impact on racist attitudes but not at the level necessary to eliminate racism in nursing.

Nurse educators in the academic setting are encouraged to facilitate curricular changes based upon the principles of social justice. This includes all types of discrimination but with a focus on racism--individual, cultural, and institutional--in particular. Nurse educators in the practice setting are called upon to consistently and intentionally include racism and antiracism content in the required continuing education offerings related to cultural competence and transcultural nursing.

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I would also like to thank my colleagues at Nebraska Wesleyan University. They were always interested in my work and provided emotional support when my confidence wavered. I could not ask for better colleagues.

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CHAPTER I

INTRODUCTION

Nursing is a science-based, caring profession. Despite growing technology and major advances in healthcare today, cure does not happen without care (Leininger & McFarland, 2006, p. 79). The caring interaction between the nurse and the patient is foundational to the practice of nursing. With an increasingly diverse patient population in the United States (Shi & Stevens, 2005; U.S. Census Bureau, 2008), attainment of this caring interaction becomes more challenging.

Leininger's body of work established the importance of providing nursing care based upon culture—culturally competent care (Leininger, 1967, 1995, 1999; Leininger & McFarland, 2006). Lack of culturally competent care has been implicated in adverse patient outcomes with racially diverse populations (Institute of Medicine, 2002; Smedley, Stith, & Nelson, 2003). The purpose of this research is to explore and describe factors, specifically racism, that interfere with cultural competence and the attainment of a positive, productive nurse-patient interaction. The intersection of these two variables (i.e., cultural competence and racism) in practicing nurses was explored with implications for nursing education.

The specific aims of this research were to explore the existence and extent of racist attitudes in Registered Nurses (RNs) who provide direct patient care as well as ascertain the relationships between demographic factors (e.g., age, gender, educational

level), level of cultural competence as measured by the Cultural Competence Assessment instrument (CCA; Doorenbos, Schim, Benkert, & Borse, 2005; Schim, Doorenbos, & Borse, 2005, 2006a), and racist attitudes as measured by the Quick Discrimination Index (QDI; Ponterotto et al., 1995; Ponterotto, Potere, & Johansen, 2002; Ponterotto, Utsey, & Pedersen, 2006). A non-experimental, descriptive, correlation research design is appropriate when the goal of the research is to describe and document relationships or associations of a situation rather than infer cause-and-effect relationships (Houser, 2008; Polit & Beck, 2008). Since there is a dearth of empirical research exploring racist attitudes of RNs and the potential association with cultural competence, this was the most appropriate design for this study.

This research project was based upon data obtained from RNs who provide direct patient care, defined as spending approximately 25% or more of their work time on caring for patients or directly supervising RNs who do. A list of all RNs licensed in the state of Nebraska was obtained from the Nebraska State Board of Nursing. From that list, a simple random sample was obtained.

Chapter I (a) outlines conceptual and theoretical frameworks, (b) provides an overview of the salient issues that lead to the problem statement and research questions, and (c) supplies a concise description of the research design and the significance of this project. Chapter I concludes with a short summary.

Conceptual and Theoretical Framework

The terms *conceptual framework* and *theoretical framework* are often used interchangeably (Polit & Beck, 2008). However, it is logical to utilize the term *conceptual framework* to indicate the concepts and the relationship of the concepts that

are the focus of the research. The term *theoretical framework* could reasonably be utilized to indicate the theory or the philosophical perspective that underpins a research project. For this project, these two related but slightly different terms were utilized in the manner described.

Assumptions and Conceptual Framework

Several literature-based assumptions inform the conceptual framework for this research project:

- Lack of culturally competent care puts racially-diverse patients at risk for adverse outcomes that in turn impact health disparities (Institute of Medicine [IOM], 2002; Seright, 2007; Smedley et al., 2003).
- Well-intentioned White healthcare providers “typically demonstrate unconscious implicit negative racial attitudes...” (Institute of Medicine, 2002, p. 4).
- Nursing remains a predominantly White profession caring for an increasingly diverse population (Sullivan, 2004; U.S. Census Bureau, 2008).
- It is unlikely that culturally competent care can be provided if racist attitudes are present in the nurse-patient interaction (Abrums & Leppa, 2001; Tyson, 2007).
- Nursing is called upon to provide equitable care to all patients based upon the principle of social justice (American Association of Colleges of Nursing, 2008c; American Nurses Association, 2001); it is unlikely that equitable care can be provided if racist attitudes are present in the nurse-patient interaction.

- It is the responsibility of the discipline of nursing as well as nurse educators to unmask and address the issue of racism in nursing (Johnstone, 2006; Johnstone & Kanitsaki, 2009; Steefel, 2008; Vaughan, 1997).

The conceptual framework for this research includes concepts identified in the assumptions. Simply stated, this researcher hypothesized that factors in addition to cultural competence impact the nurse-patient interaction (NPI) and ultimately the quality of nursing care. Because the nursing workforce remains disproportionately White (National League for Nursing, 2008; Sullivan, 2004) and is caring for an increasing number of patients who are not White, it is reasonable to consider racism/racist attitudes as one of these factors. While racism remains an issue in our country (Utsey et al., 2008; Wise, 2009), it is logical to assume that racism is an issue within nursing as well.

Figure 1 is a graphic depiction of this hypothesized relationship. The nurse's characteristics (e.g., age, educational level, cultural competence level, and racist attitudes) influence interactions with the patient. These interactions result in nursing care, ideally quality nursing care. While it is important to acknowledge that other factors (e.g., ageism, sexism, educational level, socio-economic status, power differential, language discordance) potentially impact the nurse-patient interaction, the focus of this research was racism/racist attitudes that may be present, unrecognized, and not addressed.

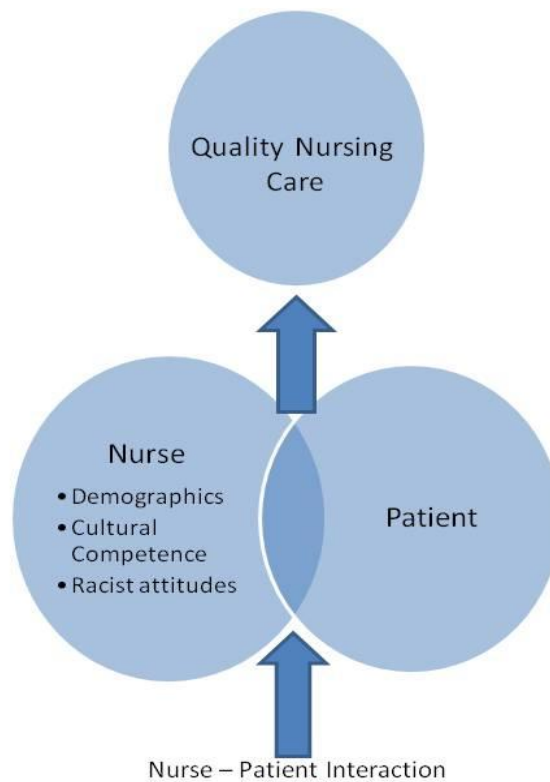


Figure 1. Nurse-patient interaction and quality nursing care.

Theoretical Framework

Critical social theory (CST) and Leininger’s culture care theory of diversity and universality (Leininger & McFarland, 2006) provided the theoretical underpinnings for this research project. Historically situated in the post-World War I era, CST is attributed to the Frankfurt School in Germany (Crotty, 1998; Duchscher, 2000; Mohammed, 2006; Powers & Knapp, 2006; Schwandt, 2001). Although CST lacks a unified definition (Mohammed, 2006), it can be viewed as a type of “umbrella” for various approaches utilized for social analysis and critique (Powers & Knapp, 2006). Several concepts of CST are congruent with this research: (a) identify and redress social injustices, (b) awareness of values and beliefs that influence interactions that may have been

unknowingly or unwillingly internalized, (c) uncover power imbalances, and (d) initiate action research to change the current state of the problem/issue (Corbett, Francis, & Chapman, 2007; Crotty, 1998; Duchscher, 2000; Maggs-Rapport, 2001; Manias & Street, 2000; Mohammed, 2006; Schwandt, 2001; Young, 2008).

While CST is typically aligned with qualitative research methodology, there is literature-based support for the utilization of quantitative methodology within this paradigm. For example, Creswell (2009) places CST within the advocacy and participatory worldview and states, “This worldview is typically seen with qualitative research, but it can be a foundation for quantitative research as well” (p. 9). Over time, CST has evolved, allowing for latitude in the choice of research methodology (Mohammed, 2006; Powers & Knapp, 2006). Because this research project was focused upon a social issue (racism) with the potential to illuminate values and beliefs that have been unknowingly or unwillingly internalized (Duchscher, 2000) by RNs, CST was an appropriate framework for this research. The value of statistical research to describe socio-cultural issues should not be underestimated as it provides a balance of objective and subjective knowledge development (Manias & Street, 2000). Further, there was a need for quantitative research on this topic because “much of the nursing research about racism uses qualitative methodologies” (Porter & Barbee, 2004, p. 33).

Leininger’s culture care theory of diversity and universality provided additional theoretical support for this research project (Leininger, 1997, 2002; Leininger & McFarland, 2002, 2006). The purpose of Leininger’s theory is to provide safe and meaningful care to patients of diverse and similar cultures (Leininger, 2002). The theory could be classified as predictive; it assumes that the provision of culturally congruent

care will lead to health and wellbeing or support for the patient facing continuing illness or impending death (Leininger, 2002; McEwen & Wills, 2011; Walker & Avant, 2005). The Sunrise model, based upon the idea of a rising sun symbolizing the bright sunrise of knowing, depicts all dimensions of the theory, can be used to guide nursing practice, and identifies specific cultural areas for further research (Leininger, 1995, 2002; Leininger & McFarland, 2006). Chapter II provides a more in-depth discussion of this theory.

The delivery of culturally competent care is essential for the provision of quality nursing care. Culturally competent care cannot be provided if racist attitudes are present in the nurse-patient interaction (Tyson, 2007). This research extends nursing theory by addressing the relationship of cultural competence and racist attitudes within the nurse-patient interaction.

Background

Cultural Competence

Historical perspective: Nursing and nursing education. Historically, nursing education has demonstrated a commitment to prepare future nurses to practice in a culturally diverse world in a culturally competent manner. In the 1950s, Dr. M. Leininger anticipated the increasing cultural diversity of the world and the trend toward globalization (Leininger & McFarland, 2006). She predicted increased interaction with different cultures based upon expansion of foreign trade and new modes of communication and travel (Leininger, 1967). Even though Leininger may not have anticipated the extent of the communication revolution, the proliferation of the World Wide Web, social networking sites such as Facebook™ and Twitter™, and the ability to utilize visual enhancements in the virtual environment have indeed made contact with

people of other cultures commonplace. Advances in the ease of travel have undoubtedly increased the movement of people from one area of the world to another.

Based upon her foresight, Leininger (1995) identified the need for nurses to provide care based upon culture, i.e., *culture care*; her work led to the development of transcultural nursing (Leininger & McFarland, 2006; Zander, 2007). Nurses are direct care providers; as such, they must be prepared to function with cultural knowledge and competencies “to ensure beneficial outcomes to people of different cultures” (Leininger & McFarland, 2006, p. 4). Leininger’s work placed nursing in the forefront of the movement to provide healthcare to an increasingly diverse world in a manner that has the greatest likelihood of achieving favorable patient outcomes. As early as 1967, she linked culture and nursing in an article that was published in the *Journal of Nursing Education* (Leininger, 1967). This early observation by Leininger implies that nursing education bears responsibility for educating nurses about culture.

Historical perspective: Other disciplines. Other healthcare disciplines have recognized the importance of teaching about culture care to address the changing demographics of the United States, albeit not as early as nursing. This has taken many forms: diversity training, multicultural education, and cross-cultural training. In the 1970s, psychologists addressed cultural bias related to research (Zander, 2007). Sue et al.’s (1982) work within the counseling disciplines led to a framework for multicultural counseling competencies (Zander, 2007). Use of the term *cultural competence* was not consistently seen in medical literature until the early 1990s (Beach, Saha, & Cooper, 2006).

Over the past decade, healthcare providers (e.g., healthcare facilities, managed care organizations, physicians, nurses, mental health professionals) have made an effort to provide culturally competent care to their constituents (Ahman, 2002; Arthur et al., 2005; Betancourt, Green, Carrillo, & Park, 2005; Bonder, Martin, & Miracle, 2001; Godfrey, 2006; Lavizzo-Mourey & Mackenzie, 1996; Leishman, 2004; Maier-Lorentz, 2008; Nelson, Bustamante, Wilson, & Onwuegbuzie, 2008; Nyatanga, 2008; Serizawa, 2007; Wood & Atkins, 2006). This effort has become more important because of mandates to increase quality of care and provide equitable care to all (Agency for Healthcare Research and Quality [AHRQ], 2008; IOM, 2001, 2002).

Regulatory bodies and recommendations of experts. Various regulatory bodies require the provision of culturally competent care. For example, the Joint Commission (2009b), an accrediting agency for various healthcare organizations (e.g., acute care hospitals, critical access hospitals, long-term care facilities), provides standards supporting effective communication, cultural competence, and patient-centered care. In August of 2009, the Joint Commission (2009a), with financial support from The Commonwealth Fund, announced the development of requirements designed to *advance* effective communication, cultural competence, and patient-centered care for hospitals seeking accreditation. The following three proposed standards and elements of performance, which were developed as a result of this work, are especially pertinent: (a) accommodation of patients' cultural and personal beliefs, (b) accommodation of patients' religious and spiritual practices, and (c) non-discrimination in care (Joint Commission, 2009c). Basically, the language of the standards has been strengthened and is more action oriented. For example, Standard RI.01.01.01, EP 6 has been changed from "The

hospital *respects...*” to “The hospital *accommodates* the patient’s cultural and personal values, beliefs, and preferences” (Joint Commission, 2009c, p. 5).

The Office of Minority Health (OMH), within the Department of Health and Human Services, published standards to guide healthcare organizations but noted that individual providers were encouraged to adhere to these standards as well and to facilitate the provision of culturally and linguistically appropriate services (CLAS; OMH, 2001). Of the 14 standards, four are mandated for organizations receiving federal funds, nine are guidelines, and one is a recommendation (OMH, 2001). As of 2007, nine guidelines have been recommended by the OMH to become federal mandates with the attendant financial incentive for compliance (OMH, 2007). Of significance to this project, Standard 1 states that “care be provided in a manner compatible with cultural health beliefs and practices” (OMH, 2001, p. 7). This standard explicates the potential for improved quality of care in the following statement: “Effective care results in positive outcomes for patients/consumers, including satisfaction; appropriate preventative services, diagnosis, and treatment; adherence; and improved health status” (OMH, 2001, p. 7).

Lack of culturally competent healthcare has been identified as a contributing factor in healthcare inequalities (AHRQ, 2005; Bebinger, 2006; Brach & Fraser, 2000; IOM, 2002; B. D. Smedley et al., 2003; Sullivan, 2004). In spite of strategies to improve the cultural competence of healthcare providers, health disparities persist and have even worsened in some outcome measures (AHRQ, 2008a). For example, Blacks had a rate of new AIDS cases 10 times higher than Whites; American Indians and Alaska Natives were twice as likely to lack prenatal care in the first trimester as Whites (AHRQ, 2008a, p. iv).

Early in 2000, the Institute of Medicine (IOM) released an extensive report detailing serious issues with patient safety in the U.S. healthcare system (Kohn, Corrigan, & Donaldson, 2000). This work was undertaken as a function of the committee on Quality of Health Care in America. While healthcare providers have professed quality of care as a fundamental goal, the publication of this troubling report, followed a short time later by the IOM report, *Crossing the quality chasm: A new health system for the 21st century*, brought the lack of quality to the forefront of the nation (Institute of Medicine, 2001b). The committee made three recommendations as well as six specific aims for improvement. Two of these aims are especially salient to this research project:

- *Patient-centered*—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions (Institute of Medicine, 2001b, pp. 39-40).
- *Equitable*—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status (Institute of Medicine, 2001b, pp. 39-40).

These aims for improvement call for all healthcare providers (i.e. nursing, physicians, physical therapists, pharmacists, etc.) to develop competencies in these areas and for healthcare profession educators to support student learning of these competencies (Finkelman & Kenner, 2007, 2010; Institute of Medicine, 2003). Culturally competent healthcare providers support attainment of these goals but it was important to ascertain what other factors may contribute as well.

Cultural Competence Definitions and Models

To fully grasp the issue at hand, it was necessary to explore the construct of *cultural competence*. The American Association of Colleges of Nursing (AACN) defines cultural competence as an ongoing process toward the development of the attitudes, knowledge, and skills necessary for providing quality care to diverse populations (American Association of Colleges of Nursing, 2009). According to Zander (2007), “The literature discussing cultural competence almost consistently describes the construct as having three elements: cultural awareness, cultural knowledge, and cultural skills” (p. 53).

Three element model of cultural competence. *Cultural awareness* is described as the cognitive process by which an individual becomes aware of one’s own culture as well as the similarities and differences of other cultural groups (Zander, 2007). Further, the individual becomes “enthusiastic and receptive” to these cultural differences (Zander, 2007, p. 53), the implication being that an attitude change occurs in the individual. Therefore, the concept of cultural awareness includes cultural attitude as well as recognition of bias based upon race, ethnicity, and/or culture (Sue et al., 1982).

Cultural knowledge is described as a process of obtaining information and understanding about culturally diverse groups (Campinha-Bacote, 2007; Zander, 2007). The practitioner must seek this knowledge from a number of different sources (e.g., textbooks, websites, novels) including the culturally diverse individuals receiving the care (Campinha-Bacote, 2007; Zander, 2007). The ability to develop a knowledge base is partially dependent upon the practitioner’s ability to establish rapport with the culturally

diverse patient; demonstrating respect for the patient's cultural values, beliefs, and practices is instrumental in this process.

Cultural skill has been described as the ability to perform a complete cultural and physical assessment of a patient in a culturally sensitive manner (Campinha-Bacote, 2007; Zander, 2007). Inherent within this concept is the ability to communicate effectively with a culturally and linguistically diverse patient. This includes linguistic competence in one or several different languages, the ability to effectively utilize interpreters, and the ability to understand non-verbal cues (Zander, 2007). Zander summarizes the work of Sue et al. (1982) by stating, "Cultural skills encompass the specific interventions and approaches required to work with diverse individuals" (p. 53).

The 3-dimensional puzzle model of cultural competence. The model utilized to frame the development of the Cultural Competence Assessment (CCA) instrument (Doorenbos et al., 2005; Schim et al., 2005, 2006a) is slightly different but congruent with the previously discussed model (Zander, 2007). The authors of the CCA define cultural competence as "the demonstration of knowledge, attitudes, and behaviors based on diverse and relevant cultural experiences" (Doorenbos et al., 2005, p. 326); they describe their model as being three-dimensional but have developed only the provider level to date (Schim et al., 2005, 2007). A graphic of the provider level shows four interlocking puzzle pieces--Awareness, Diversity, Sensitivity, and Competence (Doorenbos et al., 2005, p. 326). Evaluation of these four concepts demonstrates that the model utilized by Doorenbos et al. (2005) is congruent with the widely accepted three-element construct of cultural competence discussed by Zander (2007).

Cultural awareness is identified as knowledge regarding how groups tend to differ as well as share similarities (Doorenbos et al., 2005). This echoes Leininger's work related to the diversity and universality of culture (Leininger & McFarland, 2006). According to Zander (2007), "A part of cultural awareness is sensitivity--the knowledge that similarities as well as differences exist without infusing that knowledge with values, beliefs, or attitudes about diversity" (p. 53). The 3-Dimensional Puzzle model (3DPM; Doorenbos et al., 2005) describes cultural sensitivity as a separate concept. It is reasonable to assume that an individual could be aware of the differences and similarities between and within various cultures without necessarily being culturally sensitive. Viewing cultural sensitivity as a slightly different concept is appropriate.

Cultural sensitivity relates to identification of one's own attitudes, values, and beliefs as well as the development of communication (verbal and nonverbal) skills (Schim et al., 2006a). The discussion of communication skills within cultural sensitivity is justified in that the skillful use of communication is a way to demonstrate respect (Schim et al., 2006a). In their earlier work, this is described as "an openness to 'otherness', and respect for the complex ways in which cultural issues influence...healthcare" (Doorenbos et al., 2005, p. 326).

Cultural diversity is stated as "a fact" (Doorenbos et al., 2005, p. 326; Schim et al., 2005, p. 355, 2006a, p. 303); it is also broadly defined to include racial, ethnic, language, religion, gender, sexual orientation, ability/disability, and even access to technology as areas impacting the provider-patient interaction (Schim et al., 2005, 2006a). While this project is focused on issues related to race, this author acknowledges

that diversity per se includes all of the areas identified by Doorenbos and colleagues (2005).

Cultural competence behaviors are defined as the observable outcomes of experience with diversity, awareness, and sensitivity (Doorenbos et al., 2005). Some behaviors cited by the CCA authors include the ability to conduct a focused cultural assessment, adaptation of interventions based upon cultural practices and taboos, and seeking additional resources as needed (Doorenbos et al., 2005).

In spite of slightly different organizational patterns, the two models of cultural competence discussed include the same concepts. Therefore, it was appropriate to utilize the 3DPM (Doorenbos et al., 2005) within the framework of this research project.

Cultural Competence and the Nurse-Patient Interaction

As previously noted, lack of culturally competent care puts racially diverse patients at risk for adverse outcomes (Institute of Medicine, 2002; Seright, 2007; Smedley et al., 2003). The nurse-patient interaction is the most foundational aspect of the practice of nursing. It is in this 'place' that holistic, hands-on nursing care occurs. The question at hand was whether other factors, specifically racism, affect the attainment of cultural competence within the nurse-patient interaction. Exploration of the concepts of race and racism was necessary to inform the potential impact of racism upon the cultural competence of healthcare providers in general and nurses specifically. While there is no one definition of racism that is accepted by all scholars, there are core concepts that are explicated in the next section of this work.

Racism

Race and Racism Defined

Consideration of the concept of *race* stirs controversy within and among various disciplines. Is race biologically based, merely a social construct, or a combination of both (Barr, 2008; Glasgow, 2009; Hardy, 2007; Krieger, 2003; Ponterotto et al., 2006; Smedley & Smedley, 2005)? As scholars grapple with this question, people of color confront issues of race and racism in their lives every day (Ponterotto et al., 2006; Tang & Browne, 2008; Wise, 2009). Just as the concept of race is complex and difficult to define, the term *racism*, with the root word of *race*, is equally challenging.

Webster's New World Collegiate Dictionary offers the following definition of racism: "Belief in or doctrine asserting racial differences in character, intelligence, etc. and the superiority of one race over another...feelings or actions of hatred and bigotry toward a person or persons because of their race" (Agnes, 2002, p. 1181). This definition implies that actions based upon these beliefs are a component of racism. Utsey, Ponterotto, and Porter (2008) offer the following: "The core of racism essentially includes a prejudiced sense of superiority in an in-group with a concomitant exercise of power to subjugate an out-group" (p. 339). Ponterotto et al. (2006) espouse a three-part model of racism credited to Jones (1997): individual, institutional, and cultural. Individual racism is manifest in discriminatory acts toward a member of an 'other' race group based upon the belief in the superiority of one's own racial group (Jones, 1997; Utsey et al., 2008). Because this research project was focused upon racist attitudes originating from the nurse in the nurse-patient interaction, individual racism was of the greatest significance. However, it is important to acknowledge that the context of the

nurse-patient interaction is mediated by both institutional and cultural racism.

Institutional racism includes system level policies and procedures that cause or support inequalities and disparities among various racial groups (Jones, 1997; Utsey et al., 2008).

Cultural racism, defined as occurring “when White cultural norms and practices are deemed superior to those of other racial groups” (Utsey et al., 2008, p. 339), is significant in any discussion regarding cultural competence and racism.

Associated Issues of Fair Treatment, Equitable Care, and Equality

Typically, discussions related to the provision of healthcare to all populations include terms such as *fair treatment*, *equitable care*, and *equality*. A short review of these terms informs the subsequent discussion of racism related to healthcare.

Definition of the word *fair* includes the terms “just and honest; impartial; unprejudiced; specif., free from discrimination based on race, religion, sex, etc.” (Agnes, 2002, p. 509). Discrimination occurs when a person is treated differently based upon race or a host of other factors (e.g., gender, age; American Association of Colleges of Nursing, 2009). Synonyms of “fair” (2009) include equal, equitable, and just. To “treat” (2009) is to care for or deal with medically or surgically. Therefore, fair treatment implies caring for all in the same manner without bias or prejudice. The term *fair* is a synonym for both “equal” and “equitable” (Agnes, 2002, pp. 480-481). The term *equality* is defined as “the condition of being equal” but with the added focus on “political, social, and economic rights” (Agnes, 2002, p. 480). Since *fair*, *equitable*, and *equal* are synonymous, with *equality* closely related, these terms can logically be used interchangeably.

More troublesome is the question of how to determine if care is fair, equitable, or equal and who should make this judgment. Macinko and Starfield (2002) initially reviewed 414 articles and published an annotated bibliography summarizing scholarly work related to equity in health. Based upon their work, it is clear that a definitive method of measuring equity in health has not been developed, although the authors are optimistic about the progress that has been made (Macinko & Starfield, 2002).

Some accrediting bodies make this determination. For example, the Joint Commission (2009b, 2009c) evaluates healthcare facilities based upon their requirements to provide culturally competent care. A facility must demonstrate that the requirements are being met. The focus of this research was on the nurse-patient interaction; the individual nurse is ultimately responsible for evaluating the fairness of his or her own treatment as well as advocating for the patient regarding equitable treatment (Campbell & Campbell, 1996).

Racism and Healthcare Providers

Bebinger (2006) reported a physician comment that succinctly summarizes a germane issue in discussions of racism: “We try not to use the ‘R’ word. It’s just not productive” (p. 12). Political correctness and egalitarianism have rendered discussions of race and racism socially unacceptable (Tang & Browne, 2008). This may be especially salient for healthcare professionals who are called upon to avoid harm and to treat all clients/patients with equality (American Medical Association, 2001; American Nurses Association, 2001; American Psychological Association, 2002; Eliason, 1999; Green, Kiernan-Stern, & Baskind, 2005; Steefel, 2008). The very thought of racism is the

antithesis of what healthcare providers profess--treating all patients with equality regardless of race or ethnicity.

Regrettably, the discipline of nursing may have avoided the issue of racism altogether: “Generally, when the subject is racism, there is dialectical tension. In nursing, there is no such dialectical tension because there is little or no discussion of the subject” (Barbee, 2002, p. 194). As with society in general, nursing appears to underestimate the extent and potential impact of racism in healthcare (Barbee, 2002; Eliason, 1999; Lillie-Blanton, Brodie, Rowland, Altman, & McIntosh, 2000). More specifically, nursing education, the body of nursing responsible for the future of nursing, has not consistently included race and racism as a component of the educational process for nursing students (Abrums & Leppa, 2001). When race is included in nursing education, the focus is on disease entity (e.g., sickle cell anemia) or on modification of assessment strategies from the prevailing “norm” (i.e., White populations of European descent). For example, assessment of oxygenation based upon skin color must be modified from the norm when the patient is dark-skinned. Rarely does nursing education content address issues of racism and discrimination (American Association of Colleges of Nursing, 2008a; Porter & Barbee, 2004). Indeed, a review of literature found “an absence of empirically evaluated theory and teaching interventions addressing antiracism and racism in nursing students” (Allen, 2010, p. 319).

The concept of social justice subsumes racism. Essential VIII of *The Essentials of Baccalaureate Education for Professional Nursing Practice* (American Association of Colleges of Nursing, 2008b) calls for nursing education to facilitate the development of professional values that include social justice. Social justice is defined as “acting in

accordance with fair treatment regardless of economic status, race, ethnicity, age, citizenship, disability, or sexual orientation” (American Association of Colleges of Nursing, 2008c, p. 28). It is difficult to envision fair treatment if the nurse-patient interaction is mediated by racist attitudes originating from the nurse.

Within the past decade, the United States has become one of the most diverse countries in the world; this trend is likely to continue (Shi & Stevens, 2005). As diversity increases (U.S. Census Bureau, 2008), it is essential for nurse educators to prepare nurses to provide for this population in the most culturally competent, non-racist, caring manner possible (American Association of Colleges of Nursing, 2008c). The attainment of a positive, productive nurse-patient interaction requires that the patient feel honored and respected by the nurse; that is unlikely if the nurse harbors racist attitudes.

Problem Statement

Nursing education is charged with the development of cultural competencies within nursing students including practicing RNs who are seeking higher degrees (e.g., Associate Degree RNs seeking a Bachelor of Science in Nursing degree). To that end, in 2008, the American Association of Colleges of Nursing (AACN) released a document outlining the rationale for inclusion of cultural competency in nursing education and detailing outcome expectations. Cultural competence was also highlighted in several outcome competencies in the AACN’s *Essentials of Baccalaureate Education for Professional Nursing Practice* (American Association of Colleges of Nursing, 2008c). The rationale for inclusion of cultural competency as a required element in the discipline of nursing includes the monumental problem of health disparities as well as the moral mandate, based upon the principle of social justice, to provide culturally competent,

equitable care to all peoples (American Association of Colleges of Nursing, 2008a, 2008c).

Although cultural competence has been included in nursing education, both pre-licensure and as ongoing educational offerings for RNs, nursing education fails to address the issues of racism and discrimination directly (Lancellotti, 2008; Porter & Barbee, 2004). Perhaps racism is not an issue in nursing; however, Porter and Barbee ask why we would “expect nurses *not* to harbor racist ideologies” (p. 26). Their review of nursing research related to race and racism included five studies from 1970-1980 associated with attitudes toward culturally different “others” (Porter & Barbee, 2004). Of these five studies, two utilized students, not practicing nurses; three utilized Whites only samples; and all showed mixed results as far as both positive and negative attitudes (Porter & Barbee, 2004). Overall, Porter and Barbee reviewed 22 research reports from 1970 to 2003 related to race and racism in nursing research. This review led them to pose several important questions: “1. Where is the evidence that documents nurses as antiracists? 2. Why would nurses *not* be implicated in ...discriminatory clinical practices? and 3. Why did researchers stop studying White nurses’ attitudes toward different others?” (p. 26). Without empirical evidence, we cannot answer these questions nor with any certainty claim that racism does not exist within the discipline of nursing. Nursing cannot claim to provide equitable care if racism is impacting the nurse-patient interaction.

The focus of nursing on cultural competence, multiculturalism, and transcultural nursing as the answer to caring for a culturally diverse patient population has failed to eliminate negative patient outcomes leading to health disparities (Institute of Medicine, 2002; Seright, 2007; Smedley et al., 2003). Since cultural competence alone has not

eliminated health disparities, it is imperative to consider other social forces, specifically racism, that potentially impact the care nurses provide. It is within the nurse-patient relationship that the view of the “other” can be addressed and potentially changed (Lancellotti, 2008). Can nurses truly care for and about their patients if racist attitudes are present in the nurse-patient interaction, unacknowledged and not ameliorated? Perhaps cultural competence education does impact racism in nursing; however, research data are needed to support this stance. Nurses and nurse educators may be comfortable discussing cultural competence but they are decidedly uncomfortable considering the possibility that racism is present and impacting the care they deliver to a diverse population (Barbee, 2002). “Nursing must continue its struggle to name and acknowledge race and racism” (Porter & Barbee, 2004, p. 34). To that end, the following research questions were posed.

Research Questions

- Q1 What is the level of cultural competence of RNs providing direct patient care?
- Q2 What is the relationship between demographic factors and level of cultural competence of RNs providing direct patient care?
- Q3 Do RNs providing direct patient care report racist attitudes?
- Q4 What is the relationship between demographic factors and racist attitudes of RNs providing direct patient care?
- Q5 What is the relationship between level of cultural competence and racist attitudes of RNs providing direct patient care?

Research Design

The research design for this project was nonexperimental, descriptive, and correlational. Descriptive research focuses on describing and documenting conditions or

aspects of a situation as they exist (Houser, 2008; Polit & Beck, 2008). This type of research may “serve as a starting point for hypothesis generation or theory development” (Polit & Beck, p.274). As noted by Porter and Barbee (2004), “There are no nursing theories that deal with racism” (p. 33). Correlational design enables researchers to discover relationships (or lack thereof) between variables (Gall, Gall, & Borg, 2007). Findings from this research support development of theory related to racism in nursing. This project sought to describe racist attitudes in the research sample, ascertain if there were relationships between demographic factors and cultural competence, demographic factors and racist attitudes, and if there was a relationship between racist attitudes and cultural competence.

The population of interest for this research was registered nurses licensed to practice in Nebraska who provide direct patient care or directly supervise RNs who provide direct patient care. Institutional Review Board approval was obtained from the University of Northern Colorado. Potential research participants were provided with the URL (internet address) to the researcher’s faculty page on the Nebraska Wesleyan University website to enhance credibility and potentially increase the response rate. Chapter III provides an in-depth discussion of research design and process.

Significance and Potential Contribution to Nursing Knowledge

Critical social theory requires action to change the current state of the issue. If racist attitudes exist (and--as noted by Porter & Barbee, 2004--why would we believe that they do not?), identification and description is the first step in the action research process, i.e., fact finding (Corbett et al., 2007). While some have called for nursing to address racism (Barbee, 2002; Eliason, 1999; Lancellotti, 2008; Steefel, 2008; Tang & Browne,

2008; Vaughan, 1997), there is a paucity of empirical data describing and documenting this phenomenon. Therefore, this research adds to the body of nursing knowledge as well as informs nursing education regarding the issue of racism and the relationship with cultural competence. Modifications to current pedagogies and content for cultural competence education are a contribution of this project.

While the focus of this project was not directly aligned with the national problem of health disparities, there is an important connection. There is little doubt that racism is strongly implicated as a cause of health disparities in minority populations (Agency for Healthcare Research and Quality, 2005, 2008; Brondolo, Gallo, & Myers, 2009; Institute of Medicine, 2002; Williams & Mohammed, 2009). Registered nurses, with an estimated 2.5 million jobs, comprise the largest component of the healthcare workforce (Bureau of Labor Statistics, 2008). As such, it is logical to hypothesize that the existence and extent of racism within nursing has major implications for addressing health disparities. Research related to health disparities has become a priority within healthcare as well as within governmental agencies. For example, “NIH [National Institute of Health] ranks health disparities third among its top five organizational priorities” (Institute of Medicine, 2006, p. 2). The National Institute of Nursing Research (NINR) has identified the elimination of health disparities as one of four research priorities within its strategic plan (Grady, 2006). This research project was congruent with research priorities outlined by the NIH and the NINR and contributes to the knowledge base needed to eliminate health disparities.

Summary

In spite of strategies to improve the cultural competence of healthcare providers, health disparities persist and have even worsened in some outcome measures (AHRQ, 2008a). Tyson (2007) questions whether cultural competence is even attainable without addressing the possibility of racism in nursing. While extremely important, cultural competence alone cannot address health disparities (Carlson & Chamberlain, 2004; Flaskerud, 2007) and has not produced the outcomes expected (Brach & Fraser, 2000). To determine the impact of racism, it must first be discovered and described.

Evaluation of racist attitudes elucidates a component that informs the nurse-patient interaction and impacts quality nursing care. This phenomenon can now be addressed more directly and intentionally within nursing education. Therefore, this research adds to the body of nursing knowledge, explicates racist attitudes in nursing, and compels nursing education to address this issue. As stated by the African-American author, James A. Baldwin, “Not everything that is faced can be changed but nothing can be changed until it is faced” (Healey, 2006, p. face page; McElrath, n.d.).

CHAPTER II

REVIEW OF LITERATURE

A review of pertinent literature is an essential component of the research process (Houser, 2008). The dissertation literature review examines what is known about a particular topic based upon past research or what gaps are present if knowledge related to the topic has not been fully developed. In addition, the review of literature (ROL) provides an in-depth discussion of concepts related to the research project. According to Boote and Beile (2005), “A dissertation literature review indicates a doctoral candidate’s ability to locate and evaluate scholarly information and to synthesize research in his or her field” (p. 4). Randolph (2009) likens the process of the literature review to the research process: (a) problem formulation, (b) data collection, (c) data evaluation, (d) analysis and interpretation, and (e) public presentation. Suggestions from these sources were utilized to formulate and execute the ROL (Boote & Beile, 2005; Randolph, 2009).

There are a number of methods for organization of the ROL. The strategy utilized by this researcher combines two of the three most common formats: conceptual format and methodological format (Randolph, 2009). This method begins with an introductory section that is followed by explication of the method utilized for data collection (i.e., the literature reviewed). The results of the reviewed literature are presented for each concept and followed by a discussion of the results.

Introduction

The ROL was organized based upon the theoretical and conceptual framework of the research project. A discussion of the process used to access, organize, and evaluate the pertinent literature is followed by a discussion of relevant theories or models of cultural competence. Research related to cultural competence and direct patient care RNs is then presented. This same process is followed related to and racism/racist attitudes. The next section discusses research that includes cultural competence and racism/racist attitudes with RNs as the population of interest. The final section is a discussion of the nurse-patient interaction. Chapter II concludes with a summary.

Method of Data Collection, Organization, and Evaluation for the Review of Literature

Initial Search Strategy and Management

Over the past year, literature searches were periodically conducted using the following specific terms pertinent to this research: racism, cultural competence, and nurs* (* utilized to include all related terms). Databases searched included Proquest, CINAHL, Academic Search Premier that allows for a simultaneous search in a number of databases, Wilson Omnifile Full Text, and Proquest Dissertation and Theses. The Internet was also utilized as a potential source of scholarly work that may not be accessible from the databases listed. The University of Northern Colorado and Nebraska Wesleyan University libraries were used because the two libraries provide access to different databases. No limitations were imposed upon these initial searches as far as date or type of publication. This strategy allowed the author to review research reports, books, news articles, materials from national forums such as The Commonwealth and the Institute of Medicine as well as related materials from governmental and regulatory

agencies (e.g., Agency for Healthcare Research and Quality and American Association of Colleges of Nursing).

Related terms employed in literature searches included discrimination, bias, prejudice, racist attitudes, transcultural nursing, culture, multicultural, cross-cultural, healthcare, healthcare providers, and health disparities. Abstracts of articles were reviewed for pertinence to this project. Citations with abstracts and sometimes full text articles were entered into the EndNote™ bibliographic management program that allows for the development of custom groups; concepts related to this research topic were developed and utilized as custom groups to manage the literature. In addition, when full text versions of articles were available, these were accessed and saved in computer folders utilizing the same concept names as the custom groups developed in EndNote™. When full text articles were not available, Interlibrary Loan provided copies of pertinent articles.

Relevant books were either accessed via one of the two libraries or were purchased by this author. For example, books by Allport (1979), Jones (1997), Ponterotto et al. (2006), and Wise (2009) were reviewed to obtain a perspective regarding the historical evolution of racism. Books related to cultural competence were read or reviewed if previously read (Andrews & Boyle, 2008; Campinha-Bacote, 2007; Leininger & McFarland, 2002, 2006; Purnell & Paulanka, 2008). Literature from various sources related to healthcare, health disparities, and healthcare providers was reviewed (Barr, 2008; Brach & Fraser, 2000; Center for Disease Control, 2007, 2009; Giddings, 2005; Halle, Lewis, & Seshamani, 2009; Institute of Medicine, 2006; Mohammed, 2006).

This process provided a broad view of the literature related to cultural competence, racism/racist attitudes, and the related issue of health disparities. Of note, no research reports or theses and only one dissertation (Skinn, 2006) exploring the relationship between cultural competence and racism in Registered Nurses (RNs) providing direct patient care was discovered, indicating a gap in nursing knowledge and supporting the assertion that this research makes an important contribution to the discipline of nursing.

As the literature was reviewed, new sources emerged from the reference lists; these were obtained and reviewed for application to this research project. In March and April of 2010, additional searches were conducted using the previously outlined key words and databases to identify the most recent sources. While this strategy provided a broad foundation, the number of sources was not only overwhelming but also unnecessary for inclusion in a focused ROL. Polit and Beck (2008) suggest the use of a coding system, matrices, or a combination of both to make “sense of the mass of information contained in the articles” (p. 118). The EndNote™ bibliographic management program was used in a comparable manner.

EndNote allows for citations to be directly imported from most electronic databases (e.g., CINAHL, Proquest). Typically, this includes the abstract plus all keywords identified by the author or publisher. The user is able to enter references manually, compose additional notes regarding each source, and develop groups within the main EndNote ‘library’; references are housed in both the main library and any of the groups designated by the user. The search feature of the program supports key word searches and author searches. The citations can be sorted by author, reference type (i.e.,

book, journal article, web source), and year of publication. These features were utilized to organize and evaluate sources for the review of literature.

As previously noted, focusing the ROL is an essential step in the process. Randolph (2009) provides a step-by-step method that includes identification of the questions to be answered by the ROL, the criteria for inclusion and exclusion, and the type of coverage approach the researcher has chosen (exhaustive review, exhaustive review with selective citation, representative sample, or purposive sample). To that end, the researcher posed these questions: What questions about cultural competence and racism can be answered by the literature review? What level of data collection, in this context meaning what literature, is appropriate for inclusion?

Focused Review of Literature

Questions to be answered by the review of literature. The following questions were pertinent to this research project and had the potential to be answered by the current literature. The conceptual framework (see Figure 1, Chapter 1) guided the development of these questions.

- Theoretical questions: What is cultural competence in nursing and what are the attendant models? What are racism/racist attitudes?
- What is the level of cultural competence of Registered Nurses (RNs) providing patient care in the United States and how has this been measured?
- What is the level of racism/racist attitudes of RNs providing patient care in the United States and how has this been measured?

Inclusion and exclusion criteria. The following inclusion criteria were developed to aid in this organizational strategy:

- Primary sources--original, peer-reviewed, and published research articles including theses and dissertations (Houser, 2008, p. 141) published in 2000 or later
- Secondary sources--comments/summaries of multiple research studies (i.e., systematic reviews, meta-analysis, and meta-synthesis; Houser, 2008, p. 141); reports from various agencies (e.g., The Commonwealth Fund, the Agency for Healthcare Research and Quality); published in 2000 or later
- Seminal articles, reviews, reports, or books related to the concepts of interest; no restriction regarding publication date
- Includes all of the concepts of interest with the population of interest; no restriction regarding publication date
- All sources related to the tools being utilized for data collection regardless of publication date

The concepts of interest included cultural competence, racism/racist attitudes or a proxy term for same, and the nurse-patient interaction. The population of interest was RNs providing direct patient care or supervising those who do in the United States generally and in Nebraska more specifically.

The following exclusion criteria were utilized:

- Research conducted outside of the United States—based upon the focus population

- Registered nurse (RN) populations other than direct patient care providers or their supervisors

Level of data collection coverage. Level of data collection does not refer to research data but rather to the literature being ‘collected’ for the ROL. Although Randolph (2009) lists four categories of coverage, this researcher utilized a combination of two in practice: exhaustive and purposive. The preliminary literature searches and reviews approached exhaustive (i.e., no new relevant articles) and were definitely iterative. Newly published articles, dissertations, or theses were added during this process.

As a final step to the ROL process, a purposive method of article selection was utilized (Randolph, 2009). With this method, “the reviewer examines only the central or pivotal articles in the field,” the key being the ability to ensure the reader “that the selected articles are, in fact, the central or pivotal articles in a field, and just as importantly that the articles not chosen are not central or pivotal” (Randolph, 2009, p. 4). With this research project, an exhaustive review was combined with the purposive method to ensure that the most pertinent information was discussed in the ROL. The 400+ citations in EndNote were sorted using key terms and ordered by year of publication. Sources that fit the inclusion/exclusion criteria were examined for potential incorporation into the final ROL. Additionally, this researcher asked, “How does this source answer the questions that should be answered by the ROL?”

Review of the Literature Based Upon Conceptual Themes/Variables of Interest

Cultural Competence: Concepts, Models, and Measurement

This section of the ROL will focus on the following questions:

- Theoretical questions: What is cultural competence in nursing and what are the attendant models?
- What is the level of cultural competence of Registered Nurses (RNs) providing patient care in the United States and how has this been measured?

A concept is a mental image of a phenomenon (i.e., an object, idea, emotion, an action; Powers & Knapp, 2006; Walker & Avant, 2005). Cultural competence is a complex, multidimensional concept. Based upon complexity and abstractness, some authors would designate 'cultural competence' as a construct rather than a concept (Chinn & Kramer, 2008; Powers & Knapp, 2006; Zander, 2007). Regardless of terminology chosen, the goal is to develop a theoretical and operational definition of the phenomenon. The theoretical definition is typically abstract and difficult, if not impossible, to measure empirically; the operational definition is based upon the theoretical definition but with a specific method of measurement (Walker & Avant, 2011).

In nursing and other healthcare professions, there are a number of extant models and theories related to cultural competence. Braithwaite (2003) evaluated six models of cultural competence for utility in research: two developed by social workers, one by a psychologist, and three by nurses including Campinha-Bacote (2007) and Purnell (2000; Purnell & Paulanka, 2008) whose model was developed for use by all healthcare

providers as well as ancillary personnel. The newly published *Core Curriculum for Transcultural Nursing and Health Care* (Douglas & Pacquiao, 2010) discusses 15 interdisciplinary theories and models based upon anthropology (Marvin Harris), critical science/theory (Hegel, Marx...Habermas), and ecosocial model (social epidemiology) (Nancy Krieger) to name a few examples. Additionally, this source provides a detailed outline of nine transcultural nursing models and theories: the theory of culture care diversity and universality (Madeline Leininger), the process of cultural competence in the delivery of health care services (Josepha Campinha-Bacote), Glittenberg's Project GENESIS: community-based action research model (Jody Glittenberg), and Spector's model of cultural diversity in health and illness (Rachel Spector; Douglas & Pacquiao, 2010). It is apparent that a number of cultural-related theories and models exist across disciplines. An overview of cultural competence follows with a subsequent in-depth discussion of three nursing-generated cultural competence theories/models.

Overview—healthcare disciplines. Anthropologists originated the concept of culture and caution healthcare providers against viewing culture as static or cultural competence as a list of what should or should not be done with each racial or ethnic population group (Carpenter-Song, Schwallie, & Longhofer, 2007; Kleinman & Benson, 2006). Leininger, a registered nurse with a doctoral degree in anthropology, emphasizes the diversities and universalities of culture that are congruent with other scholars from the discipline of anthropology (Carpenter-Song et al., 2007; Kleinman & Benson, 2006; Leininger & McFarland, 2006). According to Zander (2007), psychologists and those in the counseling disciplines began addressing the issue of cultural bias in the 1970s. Sue and colleagues (1982) identified the need for cross-cultural counseling/ therapy and

proposed a framework outlining the characteristics necessary to be a “culturally skilled counseling psychologist” (p. 49) including the following three categories:

“beliefs/attitudes, knowledges [*sic*], and skills” (pp. 49-50). This framework, some with modifications, has been the basis of many definitions and standardized measures of cultural competency (Geron, 2002). However, there is no clearly identified definition, model, measure, or theory to which all healthcare professions and institutions ascribe.

The lack of comprehensive standards related to culturally competent care meant that providers (individual as well as institutional) had no clear guidance for providing appropriate care in the healthcare setting. In 1997, the Office of Minority Health (OMH) began work to develop national standards “that would support a more consistent and comprehensive approach to cultural and linguistic competence in health care” (Office of Minority Health, 2001, p. 1). The culturally and linguistically appropriate services (CLAS) standards were published in the Federal Register December of 2000 and include 14 standards as well as the following definition of cultural competence: “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” (Office of Minority Health, 2001, p. 131). As noted in Chapter I of this work, the OMH has recommended that all of these standards become federal mandates with the attendant financial incentives for compliance (Office of Minority Health, 2007).

There is a movement among healthcare professions to frame cultural competence within the larger issue of quality of care (Fernandopulle et al., 2003; Finkelman & Kenner, 2007; Institute of Medicine, 2001a, 2001b, 2003). The Commonwealth Fund is a private foundation that “aims to promote a high performing health care system that

achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults" (The Commonwealth Fund, 2010). This mission is carried out by financially supporting research on healthcare issues/problems as well as by providing grants to improve healthcare practices and policy.

A search of The Commonwealth Fund's website using the key words *cultural competence* returned 190 results including research reports, grant funding reports, and video seminar programs. Adding the term *quality* to the search only decreased the results to 175 items, indicating the strong connection between cultural competence and quality in this organization (The Commonwealth Fund, 2010). A web-cast of a Commonwealth Fund sponsored seminar provided an overview of research related to cultural competence (Beal & Saul, 2006). This seminar featured presentations by physicians, some with additional credentials in public health, utilizing research results to provide insight regarding quality of healthcare including patient outcomes for underserved, racially, and ethnically diverse patient populations.

The seminar begins with several definitions of cultural competency (slide 5), none of which are the definition advocated in the CLAS document; however, the CLAS standards are reviewed as they relate to the overarching issue of quality of care (Beal & Saul, 2006). Beal advocates a two-pronged approach to quality of care for the underserved (slide 3): Technical Quality of Care and Interpersonal Quality of Care (Beal & Saul, 2006). Technical care alone does not equal quality; patient-centered care and cultural competency (i.e., Interpersonal Quality of Care) are required to provide quality healthcare to underserved populations, which are defined as low income and racial/ethnic

minorities. Inherent within this framework is respect for the preferences of the underserved. In addition, cultural competency is required to provide quality care to the racially and ethnically diverse patient population within the underserved population group. Dr. Beal supported this assertion with a discussion of Lieu et al.'s research (2004).

Research conducted by Lieu et al. (2004) found an association between cultural competence and improved quality of care for children ($n = 1663$) with persistent asthma. The setting for this research included healthcare facilities ($N = 83$) associated with five large nonprofit health plans in three states (Massachusetts, California, and Washington) with the target population being Medicaid-insured children. These researchers utilized the culturally and linguistically appropriate services (CLAS) criteria developed by the Office of Minority Health (2001) as the measure of cultural competence (summary score range = 0-6 points). Quality of care indicators were based on national guidelines from the American Academy of Pediatrics and the National Asthma Education and Prevention Program (Lieu et al., 2004).

Using regression analysis, the final model demonstrated that patients of practice sites with the highest cultural competence scores (5-6 points) were less likely to be under using preventive asthma medications (data from parent report at follow-up; odds ratio: 0.15; 95% confidence interval: 0.06-0.41 highest to lowest categories; Lieu et al., 2004). These practice sites also received better parent ratings of care. Beal and Saul's (2006) discussion of this research (slide 12) emphasizes that this is one of the first large studies that used regression to control for many factors and demonstrated the potential for cultural competence to impact patient outcomes.

Beach et al.'s model (2006) illustrates the intersection of patient-centered care and culturally competent care (slide 29), leading to quality of care that in turn supports improved health outcomes (Beal & Saul, 2006). In this model, patient-centered care is distinct from culturally competent care but shares common actions that support both (e.g., Is aware of own biases and assumptions, Builds rapport and trust; Beach et al., 2006, p. 17). According to Beach et al., the aim of cultural competence is to make care more equitable (Beal & Saul, 2006). While this section of the presentation did not include discussion of specific research, the authors did link two of the Institute of Medicine's (2001b) aims for improvement in the quality of healthcare (patient-centered care and equitable care) with cultural competence (Beach et al., 2006; Beal & Saul, 2006).

The presentation of Ngo-Metzger et al. (2006) focused on the impact of discrimination on patient outcomes. Because discrimination is more closely aligned with the concept of racism, this section of the presentation is discussed within the racism section of this chapter.

Nursing

Because of Leininger's visionary work, nursing was one of the first healthcare disciplines to address the knowledge and skill needed to care for diverse populations (Leininger, 1967, 1997, 1999). Dr. Leininger's theory of culture care diversity and universality utilizes the Sunrise Enabler Model to depict the dimensions of the theory (Leininger, 1997; Leininger & McFarland, 2006). An in-depth discussion of her theory follows.

The first major theoretical tenet is that care differences and commonalities are present within and among the various cultures of the world; the meanings and uses of

these *diversities* and *universalities* among the cultures of the world need to be uncovered and understood (Leininger & McFarland, 2002). Developing an understanding of care diversities and universalities requires both *emic* (insider) and *etic* (outsider) knowledge discovery (Leininger & McFarland, 2006).

The second theoretical tenet states that “worldview, social structure factors..., and professional care factors would greatly influence cultural care meanings, expressions, and patterns in different cultures” (Leininger & McFarland, 2002, p. 78). Embedded within these structures are *generic* (folk) care practices. Leininger predicted that these generic practices were different from and essential to *professional* care practices (Leininger, 1997; Leininger & McFarland, 2002).

Finally, as the third theoretical tenet, Leininger conceptualized three modes of nursing decisions and actions to provide culturally congruent care: (a) culture care preservation and maintenance, (b) culture care accommodation and/or negotiation, and (c) culture care restructuring and/or repatterning (Andrews & Boyle, 2003; Leininger, 2002; Leininger & McFarland, 2002, 2006). Rarely does a nursing theory prescribe nursing decisions or actions; Leininger’s theory encourages the researcher and the practitioner to apply the cultural knowledge gained for the benefit of the client/patient (Leininger, 1997).

Several sources list 13 assumptive premises for this theory (Leininger, 1995, 1997; Leininger & McFarland, 2002) and one source lists 11 (Leininger & McFarland, 2006). In her 2002 article, in the interest of brevity, Leininger shares the following five assumptive premises:

1. Care is the essence of nursing and a distinct, dominant, central, and unifying focus.

2. Culturally based care (caring) is essential for well-being, health, growth, survival, and in facing handicaps or death.
3. Culturally based care is the most comprehensive, holistic, and particularistic means to know, explain, interpret, and predict beneficial congruent care practices.
4. Culturally based caring is essential to curing and healing, as there can be no curing without caring, although caring can occur without curing.
5. Culture care concepts, meanings, expressions, patterns, processes, and structural forms vary transculturally, with diversities (differences) and some universalities (commonalities). (Leininger, 2002, p. 192)

Although Leininger originally termed the graphic representation of her theory the “Sunrise Model” (Leininger, 1995, p. 108; Leininger, 2002, p. 191; Leininger & McFarland, 2002, p. 80), a more recent publication names the model “Leininger’s Sunrise Enabler to Discover Culture Care” (Leininger & McFarland, 2006, p. 25). Her model depicts all dimensions of the theory of culture care diversity and universality and can be accessed on the Transcultural Nursing Society’s website (<http://www.tcn.org/Theories.html>). Leininger’s body of work is useful as a theoretical framework for research, to guide nursing practice with people of diverse cultures, and to facilitate understanding of culturally competent care within a nursing education setting.

While Leininger was the first nursing scholar to develop a widely acknowledged theory of cultural care, other nurses eventually followed. The Purnell model for cultural competence was developed for utilization by all healthcare providers, not just nursing, and includes 12 cultural domains (Purnell, 2000; Purnell & Paulanka, 2005, 2008). Campinha-Bacote’s (2002, 2007, 2008a) model emphasizes cultural competence as an ongoing process with five major constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. The 3-Dimensional Puzzle Model of Culturally Congruent Care identifies four puzzle pieces at the provider level of care:

cultural awareness, cultural competence, cultural diversity, and cultural sensitivity (Doorenbos et al., 2005; Schim et al., 2006a, 2007). Zander's (2007) construct analysis identified three elements of cultural competence: cultural awareness, cultural knowledge, and cultural skill. Other nursing scholars have developed similar conceptualizations of cultural competence and/or culturally congruent care. Shen (2004) provides an annotated bibliography of models of cultural competence and cultural assessment plus cultural assessment guides used in nursing (e.g., Giger and Davidhizar, Andrews and Boyle, Spector). While most models have concepts in common (e.g., cultural awareness, cultural sensitivity), no one model is accepted as the leading or most frequently employed model of cultural competence in nursing. Two of these models are discussed in-depth in the subsequent section with evaluation of utility for this project.

Campinha-Bacote: The process of cultural competence. Campinha-Bacote's (2002, 2007) model views cultural competence as an ongoing process by which a healthcare provider works toward *becoming* culturally competent rather than *being* culturally competent. Her model shows five overlapping circles, each containing one of the five constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire (Campinha-Bacote, 2002, p. 183). All five circles intersect in the middle of the model—the process of cultural competence (Campinha-Bacote, 2002, p. 183). Over time, the depiction of the model has changed. Campinha-Bacote (2010) states,

Finally, in 2010, I began collecting evidenced-based [*sic*] research studies using my model and tool (IAPCC-R), and discovered that the pivotal and key construct in the process of becoming culturally competent was cultural encounters. With this added research-based knowledge I amended the pictorial representation to focus and center around the construct of cultural encounter... In this 19 year journey of conceptualizing a culturally conscious model of healthcare delivery, I

have recognized the dynamic changes in this field and therefore continue to be open to further revisions of my model. (para. 2)

This model is copyrighted by Campinha-Bacote and therefore is not included in this document. However, the model is available on Campinha-Bacote's website: (<http://www.transculturalcare.net/>).

The Inventory for Assessing the Process of Cultural Competence (IAPCC) was originally developed in 1997 and measured four of five constructs, excluding cultural desire (Campinha-Bacote, 1999, 2002, 2008a). Construct validity was addressed by virtue of the fact that the tool was based upon theoretical conceptualizations. In addition, the author used the known-groups technique with a group of 200 RNs in a pretest/posttest evaluation of the instrument (Campinha-Bacote, 1999). Content validity was addressed by using five transcultural healthcare experts including a certified transcultural nurse to review the tool (Campinha-Bacote, 1999).

In 2002, the IAPCC was revised by adding questions to measure the fifth construct, Cultural Desire, and was renamed the IAPCC-R (Campinha-Bacote, 2008a, 2008b). Scores on the tool range from 25-100 with a higher number indicating a greater level of cultural competence. The author provides the following specific designations: culturally proficient--91-100, culturally competent--75-90, culturally aware--51-74, and culturally incompetent--25-50 (Campinha-Bacote, 2007, p. 123).

The IAPCC-R has been utilized in research conducted in the United States as well as internationally. Reliability reports from 18 research projects within the United States showed coefficient Cronbach's alpha from a low of .72 to a high of .90 with most falling between .83 and .89. The author reports an average reliability coefficient Cronbach alpha of .83 (Campinha-Bacote, 2007, p. 120; Kardong-Edgren & Campinha-Bacote, 2008, p.

39). Two researchers reported Guttman Split Half Coefficients of .83 and .77 (Campinha-Bacote, 2008b). This measure is expected to be lower than the coefficient alpha but should exceed .6 (Houser, 2008).

Internationally, the IAPCC-R has been used in Israel, Sweden, South Africa, Taiwan, and Canada. Reliability reports reveal an average coefficient Cronbach alpha of .76 (Campinha-Bacote, 2007, p. 120). Overall, reliability measurements support the use of this instrument as a method to measure cultural competence in the intended populations that include RNs (Campinha-Bacote, 2010).

Campinha-Bacote's IAPCC-R tool would be appropriate for use in this research project. However, one of the considerations in conducting research with this tool is the cost. When either mailed as a paper tool or used in the online environment, the cost is \$20 per participant. This fee must be paid for every *potential* participant; the researcher is allowed to post one copy of the tool to the online site but must specify and pay for the number of subjects who *could* access the tool (J. Campinha-Bacote, personal communication, September 21, 2009). The cost would be \$20,000 if the invitation to participate was sent to 1000 RNs! Dr. Campinha-Bacote suggested having those who were willing to participate contact this researcher so that only the necessary number of participants was identified. Even this amount (approximately 150-200 participants at \$20 = \$3000-\$4000) was prohibitive for this project's limited budget. Thus, an equally compelling model of cultural competence with an attendant instrument was sought by this researcher.

Schim, Doorenbos, and colleagues: Cultural competence. In the 1990s, Stephanie Schim and June Miller were called upon to assist a large urban healthcare

system seeking to provide culturally appropriate care to their patient population (Schim et al., 2007). Over time, Schim, Doorenbos, and various other colleagues developed a body of work related to cultural competence (Doorenbos et al., 2005; Schim et al., 2005, 2006a, 2006b, 2007). Their work includes a model of cultural competence, a tool to assess cultural competence, and several research projects exploring and measuring cultural competence. These researchers developed their model and measurement tool for a broad audience from various disciplines, cultural groups, and education levels (Doorenbos et al., 2005, p. 325; Schim et al., 2007, p. 109).

The 3-Dimensional Puzzle Model of Cultural Competence

The model by Schim and colleagues is a work in progress. As of 2007, the authors show the Provider Level, Client Level, and Outcome as the three dimensions of their model (Schim et al., p. 104). The Provider Level of the model is well developed; the Client Level has yet to be developed but includes such concepts as “immigration status, generation, acculturation, language facility, and political history” (Schim et al., 2007, p. 108). The Outcome of the model is culturally congruent care. The Provider Level of the model is pertinent to the focus of this research project since RNs providing direct patient care is the population of interest.

The four constructs of the 3-Dimensional Puzzle Model of Cultural Competence (3DPM) Provider Level are cultural diversity, cultural awareness, cultural sensitivity, and cultural competence (Doorenbos et al., 2005; Schim et al., 2006a, 2007). Schim and Miller originally conceptualized the model as “stair steps with diversity as the bottom step and cultural competence as the top step” (Schim et al., 2007, p. 108). Over time, the visualization of the model changed to capture the essence of the relationship between the

four constructs. The puzzle conceptualization captures the nonlinear, interconnectedness of the major constructs.

The construct *cultural diversity* is stated as “a fact” (Doorenbos et al., 2005, p. 326; Schim et al., 2005, p. 355; 2006a, p. 303) and is broadly defined to include racial, ethnic, language, religion, gender, sexual orientation, ability/disability, and even access to technology as areas impacting the provider-patient interaction (Schim et al., 2005, 2006a). Cultural diversity is context and time dependent. In a given community, the amount and type of diverse cultures present varies. Schim et al. (2007) refer to Pipher’s (2002) work with immigrants as an illustration of this point. Pipher’s work centered around the increasingly diverse population of Lincoln, Nebraska. This author has been closely aligned to this community over the years and observed the change in diversity that Schim et al. (2007) and Pipher (2002) explicate.

The type and amount of cultural diversity an individual experiences can logically influence cultural competence. Others (Campinha-Bacote, 2007, 2008a; Leininger & McFarland, 2002, 2006) identify cultural exposure as a necessary step in the process of becoming culturally competent. In the context of the 3DPM, the cultural diversity piece logically fits with the cultural competence piece. The more experience a healthcare provider has with a diverse population, the greater the likelihood that awareness and sensitivity will develop. In total, diverse experience, heightened awareness, and increased sensitivity have potential to improve cultural competence.

Cultural awareness in this model is defined as “the knowledge of those areas in which major between-group differences often occur. Such knowledge allows the asking of individual questions that are likely to yield meaningful responses” (Schim et al., 2007,

p. 106). This construct requires a cognitive learning process. Cultural awareness includes developing knowledge plus a conscious, intentional thought process to analyze, synthesize, and evaluate this knowledge, thus avoiding the risk of being unconsciously incompetent (Campinha-Bacote, 2007; Purnell & Paulanka, 2005, 2008).

The knowledge developed within the cultural awareness construct enables the healthcare provider to recognize major areas of potential cultural differences and then to assess the individual's preference in that particular area. For example, food preferences and religion-based food restrictions are a major area of cultural difference. This knowledge leads the provider to discuss the individual's preference/usual practice regarding food preparation and consumption. A personal experience may help illustrate.

This author had invited an Arabic-speaking family for a meal. Because of Islamic law that allows no contact with pork, a new skillet and knife were purchased by this author to use during meal preparation. This information was shared with the guests in an attempt to increase their comfort level regarding the food being served. The husband said, "Ahhh, Linda. You not need to do that. We do not follow all those rules. Sometimes we not care" (Kahlat, personal communication, September, 2001). Although this example did not result in a problem, making assumptions based upon what a cultural group typically does can adversely impact the relationship between healthcare provider and patient/client and lead to unwarranted stereotypes. Other cultural theories and models provide guidance as to areas where cultural differences and similarities should be assessed as a part of the cultural awareness process (Leininger, 1997; Leininger & McFarland, 2006; Purnell, 2000; Purnell & Paulanka, 2008). As illustrated by the 3DPM,

cultural awareness is influenced by diversity and sensitivity that in turn influence cultural competence.

Schim et al. (2007) describe *cultural sensitivity* as an “affective or attitudinal construct” (p. 107) that includes the provider’s own attitudes, values, beliefs, and insights as well as his/her attitudes toward others. Understanding one’s own culture facilitates understanding of other cultures—how are we alike, how are we different. Equally important is a grasp of the culture of healthcare in the United States as well as within the provider’s own healthcare organization. Developing cultural sensitivity allows the provider to view his/her own culture(s) through the eyes of the patient/client. It is through this lens that the provider develops an appreciation for how absurd some healthcare practices must seem to those of a different culture. Developing cultural sensitivity encourages the healthcare provider to critically analyze healthcare practices that may be modified, thus providing care that is more congruent with the patient’s cultural practices.

Three research reports discuss communication skills (verbal and non-verbal) as an element of this construct (Schim et al., 2005, 2006a, 2006b). However, communication is not included in the in-depth discussion of the more recently published model (Schim et al., 2007) or in the research evaluating the psychometrics of the Cultural Competence Assessment (CCA) instrument (Doorenbos et al., 2005). The discussion of communication skills within cultural sensitivity is justified in that the skillful use of communication is a way to demonstrate respect (Schim et al., 2006a). In their earlier work, this is described as “an openness to ‘otherness’, and respect for the complex ways in which cultural issues influence... healthcare...” (Doorenbos et al., 2005, p. 326). In

some instances, providers learn another language to facilitate communication. When this is not feasible, the culturally sensitive healthcare provider utilizes translators and interpreters effectively to benefit the patient/client (Schim et al., 2005, 2006b)

Perhaps the most succinct description of cultural sensitivity is as follows: “The focus of cultural sensitivity is on approaching the individual patient or community with humility and taking a learner role rather than assuming a position of sufficient knowledge regarding any particular group” (Schim et al., 2007, p. 107). This is often difficult for healthcare providers who typically, by virtue of a health-related knowledge differential, are in an authority role in the nurse-patient interaction (Mohammed, 2006). An attitude of respect is the underlying requirement for developing cultural sensitivity.

The final construct in the 3DPM Provider Level is *cultural competence*. Schim and colleagues define cultural competence as behaviors or actions taken in response to cultural diversity (fact), awareness (knowledge), and sensitivity (attitude; Schim et al., 2005, 2006a, 2007). These culturally competent behaviors are the observable outcomes of the integration of cultural diversity, awareness, and sensitivity. The authors share examples of these practice behaviors: a focused cultural assessment, learning about the cultures present in the community, asking about expectations for care, adapting care to respect cultural practices or taboos, and seeking additional information and resources (Doorenbos et al., 2005; Schim, et al., 2007).

The degree of cultural competence of the healthcare provider varies in scope and depth. Scope refers to the number of diverse groups/individuals that the provider is able to care for while demonstrating culturally competent behaviors. Depth refers to the level of competency with a particular group or an individual possessed by the provider (Schim

et al., 2007). For example, this author's scope includes Native Americans (two tribes in particular), people of Arab cultures, and Vietnamese people. However, the depth of competency is claimed only with Vietnamese women in particular and less so with Vietnamese men. This author's cultural awareness (knowledge) development has been more extensive with the Vietnamese people and has developed over a period of seven to eight years. As noted by Schim et al. (2007), it is virtually impossible and unnecessary for a healthcare provider to develop expertise with every possible cultural group. If cultural diversity brings the healthcare provider into contact with new groups, cultural awareness (knowledge) and cultural sensitivity (attitude) will support the development of expertise leading to cultural competence with the new cultural group.

Although reasonable to depict the four constructs as interlocking puzzle pieces, it is also apparent that cultural competence is the goal, albeit via a lifelong process, and that cultural diversity, cultural awareness, and cultural sensitivity move the healthcare provider toward that goal. When considered from this perspective, cultural competence could be the completed puzzle rather than one piece of the puzzle. One source provides insight missing from other articles about the 3DPM. Doorenbos and Schim (2004) state, "Cultural competence is the ultimate goal and is located at the top level of the model. Cultural competence is defined as the incorporation of diversity (fact), awareness (knowledge), and sensitivity (attitude) into everyday practice and behaviors" (p. 29). This explanation addresses the concerns of this author regarding the conceptualization of the 3DPM. Unfortunately, the model does not clearly demonstrate the intended relationships between the constructs. Later publications (Doorenbos et al., 2005; Schim et al., 2007) imply interconnectedness but do not explicate diversity, awareness, and

sensitivity as antecedents to cultural competence behaviors (Walker & Avant, 2005, 2011). Schim and colleagues have not fully articulated the model, stimulated scholarly discourse, or solicited critique (Schim et al., 2007, p. 104). It is logical to expect some future modification to the model as this is accomplished.

The Cultural Competence Assessment (CCA)

The lack of cultural competence measurement instruments that are valid and reliable for a number of cultures, various healthcare disciplines, and work roles with the range of educational levels in the United States healthcare system is problematic for researchers (Fortier & Bishop, 2004; Schim et al., 2003, 2007). The following limitations in measuring cultural competence were identified by Schim and colleagues: (a) focusing on one particular category of healthcare provider, (b) testing racial/ethnic group-specific knowledge rather than the broader constructs of cultural competence, (c) measuring self-efficacy rather than the broader constructs of cultural competence, and (d) written at an advanced reading level which is problematic for interdisciplinary teams who vary from high school to post graduate education level (Doorenbos et al., 2005).

The attention to educational level is very important. For example, in the discipline of nursing, educational levels range from Licensed Practical (or Vocational) Nurse (LPN or LVN) with typically one year of post high school education to RNs who hold Doctor of Philosophy (Ph.D.) or Doctor of Nursing Practice (DNP) credentials, representing approximately 10 years of education post high school. Nursing assistants or nurse aides typically receive 80 hours of training and may not be high school graduates.

Similar situations exist in other healthcare professions. According to J. Hardy (personal communication, June 26, 2010), a Regis University physical therapy student,

the discipline of physical therapy is working toward the Doctor of Physical Therapy (DPT) as the entry to practice level; however, current practicing physical therapists include those with a bachelor's degree or a master's degree as well as those with doctoral credentials. Physical therapy aides are also common. Based upon their interest in hospice care that uses an interdisciplinary framework, these nursing scholars sought to develop an instrument "for measuring cultural competence across disciplines and educational levels" (Doorenbos et al., 2005, p. 325).

The Cultural Competence Assessment (CCA) instrument is valid and reliable (Schim et al., 2003, 2007). Doorenbos et al. (2005) provide the following overview of the reliability and validity of their tool. Test-retest reliability showed high correlation ($r = .87, p = .002$) over a four month period. The overall reliability of the CCA using Cronbach's alpha was .89 with two subscales (CAS and CCB) scoring .91 and .75, respectively. Construct validity was established by factor analysis and correlation of CCA scores with an established instrument--Camphina-Bacotes's IAPCC (2002). For an in-depth discussion of the development of the CCA, see Chapter III. Methodology. The next section addresses the second question to be answered by the ROL: What is the level of cultural competence of RNs providing patient care in the United States and how has this been measured?

Cultural Competence of Direct Patient Care RNs in the United States

How to best measure cultural competence is an issue of ongoing discussion in academia. Geron's (2002) analysis focused primarily on the shortcomings of various tools. Kumas-Tan and colleagues (Kumas-Tan, Beagan, Loppie, & MacLeod, 2007) identified 54 instruments and then analyzed the 10 most frequently used tools based upon

a set of structured questions developed by one of the researchers. Their goal was to identify underlying assumptions about what constitutes cultural competence. They concluded that problematic assumptions were embedded within these instruments. They suggested, for example, that the definition of culture needed to encompass “not only ethnicity and race, but also (at least) gender, age, income, education, sexual orientation, ability, and faith” (Kumas-Tan et al., 2007, p. 555). The CCA instrument (Doorenbos et al., 2005; Schim et al., 2003, 2007) was not one of the instruments evaluated but included this expanded definition of culture within the theoretical framework of the instrument. Campinha-Bacote’s IAPCC-R (2008a) was evaluated as a highly utilized instrument but with similar problematic assumptions. The authors opined that the power relations of social inequality were ignored in all of these instruments and should be assessed as a component of cultural competence.

The Quick Discrimination Index (Ponterotto et al., 1995, Ponterotto, Potere, 2002) was included in this review. However, this tool was not designed nor intended to be used as a measure of cultural competence (J. Ponterotto, personal communication, March 10, 2010). It would have been more appropriate for these authors to review the Multicultural Counseling Knowledge and Awareness scale (MCKAS; Ponterotto, Gretchen, 2002) as a measure of cultural competence.

As a final example, Krentzman and Townsend (2008) conducted a rigorous review of multidisciplinary measures of cultural competence that included the aforementioned MCKAS (Ponterotto, Gretchen, et al., 2002), the IPACC-R (Campinha-Bacote, 2008a), and the CCA (Schim et al., 2003). Their work was focused on utility for social work education but is useful for any healthcare discipline. The CCA scored well,

receiving only two minus marks in the evaluation matrix--one for lack of items related to social justice or racism and one for lack of social desirability scale that was in fact added to a later version of the CCA (Schim, 2009). It is apparent that there are numerous instruments available to measure cultural competence. Moreover, the qualitative research tradition should not be overlooked as an additional source of in-depth knowledge to be evaluated.

Nursing students have been evaluated for cultural competence by numerous researchers, frequently using a pretest-posttest design to evaluate the efficacy of an educational intervention (Kardong-Edgren & Campinha-Bacote, 2008; Musolino et al., 2010; Rew, Becker, Cookston, Khosropour, & Martinez, 2003). Based upon the inclusion criteria developed for this ROL, the subsequent discussion primarily focuses on research related to cultural competence and practicing nurses; it excludes nursing students with the exception of one research project that included post-licensure RNs in either a degree completion program or a master's level program with other working RNs (Lampley, Little, Beck-Little, & Yu, 2008). The research literature measuring cultural competence of non-student, direct patient care RNs in the United States is limited. Therefore, this research project adds to the body of nursing knowledge related to cultural competence in the direct patient care RN.

Schim and colleagues (2005) utilized their CCA tool in two research projects beyond the research conducted to develop the instrument discussed in Chapter III. While neither study directly reported cultural competence level of the RNs in the study, valuable data related to the ROL question were generated.

The purpose of Schim et al.'s (2005) research was to identify variables for association with cultural competence in urban, hospital-based healthcare providers in Ontario and Michigan. They utilized a convenience sample of 145 providers ($n = 71$ Ontario; $n = 74$ Michigan), 108 of whom were nurses. The remainder of the participants included clerical workers, nutritionists, occupational and physical therapists, administrators, and physicians. Sample size was based upon the expectation of a medium-sized relationship with an α of .05 and β of .20, which requires 114 participants for regression analysis with eight independent variables.

The researchers identified the following independent variables: (a) age, (b) years of hospital experience, (c) cultural competency training, (d) educational attainment, (e) number of diverse groups cared for in the last 12 months, (f) self-identified race or ethnicity, (g) discipline, and (h) state or province on the Cultural Awareness and Sensitivity (CAS) subscale and the Cultural Competence Behavior (CCB) subscale (i.e., to ascertain if area of residence was associated with either or both of these subscales). Standard multiple regression yielded the amount of variance accounted for by each variable. Two of the independent variables were significantly associated with CAS scores: prior cultural competence training ($p = .01$) and level of educational attainment ($p = .002$). The CCB subscale was significantly associated with the same two independent variables at $p = .002$ and $p < .001$, respectively, plus country ($p = .016$; Schim et al., 2005).

For statistical analysis, the researchers combined discipline categories into nursing and non-nursing. The mean scores on the CCA plus the two subscales were not reported for either group. In the discussion section, the researchers state, "Scores on the

CAS indicated that hospital-based providers in both areas (Ontario and Michigan) were generally culturally aware and sensitive” and that the CCB scores were “somewhat lower in both groups than the desirable mean scores for each subscale” (Schim et al., 2005, p. 357). The desirable scores were reported in an earlier research project: range of 1-5 with higher scores indicating greater cultural competence; an excellent mean score for each subscale is 4.5-5 (Doorenbos & Schim, 2004).

The researchers reported mean CCA scores for cultural competence by levels of educational attainment for Ontario, Michigan, and combined. Nursing could be included in any of the top three educational levels: associate degree (3.41), bachelor’s degree (3.67), or graduate degree (3.76; Schim et al., 2005). Of note, none of these scores were close to the stated excellent mean score of 4.5 to 5. It is possible that the researchers expected a higher level of cultural competence than was demonstrated in their research.

Approximately one year later, Schim and colleagues used a descriptive design specifically with hospice nurses to examine variables associated with cultural competence (Schim et al., 2006a). The hospice nurses were a convenience subsample of hospice employees and volunteers who were in attendance at hospice meetings where the data collection occurred. The CCA was utilized in paper and pencil format for data collection. Alpha level of .05 was set a priori to determine significance. Standard multiple regression analysis was utilized to determine the amount of variance accounted for by each of the following independent variables: (a) age, (b) cultural competency training, (c) educational attainment, and (d) self-identified race or ethnicity (Schim et al., 2006a, p. 304). The researchers calculated that a sample size of 82 was necessary for this analysis;

the sample size achieved was 107, thus providing adequate power to support the regression analysis.

Cultural diversity experience was reported as an index number reflective of the number of groups hospice nurses reported working with in the past year: range of 1-7 with a mean of 3.4 ($SD = 1.4$). The authors reported the means and standard deviations for each of the 16 items in the CCB subscale. The highest scoring item--*I act to remove obstacles for people of different cultures when clients and families identify such obstacles to me* had a mean of 4.10 ($SD = 1.08$) and the lowest scoring item--*I have resource books and other materials available to help me learn about clients and families from different cultures* had a mean of 2.63 ($SD = 1.30$), all with a range of 1-5 (Schim et al., 2006a, p. 305). Regression analysis indicated that the set of independent variables tended toward significance at 11% for the CCB subscale but that only *prior diversity training* reached significance ($P = .011$). Regression analysis with the CAS subscale and the set of independent variables attained significance at 12%. However, only *educational attainment* (college or higher) reached significance ($P < .05$).

Unfortunately, the researchers did not report the mean level of cultural competence for the hospice nurses for the CCA or the subscales (CAS and CCB; Schim et al., 2006a). The findings supported the importance of educational attainment and cultural diversity training in achieving cultural competence but did not answer the ROL question regarding level of cultural competence of RNs providing patient care. Evaluation of the individual item scores on the CCB has implications for designing cultural diversity training as well as for nursing education regarding cultural competence.

Hagman (2006, 2007) conducted a mixed method research project based upon an earlier quantitative pilot project (Hagman, 2004) with the aim of measuring cultural self-efficacy and exploring how cultural self-efficacy was achieved with RNs in New Mexico. Self-efficacy is described within the framework of Bandura's social learning theory--that one can successfully execute the behavior necessary to reach the desired outcome--and incorporates how much effort will be expended and for how long (Bandura, 1977; Bandura, Adams, & Beyer, 1977). Cultural self-efficacy (CSE) refers to the perceived ability to care for persons from various cultural/racial/ethnic groups. Hagman utilized the Cultural Self-Efficacy scale developed by Bernal and Froman (1987) and revised by Kulwicki and Bolonik (1996) to measure CSE with five racial/ethnic population groups in New Mexico RNs. While CSE is not conceptually the same as cultural competence, CSE provides an indication of the RN's comfort/confidence level in their ability to deliver culturally appropriate care. This is logically related to the RN's cultural knowledge, attitude, and behaviors which have been identified as cultural competence components (Campinha-Bacote, 2002; Schim et al., 2003; Sue et al., 1982; Zander, 2007). Therefore, this research is appropriate for inclusion in the ROL even though it does not directly answer the question regarding level of cultural competence of RNs providing patient care in the United States.

The pilot study included a convenience sample of 15 licensed RNs in New Mexico (Hagman, 2004). The ethnic groups included Middle East/Arab, Hispanic, African American, Native American, and Asian Pacific Islander. The items in the Cultural Self-efficacy Scale (CSES) are grouped into three categories (knowledge of cultural concepts, comfort in performing cultural nursing skills, and knowledge of

cultural patterns) and are rated on a scale of 1 to 5 (*very little confidence* to *quite a lot of confidence*, respectively). The concepts and skills are measured once with the cultural patterns being measured for each ethnic group.

The knowledge concepts mean was 3.60 ($SD = .88$) with the cultural nursing skills mean at 3.54 ($SD = .82$; score range = 1 to 5). The cultural pattern scores varied across the five ethnic groups from a low score of 2.24 ($SD = 1.01$) for Middle East/Arab group to a high score of 3.56 ($SD = .70$) for Hispanic persons. The total mean scores were correlated with the independent variables but this was of questionable value with a sample size of 15; however, age and number of years as an RN correlated with the concept/skills score ($p = <.001$) as did the scores of the participants who had studied Leininger's (Leininger & McFarland, 2006) theory ($p = .003$). Based upon comments from participants, the Middle East/Arab group was deleted and White non-Hispanics was added, the rationale being that this change more accurately reflected the patient population of New Mexico. In preparation for the larger scale research project, the researchers revised some areas of the instrument, which were then reviewed by an expert panel that included the authors of the CSES (Hagman, 2004).

The next phase of this research was a large scale descriptive, correlational project utilizing a random sample of 1000 RNs from the total population of 13,373 RNs licensed in New Mexico with an in-state mailing address (Hagman, 2006). The response rate was 41% ($n = 398$). The five ethnic groups included in this research project were White non-Hispanic, Hispanic, African American, Native American, and Asian American. The sample of RNs included 58% White non-Hispanic, 15% Hispanics, 0.2% African American, 3.3% Native American, 0.5% Other, and 21% choosing multiples of ethnic

choices. As is typical with the RN nursing workforce nationally (Agency for Healthcare Research and Quality, 2005; Spratley, Johnson, Sochalski, Fritz, & Spencer, 2000), the percent of White non-Hispanic nurses in the sample (58%) was greater than that for the general population of New Mexico (50.4%) and other ethnic groups within the RN population were less than the general population of New Mexico.

Results of particular interest for this author's research project included the level of cultural self-efficacy (CSE) of RNs licensed to practice in New Mexico. The researcher reports, "Despite an ethnically diverse population in the state, New Mexico nurses report only a moderate cultural self-efficacy" (Hagman, 2006, p. 110). The highest mean score was 4.53 (range 1-5) for caring for the White non-Hispanic ethnic group with scores of 4.15 for the Hispanic group and 3.42 for the Native American group. These results were expected since these three groups were reported as the most often cared for groups by the RNs. This finding supports the assertion of Campinha-Bacote (2010) that experience with diverse populations is fundamental to the development of cultural competence. It is logical to assume that *being* culturally competent increases cultural self-efficacy as well.

The participants who reported having studied Leininger's theory of culture care diversity and universality (Leininger & McFarland, 2006) reported higher levels of CSE across all five ethnic groups (*yes*, 2.80-4.41; *no*, 2.59-4.06; Hagman, 2006). While the finding was not statistically significant, the researcher noted that a higher level of education corresponded to higher CSE for cultural concepts and cultural nursing skills. Level of CSE with the five ethnic groups showed similar trends except that MSN respondents had higher scores than Ph.D. respondents for all five ethnic groups. This could be related to statistical analysis issues as the number of Ph.D. respondents was

small ($n = 7$) compared to other educational levels (range of $n = 25$ -133; Hagman, 2006). These results support the benefit of education generally and the value of culturally focused education for nurses specifically.

Hagman (2007) was also interested in ascertaining how the RNs in New Mexico developed CSE. To answer this question, she included an open-ended question and a response request with the quantitative CSES: (a) How did you obtain the reported level of cultural self-efficacy? and (b) Please relate an ethnic/cultural clinical experience anecdote. The research participants were not required to respond in order that the rest of their data were included in the project. Therefore, only 66 of the 398 RNs provided these qualitative data.

Themes developed from the first question were (a) work and life experience, (b) education, and 3) travel and military experience. The anecdotal experiences that the RNs shared led to three main themes plus several “other themes” (Hagman, 2007, p. 185): (a) communication, (b) traditional medicine and alternative therapies, and (c) childbearing and family dynamics. The researcher did not explicate how she decided which were *main* themes and which were *other* themes. Because qualitative research does not measure but rather describes, the value of this research in this ROL could be questioned. However, some data from this project provide insight as to how patient outcomes might be impacted by the nurse-patient interaction. For example, patient adherence to a treatment plan is a desired patient outcome. One of the anecdotal experiences shared involved an elderly Navajo woman with diabetes. She had been treating a gangrenous toe with a mixture of sheep dung, kerosene, and pinon pitch. The culturally competent

nurse worked with the woman to blend the use of traditional medicine with the ordered treatment (Hagman, 2007).

Pain control is another desired patient outcome. Another nurse shared the following story.

Hospitalized Native American children respond differently to pain. My pain assessment had to be customized to be able to give them appropriate pain medicine in a timely fashion. Otherwise patients are ignored because they will not complain or give you any impression that they are having pain. (Hagman, 2007, p. 188)

In this example, the culturally competent nurse facilitated pain management that in turn potentially impacted other patient outcomes: improved mobility, healing, and patient satisfaction. Overall, Hagman's research demonstrated a moderate level of CSE in New Mexico RNs and supports the importance of education in the attainment of cultural self-efficacy.

Several research studies used Campinha-Bacote's instruments (1999, 2008a) to measure and evaluate cultural competence of RNs (Castro & Ruiz, 2009; Lampley et al., 2008; Seright, 2007). North Carolina was the setting for Lampley et al.'s mixed method research. A convenience sample of working RNs ($n = 66$) included participants from a healthcare agency, nursing faculty, RN-BSN students, and RN-MSN students. Because the researchers did not report the categories of their participants, it was impossible to differentiate the students from the rest of the sample. Therefore, this research only partially fulfilled the inclusion criteria. Since there is a dearth of research measuring cultural competence in patient care RNs, this author chose to include the results of this research in the ROL.

Data collection consisted of a background variables data sheet (BVDS) that included the request for information on a *paradigm case* and the Inventory for Assessing the Process of Cultural Competence (IAPCC; Campinha-Bacote, 1999). The researchers defined a paradigm case as a “clinical experience that stands out and alters the way one perceives and understands future clinical situations” (Lampley et al., 2008, p. 456). These qualitative data were provided by 20 participants. Use of the IPACC rather than the revised version (IAPCC-R) was a weakness of this research project. The IAPCC was revised in 2002, six years before this article was published, although no information was provided as to when the research was conducted. The authors did not provide a reason for using the older version of the tool.

An associated issue relates to the theoretical framework utilized. Campinha-Bacote’s model of cultural competence (Campinha-Bacote, 1999, 2002, 2007) from 1991 was used even though the newer model included a fifth construct--cultural desire. This was not addressed in the research report. The authors explicated the levels of cultural competence specified by Campinha-Bacote: Culturally Incompetent, Culturally Aware, Culturally Competent, and Culturally Proficient. Benner’s (1984) model of clinical skills acquisition was linked to Campinha-Bacote’s model but in an inaccurate manner. While discussing the conceptual linkage between the two models, the authors state, “Both models have identified four stages or levels, further enabling the pairing of the competency development” (Lampley et al., 2008, p. 456). Benner’s model includes five stages, not four: Novice, Advanced Beginner, Competent, Proficient, and Expert (Benner, 1984). The authors disregarded this discrepancy and matched Benner’s first four stages with the four levels of cultural competence identified by Campinha-Bacote. When the

qualitative data were analyzed, the researchers evaluated the existence of a paradigm case and determined if this “contributed to the development of the ‘expert’ nurse” (Lampley et al., 2008, p. 457). IPACC scores (potential range of 20-80) yielded a mean of 53.05 ($SD = 6.26$), which places these RNs as a group in the Culturally Aware level and Benner’s Advanced Beginner stage. Overall, one participant (1.5%) scored Culturally Incompetent (Novice), 55 (83.3%) scored Culturally Aware (Advanced Beginner), 10 (15.2%) scored Culturally Competent (Competent), and no participant scored in the Culturally Proficient range. Statistical evaluation of demographic factors demonstrated statistically significant results in three areas. There was a statistically significant difference between mean IPACC scores for participants with 1-5 years of experience ($M = 50.47$, $SD = 6.06$) and those with >20 years of experience ($M = 57.11$, $SD=6.50$). However, this was not the case for any of the other years of experience groups (<1, 6-10, and 11-20). Overall, the higher the educational level, the higher the IPACC score. However, mean scores for Associate Degree (AD) RNs were slightly higher than for those with a baccalaureate degree. The authors did not offer an explanation. Because some of the AD RNs in the sample were enrolled in a RN-BSN degree completion program, it is possible that coursework related to cultural competence increased their scores on the IPACC while the BSN nurses may not have had cultural content, depending upon how long ago they graduated. Of note, there were no statistically significant differences for Ph.D. level of education with any of the other levels (Diploma, AD, BSN, MSN); the authors did not provide number of participants in each category but stated that 50% of the sample ($n = 33$) had an AD.

Nurses receiving continuing education related to cultural diversity at the workplace scored significantly higher than those who did not ($M = 54.43$, $SD = 6.00$; $M = 50.63$, $SD = 6.09$). The researchers did not discuss a power analysis; it is possible that the sample size ($n = 66$) was not large enough for the number of variables and the type of statistical tests used that had bearing on the results. An additional weakness was the lack of a random sample. Content analysis of the qualitative data revealed four themes: (a) language or verbal communication barrier, (b) religious beliefs, (c) different health beliefs and behaviors, and (d) culturally inappropriate nonverbal communication. The researchers shared anecdotes illustrating both appropriate and inappropriate cultural care experiences. These narratives exemplify quality nursing care or, in some cases, a lack of quality. For example, one nurse recounted an incident in which the patient's surgery had to be cancelled because the patient was "contaminated" by staff after the cleansing ceremonies had been performed by the priest (Lampley et al., 2008).

Seright (2007) utilized the IAPCC-R instrument (Campinha-Bacote, 2008a) to measure cultural competence of North Dakota RNs. The researcher termed the study randomized descriptive but did not fully explain the randomization process. The state of North Dakota was divided into four sectors. Nurses in select acute care hospital facilities were asked to participate in the study: 53 in the Northwest region, 36 in the Northeast region, 39 in the Southwest region, and 51 in the Southeast region for a total sample size of 179 (Seright, 2007, p. 59). The participants completed a demographic questionnaire in addition to the IAPCC-R. The IAPCC-R had a score range of 25-100 while the original instrument's range was 20-80. The scores were grouped as follows: 25-50--Culturally Incompetent, 51-74--Culturally Aware, 75-90--Culturally Competent, and 91-100--

Culturally Proficient. Seright chose to analyze the scores by grouping them into just three categories—low (<66), medium (66-70), and high (71+)--“for later use in bivariate cross tabulations against the demographic survey tool” (p. 60). Overall, high scores represented 32.4% of the participants, medium scores were 30.7%, and low scores were 36.9%. The mean score for the group was 68.1 ($SD = 5.7$). As a method of comparison, converting the mean score in Lampley et al.’s (2008) research to an equivalent score with the range of 25-100, the score would be $66.31 \left(\frac{53.05}{80} = .6631 \times 100 = 66.31 \right)$, which is comparable to the score of these North Dakota RNs. Utilizing Campinha-Bacote’s scoring key, this sample of RNs would be classified as Culturally Aware.

The cultural competence score was statistically significantly correlated with cultural diversity continuing education program attendance (.01 level), cultural diversity training frequency (within the past 3 years; .01 level), and articles as a method of training (.01 level). Having a cultural diversity course in their nursing program did not correlate at a statistically significant level. The author opines that this may be based upon the curriculum design and the lack of opportunity to work with people of other cultures. Because of a poorly designed question in the demographic questionnaire (Question 12; Seright, 2007, p. 62), the researchers were unable to ascertain if number of cultural contacts influenced the cultural competence score. North Dakota is essentially homogenous with “pockets” of diverse population groups on and near Indian reservations (Native Americans) and in the northeastern area of the state (immigrants). This population demographic is very similar to the state of Nebraska in which this author’s research project was set.

Castro and Ruiz (2009) also used the IAPCC rather than the revised version of the instrument. Another research study published recently used the IAPCC rather than the revised version (Wilson, Sanner, & McAllister, 2010). As previously noted, the cost of using the IAPCC-R is either \$8 for face-to-face administration or \$20 if mailed or online format (Campinha-Bacote, 2007). The IAPCC does not appear to be copyrighted nor are there charges listed for its use on the website (<http://www.transculturalcare.net>). It is logical to assume that cost was a factor in using the original rather than the revised version of the instrument.

The aim of the descriptive correlational study conducted by Castro and Ruiz (2009) was to explore the relationship between level of cultural competence of nurse practitioners (NPs) and patient satisfaction among Latina patients. The convenience sample of 15 NPs and 218 Latina patients was obtained from 11 different clinics in a large southwestern city. The researchers reported an overall score range of 63 to 92 out of a possible 100; however, this is not the score range for the IAPCC (20-80; Campinha-Bacote, 1999, p. 206) but rather for the IAPCC-R (25-100). The IAPCC-R including scoring instructions is available in Campinha-Bacote's book (2007). It is unclear which instrument was actually utilized for this research.

The mean cultural competence score of the NPs was 78.33 ($SD = 9.82$)--the Culturally Competent range. Of the 15 NPs, two scored 92 (Culturally Proficient), seven scored between 79 and 87 (Culturally Competent), and six scored between 63 and 74 (Culturally Aware). None of the NPs scored below 50 (Culturally Incompetent). The NPs' cultural competence positively correlated with cultural competence training ($r = .32$) and with the ethnicity of the NP (Latina; $r = .40$).

Patient satisfaction is a component of quality nursing care. The researchers used the Patient Satisfaction Questionnaire (PSQ-III) to measure this construct with Latina patients. Pearson's r showed a weak correlation between NPs' cultural competence and Latina patient satisfaction score ($r = .193$). Patient satisfaction correlated with only three variables at $r \geq .20$: patient time spent with provider ($r = .26$), NP cultural skill (subscale of the IAPPC; $r = 0.20$), and patient waiting time (negatively correlated at $r = -.33$). The researchers also used regression analysis, which showed that NPs' cultural competence accounted for 4% of the variance in Latina patient satisfaction. Results supported cultural competence as a component of patient satisfaction but certainly not the only nor the strongest in this patient sample.

Findley's (2008) correlational, descriptive dissertation research was conducted in a large healthcare facility with several sites in the Louisville, Kentucky metropolitan area. Although Findley is not a nurse, he was interested in determining if there was a correlation between cultural competence of the bedside nurse and several potential predictor variables (e.g., a nurse's years of experience, education level; Findley, 2008). A convenience sample of 400 RNs (100 from each of four facilities) was sought; the final sample size was 270. Campinha-Bacote's (2002) process of cultural competence in the delivery of healthcare services model served as the theoretical framework with the IAPCC-R as the primary data gathering instrument.

Results of the data analysis showed that 83% of the sample scored in the Culturally Aware range (51-74) and 17% scored in the Culturally Competent range (75-90). None of the participants scored in either the Culturally Incompetent or the Culturally Proficient range. The overall Cultural Competence score had a mean of 68.16

($SD = 6.946$)--the Culturally Aware range. Evaluating years of experience as a predictor variable for level of cultural competence showed no statistical significance with alpha set at $p = .05$ ($p = .511$). Further, the highest mean cultural competence score ($M = 70.68$) occurred in the group of RNs with less than one year of experience. In this sample, years of experience did not impact cultural competency (Findley, 2008).

Three other potential predictor variables were statistically evaluated. Cultural competence scores were associated with current educational level (diploma, associate degree, bachelor's degree, and master's degree) at $p = .002$. Further, the mean score of cultural competence increased across all educational levels: diploma ($M = 65.86$), associate degree ($M = 67.33$), bachelor's ($M = 68.58$), and master's ($M = 75.00$; Findley, 2008, p. 87). Of note, only at the master's level did the cultural competence mean score reach the Culturally Competent level. However, educational level was indicative of greater cultural competence in this sample of RNs.

The participants were also asked to indicate how frequently they interacted with a patient who was from a different cultural background than their own (level of interaction) with the following categories: rarely, occasionally, usually, and almost always. Cross tabulation showed that nurses who reported interacting with patients of different cultural background almost always exhibited higher cultural competency scores. The chi-square test was not statistically significant at $p = .06$. However, the Analysis of Variance (ANOVA) test yielded a statistically significant p level of .001, indicating that level of interaction was related to cultural competency (Findley, 2008, p. 90).

The final predictor variable examined was number of cultural diversity courses the RN had taken over his or her career (diversity coursework) with categories of 1, 2, 3,

4, 5, or >5. The chi-square test of coursework and cultural competence was not significant ($p = .066$). However, as with the level of interaction predictor variable, an increasing relationship was supported by a statistically significant ANOVA result of $p = .011$. A relationship between diversity coursework and cultural competency was indicated with this sample of RNs (Findley, 2008, p. 94). Overall, Findley found that while years of experience were not associated with cultural competence, education level, interaction with diverse patients, and number of diversity courses taken were all associated to some degree with level of cultural competency. Further, the RNs in this study were on average at the Culturally Aware level rather than the more desirable Culturally Competent or Culturally Proficient levels (Campinha-Bacote, 2002; Findley, 2008).

In spite of the methodological and theoretical weaknesses noted in some, these research studies provided evidence that cultural competence at the proficient or even the competent level has not been attained by the majority of RNs. Consistently, education (the academic setting, inservice, diversity workshops, etc.) was associated with higher cultural competence scores. None of the research addressed the issue of racism as being potentially related to cultural competence. The next section of this work addresses racism and focuses on the following ROL questions:

- What is racism/racist attitudes?
- What is the level of racism/racist attitudes of RNs providing direct patient care to patients in the United States and how has this been measured?

Racism/Racial Attitudes: Concepts and Models

As briefly discussed in Chapter I, there is not one universally accepted definition of racism. For the purpose of this work, racism was defined as discriminatory thoughts or actions based upon race with the underlying belief of the superiority of one's own race over another (Agnes, 2002; Jones, 1997; Ponterotto et al., 2006). It is not surprising that there is no universally accepted theory or model of racism. Some scholars point to the transformation of racism over the past several decades spawning contemporary models of racism (Johnstone & Kanitsaki, 2009; Ponterotto et al., 2006; Sue et al., 2007; Utsey et al., 2008). A brief historical view of racism provides a basis for subsequent discussion of several theories and models of racism.

Historically, racism and prejudice have been viewed by some theorists as an evolutionary process supporting survival of the species. Identification of those who are different, the "other," allowed the clan, tribe, or village to protect their resources (Ponterotto et al., 2006; Utsey et al., 2008). Spriggs (1995) describes this as resource retention rule theory and posits that this contributed to the development of racial prejudice. Members of the same clan, tribe, or village (in-group) tended to be phenotypically similar (e.g., skin color, facial features) while phenotypically different from members of other clans, tribes, or villages (out-group). This allowed for identification as either friend or foe (Ponterotto et al., 2006; Utsey et al., 2008).

In addition to resource retention, avoidance of illness and disease was a potent motivator. Contact with an out-group was potentially dangerous--the in-group may not have immunity or might be susceptible to a particular illness or disease (Schaller, Park, & Faulkner, 2003). One only needs to recall the experience of American Indian tribes with

smallpox exposure from White military and White settlers or even the exposure of the Native People to alcohol leading to the high incidence of the disease of alcoholism within the tribes to understand the logic of this position.

One can argue that race is solely a social construct (Glasgow, 2009; Krieger, 2003; Smedley & Smedley, 2005) based at least partially upon the fact that humans are genetically 99.9% the same (Human Genome Project, 2009). However, the 0.1% represents about three million base differences between individuals' DNA (National Institute of Health, n.d.). Some of these differences are apparent (e.g., skin color, facial features). In the past, the human brain discerned patterns based upon physical markers to identify "the others" and assess for potential threat, whether from loss of resources or from exposure to deadly illnesses/diseases. It is important to note that this evolutionary perspective does not in any way excuse racism and prejudice but rather offers a plausible explanation for the deep-rooted existence of the same.

Utsey et al. (2008) provide an overview of various conceptualizations or models of racism. Allport's seminal work, first published in 1954, describes *old-fashioned racism* as overt expressions of racial hostility with an underlying belief in White superiority (Allport, 1979). This is the form that White persons typically conceptualize as "racism" with the mistaken idea that it is no longer an issue in the United States (Sue et al., 2007; Utsey et al., 2008). This is also what Wise (2009) terms Racism 1.0. Allport (1979) espoused a five phase model of "acting out prejudice" against a particular racial or ethnic group (i.e., racism): (a) Antilocution—prejudicial speech among like-minded persons, (b) Avoidance—conscious efforts to avoid members of the group, (c) Discrimination—active steps to exclude members of the group, (d) Physical attack—

upon either property or persons from the group, and (e) Extermination—systematic and planned destruction of the group (p. 49). With the Civil Rights movement of the 1960s and the end of legal segregation, some of the overt expressions of racism became illegal. This led to the development of symbolic or modern racism that is more ambiguous and more difficult to identify because of the covert nature of the thoughts and actions (Ponterotto et al., 2006; Sue et al., 2007; Utsey et al., 2008).

Because *symbolic or modern racism* holds the view that racism is no longer an issue in the United States, this type of racism is more likely than ever to be covert. Symbolic racism is associated with the work of Sears while the term modern racism is credited to McConahay (Jones, 1997; McConahay, 1986; Sue et al., 2007; Tarman & Sears, 2005). As noted by Tarman and Sears (2005), while there are some slight conceptual differences, they have been operationalized with similar survey items on their respective tools.

Symbolic or modern racism is based on the traditional American values of individualism, work ethic, and self-reliance linked with an anti-Black (and anti-people-of-color) sentiment—*they* are too demanding in their push for equal rights (Jones, 1997; Sue et al., 2007). Basically, if *they* just worked harder...weren't so lazy...pulled themselves up by the bootstraps, they would not need special treatment. This type of racism is most closely aligned to what Wise (2009) calls Racism 2.0 (pp. 83, 104, 107). Racism 2.0 relies on character judgments about persons of color and holds that “anyone can make it if they try hard enough...” (Wise, 2009, p. 107). This viewpoint makes it easier to rationalize White privilege and ignore injustices and inequities.

Most recently, Sue and colleagues (Sue et al., 2007) proposed a theoretical model of *racial microaggressions* to explain how the therapeutic counseling process is impacted. While the counseling relationship is not the same as the nurse-patient interaction, there are similarities that make this applicable to the discipline of nursing. “Microaggressions are brief, everyday exchanges that send denigrating messages to people of color because they belong to a racial minority group” (Sue et al., 2007, p. 273). The model includes microinsult (often unconscious), microassault (often conscious), and microinvalidation (often unconscious) on the individual level as well as all three at the macro-level manifested on systemic and environmental levels. One example of microinvalidation is color blindness--“denial or pretense that a White person does not see color or race” (Sue et al., 2007, p. 278).

Barbee’s (1993) seminal nursing article, *Racism in U.S. Nursing*, identified the *color-blind* perspective as contributing to the largely unrecognized problem of racism within nursing. This egalitarian attitude precludes any acknowledgement or discussion of race: “I do not notice the color of my patients. I treat all of my patients the same.” Basically, any discussion of racism, discrimination, fairness, or equality is preempted (Abrums & Moio, 2009). As noted by Cortis (2003), this approach reduces “the potential for covert conflict by denying that conflicts could be ‘race’ related” (p. 59). This perspective allows the individual to maintain the image of self as non-racist and precludes any self-examination that might challenge this image.

Aversive racism is based upon the egalitarian position seen in the color-blind perspective but with attendant negative racial attitudes toward people of color, typically privately held and unacknowledged (Barbee, 1993; Sue et al., 2007; Utsey et al., 2008).

This dichotomy causes feelings of unease. White individuals publicly support egalitarian principles while concomitantly believing in their own racial superiority and actually fearing and avoiding people of color (Ponterotto et al., 2006; Sue et al., 2007; Utsey et al., 2008).

Critical race theory (CRT) originated in legal scholarship and is grounded in the social justice perspective (Abrums & Moio, 2009; Ford & Airhihenbuwa, 2010).

Basically, “CRT refutes two principal liberalist claims with regard to the law: (1) that it is color-blind and (2) that color blindness is superior to race consciousness” (Abrums & Moio, 2009, p. 250). CRT is actually theory combined with methodology with the goal of illuminating and transforming the relationship between and among race, racism, and power (Brown, 2008; Ford & Airhihenbuwa, 2010). CRT focuses on inclusion of the knowledge and experience of the racial and ethnic minority communities with attention to the power differentials that exist within social structures (Ford & Airhihenbuwa, 2010).

A number of tenets shape CRT: (a) Racism is viewed as an ordinary, everyday occurrence for people of color; (b) Racism is difficult to comprehend and difficult to change, in part because it brings advantages to the majority race (White people in the United States); (c) Race is a social construct with no genetic or biological reality; (d) The dominant group racializes different minority groups at different times; (e) People of color are capable of communicating their own account of their history and their lived reality including the meaning and consequences of their experiences; and (f) Various oppressions intersect with overlapping and conflicting identities for some (Abrums & Moio, 2009; Brown, 2008; Masko, 2005). At this time, CRT includes adherents from diverse disciplines such as economics, sociology, education, political science,

psychology, feminist studies, ethnic and cultural studies as well as non-academics such as activists (Abrums & Moio, 2009; Brown, 2008).

The Quick Discrimination Index (Ponterotto, 2009; Ponterotto et al., 1995), which was used in this study, is based upon Jones (1997) model of racism. His model focuses primarily on Black persons. However, his definition of the individual racist includes “other human groups defined by essential racial characteristics” (p. 417) so one can assume he includes all people of color. Jones definition of racism was published in the first edition of *Prejudice and Racism* in 1972 but was not included in the second edition. Rather, he lists five principle elements of racism:

- 1 Belief in racial superiority-inferiority, based implicitly or explicitly in biological differences
- 2 Strong in-group preference, solidarity, and the rejection of people, ideas, and customs that diverge from the in-group’s customs and beliefs
- 3 Doctrine (or cultural or national system) that conveys privilege or advantage to those in power
- 4 Elements of human thought and behavior that follow from the abstract properties, social structures, and cultural mechanism of racialism
- 5 Systematic attempts to prove the rationality of beliefs about racial differences and the validity of policies that are based on such beliefs. (Jones, 1997, p. 373)

Ponterotto et al. (2006) provide Jones’ 1972 definition of racism: “[Racism] results from the transformation of race prejudice and/or ethnocentrism through the exercise of power against a racial group defined as inferior, by individuals and institutions with the intentional or unintentional support of the entire culture” (p. 16). While the principles afford a more in-depth explanation of an extremely complex phenomenon, his definition provides the conceptual framework for his model that includes individual, institutional, and cultural racism (Jones, 1997).

A racist individual (i.e., *individual racism*) believes that

black people as a group (or other human groups defined by essential racial characteristics) are inferior to whites because of physical (i.e., genotypical and phenotypical) traits. He or she further believes that these physical traits are

determinants of social behavior and of moral or intellectual qualities, and ultimately presumes that this inferiority is a legitimate basis for that group's inferior social treatment. An important consideration is that all judgments of superiority are based on the corresponding traits of white people as norms of comparison. (Jones, 1997, p. 417)

Because people of color typically represent cultural groups as well, these cultural representations are also seen as inferior by the White racist individual who considers his or her culture as the norm and other cultural manifestations outside of this norm and, therefore, inferior (Jones, 1997). (This same process but on a larger scale is cultural racism.)

Inherent within individual racism is White race privilege. Jones (1997) chronicles numerous examples of the privileges accorded to Whites and denied to Blacks, in one instance by the very same Black doorman (p. 434). To say that many White persons are ignorant of these everyday occurrences of racism is not an exaggeration. This White author was shocked when her adopted Native American daughters told of being followed around the Target store by a security guard. Sue et al. (2007) term incidents such as this microaggressions and state that these are everyday occurrences for people of color. Ponterotto et al. (2006) allow that individual racism "can be exhibited by members of any group in a context where they hold the power over another" (p. 23). However, in the United States, this is rare indeed.

Cultural racism is defined as follows:

Cultural racism comprises the cumulative effects of a racialized worldview, based on belief in essential racial differences that favor the dominant racial group over others. These effects are suffused throughout the culture via institutional structures, ideological beliefs, and personal everyday actions of people in the culture, and these effects are passed on from generation to generation. (Jones, 1997, p. 472)

Jones statement describes succinctly how culture is connected to race: “Because Africa is the origin of both African cultures and black people—who are assigned racial status in the European cultural system—race and culture often converge” (p. 493). Substitute other racial groups and cultures and the meaning remains the same; not only does the race of the person place him or her as “the other” but also their cultural manifestations. With White culture dominant, other cultures are viewed as subordinate. In other words, Santa Claus is good but Kwanzaa is bad; God is good but Wakan Tanka (The Great Spirit) is bad.

Cultural racism is linked with both individual and institutional racism but with the added notion of being passed on from generation to generation. It is this phenomenon that Ponterotto et al. (2006) sought to change in *Preventing Prejudice: A Guide for Counselors, Educators, and Parents*.

Institutional racism is defined by Jones (1997) as follows:

Those established laws, customs, and practices which systematically reflect and produce racial inequities in American society. If racist consequences accrue to institutional laws, customs, or practices, the institution is racist whether or not the individuals maintaining those practices have racist intentions. Institutional racism can be either overt or covert (corresponding to de jure and de facto, respectively) and either intentional or unintentional. (p. 438)

Basically, the policies, practices, and procedures of various institutions make it difficult for certain racial or ethnic groups to rise to a position of equality with White persons.

The theory of institutional racism does not argue for equality of outcomes but rather equality of opportunity (Jones, 1997).

Jones (1997) provides an overview of institutional racism in economics, education, media, justice, and physical and mental health. Related to physical and mental health, Jones reports on empirical research suggesting that “racism is a recurring

phenomenon in people's experience and that it has adverse physical as well as mental health consequences" (p. 464). The seminal report produced by the Institute of Medicine (2002; Smedley et al., 2003) adds further evidence to support Jones' statement: "The study committee was struck by the consistency of research findings: even among the better-controlled studies, the vast majority indicated that minorities are less likely than whites to receive needed services, including clinically necessary procedures" (p. 2). Healthcare in the United States is an institution; there is mounting evidence that institutional racism, whether intentional or unintentional, is pervasive within the system and contributes to the well documented health disparities seen in non-White population groups (Barr, 2008; Smedley et al., 2003; Williams & Mohammed, 2009).

Whether termed structural racism (Ford & Airhihenbuwa, 2010) or institutional racism (Jones, 1997; Ponterotto et al., 2006), these systemic injustices cannot be addressed until individual racism is made visible and ameliorated. Individuals drive structures and institutions; it will be the collective work of individuals who ultimately change structures and institutions. Because nursing is the largest discipline within the healthcare provider sector, it is imperative that racism at the individual RN level be addressed so that racism at the institutional and structural level of healthcare can be eliminated. Further, Ponterotto et al. (2006) suggest that educators can and should prevent prejudice, which is an antecedent to racism (prejudicial thoughts leading to racist attitudes and actions). Nurse educators bear this responsibility within our discipline.

Racism and Other Healthcare Disciplines

Racism has been the topic of discussion and research in several healthcare disciplines. "While there is no direct evidence that provider biases affect the quality of

care for minority patients, research suggests that healthcare providers' diagnostic and treatment decisions, as well as their feelings about patients, are influenced by patients' race or ethnicity" (Institute of Medicine, 2002, p. 4). The most recent publication of the National Healthcare Disparities Report (Agency for Healthcare Research and Quality, 2010) details improvement in some core measures but, related to both access to care and quality of care, disparities persist for all population groups (Blacks, Asians, Native Americans/Alaska Natives, and Hispanics) when compared with the White population group (p. 5). Health disparities are the result of many complex issues: socioeconomic status, uninsurance, access to care, treatment response, distrust of provider, and overt or subtle biases on the part of the healthcare providers (Agency for Healthcare Research and Quality, 2008, 2010; Clark, 2009; Institute of Medicine, 2002). People of color often receive a lower quality of care than Whites even when insurance status, socioeconomic status, comorbidities, and other factors are controlled (Betancourt, 2006; Smedley et al., 2003). The fact that these disparities persist requires evaluation of other causative factors such as bias. Although the Institute of Medicine report does not use the term *racism*, the Encarta thesaurus provides the following synonyms for *racism*: racial discrimination, discrimination, prejudice, bigotry, intolerance, xenophobia, bias, racialism ("racism," 2009). It is this *bias* (i.e., racism/racist attitudes) that was the focus of this research study.

Physicians have begun to address this issue via research aimed at the identification of racism and bias in healthcare from the patient perspective (Blanchard, Nayar, & Lurie, 2007; Chen, Fryer Jr, Phillips Jr, Wilson, & Pathman, 2005; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Moody-Ayers, Stewart, Covinsky, & Inouye,

2005). The Commonwealth Fund sponsored seminar included a presentation based upon an extensive review of literature conducted by Dr. Ngo-Metzger and her colleagues (Beal & Saul, 2006; Ngo-Metzger et al., 2006). They concluded that minorities perceived more discrimination due to race, language competency, and insurance status; this perception of discrimination resulted in being less likely to seek healthcare, more likely to refuse treatment, a lower perception of general health status, and greater levels of depression (Beal & Saul, 2006; Ngo-Metzger et al., 2006). Patient perception of racism is linked to patient satisfaction, which is linked to patient compliance and utilization of healthcare services (Chen et al., 2005; LaVeist, Nickerson, & Bowie, 2000), may be related to patient trust (Moody-Ayers et al., 2005), and is associated with preference for same-race healthcare providers (Malat & Hamilton, 2006). Although research on racism from the patient perspective is replete, a search of several databases within two university libraries yielded only a few studies measuring racism on the part of physicians (Green et al., 2007; Penner et al., 2010; Sabin, Nosek, Greenwald, & Rivara, 2009; Sabin, Rivara, & Greenwald, 2008). All of these studies used the Implicit Association Test (IAT) developed by Project Implicit (<https://implicit.harvard.edu/implicit/>).

Penner et al. (2010) hypothesized that Black patients' reactions to non-Black physicians would be "least positive when physicians were low in explicit prejudice and high in implicit bias" (i.e., aversive racism; p. 437). The study involved 150 Black patients and 15 physicians. The patients received \$20 gift cards for participation while the physicians received a \$50 incentive, implying that the physicians' time was perceived as being more valuable by the researchers. Physicians completed an explicit measure of racial prejudice (the Modern Racism Scale (McConahay, 1986) and the Implicit

Association Test (IAT; Nosek, 2007) as a measure of implicit racial prejudice. After patient contact, each physician and patient privately “completed two items that assessed feelings of being on the same team” and an item assessing the perceptions of “the extent to which the physician consulted the patient on the final treatment decision” (Penner et al., 2010, p. 437). The patients also completed two items to measure physician warmth and physician friendliness (1= *not at all* to 4 = *completely*), which were aggregated and averaged ($M = 3.73$). Patients also completed a 14-item measure of patient satisfaction with an additional item asking how satisfied they were with the patient-physician interaction (1= *not at all* to 4 = *completely*), which yielded a mean of 3.66.

Statistical analysis was performed to evaluate the relationship between the bias measures and the outcome measures. As expected, patients responded more negatively to aversive racists (low explicit but high implicit bias). Somewhat surprisingly, this was true even when compared with physicians who were high in both explicit and implicit bias. Overall, the non-Black physicians in this study (3 White and 12 Indian, Pakistani, and Asian) did not display implicit racial bias and actually showed a slight, nonsignificant preference for Blacks over Whites. This was in contrast to the findings of Green et al. (2007) and Sabin et al. (2009) where the majority of the physicians showed an implicit preference for White over Black. Penner et al. (2010) felt this may be reflective of the fact that these physicians may have chosen to practice in an inner-city, low income clinic because of their own low levels of bias.

It would have been helpful to evaluate the level of both explicit and implicit bias by each population group of physicians. It is possible that the White physicians ($n = 3$) may have scored higher in both types of bias; however, this finding was modified by the

scores of the non-White physicians ($n = 12$; Penner et al., 2010). Sabin et al. (2009) found that African American medical doctors (MDs) on average did not show implicit preference for either White or Black, which is consistent for all African Americans who have taken the IAT. This phenomenon may be true for other non-White population groups.

Mental health providers, social workers, and dentists have explored racism from the provider's perspective using the Quick Discrimination Index (Green et al., 2004, 2005; Ponterotto, Potere, et al., 2002; Utsey & Ponterotto, 1999). These research studies will be briefly reviewed.

The Quick Discrimination Index (QDI) was developed to measure attitudes toward racial diversity and women's equality (Ponterotto et al., 1995). An important consideration in the development of this instrument was the focus of prior tools on the cognitive nature of prejudicial attitudes consisting of cognitive, affective, and behavioral components. While "it is difficult to measure actual behavior or behavioral intent in a paper-and-pencil measure", a well designed survey can effectively measure cognitive and affective components (Ponterotto et al., 1995, p. 1017). Healey (2006) states, "Individual prejudice has two aspects: the cognitive, or thinking aspect and the affective, or feeling, part" (p. 26). The cognitive component includes what beliefs people hold and what they think about "other" groups of people. The affective component includes how people feel about these "other" groups of people. Typically, these two dimensions of prejudice are highly correlated (Healey, 2006).

A second consideration was the need for a tool that could be used across all racial and ethnic groups. According to these researchers, most racial attitude measurements

focus on White racism toward Blacks (e.g., McConahay's Modern Racism Scale) (Ponterotto et al., 1995, 2006). A final consideration was the need for a tool that is less susceptible to social desirability contamination.

Three studies were conducted in the process of developing and revising the QDI to ensure validity, reliability, lack of social desirability contamination, and to confirm the factors of each of the three subscales: cognitive racial attitudes (CRAS), affective racial attitudes (ARAS), and gender equity (GES; Ponterotto et al., 1995). The QDI consists of 30 items scored on a 5-point Likert scale (1 = *Strongly disagree* to 5 = *Strongly Agree*). Score range for the total tool is 30-150; a higher score indicates more awareness, sensitivity, and receptivity to racial diversity and gender equality (Ponterotto, 2009). Of note, the QDI is not a direct measure of discrimination or racism but rather a measure to assess the attitudes presumed to underlie potential discriminatory or racist behavior (Green et al., 2004; Ponterotto, Potere, et al., 2002; Ponterotto et al., 2006). Chapter III provides a further discussion of reliability and validity).

In 1999, Utsey and Ponterotto sought further validation of the QDI with three samples, two of which are pertinent to this discussion (pharmacy faculty, staff, and students [$n = 532$] and dental students [$n = 118$]). Factors I and II (Cognitive Racial Attitude Scale and Affective Racial Attitude Scale, respectively) are of interest in this research study. Scores range from 9 to 45 for Factor I (CRAS) and from 7 to 35 for Factor II (ARAS). The dental students' scores were as follows: CRAS-- $M = 27.91$ ($SD = 7.44$) and ARAS-- $M = 21.95$ ($SD = 7.44$). The pharmacy faculty, staff, and students scored as follows: CRAS-- $M = 26.89$ ($SD = 6.41$) and ARAS-- $M = 22.43$ ($SD = 5.32$). These measures with data presented in Ponterotto et al. (1995) serve as normative data

for comparison with future research using the QDI (Utsey & Ponterotto, 1999, p. 333). In addition, Ponterotto and colleagues provide a table detailing means and standard deviations for the total scale and each subscale for several studies conducted from 1995-2000 using the QDI (Ponterotto, Potere, et al., 2002).

Mental health professionals (284 social workers and 421 psychologists) were randomly selected to participate in research assessing attitudes about minority populations as well as generating normative data with the QDI (Green et al., 2004). The QDI was mailed to the participants; the response rate was 52.2%. Statistics were reported for the group as a whole as well as for each subgroup on each item in the scale. Results between these two subgroups were markedly similar. The CRAS mean was 34.4 (no standard deviations reported), the ARAS mean was 24.5, and the Gender Equity Scale (GES) mean was 27.3. These scores were higher than those reported for either the dental students or the pharmacy cohort in Utsey and Ponterotto (1999). These researchers also evaluated race and sex as potential covariates using the three QDI subscales as dependent variables and respondents' profession as independent variable. No effect was found for profession but race and sex were both found to be statistically significant at the $p < .0001$ level for both. Post hoc testing showed the women reported more positive attitudes than men on the GES subscale ($t = 9.9, p < .001$) and on the ARAS ($t = 2.3, p = .02$). People of color had more positive scores than White people on the CRAS and the ARAS ($t = 2.7, p = .008$ and $t = 4.5, p < .001$, respectively; Green et al., 2004, pp. 492-493). The researchers call for the use of the QDI with other mental health professionals including psychiatric nurses.

Green (with two different colleagues) continued his work with research focused on the cognitive and affective attitudes of White social workers toward people of color (Green et al., 2005). They utilized the QDI and subscales CRAS and ARAS as their measurement instrument (Ponterotto et al., 1995; Ponterotto, Potere, et al., 2002). A random sample was drawn from the state association ($n = 300$) of the National Association of Social Workers (NASW) and from the national membership of the NASW ($n = 300$). Of the 600 invitations to participate, 296 (national— $n = 135$; state-- $n = 157$) surveys were returned for a response rate of 51.2%. The surveys were anonymous rather than confidential to decrease the likelihood of social desirability contamination. The subsamples (national and state) were statistically analyzed to assess for group differences on demographic variables. No statistically significant differences were found; therefore, the data was aggregated for analysis.

Cronbach's alpha level for internal consistency was good for both the CRAS (.78) and the ARAS (.83) scale, although the reported numbers were transposed later in the research report. The CRAS mean was 34.38 ($SD = 5.79$) with the per item mean of 3.82 ($SD = .63$). The ARAS mean was 24.73 ($SD = 3.51$) with the per item mean of 3.53 ($SD = .64$). A paired t test shows a statistically significant difference between the per item means ($t = 6.92, p < .001$) with a Cohen's d of .45, indicating a medium effect size for the relationship. This would be expected assuming the two subscales are measuring different aspects of racial attitudes. Overall, the means on the subscales from this sample of social workers were higher (indicating less racist attitudes) than almost all other participants in previous research using the QDI (Green et al., 2005).

N. L. Green (1995), an advanced practice registered nurse, developed a tool to measure the perception of racism from the patient perspective, which is discussed in the next section. However, there is a dearth of research focused on the issue of racism from the perspective of the nurse (Barbee, 2002; Eliason, 1999).

Racism and Nursing

In spite of consistent literature searches with a number of databases over an extended period of time, very little research related to racism (bias, discrimination, prejudice) within nursing was found, especially related to measuring the level of racism of RNs. Because of this gap in the literature, Green's (1995) research is included in this ROL. Her research in the development of the Perceived Racism Scale (PRS) focused on pregnant African Americans and their perception of racism in the care they received (Green, 1995). Items for the tool were developed based upon data from qualitative interviews with eight African American childbearing women and from general perceptions of racism generated by a *Business Week/Harris Poll*. Green conducted a pilot study and then a second study to evaluate the tool. Both studies revealed a strong perception of racism.

Score range for the PRS is 20 to 80 with higher scores indicative of greater racism. Results of the two studies are as follows: Study A with 109 participants ($M = 59.28$, $SD = 8.28$); Study B with 136 participants ($M = 47.82$, $SD = 8.34$). Study A was conducted anonymously with African American women from church and community organizations while Study B was conducted in a low-risk prenatal clinic of a health maintenance organization where the participants were known. This could account for the higher measurement in Study A, i.e., participants were less likely to be completely candid

if they feared that one of their caregivers would have access to their data. In this setting with this patient population, racism was perceived as a problem for childbearing African American women.

Two more recent nursing research projects evaluated patient perception of prejudice. Benkert and Peters (2005) utilized qualitative research to explore how African American women coped with healthcare prejudice. Interviews lasting from one and a half to three hours were conducted in a private room at an urban, nurse-managed health center with 20 African American adult women. The researchers discovered two main themes with attendant categories: (a) Experience with the healthcare system and (b) Coping strategies. The women shared many examples of racism. Of the 20 participants, 18 reported both overt and covert prejudice as part of their experience with the healthcare system. The coping strategies included anger, being assertive, “Learnin [sic]to unlearn” (p. 882), and “Walkin [sic] away” (Benkert & Peters, 2005, p. 883). The purpose of this research was to address prejudicial treatment within the patient-provider relationship. Although the setting was a clinic, it is likely that these acts of prejudice/racism occur wherever patients are being cared for by nurses and other healthcare providers.

Facione and Facione (2007) reported on data collected as part of a broader study of women’s health services utilization behavior in the San Francisco Bay Area. A convenience sample of 838 women (37.6% Latino, 28.2% non-Latino Black, and 34.2% non-Latino White) was recruited with 817 cases available for statistical analysis. The researchers reported on several data gathering tools but the Perceived Prejudice in Health Care scale (PPHC), consisting of two subscales (the General Perception of Prejudice [GPP] and the Personal Experience of Prejudice [PEP]), is of particular interest for this

discussion. Participants indicated the degree to which they agreed or disagreed with each item on a 4-point Likert scale; each item was scored -2 to +2 to correspond to the absence or presence of perceived prejudice. Positive scores indicate perceived prejudice while negative scores denied the perception of prejudice. Total scores ranged from -20 to +20 for the PPHC, from -12 to +12 for the GPP, and from -8 to +8 for the PEP subscale. Validity of the PEP scale was based upon a significant correlation ($r = .78$) with the Perception of Racism Scale (Green, 1995).

Scores for the GPP subscale ranged from -6.00 to +12.00 with a normal distribution and a mean of +3.98 ($SD = 3.30$), which is indicative of a general perception of prejudice in healthcare delivery. At each level of education from grade school to graduate school, GPP scores were significantly higher than the education level below. The researchers reported a small number of lesbian and bisexual women in the sample but with significantly higher scores on the GPP ($M = 6.55$, $SD = 3.79$) compared to heterosexual women ($M = 3.95$, $SD = 3.23$; $t = 4.91$, $p < .001$).

The PEP scores ranged from -4.00 to +8.00 and were skewed to the right with a mean near 0 ($M = 0.05$, $SD = 2.5$). With a skewed distribution, it is helpful to report the median score as it more accurately reflects central tendency (Polit & Beck, 2010). The researchers did not provide this statistic. PEP scores were higher for lesbian and bisexual women than for heterosexual women; women with a graduate-level education had the highest scores. Black women had the highest PEP scores followed by White women and then Hispanic women. However, these differences were explained by education level rather than by race/ethnicity. The fact that Whites scored higher than Hispanics, even taking educational level into account, was unexpected. Neither GPP nor PEP was

reported more often (i.e., higher scores) in the women who were first-generation immigrants in the United States; this was not accounted for by social desirability response bias (Facione & Facione, 2007, p. 182). One reason was the possibility that these women could not differentiate prejudice in the social interaction from other differences they viewed as American cultural norms rather than prejudicial occurrences.

The researchers detected a significant relationship between GPP and PEP scores and the health protective behavior variables (breast self exam, mammography screening, clinical breast exam, and cervical cancer screening), especially with the Hispanic women in the study (Facione & Facione, 2007). This finding gave credence to the potential for prejudice (and by extension, discrimination and racism) to adversely impact health and contribute to health disparities in the United States. These research studies confirmed that people of color, as well as other diverse groups (e.g., lesbian/bisexual), perceived prejudice within the healthcare system and on the part of healthcare providers.

Porter and Barbee (2004) conducted a systematic review of nursing research focused on race and racism. Keywords included the primary terms plus proxy terms such as bias, prejudice, discrimination; databases searched were CINAHL, MEDLINE, and Sigma Theta Tau International's library. The authors evaluated over 1000 citations published between 1970 and 2003 but, based upon the inclusion and exclusion criteria developed, included a total of 22 research reports in the final work; 8 focused on education and 14 focused on clinical practice (Porter & Barbee, 2004, p. 13). This discussion focused on the clinical practice section as being most directly related to the population of direct patient care RNs in this study.

Five overall themes were discovered by this author in this review of research.

1. People of color are discriminated against (LaFargue, 1972; McDonald, 1994).
2. Nurses are not prejudiced (LaFargue, 1972). LaFargue's research included qualitative data from Black patients ($n=10$) who shared incidents of discrimination and quantitative data from White nurses ($n=23$) who completed a questionnaire designed specifically for this study that showed low prejudicial scores. Validity of this tool was not reported.
3. Nurses and student nurses are prejudiced (Johnson, Bottorff, Hilton, Browne, & Grewell, 2002; Greipp, 1996; Kirkham, 1998; Richek, 1970) and prejudice was 'learned' during socialization (Morgan, 1983).
4. Nurses' and faculty's attitudes affect the nurse-patient relationship and quality of care with culturally diverse patients (Bonaparte, 1979; Ruiz, 1981; McDonald, 1994).
5. Direct nurse-patient contact with diverse patients changes the racial perceptions of the nurse and sometimes, but not always, decreases bias (Frenkel, Greden, Bobinson, Guyden, & Miller, 1980; Rooda, 1992).

Summary points regarding this review of literature were as follows:

1. Proxy terms were consistently used for *racism* (cultural attitudes, prejudice, interracial contact). However, "at the heart of the studies was the underappreciated truth about racism and discriminatory practices in nursing and how some researchers attempted to explore and explain the phenomenon" (Porter & Barbee, 2004, p. 25).

2. Evidence was inconsistent regarding racism but this may have been due to methodological issues in some of the studies, although several used the Cultural Attitude Survey (CAS) or a modification of same.
3. Although the focus was on practice, the studies included practicing nurses, nursing faculty, and student nurses.
4. Some studies included were more focused on culture rather than racism per se (Felder, 1990; Rooda, 1993).

Porter and Barbee (2004) rather stridently called for research on racism within nursing, both as related to quality care for diverse patients and as it related to nursing colleagues who belonged to non-White population groups.

The research discussed in this section lends credence to prejudice and racism within the healthcare system of the United States. Cultural competence on the part of the provider is imperative but has not met expectations as far as elimination of health disparities. Other factors impact the attainment of cultural competence, one being racism or racist attitudes on the part of the healthcare provider. Whereas nursing is the largest group of healthcare providers, evaluation of racism and the potential relationship with cultural competence in nurses who provide patient care is obligatory. As stated previously, only one research study included cultural competence, racism, and direct patient care RNs.

Cultural Competence and Racism

Skinn's (2006) dissertation research sought to evaluate the Skinn Model of Cultural Competence (SMCC) and the associated Cultural Competence Assessment Scale (CCAS). Walker and Avant (2011) offer eight criteria for theory testing. The research

questions posed by Skinn are congruent with these criteria. Additionally, Skinn questioned whether racism was a mediating or moderating variable in the progression of cultural competence. The SMCC is based upon the cultural competence literature, especially that of Campinha-Bacote (1999). The model (Skinn, 2006, p. 19) is very similar to an earlier Campinha-Bacote model (2007, p. 18) with five overlapping circles but with Cultural Attitude in the place of Cultural Awareness, the addition of Cultural Desire, and Racism as a mediator or moderator between Cultural Awareness and Cultural Desire. The addition of a Cultural Feedback loop is another modification of Campinha-Bacote's model. Skinn's model has a rectangle including the following as potential mediators/moderators between Cultural Awareness and Cultural Desire: Ethnocentrism, Cultural Ignorance, Cultural Imposition, Cultural Blindness, Beliefs/Values, Personal Goals, Professional Goals, and Organizational Culture. These concepts are not addressed in the research questions nor fully explained as part of the model. This violates Walker and Avant's (2011) criteria 3: "The theory's internal structure (key propositions and their interrelationships) is explicitly stated so that its relationship to study hypotheses is clear" (p. 222).

The population for this study was oncology nurses who belonged to the Oncology Nursing Society (ONS). A random sample of 600 RN members from all 50 states was generated by the ONS. Of the 600 research packets mailed, 162 were returned. The researcher sought additional participants from a local ONS meeting and by recruiting colleagues who were oncology nurses for a total sample of 172. These nurses primarily provided patient care; of the 172 participants, only three stated, "I don't take care of patients" (Skinn, 2006, p. 88).

Data were gathered with four instruments: a demographic questionnaire, the CCAS, an adapted form of the Perception of Racism scale (PRS; Green, 1995), and an adapted form of the Modern Prejudice Scale (MPS; Akrami, Ekehammar, & Araya, 2000). Psychometric testing resulted in complete removal of the Cultural Attitude scale as well as 13 items from the total CCAS, leaving a total of five subscales--Cultural Awareness, Cultural Desire, Cultural Knowledge, Cultural Skill, and Cultural Encounter --and 18 items. The total CCAS score had a range of 29 to 86 with a mean of 61.5 ($SD = 8.7$), indicating a relatively high score that is congruent with the RNs' own self-assessment of ability to care for diverse patients as *good* or *excellent* ($n = 135$; 79%). The subscale of Cultural Awareness was found to be predictive of Cultural Desire.

According to Skinn (2006), the two scales that were adapted to measure racism showed moderate reliability with Cronbach's alphas of .667 for the adapted MPS and .649 for the PRS. Houser's (2008, p. 255) interpretation classifies .4 to .7 as weak reliability. The adaptation of these scales may have been less than optimal and could have had bearing on correlational results.

To answer the question of whether racism is a mediating (facilitator; makes the relationship possible) or a moderating (produces changes in the relationship) variable, Pearson's product-moment correlation coefficients were obtained. The PRS showed a weak, negative, non-significant correlation with the Cultural Awareness subscale ($r = -.120$, $p = .12$) while the MPS showed no significance and no correlation ($r = .062$, $p = .42$). However, there was a positive correlation between the Cultural Awareness and Cultural Desire subscales ($r = .23$, $p < .01$). When controlled for the variable of racism

(as measured by the PRS and MPS), this correlation became stronger ($r = .26, p = .001$), which indicated that racism is a moderator of this relationship (Skinn, 2006, p. 107).

The researcher expected a moderate inverse relationship between CCAS scores and the racism scores (PRS and MPS), i.e., as cultural competence increased, racism decreased. Total CCAS score had a statistically significant, weak negative correlation with the MPS score ($r = -.28, p = .000$) but was not significantly correlated with the PRS score ($r = .22, p = .77$). Level of racism of these RNs was low: MPS score range = 15 to 38 ($M = 26.26, SD = 4.8, p = .05$) and PRS score range = 6 to 25 ($M = 14.83, SD = 3.7, p = .05$). As mentioned, the weak reliability of these modified scales requires careful interpretation of these scores. Further, this sample of RNs was primarily White non-Hispanic as is the demographic of nursing in general. Skinn (2006) cautions that interpretation of racism may be obscured by what Puzan (2003) calls “the unbearable whiteness of being (in nursing)” (p. 193). The research conducted by this author extends Skinn’s research.

Nurse-Patient Interaction

The nurse-patient interaction is the most foundational aspect of the practice of nursing. It is in this ‘place’ that holistic, hands-on nursing care occurs. Simply put, Watson (1979) refers to this as a transpersonal caring moment and asserts that it is crucial to the practice of nursing (Belcher & Jones, 2009). Leininger’s culture care theory of diversity and universality (Leininger, 1995; Leininger & McFarland, 2002, 2006), at the most basic level, focuses on the nurse-patient relationship as the nurse facilitates culture care preservation/maintenance, culture care accommodation/negotiation, or culture care repatterning/restructuring. It is within this relationship that the patient moves from an

objectified, depersonalized being (e.g., “the CHF [sic-congestive heart failure] patient in 422”) to an individual in need of care. This process supports the development of the “universal and profound relationship of one human being to another, where differences are acknowledged, valued, and respected” (Lancellotti, 2008, p. 180). The attainment of this type of relationship would be difficult, if not impossible, if the nurse harbors racist attitudes toward the patient.

The importance of this interaction from the patient’s perspective is exemplified in research conducted by Benkert and colleagues (Benkert, Hollie, Nordstrom, Wickson, & Bins-Emerick, 2009; Benkert & Peters, 2005; Benkert, Peters, Tate, & Dinardo, 2008; Benkert, Pohl, & Coleman-Burns, 2004). This body of research focused on White nurse practitioners (RNs) and African American/Black patients. An assumption of this research was that there is general mistrust of Whites based on exposure to racism as well as mistrust of the overall healthcare system (Benkert et al., 2009; Clark, 2009; Dovidio et al., 2008). Although focused on nurse practitioners, Benkert’s research demonstrated the importance of developing a trusting relationship within the nurse-patient interaction regardless of the care setting. If the patient perceives racism/racist attitudes on the part of the nurse and even if these perceptions remain unnamed, trust is negatively impacted, which in turn impacts quality of care (Benkert et al., 2009; Benkert & Peters, 2005; Benkert et al., 2004). Patients may not feel comfortable discussing certain healthcare issues, may not agree to or adhere to a treatment plan, or may not return (Benkert & Peters, 2005; Benkert et al., 2004; Clark, 2009; Dovidio et al., 2008).

The nurse-patient interaction is an interpersonal process (Hagerty & Patusky, 2003; Leininger, 1995; Travelbee, 1971; Watson, 1979); however, the process may be

very brief in some clinical settings (e.g., emergency departments, urgent care clinics). The nurse is in an authoritative role in this interaction based upon a healthcare knowledge differential (Hagerty & Patusky, 2003; Mohammed, 2006). Further, the patient is typically in a vulnerable position physically and emotionally and is at the mercy of the nurse for such basic needs as food, elimination, and pain control.

When the patient is of a different racial or ethnic group, this power differential is even greater. In the United States, White people are in power (Jones, 1997; Ponterotto et al., 2006; Wise, 2009) and nursing is predominantly a White profession (Nebraska Center for Nursing, 2009; National League for Nursing, 2008; Sullivan, 2004). When racism is present on the part of the nurse, the interpersonal process cannot proceed in the most optimal manner and the nurse-patient interaction is negatively influenced.

Review and evaluation of the 3-Dimensional Model of Cultural Competence developed by Schim and colleagues (Doorenbos et al., 2005; Schim et al., 2003) supports the assertion that cultural competence is embedded within the nurse-patient interaction. In fact, the title of the graphic depicting one section of the model is Provider Level (Doorenbos et al., 2005, p. 326). Literally, the starting point of culturally competent, non-racist care rests upon the provider; in nursing, this occurs within the nurse-patient interaction.

Summary

Critical social theory was the foundation of this research study. People of all colors have the right to healthcare that is equitable and just. The research detailing health disparities demonstrates that this is not the case in the United States (Halle et al., 2009; Smedley et al., 2003; Williams & Mohammed, 2009). Nursing is called upon to provide

equitable care to all patients based upon this principle of social justice (American Association of Colleges of Nursing, 2008c; American Nurses Association, 2001).

Cultural competence alone has not accomplished this goal.

Other healthcare disciplines have begun the work of exploring racism within their ranks (Green et al., 2004, 2005; LaVeist et al., 2000; Moody-Ayers et al., 2005). Nursing needs to contribute to this body of knowledge as well. This research provides new insights regarding cultural competence and racism at the frontline of nursing with RNs who provide direct patient care.

CHAPTER III

METHODOLOGY

Chapter III describes the methodology utilized for this study. The purpose of this research was to explore the existence and extent of racist attitudes in Registered Nurses (RNs) providing direct patient care as well as ascertain potential relationships between demographic factors, cultural competence, and racist attitudes. While current literature is replete with research related to cultural competence, there is a paucity of research related to cultural competence in direct patient care RNs and even less addressing racism in nursing. This chapter provides a discussion of the research design, setting and population, sampling procedure, provisions for the protection of human subjects, data collection methods, and statistical analysis of the data.

Conceptual Framework Review

The conceptual framework for this research included the following major concepts: cultural competence, nurse racism/racist attitudes, and the nurse-patient interaction. Simply stated, this researcher hypothesized that factors in addition to cultural competence impact the nurse-patient interaction (NPI) and ultimately quality nursing care (see Figure 2).

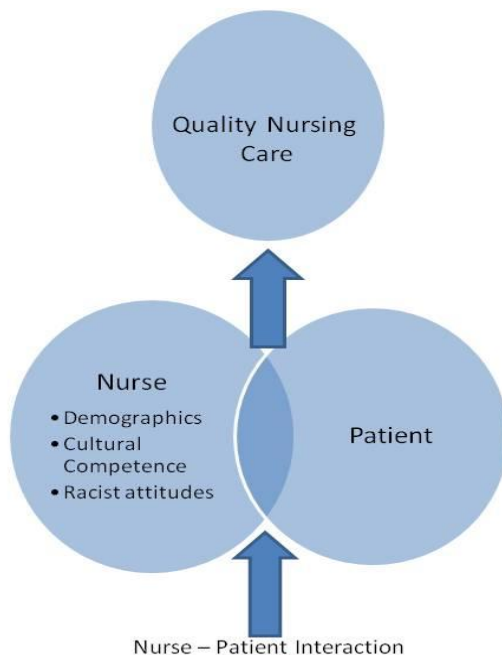


Figure 2. Cultural competence and racism in the nurse-patient interaction.

Because the nursing workforce remains disproportionately White (National League for Nursing, 2008; Sullivan, 2004) and is caring for an increasing number of patients that are not White, it was reasonable to consider racism/racist attitudes as one of these factors. Racism remains an issue in our country (Utsey et al., 2008; Wise, 2009). “Racism exists in society, so it exists in nursing” (Steeffel, 2008, p. 1).

Problem Statement

Nursing education is charged with the development of cultural competencies within nursing students including practicing RNs who are seeking higher degrees (e.g., Associate Degree RNs seeking a Bachelor of Science in Nursing degree). To that end, in 2008, the American Association of Colleges of Nursing (AACN; 2008a) released a document outlining the rationale for inclusion of cultural competency in nursing

education and detailing outcome expectations. Cultural competence is also highlighted in several outcome competencies in the AACN's *Essentials of Baccalaureate Education for Professional Nursing Practice* (American Association of Colleges of Nursing, 2008b).

The rationale for inclusion of cultural competency as a required element in the discipline of nursing includes the monumental problem of health disparities as well as the moral mandate, based upon the principle of social justice, to provide culturally competent, equitable care to all peoples (American Association of Colleges of Nursing, 2008a, 2008b).

Although cultural competence has been included in nursing education, both as pre-licensure and ongoing educational offerings for RNs, nursing education fails to address the issues of racism and discrimination directly (Fitzsimmons, 2009; Lancellotti, 2008; Porter & Barbee, 2004). Without empirical evidence, we cannot claim that racism does not exist within the discipline of nursing. Nursing cannot claim to provide equitable care if racism is impacting the nurse-patient interaction.

The focus of nursing on cultural competence, multiculturalism, and transcultural nursing as the "answer" to caring for a culturally diverse patient population has failed to eliminate negative patient outcomes leading to health disparities (Institute of Medicine, 2002; Seright, 2007; Smedley et al., 2003). It is important to note that the underlying causes of health disparities are complex; it is unreasonable to expect that culturally competent nursing care alone can eliminate health disparities. However, it is reasonable to expect that addressing this piece of the problem has the potential to improve the current healthcare situation.

Since the focus on cultural competence alone has not provided substantial progress toward eliminating health disparities, it is imperative to consider other factors, specifically racism, that potentially impact the care nurses provide. Is cultural competence related to racism/racist attitudes in nursing? Research data are needed to answer this question. Nurses and nurse educators may be comfortable discussing cultural competence but they are decidedly uncomfortable considering the possibility that racism is present and impacting the care nurses deliver to a diverse population (Barbee, 2002; Fitzsimmons, 2009). “Nursing must continue its struggle to name and acknowledge race and racism” (Porter & Barbee, 2004, p. 34). To that end, the following research questions were posed.

Research Questions

- Q1 What is the level of cultural competence of RNs providing direct patient care?
- Q2 What is the relationship between demographic factors and level of cultural competence of RNs providing direct patient care?
- Q3 Do RNs providing direct patient care report racist attitudes?
- Q4 What is the relationship between demographic factors and racist attitudes of RNs providing direct patient care?
- Q5 What is the relationship between level of cultural competence and racist attitudes of RNs providing direct patient care?

The research questions gave rise to the following hypotheses:

- H1 Level of cultural competence is associated with certain demographic characteristics (e.g., age, gender, self-reported race/ethnicity, nursing education level, and years in nursing practice).
- H 2 Racist attitudes exist in Nebraska RNs providing direct patient care.

- H3 Racist attitudes are associated with certain demographic characteristics (e.g., age, gender, self-reported race/ethnicity, nursing education level, and years in nursing practice).
- H4 Cultural competence levels are associated with racist attitudes.

Research Design

The quantitative design for this research was nonexperimental, descriptive, and correlational. Descriptive design focuses on describing and documenting conditions or aspects of a situation as they exist with the potential for future hypothesis generation or theory development (Houser, 2008; Polit & Beck, 2008). Correlational design seeks to discover relationships among variables, including the direction and strength of the relationship, but does not seek to establish cause and effect (Gall et al., 2007; Houser, 2008; Polit & Beck, 2008). This project sought to describe racist attitudes in RNs providing direct patient care as well as ascertain if any relationship exists among racist attitudes, demographic factors, and level of cultural competence. Findings of this study provide nursing with new knowledge regarding a specific phenomenon (i.e., racism in nursing) where little empirical data are available. In addition, the relationship between cultural competence and racism has been illuminated. Based upon these findings, revisions in nursing education regarding cultural competence are needed.

For this study, RNs providing direct patient care or directly supervising RNs who provide direct patient care were asked six demographic questions and completed the Cultural Competence Assessment (CCA) instrument (Doorenbos et al., 2005; Schim et al., 2005, 2006a) and the Quick Discrimination Index (QDI) instrument (Ponterotto et al., 1995, 2002, 2006). The CCA includes the Marlowe-Crowne Social Desirability Scale--Form C (MCSDS-C; Crowne & Marlowe, 1960), which was included in this research

project (Andrews & Meyer, 2003; Moss, 2008; Verardi et al., 2010). The MCSDS-C was added to the CCA in the second version (S. M. Schim, personal communication, August 13, 2010). Data from the demographic questions and the two instruments were analyzed to describe racist attitudes in this population and for any relationships among the demographic characteristics, level of cultural competence, and racist attitudes.

Research Protocol

The following section provides an overview of the research process that was utilized in this project. For clarity, the *data collection tool* included the demographic questions, the CCA, the QDI, and the MCSDS-C entered into one survey on the web-based Survey Monkey site (www.surveymonkey.com).

1. A database of the names and addresses of RNs licensed in Nebraska with a Nebraska address was obtained from the Nebraska State Board of Nursing. No email addresses are available.
2. A random sample of 1000 RNs was drawn from this population. (See subsequent section for procedure.)
3. An invitation and information document plus an informed consent document was mailed to the 1000 randomly selected RNs (see Appendices A and B). The URL Internet address to access the data collection tool on Survey Monkey was included in these documents.
4. Non-Internet users were informed that a paper format of the data collection tool would be provided upon request.

5. Based upon an inadequate response rate, the sampling plan was modified.
6. At the end of the data collection period, the data were downloaded into the Statistical Package for Social Sciences (SPSS) for data analysis.

Setting

Nebraska General Population

The setting for this study was a Midwestern state with the three largest cities situated in the far eastern portion of an essentially rural state. The following discussion of population demographics was based upon information from the U.S. Census Bureau (2009). To facilitate an understanding of the setting for this research project, comparisons were made between various counties and cities within Nebraska. This provided an overview of the patient population cared for by Nebraska nurses.

The estimated 2009 population of Nebraska was 1,796,619 with the vast majority of the population in the eastern one-third of the state. The three largest cities are Omaha (419,545), Lincoln (241,167) and Bellevue (47,594) which is situated just south of the city limits of Omaha. The fourth largest city is Grand Island (44,632), approximately 90 miles east of the geographic center of the state.

When race and ethnicity are considered, Nebraska is essentially populated by White non-Hispanic persons (84.1%), which compares to 65.6% White non-Hispanic persons for the United States. All categories of race/ethnicity are lower in Nebraska than in the remainder of the United States. The distribution of non-White population groups is sporadic with certain cities and counties in the state having a much higher percentage. For example, Douglas County (including the city of Omaha) is home to 11.7% Black persons, 2.5% Asian persons, 9.8% Hispanic or Latino persons, and 74.3% White non-

Hispanic persons while Custer County (in the center of the state) has 0.1% Black persons, 0.2% Asian persons, 1.4% Hispanic or Latino persons, and 97.1% White not Hispanic persons. Dawson County (which includes the city of Lexington--population 10,011) has 1.5% Black, 0.9% Asian, 31.2% Hispanic or Latino, and 65.8% White not Hispanic persons.

Lincoln, the capital city of Nebraska, has the highest percentage of Asians of any city in the state at 3.1% with Blacks at 3.1%. Hispanics or Latinos account for 3.6% of the population of Lincoln and 4.9% of the population of Lancaster County. One other county in far western Nebraska (Scotts Bluff) is home to a large Hispanic or Latino population at 19.1%. In contrast, Wheeler County (population 763) has 0.2% (approximately 2) American Indian/Alaska Natives and 0.6% (approximately 5) Hispanics or Latinos. Depending upon the location, a Nebraska RN may care for a number of patients from non-White population groups or may rarely/never care for a patient other than White non-Hispanic patients. As stated previously, statistical information for this section was obtained from a government website (U.S. Census Bureau, 2009).

Nebraska RN Population

The following nursing demographics are based upon data collected during the 2008 RN license renewal period (Nebraska Center for Nursing, 2009). The data were developed from surveys returned by RNs who work in Nebraska ($n=17,735$ returned and usable). By gender, male RN numbers increased by 148% from 2000-2008 but still comprise only 5.6% ($n=1,213$) of the Nebraska RN population.

Mirroring the national trend, the aging of the Nebraska RN population continues. Female RNs between 51 and 60 years of age were the highest percentage at 25.3% ($n=4,336$) with the 41-50 age group closely behind at 24.2% ($n=4,145$). Male RNs were distributed fairly equally among three age groups: 31-40 at 1.4% ($n=248$), 41-50 at 1.3% ($n=227$), and 51-60 at 1.1% ($n=194$; Nebraska Center for Nursing, 2009, p. 8).

Educational preparation of Nebraska nurses varies from the national trend with a much higher percentage having a baccalaureate degree in 2004: United States--31% of the men and 30.5% of the women had earned baccalaureate degrees; while in Nebraska, 58.7% of the men and 48.8% of the women had earned baccalaureate degrees. In 2008 in Nebraska, this trend continued with 54.5% of the men and 50% of the women holding a baccalaureate degree.

Nebraska's percentage of racial/ethnic RNs has fluctuated and increased slightly over the past eight years; however, it is still only at 3.6% compared to the national percentage in 2004 of 18.2% (Nebraska Center for Nursing, 2009, p. 10). Nebraska's nursing workforce is strongly underrepresented by racial or ethnic groups other than White non-Hispanic. Based on self-reported racial/ethnic categories of RNs licensed in Nebraska, White non-Hispanic comprised 94.9%, African American/Black was 1.2%, Hispanic was 1.4%, Native American was 0.2%, and Asian/Pacific Islander equaled 0.8%; the remainder were designated as "other" and "unknown" (Nebraska Center for Nursing, 2009). Even though the general population of Nebraska is less diverse than the U.S. population, the RN work force in Nebraska demonstrates even less diversity. The lack of a diverse RN workforce reinforced the possibility of racism/racist attitudes in nursing and confirmed the value of this research.

Sampling Procedure

A list of RNs licensed to practice in Nebraska was obtained from the State Board of Nursing in February of 2010; 23,997 names were included in an Excel spreadsheet. Utilizing the sort function, all RNs with a mailing address in Nebraska were identified and copied into a new Excel spreadsheet. This database included 22,312 RNs with a mailing address in Nebraska. The Excel spreadsheet was then opened in the Statistical Package for Social Sciences (SPSS), Version 17.0. Using the “Select Cases” function, a random sample of 1000 names was drawn (between case 1 and case 22312). This random sample of 1000 RNs was saved in an Excel spreadsheet to facilitate printing of envelopes for distribution of the invitation to participate in this research project.

The total number of RNs to sample was based upon power analysis coupled with an estimated response rate of less than 30% (see subsequent discussion). The list provided by the State Board of Nursing did not allow for a subpopulation of direct patient-care providers to be identified. Therefore, some of the sample selected did not fit the inclusion criteria. In addition, the database obtained from the State Board of Nursing was based upon license renewal in December 2008, increasing the likelihood that some addresses were incorrect. Ford and Bammer (2009) cite inaccurate addresses as one reason for low response rate for mail surveys. However, utilization of a mailing service by this researcher decreased the impact of inaccurate addresses. The mailing service was able to locate “997 mailable [*sic*] addresses” from the 1000 drawn in the random sample (B. Cummins, personal communication, January 5, 2011). Data collection in this project primarily took place in the online environment; however, the initial invitation to participate was mailed.

Power Analysis

A priori power analysis was conducted with G*Power 3 (Faul, Erdfelder, Lang, & Buchner, 2007) by a statistical consultant (L. Struwe, personal communication, October 21, 2010). Schim et al. (2005) predicted a medium-sized relationship and utilized an α of .05 and a β of .20 for regression analysis of eight independent variables, which would require a sample size of 114 with the CCA (pp. 356-357). In a subsequent research project using the same alpha and beta levels with a medium-sized relationship with four independent variables, the necessary sample size was estimated at 82 (Schim et al., 2006a, p. 304). Although the researchers expected a medium effect size, the value of Cohen's d and the effect-size correlation, using the means and standard deviations of two groups on CCA values was calculated for Schim et al. (2003) and showed a large effect size of $d = .89$. Based on this finding, using a medium effect size is more than adequate and is justified for these calculations. Because of prior research discussed in this work, assuming a directional association between the variables is unwarranted; therefore, a two tail test is most appropriate and was used for the following power analysis.

There were five demographic (independent) variables in this research project: gender, age, self-reported race or ethnicity, nursing education level, and years of nursing practice--the first three being naturally dichotomous and the last two being continuous. A sixth variable--environment of nursing practice--was utilized as an inclusion criteria check (i.e., direct-patient care deliverer or supervisor requirement) but will not be statistically analyzed. The a priori power analysis for the dichotomous items was conducted as a two tailed test with $\alpha = .05$, $\beta = .20$, and a medium effect size = .30.

Utilizing these parameters, a sample size of 134 is required to detect the critical t -value of 1.98 ($df = 132$).

The first section of research question three was examined using Analysis of Variance (ANOVA) to determine if differences in the categorical demographic characteristics (gender, racial/ethnic self-identification, educational preparation) were statistically significant compared to QDI subscale scores. Based upon the a priori power analysis ($\alpha = .05$ to achieve power of .80 and a medium effect size = .30), a sample size of 148 was required to detect the critical F-value ($F(1,146) = 3.91$).

The second section of research question three was examined using hierarchical regression analysis with the continuous demographic variables (age and years as a nurse) to evaluate whether these attributes modified QDI subscale scores. A two tailed, two predictor, hierarchical regression, a priori power analysis with an effect size = .15, $\alpha = .05$ and power of .95 required a total sample size of 89.

The outcome of the three power analyses are 134, 148, and 89. Therefore, a sample size of 150 was recruited for this research project.

Strategies to Increase Response Rate

Literature-based recommendations for increasing the likelihood of an adequate response rate were utilized in this research project. Offering an incentive for participation is an effective method to increase response rate (Division of Instructional Innovation and Assessment, 2007; MacDonald et al., 2009; Survey Monkey, 2009). With older participants, a monetary gift is thought to be more beneficial (Survey Monkey, 2009). Providing even a \$5 incentive to each of the 1000 randomly selected potential participants in this research project would cost \$5000. A more cost-effective strategy

was to offer a \$200 prize drawing to those who participate in the research project. Entry into the drawing was separate from the data collection survey site.

Providing a monetary incentive in nursing research is not morally or ethically problematic per se (Ulrich & Grady, 2004). The researcher must decide what amount would be compensatory but not coercive. The participant is, in effect, donating his or her own time to provide research data. In addition, financial incentives must be utilized with care to avoid introducing systematic bias by disproportionately increasing responses from low-income subjects (MacDonald et al., 2009). In this study, all potential participants were in the same profession (RN) with a mean salary of \$53,490 in 2008 (Nebraska Center for Nursing, 2009). Providing one \$200 prize to be randomly drawn from all participants in this project provided the possibility for compensation for time spent but was not coercive as the participants were clearly notified that only one participant would be awarded the prize.

Because this research was conducted using established tools, survey design was not an alterable element. However, when the tools were entered into the Survey Monkey site in preparation for this research, all of the questions and responses were standardized so that positive responses (*strongly agree, agree*) were to the left and negative responses (*strongly disagree, disagree*) were to the right. This strategy decreases the likelihood of confusion or frustration for participants taking the survey. In addition, a practice survey site was set up on Survey Monkey. Friends and colleagues were asked to take the survey to evaluate flow, format, and time needed to complete. The average completion time for 11 people was 15.57 minutes. According to MacDonald et al. (2009), shorter

questionnaires support higher response rates. There were no suggestions or problems identified related to format.

MacDonald et al. (2009) report that the use of colored ink in postal surveys enhances response rate. Adding color to the invitation and information document would add to the printing costs and might not be a good use of resources. However, the Survey Monkey site allowed the use of different color palettes to enhance survey design and this was utilized.

Identification of university affiliation or sponsorship provides credibility for the researcher and enhances response rate (MacDonald et al., 2009). The use of the University of Northern Colorado (UNCO) logo on the informed consent document is required and lends credibility to the research project. In addition, the invitation and information document included the URL web site address to this researcher's faculty web page at Nebraska Wesleyan University. Contact information for the researcher's advisor and the Institutional Review Board (IRB) of UNCO is on the informed consent document (see Appendix A). These strategies support an improved response rate.

The sensitive nature of the topic of racist attitudes/racism has the potential to decrease the number of participants. Anonymity rather than just confidentiality was instituted in this research project. No signed informed consent was obtained; taking the survey implied consent. This strategy also decreased the likelihood of social desirability response bias, although that was assessed with the MCSDS-C.

Response Rate

Response rate is the percentage of those asked to participate who complete the data collection procedure (e.g., questionnaire, survey, tool, interview; Division of

Instructional Innovation and Assessment, 2007; Survey Monkey, 2009). What is considered an acceptable response rate varies depending upon expert opinion as well as how the survey is administered (Badger & Werrett, 2005; Division of Instructional Innovation and Assessment, 2007). Acceptable response rates for surveys are as follows: mail--50% adequate, 60% good, 70% very good; online--30% average (Division of Instructional Innovation and Assessment, 2007, p. 1). Because the invitation to participate was mailed but the survey was administered in the online setting, a response rate of 30% was expected. This expectation was adjusted based upon the sensitive nature of the topic, the need for participants to actually go online and then type the URL (internet address) of the survey into their web browser (e.g., Internet Explorer, Firefox), and the unknown number of potential participants who would not meet the inclusion criteria. A response rate of 15% seemed more reasonable, which set the random sample size at 1000 to yield the required 150 participants.

It is important to note that a low response rate does not necessarily mean that bias has been introduced into the research. The issue is whether there is a statistically significant difference between responders and non-responders on key variables (MacDonald, Newburn-Cook, Schopflocher, & Richter, 2009). Ford and Bammer's (2009) nursing research found few differences between responders and non-responders (original $n=3,816$) and no differences in demographic or professional characteristics. Assessing non-responders in this project was difficult because of the desire to provide participants with anonymity; no contact information was recorded with the actual survey and no Internet Protocol (IP) address was stored in Survey Monkey during the survey administration. However, an invitation to non-responders to share reasons with the

researcher was included on the Invitation and Information document that was mailed to the random sample (see Appendix B). One potential participant left a telephone message stating that she was already in two research projects and did not desire to be a part of another.

Random sample. In this research project, approved by the University of Northern Colorado's Institutional Review Board (IRB; see Appendix C), 1000 randomly selected RNs were invited to participate. Originally, the data collection period was set at three weeks from the day the invitations to participate were mailed. At the end of two weeks, there were only 50 participants. Permission was obtained from this researcher's IRB to mail a reminder postcard to the original random sample (see Appendix D). This was done approximately two weeks following the original invitation to participate. The data collection period was extended by two weeks (see Appendix E for postcard message). Two weeks following the postcard reminder, 86 participants yielded an insufficient response rate of 8.6% at this point in the process.

Three potential participants requested a paper and pencil copy of the survey. One participant left the following message with her request: "I'm not sure I can get onto any kind of monkey thing on my computer." This comment illustrates a potential reason for a lower than expected response rate—difficulty with the technological aspects of an online survey. This also could be an indication of response bias. Although a paper and pencil copy was offered to potential participants, those who could not or did not want to use a computer might not go to the trouble of requesting the paper and pencil version. If an accurate assessment, this segment of the random sample was, in effect, excluded from the research.

Based upon the inadequate response rate, a Change of Protocol was filed with this researcher's IRB Committee, requesting a change from a random sample to a convenience sample (see Appendix F). The cost of the initial mailing plus the postcard was \$696.41. The option of drawing a second random sample was considered; however, to ensure adequate participants, a sample of at least 1000 would be needed at an additional cost of almost \$700 for printing and mailing the original invitation plus a follow up postcard.

Although this revision decreased the generalizability of the study, obtaining an adequate sample for statistical analysis while managing budgetary constraints made this a feasible option. According to the statistical consultant, changing the sampling plan from a random sample to a convenience sample does not change the number of participants required nor the analysis of data but does change the interpretation of the results (L. Struwe, personal communication, February 1, 2011).

Convenience sample. One month following the mailed invitation, this researcher received permission from the IRB to change to a convenience sample (see Appendix G). At that time, there were 90 participants, yielding a response rate of 9%; this was an inadequate sample size based upon the power analysis completed. These data were downloaded from Survey Monkey to enable a description of the participants before adding them from the convenience sample. One of the three participants who requested a paper and pencil copy of the survey returned the survey before the change to a convenience sample. A second and third paper and pencil survey were received after this revision and were included with the final sample. These two data sets were subsequently identified as part of the random sample within the SPSS program by date and time when

this researcher entered the data into Survey Monkey plus confirmation based upon the age of the participant and years in nursing.

With the approval of the IRB and Nebraska Wesleyan University (NWU; see Appendix H), an invitation to participate was posted on NWU's Blackboard (BB) site. The site has a section for Bachelor of Science in Nursing (BSN) and Master of Science in Nursing (MSN) students. All students in these programs must be licensed RNs. The invitation with the link to Survey Monkey was posted on the announcement page of the "BSN and MSN Nursing Program" BB site and emailed to all nursing students. The researcher also emailed all nursing friends and colleagues with the invitation and asked that the invitation be extended to other RNs who might fit the inclusion criteria (see Appendix I). Some nursing friends and colleagues were invited to participate via a social networking site, the technological version of "word of mouth" contact.

Within 48 hours of initiating the convenience sample, 60 new participants had completed the data collection tool, bringing the total to 150. The executive director of the Nebraska Nurses Association sent the invitation to participate via email to the membership five days before the close of data collection. This organization has a membership of approximately 800 RNs.

The prize drawing date had been extended when the reminder postcards were mailed. Data collection continued until the date for the prize drawing was reached. At that time, there were 245 participants in the study, although some did not represent complete data sets. Of the 245 participants, 219 had entered the drawing. Although the potential participants were assured that the prize drawing site was separate from the data collection site, some might have feared their data could be connected to their identity and,

therefore, chose not to participate in the prize drawing. In addition, some participants started the survey but did not finish. Although the URL to the prize drawing entry was provided on the last page of the survey, these RNs would not have seen the address to the prize drawing site if they did not complete the survey.

Selection of the prize drawing winner was accomplished in the following manner:

1. The list of participants who entered the drawing was downloaded from Survey Monkey into an Excel spreadsheet.
2. The spreadsheet was numbered from 3 through 221.
3. Using an online random number generator (www.random.org), one number between 3 and 221 was drawn. Number 155 was selected.
4. The participant on line 155 of the Excel spreadsheet was identified as the winner of the prize drawing. The winner was notified by email and a check for \$200 was mailed to the participant that same day. Permission was requested and received to publish the name of the winner. Her name was listed on this researcher's faculty web page, the NWU BSN and MSN student Blackboard site, and on this researcher's Facebook page.

Protection of Research Participants

The risks for participants in this research project were minimal. There is no physical risk and any emotional discomfort or anxiety should be no greater than that experienced when sensitive topics are discussed. Participants were assured of their right to decide whether to participate and whether to continue participation without fear of coercion.

Upon the advice of the developer (Ponterotto et al., 1995), Green et al. (2005) entitled the Quick Discrimination Index (QDI) *Social Attitudes Survey* in their research with White social workers. The authors of the QDI provided the following rationale:

Given the “politically correct” nature of the prejudice topic, steps were taken to attenuate the possible effects of social desirability contamination...Second, the title “Social Attitudes Survey” (not “Quick Discrimination Index”) appears on the actual instrument to control somewhat for potential subject demand characteristics and evaluation apprehension. (Ponterotto et al., 1995, p. 1018)

That terminology was utilized as the page title in Survey Monkey for the section that includes the QDI as well as in the language of the documents provided to potential participants. As discussed previously, even the use of the terms *racism* or *racist attitudes* (or *discrimination* as a proxy term for racism) is viewed as objectionable (Tang & Browne, 2008). When discussing the topic of this research project with nursing colleagues, there has typically been a pause in the conversation and sometimes an audible intake of breath. This topic was sensitive enough to justify the use of the term *social attitudes* rather than *racism* or *racist attitudes*.

All participants were licensed RNs over the age of 18. It is impossible to ascertain if any of the participants belong to a vulnerable population group. For the original random sample, potential participants were contacted via a written invitation sent through the U.S. mail service, which precluded any possibility of face-to-face coercion to participate. The informed consent document was included in the envelope with the invitation to participate. Once the participants accessed Survey Monkey, they had a second opportunity to read the informed consent document and were reminded that taking the survey implied their informed consent (see Appendix J for copy of survey). In this manner, participants remained anonymous since no identifying data were attached to their

survey nor was an Internet Protocol (IP) address collected by Survey Monkey. At the completion of the survey, participants were directed to a completely separate site within Survey Monkey to enter the drawing for the \$200 prize (see Appendix K).

Potential participants who did not have Internet access or preferred a paper survey were asked to contact the researcher. A paper and pencil copy of the survey, an addressed and stamped envelope, and a postcard for entry into the contest were mailed.

This research was conducted using the professional version of Survey Monkey that is encrypted to protect the data. During the course of the research project, downloaded data were housed on a password-protected computer in the researcher's locked office. Paper surveys were kept in the researcher's locked file cabinet in a locked office. After the data were entered into the Survey Monkey site and final data analysis was completed, paper copies were destroyed. All possible efforts were made to ensure confidentiality and security of research data and no apparent breaches in security were discovered. At the conclusion of this research project, a summary of the findings was provided on the researcher's Faculty Profile page on the Nebraska Wesleyan University website: <http://www.nebrwesleyan.edu/node/1264>

Data Collection

Three instruments plus six demographic questions were used to collect data for this research project. The following section provides an in-depth discussion of instrument development and the psychometric properties of the tools.

Cultural Competence Assessment Instrument Development

Initial development and research. Initial development of the CCA was based upon the Schim and Miller cultural competence model that became the 3DPM in later

iterations (Doorenbos et al., 2005; Schim et al., 2003). The items were derived from this model plus an extensive literature review. The authors used Dillman's tailored design method (Schim et al., 2003, p. 31). Originally there were a total of 45 items with six items addressing the cultural diversity construct and three subscales (awareness--11 items, sensitivity--10 items, and competence behaviors--17 items) addressing the remaining constructs of the model (Schim et al., 2003). The items were reviewed for clarity, grammar, and reading level (approximately the fifth-grade level) by two independent English language experts (Schim et al., 2003). This attention to language is important; the authors sought to design an instrument that was valid for most educational/literacy levels of participants.

Phase II consisted of an extensive expert review process. Because the tool was being designed for use with a broad audience of healthcare providers and hospice care involves a broad interdisciplinary team, the authors chose 10 hospice experts to review the tool, which exceeded the suggested ≥ 7 (DeVon et al., 2007, p. 161). A second group of end-of-life experts in the fields of anthropology, sociology, psychology, gerontology, education, and law were called upon to augment the review process. Each panel performed two rounds of reviews and documented their opinions via a Likert-type scale as far as relevance to concepts and the overall scale: 1 = *not well*, 2 = *somewhat well*, 3 = *well*, and 4 = *very well* (Schim et al., 2003, p. 33). Items that scored below a 3 were either deleted or revised.

Phase III consisted of field testing the revised scale with a group of seven hospice workers (pastoral care, social work, nursing, and volunteers). The CCA was administered verbally to allow for identification of items that were ambiguous or easily

misinterpreted. The authors were also concerned with the clarity and use of the *no opinion* or *not sure* responses as opposed to the use of the *neutral* response (Schim et al., 2003, p. 34). The panel did not identify this as a problem.

Phase IV involved a pilot research project utilizing a convenience sample of interdisciplinary hospice employees and volunteers. Surveys were distributed to 125 participants; 119 were returned and 113 were complete and deemed usable (Doorenbos & Schim, 2004; Schim et al., 2003). The disciplines represented in the sample included nursing, social work, nursing assistants, clerical, clergy, volunteer, administrative, and five other disciplines represented by one respondent each. The mean age was 45 and the majority was Caucasian (82%). Educational backgrounds ranged from high school (18%), associate degree (23%), bachelor's degree (26%), to graduate degree (31%) (Doorenbos & Schim, 2004; Schim et al., 2003). This sample was congruent with the goal of Schim and colleagues to develop an instrument to measure cultural competence across disciplines and educational levels.

Reliability and validity assessments resulted in the deletion of 14 items--seven based upon item-to-total correlations below 0.30 and seven based upon factor analysis (Schim et al., 2003). For the remaining 25 items, the internal consistency reliability was 0.92 with the 17-item cultural competence (behavior) subscale scoring 0.93 and the 8-item awareness and sensitivity subscale (collapsed from two subscales to one during the process of data analysis) scoring 0.75. According to DeVon et al. (2007), a coefficient alpha of 0.70 is acceptable for new scales, although they cite other scholars who opine that 0.90 should be the minimally accepted level. Of note, DeVon et al. (2007) utilized

the subsequent work of Schim et al. (2005) as an example of superior reliability testing and reporting.

The authors did not account for cultural diversity items in their discussion. They reported seven multiple choice items in Table 1 for the Pilot Test phase and the Next Step phase of development (Schim et al., 2003, p. 32). In the first draft of the instrument, six items were designated to measure the cultural diversity construct:

1. Identification of racial/ethnic/cultural groups encountered in the past year
2. Personal racial/ethnic/cultural group affiliation
3. Age
4. Educational level
5. Years of practice
6. Discipline/professional affiliation/role

As the authors stated, these questions were primarily related to demographics. In actuality, only number one measured cultural diversity as defined by the model and this related only to the scope of the experience but not the depth. Subsequent versions of the CCA addressed this issue and are discussed later.

To evaluate criterion-related validity of the CCA, the Inventory for Assessing the Process of Cultural Competence (IAPCC; Campinha-Bacote, 2002, 2008a) was administered. This model of cultural competence is well publicized and the IAPCC is an established, widely used instrument. Scores on the CCA were moderately correlated ($r = 0.66$) with the IAPCC scores, which is generally acceptable at $r = 0.50$ (DeVon et al., 2007).

The researchers reported results of the pilot study before the revisions were made to the instrument (Doorenbos & Schim, 2004). Therefore, results are reported for the 39-item CCA instrument. The mean score was computed by summing the items for each subscale and dividing by the number of items; possible scores ranged from 1 to 5 with a higher score being indicative of greater cultural competence (see Table 1 for a summary of the findings).

Table 1

Cultural Competence Scores of Hospice Employees and Volunteers

Scale	Range of Scores	Mean (<i>SD</i>)
Total Cultural Competence	2.3-4.8	3.9 (3.98)
Subscale-Awareness	3.0-4.9	4.0 (0.86)
Subscale-Sensitivity	3.5-4.9	4.0 (0.58)
Subscale-Cultural competence behavior	1.1-4.8	3.9 (3.98)

The total cultural competence scores and the cultural competence behavior subscale (CCB) showed a large variance with both standard deviations at 3.98 and the range of scores of the latter at 3.7 points. These scores indicate a wide variation in the cultural competence of the hospice staff that participated in this research project (Schim et al., 2003).

The cultural diversity construct, as measured in this research by the six items discussed in the previous section, yielded no statistically significant differences except for educational level. Using ANOVA, the CCA scores were significantly different, $F(3, 89) = 5.32, p = .002$. Participants with a high school education scored significantly lower than participants with a bachelor's degree ($p = .017$) or with a graduate degree ($p = .001$). Related to education, respondents who reported having previously received diversity training (mean = 4.3, $SD = 3.4$) had significantly higher cultural competence scores than those reporting no training (mean = 3.4, $SD = 4.6$). Of note, the number of racial/ethnic groups with which the respondents had experience did not yield statistically significant differences in scores. Assuming that this is an accurate measure of the cultural diversity construct, these results are unexpected and differ from the evidence-based focus that Campinha-Bacote (2010) has recently accorded cultural encounters as a key element in the development of cultural competence.

Modifications and subsequent research. The next phase of instrument development and testing included two research projects--one with hospice workers ($n = 51$) and one with a group of healthcare providers ($n = 405$; Doorenbos et al., 2005)--with the aim of examining the test-retest reliability of the CCA with the hospice workers and the reliability and validity of the CCA with healthcare providers in non-hospice settings.

Test-retest reliability was established by evaluation of data from a quasi-experimental, crossover designed research project with 51 of 130 total hospice workers (Doorenbos et al., 2005; Schim et al., 2006b). The aim of this study was to evaluate the effect of an educational intervention on level of cultural competence with the additional capability to assess the test-retest reliability of the CCA instrument (Schim et al., 2006b).

Eight hospice agencies were assigned by cluster randomization to intervention or control groups. The intervention and control groups completed the CCA at baseline followed by a one-hour cultural competence educational session (intervention) or a one-hour educational program related to ethics and legal issues with end-of-life care (control). Both groups completed the CCA immediately following the educational session (posttest time 1). The crossover occurred three to four months later with the intervention group receiving the ethics program and the control group receiving the cultural competence program. Again, the CCA (posttest time 2) was administered to both groups following the educational sessions.

The sample ($n = 130$) reflected the characteristics of hospice healthcare providers: varied educational levels (high school through graduate school) as well as professions (administration, clergy, clerical, nurse, nursing assistant, social work, volunteers, and other). The self-identified racial/ethnic groups represented were White (78%), African American (19%), American Indian (2%), and Hispanic (1%; Schim et al., 2006b).

Results of this research showed statistically significant increases in cultural competence scores following the modest (one-hour) cultural competence educational intervention in both the intervention and control groups. There was no statistically significant difference in the pretest score between the two groups, indicating that the randomization process was adequate (i.e., equivalent at the beginning of the research project). The overall cultural competence scores were significantly higher following the educational intervention ($X = 4.5$) than at baseline ($X = 3.4$; $p = .034$). At time 1, the intervention group's cultural competence score changed by .56 while the control group's cultural competence score changed by .11. With the crossover, the control group's

cultural competence score increased by .39 and the intervention group's cultural competence score increased by .22 following the ethics educational intervention. The increase in the intervention group from time 1 to time 2 was attributed to "having time after the educational intervention to put new skills and perspectives into practice before the time 2 assessment" (Schim et al., 2006b, p. 409). It is possible that some content or discussion within the ethics educational intervention impacted the CCA score as well, although "ethical issues involving either culture or diversity were excluded from the control program" (Schim et al., 2006b, p. 407). The control group also showed an increase in the CCA score following the ethics educational program from 3.81 to 3.92 but this was not reported as being statistically significant. No results by profession were reported.

Doorenbos et al. (2005) utilized data from the 51 control group participants to assess the test-retest reliability for the CCA tool including the two subscales (CCB and CAS). Reliability coefficients $\geq .80$ are considered sufficiently reliable for use in research (Gall et al., 2007; Polit & Beck, 2008). Over a four-month period, the overall CCA tool showed $r = .85$ ($p = .002$), the subscale CCB scored $r = .87$ ($p = .002$), and the CAS scored $r = .82$ ($p = .002$; Doorenbos et al., 2005). These measures exceeded the necessary level ($r = .80$) to establish test-retest reliability.

To evaluate reliability and validity, the researchers recruited a convenience sample of 405 healthcare providers from hospitals, a community health agency, and a home health agency (Doorenbos et al., 2005). Participants were asked to complete the paper and pencil form with the original 38 items that were included in the subscales: awareness--11 items, sensitivity--10 items, and competence behaviors--17 items

(Doorenbos et al., 2005; Schim et al., 2003). Factor analysis was utilized to obtain a two-factor solution. The 16 CCB items accounted for 38% of total variance and the 11 CAS items accounted for 18% of total variance (Doorenbos et al., 2005).

The internal consistency of the tool was evaluated by determining the Cronbach's alpha coefficients for the whole scale (CCA) and the subscales. Reliability of the CCA and the two subscales was acceptable (CCA = .89, CCB = .91, and CAS = .75). Additionally, the Cronbach's alpha-if-item-deleted scores ranged from .87 to .89, which means that no items were found to be unreliable. With the final version (27 items total in the CCB and the CAS subscales), the item to total correlation coefficients ranged from .32 to .60, indicating that all items should be part of the scale (< .30 being the cut-off value; Doorenbos et al., 2005).

One item asked if the participant had previous diversity training. CCA scores of the two groups (training vs. no training) were then compared using a two-tailed *t* test. Scores for the providers who reported previous diversity training were significantly higher: $t(392) = 2.22, p < .001$, two-tailed (Doorenbos et al., 2005). This finding supports the sensitivity of the tool "in detecting differences in cultural competence among healthcare providers" (Doorenbos et al., 2005, p. 328).

Cultural diversity is identified as an index (based upon one measure) rather than a subscale (Doorenbos et al., 2005). This was reported as a mean number of racial/ethnic groups cared for; the range was 0-6 (Doorenbos et al., 2005; Schim et al., 2006b). As noted previously, this index does not completely capture either the breadth or depth of individual experiences with diverse populations nor does it align with the theoretical definition of diversity used by these nursing scholars (Doorenbos et al., 2005; Schim et

al., 2006a, 2006b, 2007). The authors revised the tool to include other diverse population groups (e.g., mentally or emotionally ill; gay, lesbian, bisexual, or transgender) and questions assessing percent of time spent with each group (racial/ethnic groups and other diverse groups). In the 2005 work, the researchers report a plan to scale the cultural diversity items for the amount of contact with each group and suggest that this revision “will allow for diversity experience to be treated as a subscale comparable to the CAS and the CCB, and to be included in the overall CCA scale...” (Doorenbos et al., p. 330).

The most recent version of the CCA includes the questions as discussed above; however, the *percent of time* questions are scored by describing the distribution pattern rather than being scaled as was originally planned (Schim, 2009). A question assessing the respondents’ self-reported cultural competence has been added as well (“Overall, how competent do you feel working with people who are from cultures different than your own?”) and is answered with a 5-point Likert scale ranging from *very competent* to *very incompetent* (Schim, 2009). This version of the CCA has also been reformatted from the original 5-point Likert scale to a 7-point Likert scale for the remainder of the questions. While this makes comparisons of cultural competence levels from previous research more challenging, it also provides higher quality data for statistical evaluation (L. Struwe, personal communication, October 9, 2010). The development of the diversity subscale has not been accomplished at this time.

Because of the potential for respondents to be strongly influenced by social desirability, the Marlowe-Crowne Social Desirability Scale (MCSDS)--Version C was added to the CCA in the second version of the tool (Doorenbos et al., 2005; S. Schim, personal communication, August 13, 2010). This is a 13-item instrument (Short Form C)

based upon the original Social Desirability scale developed in 1960 by Crowne and Marlowe (Andrews & Meyer, 2003; Moss, 2008; Reynolds, 1982). Based upon reliability and validity, this short form of the MCSDS was identified as one of the two strongest forms psychometrically (Reynolds, 1982, p. 124). Internal consistency scores ranged from .62 to .89 (Andrews & Meyer, 2003; Moss, 2008). A six-week test-retest correlation of .74 and correlation with scores on the original MCSDS of .91 to .965 provided support for the use of this abbreviated tool (Andrews & Meyer, 2003).

The reliability and validity of this instrument supports its use in this research project. Permission for the use of the tool was obtained from Dr. Schim with the caveat that reliability statistics be reported to her following the research data analysis. At this time, no fee is assessed for the use of the tool. It is appropriate for use with RNs--the population of interest in this project.

Quick Discrimination Index Instrument

The Quick Discrimination Index (QDI; Ponterotto, 2009) is a 30-item Likert-type, self-report tool developed to measure attitudes toward racial diversity and women's equality (Ponterotto et al., 1995). It consists of three subscales: Factor 1--Cognitive Racial Attitude Scales, Factor 2--Affective Racial Attitude Scale, and Factor 3--Attitudes Toward Women's Equity Scale. The QDI assesses attitudes or positive/negative objects of thought toward racial minorities (Factors 1 and 2) and toward women (Factor 3; Ponterotto et al., 2002). The first two subscales (factors) will be used in this research project with the author's approval; when scoring separate subscales, 23 items are scored (J. Ponterotto, personal communication, May 27, 2009). Of note, the QDI is not a direct measure of discrimination or racism but rather a measure to assess the attitudes presumed

to underlie potential discriminatory or racist behavior (Green, Hamlin, Ogden, & Walters, 2004; Ponterotto et al., 2006). Discrimination occurs when a person is treated differently based upon race or other personal attributes. Racism is discriminatory feelings or actions that are based upon race (Agnes, 2002). The QDI Factors 1 and 2 serve as a proxy measure for racist attitudes.

The QDI possesses adequate to good psychometric properties. Cronbach's alpha for the full scale was .88, Factor 1 was .80, and Factor 2 was .83 (Ponterotto et al., 1995). Fifteen-week test-retest coefficients yielded a mean of .90 for Factor 1 and .82 for Factor 2. Convergent and discriminant validity checks were conducted using the New Racism Scale (NRS; Jacobson, 1985), the Multicultural Counseling Awareness Scale (MCAS; Ponterotto, Gretchen, et al., 2002; Ponterotto et al., 1994), and the Marlowe-Crowne Social Desirability Scale (SDS; Andrews & Meyer, 2003; Reynolds, 1982; Verardi et al., 2010). The NRS correlated with all three QDI scales and more highly, as would be expected, with Factors 1 and 2 (Ponterotto et al.). Based upon correlations with the SDS scores, "social desirability contamination is not a concern" with the QDI (Ponterotto et al., p. 1028). For an in-depth discussion of the development and properties of this instrument, see Chapter II.

Demographic questions include gender, age, self-selected race/ethnicity, nursing education, years in nursing, and environment of nursing practice area. These questions are based upon those included in the CCA with modifications appropriate for this research project. The question eliciting type/area of nursing practice will be utilized as an inclusion/exclusion criteria check.

Data for this research project were primarily collected using an online data collection site. Survey Monkey is used extensively by business as well as academic entities to collect data. When the questions from each of the instruments (CCA, QDI, MCSDS-C) were entered into Survey Monkey, any which required reverse scoring were entered as such. Therefore, when the data were downloaded from Survey Monkey, they were ready for analysis. The complete survey instrument can be reviewed in Appendix J.

Statistical Analysis

Data were analyzed by L. Struwe, a statistical consultant, and this author using SPSS Version 17.0. Preliminary analysis included descriptive statistics and frequency on all outcomes. Descriptive statistics were used to describe the sample characteristics as well as measurements of the CCA and QDI including all appropriate subscales and included means, frequencies, standard deviations, and reliability measures. The data from the MCSDS-C were evaluated for correlation with the CCA, the CRAS, and the ARAS. With this scale, scores range from 0-13 with higher scores indicating more need for approval.

The following section provides a review of each research question and a discussion of the attendant statistical procedures that were used to answer the question.

Q1 What is the level of cultural competence of Nebraska RNs providing direct patient care?

This question was answered with data collected from the Cultural Competence Assessment (CCA) tool. Coding and scoring information was provided to this researcher by the author (S. C. Schim, personal communication, November, 2009). The CCA includes two subscales: Cultural Awareness and Sensitivity (CAS) and Cultural Competence Behavior (CCB) plus two items to directly measure diversity experience.

The diverse populations encountered will be tallied so that the higher the number the greater the diversity experience of the respondent (cultural diversity--CD); the range is 0-16. The CAS is an 11-item subscale that uses a 7-point Likert type scale with reverse scored items to preclude response set bias; the range is 1-7 with a larger number indicating greater cultural awareness and sensitivity.

The CCB is similarly designed but includes 14 cultural behavior items with a range of 1-7. A larger number is indicative of more cultural competence behaviors. The total CCA score (range is 2-30) is obtained by adding the scores of the CAS (range is 1-7), the CCB (range is 1-7), and the diversity experience number (CD--range is 0-16). Descriptive statistics will be used to describe the cultural competence of direct patient care RNs including all three subscales plus the total CCA score.

In addition, descriptive statistics were utilized to evaluate the MCSDS-C scores. Possible scores range from 0-13 with a higher score being indicative of more need for approval. These data were used to evaluate the sample for the potential of social desirability contamination with Pearson correlations.

Q2 What is the relationship between demographic factors and level of cultural competence of RNs providing direct patient care?

Analysis of variance (ANOVA) was used to determine if differences in the categorical demographic characteristics (gender, racial/ethnic self-identification, educational preparation) compared to CCA total scores were statistically significant. Hierarchical analysis was used with the continuous demographic variables (age and years as a nurse) to evaluate whether these attributes modified CCA total scores.

Q3 Do Nebraska RNs providing direct patient care report racist attitudes?

This question was answered with data collected by the Quick Discrimination Index (QDI) using the following two subscales: Factor 1--Cognitive Racial Attitude Scales (CRAS) and Factor 2--Affective Racial Attitude Scale (ARAS). When using separate subscales, the total score should not be used (Ponterotto, 2009). The CRAS includes 9 items with a score range of 9-45. The ARAS includes 7 items with a score range of 7-35. Higher scores indicate more positive attitudes and receptivity toward racial diversity (Ponterotto; Ponterotto et al., 1995). In other words, higher scores on these two subscales indicate less racist attitudes.

The use of this instrument with RNs was not discovered in the literature nor did the author know of its use with this population (J. G. Ponterotto, personal communication, August 27, 2010). However, data are available for social workers (Green et al., 2004, 2005); psychologists (Green et al., 2004); and college, pharmacy, and dental students (Utsey & Ponterotto, 1999). These data provide context and normative data, albeit not within the nursing discipline, within which to view the results of the QDI in this research project (Utsey & Ponterotto, 1999, p. 333). Descriptive statistics were used to analyze the data.

Q4 What is the relationship between demographic factors and racist attitudes of Nebraska RNs providing direct patient care?

Analysis of variance (ANOVA) was used to determine if differences in the categorical demographic characteristics (gender, racial/ethnic self-identification, educational preparation) compared to QDI subscale scores were statistically significant. Hierarchical analysis was used with the continuous demographic variables (age and years as a nurse) to evaluate whether these attributes modified QDI subscale scores.

Q5 What is the relationship between level of cultural competence and racist attitudes of Nebraska RNs providing direct patient care?

This question was answered utilizing Pearson's r Product Moment Correlation coefficient. Total CCA scores were evaluated for correlation with the QDI subscales of CRAS and ARAS. In addition, the CCA subscales of CAS and CCB were evaluated for correlation with the QDI subscales.

In addition, reliability measures of the CCA and the two subscales of the QDI with this research sample were performed. The results of data analysis are reported in narrative and table format in Chapter IV.

Summary

This study used the CCA and the QDI to describe the existence and extent of racist attitudes in Registered Nurses (RNs) who provide direct patient care (DPC) as well as ascertain the relationships between and among demographic factors, level of cultural competence, and racist attitudes. A non-experimental, descriptive, correlation research design was used to (a) measure the cultural competence of DPC RNs; (b) measure racist attitudes of DPC RNs; and (c) describe relationships between and among cultural competence, racist attitudes, and several demographic variables. The findings of this study extended nursing theory related to cultural competence by explicating the relationship between cultural competence and racism. In addition, these results suggested the need for revisions in nursing education related to the care of a diverse patient population.

CHAPTER IV

RESULTS

This chapter presents the results of the study. The first section describes the demographic characteristics of the sample participants. The following section presents the results of the Cultural Competence Assessment Survey (CCA; Schim, 2009), the Quick Discrimination Index (QDI; Ponterotto, 2009), and the Marlowe-Crowne Social Desirability Scale--Form C (MCSDS-C; Andrews & Meyer, 2003; Reynolds, 1982).

These results are reported utilizing the framework of the following five research questions:

- Q1 What is the level of cultural competence of RNs providing direct patient care?
- Q2 What is the relationship between demographic factors and level of cultural competence of RNs providing direct patient care?
- Q3 Do RNs providing direct patient care report racist attitudes?
- Q4 What is the relationship between demographic factors and racist attitudes of RNs providing direct patient care?
- Q5 What is the relationship between level of cultural competence and racist attitudes of RNs providing direct patient care?

The hypotheses generated by the research questions were as follows:

- H1 Level of cultural competence is associated with certain demographic characteristics (e.g., age, gender, self-reported race/ethnicity, nursing education level, and years in nursing practice).
- H2 Racist attitudes exist in Nebraska RNs providing direct patient care.

H3 Racist attitudes are associated with certain demographic characteristics (e.g., age, gender, self-reported race/ethnicity, nursing education level, and years in nursing practice).

H4 Cultural competence levels are associated with racist attitudes.

The final section offers conclusions based upon these results. The *a priori* level of significance was set at $\alpha = 0.05$ for all statistical analyses.

Description of the Sample

Random Sample

In this research project, 1000 randomly selected RNs were invited to participate. Originally, the data collection period was set at three weeks from the day the invitations to participate were mailed. At the end of two weeks, there were only 50 participants. Permission was obtained from this researcher's Institutional Review Board (IRB) to mail a reminder postcard to the original random sample. This was done approximately two weeks following the original invitation to participate. The data collection period was extended by two weeks. Two weeks following the postcard reminder, there were 86 participants, yielding an insufficient response rate of 8.6%.

At one month following the mailed invitation, this researcher received permission from the IRB to change to a convenience sample. At that time, there were 90 participants for a response rate of 9%; this was an inadequate sample size based upon the power analysis completed. These data were downloaded from Survey Monkey to enable a description of the participants before adding participants from the convenience sample. One of the three participants requesting a paper and pencil copy of the survey returned the survey before the change to a convenience sample. Two additional paper and pencil surveys were received after this revision; these two participants were identified as part of

the random sample based upon date and time this researcher entered the data sets into Survey Monkey. Correct identification of the participants was confirmed based upon age and years in nursing.

Fifteen participants completed only the demographic section of the instrument; these cases were deleted from the data set. Table 2 provides a summary of the randomly chosen participants' demographics. A difference in the number of cases analyzed is due to missing data (e.g., some did not provide their age). Of note, environment of nursing practice was used to confirm adherence to the inclusion criteria and was not used in data analysis.

As these data were reviewed, it was important to address an issue. Related to the Race and Ethnicity Self-classification and the Racial and Ethnic Population Groups categories, the terms *Black/African American/Negro* were used in the demographics section of the CCA. The term *Negro* is not typically used at this point in history. Although no justification was provided by the authors of the CCA for retaining this term (Schim et al., 2003), possibly that was a label older nurses were familiar with or some older Black persons used to describe self. Because this tool was valid and reliable as written, this terminology was retained in this research project.

Table 2

Characteristics of Randomly Drawn Study Participants

Characteristics	<i>n</i>	%	<i>M (SD)</i>	Range
Age	90		47.2 (12.16)	25-77
Gender	91			
Male	6	6.6		
Female	85	93.4		
Race and Ethnicity Self-classification	91			
HL	1	1.1		
W	86	94.5		
B	2	2.2		
AI/AN	0			
A	1	1.1		
NH/PI	0			
AA	0			
Other	0			
Years in Nursing Practice	90		22.44 (12.94)	1-46
Highest Level Of Nursing Education	91			
Diploma	18	19.8		
Associate degree	12	13.2		
Bachelor's degree	49	53.8		
Master's degree	11	12.1		
Doctorate	1	1.1		

Note. Totals may not add up to 100% based upon missing values; HL=Hispanic Latino; W= White/Caucasian/European American; B=Black/African American/Negro; AI/AN=American Indian/Alaska Native; A=Asian; NH/PI=Native Hawaiian/Pacific Islander; AA=Arab American/Middle Eastern.

Convenience Sample

With the approval of the IRB and Nebraska Wesleyan University (see Appendix H), an invitation to participate was posted on NWU's Blackboard (BB) site. The site has a section for Bachelor of Science in Nursing (BSN) and Master of Science in Nursing (MSN) students. All students in these programs must be licensed RNs. The invitation with the link to Survey Monkey was posted on the announcement page of the BSN and

MSN Nursing Program BB site and emailed to all nursing students. The researcher also emailed all nursing friends and colleagues with the invitation and asked that the invitation be extended to other RNs who might fit the inclusion criteria (see Appendix I). Some nursing friends and colleagues were invited to participate via a social networking site--the technological version of "word of mouth" contact.

Within 48 hours of initiating the convenience sample, 60 new participants had completed the data collection tool, bringing the total to 150. The executive director of the Nebraska Nurses Association sent the invitation to participate via email to the membership five days before the close of data collection. This organization has approximately 800 RNs as members.

The prize drawing date was extended when the reminder postcards were mailed. Data collection continued until the date of the prize drawing was reached. At that time, there were 245 participants in the study who had at least begun the survey. Of this total, 219 of the participants entered the drawing. As noted previously, a number of participants who completed only the demographics plus two data sets had an extraordinarily high number of missing data points. For example, one participant skipped questions 17-30 on the CCA section as well as all the questions on the MCSDS-C. These data sets were removed from the data analysis, leaving a total sample size of 230, 91 that were part of the random sample and 139 that were part of the convenience sample. Table 3 shows the demographic characteristics of the convenience sample.

Table 3

Characteristics of Convenience Sample Study Participants

Characteristics	<i>n</i>	%	<i>M (SD)</i>	Range
Age	138		44.01 (11.81)	22-70
Gender	139			
Male	7	5.0		
Female	131	94.2		
Race and Ethnicity Self-Classification	139			
HL	1	0.7		
W	132	95.0		
B	2	1.4		
AI/AN	0			
A	2	1.4		
NH/PI	0			
AA	0			
Other	2	1.4		
Years in Nursing Practice	139		18.53 (12.84)	1-47
Highest Level of Nursing Education	139			
Diploma	21	15.1		
Associate degree	23	16.5		
Bachelor's degree	64	46.0		
Master's degree	23	16.5		
Doctorate	6	4.3		

Note. Totals may not add up to 100% based upon missing values; HL=Hispanic Latino; W= White/Caucasian/European American; B=Black/African American/Negro; AI/AN=American Indian/Alaska Native; A=Asian; NH/PI=Native Hawaiian/Pacific Islander; AA=Arab American/Middle Eastern.

Comparison of Samples

Table 4 provides a comparison of the random and convenience sample demographics. Using ANOVA for statistical analysis, these two groups showed no statistically significant differences between the groups on the total CCA score, the MCSDS-C, or either of the QDI subscales of CRAS and ARAS: $F(1, 208) = 2.67, p =$

.104; $F(1, 221) = .893, p = .346$; $F(1, 219) = 3.394, p = .067$; $F(1, 223) = 1.157, p = .283$, respectively. Although slight, there was a statistically significant difference between the two groups in age and years in nursing practice: $F(1, 226) = 3.871, p = .050$; $F(1, 227) = 5.04, p = .026$, respectively. Using only random sample data was not an option as the response rate was too low. Although minor, the difference in age and years of nursing practice between the two subsamples must be considered a limitation of this study.

Table 4

Comparison of Random vs. Convenience Samples

Characteristic	Random Sample				Convenience Sample			
	<i>n</i>	%	<i>M</i> (<i>SD</i>)	Range	<i>n</i>	%	<i>M</i> (<i>SD</i>)	Range
Age	90		47.2 (12.16)	25-77	138		44.01 (11.81)	22-70
Gender	91				139			
Male	6	6.6			7	5.0		
Female	85	93.4			131	94.2		
Race and Ethnicity	91				139			
Self-classification								
HL	1	1.1			1	0.7		
W	86	94.5			132	95.0		
B	2	2.2			2	1.4		
AI/AN	0				0			
A	1	1.1			2	1.4		
NH/PI	0				0			
AA	0				0			
Other	0				2	1.4		
Years in nursing practice	90		22.44 (12.94)	1-46	139		18.53 (12.84)	1-47
Highest level of education	91				139			
Diploma	18	19.8			21	15.1		
Associate degree	12	13.2			23	16.5		
Bachelor's degree	49	53.8			64	46		
Master's degree	11	12.1			23	16.5		
Doctorate	1	1.1			6	4.3		

Note. Totals may not add up to 100% based upon missing values; HL=Hispanic Latino; W= White/Caucasian/European American; B=Black/African American/Negro; AI/AN=American Indian/Alaska Native; A=Asian; NH/PI=Native Hawaiian/Pacific Islander; AA=Arab American/Middle Eastern.

Final Combined Sample

The final sample of both randomly selected participants and convenience sample participants was similar to the Nebraska RN population. This sample was slightly younger ($M = 45.27$, $SD = 12.03$) than the Nebraska RN population in 2008 ($M = 46.6$; Nebraska Center for Nursing, 2009). This sample lacked racial/ethnic diversity at a similar rate: White = 94.8% sample vs. 94.9% Nebraska RN population (Nebraska Center for Nursing, 2009). The sample varied slightly in other groups when compared to the Nebraska RN population: Hispanic = 0.9% vs. 1.4%; Black = 1.7% vs. 1.2%; Asian = 1.3% vs. 0.8%, respectively. Educational preparation was reported separately for men and women, making direct comparison difficult (Nebraska Center for Nursing, 2009). In 2008, 54.5% of the men and 50% of the women held a baccalaureate degree compared to 49.1% of the sample. Overall, the final sample for this research, while not equivalent, was very similar to the Nebraska RN population (see Table 5 for demographic characteristics).

Table 5

Characteristics of Final Sample Study Participants

Characteristics	<i>n</i>	%	<i>M (SD)</i>	Range
Age	228		45.27(12.03)	22-77
Gender	230			
Male	13	5.7		
Female	216	93.9		
Race and Ethnicity	230			
Self-classification				
HL	2	0.9		
W	218	94.8		
B	4	1.7		
AI/AN	0			
A	3	1.3		
NH/PI	0			
AA	0			
Other	2	0.9		
Years in Nursing Practice	229		20.07(12.99)	1-47
Highest Level of Nursing Education	230			
Diploma	39	17.0		
Associate degree	35	15.2		
Bachelor's degree	113	49.1		
Master's degree	34	14.8		
Doctorate	7	3.0		

Note. Totals may not add up to 100% based upon missing values; Total $n=230$ but may not add up to that number based upon missing data points; HL=Hispanic Latino; W= White/Caucasian/European American; B=Black/African American/Negro; AI/AN=American Indian/Alaska Native; A=Asian; NH/PI=Native Hawaiian/Pacific Islander; AA=Arab American/Middle Eastern.

Results Based Upon Research Questions

Preparation for Data Analysis

Prior to analysis, all variables were examined for accuracy of data entry, missing values, and fit between their distributions and the assumptions of the univariate and

multivariate analysis. The variables were examined separately for the convenience and random participants.

Evaluation of the data sets revealed 15 cases where the participant completed the demographic section of the instrument but did not complete any of the other items. As stated previously, these cases were deleted from the data set.

All original variables had less than 3% missing values. When the subscales and scales were constructed, the missing data ranged from 0% to 9.5%. Listwise and pairwise deletion was used as appropriate for all analysis; no imputation was implemented (L. Struwe, personal communication, February 26, 2011). Therefore, the number (i.e., *n*) reported varied throughout the report of the results.

The variables were evaluated for normality with skewness and kurtosis. The CCA variables had six variables that were highly leptokurtic and three variables that were moderately negatively skewed. The decision was made to not transform these variables; they were part of the CCA scale that was not skewed or kurtotic when these variables were used in its construction. The variables that built the MCSDS-C, CRAS, and ARAS were within norms for skewness and kurtosis as were the scales themselves (L. Struwe, personal communication, February 26, 2011).

Outliers in the continuous univariate data were examined with z scores. Cases with standardized scores in excess of ± 3.29 were considered outliers. Only one outlier was found in the CCA score (-3.049); the case was retained. Outliers in the Likert data were examined with box plots. Variables that were skewed also showed outliers, which was to be expected since the data were not transformed. A pattern of outliers was seen in CCA variables 17-30 where the response option of "0" showed as an outlier on several

variables (L. Struwe, personal communication, February 26, 2011). This response option was labeled *Not sure*. The other Likert variables met the assumptions for outliers.

Linearity was assessed in the continuous scale variables through bivariate scatterplots.

The research questions and hypotheses were statistically analyzed by L. Struwe and this author. Levene tests, hierarchical analysis, and post hoc Tukey HSD were run in SPSS 17.0 by L. Struwe with subsequent discussion with this author to ensure understanding of the meaning of these tests with the research data. Utilization of a statistical consultant ensured proper analysis of the research data.

Research Question 1

Q1 What is the level of cultural competence of RNs providing direct patient care?

Because this was a measurement question, there was no associated hypothesis. The CCA tool yielded measurements on two subscales: Cultural Awareness and Sensitivity (CAS) and Cultural Competence Behavior (CCB). In addition, a diversity experience index number was added to the CAS and CCB subscales to obtain the total CCA score. Of note, the CCA tool asked participants to indicate a percentage of total population in their current environment that was made up of the listed racial/ethnic groups. However, these data were not included in the total CCA score in any manner and, therefore, are not reported here.

Because the CCA was revised from a 5-point Likert scale to a 7-point Likert scale, no published normative data were found in the literature. According to the authors, “an excellent mean score range for each subscale is 4.5 to 5” (Doorenbos & Schim, 2004, p. 31). Dr. Schim was contacted by email for guidance; she forwarded these questions to Dr. Doorenbos for review. At the time of publication of this dissertation, no response was

received. Logically, using the range of 4.5-5 as excellent, then 6.3-7 would be considered an excellent mean score range. By the same logic, 4.5 is to 5 (4.5/5) as 27 is to 30 (27/30) for the total CCA score; thus, designating 27-30 was an excellent mean score range for the total CCA. Based upon these guidelines, this sample of Nebraska direct patient care RNs did not attain an excellent mean score range on the CAS, the CCB, or the total CCA score. Results of the CCA including the two subscales and the diversity index are presented in Table 6.

Table 6

Cultural Competence Scores of Direct Patient Care RNs

Scale	<i>n</i>	<i>M (SD)</i>	Range
CCA-Total Cultural Competence (Range=2-30)	210	20.50 (3.08)	11.10-26.64
CAS-Awareness/Sensitivity (Range=1-7)	223	6.10 (0.46)	4.73-7.00
CCB-Cultural Competence Behavior (Range=1-7)	217	4.86 (1.23)	0.00-7.00
Cultural Diversity Index (Range=0-16)	230	9.52 (2.52)	1.00-13.00

The MCSDS-C was included within the CCA and had a possible score range of 0-13, a higher score being indicative of more need for approval or social desirability. Typically, Pearson's product moment correlation is used to assess a relationship between the CCA score and social desirability (MCSDS-C) score (S. Schim, personal communication, November 23, 2010). According to Houser (2008), "less than .2

indicates no relationship” (p. 380). There was no correlation between these two variables, indicating that social desirability did not significantly impact the scores on the CCA [$r = -.119, n = 205, \rho = .088$].

Research Question 2

- Q2 What is the relationship between demographic factors and level of cultural competence of RNs providing direct patient care?

This research question gave rise to the following hypothesis:

- H1 Level of cultural competence is associated with certain demographic characteristics (e.g., age, gender, self-reported race/ethnicity, nursing education level, and years in nursing practice).

Analysis of variance (ANOVA) was used to determine if differences in the categorical demographic characteristics (gender, racial/ethnic self-identification, educational preparation) compared to CCA total scores were statistically significant. Levene’s Test of Equality of Error Variances was used to test the assumption of homogeneity, a precondition necessary for the utilization of ANOVA (Munro, 2005). There was no statistically significant effect of any of these variables on CCA scores. All met the assumption of homogeneity of variance based upon the Levene Test (see Table 7).

Hierarchical analysis conducted by L. Struwe, statistical consultant, was used to evaluate whether age and years as a nurse modified CCA scores. The results indicated that two predictors explained 2.5% of the variance ($R^2=.158, F(2,204)=2.601, p=.077$). Effect size was medium ($f^2 = 0.1876$). Age accounted for 1% of the variance in the CCA scores; the addition of years as a nurse increased the variance from 1% to 2.5%. Age significantly predicted CCA scores ($\beta = .301, p=.025$), while years as a nurse did not ($\beta = -.237, p=.077$). The Durbin-Watson was .052, showing a positive autocorrelation (L.

Stuwe, personal communication, February 26, 2011; April 2, 2011). Therefore, years as nurse was not retained in the model. As age increased, the CCA score increased.

Table 7

ANOVA for Cultural Competence Assessment and Categorical Demographic Variables

Variable	SS	df	MS	F	p value	Levene Statistic	Levene P value
Gender	^a 22.781	1	22.781	2.411	.122	.234	.629
	^b 1955.994	207	9.449				
Educational Preparation	^a 48.543	4	12.136	1.282	.278	.158	.959
	^b 1931.270	204	9.467				
^c Race/Ethnicity	^a .795	1	.795	.083	.773	.008	.928
	^b 1981.798	207	9.574				

Note. ^a= between groups, ^b=within groups; ^cNot enough subjects in the 8 subgroups of race to analyze the data. Analysis conducted with 218 Whites and 11 non-Whites.

The first research hypothesis was retained for the demographic characteristic of age but was rejected for the remaining characteristics: gender, racial/ethnic self-identification, educational preparation, and years as a nurse.

Research Question 3

Q3 Do Nebraska RNs providing direct patient care report racist attitudes?

The associated hypothesis was as follows.

H2 Racist attitudes exist in Nebraska RNs providing direct patient care.

This question was answered with data collected by the Quick Discrimination Index (QDI) using the following two subscales: Factor 1--Cognitive Racial Attitude Scales (CRAS) and Factor 2--Affective Racial Attitude Scale (ARAS). When using

separate subscales, the total score should not be used (Ponterotto, 2009). The CRAS included nine items with a score range of 9-45. The ARAS included seven items with a score range of 7-35. Higher scores indicated more positive attitudes and receptivity toward racial diversity (Ponterotto, 2009; Ponterotto et al., 1995). In other words, higher scores on these two subscales indicated less racist attitudes. Descriptive statistics were used to analyze the data (see Table 8).

Table 8

Quick Discrimination Index Measures of Racist Attitudes for Direct Patient Care RNs

Scale	<i>n</i>	<i>M (SD)</i>	Range
CRAS (Range 9-45)	221	28.81 (5.73)	12-45
ARAS (Range 7-35)	225	24.97 (4.14)	14-34

The use of this instrument with RNs was not discovered in the literature nor did the author know of its use with this population (J. G. Ponterotto, personal communication, August 27, 2010). However, data were available for social workers (Green et al., 2004; Green et al., 2005); psychologists (Green et al., 2004); and pharmacy faculty, staff, and students, plus dental students (Utsey & Ponterotto, 1999). These data provided context and normative data, albeit not within the nursing discipline, to view the results of the QDI in this research project (Utsey & Ponterotto, 1999, p. 333). Table 9 provides a comparison of these data.

Table 9

Comparison of Cognitive Racial Attitude Scales and Affective Racial Attitude Scale Scores of Direct Patient Care RNs with Other Healthcare Providers

Population	<i>n</i>	CRAS <i>M</i> (<i>SD</i>)	CRAS Range	ARAS <i>M</i> (<i>SD</i>)	ARAS Range
Pharmacy Faculty, Staff, Students ^a	532	26.89 (6.41)	NR	22.43 (5.32)	NR
Dental Students ^a	118	27.91 (7.44)	NR	21.95 (4.91)	NR
Mental Health Professionals ^b	705	34.40 (NR)	NR	24.50 (NR)	NR
White Social Workers ^c	296	34.38 (5.79)	15-45	24.73 (3.51)	13-35
Direct Patient Care RNs	^d 221 ^e 225	28.81 (5.73)	12-45	24.97 (4.14)	14-34

Note. NR = No Report. ^a= Utsey & Ponterotto, 1999. ^b=Green et al., 2004. ^c=Green et al., 2005. ^dNumber of DPC RNs analyzed-CRAS. ^eNumber of DPC RNs analyzed-ARAS.

On the CRAS subscale, both mental health professionals and White social workers scored higher than DPC RNs, indicating that the sample population in this research project possessed more cognitive racist attitudes than the two healthcare provider populations. Conversely, the DPC RNs scored higher than all other populations on the ARAS subscale, indicating that the DPC RNs possessed less affective racist attitudes than their counterparts. While the authors of the QDI cautioned against establishing score categories (e.g., *very prejudiced*, *somewhat prejudiced*; Ponterotto et al., 2002), none of these healthcare provider categories, including direct patient care RNs, approached the top of the range of the CRAS or the ARAS mean scores. Based on these data, hypothesis 3 was retained.

The QDI was evaluated for social desirability vulnerability during development and was found to be less susceptible to social desirability contamination (Ponterotto et al., 1995; Ponterotto et al., 2002). This was confirmed by the following Pearson's r results for the CRAS and the ARAS respectively when compared to the MCSCS-C: [$r = .036, n = 215, \rho = .604$]; [$r = .019, n = 219, \rho = .782$].

Research Question 4

Q4 What is the relationship between demographic factors and racist attitudes of Nebraska RNs providing direct patient care?

The associated hypothesis was stated as follows:

H3 Racist attitudes are associated with certain demographic characteristics (e.g., age, gender, self-reported race/ethnicity, nursing education level, and years in nursing practice).

CRAS subscale. Analysis of variance (ANOVA) was used to determine if differences in the categorical demographic characteristics (gender, racial/ethnic self-identification, educational preparation) compared to QDI subscale scores were statistically significant. A one-way between subjects ANOVA was conducted to compare the effect of gender on CRAS scores. There was no significant effect of gender on CRAS scores at the $p < .05$ level for males and females $F(1,218) = .089, p = .765$. Levene Statistic was .61, showing homogeneity of variances across the two groups.

A one-way between subjects ANOVA was conducted to compare the effect of educational preparation on CRAS scores. No significant effect of educational preparation was found on CRAS scores at the $p < .05$ level for all groups $F(4,218) = .773, p = .544$. Levene Statistic was .86, showing homogeneity of variances across the two groups.

While there were enough cases to analyze race/ethnicity with all eight groups, the homogeneity of variance assumption was violated and the cells had fewer than two cases;

thus, follow-up analysis could not be conducted. Therefore, a one-way between subjects ANOVA was conducted to compare the effect of race on CRAS scores. This analysis was conducted using 218 Whites and 11 non-Whites. There was a significant effect of race on CRAS scores at the $p < .05$ level for Whites and non-Whites $F(1,218) = 12.264$, $p = .001$. Effect size was $n^2 = .053$, i.e., 5.3% of variance is accounted for by race.

However, this is biased as the sample size is very unbalanced with 218 White and only 11 non-White participants (L. Struwe, personal communication, April 2, 2011). Levene Statistic was .71, showing homogeneity of variances across the two groups. Complete statistical data are reported in Table 10.

Table 10

ANOVA for Cognitive Racial Attitude Scales and Categorical Demographic Variables

Variable	SS	df	MS	<i>F</i>	<i>p</i> value	Levene Statistic	Levene <i>P</i> value
Gender	^a 2.934 ^b 7163.811	1 218	2.934 32.862	.089	.765	3.559	.061
Educational Preparation	^a 102.569 ^b 7096.180	4 214	25.642 33.160	.773	.544	.327	.860
^c Race/ Ethnicity	^a 383.758 ^b 6821.679	1 218	383.758 31.292	12.264	.001	3.293	.071

Note. ^a= between groups, ^b=within groups; ^cNot enough subjects in the 8 subgroups of race to analyze the data. Analysis conducted with 218 Whites and 11 non-Whites.

Hierarchical analysis was used to evaluate whether age and years as a nurse modified CRAS scores. The results indicated the two predictors explained 2.1% of the variance ($R^2 = .144$, $F(2,216) = 2.292$, $p = .104$) with a medium effect size of $f^2 = 0.1682$ (L. Struwe, personal communication, February 26, 2011; April 2, 2011). Age accounted for

2.0% of the variance in the CRAS scores; addition of the predictor years as a nurse increased the variance from 2% to 2.1%.

Age significantly predicted CRAS scores ($\beta = -.140, p=.038$) but not when years as a nurse was added to the model ($\beta = -.087, p=.489$), while years as a nurse did not ($\beta = .063, p=.615$). The Durbin-Watson was 1.850, which showed very little autocorrelation. Therefore, years as nurse was not retained in the model. As age increased, the score of the CRAS decreased, i.e., the older the participant, the greater the racist attitude.

Overall, the CRAS subscale was statistically, significantly associated with race/ethnicity (White vs. non-White) and age but not with gender, educational preparation, or years as a nurse.

ARAS subscale. A one-way between subjects ANOVA was conducted to compare the effect of gender on ARAS scores. There was no significant effect of gender on ARAS scores at the $p<.05$ level for males and females $F(1,222) = 1.280, p = .259$. Levene Statistic was .508, showing homogeneity of variances across the two groups.

A one-way between subjects ANOVA was conducted to compare the effect of educational preparation on ARAS scores. No significant effect of educational preparation on ARAS scores was found at the $p<.05$ level for all groups $F(4,218) = 2.202, p = .070$. Levene Statistic was .859, which showed homogeneity of variances across the two groups.

A one-way between subjects ANOVA was conducted to compare the effect of race on ARAS scores. A significant effect of race on ARAS scores was found at the $p<.05$ level for race groups $F(4,219) = 3.463, p = .009$ with an effect size of $n^2 = .059$, i.e., 5.9% of variance is accounted for by race. However, as stated in the CRAS

discussion, this is biased as the sample size is very unbalanced. Levene Statistic was .803, showing homogeneity of variances across the two groups (L.Struwe, personal communication, February 26, 2011; April 2, 2011).

Post hoc comparisons using Tukey HSD indicated that the mean score for Whites and Black/African American/Negro was significantly different. Mean differences showed Black/African American/Negro scored -5.97535 less on the ARAS score than Whites ($SD=2.04116$, $p=.031$). In other words, White participants scored less racist attitudes than Black/African American/Negro participants. However, since there were very uneven group sizes (Whites = 214; Black/African American/Negro = 4), the harmonic mean was used in calculations and Type I error levels were not guaranteed. A Type I error occurs when the statistical results indicate that a difference between the two groups exists when a difference does not in fact exist. Therefore, these results must be viewed with caution. Table 11 provides a complete report of these data less the post hoc comparisons.

Table 11

ANOVA for Affective Racial Attitude Scale and Categorical Demographic Variables

Variable	SS	df	MS	<i>F</i>	<i>p</i> value	Levene Statistic	Levene <i>P</i> value
Gender	^a 21.981 ^b 3810.801	1 222	21.981 17.166	1.280	.259	.440	.508
Educational Preparation	^a 148.346 ^b 3672.111	4 218	37.086 16.845	2.202	.070	.327	.859
^c Race/ Ethnicity	^a 226.562 ^b 3582.433	4 219	56.641 16.358	3.463	.009	.407	.803

Note. ^a= between groups, ^b=within groups; ^cNot enough subjects in the 8 subgroups of race to analyze the data. Analysis conducted with 214 Whites and 9 non-Whites.

Hierarchical analysis was used to evaluate whether age and years as a nurse modified ARAS scores. The two predictors explained 6.5% of the variance ($R^2=.065$, $F(2,219)=7.671$, $p=.001$) with a small to medium effect size of $f^2 = 0.065$ (small = .02, medium = .15; large = .35). Age accounted for 2.6% of the variance in the ARAS scores; the addition of the predictor years as a nurse increased the variance from 2.6% to 6.5%. It was found that age did not significantly predict ARAS scores ($\beta = .156$, $p=.205$) while years as a nurse did ($\beta = -.374$, $p=.003$). The Durbin-Watson was 1.698, which showed very little autocorrelation. Therefore, age was not retained in the model (L. Struwe, personal communication, February 26, 2011; April 2, 2011). As years as a nurse decreased, the score of the ARAS increased. In other words, nurses with less years of experience also had less affective racist attitudes.

The ARAS subscale was statistically, significantly associated with race/ethnicity (White vs. non-White) and years as a nurse but not with gender, educational preparation, or age.

Hypothesis 3. The third hypothesis was retained for race/ethnicity, age, and years in nursing practice but not for gender or educational level. As might be expected in this sample population, age and years in nursing practice were strongly, positively correlated for Pearson's r : [$r = .847$, $n = 227$, $\rho = .01$, 2-tailed]. Although these two variables were associated with different racist attitude subscales, overall younger in age or "younger" in years of nursing practice was associated with less racist attitudes.

Research Question 5

Q5 What is the relationship between level of cultural competence and racist attitudes of Nebraska RNs providing direct patient care?

The associated hypothesis is as follows:

H4 Cultural competence levels are associated with racist attitudes.

This question was answered utilizing Pearson's r Product Moment Correlation coefficient. Total CCA scores were evaluated for correlation with the QDI subscales of CRAS and ARAS. CCA scores were weakly positively correlated with both CRAS and ARAS subscales: CRAS = $r = .239$, $n = 203$, $\rho = .001$, significant at .01 level, 2-tailed with Cohen's $d = 0.4922$, indicating a medium effect size; ARAS = $r = .207$, $n = 206$, $\rho = .003$, significant at .01 level, 2-tailed with Cohen's $d = 0.4231$, indicating a small to medium effect size (L. Struwe, personal communication, February 26, 2011; April 2, 2011). These results indicate that as the participants' cultural competence scores increased, their racist attitude scores increased as well. The higher the CRAS and ARAS scores (i.e., racist attitudes scores), the lower the level of racist attitudes, i.e., as cultural competence increased, racist attitudes decreased. Hypothesis 4 was retained but with the caveat that this was considered a weak correlation (Houser, 2008).

Reliability of Instruments

Cronbach's alpha correlation coefficient was used to evaluate the CCA with this sample. Cronbach's alpha was .70 for 11 items on the CAS subscale and .94 for 14 items on the CCB subscale. Total CCA Cronbach's alpha was .90. This compared favorably with reported reliability of CCA at .89, CAS at .75, and CCB at .91 (Doorenbos et al., 2005).

Evaluation of the two subscales of the QDI revealed a Cronbach's alpha of .814 for the CRAS (nine items) and .743 for the ARAS (seven items). Ponterotto et al. (1995) reported a Cronbach's alpha of .80 for the CRAS and .83 for the ARAS. Typically,

reliability measures above .80 are considered good with .70 considered moderate reliability (Houser, 2008; Polit & Beck, 2010). Overall, reliability of these instruments was acceptable to excellent.

Conclusion

Analysis of CCA scores and the QDI subscale scores of CRAS and ARAS from a convenience sample of direct patient care RNs in Nebraska showed that cultural competence levels were lower than desired, that racist attitudes did exist within this population of healthcare providers, and that cultural competence and racist attitudes were correlated, albeit weakly. Overall, gender and educational level were not associated with either cultural competence or racist attitude scores. However, race/ethnicity, age, and years as a nurse were associated with some of the subscale scores. For example, as age increased, so did cultural competence and cognitive racist attitudes. These findings provided a more comprehensive picture of what the nurse brings to the nurse-patient interaction when caring for a diverse patient population. These data can guide theory revision as well as nursing education modifications. Further discussion of the results and implications follows in Chapter V.

CHAPTER V

DISCUSSION

This chapter begins with a summary of the purpose, methodology, and setting of the research. The next section presents the research results interpreted within the extant literature and framework of the research questions. The theoretical and nursing education implications based upon these results are presented. The final section discusses limitations of this study and provides recommendations for future research. Conclusions complete the chapter.

Summary of the Study and Results

Purpose

The purpose of this study was to (a) explore and describe cultural competence and racist attitudes in direct patient care RNs (DPC RNs); (b) ascertain if there are relationships between demographic factors, cultural competence, and racist attitudes; and (d) determine if there is a relationship between cultural competence and racist attitudes. This researcher hypothesized that racist attitudes on the part of the nurse negatively impacted the nurse-patient interaction, which in turn undermined attempts to provide culturally competent care to a diverse patient population. Ultimately, the quality of nursing care was compromised.

Nursing scholars opine that racism/racist attitudes exist in nursing; however, there is a dearth of empirical evidence to support this assertion (Barbee, 1993, 2002; Eliason,

1999; Porter & Barbee, 2004; Tyson, 2007). The results of this research provided this evidence in the sample population of Nebraska DPC RNs.

Review of Methodology and Setting

Chapter III provided an in-depth discussion of the methodology used in this study. A quantitative, descriptive, correlational design was utilized to answer the five research questions. A random sample of 1000 was drawn from the approximately 23,000 RNs licensed in the state of Nebraska. Nebraska is essentially rural with the three largest cities situated in the far eastern side of the state. The population of the state is 84.1% White non-Hispanic but with areas of both greater and less diversity. For example, one county has a population that is 99.2% White non-Hispanic (U.S. Census Bureau, 2009). The population of RNs in Nebraska is even less diverse with White non-Hispanic nurses comprising 94.9% of the total (Nebraska Center for Nursing, 2009).

Invitations to participate were mailed to this group along with an informed consent document and instructions to enter the \$200 prize drawing for participants. Of this sample, 91 respondents completed the Cultural Competence Assessment (CCA), two subscales (Cognitive Racist Attitudes Survey [CRAS] and Affective Racist Attitudes Survey [ARAS]) of the Quick Discrimination Index (QDI), and the Marlowe-Crowne Social Desirability Scale-Version C (MCSDS-C) via the researcher's Survey Monkey site. Based upon power analysis completed (see Chapter III), 150 participants were needed for statistical analysis. This response rate was inadequate and more participants were needed.

Approval was received from the IRB to change to a convenience sample. Email invitations to participate were distributed to BSN and MSN students at the researcher's

institution via the researcher's email and social networking site and by the Nebraska Nurses Association's member email address database. At the close of the data collection period, 246 participants had at least accessed the survey. The \$200 prize drawing for participants was conducted via a random selection process and a check was mailed to the winner.

Of the 246 participants who accessed the instruments via Survey Monkey, a number completed only the demographics section plus others had an extraordinarily high number of missing data points. When these data sets were removed, 230 participants remained: 91 who were part of the randomly drawn sample and 139 who were part of the convenience sample.

Results

Comparison of the random sample and convenience sample revealed no statistically significant differences between the two groups on total CCA score, on the QDI subscales, or on the MCSDS-C. A statistically significant difference was found between the two groups regarding age and years in nursing practice ($p = .05$ and $p = .026$, respectively) with the random sample being older ($M = 47.2$, $SD = 12.16$ vs. $M = 44.01$, $SD = 11.81$) and having more years in nursing practice ($M = 22.44$, $SD = 12.94$ vs. $M = 18.53$, $SD = 12.84$). All results were reported for the combined random and convenience sample but this difference between the two groups must be considered a limitation of this study.

Questions 1 and 2 related to the level of cultural competence of DPC RNs and the relationship of cultural competence with demographic factors. As noted in Chapter IV, there is no published normative data for the CCA using the 7-point Likert scale.

Evaluation of the scores based upon possible range for subscales CAS and CCB (1-7) indicated that this sample of Nebraska DPC RNs did not score at the top of the range (CAS = $M = 6.10$, $SD = .46$; CCB = $M = 4.86$, $SD = 1.23$). However, the CAS score was higher than the CCB score, indicating that awareness and sensitivity were more evident in this group than actual culturally competent behaviors. When the diversity index score was added to the CAS and CCB to calculate the total CCA score, the score was even farther from the top of the range (Range = 2-30; $M = 20.50$, $SD = 3.08$). This might be reflective of Nebraska population demographics that included “pockets” of diverse population groups, mainly in the eastern one-third of the state, contrasted with large geographic areas of very little diversity (U.S. Census Bureau, 2009).

Another way of interpreting this data was by extrapolating the scores based upon previously published guidelines. According to Doorenbos and Schim (2004), “An excellent mean score range for each subscale is 4.5 to 5” (p. 31). Logically, using the range of 4.5-5 as excellent, then 6.3-7 would be considered an excellent mean score range. By the same logic, 4.5 was to 5 ($4.5/5$) as 27 was to 30 ($27/30$) for the total CCA score, thus designating 27-30 as an excellent mean score range for the total CCA. Based upon these guidelines, this sample of Nebraska direct patient care RNs did not attain an excellent mean score range on the CAS, the CCB, or the total CCA score. Evaluation of these data via either process led to the conclusion that DPC RNs in Nebraska had not attained the optimal level of cultural competence.

The only demographic characteristic that was associated with the CCA score was age. As the age of the nurse increased, so did the cultural competence level. This might be related to experiential learning over the years as to how to effectively care for patients

of diverse cultural groups. Of note, this does not necessarily preclude the harboring of racist attitudes toward persons associated with these diverse groups. Hagman (2004) found a similar association with a subscale of the Cultural Self-Efficacy Scale (CSES) at $p = .001$. However, this result was from a pilot study with only $n = 15$ and was either not significant or not reported in her larger research project with $n = 398$ (Hagman, 2006). Other research studies showed either non-significance of this demographic variable or it was not included in the research report (Lampley et al., 2008; Seright, 2007).

In the literature, the demographic variable of years as a nurse was found to be statistically significantly associated with the CSES by Hagman (2004) and with cultural competence by Lampley et al. (2008). Educational level and/or diversity workshops/continuing education were found to be significantly associated with cultural competence in several studies (Findley, 2008; Lampley et al., 2008; Schim et al., 2005, 2006a; Seright, 2007). These variables were not statistically significantly associated with cultural competence in this sample. It is possible that the lack of diversity in Nebraska compared to other areas in the country impacted the diversity experience over the years as well as the diversity of the patient population during the educational process, i.e., depending upon the location of nursing programs within the state, the diversity of the patients in clinical rotations might vary considerably. This discrepancy between these research results and those reported in the literature is an opportunity for further research.

Questions 3 and 4 addressed the level of racist attitudes of DPC RNs and the relationship of those attitudes with demographic factors. As discussed in Chapter IV, this instrument has not been used with RNs; therefore, no normative data were available for this population. Higher scores on the CRAS and the ARAS indicate more positive

attitudes and receptivity toward racial diversity (Ponterotto, 2009; Ponterotto et al., 1995) or less racist attitudes. Nebraska DPC RNs' mean scores were well below the upper limit of the score range for both the CRAS (range = 9-45) and the ARAS (range = 7-35): CRAS = $M = 28.81$, $SD = 5.73$; ARAS = $M = 24.97$, $SD = 4.14$, indicating the presence of some level of racist attitudes. The authors of the QDI do not advocate establishing score categories (Ponterotto, Potere, et al., 2002). When the scores of the DPC RNs in this study were compared with other healthcare provider scores, the DPC RNs scored less than some (i.e., more racist attitudes) on the CRAS and better than the other four groups (i.e., less racist attitudes) on the ARAS (see Table 9, Chapter IV). Based upon these findings, the claim of no racist attitudes in DPC RNs in Nebraska could not be supported, although nursing may have made progress in this area similar to other healthcare provider groups.

Because of the low numbers of racial/ethnic groups other than White, statistical comparisons were conducted using White and non-White groups. Race/ethnicity was statistically significantly associated with the CRAS ($p = .001$) and the ARAS ($p = .009$). As discussed in Chapter IV, a post hoc comparison using Tukey HSD indicated that the mean score for Whites and Black/African American/Negro groups was significantly different with the Black/African American/Negro group showing more racist attitudes. This was an unexpected result and could be related to a Type I error. Another possibility was related to what population groups were used to validate the instrument during development (L. Struwe, personal communication, March 4, 2011). This second option was less likely since the development sample included "roughly 66% Caucasian, 21%

African American, 6% Hispanic, 3% Asian American, 1% Native American, and 3% other” (Ponterotto et al., 1995, p. 1019), which is a racially diverse sample.

Age significantly predicted the CRAS score (as age increased, so did racist attitudes) but not the ARAS score. Conversely, years as a nurse significantly predicted ARAS scores (as years as a nurse decreased, so did racist attitudes). Not surprisingly, age and years as a nurse were strongly, positively correlated in this sample per Pearson’s r : [$r = .847$, $n = 227$, $p = .01$, 2-tailed]. Although these two variables were associated with different racist attitude subscales, overall, younger in age or “younger” in years of nursing practice was associated with less racist attitudes. Racism has been confronted in U.S. society over the past 50 years. Some would say that racism has just changed form (less overt, more covert; Allport, 1979; Ponterotto et al., 2006; Wise, 2009) but there was support for an actual decrease of racist attitudes with younger DPC RNs in this study.

The measurement of racism in nursing within the United States was nearly absent in the literature. Skinn’s (2006) dissertation research measured racism using two modified scales: Perception of Racism scale (PRS; Green, 1995) and an adapted form of the Modern Prejudice Scale (MPS; Browne, Johnson, Bottorff, Grewal, & Hilton, 2002). According to Skinn (2006), the two scales that were adapted to measure racism showed moderate reliability with Cronbach’s alphas of .667 for the adapted MPS and .649 for the PRS. Houser’s (2008, p. 255) interpretation classified .4 to .7 as weak reliability. The adaptation of these scales might have been less than optimal. Level of racism of these RNs was low--MPS score range = 15 to 38 ($M = 26.26$, $SD = 4.8$, $p = .05$) and PRS score range = 6 to 25 ($M = 14.83$, $SD = 3.7$, $p = .05$)--but certainly present in this study population. The researcher expected a moderate inverse relationship between the cultural

competence scale scores and the racism scores (PRS and MPS), i.e., as cultural competence increased, racism decreased. The total CCAS score had a statistically significant, weak negative correlation with the MPS score ($r = -.28, p = .000$) but was not significantly correlated with the PRS score ($r = .22, p = .77$). Cultural competence and racism were weakly correlated, leading to the conclusion that the two concepts overlapped but were not the same.

As with cultural competence, gender and educational preparation were not associated with CRAS or ARAS scores. Regarding educational preparation, racism or antiracism topics have not been included in nursing education (Abrums & Leppa, 2001; Allen, 2010; American Association of Colleges of Nursing, 2008c; Porter & Barbee, 2004), so it would be surprising if there was an association.

Results for Question 5 showed that cultural competence and racist attitudes were positively, weakly correlated (CRAS [$r = .239, n = 203, \rho = .001$, significant at .01 level, 2-tailed] and ARAS [$r = .207, n = 206, \rho = .003$, significant at .01 level, 2-tailed]), giving rise to the possibility that nurses could function in a culturally competent manner, exhibit culturally competent behaviors, but still harbor racist attitudes with the potential of impacting the nurse-patient interaction. The literature offered numerous examples of care perceived as racist by the recipients (Benkert & Peters, 2005; Benkert et al., 2008; Facione & Facione, 2007; Green, 1995). Because knowledge, attitude, and behaviors are embedded within cultural competence (CAS and CCB) and racist attitudes (CRAS and ARAS), some correlation between the measures of these concepts was to be expected. However, they cannot be viewed as the same.

Direct patient care RNs in Nebraska are culturally competent but certainly not at the highest level possible. They also compared favorably with other healthcare providers as far as racist attitudes but, again, there is much room for improvement. Race/ethnicity, age, and years as a nurse were associated with cultural competence and racist attitudes while gender and educational level were not. If cultural competence alone was enough to attend to racist attitudes, the correlation between the CCA score and the QDI subscale scores would have been much stronger than the Pearson's *r* scores of .239 and .207 attained with this sample.

Implications and Recommendations

Theoretical Implications

Critical social theory. The theoretical framework for this study was two-fold: critical social theory (CST) and Leininger's (Leininger & McFarland, 2006) culture care diversity and universality theory. Several concepts of CST were related to this research: (a) identify and redress social injustices, (b) awareness of values and beliefs that influence interactions that might have been unknowingly or unwillingly internalized, (c) uncover power imbalances, and (d) initiate action research to change the current state of the problem/issue (Corbett et al., 2007; Crotty, 1998; Duchscher, 2000; Maggs-Rapport, 2001; Manias & Street, 2000; Mohammed, 2006; Schwandt, 2001; Young, 2008). To some extent, this research had implications in each area.

For the purpose of this work, racism was defined as discriminatory thoughts or actions based upon race with the underlying belief of the superiority of one's own race over another (Agnes, 2002; Jones, 1997; Ponterotto et al., 2006). Racism is the pinnacle of social injustice. If racist attitudes exist, identification and description is the first step

in the action research process, i.e., fact finding (Corbett et al., 2007). Most nurses would be shocked to even consider that racist attitudes might be present and impact the care they or their nursing peers provide. This study demonstrated that racist attitudes were present in DPC RNs in Nebraska.

Bringing these results to the attention of the discipline of nursing supports awareness of attitudes and beliefs that were most likely unknowingly internalized. As a predominantly White profession (Nebraska Center for Nursing, 2009; Sullivan, 2004) and with White people in power in the United States (Jones, 1997; Ponterotto et al., 2006; Wise, 2009), it is likely that racism/racist attitudes were not even recognized by most nurses. Actually saying the word *racism* in connection with nursing was so shocking that this author witnessed a pervasive silence descend over the room when the topic was introduced.

This research was not focused specifically on power imbalances but, again, racism is perhaps the most onerous power imbalance of all. In the United States, the White population holds the power, particularly White males (Ponterotto et al., 2006; Wise, 2009). RNs are already in a position of power based upon a healthcare knowledge differential (Hagerty & Patusky, 2003; Mohammed, 2006) and the fact that patients are typically in a vulnerable position physically and emotionally when in the care of a nurse. When the nurse is White and the patient is of a different racial or ethnic group, the power differential is even greater. Adding racist attitudes on the part of the nurse to this interaction decreases the likelihood of quality care being provided.

Viewed within the critical social theory (CST) paradigm, the action research process is cyclical and involves fact-finding, planning, action, reflection, and evaluation;

education is considered a part of this problem-solving process (Corbett et al., 2007, p. 82). Based upon the findings of this study, a shift in cultural competence education to include racism was called for by this researcher.

Social justice is logically subsumed under the umbrella of CST. Indeed, the first tenet of CST discussed here was identify and redress social injustices. The American Association of Colleges of Nursing (AACN) repeatedly called for nurse educators to foster the development of nurses who attend to social injustices and work toward the elimination of health disparities (American Association of Colleges of Nursing, 2008b, pp. 21, 25, 28). The AACN repeated this call for social justice in the work on cultural competence: “Competency 4: Advocate for social justice, including commitment to the health of vulnerable populations and the elimination of health disparities” (American Association of Colleges of Nursing, 2009, p. 2). Of note, this document defined *discrimination* and *stereotyping* but the term *racism* was conspicuously absent (American Association of Colleges of Nursing, 2009, pp. 3-4).

Social justice could well serve as the centerpiece of curricular reform wherein all forms of discrimination are addressed. Addressing all forms of discrimination is congruent with the *Healthy People 2010* (n.d.) overarching Goal 2: Eliminate health disparities and with the newly expanded focus for 2020:

Although the term *disparities* is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen in a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual’s ability to achieve good health. It is important to recognize the impact that social determinants have on health outcomes of specific populations. *Healthy People 2020* (n.d.) strives to improve the health of all groups. (*Healthy People 2020*, n.d., para. 1)

As the largest sector of healthcare providers, nursing has the potential to impact the elimination of health disparities in the United States.

Leininger's theory of culture care diversity and universality. Leininger's theory presumes that the provision of culturally congruent care will lead to health and wellbeing (or the ability to face disability or death; Leininger & McFarland, 2002). The extent and persistence of health disparities in the United States demonstrates that cultural competence alone has not solved this multifactorial problem (Agency for Healthcare Research and Quality, 2010; Smedley et al., 2003; Williams & Mohammed, 2009). Racism has been strongly implicated as a cause of health disparities in minority populations (Agency for Healthcare Research and Quality, 2005, 2008; Barr, 2008; Brondolo et al., 2009; Institute of Medicine, 2002; Williams & Mohammed, 2009). Results of this study confirmed racist attitudes present in the Nebraska DPC RN population.

Leininger discusses racism in her writing but implies that understanding "cultural variability and patterns of diverse thinking and acting" enables the nurse to avoid prejudice, discrimination, and stereotyping (Leininger & McFarland, 2002, p. 71). This may be true for what Jones (1997) terms cultural racism but not necessarily true for individual racism. Results of this research showed that as age of the RN increased, so did the level of cultural competence; however, cognitive racist attitudes increased as well. A nurse could practice in a culturally competent manner and still harbor individual racist attitudes. Cultural competence alone does not address all of the social factors, including racism, that potentially impact on the nurse-patient interaction.

It is possible that nurses misunderstand Leininger's Sunrise Enabler Model, making it difficult to apply in the nurse-patient interaction (Leininger & McFarland, 2006). First, it is logical to place racism within the social structure factor of the model but this may be unclear to some. Exposure to racism should be clearly identified as a social structure factor in the cultural assessment. Some racial and ethnic groups have been exposed to chronic and sometimes extreme racism (e.g., genocide of family and friends) either in their country of origin or right here in the United States. This emic knowledge and experience has implications for physical and mental wellbeing. If the patient has experienced racism at the hands of healthcare providers, and there is ample evidence in the literature that this is probable (Benkert & Peters, 2005; Benkert et al., 2008; Bonham, 2001; Chen et al., 2005; LaVeist et al., 2000; Williams & Mohammed, 2009), this information becomes even more important for the nurse. Illuminating racism in the experience of the patient and within one's self as the nurse is essential for the delivery of quality nursing care.

Second, nursing care decisions and actions are vulnerable to racist attitudes on the part of the nurse. The course of nursing action chosen--culture care preservation/maintenance, culture care accommodation/negotiation, or culture care repatterning/restructuring (Leininger & McFarland, 2006)--may be based at least partially on racist attitudes that enter into the nurse's decision making process. In the Sunrise Enabler Model, the addition of *racist attitudes* with an "influence" line to transcultural care decisions and actions would bring awareness to all nurses using this model to provide care to diverse patient populations of the possibility of racist attitudes as a modifier of nursing care. Within the framework of the *Healthy People 2020* (n.d.) goals and the

recommendations from the AACN, perhaps *discriminatory attitudes* would be more appropriate since it encompasses all types of “isms” (e.g., sexism, ageism; American Association of Colleges of Nursing, 2008b). The Sunrise Enabler Model can be viewed on the Transcultural Nursing Society’s website (www.tcns.org/Theories.html).

The 3-dimensional puzzle model. Although the 3-dimensional puzzle model (3DPM) of culturally congruent care (Schim et al., 2007) was not identified as a theoretical framework for this study, the results had implications for the model. Cognitive means what we know and think while affective means what we feel and do. As racist attitudes were framed in these terms (CRAS and ARAS), it was easy to see an overlap with cultural awareness (knowledge) and sensitivity (attitude) as well as with cultural behaviors (the concepts that were measured by the CAS and CCB)—three of the puzzle pieces at the provider level of the 3DPM (Schim et al., 2007). Being aware is part of knowing and sensitivity is related to how we think and feel—our attitude about things. Behaviors are what we do. The conceptual definitions of cultural competence and racist attitudes, as used in the CCA and the QDI subscales, are related.

Although the correlation between cultural competence and racist attitudes was weak, racist attitudes do, in some way, affect awareness, sensitivity, and behaviors of the provider. Adding survey items to “tease out” cognitive and affective racist attitudes to the CCA tool has the potential to provide insight as to the nature of the relationship between cultural competence and racism.

Hardy’s model of the nurse-patient interaction. Based upon the results of this study, the model was modified to include the elements of demographics, cultural competence, and racist attitudes that are significant to the nurse-patient interaction (see

Figure 3). Because the nurse-patient interaction is the most intimate and sustained (time-wise) relationship of all professional healthcare providers, compromising this interaction with racist attitudes on the part of the nurse has great potential to negatively impact the quality of nursing care provided. Nursing education is identified as the primary strategy to decrease racism/racist attitudes in the DPC RN as well as in the discipline of nursing as a whole.

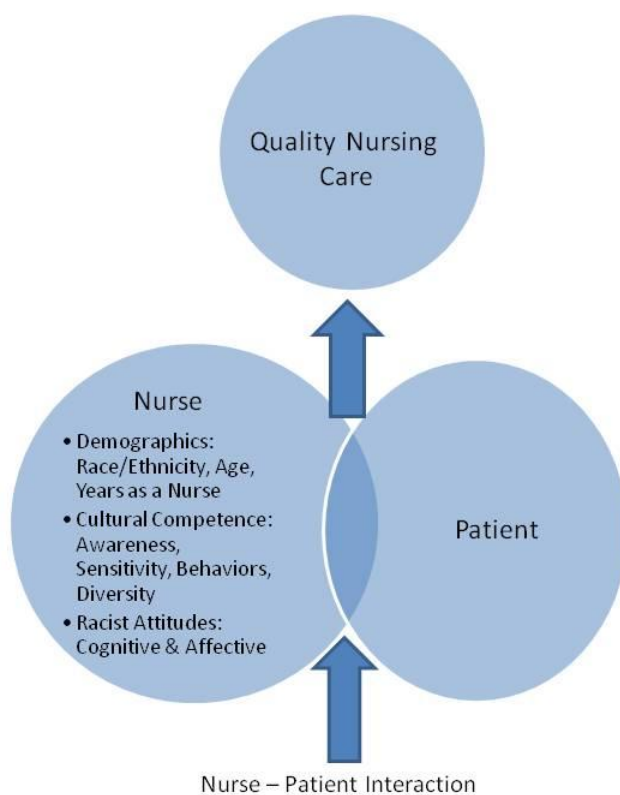


Figure 3. Hardy's model of cultural competence, racist attitudes, and the nurse-patient interaction.

Nursing Education Implications

As a nurse educator, this author is called upon to facilitate the development of cultural competence in her nursing students. All of these students are practicing RNs and are enrolled in either the RN to BSN program or the MSN program. Books, articles, conferences, formal graduate-level courses, and designation as a Certified Transcultural Nurse-Advanced prepared this author for this role. Every course taught included transcultural nursing and cultural competence content to some extent. However, racism and racist attitudes had not been addressed. The assumption was that cultural competence was enough to facilitate provision of quality, non-discriminatory nursing care by these students--all practicing RNs. Most, if not all, had received cultural competency/multicultural educational offerings within their pre-licensure programs as well as via inservice offerings (often mandatory) at their work site.

A comment by a student who was in a charge-nurse position in an acute care facility led to a concern that cultural competence education was not enough: “Why do we have to learn all this stuff? They’re in our ‘house’. Why can’t they learn to do things our way?” (name withheld, personal communication, spring semester, 2008). Was this comment based upon ethnocentrism or was there a deeper issue? The implication of ‘our’ vs. ‘they’ is congruent with the concepts of in-group vs. out-group that is the basis of racism (Allport, 1979; Jones, 1997).

While discussing cultural competence with another RN to BSN student, she expressed dismay at the way she saw non-White patients being treated by nurses in her workplace (S. Shafer, personal communication, February 11, 2009). This was especially disheartening since the clinic was specifically designed to “provide culturally respectful,

quality health care to the underserved” populations of a large metropolitan area (One World Community Health Centers, 2009, p. 1). Her comments lent credence to the results of this study which showed that racism was present as a variable in the nursing population currently providing care to a diverse patient population. Because these students are practicing nurses, they internalize course work and class discussions and then return to their work place where they view what they see in nursing practice with a new perspective. These observations provide valuable insights regarding the current state of patient care.

Other nursing scholars have discussed the absence of the topic of racism as a component of nursing education (Abrums & Leppa, 2001; Allen, 2010; American Association of Colleges of Nursing, 2008a; Porter & Barbee, 2004). According to Cortis (2003), “There is a need for nurses to understand and study the concept of racism. It is only through this activity that it will start to become recognized” (p. 59). The results of this research supported the assumption that racist attitudes are present in DPC RNs. The anecdotal information shared supported the notion that racist attitudes and racism need to be addressed consistently within all levels of nursing education. Nursing education must take responsibility for addressing this issue clearly and intentionally with current and future nurses.

Because greater age and years as a nurse were both associated with increased racist attitudes, how can/should nursing education address this issue? These older nurses are less likely to be in the classroom where the nurse educator has the opportunity to address issues of racism. Nurse educators can impact practicing nurses outside academia via educational offerings in the form of poster or podium presentations at nursing

organization meetings such as Nebraska Nurses Association (NNA) or Sigma Theta Tau International Nursing Honor Society programs at the local, regional, national, or international level. Other specialty nursing organizations (e.g., Oncology Nurses Society, American Association of Critical Care Nurses) typically have state or local level organizations that offer educational programs. The NNA publishes a quarterly newsletter that includes self-directed learning modules designed for nurses to earn Continuing Education Units (CEUs) for re-licensure. Although the NNA has an approximate membership of 800 RNs, this free newsletter is sent to all 22,000⁺ RNs who hold a license in the state of Nebraska. A learning module on racism in nursing has the potential to reach many practicing nurses outside academia.

Staff inservice is another area where nurse educators can address the issue of racism within nursing. Volunteering to facilitate cultural training sessions, mandated by accrediting bodies, provides a forum for discussions that include racism and antiracism content.

Ponterotto et al. (2006) suggest that educators can and should prevent prejudice, which is an antecedent to racism (prejudicial thoughts leading to racist attitudes and actions). They suggest a number of pedagogical approaches to facilitate cognitive and affective learning about racism. Their publication includes lists of films/movies with associated discussion questions and class exercises to support the learning process (Ponterotto et al., 2006, pp. 268-272). The inclusion of immersion experiences is another powerful learning strategy. These need not include extensive travel; even in Nebraska, county health departments typically are involved with healthcare of diverse patient populations. Nursing students could participate in clinical experiences with non-White

population groups. Overall, nurse educators are responsible for guiding this process within academia or in the practice setting.

As mentioned previously, nursing education curriculum revisions should be undertaken to include social justice as a thread throughout the program rather than just cultural competence as is the case at this author's institution. Content should include all types of racism—individual, cultural, and institutional (Jones, 1997; Ponterotto et al., 2006). Lancellotti (2008) suggests Leininger's culture care theory be threaded throughout nursing curricula. This suggestion has merit especially because this is a nursing theory; however, including all types of discrimination, including racism, would be paramount.

Limitations and Recommendations for Future Research

Limitations

The major limitation of this research project was the need to change from a random sample to a convenience sample. Although the convenience sample was very similar to the random sample, there was a statistically significant difference in age and years of nursing practice. This difference precluded generalization of the study results to all direct patient care RNs in Nebraska.

The population demographics of Nebraska are different than those of the United States as a whole and certainly different than states along the East or West Coast. Therefore, ascribing these results to the DPC RNs population of the United States or even other states is not supported. As mentioned earlier in this work, some Midwestern states possess similar demographics (e.g., North Dakota); this research may provide insight into

cultural competence and racist attitudes of DPC RNs in this area of the country, although strict generalization is not endorsed by this researcher based upon the study design.

Another limitation related to the inclusion criteria. The description read as follows:

To be included in this research, you must meet the following criteria: 1. Registered Nurse (RN) in the state of Nebraska; 2. Mailing address in the state of Nebraska; 3. Your nursing practice includes 25% or more of your time in the past year providing direct patient care or directly supervising RNs who provide direct patient care. This can be in an acute care setting, community setting, clinic setting, or other areas of practice. Depending upon your practice situation, you may be a staff nurse, public health nurse, a charge nurse, a unit manager, or even a director of nursing in a small facility. You might be a nurse educator who works with students in the clinical area directly supervising the nursing care provided by your students. (see Appendix G)

This description lacked clarity related to the nurse educator statement. This researcher received a telephone call asking if supervising students who were not RNs qualified for inclusion in the study. Since she directly supervised the nursing care these pre-licensure RN students were providing, she was included in the study. It is probable that other potential participants were confused by this statement and chose not to participate.

While a total of 246 participants started the data collection process, only 230 completed a substantial portion of the tools. Because this included three instruments and racism is a sensitive topic, this number may be acceptable. Of note, the total participants surpassed the sample size required by the power analysis that was conducted.

If the invitation to participate could have been emailed with the link to the Survey Monkey site included in the email, it is very likely that more of those in the random sample would have participated. Having to type the Survey Monkey address into the computer browser was problematic for some who called the researcher for assistance. It is likely that many just did not bother with it. Some potential participants might not have

had ready access to a computer and did not want to bother requesting the paper and pencil copy of the data collection tool. Using a web-based data collection site may have systematically eliminated a subgroup of DPC RNs from this study, thus introducing bias.

Overall, the design of the study was strong with a good sample size attained. The results provide new nursing knowledge as well as a starting point for the further generation of knowledge in theory, research, and practice. The pragmatic suggestions for changes in nursing education have potential for immediate application.

Recommendations for Future Research

Based upon the findings of this study, several research recommendations are made. The Cultural Competence Assessment instrument includes an item asking participants to identify their own level of cultural competence on a 5-point Likert scale. Comparison of this item with the actual score on the CCA and the subscales would provide data regarding a potential difference between perceived and actual cultural competence in this population of direct patient care RNs. This information has potential for nurse educators in academia as well as those in staff development positions. Similarly, evaluation of the items of the CCA subscales and the CRAS and ARAS subscales with regard to demographic differences could provide a deeper understanding of these variables and provide direction for specific educational topics related to cultural competence and racism.

It would be valuable to replicate this study with nurse educators as the population. Nurse educators are called upon to instill the principles of social justice in our students. If nurse educators are less culturally competent than desired and harbor unrecognized

racist attitudes, it will be difficult to inculcate the principles of social justice in our students.

Critical social theory calls for action research to address social injustice. Based upon these research findings, curricular revisions in nursing education were suggested. The efficacy of these revisions should be evaluated with research. Does the addition of social justice as a curricular thread change discriminatory attitudes related to all diverse population groups? This includes not only racially/ethnically diverse groups but also those from low socioeconomic groups, the physically disabled, and the gay, lesbian, transgendered, bisexual group for example. Did the action of intentionally addressing social justice across the curriculum change the attitudes and actions of the nursing students?

Finally, while not a research suggestion per se, a scholarly discourse regarding the extension of Leininger's (1997) theory of culture care diversity and universality to include racism and racist attitudes should be initiated. The extension of existing nursing theory is of great value to the discipline. Sharing the results of this research and the implications for theory revision with other transcultural nursing experts via publication and presentations supports the development of new nursing knowledge in this important area of nursing practice--that of providing culturally competent, non-racist, quality nursing care to a diverse patient population.

Conclusion

This study explored and described cultural competence and racist attitudes in the DPC RN. Some scholars may dismiss the value of focusing on individual racism when institutional racism has more far-reaching effects. However, these systemic injustices

cannot be addressed until individual racism is made visible and ameliorated. Individuals drive structures and institutions; it will be the collective work of individuals who ultimately change structures and institutions. Because nursing is the largest discipline within the healthcare provider sector, it is imperative that racism at the individual RN level be addressed so that racism at the institutional and structural level of healthcare can be eliminated.

The results of this study addressed a gap in the literature by providing empirical data concerning the current state of racism (racist attitudes) of RNs in this Midwestern state. This should be the beginning of a concerted effort by nurse researchers to more fully describe cultural competence and racism within our ranks. As unpopular as this may be, the topic of racism in nursing can no longer be taboo. Nursing as a professional discipline must face racism as a very real threat to the quality care provided to all patients. Those of us who are nurse educators must bravely say the word—*racism*—to our students and our nursing peers and then work diligently toward providing educational experiences that will decrease the racist attitudes that we bring to the nurse-patient interaction.

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APPENDIX A

**INFORMED CONSENT FOR PARTICIPATION
IN RESEARCH**

UNIVERSITY of
NORTHERN COLORADO



Informed Consent for Participation in Research
University of Northern Colorado (UNCO)

Project Title: Cultural Competence and Social Attitudes of Direct Patient Care RNs in a
Midwestern State

Researcher: Linda K. Hardy, RN, MSN, Doctoral Student,
University of Northern Colorado
Office: 402-465-2416 or 800-541-3818, Ext. 2416; Home: 402-642-5755
Email: lhardy@nebrwesleyan.edu
Research Advisor: Faye Hummel, PhD, RN; University of Northern Colorado School of Nursing,
Office: 970-351-1697; E-mail: faye.hummel@unco.edu

Dear Nursing Colleague,

In today's healthcare system, RNs are called upon to provide nursing care to an increasingly diverse population. The purpose of this research project is to explore and describe factors such as cultural competence and social attitudes that influence the attainment of a positive, productive nurse-patient interaction. Results may be submitted for publication to a peer-reviewed nursing journal.

Participation is voluntary. You may decide not to participate and if you begin participation, you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled.

If you volunteer to participate in this research project, you will be asked to complete a survey using Survey Monkey™, a web-based survey site. Completion of the survey will take approximately 20-25 minutes. (A group of 11 people taking the survey for practice equaled an average of 15.57 minutes to completion.) If you do not have access to a computer and/or the Internet but are willing to participate, please call me at 1-800-541-3818, ext. 2416 or at my home number 402-642-5755 and I will mail a paper copy of the survey with a self-addressed, stamped envelope for return.

All RNs who complete the survey can choose to be entered into a drawing for a **\$200 cash prize**. At the end of the survey, those using the Survey Monkey site will be directed to a separate site within Survey Monkey to provide contact information for entry into the drawing. This site is completely separate from the research site; your research data will not be connected to your identity in any manner. If you choose to utilize the paper survey, a stamped postcard addressed to a member of my dissertation research committee will be provided for your entry into the drawing. This action prevents the researcher from connecting your paper survey to your contact information.

This research will be conducted using the Professional version of Survey Monkey which is encrypted to protect your data. During the course of the research project, downloaded data will be housed on a password protected computer in the researcher's locked office. Paper and pencil surveys will be kept in the researcher's locked file cabinet in the locked office. After the data is entered into a data analysis program, the paper and pencil copy will be destroyed. While all efforts will be made to ensure confidentiality and security of research data, this cannot be absolutely guaranteed. Accidental disclosure will not put the participant at risk. Participants may experience mild emotional discomfort or anxiety as they examine their experience related to cultural competence and social attitudes. There will be no direct benefit to participants; however, your participation will contribute to the development of new nursing knowledge and may lead to changes in nursing education related to diverse patient populations.

Because it is important to separate your identity from the research data you provide (participants remain anonymous), taking the survey will serve as an indication of your informed consent to participate in the research. A signed consent form will be waived. If you are willing to participate, please go to the Survey Monkey site by using the Internet (URL) address provided on the enclosed Information and Instructions Sheet and listed below or telephone me to request a paper and pencil copy of the survey.

Please feel free to contact me or my research advisor, Dr. Faye Hummel, if you have questions or concerns about this research. This project has been approved by the UNC Institutional Review Board (IRB). Thank you for assisting me with my research.

Sincerely,
Linda Hardy, RN, MSN

Participation is voluntary. You may decide not to participate in this study and if you begin participation, you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. If you have any concerns about your selection or treatment as a research participant, please contact the Sponsored Programs and Academic Research Center, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-1907.

Researcher's Signature

Date

Web address (URL) to access the survey: <https://www.surveymonkey.com/s/hardy>

APPENDIX B

INVITATION AND INFORMATION

WIN \$200 Prize: Invitation to Nebraska RNs & Instructions for Participation in Research

Project

Researcher: Linda K. Hardy, RN, MSN, Doctoral Student, University of Northern Colorado (UNCO)

Office: 402-465-2416 or 800-541-3818, Ext. 2416; Home: 402-642-5755

Email: lhardy@nebrwesleyan.edu

Research Advisor: Faye Hummel, PhD, RN; UNCO School of Nursing,

Office: 970-351-1697; E-mail: faye.hummel@unco.edu

Dear Nebraska Nursing Colleague:

My name is Linda Hardy. My credentials include RN, MSN, CNE (certified nurse educator—NLN), and CTN-A (certified transcultural nurse-advanced—Transcultural Nursing Society). I am an Assistant Professor of Nursing at Nebraska Wesleyan University, Lincoln, NE and a PhD in Nursing Education candidate at the University of Northern Colorado in Greeley, CO. As part of my doctoral dissertation work, I am seeking volunteers to participate in my research project.

The purpose of my research project is to describe the cultural competence and social attitudes of Nebraska RNs who provide direct patient care or directly supervise RNs who provide direct patient care. Your name was selected randomly from a list of RNs licensed in Nebraska obtained from the State Board of Nursing. To be included in this research, you must meet the following criteria:

- Registered nurse (RN) licensed in the state of Nebraska
- Mailing address in the state of Nebraska
- Your nursing practice includes 25% or more of your time in the past year providing direct patient care or directly supervising RNs who provide direct patient care. This can be in an acute care setting, community setting, clinic setting or other areas of practice. Depending upon your practice situation, you may be a staff nurse, public health nurse, a charge nurse, a unit manager, or even a director of nursing in a small facility. You might be a nurse educator who works with students in the clinical area directly supervising the nursing care provided by your students.

If you are willing to participate, please read the complete Informed Consent document that follows. Taking the survey implies your consent to participate in my research project. It will take approximately 20-25 minutes to complete the survey. (A group of people taking the survey for practice equaled an average of 15.57 minutes to completion). An icon will show how much of the survey you have completed as you go along.

At the end of the survey, you will be redirected to a completely separate Survey Monkey site so that you can enter your contact information for a **\$200 prize drawing** for those who participate in my research! Based upon estimates in nursing literature, I am expecting a response of approximately 150 RNs. **You have a good chance to win the \$200 prize!**

The **Data Collection Period** will begin approximately December 28, 2010 and will end January 19, 2011.

To access the online version of the survey:

- Open your preferred Internet Browser—Internet Explorer, Firefox, etc.
- In the navigation box type in the following URL:
<https://www.surveymonkey.com/s/hardy>
- You will have a second opportunity to read the Informed Consent document. Beginning the survey implies your informed consent. DO NOT include your name anywhere on this survey.
- The complete survey (Cultural Competence plus Social Attitudes) will take approximately 20-25 minutes of your time. (A practice group averaged 15.57 minutes to complete the survey.)
- At the end of the survey, you will find a navigation button. Click on this button to take you to a separate survey site within Survey Monkey. In the unlikely event that the link is not functioning,

the web address (URL) for the \$200 prize drawing site will be provided on the last page of the survey.

- You will be asked to provide your contact information to be entered into the **\$200 prize drawing** for those participating in this project. The drawing will be held one week following the close of the data collection period. If you are the winner, a check will be mailed to the address you provided.

To use a paper and pencil version of the survey:

- Call the researcher (Linda Hardy) at one of the telephone numbers provided above to request a paper and pencil version of the survey.
- I will mail you a paper and pencil copy of the survey, a self-addressed, stamped envelope for returning the survey to me, and a stamped postcard addressed to a member of my dissertation committee for you to enter your contact information for the **\$200 prize drawing**. The drawing will be held one week following the close of the data collection period. If you are the winner, a check will be mailed to the address you provided.

If you experience any problems accessing the survey or the prize drawing site, please call or email me.

If you choose not to participate, I would appreciate any information regarding nonparticipation that you would be willing to share: lhady@nebrwesleyan.edu or 800-541-3818, ext. 2416

At the conclusion of this research project, a summary of the findings will be provided on the researcher's Faculty Profile page on the Nebraska Wesleyan University website:
<http://www.nebrwesleyan.edu/node/1264>

APPENDIX C
INSTITUTIONAL REVIEW BOARD APPLICATION
AND APPROVAL

Research Involving Human Participants Coversheet for UNC IRB Application



Project Title: Cultural Competence and Racist Attitudes of Direct Patient Care RNs in a Midwestern State

Contact Information (reviewers will communicate via e-mail)

Lead Investigator: Linda K. Hardy phone: 402-642-5755; 402-480-8250

School: School of Nursing UNC e-mail: hard7096@bears.unco.edu

Research Advisor: Dr. Faye Hummel UNC e-mail: faye.hummel@unco.edu
(required for students)

CERTIFICATION OF LEAD INVESTIGATOR

I certify that this application accurately reflects the proposed research and that I and all researchers who will have contact with the participants or access to the data have reviewed this application and the Guidelines of the UNC IRB and will comply with the letter and spirit of these policies. I understand that any changes in procedure which affect participants must be submitted to the IRB (using the Request for Change in Protocol Form) for written approval prior to their implementation. I further understand that any adverse events and significant changes in risk for participants must be immediately reported in writing to the UNC IRB.

Linda K. Hardy 11-4-10
Signature of Lead Investigator Date of Signature

CERTIFICATION OF RESEARCH ADVISOR (If Lead Investigator is a Student)

I certify that I have thoroughly reviewed this application, confirm its accuracy, and accept responsibility for monitoring the conduct of this research, the maintenance of any consent documents as required by the IRB, and, in the case of expedited reviews, the continuation review of this project in approximately one year.

Signature of Research Advisor Date of Signature

Summary Information (to be completed by Lead Investigator)

Review Category: Exempt (2-3 weeks) Expedited (3-4 weeks) Full-Board (4-6 weeks)

Research participants will be:
(e.g., adults, elderly, children,
healthy, unhealthy, etc.)

adults

Type of data collected will be:
(e.g., survey responses, interviews,
blood samples, existing data, etc.)

survey responses

Location of data collection:

Registered nurse population in the state of Nebraska

Is standard consent documentation used? YES NO If NO, must be addressed within application.

Is permission required (e.g., school district)? YES NO If YES, must include letter (this is not consent).

Is this a funded research project? YES NO If YES, must provide source within application.

Submit the original and one copy of the cover page, narrative, and all attachments to OSP, Kepner Hall #25, Attn: Sherry May

Clear Form

University of Northern Colorado IRB Application Narrative

Project Title: Cultural Competence and Racist Attitudes of Direct Patient Care RNs in a Midwestern State

A. Purpose

1. The purpose of this research study is to explore the existence and extent of racist attitudes in Registered Nurses (RNs) who provide direct patient care as well as ascertain the relationships between demographic factors (e.g. age, gender, educational level), level of cultural competence, and racist attitudes.

A lack of culturally competent healthcare has been identified as a contributing factor in healthcare inequalities (AHRQ, 2005; Bebinger, 2006; Brach & Fraserirector, 2000; IOM, 2002; Smedley, Stith, & Nelson, 2003; Sullivan, 2004). In spite of strategies to improve the cultural competence of healthcare providers, health disparities persist and have even worsened in some outcome measures (AHRQ, 2008a). For example, Blacks had a rate of new AIDS cases 10 times higher than Whites; American Indians and Alaska Natives were twice as likely to lack prenatal care in the first trimester as Whites (AHRQ, 2008a, p. iv).

Nursing remains a predominantly White profession caring for an increasingly diverse population (Sullivan, 2004; U.S. Census Bureau, August 18, 2008). The focus of nursing on cultural competence, multiculturalism, and transcultural nursing as the 'answer' to caring for a culturally diverse patient population has failed to eliminate negative patient outcomes leading to health disparities (IOM, 2002; Seright, 2007; Smedley et al., 2003). Since cultural competence alone has not eliminated health disparities, it is imperative to consider other social factors, specifically racism, that potentially impact the care nurses provide. It is unlikely that culturally competent care can be provided if racist attitudes are present in the nurse-patient interaction (Abrums & Leppa, 2001; Tyson, 2007).

There is a paucity of empirical nursing research addressing racism in nursing. Other healthcare disciplines have begun the work of exploring racism within their ranks (Green, Hamlin, Ogden, & Walters, 2004; Green, Kiernan-Stern, & Baskind, 2005; LaVeist, Nickerson, & Bowie, 2000; Moody-Ayers, Stewart, Covinsky, & Inouye, 2005). Nursing needs to contribute to this body of knowledge as well. This research will provide new insights regarding cultural competence and racism at the frontline of nursing with RNs who provide direct patient care. It is the responsibility of the discipline of nursing as well as nurse educators to unmask and address the issue of racism in nursing (Johnstone, 2006; Johnstone & Kanitsaki, 2009; Steefel, 2008; Vaughan, 1997).

To that end, the following research questions are posed:

1. What is the level of cultural competence of RNs providing direct patient care?
2. Do RNs providing direct patient care report racist attitudes?
3. What is the relationship between demographic factors and racist attitudes of RNs providing direct patient care?
4. What is the relationship between level of cultural competence and racist attitudes of RNs providing direct patient care?

The research questions give rise to the following hypotheses:

H1 Racist attitudes exist in Nebraska RNs providing direct patient care.

H2 Racist attitudes are associated with certain demographic characteristics (e.g. age, gender, self-reported race/ethnicity, nursing education level, and years in nursing practice).

H3 Cultural competence levels are associated with racist attitudes.

2. Expedited review is appropriate for this category for the following reasons:

- a. This research presents no more than minimal risk to human participants.
- b. This is research on individual characteristics related to cultural beliefs, cognitive and affective racist attitudes and employs survey design.
- c. Data will be collected anonymously rather than confidentially which decreases risk in the case of accidental disclosure of research data.

B. Methods

1. Participants

A list of RNs licensed to practice in Nebraska was obtained from the State Board of Nursing in February of 2010; it included 23,997 names in an Excel spreadsheet. Utilizing the sort function, all RNs with a mailing address in Nebraska were identified and copied into a new Excel spreadsheet. This database included 22,312 RNs with a mailing address in Nebraska. The Excel spreadsheet was then opened in the Statistical Package for Social Sciences (SPSS), Version 17.0. Using the 'Select Cases' function, a random sample of 600 names was drawn (between case 1 and case 22312). This random sample of 600 RNs was saved in an Excel spreadsheet.

The sample size was based upon power analysis for the statistical procedures necessary to analyze the data (n=150) (Faul, Erdfelder, Lang, & Buchner, 2007) plus an estimate of a 25-30% response rate for the online environment (Division of Instructional Innovation and Assessment, 2007). If necessary (e.g. inadequate response rate, extreme number of incomplete data sets), an additional random sample will be drawn using the same procedure to ensure adequate sample size for statistical analysis.

The 600 RNs will be mailed an Invitation and Instructions for Participation (see Appendix A) and the Informed Consent document (see Appendix B). Willing participants will then either access the data collection tool online via Survey Monkey or will contact the primary researcher for a paper and pencil copy of the survey.

All potential participants are age 18 or older and are licensed Registered Nurses in Nebraska. It is impossible to ascertain if any of the potential participants are cognitively disabled or pregnant. Prisoners would not be currently licensed to practice as a RN in Nebraska.

2. Data Collection Procedures

1. RNs will be invited to participate in the research project via a mailed invitation with instructions to access the Survey Monkey website to access the data collection instruments or to request a paper and pencil copy via telephone or email request from the primary researcher.
2. Three instruments plus six demographic questions will be used to collect data for this research project.
 - a. Demographic questions include gender, age, self-selected race/ethnicity, nursing education, years in nursing, and environment of nursing practice area. The question eliciting type/area of nursing practice will be utilized as an inclusion/exclusion criteria check.
 - b. The Cultural Competence Assessment (CCA) instrument is a 30-item tool designed to measure cultural competence (Schim, November, 2009; Schim, Doorenbos, Miller, & Benkert, 2003). Most items use a 7-point Likert scale. There are two subscales: Cultural Awareness and Sensitivity (CAS) and Cultural Competence Behavior (CCB).

- e. The Quick Discrimination Index (QDI) is a 30-item Likert-type self-report tool developed to measure attitudes toward racial diversity and women's equality (Ponterotto et al., 1995). The QDI is not a direct measure of discrimination or racism but rather a measure to assess the attitudes presumed to underlie potential discriminatory or racist behavior (Green et al., 2004; Ponterotto, Potere, & Johansen, 2002; Ponterotto, Utsey, & Pedersen, 2006). It consists of three subscales: Factor 1: Cognitive Racial Attitude Scales (CRAS), Factor 2: Affective Racial Attitude Scale (ARAS), and Factor 3: Gender Equity Scale. The first two subscales (factors) will be used in this research project with the author's approval.
- d. The Marlowe-Crowne Social Desirability Scale (MCSDS), Version C was added to the CCA in the second version of the tool (Doorenbos, Schim, Benkert, & Borse, 2005; Schim, August 13, 2010, p. personal communication). This is a 13-item instrument (Short Form C) based upon the original Social Desirability Scale developed in 1960 by Crowne and Marlowe (Andrews & Meyer, 2003; Moss, 2008; Reynolds, 1982).
- All demographic questions, the CCA, the QDI, and the MCSDS, Version C were entered into one survey on the Survey Monkey website.
3. The data collection period will be 3 weeks long from the date that the invitation is mailed.
 4. Within one week following the data collection period, the \$200 prize drawing will be held and the prize will be mailed to the winner. See Costs and Compensation section for further information.
 5. Following data analysis, a summary of the research results will be posted on the researcher's Faculty Profile Page.

The QDI survey is entitled "Social Attitudes" on all materials that prospective participants view as well as on the Survey Monkey site and instrument. The authors of the QDI provide the following rationale:

Given the "politically correct" nature of the prejudice topic, steps were taken to attenuate the possible effects of social desirability contamination...Second, the title "Social Attitudes Survey" (not "Quick Discrimination Index") appears on the actual instrument to control somewhat for potential subject demand characteristics and evaluation apprehension. (Ponterotto et al., 1995, p. 1018)

The use of the term *racism* or *racist attitudes* (or *discrimination* as a proxy term for racism) is viewed as objectionable (Tang & Browne, 2008). When discussing the topic of this research project with nursing colleagues, there is typically a pause in the conversation and sometimes an audible intake of breath. The topic is sensitive enough to justify the use of the term *social attitudes* rather than *racism* or *racist attitudes*. In actuality, using the term *social attitudes* may decrease potential emotional discomfort for participants.

At the conclusion of this research project, a summary of the findings will be provided on the researcher's Faculty Profile Page on Nebraska Wesleyan University's website: <http://www.nebrwesleyan.edu/node/1264> This information is provided to the participants on the Information and Instructions for Participation sheet.

3. Data Analysis Procedures

At the end of the data collection period, the data will be downloaded from Survey Monkey into Excel. Data analysis will be accomplished with SPSS, version 17.

1. Descriptive statistics will be used to describe the sample characteristics as well as measurements of the CCA and the QDI including all appropriate subscales. Descriptive statistics will include means, frequencies, standard deviations, and reliability measures. Descriptive statistics will be provided for the MCSDS-C for this sample.
2. Analysis of variance (ANOVA) will be used to determine if differences in the categorical demographic characteristics (gender, racial/ethnic self-identification, educational preparation) compared to QDI subscale scores are statistically significant. Hierarchical regression analysis will be used with the

2. Analysis of variance (ANOVA) will be used to determine if differences in the categorical demographic characteristics (gender, racial/ethnic self-identification, educational preparation) compared to QDI subscale scores are statistically significant. Hierarchical regression analysis will be used with the continuous demographic variables (age and years as a nurse) to evaluate whether these attributes modified QDI subscale scores.

3. Pearson's r Product Moment Correlation coefficient will be used to evaluate total CCA scores for correlation with the QDI subscales of CRAS and ARAS. In addition, the CCA subscales of CAS and CCB will be evaluated for correlation with the QDI subscales. The existence, magnitude, and direction of any relationships will be analyzed and evaluated.

4. Data Handling Procedures

This research will be conducted using the Professional version of Survey Monkey which is encrypted to protect research data. During the course of the research project, downloaded data will be housed on a password protected computer in the researcher's locked office. Paper and pencil surveys will be kept in the researcher's locked file cabinet in the locked office. After the data is entered into a data analysis program, the paper and pencil copy will be destroyed.

Subjects will be anonymous. A signed consent form will be waived and taking the survey will serve as indication of informed consent. Once the participant accesses Survey Monkey, they will have a second opportunity to read the informed consent document and will be reminded that taking the survey implies their informed consent (see Appendix C for copy of survey). In this manner, participants will remain anonymous as no identifying data will be attached to their survey nor will an Internet Protocol (IP) address be collected by Survey Monkey. At the completion of the survey, participants will be directed to a completely separate site within Survey Monkey to enter the drawing for the \$200 prize (see Appendix D). In no way is the research site on Survey Monkey connected to the prize drawing site on Survey Monkey.

If participants do not have Internet access or would prefer a paper survey, they will be asked to contact the researcher. Contact information will be obtained by a member of the researcher's dissertation committee to maintain anonymity with the researcher. A paper copy of the survey will be mailed with an additional copy of the informed consent document. Completion and return of the survey in the self-addressed stamped envelope will serve as informed consent. To maintain anonymity, a stamped postcard addressed to a member of the researcher's dissertation committee will be provided for entry into the \$200 prize drawing. The dissertation committee member will enter the contact information into the Survey Monkey site so that the researcher has no ability to connect the paper survey with the participant.

5. Risks, Discomforts, Benefits

The risks for participants in this research project are minimal. There is no physical risk and any emotional discomfort or anxiety should be no greater than that experienced when sensitive topics are discussed. Participants are assured of their right to decide whether to participate and whether to continue participation without fear of coercion. Because potential participants are invited by mail, there is no possibility of face-to-face coercion.

While all efforts will be made to ensure confidentiality and security of research data, this cannot be absolutely guaranteed. Accidental disclosure will not put the participant at risk. Participants may experience mild emotional discomfort or anxiety as they examine their experience related to cultural competence and social attitudes. There will be no direct benefit to participants; however, participation will contribute to the development of new nursing knowledge and may lead to changes in nursing education related to diverse patient populations.

6. Costs and Compensation

Cost for the participant is essentially the time it takes to read the information and informed consent and take the survey. The survey is estimated to take 20-25 minutes.

Offering an incentive for participation is an effective method to increase response rate (Division of Instructional Innovation and Assessment, 2007; MacDonald, Newburn-Cook, Schopflocher, & Richter, 2009; Survey Monkey, 2009). With older participants, a monetary gift is thought to be more beneficial (Survey Monkey, 2009). Providing even a \$5 incentive to each of the 600 randomly selected potential participants in this research project would cost \$3000. A more cost-effective strategy is to offer a \$200 prize drawing to those who participate in the research project.

Providing a monetary incentive in nursing research is not morally or ethically problematic per se (Ulrich & Grady, 2004). The researcher must decide what amount would be compensatory but not coercive. Additionally, financial incentives must be utilized with care to avoid introducing systematic bias by disproportionately increasing responses from low-income subjects (MacDonald et al., 2009, p. 99). However, that issue is less likely in that all potential participants are the same profession (RN) with a mean salary of \$53,490 in 2008 (Nebraska Center for Nursing, 2009). Providing one \$200 prize to be randomly drawn from all participants in this project provides the possibility for compensation for time spent but is not coercive as the participants are clearly notified that only one participant will be awarded the prize.

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Appendix A

WIN \$200 Prize: Invitation to Nebraska RNs & Instructions for Participation in Research Project

Researcher: Linda K. Hardy, RN, MSN, Doctoral Student, University of Northern Colorado (UNCO)
 Office: 402-465-2416 or 800-541-3818, Ext. 2416; Home: 402-642-5755
 Email: lhardy@nebrwesleyan.edu
 Research Advisor: Faye Hummel, PhD, RN; UNCO School of Nursing.
 Office: 970-351-1697; E-mail: faye.hummel@unco.edu

Dear Nebraska Nursing Colleague:

My name is Linda Hardy. My credentials include RN, MSN, CNE (certified nurse educator—NLN), and CTN-A (certified transcultural nurse-advanced—Transcultural Nursing Society). I am an Assistant Professor of Nursing at Nebraska Wesleyan University, Lincoln, NE and a PhD in Nursing Education candidate at the University of Northern Colorado in Greeley, CO. As part of my doctoral dissertation work, I am seeking volunteers to participate in my research project.

The purpose of my research project is to describe the cultural competence and social attitudes of Nebraska RNs who provide direct patient care or directly supervise RNs who provide direct patient care. Your name was selected randomly from a list of RNs licensed in Nebraska obtained from the State Board of Nursing. To be included in this research, you must meet the following criteria:

- Registered nurse (RN) licensed in the state of Nebraska
- Mailing address in the state of Nebraska
- Your nursing practice includes 25% or more of your time in the past year providing direct patient care or directly supervising RNs who provide direct patient care. This can be in an acute care setting, community setting, clinic setting or other areas of practice. Depending upon your practice situation, you may be a staff nurse, public health nurse, a charge nurse, a unit manager, or even a director of nursing in a small facility. You might be a nurse educator who works with students in the clinical area directly supervising the nursing care provided by your students.

If you are willing to participate, please read the complete Informed Consent document that follows. Taking the survey implies your consent to participate in my research project. It will take approximately 20-25 minutes to complete the survey. (A group of people taking the survey for practice equaled an average of 15.57 minutes to completion). An icon will show how much of the survey you have completed as you go along.

At the end of the survey, you will be redirected to a completely separate Survey Monkey site so that you can enter your contact information for a **\$200 prize drawing** for those who participate in my research! Based upon estimates in nursing literature, I am expecting a response of approximately 150 RNs. **You have a good chance to win the \$200 prize!**

The **Data Collection Period** will begin approximately December 28, 2010 and will end January 19, 2011.

To access the online version of the survey:

- Open your preferred Internet Browser—Internet Explorer, Firefox, etc.
- In the navigation box type in the following URL: <https://www.surveymonkey.com/s/hardy>

- You will have a second opportunity to read the Informed Consent document. Beginning the survey implies your informed consent. DO NOT include your name anywhere on this survey.
- The complete survey (Cultural Competence plus Social Attitudes) will take approximately 20-25 minutes of your time. (A practice group averaged 15.57 minutes to complete the survey.)
- At the end of the survey, you will find a navigation button. Click on this button to take you to a separate survey site within Survey Monkey. In the unlikely event that the link is not functioning, the web address (URL) for the \$200 prize drawing site will be provided on the last page of the survey.
- You will be asked to provide your contact information to be entered into the **\$200 prize drawing** for those participating in this project. The drawing will be held one week following the close of the data collection period. If you are the winner, a check will be mailed to the address you provided.

To use a paper and pencil version of the survey:

- Call the researcher (Linda Hardy) at one of the telephone numbers provided above to request a paper and pencil version of the survey.
- I will mail you a paper and pencil copy of the survey, a self-addressed, stamped envelope for returning the survey to me, and a stamped postcard addressed to a member of my dissertation committee for you to enter your contact information for the **\$200 prize drawing**. The drawing will be held one week following the close of the data collection period. If you are the winner, a check will be mailed to the address you provided.

If you experience any problems accessing the survey or the prize drawing site, please call or email me.

If you choose not to participate, I would appreciate any information regarding nonparticipation that you would be willing to share: lhardy@nebrwesleyan.edu or 800-541-3818, ext. 2416

For further researcher information, please go to my Faculty Profile Page on Nebraska Wesleyan University's website: <http://www.nebrwesleyan.edu/node/1264>

At the conclusion of this research project, a summary of the findings will be provided on the researcher's Faculty Profile Page on Nebraska Wesleyan University's website:
<http://www.nebrwesleyan.edu/node/1264>



Informed Consent for Participation in Research
University of Northern Colorado (UNCO)

Project Title: Cultural Competence and Social Attitudes of Direct Patient Care RNs in a Midwestern State

Researcher: Linda K. Hardy, RN, MSN, Doctoral Student, University of Northern Colorado

Office: 402-465-2416 or 800-541-3818, Ext. 2416; Home: 402-642-5755

Email: lhardy@nebrwesleyan.edu

Research Advisor: Faye Hummel, PhD, RN;

University of Northern Colorado, School of Nursing

Office: 970-351-1697; E-mail: faye.hummel@unco.edu

Dear Nursing Colleague,

In today's healthcare system, RNs are called upon to provide nursing care to an increasingly diverse population. The purpose of this research project is to explore and describe factors such as cultural competence and social attitudes that influence the attainment of a positive, productive nurse-patient interaction. Results may be submitted for publication to a peer-reviewed nursing journal.

Participation is voluntary. You may decide not to participate and if you begin participation, you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled.

If you volunteer to participate in this research project, you will be asked to complete a survey using Survey Monkey™, a web-based survey site. Completion of the survey will take approximately 20-25 minutes. (A group of 11 people taking the survey for practice equaled an average of 15.57 minutes to completion.) If you do not have access to a computer and/or the Internet but are willing to participate, please call me at 1-800-541-3818, ext. 2416 or at my home number 402-642-5755 and I will mail a paper copy of the survey with a self-addressed, stamped envelope for return.

All RNs who complete the survey can choose to be entered into a drawing for a **\$200 cash prize**. At the end of the survey, those using the Survey Monkey site will be directed to a separate site within Survey Monkey to provide contact information for entry into the drawing. This site is completely separate from the research site; your research data will not be connected to your identity in any manner. If you choose to utilize the paper survey, a stamped postcard addressed to a member of my dissertation research committee will be provided for your entry into the drawing. This action prevents the researcher from connecting your paper survey to your contact information.

This research will be conducted using the Professional version of Survey Monkey which is encrypted to protect your data. During the course of the research project, downloaded data will be housed on a password protected computer in the researcher's locked office. Paper and pencil surveys will be kept in the researcher's locked file cabinet in the locked office. After the data is entered into a data analysis program, the paper and pencil copy will be destroyed. While all efforts will be made to ensure confidentiality and security of research data, this cannot be absolutely guaranteed. Accidental disclosure will not put the participant at risk. Participants may experience mild emotional discomfort or anxiety as

they examine their experience related to cultural competence and social attitudes. There will be no direct benefit to participants; however, your participation will contribute to the development of new nursing knowledge and may lead to changes in nursing education related to diverse patient populations.

Because it is important to separate your identity from the research data you provide (participants remain anonymous), taking the survey will serve as an indication of your informed consent to participate in the research. A signed consent form will be waived. If you are willing to participate, please go to the Survey Monkey site by using the Internet (URL) address provided on the enclosed Information and Instructions Sheet and listed below or telephone me to request a paper and pencil copy of the survey.

Please feel free to contact me or my research advisor, Dr. Faye Hummel, if you have questions or concerns about this research. This project has been approved by the UNC Institutional Review Board (IRB). Thank you for assisting me with my research.

Sincerely,
Linda Hardy, RN, MSN

Participation is voluntary. You may decide not to participate in this study and if you begin participation, you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. If you have any concerns about your selection or treatment as a research participant, please contact the Sponsored Programs and Academic Research Center, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-1907.

Researcher's Signature

Date

Web address (URL) to access the survey: <https://www.surveymonkey.com/s/hardy>

Appendix C

Survey Instrument from Survey Monkey Website
Includes Demographic questions, CCA, QDI, MCSDS-short form C

Cultural Competence & Social Attitude Survey

My name is Linda Hardy. My credentials include RN, MSN, CNE (certified nurse educator--NLN), and CTN-A (certified transcultural nurse-advanced--Transcultural Nursing Society). I am an Assistant Professor of Nursing at Nebraska Wesleyan University, Lincoln, NE and a PhD in Nursing Education student at the University of Northern Colorado in Greeley, CO.

The purpose of my research project is to describe the cultural competence and social attitudes of Nebraska RNs who provide direct patient care or directly supervise RNs who provide direct patient care. If, within the past year, you

- have been licensed as a Registered Nurse in Nebraska
- have a mailing address in Nebraska
- provide direct patient care 25% or more of your work time or
- directly supervise those who do

you qualify for participation in my research project!

If you are willing to participate, please read the complete Informed Consent document on the next page. Taking the survey implies your consent to participate in my research project. There are 65 items on the survey. It will take approximately 20-25 minutes to complete. (A practice group completed the survey in an average time of 15.57 minutes.) An icon will show how much of the survey you have completed as you go along.

At the end of this anonymous survey, you will be redirected to a completely separate Survey Monkey site so that you can enter your contact information for the \$200 prize drawing for those who participate in my research!

Informed Consent

Researcher: Linda K. Hardy, RN, MSN, Doctoral Student, University of Northern Colorado
 Home: 402-642-5755; Office: 402-465-2416 or 800-541-3818, Ext. 2416;
 Email: lhardy@nebrwesleyan.edu
 Research Advisor: Faye Hummel, PhD, RN; UNCo School of Nursing,
 Office: 970-351-1697; E-mail: faye.hummel@unco.edu

Dear Nursing Colleague: In today's healthcare system, RNs are called upon to provide nursing care to an increasingly diverse population. The purpose of this research project is to explore and describe factors such as cultural competence and social attitudes that influence the attainment of a positive, productive nurse-patient interaction. Results may be submitted for publication to a peer-reviewed nursing journal.

Participation is voluntary. You may decide not to participate and if you begin participation, you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled.

To participate in this research project, you will be asked to complete this survey. All RNs who complete the survey can choose to be entered into a drawing for a \$200 cash prize. At the end of the survey, you will be directed to a separate site within Survey Monkey to provide contact information for entry into the drawing. This site is completely separate from the research site; your research data will not be connected to your identity in any manner.

This research will be conducted using the Professional version of Survey Monkey which is encrypted to protect your data. During the course of the research project, downloaded data will be housed on a password protected computer in the researcher's locked office. While all efforts will be made to ensure confidentiality and security of research data, this cannot be absolutely guaranteed. Accidental disclosure will not put the participant at physical risk. Participants may experience mild emotional discomfort or anxiety as they examine their experience related to cultural competence and social attitudes. There will be no direct benefit to participants; however, your participation will contribute to the development of new nursing knowledge and may lead to changes in nursing education related to diverse patient populations.

Because it is important to separate your identity from the research data you provide, taking the survey will serve as an indication of your informed consent to participate in the research. A signed consent form will be waived.

Cultural Competence & Social Attitude Survey

Please feel free to contact me or my research advisor, Dr. Faye Hummel, if you have questions or concerns about this research. This project has been approved by the UNC Institutional Review Board (IRB). Thank you for assisting me with my research.

Sincerely,
Linda Hardy, RN, MSN

Participation is voluntary. You may decide not to participate in this study and if you begin participation, you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. If you have any concerns about your selection or treatment as a research participant, please contact the Sponsored Programs and Academic Research Center, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-1907.

Taking the survey constitutes your informed consent to participate in this research project.

Please answer the following demographic questions. Your responses are confidential.

1. What is your gender?

- Male
 Female

2. What is your current age in years?

Enter age here:

3. Self reported race/ethnicity

- Hispanic/Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)
 White/Caucasian/European American
 Black/African American/Negro
 American Indian/Alaska Native
 Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)
 Native Hawaiian/Pacific Islander
 Arab American/Middle Eastern
 Other (specify)

Other (please specify)

4. Highest level of nursing education obtained

Indicate here Diploma Associate degree Bachelor's degree Master's degree Doctorate

Cultural Competence & Social Attitude Survey

5. Environment of nursing practice

- Hospital/Inpatient Setting
 Clinic/Outpatient Setting
 Community/Home Based Setting
 Educational Institution
 Other

Other (please specify)

6. Number of years of nursing practice

Enter whole number in the box.

The survey questions were designed by the authors to explore your knowledge, feelings, actions, and social attitudes. There are no "right" or "wrong" answers. Your answers are strictly confidential. DO NOT put your name anywhere on the survey. This survey will not be connected to your contact information for the \$200 prize drawing in any manner!

1. In the past 12 months, which of the following racial/ethnic groups have you encountered among your clients and their families or within the healthcare environment or workplace? Mark all that apply.

- Hispanic/Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)
 White/Caucasian/European American
 Black/African American/Negro
 American Indian/Alaska Native
 Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, other Asian)
 Native Hawaiian/Pacific Islander
 Arab American/Middle Eastern
 Other (please specify)

Other (please specify)

Cultural Competence & Social Attitude Survey

2. In your current environment, what percentage of the total population is made up of people from these racial/ethnic groups? Enter numbers to add up to 100%.

Hispanic/Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)

White/Caucasian/European American

Black/African American/Negro

American Indian/Alaska Native

Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, other Asian)

Native Hawaiian/Pacific Islander

Arab American/Middle Eastern

All other groups combined.

3. In the past 12 months, which of the following special population groups have you encountered among your clients and their families or within the health care environment or workplace? Mark all that apply.

- Mentally or Emotionally Ill
- Physically Challenged/Disabled
- Homeless/Housing Insecure
- Substance Abusers/Alcoholics
- Gay, Lesbian, Bisexual, or Transgendered
- Different Religious/Spiritual backgrounds
- Other (specify)

Other (please specify)

Cultural Competence & Social Attitude Survey

4. In your current environment, what percentage of the total population is made up of people from these special population groups? Write in a whole number to indicate percent; may not total 100%.

Mentally or Emotionally Ill

Physically Challenged/Disabled

Homeless/Housing Insecure

Substance Abusers/Alcoholics

Gay, Lesbian, Bisexual, or Transgendered

Different Religious/Spiritual backgrounds

Other (specify)

5. Overall, how competent do you feel working with people who are from cultures different than your own?

Very competent Somewhat competent Neither competent nor incompetent Somewhat incompetent Very incompetent

Please mark the appropriate answer to the right

6. Race is the most important factor in determining a person's culture.

Strongly agree Agree Somewhat agree Neutral Somewhat disagree Disagree Strongly disagree No opinion

Please mark the appropriate answer to the right.

7. People with a common cultural background think and act alike.

Strongly agree Agree Somewhat agree Neutral Somewhat disagree Disagree Strongly disagree No opinion

Please mark the appropriate answer to the right.

8. Many aspects of culture influence health and health care.

Strongly agree Agree Somewhat agree Neutral Somewhat disagree Disagree Strongly disagree No opinion

Please mark the appropriate answer to the right.

Cultural Competence & Social Attitude Survey

9. Aspects of cultural diversity need to be assessed for each individual, group and organization.

Please mark the appropriate answer to the right.

	Strongly agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly disagree	No opinion
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. If I know about a person's culture, I do not need to assess their personal preferences for health services.

Please mark the appropriate answer to the right.

	Strongly agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly disagree	No opinion
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11. Spirituality and religious beliefs are important aspects of many cultural groups.

Please mark the appropriate answer to the right.

	Strongly agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly disagree	No opinion
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. Individual people may identify with more than one cultural group.

Please mark the appropriate answer to the right.

	Strongly agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly disagree	No opinion
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. Language barriers are the only difficulties for recent immigrants to the United States.

Please mark the appropriate answer to the right.

	Strongly agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly disagree	No opinion
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. I believe that everyone should be treated with respect no matter what their cultural heritage.

Please mark the appropriate answer to the right.

	Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No opinion
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Cultural Competence & Social Attitude Survey

15. I understand that people from different cultures may define the concept of "healthcare" in different ways.

Please mark the appropriate answer to the right.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No opinion
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. I think that knowing about different cultural groups helps direct my work with individuals, families, groups and organizations.

Please mark the appropriate answer to the right.

Strongly agree	Agree	Somewhat agree	Neutral	Somewhat disagree	Disagree	Strongly disagree	No opinion
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Cultural Competence & Social Attitude Survey

1. For each of the following statements mark the box that best describes how often you do the following:

	Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
17. I include cultural assessment when I do individual or organizational evaluations.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. I seek information on cultural needs when I identify new people in my work or school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. I have resource books and other materials available to help me learn about people from different cultures.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. I use a variety of sources to learn about the cultural heritage of other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. I ask people to tell me about their own explanations of health and illness.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. I ask people to tell me about their expectations for health services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. I avoid using generalizations to stereotype groups of people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. I recognize potential barriers to service that might be encountered by different people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. I remove obstacles for people of different cultures when I identify barriers to services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. I remove obstacles for people of different cultures when people identify barriers to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. I welcome feedback from clients about how I relate to people from different cultures.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. I find ways to adapt my services to individual and group cultural preferences.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. I document cultural assessments if I provide direct client services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Cultural Competence & Social Attitude Survey					
30. I document the adaptations I make with clients if I provide direct client services.					
1. I really think affirmative action programs on college campuses constitute reverse discrimination.					
Please mark the appropriate answer to the right.	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I feel I could develop an intimate relationship with someone from a different race.					
Please mark the appropriate answer to the right.	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. My friendship network is very racially mixed.					
Please mark the appropriate answer to the right.	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I am against affirmative action programs in business.					
Please mark the appropriate answer to the right.	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I would feel okay about my son or daughter dating someone from a different race.					
Please mark the appropriate answer to the right.	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. In the past few years there has been too much attention directed toward multicultural issues in education.					
Please mark the appropriate answer to the right.	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Most of my close friends are from my own racial group.					
Please mark the appropriate answer to the right.	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Cultural Competence & Social Attitude Survey

8. I think that it is (or would be) important for my children to attend schools that are racially mixed.

Please mark the appropriate answer to the right.

Strongly Agree Agree Not Sure Disagree Strongly Disagree

9. In the past few years there has been too much attention directed towards multicultural issues in business.

Please mark the appropriate answer to the right.

Strongly Agree Agree Not Sure Disagree Strongly Disagree

10. Overall, I think racial minorities in America complain too much about racial discrimination.

Please mark the appropriate answer to the right.

Strongly Agree Agree Not Sure Disagree Strongly Disagree

11. I think white people's racism toward racial minority groups still constitutes a major problem in America.

Please mark the appropriate answer to the right.

Strongly Agree Agree Not Sure Disagree Strongly Disagree

12. I think the school system, from elementary school through college, should encourage minority and immigrant children to learn and fully adopt traditional American values.

Please mark the appropriate answer to the right.

Strongly Agree Agree Not Sure Disagree Strongly Disagree

13. If I were to adopt a child, I would be happy to adopt a child of any race.

Please mark the appropriate answer to the right.

Strongly Agree Agree Not Sure Disagree Strongly Disagree

14. I think the school system, from elementary through college, should promote values representative of diverse cultures.

Please mark the appropriate answer to the right.

Strongly Agree Agree Not Sure Disagree Strongly Disagree

Cultural Competence & Social Attitude Survey

15. I believe that reading the autobiography of Malcolm X would be of value.

Please mark the appropriate answer to the right.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. I think it is better if people marry within their own race.

Please mark the appropriate answer to the right.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Your answers to these last few questions will help us understand responses from different kinds of people who complete the survey. All answers are strictly confidential!

Read each item and decide whether the statement is true or false as it pertains to you personally. Mark the appropriate answer.

1. It is sometimes hard for me to go on with my work if I am not encouraged.

Mark answer to the right.

True	False
<input type="radio"/>	<input type="radio"/>

2. I sometimes feel resentful when I don't get my way.

Mark answer to the right.

True	False
<input type="radio"/>	<input type="radio"/>

3. On a few occasions, I have given up doing something because I thought too little of my ability.

Mark answer to the right.

True	False
<input type="radio"/>	<input type="radio"/>

4. There have been times when I felt like rebelling against people in authority even though I knew they were right.

Mark answer to the right.

True	False
<input type="radio"/>	<input type="radio"/>

5. No matter who I'm talking to, I'm always a good listener.

Mark answer to the right.

True	False
<input type="radio"/>	<input type="radio"/>

6. There have been occasions when I took advantage of someone.

Mark answer to the right.

True	False
<input type="radio"/>	<input type="radio"/>

7. I'm always willing to admit it when I make a mistake.

Mark answer to the right.

True	False
<input type="radio"/>	<input type="radio"/>

Cultural Competence & Social Attitude Survey

8. I sometimes try to get even rather than forgive and forget.

Mark answer to the right. True False

9. I am always courteous, even to people who are disagreeable.

Mark answer to the right. True False

10. I have never been irked when people expressed ideas very different from my own.

Mark answer to the right. True False

11. There have been times when I was quite jealous of the good fortune of others.

Mark answer to the right. True False

12. I am sometimes irritated by people who ask favors of me.

Mark answer to the right. True False

13. I have never deliberately said something to hurt someone's feelings.

Mark answer to the right. True False

Thank you for completing this survey and participating in my research project. Clicking the icon will take you to a separate Survey Monkey site where you can enter your contact information to be entered into the \$200 prize drawing.

If there is a problem with the link, click on this link or type this URL into your browser to access the prize drawing entry site.

[Click here to take survey](https://www.surveymonkey.com/s/HardyDrawing)

<https://www.surveymonkey.com/s/HardyDrawing>

Appendix D Survey Monkey Drawing Site

The screenshot shows a web browser window with the title "[SURVEY PREVIEW] \$200 Prize Drawing-Hardy-CC & SA Survey - Internet Explorer provided by UCI". The address bar contains a long URL. The page content includes a header "Exit this survey" and a section titled "Contact information". Below this, there is a paragraph: "Please enter your contact information to be entered into a drawing for a \$200 prize for any RN who completed the Cultural Competence and Social Attitudes Survey. Drawing will take place one week following the close of the survey." A bolded instruction reads: "*Please enter your contact information here." The form fields are: Name, Address, Address 2, City/Town, State (a dropdown menu with "-- select state --"), ZIP, Country, Email Address, and Phone Number. A "Done" button is located at the bottom right of the form area. The browser's status bar at the bottom shows "Internet | Protected Mode: On" and the system tray includes the date and time "11:45 AM".



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Human Participant Protections Education for Research Teams

Completion Certificate

This is to certify that

Linda Hardy

has completed the **Human Participants Protection Education for Research Teams** online course, sponsored by the National Institutes of Health (NIH), on 08/03/2007.

This course included the following:

- key historical events and current issues that impact guidelines and legislation on human participant protection in research.
- ethical principles and guidelines that should assist in resolving the ethical issues inherent in the conduct of research with human participants.
- the use of key ethical principles and federal regulations to protect human participants at various stages in the research process.
- a description of guidelines for the protection of special populations in research.
- a definition of informed consent and components necessary for a valid consent.
- a description of the role of the IRB in the research process.
- the roles, responsibilities, and interactions of federal agencies, institutions, and researchers in conducting research with human participants.

National Institutes of Health
<http://www.nih.gov>

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A Service of the National Cancer Institute



FIRSTGLOW



December 2, 2010

TO: John Latham
 MCB

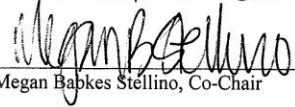
FROM: Megan Babkes Stellino, Co-Chair ^{MS}
 UNC Institutional Review Board

RE: Expedited Review of Proposal, *Cultural Competence and Racist Attitudes of Direct Patient Care RNs in a Midwestern State*, submitted by Linda K. Hardy (Research Advisor: Faye Hummel)

First Consultant: The above proposal is being submitted to you for an expedited review. Please review the proposal in light of the Committee's charge and direct requests for changes directly to the researcher or researcher's advisor. If you have any unresolved concerns, please contact Megan Babkes Stellino, School of Sport and Exercise Science, Campus Box 39, (x1809). When you are ready to recommend approval, sign this form and return to me.

I recommend approval as is:  Jan 1 / 2011
 Signature of First Consultant Date

The above referenced prospectus has been reviewed for compliance with HHS guidelines for ethical principles in human subjects research. The decision of the Institutional Review Board is that the project is approved as proposed for a period of one year: JAN 1, 2011 to JAN 1, 2012

 1/1/11
 Megan Babkes Stellino, Co-Chair Date

Comments:
 update osp info
 & dates for summary } only minor

APPENDIX D

**INSTITUTIONAL REVIEW BOARD PERMISSION
FOR POSTCARD REMINDER**

Date: Fri, 21 Jan 2011 11:33:35 -0700 [01/21/2011 12:33:35 PM CST]
From: Hummel, Faye <Faye.Hummel@unco.edu>
To: Lahman, Maria <Maria.Lahman@unco.edu>
Cc: Linda Hardy <lindakhardy@yahoo.com>, lhardy@nebrwesleyan.edu
Subject: RE: IRB clarification

Thanks so much...

For written clarification, Linda will be sending postcard reminders to her original sample. In the event she is unable to reach her sample size within a reasonable amount of time with this reminder, Linda and I will rethink her original sampling plan and resubmit to IRB.

Much appreciated...

Faye Hummel, RN, PhD, CTN
 Professor
 University of Northern Colorado
 School of Nursing
 Campus Box 125
 Greeley, CO 80639
 970-351-1697

-----Original Message-----

From: Lahman, Maria
 Sent: Friday, January 21, 2011 11:27 AM
 To: Hummel, Faye
 Subject: Re: Voice Message from Hummel, Faye (3511697)

I really appreciate you asking.

I believe this is not enough to warrant a change to protocol.

If she does decide to sample a new group she will want to send that in using the change of protocol form.

I suggest you both keep this email with her IRB materials since thesis/dissertation research is high stakes research.

Best wishes,

Maria K. E. Lahman, Ph.D.
 IRB Co-Chair
 Associate Professor
 Applied Statistics and
 Research Methods
 University of Northern Colorado
 970-351-1603

APPENDIX E
POSTCARD REMINDER

**Linda K. Hardy's Research Project
Cultural Competence & Social Attitudes of Direct Patient
Care RNs in a Midwestern State**

Your name was randomly selected from RNs licensed in Nebraska. If you have already participated in my research, thank you! If not, this is to inform you that the data collection period has been extended to February 11, 2011. You still have time to participate and to be entered into the \$200 Prize Drawing for participants! The drawing will now be held February 18, 2011.

For ease of access, send an email to me at **lhardy@nebrwesleyan.edu** and I will send a reply to you with a link to the survey. All you will need to do is click on the link. Alternately, you can open your Internet home page and type the following address in the URL address line (NOT the search engine box) and hit the "Enter" key on your computer:
<http://www.surveymonkey.com/s/hardy>

Thank you for your consideration and for your assistance in the development of new nursing knowledge in Nebraska!

APPENDIX F

**INSTITUTIONAL REVIEW BOARD CHANGE
OF PROPOSAL REQUEST**

Request for IRB Change

Submit this request and all attachments to Sherry May, IRB Administrator,
Office of Sponsored Programs, Kepner Hall, Suite #25



Date of Original UNC IRB Approval: January 2, 2011

Project Title: Cultural Competence and Racist Attitudes of Direct Patient Care RNs in a Midwestern State

Lead Investigator Name: Linda K. Hardy
 School: Nursing
 Email: lhardy@nebrwesleyan.edu; hard7096@bears.unco.edu
 Phone: H: 402-642-5755; W: 402-465-2416; C: 402-480-8250

Research Advisor Name: Faye Hummel, PhD, RN
 (if applicable) School: Nursing
 Email: faye.hummel@unco.edu
 Phone: 970-351-1697

On a separate page, describe and provide justification for the changes being proposed. Be concise and specific in describing methodological changes that affect the experience of participants and/or relate to the risks/benefits of participation. Explain why these changes are necessary.

Yes No The proposed changes in protocol will necessitate changes in documents such as recruitment flyers, consent forms, debriefing forms, or other project-related documents.

Yes No If yes, copies of the revised documents with changes highlighted are attached to this request.

CERTIFICATION OF LEAD INVESTIGATOR

I certify that information contained in this request is complete and accurate.

Linda K. Hardy 2-1-11
 Signature of Lead Investigator Date

CERTIFICATION OF RESEARCH ADVISOR (If Lead Investigator is a Student)

I certify that information contained in this request is complete and accurate.

 Signature of Research Advisor Date

Approved by:

 Chairperson, Institutional Review Board Date

Clear Form

Date Request Received by OSP: _____

IRB Proposal Change Request

February 1, 2011

Title: Cultural Competence and Racist Attitudes of Direct Patient Care RNs in a Midwestern State

Primary Investigator: Linda K. Hardy; Faculty Advisor: Dr. Faye Hummel

This change in protocol does not affect the experience of participants or change the risk/benefits of participation. Additionally, it does not require changes in any documents but does require the addition of the email 'invitation to participate' message and changes the sampling plan.

The PI mailed 1000 invitations to participate on January 7, 2011 with the data collection period designated as January 7-January 28, 2011. Based upon the study design, 150 participants are necessary for adequate statistical analysis. As of January 21, 51 participants had completed the data collection instrument on Survey Monkey. Two RNs requested a paper and pencil copy which were mailed. One participant returned the survey. It is possible that some potential participants struggle with entering the URL address to access the survey into their web browser.

Permission was requested and received from the co-chair of the IRB to mail a reminder postcard to the original random sample (see Appendix A). This extended the data collection period to February 11, 2011 and the prize drawing moved to February 18, 2011 (see Appendix B for postcard message).

The associated cost for printing and mailing the invitation to participate and the reminder postcard was \$489. As of February 1, 2011, 75 nurses have completed the survey. Based upon these response rates, it would be necessary to draw an additional random sample of at least 1000 RNs plus mail a reminder postcard at an additional expense of nearly \$500 to reach the needed 150 participants.

It is likely that a better response rate will be attained if the invitation to participate is emailed with the link to the survey in the email message. This would enable potential participants to just click on the link to begin the survey. Because the Nebraska State Board of Nursing does not provide email addresses, this strategy necessitates changing from a random sample to a convenience sample. RNs could be recruited via the Nebraska Nurses Association, RN to BSN and MSN students in several academic settings, and by word-of-mouth. Although this revision decreases the generalizability of the study, obtaining an adequate sample for statistical analysis while managing budgetary constraints makes this a feasible option.

According to my statistical consultant, changing the sampling plan from a random sample to a convenience sample does not change the number of participants required nor the analysis of data but does change the interpretation of the results (L. Struwe, personal communication, February 1, 2011). The invitation to participate will be sent by email with the link to the survey included in the email. The Nebraska Nurses Association's executive director has agreed to send my request for participants to the membership (approximately 800 RNs). Additional participants will be sought in nursing programs that include RN to BSN and MSN students via platforms such as Blackboard, by asking participants to forward the email invitation to other RNs who fit the inclusion criteria, and by word-of-mouth (see Appendix C for email message). Schools requiring IRB approval will be provided a copy of the University of Northern Colorado's IRB approval document.

Appendix A
Approval for Reminder Postcard

Date: Fri, 21 Jan 2011 11:33:35 -0700 [01/21/2011 12:33:35 PM CST]
From: Hummel, Faye <Faye.Hummel@unco.edu>
To: Lahman, Maria <Maria.Lahman@unco.edu>
Cc: Linda Hardy <lindakhardy@yahoo.com>, lhardy@nebrwesleyan.edu
Subject: RE: IRB clarification

Thanks so much...

For written clarification, Linda will be sending postcard reminders to her original sample. In the event she is unable to reach her sample size within a reasonable amount of time with this reminder, Linda and I will rethink her original sampling plan and resubmit to IRB.

Much appreciated...

Faye Hummel, RN, PhD, CTN
 Professor
 University of Northern Colorado
 School of Nursing
 Campus Box 125
 Greeley, CO 80639
 970-351-1697

-----Original Message-----

From: Lahman, Maria
 Sent: Friday, January 21, 2011 11:27 AM
 To: Hummel, Faye
 Subject: Re: Voice Message from Hummel, Faye (3511697)

I really appreciate you asking.

I believe this is not enough to warrant a change to protocol.

If she does decide to sample a new group she will want to send that in using the change of protocol form.

I suggest you both keep this email with her IRB materials since thesis/dissertation research is high stakes research.

Best Wishes,

Maria K. E. Lahman, Ph.D.
 IRB Co-Chair
 Associate Professor
 Applied Statistics and
 Research Methods
 University of Northern Colorado
 970-351-1603

Appendix B
Postcard Message

Linda K. Hardy's Research:

Cultural Competence & Social Attitudes of Direct Patient Care RNs in a Midwestern State

Your name was randomly selected from RNs licensed in Nebraska. If you have already participated in my research, thank you! If not, this is to inform you that the data collection period has been extended to February 11, 2011. You still have time to participate and to be entered into the \$200 Prize Drawing for participants! The drawing will now be held February 18, 2011.

For ease of access, send an email to me at lhardy@nebrwesleyan.edu and I will send a reply to you with a link to the survey. All you will need to do is click on the link. Alternately, you can open your Internet home page and type the following address in the URL address line (NOT the search engine box) and hit the "Enter" key on your computer:
<http://www.surveymonkey.com/s/hardy>

Thank you for your consideration and for your assistance in the development of new nursing knowledge in Nebraska!

Appendix C

Email Message: Invitation to Participate

Subject Line: RN Research Participants Needed

My name is Linda Hardy. I am an Assistant Professor of Nursing at Nebraska Wesleyan University, Lincoln, NE and a PhD in Nursing Education candidate at the University of Northern Colorado in Greeley, CO. As part of my doctoral dissertation work, I am seeking volunteers to participate in my research project. This research has been approved by the University of Northern Colorado's IRB Committee. The purpose of my research project is to describe the cultural competence and social attitudes of Nebraska RNs who provide direct patient care or directly supervise RNs who provide direct patient care.

To be included in this research, you must meet the following criteria: 1. Registered nurse (RN) licensed in the state of Nebraska; 2. Mailing address in the state of Nebraska; 3. Your nursing practice includes 25% or more of your time in the past year providing direct patient care or directly supervising RNs who provide direct patient care. This can be in an acute care setting, community setting, clinic setting or other areas of practice. Depending upon your practice situation, you may be a staff nurse, public health nurse, a charge nurse, a unit manager, or even a director of nursing in a small facility. You might be a nurse educator who works with students in the clinical area directly supervising the nursing care provided by your students.

*Anyone who completes the survey by February 18, 2011 can be entered into a **drawing for a \$200 prize**. It took a practice group an average of 15.52 minutes to complete the survey.

**To participate in my research, click on this link:

<https://www.surveymonkey.com/s/hardy>

(You can also copy and paste the link into your browser.) If you know of other RNs who meet the requirements to be included in my research, please forward this email to them. You may contact me at lhardy@nebrwesleyan.edu or by calling any of these phone numbers: Home: 402-642-5755; Work: 402-465-2416; Cell: 402-480-8250. Thank you for your assistance!

APPENDIX G

**INSTITUTIONAL REVIEW BOARD PROPOSAL
CHANGE APPROVAL**

Request for IRB Change

Submit this request and all attachments to Sherry May, IRB Administrator,
Office of Sponsored Programs, Kepner Hall, Suite #25

UNIVERSITY OF
NORTHERN COLORADO
STUDENT'S COPY

Date of Original UNC IRB Approval: January 2, 2011

Project Title: Cultural Competence and Racist Attitudes of Direct Patient Care RNs in a Midwestern State

Lead Investigator Name: Linda K. Hardy
School: Nursing
Email: lhardy@nebrwesleyan.edu; hard7096@bears.unco.edu
Phone: H: 402-642-5755; W: 402-465-2416; C: 402-480-8250

Research Advisor Name: Faye Hummel, PhD, RN
(if applicable) School: Nursing
Email: faye.hummel@unco.edu
Phone: 970-351-1697

On a separate page, describe and provide justification for the changes being proposed. Be concise and specific in describing methodological changes that affect the experience of participants and/or relate to the risks/benefits of participation. Explain why these changes are necessary.

Yes No The proposed changes in protocol will necessitate changes in documents such as recruitment flyers, consent forms, debriefing forms, or other project-related documents.

Yes No If yes, copies of the revised documents with changes highlighted are attached to this request.

CERTIFICATION OF LEAD INVESTIGATOR

I certify that information contained in this request is complete and accurate.

Linda K. Hardy 2-1-11
Signature of Lead Investigator Date

CERTIFICATION OF RESEARCH ADVISOR (If Lead Investigator is a Student)

I certify that information contained in this request is complete and accurate.

[Signature] 2/1/11
Signature of Research Advisor Date

Approved by:

[Signature] 2/6/2011
Chairperson, Institutional Review Board Date

SPONSORED PROGRAMS FEB 02 2011

Clear Form

Date Request Received by OSP: _____

IRB Proposal Change Request

February 1, 2011

Title: Cultural Competence and Racist Attitudes of Direct Patient Care RNs in a Midwestern State

Primary Investigator: Linda K. Hardy; Faculty Advisor: Dr. Faye Hummel

This change in protocol does not affect the experience of participants, or change the risk/benefits of participation. Additionally, it does not require changes in any documents but does require the addition of the email 'invitation to participate' message and changes the sampling plan.

The PI mailed 1000 invitations to participate on January 7, 2011 with the data collection period designated as January 7-January 28, 2011. Based upon the study design, 150 participants are necessary for adequate statistical analysis. As of January 21, 51 participants had completed the data collection instrument on Survey Monkey. Two RNs requested a paper and pencil copy which were mailed. One participant returned the survey. It is possible that some potential participants struggle with entering the URL address to access the survey into their web browser.

Permission was requested and received from the co-chair of the IRB to mail a reminder postcard to the original random sample (see Appendix A). This extended the data collection period to February 11, 2011 and the prize drawing moved to February 18, 2011 (see Appendix B for postcard message).

The associated cost for printing and mailing the invitation to participate and the reminder postcard was \$489. As of February 1, 2011, 75 nurses have completed the survey. Based upon these response rates, it would be necessary to draw an additional random sample of at least 1000 RNs plus mail a reminder postcard at an additional expense of nearly \$500 to reach the needed 150 participants.

It is likely that a better response rate will be attained if the invitation to participate is emailed with the link to the survey in the email message. This would enable potential participants to just click on the link to begin the survey. Because the Nebraska State Board of Nursing does not provide email addresses, this strategy necessitates changing from a random sample to a convenience sample. RNs could be recruited via the Nebraska Nurses Association, RN to BSN and MSN students in several academic settings, and by word-of-mouth. Although this revision decreases the generalizability of the study, obtaining an adequate sample for statistical analysis while managing budgetary constraints makes this a feasible option.

According to my statistical consultant, changing the sampling plan from a random sample to a convenience sample does not change the number of participants required nor the analysis of data but does change the interpretation of the results (L. Struwe, personal communication, February 1, 2011). The invitation to participate will be sent by email with the link to the survey included in the email. The Nebraska Nurses Association's executive director has agreed to send my request for participants to the membership (approximately 800 RNs). Additional participants will be sought in nursing programs that include RN to BSN and MSN students via platforms such as Blackboard, by asking participants to forward the email invitation to other RNs who fit the inclusion criteria, and by word-of-mouth (see Appendix C for email message). Schools requiring IRB approval will be provided a copy of the University of Northern Colorado's IRB approval document.

Appendix A
Approval for Reminder Postcard

Date: Fri, 21 Jan 2011 11:33:35 -0700 [01/21/2011 12:33:35 PM CST]

From: Hummel, Faye <Faye.Hummel@unco.edu>

To: Lahman, Maria <Maria.Lahman@unco.edu>

Cc: Linda Hardy <lindakhardy@yahoo.com>, lhardy@nebrwesleyan.edu

Subject: RE: IRB clarification

Thanks so much...

For written clarification, Linda will be sending postcard reminders to her original sample. In the event she is unable to reach her sample size within a reasonable amount of time with this reminder, Linda and I will rethink her original sampling plan and resubmit to IRB.

Much appreciated...

Faye Hummel, RN, PhD, CTN
Professor
University of Northern Colorado
School of Nursing
Campus Box 125
Greeley, CO 80639
970-351-1697

-----Original Message-----

From: Lahman, Maria

Sent: Friday, January 21, 2011 11:27 AM

To: Hummel, Faye

Subject: Re: Voice Message from Hummel, Faye (3511697)

I really appreciate you asking.

I believe this is not enough to warrant a change to protocol.

If she does decide to sample a new group she will want to send that in using the change of protocol form.

I suggest you both keep this email with her IRB materials since thesis/dissertation research is high stakes research.

Best wishes,

Maria K. E. Lahman, Ph.D.
IRB Co-Chair
Associate Professor
Applied Statistics and
Research Methods
University of Northern Colorado
970-351-1603

Appendix B
Postcard Message

Linda K. Hardy's Research:

Cultural Competence & Social Attitudes of Direct Patient Care RNs in a Midwestern State

Your name was randomly selected from RNs licensed in Nebraska. If you have already participated in my research, thank you! If not, this is to inform you that the data collection period has been extended to February 11, 2011. You still have time to participate and to be entered into the \$200 Prize Drawing for participants! The drawing will now be held February 18, 2011.

For ease of access, send an email to me at lhardy@nebrwesleyan.edu and I will send a reply to you with a link to the survey. All you will need to do is click on the link. Alternately, you can open your Internet home page and type the following address in the URL address line (NOT the search engine box) and hit the "Enter" key on your computer:
<http://www.surveymonkey.com/s/hardy>

Thank you for your consideration and for your assistance in the development of new nursing knowledge in Nebraska!

Appendix C
Email Message: Invitation to Participate

Subject Line: RN Research Participants Needed

My name is Linda Hardy. I am an Assistant Professor of Nursing at Nebraska Wesleyan University, Lincoln, NE and a PhD in Nursing Education candidate at the University of Northern Colorado in Greeley, CO. As part of my doctoral dissertation work, I am seeking volunteers to participate in my research project. This research has been approved by the University of Northern Colorado's IRB Committee. The purpose of my research project is to describe the cultural competence and social attitudes of Nebraska RNs who provide direct patient care or directly supervise RNs who provide direct patient care.

To be included in this research, you must meet the following criteria: 1. Registered nurse (RN) licensed in the state of Nebraska; 2. Mailing address in the state of Nebraska; 3. Your nursing practice includes 25% or more of your time in the past year providing direct patient care or directly supervising RNs who provide direct patient care. This can be in an acute care setting, community setting, clinic setting or other areas of practice. Depending upon your practice situation, you may be a staff nurse, public health nurse, a charge nurse, a unit manager, or even a director of nursing in a small facility. You might be a nurse educator who works with students in the clinical area directly supervising the nursing care provided by your students.

*Anyone who completes the survey by February 18, 2011 can be entered into a **drawing for a \$200 prize**. It took a practice group an average of 15.52 minutes to complete the survey.

**To participate in my research, click on this link:

<https://www.surveymonkey.com/s/hardy>

(You can also copy and paste the link into your browser.) If you know of other RNs who meet the requirements to be included in my research, please forward this email to them. You may contact me at lhardy@nebrwesleyan.edu or by calling any of these phone numbers: Home: 402-642-5755; Work: 402-465-2416; Cell: 402-480-8250. Thank you for your assistance!

APPENDIX H

NEBRASKA WESLEYAN UNIVERSITY SITE APPROVAL



NEBRASKA
WESLEYAN
UNIVERSITY

Nebraska Wesleyan Nursing Program
Rita McGuire, PhD, RN
Nursing Program Director
Nebraska Wesleyan University
5000 St Paul Avenue
Lincoln, NE 68504-2794
Phone 402-465-2334

2-2-11

Dear Professor Hardy,

Based upon my review of your research proposal, I give permission for you to conduct the study titled "Cultural Competence and Racist Attitudes of Direct Patient Care RNs in a Midwestern State" within the Nebraska Wesleyan Nursing Program. As part of this study, I authorize you to invite BSN and MSN students to participate in the survey. Their participation will be voluntary and at their own discretion. We reserve the right to withdraw from the study at any time if our circumstances change.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the research team without permission from the Nebraska Wesleyan UCRRB.

Sincerely,

A handwritten signature in cursive script that reads "Rita McGuire".

Rita McGuire, PhD, RN

APPENDIX I

EMAIL INVITATION FOR CONVENIENCE SAMPLE

Subject Line: RN Research Participants Needed

My name is Linda Hardy. I am an Assistant Professor of Nursing at Nebraska Wesleyan University, Lincoln, NE and a PhD in Nursing Education candidate at the University of Northern Colorado (UNCO) in Greeley, CO. As part of my doctoral dissertation work, I am seeking volunteers to participate in my research project. This research has been approved by the UNCO's IRB Committee. The purpose of my research is to describe the cultural competence and social attitudes of Nebraska RNs who provide direct patient care or directly supervise RNs who provide direct patient care.

To be included in this research, you must meet the following criteria: 1. Registered Nurse (RN) in the state of Nebraska; 2. Mailing address in the state of Nebraska; 3. Your nursing practice includes 25% or more of your time in the past year providing direct patient care or directly supervising RNs who provide direct patient care. This can be in an acute care setting, community setting, clinic setting, or other areas of practice. Depending upon your practice situation, you may be a staff nurse, public health nurse, a charge nurse, a unit manager, or even a director of nursing in a small facility. You might be a nurse educator who works with students in the clinical area directly supervising the nursing care provided by your students.

*Anyone who completes the survey by February 18, 2011 can be entered into **a drawing for a \$200 prize**. It took a practice group an average of 15.52 minutes to complete the survey.

**To participate in my research, click on this link:

<https://www.surveymonkey.com/s/hardy>

(You can also copy and paste the link into your browser.) If you know of other RNs who meet

the requirements to be included in my research, please forward this email to them. You may

contact me at lhardy@nebrwesleyan.edu or by calling any of these phone numbers:

Home: 402-642-5755; Work: 402-465-2416; Cell: 402-480-8250.

Thank you for your assistance!

APPENDIX J

**SURVEY MONKEY SITE-DATA COLLECTION TOOL:
CULTURAL COMPETENCE AND SOCIAL
ATTITUDES SURVEY**

Cultural Competence & Social Attitude Survey

My name is Linda Hardy. My credentials include RN, MSN, CNE (certified nurse educator--NLN), and CTN-A (certified transcultural nurse-advanced--Transcultural Nursing Society). I am an Assistant Professor of Nursing at Nebraska Wesleyan University, Lincoln, NE and a PhD in Nursing Education student at the University of Northern Colorado in Greeley, CO.

The purpose of my research project is to describe the cultural competence and social attitudes of Nebraska RNs who provide direct patient care or directly supervise RNs who provide direct patient care. If, within the past year, you

- have been licensed as a Registered Nurse in Nebraska
- have a mailing address in Nebraska
- provide direct patient care 25% or more of your work time or
- directly supervise those who do

you qualify for participation in my research project!

If you are willing to participate, please read the complete Informed Consent document on the next page. Taking the survey implies your consent to participate in my research project. There are 65 items on the survey. It will take approximately 20-25 minutes to complete. (A practice group completed the survey in an average time of 15.57 minutes.) An icon will show how much of the survey you have completed as you go along.

At the end of the survey, you will be redirected to a completely separate Survey Monkey site so that you can enter your contact information for the \$200 prize drawing for those who participate in my research!

Informed Consent

Researcher: Linda K. Hardy, RN, MSN, Doctoral Student, University of Northern Colorado
Home: 402-642-5755; Office: 402-465-2416 or 800-541-3818, Ext. 2416;
Email: lhardy@nebrwesleyan.edu
Research Advisor: Faye Hummel, PhD, RN; UNCo School of Nursing,
Office: 970-351-1697; E-mail: faye.hummel@unco.edu

Dear Nursing Colleague: In today's healthcare system, RNs are called upon to provide nursing care to an increasingly diverse population. The purpose of this research project is to explore and describe factors such as cultural competence and social attitudes that influence the attainment of a positive, productive nurse-patient interaction. Results may be submitted for publication to a peer-reviewed nursing journal.

Participation is voluntary. You may decide not to participate and if you begin participation, you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled.

To participate in this research project, you will be asked to complete this survey. All RNs who complete the survey can choose to be entered into a drawing for a \$200 cash prize. At the end of the survey, you will be directed to a separate site within Survey Monkey to provide contact information for entry into the drawing. This site is completely separate from the research site; your research data will not be connected to your identity in any manner.

This research will be conducted using the Professional version of Survey Monkey which is encrypted to protect your data. During the course of the research project, downloaded data will be housed on a password protected computer in the researcher's locked office. While all efforts will be made to ensure confidentiality and security of research data, this cannot be absolutely guaranteed. Accidental disclosure will not put the participant at physical risk. Participants may experience mild emotional discomfort or anxiety as they examine their experience related to cultural competence and social attitudes. There will be no direct benefit to participants; however, your participation will contribute to the development of new nursing knowledge and may lead to changes in nursing education related to diverse patient populations.

Because it is important to separate your identity from the research data you provide, taking the survey will serve as an indication of your informed consent to participate in the research. A signed consent form will be waived.

Please feel free to contact me or my research advisor, Dr. Faye Hummel, if you have questions or concerns about this research. This project has been approved by the UNC Institutional Review Board (IRB). Thank you for assisting me with my research.

Sincerely,
Linda Hardy, RN, MSN

Participation is voluntary. You may decide not to participate in this study and if you begin participation, you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. If you have any concerns about your selection or treatment as a research participant, please contact the Sponsored Programs and Academic Research Center, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-1907.

Taking the survey constitutes your informed consent to participate in this research project.

Cultural Competence & Social Attitude Survey

Please answer the following demographic questions. Your responses are confidential.

1. Gender

Mark gender here Male Female

2. What is your current age in years?

Enter age here:

3. Self reported race/ethnicity

Hispanic/Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)

White/Caucasian/European American

Black/African American/Negro

American Indian/Alaska Native

Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)

Native Hawaiian/Pacific Islander

Arab American/Middle eastern

Other (specify)

Other (please specify)

4. Highest level of nursing education obtained

Indicate here Diploma Associate degree Bachelor's degree Master's degree Doctorate

5. Environment of nursing practice

Hospital/Inpatient Setting

Clinic/Outpatient Setting

Community/Home Based Setting

Educational Institution

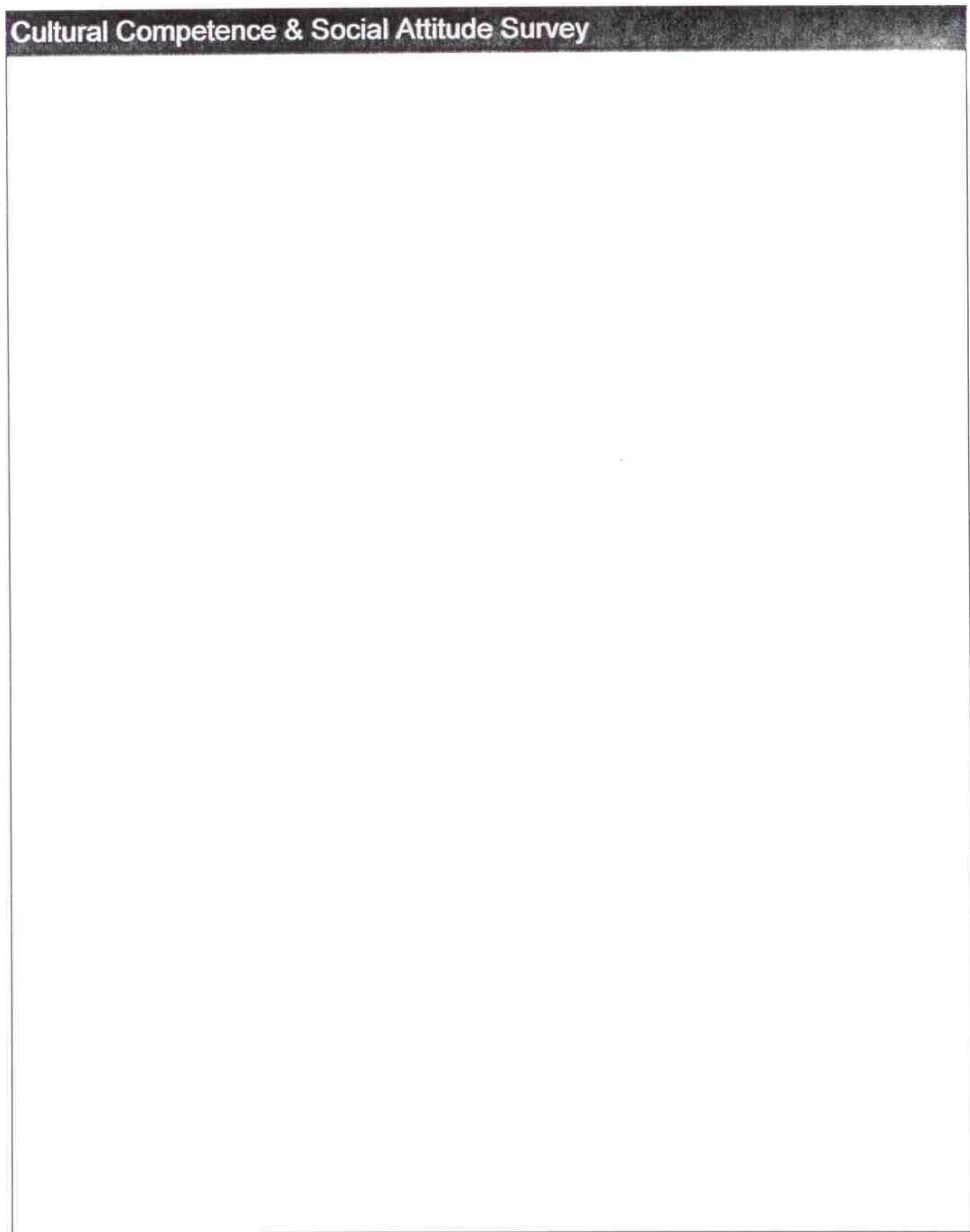
Other

Other (please specify)

6. Number of years of nursing practice

Enter whole number in the box.

Cultural Competence & Social Attitude Survey



Cultural Competence & Social Attitude Survey

The survey questions were designed by the authors to explore your knowledge, feelings, actions, and social attitudes. There are no "right" or "wrong" answers. Your answers are strictly confidential. DO NOT put your name anywhere on the survey. This survey will not be connected to your contact information for the \$200 prize drawing in any manner!

1. In the past 12 months, which of the following racial/ethnic groups have you encountered among your clients and their families or within the healthcare environment or workplace? Mark all that apply.

- Hispanic/Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)
- White/Caucasian/European American
- Black/African American/Negro
- American Indian/Alaska Native
- Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, other Asian)
- Native Hawaiian/Pacific Islander
- Arab American/Middle Eastern
- Other (please specify)

Other (please specify)

2. In your current environment, what percentage of the total population is made up of people from these racial/ethnic groups? Enter numbers to add up to 100%.

Hispanic/Latino (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, other Spanish)	<input style="width: 150px; height: 15px;" type="text"/>
White/Caucasian/European American	<input style="width: 150px; height: 15px;" type="text"/>
Black/African American/Negro	<input style="width: 150px; height: 15px;" type="text"/>
American Indian/Alaska Native	<input style="width: 150px; height: 15px;" type="text"/>
Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, other Asian)	<input style="width: 150px; height: 15px;" type="text"/>
Native Hawaiian/Pacific Islander	<input style="width: 150px; height: 15px;" type="text"/>
Arab American/Middle Eastern	<input style="width: 150px; height: 15px;" type="text"/>
All other groups combined.	<input style="width: 150px; height: 15px;" type="text"/>

Cultural Competence & Social Attitude Survey

3. In the past 12 months, which of the following special population groups have you encountered among your clients and their families or within the health care environment or workplace? Mark all that apply.

- Mentally or emotionally ill
- Physically Challenged/Disabled
- Homeless/Housing Insecure
- Substance Abusers/Alcoholics
- Gay, Lesbian, Bisexual, or Transgendered
- Different religious/spiritual backgrounds
- Other (specify

Other (please specify)

4. In your current environment, what percentage of the total population is made up of people from these special population groups? Write in a whole number to indicate percent; may not total 100%.

Mentally or emotionally ill	<input type="text"/>
Physically Challenged/Disabled	<input type="text"/>
Homeless/Housing Insecure	<input type="text"/>
Substance Abusers/Alcoholics	<input type="text"/>
Gay, Lesbian, Bisexual, or Transgendered	<input type="text"/>
Different religious/spiritual backgrounds	<input type="text"/>
Other (specify	<input type="text"/>

5. Overall, how competent do you feel working with people who are from cultures different than your own?

	Very competent	Somewhat competent	Neither competent nor incompetent	Somewhat incompetent	Very incompetent
Please mark the appropriate answer to the right	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. Race is the most important factor in determining a person's culture.

	Strongly agree	Agree	Somewhat agree	Neutral	Somewhat disagree	Disagree	Strongly disagree	No opinion
Please mark the appropriate answer to the right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Cultural Competence & Social Attitude Survey								
7. People with a common cultural background think and act alike.								
	Strongly agree	Agree	Somewhat agree	Neutral	Somewhat disagree	Disagree	Strongly disagree	No opinion
Please mark the appropriate answer to the right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Many aspects of culture influence health and health care.								
	Strongly agree	Agree	Somewhat agree	Neutral	Somewhat disagree	Disagree	Strongly disagree	No opinion
Please mark the appropriate answer to the right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Aspects of cultural diversity need to be assessed for each individual, group and organization.								
	Strongly agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly disagree	No opinion
Please mark the appropriate answer to the right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. If I know about a person's culture, I do not need to assess their personal preferences for health services.								
	Strongly agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly disagree	No opinion
Please mark the appropriate answer to the right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Spirituality and religious beliefs are important aspects of many cultural groups.								
	Strongly agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly disagree	No opinion
Please mark the appropriate answer to the right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Individual people may identify with more than one cultural group.								
	Strongly agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly disagree	No opinion
Please mark the appropriate answer to the right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Language barriers are the only difficulties for recent immigrants to the United States.								
	Strongly agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly disagree	No opinion
Please mark the appropriate answer to the right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Cultural Competence & Social Attitude Survey

14. I believe that everyone should be treated with respect no matter what their cultural heritage.

Please mark the appropriate answer to the right.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No opinion
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

15. I understand that people from different cultures may define the concept of "healthcare" in different ways.

Please mark the appropriate answer to the right.

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No opinion
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. I think that knowing about different cultural groups helps direct my work with individuals, families, groups and organizations.

Please mark the appropriate answer to the right.

Strongly agree	Agree	Somewhat agree	Neutral	Somewhat disagree	Disagree	Strongly disagree	No opinion
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Cultural Competence & Social Attitude Survey

1. For each of the following statements mark the box that best describes how often you do the following:

	Always	Very Often	Somewhat Often	Often	Sometimes	Few Times	Never	Not sure
17. I include cultural assessment when I do individual or organizational evaluations.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. I seek information on cultural needs when I identify new people in my work or school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. I have resource books and other materials available to help me learn about people from different cultures.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. I use a variety of sources to learn about the cultural heritage of other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. I ask people to tell me about their own explanations of health and illness.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. I ask people to tell me about their expectations for health services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. I avoid using generalizations to stereotype groups of people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. I recognize potential barriers to service that might be encountered by different people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. I remove obstacles for people of different cultures when I identify barriers to services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. I remove obstacles for people of different cultures when people identify barriers to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. I welcome feedback from clients about how I relate to people from different cultures.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. I find ways to adapt my services to individual and group cultural preferences.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. I document cultural assessments if I provide direct client services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Cultural Competence & Social Attitude Survey

30. I document the adaptations I make with clients if I provide direct client services.

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1. I really think affirmative action programs on college campuses constitute reverse discrimination.

Please mark the appropriate answer to the right.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. I feel I could develop an intimate relationship with someone from a different race.

Please mark the appropriate answer to the right.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. My friendship network is very racially mixed.

Please mark the appropriate answer to the right.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. I am against affirmative action programs in business.

Please mark the appropriate answer to the right.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. I would feel okay about my son or daughter dating someone from a different race.

Please mark the appropriate answer to the right.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. In the past few years there has been too much attention directed toward multicultural issues in education.

Please mark the appropriate answer to the right.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. Most of my close friends are from my own racial group.

Please mark the appropriate answer to the right.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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8. I think that it is (or would be) important for my children to attend schools that are racially mixed.					
	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
Please mark the appropriate answer to the right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. In the past few years there has been too much attention directed towards multicultural issues in business.					
	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
Please mark the appropriate answer to the right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Overall, I think racial minorities in America complain too much about racial discrimination.					
	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
Please mark the appropriate answer to the right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I think white people's racism toward racial minority groups still constitutes a major problem in America.					
	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
Please mark the appropriate answer to the right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I think the school system, from elementary school through college, should encourage minority and immigrant children to learn and fully adopt traditional American values.					
	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
Please mark the appropriate answer to the right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. If I were to adopt a child, I would be happy to adopt a child of any race.					
	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
Please mark the appropriate answer to the right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. I think the school system, from elementary through college, should promote values representative of diverse cultures.					
	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
Please mark the appropriate answer to the right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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15. I believe that reading the autobiography of Malcolm X would be of value.					
	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
Please mark the appropriate answer to the right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. I think it is better if people marry within their own race.					
	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
Please mark the appropriate answer to the right.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Your answers to these last few questions will help us understand responses from different kinds of people who complete the survey. All answers are strictly confidential!

Read each item and decide whether the statement is true or false as it pertains to you personally. Mark the appropriate answer.

1. It is sometimes hard for me to go on with my work if I am not encouraged.

Mark answer to the right. True False

2. I sometimes feel resentful when I don't get my way.

Mark answer to the right. True False

3. On a few occasions, I have given up doing something because I thought too little of my ability.

Mark answer to the right. True False

4. There have been times when I felt like rebelling against people in authority even though I knew they were right.

Mark answer to the right. True False

5. No matter who I'm talking to, I'm always a good listener.

Mark answer to the right. True False

6. There have been occasions when I took advantage of someone.

Mark answer to the right. True False

7. I'm always willing to admit it when I make a mistake.

Mark answer to the right. True False

8. I sometimes try to get even rather than forgive and forget.

Mark answer to the right. True False

9. I am always courteous, even to people who are disagreeable.

Mark answer to the right. True False

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10. I have never been irked when people expressed ideas very different from my own.

True

False

Mark answer to the right.

11. There have been times when I was quite jealous of the good fortune of others.

True

False

Mark answer to the right.

12. I am sometimes irritated by people who ask favors of me.

True

False

Mark answer to the right.

13. I have never deliberately said something to hurt someone's feelings.

True

False

Mark answer to the right.

Cultural Competence & Social Attitude Survey

Thank you for completing this survey and participating in my research project. Clicking the icon will take you to a separate Survey Monkey site where you can enter your contact information to be entered into the \$200 prize drawing.

If there is a problem with the link, click on this link or type this URL into your browser to access the prize drawing entry site:
Click here to take survey

<https://www.surveymonkey.com/s/HardyDrawing>

APPENDIX K

SURVEY MONKEY SITE--PRIZE DRAWING ENTRY

