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Evaluation Of The Antecedents Of Cultural Competence

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EVALUATION OF THE ANTECEDENTS OF CULTURAL COMPETENCE

by

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ABSTRACT

Purpose: The threefold purpose of this research is to identify the essential antecedents of cultural competence as identified by international nurse researchers, to compare the content of the extant cultural competence instruments to these antecedents and to potentially identify gaps in their conceptualization. A secondary aim of this research is to initiate validation of Harper's model of ethical multiculturalism.

Conceptual Basis: The model of ethical multiculturalism depicts the attributes of ethical multiculturalism as the fulcrum of a balance between two ethical philosophies of fundamentalism and relativism. The attributes of moral reasoning, beneficence/nonmaleficence, respect for persons and communities, and cultural competence form the pyramidal fulcrum. The antecedents form the base of the pyramid and include cultural awareness, culture knowledge, cultural sensitivity, cultural encounters, cultural skill and understanding of ethical principles.

Methodology: An on-line Delphi method was conducted with 35 international nurse researchers identified through published research, university directories, and professional organizations**.** Consensus was reached after two rounds. Following the Delphi rounds, sixteen members of the expert panel participated in an on-line focus group to validate results of the Delphi and discuss cultural competence in the international arena.

Findings: Eighty antecedents of cultural competence were identified. Focus group discussion validated findings of the Delphi. Consensual thematic analysis of the focus group transcripts resulted in six themes: chimerical, contact, contextual,

collaboration, connections, and considering impact. The Transcultural Self-Efficacy Tool (TSET) contained the most antecedents identified by the expert panel.

Conclusions: Cultural competence is a process, not an outcome, and must be considered from the perspective of the recipient of care or research participant. Nurses must strive to deliver culturally acceptable care. The model of ethical multiculturalism is revised to include cultural desire as an antecedent. Nurses must understand the impact of globalization on individual health and care delivery.

Implications for Nursing: Further testing of cultural competence instruments is needed to determine the correlation of self-efficacy with behavior, self-assessment with client assessment, and cultural competence with client outcomes. In education, research is needed to determine the most effective methods of teaching cultural competence. Increased recruitment of minorities into nursing programs is warranted. In practice, nurses must be prepared to provide language assistance as needed, recruitment and hiring of minorities must be increased, and minority thresholds must be used to determine cultural knowledge content for organizations.

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Finally, to my heavenly Father, I’m not exactly sure why you put me up to this, but I look forward to finding out. Thank you for giving me the strength for the journey.

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LIST OF ABBREVIATIONS

AAN	American Academy of Nursing
CAS	Cultural Awareness Scale
CCA	Cultural Competence Assessment
CCAI	Cross-Cultural Adaptability Inventory
CCET	Cross-Cultural Evaluation Tool
CLAS	Culturally and Linguistically Appropriate Services
CSES	Cultural Self-Efficacy Scale
CVI	Content Validity Index
IAPCC	Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals
IAPCC-R	Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals – Revised
IRB	Institutional Review Board
IOM	Institute of Medicine
LEP	Limited English Proficiency
NIH	National Institutes of Health
NCMHD	National Center on Minority Health and Health Disparities
OMH	Office of Minority Health
PDF	Portable Document Format
PRPCC	Patient-Reported Provider Cultural Competence
TSET	Transcultural Self-Efficacy Tool

CHAPTER 1: INTRODUCTION

The current focus on cultural and linguistic competence in the health care arena is a result of the changing demographics in the United States (n.d.), increases in health care disparities among vulnerable populations (Betancourt, Green, Carrillo & Park, 2005; Ponce, Hays, & Cunningham, 2006), and enhanced recognition of the influence that culture exerts on both the provider and recipient of health care (Genao, Bussey-Jones, Brady, Branch, & Corbie-Smith, 2003; Nápoles-Springer, Santoyo, Houston, Pérez-Stable, & Stewart, 2005; Smedley, Stith, & Nelson, 2003; van Ryn & Fu, 2003). Federal policy has also provided impetus to the movement through legislation such as Title VI of the Civil Rights Act of 1964 and President Clinton's Executive Order entitled "Improving Access to Services for Persons with Limited English Proficiency," signed in 2000 (Lindsay, 2005). The development of the federal Office of Minority Health (OMH) (Office of Minority Health, n.d.) in 1986 has spurred more than two-thirds of the states to develop their own OMH to develop programs to eliminate the growing health disparities among ethnic and racial minorities in the United States (Ladenheim & Groman, 2006). In spite of this flurry of interest and legislation, in 2004, the federal OMH found that most of the literature related to cultural and linguistic competence is descriptive, providing little empirical evidence for the impact of cultural competence on health-related outcomes (Fortier & Bishop, 2004). The same remains true today (Giger et al., 2007a; Goode, Dunne, & Bronheim, 2006).

Individuals belonging to racial and/or ethnic minorities are particularly prone to healthcare disparities, especially if they have limited English proficiency (LEP) (Aday,

2001; Agency for Healthcare Research and Quality, n.d.; Giger et al., 2007a; Ponce et al., 2006; Zoucha, 2005). Ethnic minorities will make up approximately 50% of the population by the year 2050 (U.S. Census Bureau, 2004). Health disparities are defined by the Institute of Medicine (IOM) as “racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention” (Smedley et al., 2003, pp.3 - 4). The IOM Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care found that disparities are often associated with undesirable outcomes and may be caused in part by health care providers’ prejudice, bias, or stereotyping (Smedley et al., 2003). Cultural and linguistic competence of health care providers, with a concomitant goal of providing quality care to all, is viewed as one mechanism to help reduce health disparities (Beach, Saha & Cooper, 2006; Betancourt, 2006; Betancourt et al., 2005; Brach, Fraser & Paez, 2005; Genoa et al, 2003; Lipson & Desantis, 2007). Unfortunately, a lack of conceptual consensus and standardized measurement have presented barriers to the evaluation of the effectiveness of educational strategies for providers and the outcomes of interventions designed to promote culturally competent care (Fortier & Bishop, 2004; Giger et al., 2007a; Goode et al., 2006; Gray & Thomas, 2005; Schim, Doorenbos, Benkert, & Miller, 2007; Xu, Shelton, Polifroni, & Anderson, 2006).

Cultural competence is defined in a myriad of ways. Purnell (2002)refers to cultural competence as the “adaptation of care” to be in harmony with the client’s culture. Others describe cultural competence as a process (Caffrey, Neander, Markle, & Stewart, 2005; Campinha-Bacote, 2003b; Jeffreys, 2006) or as behaviors (Doorenbos & Schim, 2004; Schim et al., 2007). Cultural competence has been portrayed as one

component of providing culturally congruent care (Jeffreys, 2006; Schim et al., 2007). In the standards for Culturally and Linguistically Appropriate Services (CLAS), the OMH defines cultural and linguistic competence as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations” (Office of Minority Health, 2001, p. 3). The American Academy of Nursing (AAN) Expert Panel on Cultural Competence suggests that the standard definition of cultural competence should be “having the knowledge, understanding, and skills about a diverse cultural group that allows the health care provider to provide acceptable cultural care” (Giger et al., 2007a, p. 100). While the AAN definition is similar to that of the OMH, Giger et al. (2007b) posit that standardized definitions will not only promote consistency but also enhance the provision of culturally competent care.

Lack of standardized measurement tools is another barrier to understanding cultural competence among health care providers (Fortier & Bishop, 2004). A review of seven cultural competence instruments found only two that purport to measure cultural competence among healthcare providers (Campinha-Bacote, 2007; Doorenbos, Schim, Benkert, & Borse, 2005). The remaining instruments measure self-efficacy (Bernal, 1993; Jeffreys, 2006), cultural awareness (Rew, Becker, Cookston, Khosropour, & Martinez, 2003), interaction (T.L.Freeman, personal communication, June 3, 2007), or adaptability (Meyers, 2001) and assume that these characteristics translate into the ability to provide culturally competent care. All instruments are self-assessments and have psychometric limitations (Harper, 2007). At least two of the instruments are subject to social desirability bias (Brathwaite, 2005; Doorenbos et al., 2005). Many have been

used primarily in academia with students and faculty (Alpers, 1996; Doutrich & Storey, 2004; Jeffreys, 2000; Jeffreys & Smodlaka, 1998; Kardong-Edgren et al., 2005; Kulwicki & Bolonich, 1996; Lim, Downie, & Nathan, 2004; Nokes, Nickitas, Keida, & Neville, 2005; Sargent, Sedlak, & Martsolf, 2005; St. Clair & McHenry, 1999; Vito, Toszkowski, & Wieland, 2005; Williamson, Allen, & Coppens, 1996) with little focus on practicing professionals (Bernal & Froman, 1987, 1993; Brathwaite, 2005, 2006; Doorenbos & Schim, 2004; Doorenbos et al., 2005; Hagman, 2006; Hughes & Hood, 2007; Schim, Doorenbos, & Borse, 2005, 2006). As nursing moves toward consensus of definition of cultural competence (Giger et al., 2007a), standardization of measurement is also needed to evaluate the effectiveness of educational strategies to enhance cultural competence among clinicians (Fortier & Bishop, 2004).

In addition to national initiatives to promote cultural competence, the move toward a global health perspective (Faulk-Rafael, 2006) has prompted nursing leaders to call for a “global nursing ethic” that involves a partnership with citizens of diverse cultures (Crigger, Brannigan, and Baird, 2006). Nurses are challenged to become citizens of the world by engaging in personal reflection, seeking to understand others, and by advocating for social justice. These activities are operationalized in research through ethical multiculturalism. A term coined by Crigger, Holcomb, and Weiss (2001), ethical multiculturalism involves conducting international research in a manner that applies fundamental ethical principles in a contextually relevant manner. In an evolutionary concept analysis, Harper (2006) identified four attributes of ethical multiculturalism: moral reasoning, respect for persons and communities, beneficence/nonmaleficence, and cultural competence. Challenges faced by nurses in

pursuit of this global health perspective to achieve ethical multiculturalism include the attainment of cultural competence and the establishment of a global code of ethics that recognizes fundamental rights while honoring cultural diversity.

Papadopoulos and Lees (2002) posit that while application may differ, the same types of cultural competence are needed for nursing clinicians and nurse researchers. In addition, they assert that culturally competent research is a prerequisite to culturally competent practice. Therefore, knowledge of how nurses who conduct research in diverse cultures achieve cultural competence may inform nurses in the practice setting.

Problem

In order for nurses to achieve ethical multiculturalism in any cross-cultural research or health care arena, whether national or international, an understanding of cultural competence is imperative. The current lack of a standardized definition and instrument to measure cultural competence is a problem facing nursing scientists, health care administrators, nursing educators, and various accreditation and governmental agencies. Lack of standardization impedes measurement of progress toward the goal of teaching and delivering culturally competent health care.

Purpose

The threefold purpose of this research is to identify the essential antecedents of cultural competence as identified by international nurse researchers, to compare the content of the extant cultural competence instruments to these antecedents and to

potentially identify gaps in their conceptualization. A secondary aim of this research is to initiate validation of Harper's model of ethical multiculturalism.

Research Questions

What are key attributes of cultural competence?

Do extant instruments that measure cultural competence also measure key attributes as identified by the expert panel of participants?

Are the antecedents of cultural competence in Harper's model of ethical multiculturalism consistent with the attributes identified by international nurse researchers?

The exploration of these research questions will advance nursing knowledge of cultural competence and enable the profession to effectively teach culturally competent behaviors. Evaluation of extant instruments may promote standardized measurement to facilitate appraisal of progress toward the legislated goal of providing culturally competent care. Cultural and linguistic competence of health care providers, with a concomitant goal of providing quality care to all, is viewed as one mechanism to help reduce health disparities (Beach et al., 2006; Betancourt, 2006; Betancourt et al., 2005; Brach et al., 2005; Genao et al., 2003; Lipson & Desantis, 2007). Likewise, this research may contribute to development of a global nursing ethic.

Definition of Terms

Based on the glossary of standard definitions proposed by the AAN Expert Panel on Cultural Competence, culture is defined as "a learned, patterned behavioral

response acquired over time that includes explicit and implicit beliefs, attitudes, values, customs, norms, taboos, arts, habits, and life ways accepted by a community of individuals" (Giger et al., 2007a, p. 100).

Cultural competence, as defined by the AAN Expert Panel on Cultural Competence, is "having the knowledge, understanding, and skills about a diverse cultural group that allows the health care provider to provide acceptable cultural care" (Giger et al., 2007a, p. 100).

International cross-cultural research is an investigation involving participants from a country and culture, race, and/or ethnicity different from that of the investigator and that occurs in the native country of the participant.

An antecedent is a primary factor that must be present before the concept of interest, in this case, cultural competence, is achieved. For purposes of this study, it may be used synonymously with the words attribute or characteristic.

Assumptions

1. International cross-cultural nurse researchers are experts in cross-cultural research and have experience navigating a culture other than their own.
2. Participants will be truthful and share insights based on experiences while studying another culture.
3. Participants will be comfortable and proficient with electronic communication.
4. Participants have a common understanding of the meaning of culture and its place in provision of care to clients.

CHAPTER 2: REVIEW OF LITERATURE

Cultural competence is needed to achieve ethical multiculturalism and meet the needs of the global community (Faulk-Rafael, 2006) as well as help reduce health disparities within the United States (Beach et al., 2006; Giger et al., 2007a). Lack of standardized conceptualization and measurement are barriers to understanding progress toward the goal of cultural competence of nurses. The threefold purpose of this research is to identify the essential antecedents of cultural competence as identified by international nurse researchers, to compare the content of the extant cultural competence instruments to these antecedents and to potentially identify gaps in their conceptualization. A secondary aim of this research is to initiate validation of Harper's model of ethical multiculturalism. This chapter will examine the current literature related to cultural competence and its measurement.

Globalization

Globalization is the increase in interactions among people, businesses, governments and other institutions that has been facilitated by technology (Carnegie Endowment for International Peace, n.d.; Crigger, 2008; Davidson, Meleis, Daly & Douglas, 2003). While often considered in the context of trade and investment, globalization influences the practice of nursing as well. The International Council of Nurses' (n.d.) reflects this global influence in its mission to "ensure quality nursing care for all, sound health policies globally, the advancement of nursing knowledge, and the presence worldwide of a respected nursing profession…." Issues such as the

management of infectious disease in a mobile world population, the juxtaposition of obesity and starvation as two major health problems, and migration demonstrate the impact of globalization on nursing practice. Although globalization has promoted uniformity in many contexts, it has also illuminated diversity and disparities among individuals (Davidson et al., 2003). Nurses must understand the influences of culture and prepare themselves to be culturally competent leaders (Davidson et al., 2003).

Culture

Loustaunau and Sobo (1997) offer a brief definition of culture: "all the shared, learned knowledge that people in a society hold" (p. 10). This shared perspective impacts every facet of life including worldview, beliefs, values, customs, communication, rituals, art, and ideas (Helman, 2000; Loustaunau & Sobo, 1997). Subcultures exist within every society (Helman, 2000). While they share many values, beliefs, and customs of the primary culture, subcultures also have distinctions that separate them from the main group, making it difficult to form generalizations about an overall culture.

Since culture affects every facet of life, its influence on health and healthcare beliefs is important to recognize. For example, definitions of illness vary from one culture to another (Loustaunau & Sobo, 1997). Among the Hmong, although epilepsy is acknowledged to be potentially dangerous, it is seen as evidence that an individual is able to see beyond the visible realm and that the afflicted person is called to be a shaman (Fadiman, 1997). As a result, parents of an epileptic child may demonstrate pride in their child's seizures and resist treatment aimed at eliminating the convulsions. Culture also influences how individuals view treatment, prevention, causative attribution,

and type of healthcare provider consulted (Helman, 2000; Loustaunau & Sobo, 1997). Cultural variation is also evident in perceptions of diet and nutrition, life cycle events such as birth and death, gender and family roles, and pain perceptions.

According to the IOM (Smedley et al., 2003), variations in cultural views toward health and health care may contribute to health care disparities within the United States. Client-level factors such as individual preferences, refusal to accept or adhere to treatment, and biological differences may combine with health system factors and provider-level factors to cause inequalities. The IOM calls for education of health care clinicians in the areas of cross cultural attitudes, knowledge, and skills to address the variations in cultural views.

Cultural Competence

Cross cultural attitudes, knowledge, and skills have commonly been considered components of cultural competence (Campinha-Bacote, 2007). The seeds of the cultural competence movement were planted in the 1950s by Madeleine Leininger (1997) who recognized that the world was rapidly becoming multicultural. She developed the Theory of Culture Care to “discover, document, interpret, and explain the predicted and multiple factors influencing and explaining care from a cultural holistic perspective” (Leininger, 1997, p. 36). Her Theory of Cultural Care Diversity and Universality has been called a grand theory (Xu et al., 2006) that has served as the foundation for midrange and microtheories of cultural competence (Schim et al., 2007; Xu et al., 2006).

Despite Leininger's seminal work on cultural competence, a standardized conceptualization of cultural competence in nursing is lacking. Purnell (2002) refers to cultural competence as the "adaptation of care" to be in harmony with the client's culture. The OMH identifies cultural and linguistic competence as the ability to work effectively with other cultures (Office of Minority Health, 2001). Cultural competence is described as a process (Caffrey et al., 2005; Campinha-Bacote, 2003b), attitudes, policies (Office of Minority Health, 2001), or behaviors (Doorenbos & Schim, 2004; Office of Minority Health, 2001; Schim et al., 2007). Cultural competence has been portrayed as one component of providing culturally congruent care (Schim et al., 2007). The American Academy of Nursing (AAN) Expert Panel on Cultural Competence suggests that the standard definition of cultural competence should be "having the knowledge, understanding, and skills about a diverse cultural group that allows the health care provider to provide acceptable cultural care" (Giger et al., 2007a, p. 100). While the AAN definition is similar to that of the OMH cited earlier, a standard definition of cultural competence is needed to promote advancing the scientific knowledge base of cultural competence.

Recognizing the lack of clarity surrounding the concept of cultural competence, Suh (2004) conducted a concept analysis based on the nursing, sociology, medicine, psychology, and education literature. This analysis revealed that the antecedents of cultural competence group into four domains: affective, cognitive, behavioral, and environmental. In the affective domain, cultural sensitivity includes the perception and acceptance of cultural differences. Cultural awareness and cultural knowledge comprise the cognitive domain. Awareness is simply the acknowledged need for cultural

competence while cultural knowledge consists of factual learning about various elements of another culture such as politics, economics, and worldview. The behavioral domain of cultural competence, cultural skill, encompasses the ability to conduct cultural assessments and intercultural communication. Finally, cultural encounters, or interactions with members of another culture, occur in the environmental domain.

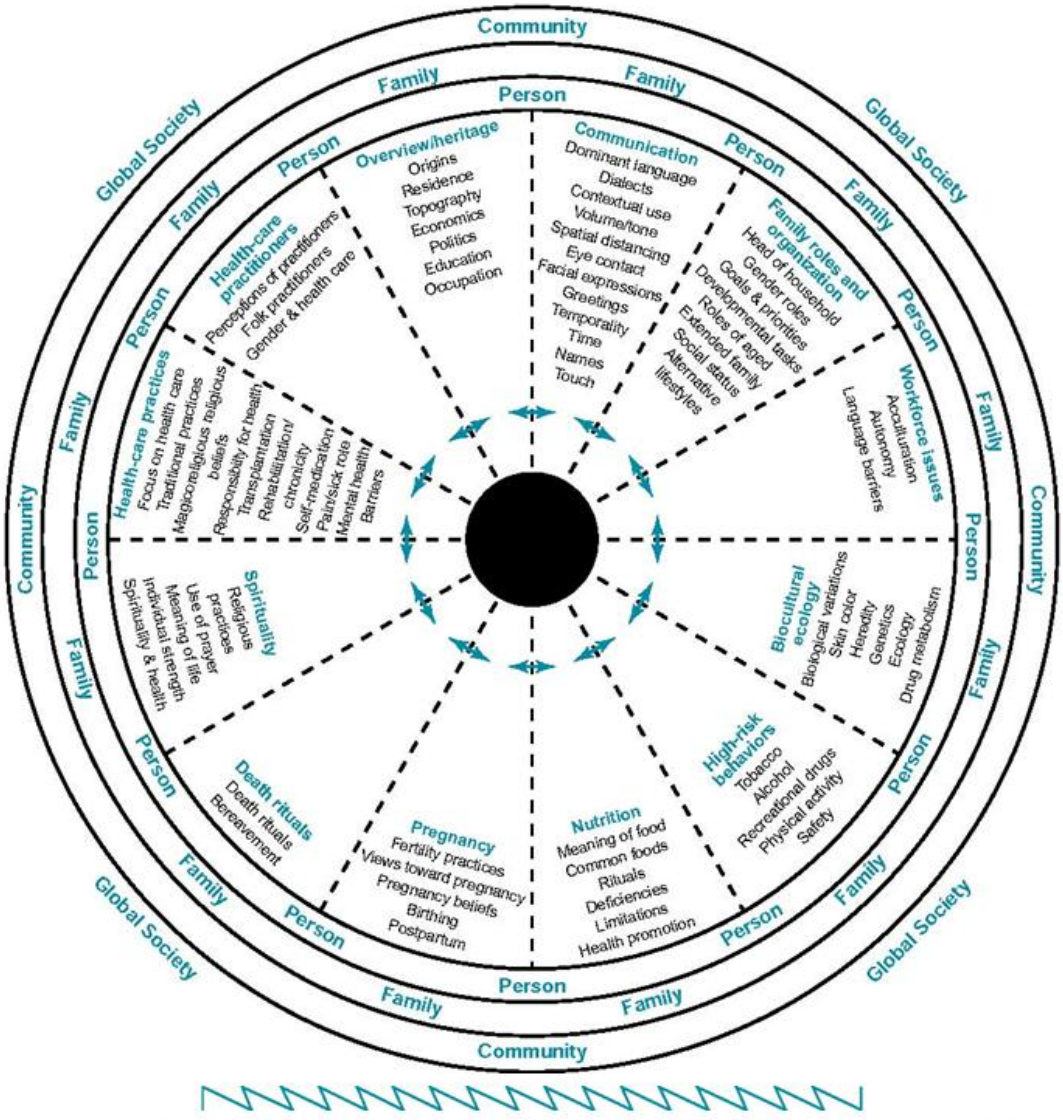
Theories of Cultural Competence

Leininger's (1997) Theory of Cultural Care Diversity and Universality is a grand theory (Xu et al., 2006) that has served as the foundation for midrange and microtheories of cultural competence (Schim et al., 2007; Xu et al., 2006). Leininger (2007; Leininger & McFarland, 2006) disparages the current nursing paradigm of nursing, person, health and environment (Potter & Perry, 2005) for its lack of inclusion of the key concepts of care and culture. She maintains that these concepts are essential to understand and explain nursing (Leininger & McFarland, 2006) and proposes a new nursing paradigm called the "cultural care nursing paradigm" (Leininger, 2007, p.12). The Sunrise Model depicts the key dimensions of cultural knowledge that must be ascertained to guide nursing care and decisions. Leininger's (1997) theory assumes that culturally congruent care is possible only when the care provided by the nurse is consistent with cultural patterns and values.

Culturally congruent care is the outcome of nursing care provided by a culturally competent nurse (Jeffreys, 2006). While several cultural competence models exist, the Purnell (2005) Model for Cultural Competence and the Process of Cultural Competence in the Delivery of Healthcare Services (Campinha-Bacote, 2005) are often used in

nursing curricula (Lipson & Desantis, 2007) and were used to inform this study. These models have been evaluated using Smith's (2003) framework for the evaluation of middle range theories. Although these two models have been identified as microtheories (Xu et al., 2006), their multidisciplinary perspective elevates them above the limited scope of microtheory identified by Im and Meleis (1999).

The Purnell Model for Cultural Competence, based on systems theory (Xu et al., 2006), is designed as a multidisciplinary framework for learning cultural concepts and characteristics (Purnell, 2000, 2002, 2005). It has evolved from a set of 18 to 21 assumptions about the nature of culture, individuals, and caregivers. (Purnell, 2000, 2005). As seen in Figure 1, Purnell's model is depicted as three concentric circles representing community, family, and person within the overall framework of global society.



Primary characteristics of culture: age, generation, nationality, race, color, gender, religion
Secondary characteristics of culture: educational status, socioeconomic status, occupation, military status, political beliefs, urban versus rural residence, enclave identity, marital status, parental status, physical characteristics, sexual orientation, gender issues, and reason for migration (sojourner, immigrant, undocumented status)
Unconsciously incompetent: not being aware that one is lacking knowledge about another culture
Consciously incompetent: being aware that one is lacking knowledge about another culture
Consciously competent: learning about the client's culture, verifying generalizations about the client's culture, and providing culturally specific interventions
Unconsciously competent: automatically providing culturally congruent care to clients of diverse cultures

Figure 1. The Purnell model for cultural competence.
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The model contains twelve pie-shaped domains surrounding an empty central core. This core represents the unknown characteristics of a given culture while the twelve domains represent overview/heritage, communication, family roles and organization, workforce issues, biocultural ecology, high-risk behaviors, nutrition, pregnancy, death rituals, spirituality, healthcare practices, and health-care practitioners. Each domain is composed of several components. For example, biocultural ecology includes biological variations, skin color, heredity, genetics, and ecology and drug metabolism. Below the model is a saw-toothed scale of cultural consciousness ranging from unconsciously incompetent to consciously incompetent, to consciously competent, and finally to unconsciously competent. The saw-toothed nature of the scale indicates that cultural competence advances and regresses based on circumstances and cultures that one encounters. Below the scale, the primary and secondary characteristics of culture are listed. Primary characteristics are those that are unchangeable or that if changed may cause significant difficulty, such as stigmatization, for the individual. These characteristics include age, generation, nationality, race, color, gender, and religion. Secondary characteristics are changeable attributes such as education, socioeconomic status, occupation, political beliefs, marital status, and sexual orientation, among others (Purnell, 2000, 2002, 2005).

Evaluation of the substantive foundations is the first step in the Smith (2003) framework. Strengths of the Purnell model include explicitly stated assumptions that are consistent with the focus of the model and clear descriptions of the constructs. In addition, the model is rooted in the author’s practice, research, and lived experiences. Although the model is applicable to many disciplines, it focuses within the discipline of

nursing in its consideration of the nursing phenomena of person, environment, health, and health care practitioners within its 12 domains.

Structural integrity, according to Smith (2003), evaluates the concepts in the model. The concepts are clearly defined by Purnell (2000; 2002; 2005). The model depicts the domains and their interrelationships logically. However, overlap of concepts between domains is present (Purnell, 2000). Smith states that there should be no more concepts than needed to explain the phenomenon. The multitude of concepts within each domain of the Purnell model promotes an appearance of complexity and is not necessary on the model diagram. The busyness of the model is a significant weakness that may detract from its utility.

The final category of evaluation, according to Smith (2003), is functional adequacy and relates to the model's use in practice and research, and the resultant evolution. The Purnell model is used in baccalaureate nursing curricula as a framework for integration into various courses (Lipson & Desantis, 2007). It has been used as an organizing model for student journals for an immersion course (Purnell, 2000). Purnell reports use by multiple disciplines in various countries but evidence of this has not been found in the literature (Purnell, 2000, 2002). Purnell (1999; 2001) has conducted research in Panama and Guatemala using his model as a guide for questionnaire development to determine cultural practices in each of the 12 domains but no empirical indicators have been found. The number of explicit assumptions has increased with each release of the model (Purnell, 2000, 2002, 2005).

Campinha-Bacote's (2003b) model, The Process of Cultural Competence in the Delivery of Healthcare Services, assumes cultural competence is a process. As seen in

Figure 2, the model is portrayed as a volcano called cultural desire that erupts the process of cultural competence.

Figure 2. The process of cultural competence in the delivery of healthcare services. Campinha-Bacote (2002). Reprinted with permission from Transcultural C.A.R.E. Associates

The “eruption” of cultural competence contains cultural awareness, cultural skill, cultural knowledge, and cultural encounters. Cultural desire, a spiritual component of the model, involves the nurse’s motivation, caring and willingness to sacrifice prejudice (Campinha-Bacote, 2003a, 2003b). Humility, respect for diversity, willing commitment to identify similarities as a foundation for the relationship, and eagerness to learn from the client are all integral to this construct. Cultural awareness is a consciousness to one’s own

attitudes and assumptions toward diverse others, including racism, bias, and stereotyping. Cultural knowledge is the cognitive awareness of health conditions associated with specific races and ethnic groups as well as their response to treatment and the client's beliefs and values about health care. Cultural skill is the ability to assess the client in a culturally appropriate manner while cultural encounters involve interactions with culturally diverse individuals and includes linguistic needs.

Like the Purnell model, the Campinha-Bacote model is designed for multidisciplinary application. Using Smith's (2003) evaluative framework, the substantive strengths of the model include its explicitly stated assumptions related to cultural competence and its clear explanation of cultural competence as a process. The model represents the blended practice and scholarly endeavors of its author in the fields of psychiatric nursing and theology and her personal experiences as a second generation Cape Verdean (Campinha-Bacote, 2003b).

Structurally, the concepts in the model are clearly defined. The model clearly depicts cultural desire as the source of cultural competence and the interconnectedness of cultural awareness, skill, knowledge, and encounters. These concepts are broad enough to encompass the majority of the constructs contained in Purnell's 12 domains. The simplicity of the Campinha-Bacote model is appealing.

The functional adequacy of the Campinha-Bacote model is demonstrated by its extensive use in education and research, (Brathwaite, 2003, 2005; Doutrich & Storey, 2004; Nokes et al., 2005; Sargent et al., 2005) in part due to the author's development of the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals (IAPCC) (Campinha-Bacote, 1999) and the revised version, the IAPCC-

R© (Campinha-Bacote, 2003b). Use in public health and rehabilitation nursing practice is described in the literature (Campinha-Bacote, 2001; Doutrich & Storey, 2004). The structural appearance of the model has evolved over time as a result of the author's theological studies, not necessarily due to scholarly inquiry. A Biblically based version of the model has been developed (Campinha-Bacote, 2005). Overall, the use of the Campinha-Bacote model is more extensively described in the literature than the Purnell model.

Both the Campinha-Bacote and Purnell models have strengths and weaknesses that must be considered in the provision of culturally competent healthcare. Campinha-Bacote's (2003a) identification of cultural desire as the key concept from which cultural competence flows is consistent with caring as an integral component of nursing. Cultural desire encompasses the "commitment to be open and flexible with others, and to respect differences but build on similarities," (p. 21) a concept missing from the Purnell model. The Purnell model focuses on identification of differences between cultures based on the 12 domains. Although he acknowledges "core similarities" of cultures in his assumptions, the Purnell model fails to recognize that cultures tend to have more commonalities than differences (Gudykunst & Kim, 2003).

The Purnell model recognizes the individual's place within a family, community, and global society. The Campinha-Bacote model does not. Global events have significant influence on individuals and how individuals from diverse cultures interact as evidenced by ethnic profiling by airport security after the terrorist attacks on September 11, 2001. Furthermore, individual relationships within the family and community vary in

collectivistic and individualistic societies, creating diverse dynamics in the health care arena. The systems view offered by Purnell is an asset for the model.

Another strength of the Purnell model is the nonlinear scale of cultural consciousness extending from unconsciously incompetent to unconsciously competent. Campinha-Bacote uses the Purnell stages in her description of the concept of cultural awareness but she describes the scale as a continuum, implying linearity. The nonlinear nature of competence is intuitively appealing. For example, an individual may be at a high level of competence in a business situation with an individual from another culture but regress to a lower level in a social context.

The development of an instrument for measuring cultural competence is considered a strength of the Campinha-Bacote model (Xu et al., 2006). The IAPCC and the revised version (IAPCC-R©) have been extensively used to measure cultural competence (Brathwaite, 2005, 2006; Campinha-Bacote, 1999; Doutrich & Storey, 2004; Gulas, 2005; Nokes et al., 2005; Reeves & Fogg, 2006; Sargent et al., 2005; Smith-Campbell, 2005) even though the psychometric properties of the instrument are weak (Harper, 2007).

Considerable criticism of current models of cultural competence based on the essentialist perspective are emerging in the literature (Gray & Thomas, 2005, 2006; Gustafson, 2005; Lynam, Browne, Kirkham, & Anderson, 2007). Critics posit that extant theoretical constructs promote superficial awareness of cultures as static entities thereby promoting and maintaining stereotypes. Some also assert that current models assume a white identity of the health care provider and imply that others are “different” (Gustafson, 2005; Williams, 2006), perpetuating historical power relations (Gray &

Thomas, 2005). Consideration of a critical constructivist perspective that views culture within the current social context of both health care provider and client is encouraged (Gray & Thomas, 2006; Gustafson, 2005; Lynam et al., 2007). This viewpoint acknowledges that individuals belong to and are influenced by multiple cultures (Gray & Thomas, 2005). Gray and Thomas note that the Campinha-Bacote model demonstrates characteristics of a constructivist approach through the concept of cultural desire and its focus on understanding and respecting differences. Constructivist ideology is also evident in Campinha-Bacote's (2003a) assertion that the healthcare provider-client interaction is an opportunity for mutual learning.

Leininger's foresight half a century ago laid a strong theoretical foundation for cultural competence. Subsequent models have identified components of cultural competence and have developed instruments to measure the construct in an effort to obtain empirical evidence to support these models. Unfortunately, the result has been a plethora of measurement instruments leading the profession of nursing away from standardization of conceptualization and measurement of cultural competence.

Measurement of Cultural Competence

In 2001, the Office of Minority Health convened a research advisory committee to evaluate how to advance research on cultural competence interventions (Fortier & Bishop, 2004). The resulting document, *Setting the Agenda for Research on Cultural Competence in Health Care*, published in 2004, identified key areas for research as well as obstacles to promoting the agenda. One challenge identified is the lack of standardized measurement instruments. As a result, a key research question posed is

“How can the reliability of data collection on providers be improved?” (p. 46). Evaluation of the psychometric properties of extant instruments to identify the most valid and reliable tools for measuring cultural competence is necessary to move toward standardization. An evaluation and comparison of instruments used in recent research to measure the cultural competence of health care providers follows.

A computerized search of the Academic Search Premier, Alt HealthWatch Health Source: Nursing/Academic Edition, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Pre-CINAHL, PsycARTICLES, PsycINFO, and PubMed databases was conducted to identify various instruments used in measurement of cultural competence of health care providers. In addition to computerized searches, a manual review of all references from Campinha-Bacote’s (2003b) book on the Process of Cultural Competence model was conducted. The Transcultural Clinical Administrative Research and Education (C.A.R.E.) Association (2006) website was also searched. The following inclusion criteria were used: English publication, used to measure cultural competence in health care providers in at least one study, psychometric data published, and initial instrument development information accessible.

Seven instruments were identified for review: the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals – Revised (IAPCC-R©) (Campinha-Bacote, 2003b), the Cultural Self-Efficacy Scale (CSES) (Bernal & Froman, 1987), the Transcultural Self-Efficacy Tool (TSET) (Jeffreys & Smodlaka, 1998), the Cultural Competence Assessment (CCA) (Schim, Doorenbos, Miller, & Benkert, 2003), the Cross-Cultural Adaptability Inventory (CCAI) (Kelley & Meyers, 1987), The Cross-Cultural Evaluation Tool (CCET) (T.L. Freeman, personal

communication, June 3, 2007), and the Cultural Awareness Scale (CAS) (Rew et al., 2003). The initial IAPCC was combined with the IAPCC-R© in this review since the revised instrument contains all the items in the former instrument and the IAPCC is no longer used (Transcultural C.A.R.E. Associates, 2008). Table 1 gives an overview of the instruments including authors, factors measured, number of items, and measurement scale. Table 2 presents the psychometric properties of each instrument. Instruments for which permission to reprint was obtained are included in the appendices.

Table 1. Cultural competence measurement instrument comparison

Instrument	Author(s)	Factors	# Items/Scoring
IAPCC-R	Campinha-Bacote (2003)	Cultural awareness Cultural knowledge Cultural skill Cultural encounters Cultural desire	25 items 4 point Likert Scale
CSES	Bernal (1987)	Knowledge of cultural concepts Cultural patterns Skills with transcultural nursing functions	30 items 5 point Likert Scale
TSET	Jeffreys & Smodlaka (1998)	Recognition Kinship and social factors Professional nursing care Cultural background and identity Lifecycle transitional phenomena Awareness of cultural gap Communication Self Awareness Appreciation	83 items 10 point Likert scale
CCA	Schim, Doorenbos, Miller, and Benkert (2003)	Cultural competence behaviors Cultural awareness and sensitivity Cultural diversity experience	26 items 5 point Likert scale
CCAI	Kelley & Meyers (1995)	Emotional resilience Flexibility/openness Perceptual acuity Personal autonomy	50 items 6 point Likert scale
CCET	Freeman, (1993)	Cross-cultural interaction	20 items 5 point Likert scale
CAS	Rew, Becker, Cookston, Khosrophor, Martinez (2003)	General educational experiences Cognitive awareness Research issues Behaviors/comfort with interaction Patient care/clinical issues	36 items 7 point Likert scale

IAPCC – R©: Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals – Revised, CSES: Cultural Self-Efficacy Scale, TSES: Transcultural Self Efficacy Scale, CCA: Cultural Competence Assessment, CCAI: Cross-Cultural Adaptability Inventory, CCET: Cross Cultural Evaluation Tool, CAS: Cultural Awareness Scale

Table 2. Psychometric properties of cultural competence measurement instruments

	IAPCC-R	CSES	TSET	CCA	CCAI	CCET	CAS
Population	Healthcare Professionals	Nurses	Undergraduate Student Nurses	Interdisciplinary healthcare team at all levels education	Individuals living and working in other cultures, multicultural work groups	Attendees at cultural diversity workshops, nurses	Nursing students
Reliability Internal Consistency Cronbach's α	.71-.96	.86-.98	Total .93- 98 Subscale .90-.99	.89 - .91 Subscale .76-.93	.90 Subscales .68-82	.83 - .83 Pretest:.73 - .84 Posttest: .74 - .87	.82 - .92 Subscales: .66 - .94
Spearman Brown (estimates reliability of shortened test)	None found	None found	None found	None found	None found	None found	None found
Split Half Reliability Guttman Split Half	.77 - .83	None found	Total .70 - .93 Subscales .63-.92	None found	None found	None found	None found
Stability: Test-Retest (Percent agreement and/or Cohen's K = proportion	None found	None found	r = .63 - .84	r=.85 p=.002	None found	None found	None found

	IAPCC-R	CSES	TSET	CCA	CCAI	CCET	CAS
non-chance agreement Size of difference = amt of susceptibility to chance							
Validity							
Content Validity	Expert panel	Expert panel	Expert panel	Expert panel	Professional literature & expert panel	None found	Review of literature and expert panel
Construct Validity	Linked with Campinha-Bacote's model of cultural competence No factor analysis found	Regression analysis fit social cognitive theory. PFA – 4 factors account for 90% total item covariation	Factoral analysis consistent with cognitive learning theory 13 factors with Eigenvalues › 1.0. First 9 accounted for 62% total variance	Two factor solution identified, 25 items account for 56% variance	Davis & Finney (2003) found fit of 4-factor model to be poor: Chi square = .5381.5 p < .000 RMSEA = .082 CFI = .70 Large correlations among factors .87-.98 EFA – 4 factors accounted	Factor analysis with principal components analysis – 4 factors account for 51.9% of variance in cross-cultural interaction scores	Factor analysis with principal components analysis with varimax rotation: 5 subscales accounted for 51% of variance in overall scores

	IAPCC-R	CSES	TSET	CCA	CCAI	CCET	CAS
					for 41.19% total variance		
Concurrent Validity	None found	None found	None found	r = .66 compared to IAPCC	None found	None found	None found
Contrasted groups	None found	None found	Statistically significant differences in 1st semester & 4th semester ADN students on Cognitive and Practical subscales. Affective subscale changes not significant.	Statistically significant differences with education level and cultural diversity training	None found	None found	None found
Citations in ISI Web of Science	31	13	2	2	0	0	1

IAPCC – R©: Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals – Revised, CSES: Cultural Self-Efficacy Scale, TSES: Transcultural Self Efficacy Scale, CCA: Cultural Competence Assessment, CCAI: Cross-Cultural Adaptability Inventory, CCET: Cross Cultural Evaluation Tool, CAS: Cultural Awareness Scale

Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals – Revised (IAPCC-R©)

Background

The IAPCC was developed by Campinha-Bacote (1999) based on her model, The Process of Cultural Competence in the Delivery of Healthcare Services. It measures four domains of cultural competence: cultural awareness, cultural knowledge, cultural skill, and cultural encounters. Upon revision, a fifth domain, cultural desire, was added to reflect an additional domain in the model (Campinha-Bacote, 2003b). Cultural competence is defined as a process of striving to work effectively within the context of the client's culture.

Instrument Description

The IAPCC-R© consists of 25 items, 5 questions for each domain, scored on a 4 point Likert type scale (see Appendix A). The Likert type scales include response categories from strongly agree to strongly disagree, very aware to not aware, very knowledgeable to not knowledgeable, very comfortable to not comfortable, and very involved to not involved. Scores of 25-50 indicate cultural incompetence, scores of 51-74 indicate cultural awareness, scores of 75-90 indicate cultural competence, while scores of 91-100 indicate cultural proficiency (Transcultural C.A.R.E. Associates, 2006).

Psychometrics

The original IAPCC was field tested with 15 acute care hospital nurses who completed the instrument and provided feedback to the author. Further psychometric

testing was conducted with 200 nurses participating in a day long cultural competence workshop (Campinha-Bacote, 1999).

Content validity. A panel of five transcultural health care and transcultural nursing experts evaluated the IAPCC for content validity.

Construct validity. The IAPCC and IAPCC-R© were based on the Process of Cultural Competence in the Delivery of Healthcare Services model (Campinha-Bacote, 1999), lending theoretical support for the construct (Polit & Beck, 2004). Known-groups technique, using pre- and post-tests administered in conjunction with a daylong cultural competence workshop that taught Campinha-Bacote's model, resulted in higher scores on the IAPCC after the course. Statistical significance of the difference in the scores was not presented. No factor analysis has been found.

Reliability. Although values were not reported, Campinha-Bacote (1999) reported that initial tests of internal reliability resulted in low correlation coefficients, citing bias, clarity, and format of the instrument as possible causes. Subsequent studies with the IAPCC also failed to report correlation coefficients (Doutrich & Storey, 2004; Reeves & Fogg, 2006). For studies that reported reliability of the IAPCC, Cronbach's alpha ranging from 0.46 to 0.69 on pretest and 0.59 to 0.77 on post-test were reported (Nokes et al., 2005; Salman et al., 2007; Sargent et al., 2005; Smith-Campbell, 2005). Cronbach's alpha ranging from 0.77 to 0.90 have been reported for the IAPCC-R© (Brathwaite, 2005; Campinha-Bacote, 2003b; Gulas, 2005; Kardong-Edgren, 2007; Salman et al., 2007; Vito et al., 2005) with a Guttman split-half reliability of 0.77 (Gulas, 2005).

Evaluation of Instrument

Campinha-Bacote's (2003b) theory of the process of cultural competence and the instruments based on her theory are widely used in nursing research. The IAPCC-R© has only 25 items and takes less than 15 minutes to complete. The tool's specificity to health care professionals acknowledges the difference in relationships that may occur between individuals in a health care setting. The instrument's theoretical foundation enhances its construct validity but the known groups technique using pre-test post-test technique to establish validity is suspect since the day long educational course taught Campinha-Bacote's model. Factor analysis may serve to further validate the domains of cultural competence proposed by the author. While reliability measures have improved since revision of the instrument to include cultural desire, the question arises as to whether the increased reliability is merely a function of increased items on the scale. Vito et al. (2005) suggest that elimination of the seven reverse scored items that have the lowest correlation with the overall score may raise the Cronbach's alpha from 0.77 to 0.82. Brathwaite (2006; 2005) has modified the instrument by removing "I" statements in an effort to minimize social desirability bias. Further use of this instrument is not recommended until factor analysis has been performed to confirm the theoretical domains of cultural competence and until social desirability has been assessed.

The Cultural Self-Efficacy Scale (CSES)

Background

The CSES was developed by Bernal and Froman (1987) to determine the level of self-efficacy of community health nurses in caring for clients from a different culture. The

instrument was based on Bandura's social cognitive theory and posits that self-efficacy, the personal belief that one can complete an activity, is an accurate predictor of behavior. Items in the scale were gleaned from transcultural nursing and anthropological literature to exemplify important skills, knowledge, and concepts in cultural competence.

Instrument description

The CSES consists of 26 items that are scored on a 5 point Likert type scale representing three conceptual domains: "health beliefs and practices, life-style patterns and practices, and cultural sensitivity" (Bernal & Froman, 1987, p. 201). These items are categorized according to knowledge, cultural patterns, and skill in performing transcultural nursing functions. Ten general items that apply to all groups are answered once and 16 items are answered separately for Puerto Rican, Black and Southeast Asian clients. As a result, each participant responds to a total of 58 items. Higher scores suggest higher self-efficacy.

Psychometrics

One hundred ninety visiting, health department, occupational, and school nurses in Connecticut who responded to a mailed survey constituted the initial sample for the CSES (Bernal & Froman, 1987). Subsequent factor analysis was conducted using a sample of 206 community health nurses from 11 states who responded to mailed surveys (Bernal & Froman, 1993).

Content validity. Items in the CSES were drawn from concepts identified from transcultural nursing and anthropological literature. Content validity was established by a panel of 5 public health nursing experts (Bernal & Froman, 1987).

Construct validity. Four factors, accounting for 90% of the variance of items, emerged from principal factor analysis (Bernal & Froman, 1993). One factor, Self-Efficacy in General Cultural Skills, consisted of the 10 general items pertaining to all cultural groups. Factor loading for each item was 0.50 or higher. The other factors were specific to the cultural groups and were named Black Cultural Self-Efficacy, Latino Cultural Self-Efficacy, and Southeast Asian Cultural Self-Efficacy. No items loaded on more than one factor.

Reliability. The internal consistency for the initial sample of 190 Connecticut nurses and for the second sample of 206 community health nurses was 0.97 (Bernal & Froman, 1987, 1993). In an integrative review of studies using the CSES, Coffman, Shellman, and Bernal (2004) identified 26 uses of the instrument, 20 of which they were able to evaluate. For the six studies that reported Cronbach's alpha, the range was 0.86 to 0.98 with a mean of 0.95. Studies conducted after this integrative review also report Cronbach's alphas ranging from 0.86 to 0.98 (Hagman, 2006; Jimenez, Shellman, Gonzalez & Bernal, 2006; Kardong-Edgren et al., 2005).

Evaluation of Instrument

The CSES has been widely used with nurses and nursing students and demonstrates good reliability (Coffman et al., 2004). It has been modified to reflect cultural groups of interest (Hagman, 2006; Jimenez et al., 2006) and age-specific client

populations (Shellman, 2006) while maintaining reliability. It has also been translated into Spanish, demonstrating Cronbach's alpha scores of 0.90 to 0.95 (Jimenez et al., 2006). Capell, Veenstra, and Dean (2007) criticize its lack of use among disciplines other than nursing.

Factors obtained by principal factor analysis are consistent with the structure of the instrument in evaluating self-efficacy of caring for specific cultural groups but do not provide evidence for the three conceptual domains posited by its developers. While this instrument possesses adequate psychometric properties, further evaluation of the conceptual validity of cultural self-efficacy is needed. Although a plethora of research indicates a positive correlation between self-efficacy and motivation and performance in a variety of areas (Bandura & Locke, 2003), research is warranted to determine if cultural self-efficacy translates into care that is perceived as culturally competent by clients of diverse cultures.

The Transcultural Self-Efficacy Tool (TSET)

Background

The TSET (see Appendix B) was developed to measure the self-efficacy of nursing students in implementation of the nursing process with diverse populations (Jeffreys & Smodlaka, 1998). Like the Cultural Self-efficacy Scale, the TSET was based on Bandura's social cognitive theory. The authors defined transcultural self-efficacy as "the degree to which an individual believes he/she has the ability to perform the various transcultural nursing skills needed for culture-specific care" (p. 217). Consistent with this definition, the developers acknowledged the multidimensional nature of transcultural

nursing that requires learning affective, cognitive, and practical skills. The initial goal of this instrument was to determine student needs, identify stressful or difficult skills, evaluate teaching methods, and measure changes over time pertaining to transcultural self-efficacy.

Instrument Description

The TSET is composed of 83 items grouped into 3 different subscales with learning outcomes within each subscale progressing from simple to complex (Jeffreys, 2000, 2006; Jeffreys & Smodlaka, 1998). The cognitive subscale consists of 25 items and queries participants about self-confidence in personal knowledge of factors that influence care of culturally diverse clients. The practical subscale consists of 28 items related to self-confidence in interviewing culturally diverse clients about their beliefs and values and other activities in the psychomotor domain. The affective subscale has 30 items that measure participants' attitudes and values. Each item is ranked on a 10-point Likert type scale with only the extreme anchors of not confident and totally confident. Higher scores are indicative of higher self-efficacy. The instrument takes 20 to 30 minutes to complete.

Psychometrics

A pilot study was conducted with a sample of 357 associate degree nursing students to determine initial psychometric properties of the TSET. Subsequently it was administered to 1,260 undergraduate nursing students to evaluate factorial composition

(Jeffreys & Smodlaka, 1998). Construct validation was established using a sample of 566 first-semester and fourth-semester associate degree nursing students.

Content validity. The TSET was developed from a review of transcultural nursing and self-efficacy literature. An expert review panel composed of six doctoral level nurses who were also certified in transcultural nursing evaluated the content (Jeffreys & Smodlaka, 1998). As a result of this expert panel review, 13 of the initial items were eliminated, one item was expanded into four separate items, and one item was revised to promote clarity.

Construct validity. Exploratory principal components analysis resulted in 13 factors using both unrotated and varimax rotation techniques (Jeffreys & Smodlaka, 1998). The number of factors was reduced to nine by using only factors with a minimum of three items with a primary loading on only one factor. The nine factors accounted for 62% of the variance in the total scale. These factors were labeled recognition, kinship and social factors, professional nursing care, cultural background and identity, lifecycle transitional phenomena, awareness of cultural gap, communication, self-awareness, and appreciation. All items in each of the nine factors grouped on single educational subscale. For example, all items in lifestyle transitional phenomena fell under the cognitive subscale while all items in the communication factor fell under the practical subscale. The developers posited that each subscale is composed of several dimensions that are consistent with the transcultural nursing literature.

Jeffreys and Smodlaka (1999b) conceptualized transcultural self-efficacy as a construct that changes over time as a result of experience and education. Using a contrasted groups approach, they compared the TSET scores of first and fourth-

semester associate degree nursing students and found statistically significant differences in scores on the cognitive (t = -2.20; p = 0.03) and practical (t = -2.38; p = 0.02) subscales but no significant difference in the affective (t = -1.87; p = 0.06) subscale. In a two year longitudinal study of 51 associate degree nursing students, Jeffreys and Smodlaka (1999a) found statistically significant increases in transcultural self-efficacy over time.

Reliability. Pilot testing of the TSET resulted in split-half reliability scores of 0.70 to 0.93 for the total scale and each of the subscales separating items by odd and even numbers (Jeffreys & Smodlaka, 1998). Test-retest reliability, conducted at a two-week interval in the pilot study, resulted in correlation coefficients ranging from 0.63 to 0.84 for the subscales. Total TSET test-retest reliability for the pilot study was not reported. Cronbach's alpha for the total scale was 0.97 and 0.98 in the pilot study with subscales ranging from 0.90 to 0.98. Subsequent testing with 1260 nursing students yielded an alpha of 0.98 for the total scale and 0.96 to 0.97 for the subscales (Jeffreys & Smodlaka, 1998). In another study by the developers of the instrument with 566 associate degree nursing students, the total scale Cronbach's alpha was 0.98 with subscales ranging from 0.95 to 0.98. In a sample of 196 nursing students in Western Australia, Lim, Downie, and Nathan (2004) obtained a total scale Cronbach's alpha of 0.93.

Evaluation of Instrument

As an instrument developed for nursing students with a focus on teaching students culturally competent care, subscales that reflect the domains of learning are

appropriate. The domains obtained by factor analysis reflect important constructs of cultural competence. Although the instrument contains 83 items, it may be completed in 30 minutes or less and therefore does not present significant respondent burden. The large number of items, however, may contribute to the high reliability of the total scale, since reliability is positively correlated to the number of items in the scale (Streiner & Norman, 2003). Evaluation of the reliability of a shortened version of the instrument using the Speaman-Brown formula may be warranted. In addition, the TSET reliability may be dubious considering the low test-retest reliability obtained for at least one subscale in the pilot study. The appropriateness of using split-half reliability with a scale that has items that have progressive levels of difficulty is questionable. Because of the strong theoretical foundation of this instrument in the domains of learning and the factor analysis that accurately reflects constructs of cultural competence, further reliability testing is recommended. Finally, this instrument is based on the assumption that self-efficacy will translate into culturally competent behaviors (Jeffreys, 2006). No empirical evidence has been found to support this assumption, reflecting the need for research in this area.

The Cultural Competence Assessment (CCA)

Background

Schim, Doorenbos, Miller, and Benkert (2003) cited evaluation of culture specific knowledge, limitation to one type of health care worker, and need for high levels of literacy or education as limitations of cultural competence assessment instruments. As a result, they developed the CCA for use with hospice workers from multiple disciplines

with varying levels of education and experience (see Appendix C). It was based on the Shim and Miller Cultural Competence Model that is portrayed as four pieces of a jigsaw puzzle labeled cultural diversity, cultural competence, cultural sensitivity, and cultural awareness (Doorenbos et al., 2005; Schim et al., 2003). Cultural competence was defined as “the incorporation of one’s cultural diversity experience (fact), awareness (knowledge) and sensitivity (attitude) into everyday practice behaviors” (Schim et al., 2003, p. 31). Subsequent application to healthcare professionals other than hospice workers purported to address the need for standardized, valid and reliable instruments to measure cultural competence identified in the Agenda for Research on Cultural Competence in Health Care (Fortier & Bishop, 2004).

Instrument description

The original CCA consisted of 45 items and was reduced to 38 items after expert panel review and field testing (Schim et al., 2003). Seven items with item-to-total correlations of less than 0.30 were deleted as were seven items that failed to load on a factor during factor analysis. The current version of the CCA consists of 25 items. Eight items measure the cultural attitudes and sensitivity subscale and 17 items measure cultural competence behaviors (Doorenbos et al., 2005; Schim et al., 2003). Items are measured on a five point Likert type scale ranging from “strongly agree” to “no opinion” for the cultural awareness and sensitivity subscale and from “always” to “never” with an option for “not sure” on the cultural competence behavior subscale. The final item measures experience in cultural diversity by ascertaining the number of cultural groups the participant has cared for in the previous year (Schim et al., 2005). Higher scores

reflect higher levels of cultural competence. The instrument takes 15 to 30 minutes to complete.

Psychometrics

Following expert panel review, initial field testing was conducted with seven multidisciplinary hospice workers (Schim et al., 2003). Revisions were made as indicated and a pilot test was conducted with 113 interdisciplinary hospice employees and volunteers.

Content validity. Items in the instrument were developed from a review of literature and the Shim and Miller Cultural Competence Model (Schim et al., 2003). Two expert panels reviewed the initial instrument. One panel was composed of ten hospice experts including nurses, physicians, social workers, nursing assistants, and volunteers. The other panel consisted of end-of-life experts from a variety of professions such as sociology, education, law, gerontology, psychology, and anthropology.

Criterion-related validity. The IAPCC was selected for testing concurrent validity (Schim et al., 2003). In this study, Cronbach's alpha for the IAPCC was 0 0.67. The correlation coefficient of the CCA with the IAPCC was 0.66.

Construct validity. Construct validity was tested using contrasted groups. In the pilot test with hospice workers, individuals who had prior diversity training scored statistically significantly higher (t = 2.12; p = 0.004) than those who had no prior diversity training (Schim et al., 2003). In addition, individuals with bachelor's degrees or higher, scored significantly higher than those with a high school education. The findings were similar for subsequent studies with other diverse health care providers (Doorenbos

et al., 2005). Factor analysis in pilot testing with hospice workers resulted in the removal of seven items from the instrument due to their failure to load on either of two main factors (Schim et al., 2003). Factor analysis with both hospice workers (Schim et al., 2003) and health care providers in a non-hospice setting (Doorenbos et al., 2005) supported a two factor solution. The cultural competence behavior and cultural awareness and sensitivity subscales accounted for 56% of the total variance.

Reliability. In the pilot test, Cronbach's alpha for the initial CCA with 39 items was 0.91 (Schim et al., 2003). The final 25-item version had a Cronbach's alpha of 0.92 with a cultural competence behavior subscale alpha of 0.93 and an awareness and sensitivity subscale alpha of 0.75 for the pilot study sample. Subsequent administration of the CCA has resulted in total alphas of 0.89 (Doorenbos et al., 2005; Schim et al., 2005).

Test-retest reliability using the early 38-item scale with hospice workers at four months yielded a correlation coefficient of 0.85 for the total scale, 0.87 for the cultural competence behavior subscale, and 0.82 for the cultural attitudes and sensitivity subscale.

Evaluation of Instrument

The CCA is a new instrument for measuring cultural competence and has not been used by investigators other than its developers. The initial intent of the instrument was to measure cultural competence among various levels of hospice workers (Schim et al., 2003). Content validity was established by hospice workers and end-of-life experts, not experts in transcultural health care. In addition, members of the hospice

expert panel included nursing assistants and volunteers whose education and background are not described rendering their description as “experts” suspect. Failure to establish content validity with cultural competence experts renders the content validity dubious among hospice workers and further prevents extension of the instrument’s use with diverse health care providers.

Criterion-related validity was presented through concurrent administration of the CCA with the IAPCC to the pilot study sample of various levels of hospice workers (Schim et al., 2003). The CCA developers presented multiple criticisms of the IAPCC including its “advanced reading level” (p. 30) and use of multiple response sets that preclude its use with groups with varying levels of education. However, 18% of their pilot study sample had a high school education and 23% had associate degrees. Based on the developers’ criticism of the IAPCC, the IAPCC would not be appropriate for use with this group. In addition, the reliability of the IAPCC in the pilot study was low (alpha = 0.66). Instruments should demonstrate sufficient reliability to be appropriately used to measure criterion-related validity (Waltz, Strickland, & Lenz, 2005).

Finally, Doorenbos et al. (2005) acknowledge the tendency of the CCA to be subject to social desirability bias. They report that future studies will include assessments of social desirability. In addition to assessment of social desirability, the CCA needs further validity testing to enhance its use as an instrument to measure cultural competence.

The Cross-Cultural Adaptability Inventory (CCAI)

Background

The CCAI is an instrument used in numerous studies to measure an individual's ability to interact with diverse cultures (Davis & Finney, 2006). The instrument was developed by Drs. Colleen Kelley and Judith Meyers (1987) in response to a request by cross-cultural trainers for an instrument to measure cross-cultural adaptability and was not developed specifically for health care providers. The CCAI was revised in 1992. Cross-cultural adaptability was defined as "one's readiness to interact with members of another culture or even adapt to life in another culture" (Davis & Finney, 2006, p. 318).

Instrument description

The CCAI consists of 50 items that are rated on a six-point Likert type scale ranging from "definitely true" to "definitely not true" (Davis & Finney, 2006). It consists of four subscales (Kelley & Meyers, 1987; Magee, Darby, Connolly, & Thomson, 2004; Meyers, 2001). The emotional resilience subscale consists of 18 items and measures the ability to remain positive when confronted with the unfamiliar. The flexibility/openness subscale measures the tendency to be open-minded and contains 15 items. Ten items measure perceptual acuity, the level of effectiveness and comfort when communicating with those from another culture, and seven items measure personal autonomy, the ability to maintain a positive personal identity even when negative reactions are encountered. High scores indicate high levels of adaptability. Twenty to thirty minutes are required for completion (Davis & Finney, 2006).

Psychometrics

The CCAI was initially tested with transcultural experts and the general public (Davis & Finney, 2006; Meyers, 2001). Pursuant to revisions made from feedback from the initial respondents, the CCAI was administered by cross-cultural trainers to 653 individuals from diverse age groups, educational levels, and occupations.

Content validity. The CCAI was developed from a review of the literature and with input from an expert panel (Meyers, 2001).

Construct validity. Principal components analysis of items following administration to the sample of 653 resulted in a reduction from five subscales to the four current subscales of the instrument (Meyers, 2001). In a study to evaluate the four subscales, Davis and Finney (2006) administered the CCAI to a random sample of 725 university sophomores. Confirmatory factor analysis revealed poor model fit using the root mean square error of approximation (RMSEA), the minimum fit function chi-square, the Tucker-Lewis index (TLI) and the comparative fit index (CFI). The standardized root mean square (SRMS) indicated adequate fit. In addition, Davis and Finney found significant overlap between factors.

Reliability. In the initial sample of 653 diverse individuals, Kelley and Meyers (1987) obtained a Cronbach's alpha of 0.90 for the total scale with subscales ranging from 0.68 (personal autonomy) to 0.82 (emotional resilience). With a sample of physical therapy students, Kraemer and Beckstead (2003) also obtained a Cronbach's alpha of 0.90. Subscales ranged from 0.59 (personal autonomy) to 0.83 (emotional resilience). Davis and Finney's (2006) survey of university sophomores produced subscale alphas ranging from 0.54 (flexibility/openness) to 0.80 (emotional resilience). No total scale

reliability was reported. Other studies with health care workers also failed to report reliability (Magee et al., 2004; Majumdar, Keystone, & Cuttress, 1999).

Evaluation of Instrument

Although the CCAI has been widely used in various cross-cultural disciplines, its use has been very limited in health care professions with studies only found with physical therapy students (Kraemer & Beckstead, 2003), dental hygiene students (Magee et al., 2004), and graduates of foreign medical schools (Majumdar et al., 1999). Since content validity was established using cross-cultural literature, the content may not be valid for health care professionals. Construct validity is questionable based on the findings of Davis and Finney (2006). Insufficient reliability has been reported for health care professionals. In addition, the CCAI has been criticized for it's social desirability bias (Capell et al., 2007). Currently this instrument is available through online organizational management companies for a fee. Its availability for scholarly research is unclear. Significant psychometric testing is indicated for use of this instrument in the health care arena.

Cross-Cultural Evaluation Tool

Background

Developed by Freeman in 1993, the Cross Cultural Evaluation Tool (CCET) (see Appendix D) has been primarily used by its author for participant self-assessment during cultural diversity workshops (T.L. Freeman, personal communication, June 3, 2007). Its use in nursing research emerged in 2007 (Hughes & Hood).

Instrument description

The CCET consists of 20 statements scored on a 5-pointLikert type scale ranging from always (5) to never (1). Scores are summed to obtain a cross-cultural interaction score. A score of 95 – 100 is labeled as “outstanding,” a score of 85 – 94 is “good,” a score of 75 – 84 is “average (work on weaker areas),” and scores below 75 indicate that the individual “needs improvement” (T.L. Freeman, personal communication, June 3, 2007).

Psychometrics

The CCET was used as a pre-test/post-test measure for a 16-week professional development course in a baccalaureate school of nursing (Hughes & Hood, 2007). The course content included a unit on Leininger’s theory and ethnonursing. Scores from five different classes were reported.

Construct validity. Factor analysis using principal components analysis indicated four factors: cross-cultural sharing, cultural awareness/sensitivity, collaboration, and embracing diversity (Hughes & Hood, 2007). These factors explained 51.9% of the variance in cross-cultural interaction scores.

Reliability. Cronbach’s alpha for individual classes ranged from 0.73 to 0.84 on pre-test and from 0.74 to 0.87 on post-test. For all classes combined, Cronbach’s alpha was 0.83 for pre-test and 0.87 for post-test.

Evaluation

Insufficient psychometric testing has been done with the CCET. No content validity or criterion related validity has been found. Inspection of the tool reveals that several individual items contain more than one distinct concept such as, “I seek skills, information, and mentors to learn…” (T.L. Freeman, personal communication, June 3, 2007). Such “double-barreled” questions promote confusion and do not allow the participant to agree with only one portion of the item (Polit & Beck, 2004). The instrument is subject to social desirability through its use of phrases like “because I have a philosophy of fairness.” One of the originators of the term “ethical multiculturalism” evaluated the instrument and found that it needed further development (N.J. Crigger., personal communication, June 4, 2007). Significant psychometric testing must be conducted before further use of this instrument in the health care arena.

Cultural Awareness Scale

Background

The Cultural Awareness Scale (CAS) (see Appendix E) was initially developed to measure the outcomes of a nursing school program designed to enhance cultural awareness among faculty and students (Rew et al., 2003). Its authors acknowledged that cultural awareness is only one component of cultural competence. They cited lack of standardized definitions and instruments to measure cultural competence as barriers to measuring educational outcomes of nursing programs designed to increase cultural competence. An adapted version of the CAS has also been used with practicing nurses in a geriatric setting (Salman et al., 2007). One citation of the instrument development

article was found, however the citation did not use the instrument for further research (Tan et al., 2006).

Instrument description

The CAS consists of 36 items that measure five subscales of cultural awareness (Rew et al., 2003). The first subscale, General Educational Experience contains 14 items. The second subscale, Cognitive Awareness, uses seven items to measure beliefs. The Research Issues subscale consists of four items while the Behaviors/Comfort with Interactions factor contains six items. The final factor, Patient Care/Clinical Issues, has five items. Each item is measured on a seven-point Likert type scale ranging from strongly disagree to strongly agree.

Psychometrics

Initial psychometric testing was conducted on a group of 72 nursing students from one nursing school who volunteered to be part of a focus group (Rew et al., 2003). The second phase of testing was conducted with 118 nursing students from the same university.

Content validity. The CAS was developed from a review of the literature that identified five subscales of cultural awareness (Rew et al., 2003). Subsequent review by an expert panel made up of seven culturally and racially diverse nursing faculty with cultural competence expertise from different educational institutions was conducted. This review yielded a content validity index (CVI) of 0.88 (Rew et al., 2003). The authors indicated that the expert panelists were instructed to rate the relevance of each item but

failed to indicate if the reported CVI was item level or scale level, an important distinction (Polit & Beck, 2006). For interpretation of CVI values, researchers should report ranges of values for individual items and should indicate how the overall scale value was calculated. Setting the standard for overall scale CVI values at 0.90 ensures "excellent content validity"(Polit & Beck, 2006, p. 496).

Construct validity. Factor analysis using principal components analysis with varimax rotation, validated the five subscales initially identified by the instrument's developers with General Educational Experience, Cognitive Awareness, Research Issues, Behaviors/Comfort with Interactions, and Patient Care/Clinical Issues accounting for 51% of the variance in the overall scale scores (Rew et al., 2003).

Reliability. In phase one, Cronbach's alpha ranged from 0.66 – 0.88 for the five subscales with a total scale alpha of 0.91 (Rew et al., 2003). In phase two, Cronbach's alpha ranged from 0.71 to 0.94 for the subscales with a Cronbach's alpha for the total scale of 0.82. The modified CAS for use with staff nurses, consisting of only 13 items, reported pre-test Cronbach's alpha of 0.68 and post-test reliability of 0.73. Inadequate description of the instrument modification was given to allow for evaluation.

Evaluation

The CAS was developed specifically for nursing students and measures only one component of cultural competence (Rew et al., 2003). While the instrument demonstrates acceptable reliability, further exploration of content validity and the content validity score is needed. Since this instrument has been tested with only one student population, further psychometric testing is indicated with a larger student

population. Twenty-three of the items on this instrument evaluate the student's perceptions of faculty and the educational institution and therefore do not lend themselves to use with samples of practicing nurses.

Measurement of Client Perceptions of Cultural Competence

Patient-Reported Provider Cultural Competency (PRPCC)

Background

The Patient-Reported Provider Cultural Competency (PRPCC) instrument was developed in response to a lack of instruments to measure client perceptions of physician behaviors (Thom & Tirado, 2006). The items on the instrument were developed from input obtained from minority physicians who serve minority clients. In addition to the client report measure, a self-report measure for physicians was also formulated to allow for comparison of perceptions of cultural competence.

Instrument Description

The PRPCC consists of 13 items describing a physician behavior scored on a five point Likert type scale ranging from never to always (Thom & Tirado, 2006). Physician behaviors are grouped into two subscales: history taking and explaining.

Psychometrics

The PRPCC was piloted with a convenience sample of 14 culturally diverse individuals and then with Spanish and Chinese speaking focus groups (Thom & Tirado,

2006). The initial study was conducted with 429 ethnically diverse clients from four primary practice locations.

Construct validity. Construct validity was established using correlation with client satisfaction ($r = 0.32$, $p < .0010$) and client trust ($r = 0.53$, $p < .0010$) (Thom & Tirado, 2006).

Reliability. Cronbach's alpha of 0.89 was reported in the initial study.

Evaluation

The PRPCC makes a foray into a much-needed area of knowledge development: the evaluation of client perceptions of cultural competence. No results of the pilot testing were found. No description of the measures of client satisfaction or client trust was given. The authors assume that client satisfaction and client trust are outcomes of care received by culturally competent providers but provide no evidence supporting this claim. Further psychometric testing is warranted. Adaptation of the tool to measure client perceptions of nurses' cultural competence may prove to be fruitful.

Comparison of the PRPCC to other research to determine client perceptions of cultural competence of health care providers informed this evaluation process. In a telephone survey of 6299 Caucasian, Black, Asian and Hispanic adults, investigators determined that Hispanics and Asians were less likely than Caucasians and Blacks to indicate that their physician listened to and understood them, involved them in decision making, and spent sufficient time with them (Johnson, Saha, Arbelaez, Beach, & Cooper, 2004). The PRPCC measures whether the client perceives that the physician helps the client understand and whether the physician involves the client in decision

making; no items are included to elicit client perceptions of physician listening or spending adequate time with them. Although Johnson et al. used a structured interview with quantitative data analysis, their instrument consisted of investigator-developed items that were not psychometrically evaluated.

In a qualitative study of four South Asian clients and three of their relatives in the United Kingdom, Clegg (2003) found that the respondents considered respect, understanding, facilitation of religious practices, and maintenance of dignity as key components of culturally sensitive care. Another qualitative research study using 19 stratified focus groups of 163 African-American, Latinos, and non-Latino whites found common and unique cultural factors that exerted influence on the health care encounters of participants (Nápoles-Springer et al., 2005). All three ethnic groups identified discrimination based on age, health insurance coverage, and social class as issues. In addition, provider willingness to accept alternative medicine practices and ethnic similarity between client and provider were identified by all three groups as cultural factors influencing client-provider relationships. Other cultural factors identified included modesty, spirituality, family involvement, language, immigration status, diet, deference to physicians, and physician emphasis on a medical model. While several of these factors are included in the PRPCC, expansion of the instrument to include the items found in these qualitative studies may enhance its validity.

Summary and Recommendations for Measurement of Cultural Competence

All of the instruments measuring cultural competence reviewed have strengths and limitations. The Cross-Cultural Adaptability Inventory has been widely used in

cross-cultural studies but lacks sufficient psychometric testing with health care professionals. The Cross-Cultural Evaluation Tool and the Cultural Competence Assessment show promising initial reliability but need further content validation. The Transcultural Self-Efficacy Tool has merit in its foundation in both cultural theory and educational domains but is limited to the student nurse population. The Cultural Awareness Scale is also limited to student nurses. The Cultural Self-Efficacy Scale is based on the enduring self-efficacy theory and has good psychometric properties yet research is needed to determine if cultural self-efficacy translates into providing culturally competent care. The IAPCC-R© possesses intuitive appeal based on its theoretical foundation on the process of cultural competence. However, further testing of construct validity and social desirability is needed. Client perceptions of provider cultural competence warrants further study with an emphasis on nursing.

This review of extant instruments used to measure cultural competence supports the assertion that a lack of standardized measurement is a barrier to assessment of health care professionals' ability to provide culturally competent care to diverse clients. Of the instruments evaluated, only two claim to measure cultural competence, the IAPCC-R© and the Cultural Competence Assessment (CCA). The remaining instruments measure cultural self-efficacy, adaptability, awareness, or interaction and therefore assume that these characteristics translate into the ability to provide culturally competent care. Empirical evidence is needed to support these assumptions.

Culturally Competent Scholarship

Advancing the nursing profession's knowledge of cultural competence requires scholarly inquiry (Meleis, 1996; Papadopoulos & Lees, 2002). This inquiry must be conducted in a culturally competent manner to produce valid results (Leininger, 2002; Papadopoulos & Lees, 2002). As early as 1995, Sawyer et al. identified "the production of culturally unbiased nursing knowledge" (p. 557) as a mandate for the profession.

Recognizing the need for a nursing knowledgebase from which to derive mechanisms to provide culturally competent care, Meleis (1996) developed eight criteria to direct and evaluate culturally competent research and theory development. Contextuallity refers to lifestyle, social, political and historical influences on research participants. Relevance involves an evaluation of the significance and utility of the research to the participants. Communication styles evaluate the use of appropriate, preferred communication with participants and their communities. The criterion, awareness of identity and power differential, addresses collaboration by ensuring that the participant shares in the development of the research question, maintains the right of refusal to participate, and owns the data. Disclosure refers to the right of the participant to decline to respond to portions of the research. Reciprocation involves identifying and striving to achieve the goals of the participants as well as the researchers in the research project. Empowerment is evaluated by determining the ability of participants to question and/or modify the research process. The final criterion Meleis identified for evaluating the cultural competence of research is flexibility of time. Recognizing that time orientations vary among cultures, culturally competent

researchers use time flexibly to ensure that the previously described criteria are achieved.

Meleis' (1996) criteria for evaluating rigor in culturally competent research have been used to evaluate the cultural competence of nursing research. Jacobson, Chu, Pascucci, and Gaskins (2005) evaluated 167 nursing research articles concerned with race, ethnicity and/or culture using the eight criteria. Using a scale of zero to eight to measure the number of criteria met by a study, the mean score was 2.92. Only one study met all eight criteria and six studies demonstrated none. Contextuality, relevance and communication style were the criteria that were present most often while disclosure, time and empowerment were found the least.

Mendias and Guevara (2001) used Meleis' (1996) criteria for self-evaluation of an international field research course in a school of nursing. The initial evaluation led to ongoing assessment and process improvement. As a result of the evaluation, the researchers adjusted course requirements to permit a wider understanding of contextuality. The investigators indicated that future plans for the research course include improvements in communicating and validating results with the participants.

The Culture-Generic, Culture-Specific Competence Model for Health Research

In an evaluation of ten nursing research textbooks, Papadopoulos and Lees (2002) found limited or no content on issues related to cultural competence in research. Pursuant to this evaluation, the authors developed the culture-generic, culture-specific competence model for health research. In this model, culture-generic competence is defined as knowledge and skills that are applicable to all ethnicities and culture-specific

competence as knowledge and skills related to a single ethnic group that a researcher would need to conduct research with that group. Both culture-generic and culture-specific competence are composed of cultural awareness, cultural knowledge, cultural sensitivity, and cultural competence. Cultural awareness involves the process of introspection on the part of the researcher to determine personal values and their influence on the research process. Cultural knowledge is multidisciplinary and encompasses knowledge of health inequities and the role of health care professionals within the society. Cultural sensitivity involves creating partnerships through collaboration. Ultimately, cultural competence is the result of the amalgamation and application of the three previous concepts.

Within the culture-generic, culture-specific competency model for health research (Papadopoulos & Lees, 2002) culture-generic competence is required to develop culture-specific competence. Culture-specific competence provides feedback to enhance culture generic competence. As investigators conduct research with different ethnic groups, additional layers of culture-specific competence are added.

Although the Papadopoulos and Lees (2002) model is a model for health research, the authors posit that the same types of cultural competence behaviors are needed by nursing clinicians and researchers. They state, “The only difference between a culturally competent practitioner and researcher lies in the application of their specific skills” (p. 263). In addition, Papadopoulos and Lees assert that culturally competent research is necessary for evidence-based culturally competent practice. Their culture-generic, culture-specific competence model does not indicate how cultural competence should be measured.

Conceptual Framework for the Current Study

Based on Papadopoulos' and Lees' (2002) assertion that cultural competence is the same in practice and in research and Crigger's (2008) call for a "global nursing ethic," Harper's (2006) model of ethical multiculturalism is used for this study. In an evolutionary concept analysis, Harper (2006) defined ethical multiculturalism as "the use of moral reasoning to apply the basic ethical principles of beneficence and respect for persons and communities in a culturally competent manner to research in various societies or cultures" (p. 116). The model of ethical multiculturalism (see Figure 3) depicts the attributes of ethical multiculturalism as the fulcrum of a balance between two ethical philosophies of fundamentalism and relativism.

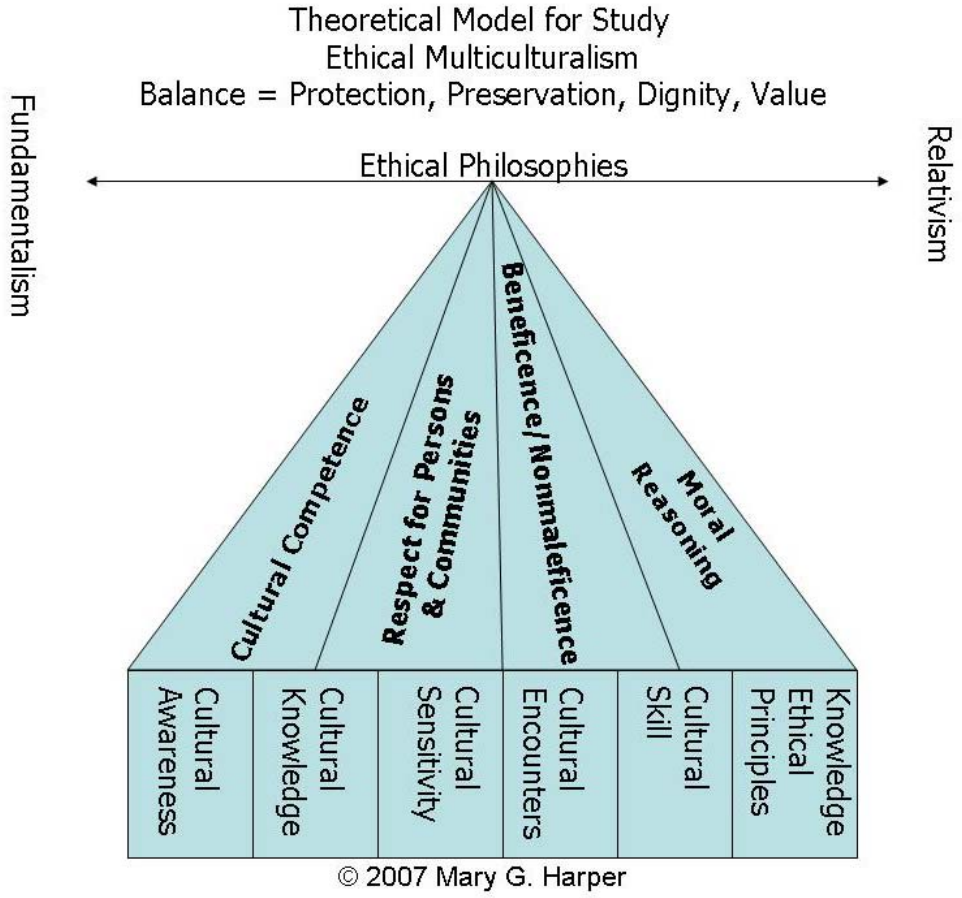


Figure 3. Theoretical model of ethical multiculturalism used for current study

The attributes gleaned from the literature, moral reasoning, beneficence/nonmaleficence, respect for persons and communities, and cultural competence, form the pyramidal fulcrum. The antecedents produce the base of the pyramid that supports the attributes. Since cultural competence is an attribute of ethical multiculturalism, antecedents of cultural competence are antecedents of ethical multiculturalism. These antecedents are drawn from Campinha-Bacote's (1999) practice model, the Process of Cultural Competence in the Delivery of Healthcare Services, and from Suh's (2004) concept analysis of cultural competence. Antecedents of cultural competence in this model are cultural awareness, culture knowledge, cultural sensitivity, cultural encounters, and cultural skill (Campinha-Bacote, 1999, 2003b; Suh, 2004). The final antecedent of ethical multiculturalism is the understanding of ethical principles (Macklin, 2002). Knowledge of the intent of the principles of beneficence, respect for persons, and respect for communities prepares investigators to apply moral reasoning as an attribute of ethical multiculturalism. In this model, when the attributes are equally situated between the fundamental and relativistic philosophies, balance, representing ethical multiculturalism, is achieved. The result is the protection of human subjects and the preservation of cultural norms while maintaining the dignity of participants and their communities. In addition, these individuals and their communities perceive that they are valued.

This model is selected for this study because it is consistent with the role of nursing as a "global discipline" and may contribute to the development of the "global nursing ethic" called for by Crigger (2008). Harper's (2006) model of ethical multiculturalism may be applicable to any type of cross-cultural nursing research. As

Davidson et al. (2003) indicate, understanding of cultural competence is necessary for nurses to participate in a global nursing environment. Since cultural competence is an integral component of ethical multiculturalism, it must be clearly conceptualized with valid and reliable methods of measurement in order to evaluate progress toward its achievement.

Summary

Globalization has intensified the evidence of diversity and compelled nursing leaders to call for a "global nursing ethic." Harper's (2006) model of ethical multiculturalism may provide a beginning framework for this global nursing ethic through its identification of the need to balance universal ethical principles within the context of the client and his/her culture. Cultural competence is an attribute of ethical multiculturalism.

Nurses must understand the influence of culture on perceptions of health and health care. Although much attention is given to the cultural competence of nurses, the profession lacks a standardized definition and mechanism for measuring cultural competence. Inconsistent conceptualization and measurement are barriers to advancing nursing knowledge about cultural competence. Without adequate measurement techniques, efforts to develop cultural competence among nurses cannot be evaluated. Research is needed to identify the attributes of cultural competence in order to promote a coherent theoretical basis for providing culturally competent care and for conducting culturally competent research. This study will begin to address this gap in nursing knowledge by identifying the essential antecedents of cultural

competence and comparing these antecedents to the extant cultural competence instruments. Identification of the antecedents of cultural competence will also initiate validation of Harper's (2006) model of ethical multiculturalism and its usefulness in the promotion of a "global nursing ethic."

CHAPTER 3: METHODS

The threefold purpose of this research was to identify the essential antecedents of cultural competence as identified by international nurse researchers, to compare the content of the extant cultural competence instruments to these antecedents and to potentially identify gaps in their conceptualization. A secondary aim of this research was to initiate validation of Harper's model of ethical multiculturalism.

Design

A descriptive, mixed methods design was used to determine the essential components of cultural competence identified by international nurse researchers. A descriptive design was appropriate to describe a phenomenon in the early stages of theory development (Polit & Beck, 2004). Quantitative data were obtained by a Delphi method using an Internet-based survey tool. Qualitative data were elicited from an on-line focus group using a threaded discussion Web site.

A Delphi is a method for gaining consensus from experts though two or more rounds of surveys (Hasson, Keeney, & McKenna, 2000). Delphi methods are indicated when the research aims are complex and are not conducive to an analytic approach but could benefit from collective, subjective judgments (deMeyrick, 2003; Keeney, Hasson, & McKenna, 2006; Linstone & Turoff, 1975). In addition, the Delphi method is useful for eliciting feedback from a diverse group without face to face interaction, allowing input from geographically separated experts (deMeyrick, 2003; Keeney, Hasson, & McKenna, 2006; Powell, 2003). This approach allows participants to provide input that is

anonymous to other panelists at their convenience (Linstone & Turoff, 1975), without concern for disapproval for their opinions (de Meyrick, 2003; Goodman, 1987; Mead & Moseley, 2001a). Anonymity among panelists has further advantages of allowing for changing positions based on group feedback without the need to defend such change, avoiding undue influence of reputable experts, and inability of one member to dominate the expert panel (de Meyrick, 2003). As a result, findings are apt to be more comprehensive than what may be obtained in a face-to-face meeting (Mead & Moseley, 2001b). All of these characteristics of the Delphi method constituted rationale for its use in this study.

One weakness of the Delphi method is the lack of opportunity for the participants to discuss and evaluate the results (Keeney et al., 2006). Focus groups have been identified as one mechanism to validate the data (de Meyrick, 2003; Keeney et al., 2001; Keeney et al., 2006). A threaded Internet discussion focus group was conducted to validate the findings of the Delphi.

Subjects/Sampling

The population for this study was nurses who conduct international cross-cultural research. International cross-cultural research was defined as an investigation involving participants from a country and culture, race, and/or ethnicity different from that of the investigator and that occurs in the native country of the participant. Inclusion criteria included being a nurse, completion of at least one international cross-cultural research study either as the principal investigator or co-investigator, ability to read and write English, and Internet access for receiving and responding to the questionnaires and for

participation in a threaded discussion. Nurses conducting cross-cultural research within their own country with groups who have immigrated were excluded from the study due to the acculturation that can occur when individuals become part of a different culture. Known cultural competence theorists or developers of cultural competence measurement instruments were also excluded due to potential bias.

One criticism of the Delphi method has been the potential to select participants who are not true experts in the field of interest (Baker, Lovell, & Harris, 2006; Beech, 2001). Experts with differing experience and a broad perspective have been identified as one way to add depth to the findings (de Meyrick, 2003; Mead & Moseley, 2001b). Goodman (1987) acknowledged that providing evidence of panelists' expertise ensures content validity. International cross-cultural nurse researchers, through their personal involvement in cross-cultural research, have experience navigating a culture other than their own. Participants in this study were natives of different countries and conducted research in a variety of countries other than their own. They represented an untapped source of expertise and a fresh perspective to the ongoing dialogue on cultural competence and the conduct of culturally competent research.

Setting

This study was carried out entirely electronically via the Internet. Invitations to participate in the study were distributed using e-mail. Informed consent was obtained using an electronic signature Web site. Delphi rounds were conducted using an online survey Web site. Finally, the qualitative component of the study was achieved using an electronic focus group Web -forum. The Internet allowed recruitment of international

nurse researchers without concern for geographic location or time zone, bringing together experts from the United States, Canada, the United Kingdom, Australia, Finland, Jordan, and Malta.

Sample

A target sample size of 15 – 30 was established since samples larger than 30 have not been shown to improve results of a Delphi study (De Villiers, De Villiers, & Kent, 2005). Furthermore, a sample size of 15 – 30 is manageable and allows for brisk follow-up. A total of 261 individual e-mail invitations were sent out to potential participants identified from published research, on-line university directories, the attendance list for the 33rd Annual Transcultural Nursing Society Conference, and personal referrals from contacts made at the conference. Ten invitees responded that they did not meet inclusion criteria. Of the remaining 251, 29 participants were recruited for a response rate of 11.55%. Due to slow recruitment from the initial e-mail invitations, information concerning the study was posted on the Southern Nursing Research Society listserv and resulted in the recruitment of an additional nine participants. Thirty-eight participants were recruited for Round One of the Delphi method. Everyone who met the inclusion criteria and agreed to participate was included, even though the initial sample size exceeded 30, to allow for attrition as the study progressed.

Protection of Human Subjects

Approval to conduct this study was obtained from the University of Central Florida Institutional Review Board (IRB) prior to participant recruitment (see Appendix

F). An electronically signed informed consent was obtained from each participant using a Web -based electronic signature site, EchoSign™. Electronically signed consent forms were maintained on the secure, password protected EchoSign™ Web site under the investigator's account and on her password protected personal computer. All participants were informed of potential risks associated with use of the Internet, such as unwanted discovery of an e-mail address or receipt of unwanted spam. However, the risks involved in this study were no greater than those associated with every day Internet use. Participants were assured that efforts would be taken to maintain their anonymity, including use of blind copy e-mail and a password protected threaded discussion site where pseudonyms were used. Confidentiality of results, voluntariness of participation and ability to withdraw from the study at any time were ensured.

Responses obtained during the Delphi rounds of data collection were kept confidential through password protection in a personal computer file with back-up copies kept in a password protected jump drive. Identifiers were removed and participant numbers assigned on printed hard copies. Pseudonyms were assigned for the threaded discussion and alternate e-mail accounts, accessible only to the investigator, were set up for each participant during the threaded discussion to prevent e-mail notification of another participant's identity. No disclosure of the identity of participants was in written reports of the research. Individual participants received a report of how personal responses compared to the aggregate results in the Delphi rounds. For other reporting purposes, all responses were presented in aggregate form except for individual quotes without personal identifiers from the qualitative threaded discussion.

Pilot Study

A pilot study was conducted with ten nurse researchers who conduct research with a culture different from their own. Participation in international research was not a criterion for inclusion in the pilot study in order to preserve the international nurse researcher sample for the primary research. Electronic signatures were obtained for informed consent and two rounds of a Delphi method were conducted.

A threaded discussion trial was conducted with colleagues of the investigator. During the trial, the investigator discovered that participants were notified by e-mail when another participant responded to their postings. This e-mail notification contained the e-mail address of the participant and served as a mechanism to identify respondents. Despite efforts by the Web forum webmaster, no mechanism was readily available to prevent e-mail notification of a participant when another individual responded to his/her posting. To solve this potential breach of anonymity, the investigator developed an alternate e-mail address known only to herself for each participant so that notification of the response to postings would not be apparent to the participants.

Procedure

Invitation and Consent

Using the EchoSign™ Web site, www.EchoSign.com, an invitation to participate was sent to potential participants using e-mail with a link to the EchoSign™ Web site (see Appendix G). At the EchoSign™ Web site, the individual affixed an electronic signature to the IRB approved consent form. Once the electronic signature was

attached to the document, a portable document format (PDF) version was automatically generated and e-mailed to both the investigator and the participant from the EchoSign™ Web site. A sample of an electronically signed informed consent is in Appendix H.

Delphi Method

The first research question was: What are key attributes of cultural competence? A Delphi method determined the essential antecedents of cultural competence as identified by the international nurse researchers. The Delphi technique involved using a series of questionnaires to seek consensus from the panel of experts. In this study, consensus was reached after two rounds of questionnaires.

Round One Survey

For Round One in this Delphi study, instructions to complete the initial questionnaire using a private link to the SurveyMonkey questionnaire Web site were included in the e-mailed invitation to participate. The initial questions on the survey confirmed that the participant had given informed consent to participate and was over the age of 18. After completion of a demographic survey (see Appendix I), participants completed the first round questionnaire developed by the investigator that consisted of a list of 74 cultural competence characteristics obtained from a review of the literature (see Appendix J). The review of literature resulted from a computerized search of the Academic Search Premier, Alt HealthWatch, Health Source: Nursing/Academic Edition, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Pre-CINAHL, PsycARTICLES, PsycINFO, and PubMed databases using the terms “cultural

competence," "culture*," "nurs*," and "patient perception." Previously obtained literature used from the review of instruments that measure cultural competence was also used. Antecedents of cultural competence were identified from the literature and were drawn heavily from the Purnell Model for Cultural Competence (Purnell, 2005) and the Process of Cultural Competence in the Delivery of Healthcare Services (Campinha-Bacote, 2003b). A panel of four expert researchers reviewed the Delphi items prior to use in this study.

Participants ranked the importance of each characteristic in the Round One survey using a 5-point Likert type scale ranging from "not important at all" (1) to "extremely important" (5). One open-ended question was included to elicit characteristics of cultural competence that did not appear on the initial list developed by the investigator. E-mail reminders were sent at least weekly to individuals who consented to participate but had not completed Round One. The Round One survey remained open for seven weeks to allow for recruitment of the desired sample size. During the seven weeks, participants who had been recruited early were sent periodic e-mail updates to apprise them of the status of the study. One week before the survey was closed, those who had not completed Round One were notified of the deadline for inclusion in the study.

Data from the first Delphi round were downloaded from SurveyMonkey© in aggregate and individualized format. The data were analyzed for central tendency and dispersion of scores using SPSS Graduate Pack 14.0™. A histogram was constructed for each item to display dispersion, allowing for further evaluation (Greatorex & Dexter, 2000; Keeney et al., 2006). Consensus should be defined before data collection is

initiated to enhance the rigor of the study (de Meyrick, 2003; Goodman, 1987; Greatorex & Dexter, 2000) and should ideally fall between 51% and 80% (Hasson et al., 2000). Prior to this study, consensus was defined as 65% of participants indicating scores of three, four, or five for an item. This consensus level falls in the middle of the recommended levels.

Five items that less than 65% of the respondents rated as a “3” or higher were removed from the questionnaire after Round One. In addition, 16 items that at least 85% of the participants scored as “4” or “5” and no participants scored as “1” or “2” were considered to have achieved consensus and were not included in the subsequent round. This level of consensus exceeded the a priori benchmark set for the study and was selected to minimize respondent burden in Round Two. Fourteen items elicited from the open-ended question in Round One were added to Round Two to be ranked by the participants (see Table 8).

Round Two Survey

Before Round Two, each participant was e-mailed the minimum and maximum range, mean, standard deviation, and personal score for each item from Round One along with the SurveyMonkey© Web link for the Round Two survey. Participants ranked the importance of 67 characteristics of cultural competence (see Appendix K) using a 5-point Likert type scale ranging from “not important at all” (1) to “extremely important” (5). Participants were given three weeks to access the survey. Weekly reminder e-mails were sent to those who had not yet completed the survey. Data were analyzed using the same methods used in Round One and indicated group consensus.

Comparison of Delphi Results with Cultural Competence Instruments

The second research question was: Do extant instruments that measure cultural competence also measure key attributes as identified by the expert panel of participants? To evaluate this question, consensual items from the Delphi method were compared in a tabular format to the following instruments: IAPCC-R© (see Appendix A), TSET (see Appendix B), CCA (see Appendix C), CCET (see Appendix D), CSES, and the CCAI (see Table 12). The CAS (see Appendix E) was determined to be too specific to students in a university setting to provide meaningful use in this study and was not included in the comparison. The most recent versions of each tool were obtained from the author when possible. Since the investigator was unable to contact the originators of the CSES and CCAI, evaluation was carried out using item lists from published research using the instruments. Once determination was made of which tool was most concordant with the items from the Delphi round, the most congruous instrument was cross-evaluated to determine if it contained items not listed in the Delphi results.

Comparison of Delphi Results with Model of Ethical Multiculturalism

The third research question was: Are the antecedents of cultural competence in Harper's model of ethical multiculturalism consistent with the attributes identified by international nurse researchers? Since the antecedents of cultural competence in the model of ethical multiculturalism were drawn from the Process of Cultural Competence in the Delivery of Healthcare Services (Campinha-Bacote, 1999) and antecedents of cultural competence identified by Suh (2004), Delphi results were compared to these two sources (see Table 15). Then, a tabular comparison of the current Campinha-

Bacote (2007) model with the Delphi items determined which items were in the model that did not appear in the Delphi results (see Table 16).

Electronic Focus Group

Keeney et al. (2006) criticized the Delphi method for its lack of opportunity for participants to discuss and evaluate the results. Focus groups have been identified as one mechanism to validate Delphi data (de Meyrick, 2003; Keeney et al., 2001; Keeney et al., 2006). Therefore, once consensus of the key attributes of cultural competence was achieved in Round Two, a threaded Internet discussion focus group was conducted to validate the findings of the Delphi. The e-FocusGroups ® Brainchild Forum (Qualitative Research Consultants Association), a password protected Web site, was used to maintain privacy and to ensure that only the invited participants participated in the discussion.

With consensus reached in the second round of the Delphi, the results of Round Two including minimum, maximum, mean, standard deviation and personal responses were e-mailed to participants along with an invitation to participate in an electronic focus group. Instructions for accessing the threaded discussion Web site were included (see Appendix L). Before giving participants access to the threaded discussion, the investigator established a pseudonym and a study e-mail account to maintain anonymity. The pseudonym served as the participant identification for logging on to the Web site. A password for the Web site was given to each participant to prevent intrusion from non-participants.

Participants were asked to respond to six questions concerning the results of the Delphi rounds and how to implement behaviors consistent with the antecedents identified (see Appendix M). Another question gave participants an opportunity to discuss items from the Delphi survey that achieved consensus but had a wide dispersion of responses. One additional probing question was added during the second week: "Culture brokers have been mentioned several times. How do you differentiate between a key informant and a culture broker?" Each question was posted as a separate topic, or thread, on the Web site allowing for all responses to each question to be aggregated.

On the second day of the threaded discussion, a participant's e-mail address appeared on her Web site posting instead of her pseudonym. The investigator immediately notified the webmaster and chair of her dissertation committee. Upon investigation, the webmaster discovered that the participant had followed instructions to register as a first-time user on the first page of the threaded discussion and supplied her personal e-mail address. The webmaster copied and pasted her response to her pseudonym identification and removed the response with her e-mail address as the identifier. Examination of the times of posted responses revealed that only one other participant had accessed the discussion during the time when the participant's e-mail was evident. The investigator sent an explanatory e-mail to the participant, apologizing for the failure to indicate in the instructions that further registration with first time log-on was not necessary. The participant responded that she was not concerned about the possible breach in anonymity. Although she did not participate in the discussion any further, 75% of the participants responded only once. Since the IRB classified the study

as exempt, the investigator did not notify the IRB of the incident. Pursuant to this incident, all study participants were notified by e-mail that registration as a first time user was not necessary.

The threaded discussion Web site remained open to participants for three weeks. Weekly e-mail reminders were sent to all participants to promote participation. In addition, on the final day the Web site was open, a reminder was e-mailed to all participants. Upon completion of data collection, an e-mail was sent to all participants thanking them for their participation in the study.

After the online threaded discussion was complete, transcripts were downloaded from the e-FocusGroups ® Web site by the investigator. Transcripts were organized with the questions posed by the investigator followed by participant responses for that question. Responses were labeled with the participant pseudonym with the exception of one participant whose e-mail address printed on the transcript. The investigator verified that only the participant's pseudonym appeared on the Web site. Since the participant's e-mail was not evident on the Web site, the investigator replaced the participant's e-mail address on the transcript with the pseudonym. This participant was a different participant than the one discussed previously whose e-mail was visible on the Web site.

Qualitative Data Analysis

A group of four doctoral candidates who had completed a course in qualitative data analysis and a professor of nursing analyzed the data collected in the threaded discussion. Two of the doctoral candidates previously participated in qualitative research studies and three previously conducted data analysis (Dennis, Edmonds,

Weinstein & Decker, 2007; Knapp, Byers & Polizze, 2008; Powel & Harper, 2007). Transcripts were e-mailed to the analysis team for preliminary review before the team met to conduct content analysis. Responses for each thread were analyzed individually. Validation of Delphi findings were determined by calculating the percentage of participants who agreed with the Delphi findings, disagreed with the findings, or indicated that antecedents of cultural competence were dependent on the context.

Each thread was read aloud and followed by discussion and open coding to establish concepts that emerged from the data (Richards & Morse, 2007). Responses to the focus group questions were highly congruent resulting in consistency of opinion of the data analysis team. Discussion of differences in opinion on coding resulted in agreement. Once codes were established for each thread, the investigator analyzed the data to establish themes from the combined threads. The themes were e-mailed to the analysis team for review and to establish consensus.

Summary

Globalization has focused the attention of the nursing profession on the development of a “global nursing ethic” (Crigger, 2008). Harper’s model of ethical multiculturalism may provide a beginning framework for this “global nursing ethic” through its identification of the need to balance universal ethical principles within the cultural context of the client. Cultural competence has been identified as an attribute of ethical multiculturalism (Harper, 2006). This mixed methods descriptive study aimed to promote clarification of the conceptualization and measurement of cultural competence.

A Delphi method determined the attributes of cultural competence as identified by a sample of international nurse researchers. A comparison of the results of the Delphi to instruments that measure cultural competence determined which instrument contained the most attributes identified by the expert panel in this study. Finally, Delphi items were compared to Harper's (2006) model of ethical multiculturalism. Qualitative results obtained from an electronic focus group were used to validate the Delphi findings.

The findings of this study may inform the on-going discussion of cultural competence and perhaps contribute to standardization of conceptualization and measurement. Ultimately, an understanding of cultural competence supports the development of ethical multiculturalism and a "global nursing ethic."

CHAPTER 4: FINDINGS

The threefold purpose of this research was to identify the essential antecedents of cultural competence as identified by international nurse researchers, to compare the content of the extant cultural competence instruments to these antecedents and to potentially identify gaps in their conceptualization. A secondary aim of this research was to initiate validation of Harper's model of ethical multiculturalism. This chapter will present the findings of this study.

Sample

Round One Participants

Forty-three invitees gave informed consent to participate in the study but only 38 individuals completed the first round of the study. Two respondents did not meet inclusion criteria and were excluded from the study. Another gave insufficient information on the first round for the survey to be useable and was excluded from the study.

Of the 35 remaining participants in Round One, ninety-four percent were female (see Tables 3 and 4). Age of participants ranged from 35 – 65 years with a mean age of 53.3 years. Eighty percent of the participants had either a PhD or Doctorate degree and 60% of these degrees were in nursing. All participants had a minimum of a Master's degree. The number of years since obtaining an entry level nursing degree ranged from seven to forty-two with an average of 28 years. Eighty percent were in academic

positions. All participants conducted at least one international study as the principal investigator or as the co-investigator with one participant taking part in ten international studies. While the average number of studies per respondent was three, 57% had conducted only one or two international studies.

Round Two Participants

Twenty-nine participants completed the Round Two survey. One participant opted out of the Delphi rounds stating that the term cultural competence was "misleading." This participant was given the option to rejoin the research during the threaded discussion. Another participant began Round Two but only completed one question. When offered the opportunity to complete the remainder of the survey, she stated that she was withdrawing from the study. Four other participants failed to complete the survey by the deadline in spite of weekly e-mail reminders. Two participants asked to access the survey after the deadline but only one completed the round. Independent samples *t*-test revealed no statistically significance in age, total studies, length of residence in current country, and number of years since entry-level nursing degree between Round One and Round Two respondents. Crosstabs analysis found a highly homogenous group with no statistically significant difference in gender, highest degree in nursing, highest overall degree, position, formal transcultural education, currently teaching cultural competence, previously taught cultural competence, country of birth, country of residence, or primary language between the two groups. Tables 3 and 4 compare the demographics of participants for each stage of the research.

Table 3. Descriptive statistics

Characteristic	Round 1 (n = 35)	Round 2 (n = 29)	Focus Group (n = 16)	*t*-test *F* (*p*)
Age	53.31	54.07	55.88	.292(.593)
Years since entry level nursing degree	28.17	28.34	29.95	2.383(.132)
Total number of international studies	3.06	3	3.375	1.994(.167)
Length of residence in current country	43.67	46.86	47	.986(.328)

*Independent samples t-test revealed no statistically significant differences

Table 4. Demographics

Characteristic	n (%)			
	Round 1 (n = 35)	Round 2 (n = 29)	Focus Group (n = 16)	Crosstabs analysis
Gender				
Male	2(5.7%)	1(3.4%)	0	*p* = .181
Female	33 (94.3%)	28 (96.6%)	16 (100%)	
Highest education level				
Master's	7(20%)	7(24.1%)	3(18.8%)	*p* = .054
PhD	21(60%)	15(55.2%)	7(43.8%)	
Doctorate	7(20%)	6(20.7%)	6(37.5%)	
Highest degree in nursing				
Bachelor's	4(11.4%)	4(13.8%)	0	*p* = .070
Master's	10(28.6%)	10(34.5%)	5(31.3%)	
PhD	15(42.9%)	10(34.5%)	6(37.5%)	
Doctorate	6(17.1%)	5(17.2%)	5(31.3%)	
Formal transcultural education (course or continuing education)	21(60%)	17(58.6%)	10(62.5%)	*p* = .782
Yes	14(40%)	12(41.4%)	6(37.5%)	
No				
Currently teach course/module on cultural competence				
Yes	13(37.1%)	12(41.4%)	6(37.5%)	*p* = .968
No	22(62.9%)	17*58.6%)	10(62.5%)	
Current position				
Academia	28(80%)	24(82.8%)	14(87.5%)	*p* = .376
Service	5(14.3%)	3(10.3%)	2(12.5%)	
Combination	2(5.7%)	2(6.9%)	0	
Country of birth				
USA	26(74.3%)	21(72.4%)	13(81.3%)	*p* = .267
England	3(8.6%)	3(10.3%)	0	
Canada	1(2.9%)	1(3.4%)	0	
Finland	1(2.9%)	1(3.4%)	0	
Malta	1(2.9%)	1(3.4%)	1(6.3%)	
South Korea	1(2.9%)	0	0	
Switzerland	1(2.9%)	1(3.4%)	1(6.3%)	
Thailand	1(2.9%)	1(3.4%)	1(6.3%)	
Country of current residence				
USA	27(77.1%)	22(75.9%)	14(87.5)	*p* = .347
Australia	2(5.7%)	1(3.4%)	0	
Scotland	1(2.9%)	1(3.4%)	0	
Canada	1(2.9%)	1(3.4%)	0	
England	1(2.9%)	1(3.4%)	0	
Finland	1(2.9%)	1(3.4%)	0	
Jordan	1(2.9%)	1(3.4%)	1(6.3%)	
Malta	1(2.9%)	1(3.4%)	0	
Primary language				
English	31(88.6%)	26(89.7%)	14(87.5%)	*p* = .562
Swedish	1(2.9%)	1(3.4%)	0	
Thai	1(2.9%)	1(3.4%)	1(6.3%)	
Other	2(5.7%)	1(3.4%)	1(6.3%)	

*Crosstabs analysis found no statistically significant difference among groups

Electronic Focus Group

Sixteen participants completed the online threaded discussion representing 46% percent of the respondents who participated in the initial Delphi round and 55% of those who participated in the second Delphi round. Independent samples *t*-test revealed no statistically significant difference in age, total number of international studies, number of years since entry-level nursing degree, or length of residence in current country between the initial round sample and those who completed the online focus group. Crosstabs analysis found no statistically significant difference in gender, highest degree in nursing, highest overall degree, position, formal transcultural education, currently teaching cultural competence, previously taught cultural competence, country of birth, country of residence, or primary language among the groups. Tables 3 and 4 compare the demographics of the participants of the online focus groups with the participants of Round One and Round Two.

Round One Delphi Findings

Thirty-five participants met inclusion criteria and completed usable surveys. One participant did not respond to the Likert items in the survey but stated in the comments, “I am sorry but I cannot respond to ‘cultural competence.’ I believe that this word is misleading.” This participant’s survey was not included in the data analysis but the participant was invited to participate in the threaded discussion to discuss her viewpoint. She did not participate in the threaded discussion.

Results of Round One are listed in Tables 5 and 6. Five items were dropped from the list of antecedents during Round One because less than 65% of the participants

scored them as a “3” or higher. These items were “economic status of participant/patient,” “politics of participant’s/patient’s native country,” “occupation of participant/patient,” “knowledge of drug metabolism by participant’s/patient’s race,” and “telephone encounters.” Over 45% of the participants ranked “economic status of the participant/patient” as a “1” (not important at all) or “2” and over 44% ranked “occupation of the participant/patient” similarly. “Occupation of the participant/patient” was the only item in Round One that no participants scored as a “5” (extremely important).

Items reaching consensus in Round One that 85% of the participants scored as “4” or “5” and that none of the participants scored as “1” or “2” are listed in Table 7. The item with the highest level of consensus was “respect” with 91.2% of participants ranking it as a “extremely important.” “Respect” also had the highest mean rating, 4.91. “Flexibility” was ranked by 85.3% of the participants as “extremely important” and had a mean rating of 4.79. Both “Ethnosensitivity – accepting and valuing differences” and “Willingness to learn from others” had a mean rating of 4.82.

Fourteen items were added to Round Two of the Delphi based on suggestions from participants during Round One. These items are delineated in Table 8. Some respondent suggestions such as “time and space”, “living standards,” “health care availability,” and “who provides health education” were determined to be covered by items already in the survey.

Table 5. Round One results (n = 35)

	Range			
Item	Minimum	Maximum	Mean	Std Deviation
Native culture of participant/patient	2	5	4.15	.958
Current residence of participant/patient	1	5	3.41	1.328
Economic status of participant/patient	1	5	2.97	1.403
Politics of participant's/patient's native country	1	5	2.97	1.291
Education level of participant/patient	1	5	3.32	1.147
Occupation of participant/patient	1	4	2.56	.927
Dominant language of participant/patient	1	5	4.00	.985
Nurse researcher's ability to speak language of participant/patient (language concordance)	1	5	3.50	1.022
Nurse researcher's ability to read language of participant/patient	1	5	3.18	1.114
Spatial distancing with participant/patient	1	5	3.59	1.104
Appropriate eye contact with participant/patient	1	5	3.97	1.029
Understanding of facial expressions of participant/pt.	1	5	4.12	1.038
Use of greetings understood by participant/pt .	1	5	4.50	.929
Understanding of participant/patient's cultural orientation in past, present, or future (temporality)	2	5	4.50	.788
Social meanings of time for participant/patient	3	5	4.50	.707
Appropriate use of touch with	1	5	4.59	.821

	Range			
Item	Minimum	Maximum	Mean	Std Deviation
participant/patient				
Acceptable use of names and/or titles with participant/patient	2	5	4.59	.701
Understanding of gender roles in participant/patient's culture	3	5	4.67	.595
Understanding of child rearing practices in participant/patient's culture	2	5	4.36	.783
Understanding of definition of family in participant/patient's culture	2	5	4.45	.711
Understanding of importance of family in participant/patient's culture	3	5	4.67	.540
Family involvement in health care in participant/patient's culture	3	5	4.52	.755
Individual vs. collective viewpoint in participant/patient's culture	3	5	4.42	.708
Understanding of social status in participant/patient's culture	2	5	4.36	.742
Understanding of worldview of participant/patient's culture	3	5	4.45	.711
Understanding of head of household in participant/patient's culture	3	5	4.39	.659
Knowledge of drug metabolism by participant/patient's race	1	5	2.88	1.193
Knowledge of disease incidence and prevalence in participant/patient's race	2	5	3.91	.980
Common foods in participant/patient's culture	2	5	4.00	.866
Knowledge of meaning of foods in	2	5	4.18	.846

	Range			
Item	Minimum	Maximum	Mean	Std Deviation
participant/patient's culture				
Food rituals in participant/patient's culture	2	5	4.12	.893
Food taboos in participant/patient's culture	2	5	4.24	.830
Use of food in illness and wellness in participant/patient's culture	2	5	4.30	.810
Fertility practices in participant/patient's culture	2	5	3.79	1.023
Birth control practices in participant/patient's culture	2	5	3.85	1.034
Pregnancy practices in participant/patient's culture	2	5	4.06	1.045
Views toward pregnancy in participant/patient's culture	2	5	4.15	1.004
Death rituals in participant/patient's culture	2	5	4.15	.906
Bereavement patterns in participant/patient's culture	2	5	4.15	.906
Religious practices in participant/patient's culture	2	5	4.48	.755
Role of prayer in participant/patient's culture	2	5	4.27	.839
Role of spirituality in health/illness in participant/patient's culture	2	5	4.55	.754
Health care beliefs in participant/patient's culture	2	5	4.67	.645
Focus of health care (preventive vs. acute) in participant/patient's culture	2	5	4.45	.711
Self-medication in participant/patient's culture	2	5	4.09	.914

	Range			
Item	Minimum	Maximum	Mean	Std Deviation
Ethnic pharmacology of participant/patient's race	2	5	4.25	.842
Use of herbs in participant/patient's culture	2	5	4.30	.883
Beliefs about pain in participant/patient's culture	2	5	4.48	.712
Barriers to health care in participant/patient's culture	2	5	4.58	.708
Status of health care practitioner in participant/patient's culture	2	5	4.41	.875
Type of health care practitioner typically consulted (magicoreligious, biomedical, etc) in participant/patient's culture	2	5	4.42	.830
Explanatory model of illness (biomedical, spiritual, etc) in participant/patient's culture	2	5	4.33	.816
Folk systems of care in participant/patient's culture	2	5	4.48	.834
Culturally based physical assessment of participant/patient	2	5	4.21	.893
Caring	1	5	4.56	.927
Platonic love	1	5	3.24	1.251
Sacrifice of prejudice and bias	1	5	4.50	.842
Moral commitment	1	5	4.39	.899
Passion	3	5	4.12	.844
Openness	3	5	4.65	.646
Flexibility	3	5	4.79	.538

	Range			
Item	Minimum	Maximum	Mean	Std Deviation
Awareness of differences	4	5	4.79	.410
Commitment to build on similarities	2	5	4.29	.938
Willingness to learn from others	4	5	4.82	.387
Humility	3	5	4.71	.579
Self-evaluation of biases and prejudices	3	5	4.79	.479
Ethnosensitivity – accepting and valuing differences	4	5	4.82	.387
Ethnorelativity – use of multicultural frame of reference in decision making	3	5	4.52	.619
Ethnocentrism – viewing different culture from perspective of own culture	1	5	3.24	1.458
Face-to-face encounters	1	5	4.50	.929
Telephone encounters	1	5	2.73	1.257
Mutual understanding	2	5	4.53	.706
Respect	4	5	4.91	.288
Listening	1	5	4.76	.741

Table 6. Round One rating response distribution (n = 35)

	Rating				
Item	1	2	3	4	5
Native culture of participant/patient	0%	8.8%	11.8%	35.3%	44.1%
Current residence of participant/patient	8.8%	20.6%	17.6%	26.5%	26.5%
Economic status of participant/patient	15.2%	30.3%	18.2%	15.2%	21.2%
Politics of participant's/patient's native country	14.7%	23.5%	26.5%	20.6%	14.7%
Education level of participant/patient	8.8%	14.7%	23.5%	41.2%	11.8%
Occupation of participant/patient	14.7%	29.4%	41.2%	14.7%	0%
Dominant language of participant/patient	2.9%	2.9%	20.6%	38.2%	35.3%
Nurse researcher's ability to speak language of participant/patient (language concordance)	2.9%	11.8%	35.3%	32.4%	17.6%
Nurse researcher's ability to read language of participant/patient	5.9%	20.6%	38.2%	20.6%	14.7%
Spatial distancing with participant/patient	2.9%	11.8%	35.3%	23.5%	26.5%
Appropriate eye contact with participant/patient	5.9%	0%	17.6%	44.1%	32.4%
Understanding of facial expressions of participant/patient	5.9%	0%	11.8%	41.2%	41.2%
Use of greetings understood by participant/pt.	2.9%	2.9%	2.9%	23.5%	67.6%
Understanding of participant/patient's cultural orientation in past, present, or future (temporality)	0%	5.9%	0%	32.4%	61.8%
Social meanings of time for participant/patient	0%	0%	11.8%	26.5%	61.8%

	Rating				
Item	1	2	3	4	5
Appropriate use of touch with participant/patient	2.9%	0%	2.9%	23.5%	70.6%
Acceptable use of names and/or titles with participant/patient	0%	2.9%	2.9%	26.5%	67.6%
Understanding of gender roles in participant/patient's culture	0%	0%	6.1%	21.2%	72.7
Understanding of child rearing practices in participant/patient's culture	0%	3.0%	9.1%	36.4%	51.5%
Understanding of definition of family in participant/patient's culture	0%	3.0%	3.0%	39.4%	54.5%
Understanding of importance of family in participant/patient's culture	0%	0%	3.0%	27.3%	69.7%
Family involvement in health care in participant/patient's culture	0%	0%	15.2%	18.2%	66.7%
Individual vs. collective viewpoint in participant/patient's culture	0%	0%	12.1%	33.3%	54.5%
Understanding of social status in participant/patient's culture	0%	3.0%	6.1%	42.4%	48.5%
Understanding of worldview of participant/patient's culture	0%	0%	12.1%	30.3%	57.6%
Understanding of head of household in participant/patient's culture	0%	0%	9.1%	42.4%	48.5%
Knowledge of drug metabolism by participant/patient's race	12.1%	27.3%	33.3%	15.2%	12.1%
Knowledge of disease incidence and prevalence in participant/patient's race	0%	9.1%	24.2%	33.3%	33.3%
Common foods in participant/patient's culture	0%	6.1%	18.2%	45.5%	30.3%

	Rating				
Item	1	2	3	4	5
Knowledge of meaning of foods in participant/patient's culture	0%	3.0%	18.2%	36.4%	42.4%
Food rituals in participant/patient's culture	0%	3.0%	24.2%	30.3%	42.4%
Food taboos in participant/patient's culture	0%	3.0%	15.2%	36.4%	45.5%
Use of food in illness and wellness in participant/patient's culture	0%	3.0%	12.1%	36.4%	48.5%
Fertility practices in participant/patient's culture	0%	15.2%	18.2%	39.4%	27.3%
Birth control practices in participant/patient's culture	0%	15.2%	15.2%	39.4%	30.3%
Pregnancy practices in participant/patient's culture	0%	12.5%	12.5%	31.3%	43.8%
Views toward pregnancy in participant/patient's culture	0%	9.1%	15.2%	27.3%	48.5%
Death rituals in participant/patient's culture	0%	6.1%	15.2%	36.4%	42.4%
Bereavement patterns in participant/patient's culture	0%	6.1%	15.2%	36.4%	42.4%
Religious practices in participant/patient's culture	0%	3.0%	6.1%	30.3%	60.6%
Role of prayer in participant/patient's culture	0%	3.0%	15.2%	33.3%	48.5%
Role of spirituality in health/illness in participant/patient's culture	0%	3.0%	6.1%	24.2%	66.7%
Health care beliefs in participant/patient's culture	0%	3.0%	0%	24.2%	72.7%
Focus of health care (preventive vs. acute) in participant/patient's culture	0%	3.0%	3.0%	39.4%	54.5%

	Rating				
Item	1	2	3	4	5
Self-medication in participant/patient's culture	0%	6.1%	18.2%	36.4%	39.4%
Ethnic pharmacology of participant/patient's race	0%	3.1%	15.6%	34.4%	46.9%
Use of herbs in participant/patient's culture	0%	6.1%	9.1%	33.3%	51.5%
Beliefs about pain in participant/patient's culture	0%	3.0%	3.0%	36.4%	57.6%
Barriers to health care in participant/patient's culture	0%	3.0%	3.0%	27.3%	66.7%
Status of health care practitioner in participant/patient's culture	0%	6.3%	6.3%	28.1%	59.4%
Type of health care practitioner typically consulted (magicoreligious, biomedical, etc) in participant/patient's culture	0%	3.0%	12.1%	24.2%	60.6%
Explanatory model of illness (biomedical, spiritual, etc) in participant/patient's culture	0%	3.0%	12.1%	33.3%	51.5%
Folk systems of care in participant/patient's culture	0%	3.0%	12.1%	18.2%	66.7%
Culturally based physical assessment of participant/patient	0%	3.0%	21.2%	27.3%	48.5%
Caring	2.9%	2.9%	2.9%	17.6%	73.9%
Platonic love	12.1%	12.1%	33.3%	24.2%	18.2%
Sacrifice of prejudice and bias	3.1%	0%	3.1%	31.3%	62.5%
Moral commitment	3.0%	0%	9.1%	30.3%	57.6%
Passion	0%	0%	29.4%	29.4%	41.2%
Openness	0%	0%	8.8%	17.6%	73.5%

	Rating				
Item	1	2	3	4	5
Flexibility	0%	0%	5.9%	8/8%	85.3%
Awareness of differences	0%	0%	0%	20.6%	79.4%
Commitment to build on similarities	0%	5.9%	14.7%	23.5%	55.9%
Willingness to learn from others	0%	0%	0%	17.6%	82.4%
Humility	0%	0%	5.9%	17.6%	76.5%
Self-evaluation of biases and prejudices	0%	0%	2.9%	14.7%	82.4%
Ethnosensitivity – accepting and valuing differences	0%	0%	0%	17.6%	82.4%
Ethnorelativity – use of multicultural frame of reference in decision making	0%	0%	6.1%	36.4%	57.6%
Ethnocentrism – viewing different culture from perspective of own culture	18.2%	12.1%	24.2%	18.2%	27.3%
Face-to-face encounters	2.9%	2.9%	2.9%	23.5%	67.6%
Telephone encounters	18.2%	24.2%	39.4%	3.0%	15.2%
Mutual understanding	0%	2.9%	2.9%	32.4%	61.8%
Respect	0%	0%	0%	8.8%	91.2%
Listening	2.9%	0%	0%	11.8%	85.3%

Table 7. Round One items reaching consensus

Item
Social meanings of time for participant/patient
Understanding of gender roles in participant's/patient's culture
Understanding of importance of family in participant's/patient's culture
Family involvement in health care in participant's/patient's culture
Individual vs. collective viewpoint in participant's/patient's culture
Understanding of worldview of participant's/patient's culture
Understanding of head of household in participant's/patient's culture
Openness
Flexibility
Awareness of differences
Willingness to learn from others
Humility
Self-evaluation of biases and prejudices
Ethnosensitivity – accepting and valuing differences
Ethnorelativity – use of multicultural frame of reference in decision making
Respect

Table 8. Round Two: Items added by expert panel

Item
Understanding of history/how the society was shaped
Empathy
Communication skills
Equity
Social inclusion
Health inequalities
Acceptance
Communitarianism
Universality
Gratitude
Promotion of common good
Humor
Positivity
Internet encounters

Round Two Delphi Findings

Twenty-nine participants completed Round Two. Results of Round Two are listed in Tables 9 and 10. Three additional items were eliminated during Round Two: “current residence of participant/patient,” ethnocentrism – viewing different culture from perspective of own culture,” and “Internet encounters.” Nearly 61% of the respondents rated “ethnocentrism” as a “1” or “2” and 35.7% rated both “current residence” and “Internet encounters” as a “1” or “2.” “Internet encounters” was the only item in Round Two that no respondents rated as a “5, extremely important.”

All remaining items in Round Two achieved consensus defined a priori as 65% of the respondents rating as a “3” or higher. “Listening” achieved a mean rating of 4.93 with 93.1% of the participants rating it as “5, extremely important.” The mean rating of “Communication skills” was 4.83 with 82.8% of the participants rating it as “5, extremely important.” “Appropriate use of touch,” “acceptance,” and “moral commitment” all had a mean rating of 4.76 with over three-quarters of the participants rating them as “extremely important.”

Table 9. Round Two results (n = 29)

	Range			
Item	Minimum	Maximum	Mean	Std Deviation
Native culture of participant/patient	1	5	3.75	1.481
Current residence of participant/patient	1	5	2.86	1.145
Education level of participant/patient	1	5	3.28	1.251
Dominant language of participant/patient	1	5	3.93	1.120
Nurse researcher's ability to speak language of participant/patient (language concordance)	2	5	3.45	.870
Nurse researcher's ability to read language of participant/patient	1	5	2.97	.906
Spatial distancing with participant/patient	2	5	4.17	.805
Appropriate eye contact with participant/patient	2	5	4.32	.723
Understanding of facial expressions of participant/patient	3	5	4.48	.574
Use of greetings understood by participant/patient	3	5	4.55	.632
Understanding of participant/patient's cultural orientation in past, present, or future (temporality)	3	5	4.62	.561
Appropriate use of touch with participant/patient	4	5	4.76	.435
Acceptable use of names and/or titles with participant/patient	4	5	4.66	.484
Understanding of child rearing practices in participant/patient's culture	1	5	4.24	.830

	Range			
Item	Minimum	Maximum	Mean	Std Deviation
Understanding of definition of family in participant/patient's culture	1	5	4.48	.829
Understanding of social status in participant/patient's culture	3	5	4.52	.634
Knowledge of disease incidence and prevalence in participant/patient's race	3	5	4.00	.802
Common foods in participant/patient's culture	2	5	3.83	.805
Knowledge of meaning of foods in participant/patient's culture	2	5	4.03	.906
Food rituals in participant/patient's culture	3	5	4.07	.842
Food taboos in participant/patient's culture	3	5	4.14	.789
Use of food in illness and wellness in participant/patient's culture	3	5	4.28	.702
Fertility practices in participant/patient's culture	2	5	4.00	.845
Birth control practices in participant/patient's culture	3	5	4.07	.704
Pregnancy practices in participant/patient's culture	3	5	4.11	.685
Views toward pregnancy in participant/patient's culture	3	5	4.17	.658
Death rituals in participant/patient's culture	1	5	4.14	.915
Bereavement patterns in participant/patient's culture	2	5	4.28	.841
Religious practices in participant/patient's culture	3	5	4.52	.574

	Range			
Item	Minimum	Maximum	Mean	Std Deviation
Role of prayer in participant/patient's culture	3	5	4.14	.848
Role of spirituality in health/illness in participant/patient's culture	3	5	4.57	.634
Health care beliefs in participant/patient's culture	3	5	4.59	.568
Focus of health care (preventive vs. acute) in participant/patient's culture	1	5	4.24	.872
Self-medication in participant/patient's culture	2	5	4.21	.861
Ethnic pharmacology of participant/patient's race	3	5	4.14	.756
Use of herbs in participant/patient's culture	2	5	4.14	.803
Beliefs about pain in participant/patient's culture	3	5	4.14	.705
Barriers to health care in participant/patient's culture	3	5	4.54	.637
Status of health care practitioner in participant/patient's culture	1	5	4.03	.865
Type of health care practitioner typically consulted (magicoreligious, biomedical, etc) in participant/patient's culture	3	5	4.28	.702
Explanatory model of illness (biomedical, spiritual, etc) in participant/patient's culture	3	5	4.52	.688
Folk systems of care in participant/patient's culture	3	5	4.34	.721
Culturally based physical assessment of participant/patient	2	5	4.10	.772

	Range			
Item	Minimum	Maximum	Mean	Std Deviation
Caring	3	5	4.48	.738
Platonic love	1	5	3.07	1.252
Sacrifice of prejudice and bias	1	5	4.36	1.026
Moral commitment	4	5	4.76	.435
Passion	2	5	4.28	.922
Commitment to build on similarities	1	5	4.24	.872
Ethnocentrism – viewing different culture from perspective of own culture	1	5	2.50	1.478
Face-to-face encounters	3	5	4.34	.769
Mutual understanding	2	5	4.41	.825
Listening	4	5	4.93	.258
Understanding of history/how the society was shaped	2	5	4.28	.922
Empathy	2	5	4.24	.872
Communication skills	4	5	4.83	.384
Equity	2	5	4.30	.823
Social inclusion	2	5	4.25	.752
Health inequalities	3	5	4.21	.675
Acceptance	3	5	4.76	.511
Communitarianism	2	5	3.96	.790
Universality	1	5	3.67	1.144
Gratitude	2	5	3.85	1.064

	Range			
Item	Minimum	Maximum	Mean	Std Deviation
Promotion of common good	3	5	4.37	.688
Humor	2	5	3.96	.881
Positivity	1	5	4.22	.974
Internet encounters	1	4	2.54	.962

Table 10. Round Two rating response distribution (n = 29)

	Rating				
Item	1	2	3	4	5
Native culture of participant/patient	10.7%	14.3%	14.2%	10.7%	50.0%
Current residence of participant/patient	14/3%	21.4%	35.7%	21.4%	7.1%
Education level of participant/patient	10.3%	20.7%	13.8%	41.4%	13.8%
Dominant language of participant/patient	3.6%	7.1%	21.4%	28.6%	39.3%
Nurse researcher's ability to speak language of participant/patient (language concordance)	0%	10.3%	48.3%	27.6%	13.8%
Nurse researcher's ability to read language of participant/patient	3.4%	27.6%	41.4%	24.1%	3.4%
Spatial distancing with participant/patient	0%	3.4%	13.8%	44.8%	37.9%
Appropriate eye contact with participant/patient	0%	3.6%	3.6%	50.0%	42.9%
Understanding of facial expressions of participant/patient.	0%	0%	3.4%	44.8%	51.7%
Use of greetings understood by participant/patient	0%	0%	6.9%	31.0%	62.1%

	Rating				
Item	1	2	3	4	5
Understanding of participant/patient's cultural orientation in past, present, or future (temporality)	0%	0%	3.4%	31.0%	65.5%
Appropriate use of touch with participant/patient	0%	0%	0%	24.1%	75.9%
Acceptable use of names and/or titles with participant/patient	0%	0%	0%	34.5%	65.6%
Understanding of child rearing practices in participant/patient's culture	3.4%	0%	3.4%	55.2%	37.9%
Understanding of definition of family in participant/patient's culture	3.4%	0%	0%	37.9%	58.6%
Understanding of social status in participant/patient's culture	0%	0%	6.9%	34.5%	58.6%
Knowledge of disease incidence and prevalence in participant/patient's race	0%	0%	31.0%	37.9%	31.0%
Common foods in participant/patient's culture	0%	3.4%	31.0%	44.8%	20.7%
Knowledge of meaning of foods in participant/patient's culture	0%	3.4%	27.6%	31.0%	37.9%
Food rituals in participant/patient's culture	0%	0%	31.0%	31.0%	37.9%
Food taboos in participant/patient's culture	0%	0%	24.1%	37.9%	37.9%
Use of food in illness and wellness in participant/patient's culture	0%	0%	13.8%	44.8%	41.4%
Fertility practices in participant/patient's culture	0%	3.4%	24.1%	41.4%	31.0%
Birth control practices in participant/patient's culture	0%	0%	20.7%	51.7%	27.6%

	Rating				
Item	1	2	3	4	5
Pregnancy practices in participant/patient's culture	0%	0%	17.9%	53.6%	28.6%
Views toward pregnancy in participant/patient's culture	0%	0%	13.8%	55.2%	31.0%
Death rituals in participant/patient's culture	3.4%	0%	13.8%	44.8%	37.9%
Bereavement patterns in participant/patient's culture	0%	3.4%	13.8%	34.5%	48.3%
Religious practices in participant/patient's culture	0%	0%	3.4%	41.4%	55.2%
Role of prayer in participant/patient's culture	0%	0%	28.6%	28.6%	42.9%
Role of spirituality in health/illness in participant/patient's culture	0%	0%	7.1%	28.6%	64.3%
Health care beliefs in participant/patient's culture	0%	0%	3.4%	34.5%	62.1%
Focus of health care (preventive vs. acute) in participant/patient's culture	3.4%	0%	6.9%	48.3%	41.4%
Self-medication in participant/patient's culture	0%	3.4%	17.2%	34.5%	44.8%
Ethnic pharmacology of participant/patient's race	0%	0%	21.4%	42.9%	35.7%
Use of herbs in participant/patient's culture	0%	3.6%	14.3%	46.4%	35.7%
Beliefs about pain in participant/patient's culture	0%	0%	17.9%	50.0%	32.1%
Barriers to health care in participant/patient's culture	0%	0%	7.1%	32.1%	60.7%

	Rating				
Item	1	2	3	4	5
Status of health care practitioner in participant/patient's culture	3.4%	0%	13.8%	55.2%	27.6%
Type of health care practitioner typically consulted (magicoreligious, biomedical, etc) in participant/patient's culture	0%	0%	13.8%	44.8%	41.4%
Explanatory model of illness (biomedical, spiritual, etc) in participant/patient's culture	0%	0%	10.3%	27.6%	62.1%
Folk systems of care in participant/patient's culture	0%	0%	13.8%	37.9%	48.3%
Culturally based physical assessment of participant/patient	0%	3.4%	13.8%	51.7%	31.0%
Caring	0%	0%	13.8%	24.1%	62.1%
Platonic love	13.8%	13.8%	41.4%	13.8%	17.2%
Sacrifice of prejudice and bias	3.6%	3.6%	7.1%	25.0%	60.7
Moral commitment	0%	0%	0%	24.1%	75.9%
Passion	0%	6.9%	10.3%	31.0%	51.7%
Commitment to build on similarities	3.4%	0%	6.9%	48.3%	41.4%
Ethnocentrism – viewing different culture from perspective of own culture	32.1%	28.6%	14.3%	7.1%	17.9%
Face-to-face encounters	0%	0%	17.2%	31.0%	51.7%
Mutual understanding	0%	3.4%	10.3%	27.6%	58.6%
Listening	0%	0%	0%	6.9%	93.1%
Understanding of history/how the society was shaped	0%	6.9%	10.3%	31.0%	51.7%
Empathy	0%	6.9%	6.9%	41.4%	44.8%

	Rating				
Item	1	2	3	4	5
Communication skills	0%	0%	0%	17.2%	82.8%
Equity	0%	3.7%	11.1%	37.0%	48.1%
Social inclusion	0%	3.6%	7.1%	50.0%	39.3%
Health inequalities	0%	0%	13.8%	51.7%	34.5%
Acceptance	0%	0%	3.4%	17.2%	79.3%
Communitarianism	0%	4.0%	20.0%	52.0%	24.0%
Universality	7.4%	7.4%	18.5%	44.4%	22.2%
Gratitude	0%	11.1%	29.6%	22.2%	37.0%
Promotion of common good	0%	0%	11/1%	40.7%	48.1%
Humor	0%	7.1%	17.9%	46.4%	28.6%
Positivity	3.7%	0%	14.8%	33.3%	48.1%
Internet encounters	21.4%	14.3%	53.6%	10.7%	0%

Histograms of each item were evaluated for dispersion. Six items that achieved consensus among participants had a wide range of responses. These items included “native culture of participant/patient,” “education level of participant/patient,” “dominant language of participant/patient,” “nurse researcher's ability to read language of participant/patient,” “platonic love,” and “universality.” A discussion question was added to the electronic focus group to elicit participant input concerning the wide dispersion of responses on those six items.

The final results yielded 80 items from both rounds of the Delphi that met the pre-established definition of consensus. These items are listed in Table 11.

Table 11. Final Delphi results: Antecedents of cultural competence

Delphi Item
Native culture of participant
Education level of participant
Dominant language of participant
Nurse researcher's ability to speak language of participant
Nurse researcher's ability to read language of participant
Spatial distancing with participant
Appropriate eye contact with participant
Understanding of facial expressions of participant
Use of greetings understood by participant
Understanding of participant's cultural orientation in past, present, or future
Social meanings of time for participant
Appropriate use of touch with participant
Acceptable use of names and/or titles with participant
Understanding of gender roles in participant's culture
Understanding of child rearing practices in participant's culture
Understanding of definition of family in participant's culture
Understanding of importance of family in participant's culture
Family involvement in health care in participant's culture

Delphi Item
Individual vs. collective viewpoint in participant's culture
Understanding of social status in participant's culture
Understanding of worldview of participant's culture
Understanding of head of household in participant's culture
Knowledge of disease incidence and prevalence in participant's culture
Common foods in participant's culture
Knowledge of meaning of foods in participant's culture
Food rituals in participant's culture
Food taboos in participant's culture
Use of food in illness and wellness in participant's culture
Fertility practices in participant's culture
Birth control practices in participant's culture
Pregnancy practices in participant's culture
Views toward pregnancy in participant's culture
Death rituals in participant's culture
Bereavement patterns in participant's culture
Religious practices in participant's culture
Role of prayer in participant's culture
Role of spirituality in health/illness in participant's culture
Health care beliefs in participant's culture
Focus of health care (preventive vs. acute) in participant's culture

Delphi Item
Self-medication in participant's culture
Ethnic pharmacology for participant's race
Use of herbs in participant's culture
Beliefs about pain in participant's culture
Barriers to health care in participant's culture
Status of health care practitioner in participant's culture
Type of health care practitioner typically consulted (magicoreligious, biomedical, etc.) in Participant's culture
Explanatory model of illness (biomedical, spiritual, etc.) in participant's culture
Folk systems of care in participant's culture
Caring
Platonic love
Sacrifice of prejudice and bias
Moral commitment
Passion
Openness
Flexibility
Awareness of differences
Commitment to build on similarities
Willingness to learn from others
Humility
Self-evaluation of biases and prejudices

Delphi Item
Ethnosensitivity – accepting and valuing differences
Ethnorelativity – use of multicultural frame of reference in decision making
Face-to-face encounters
Mutual understanding
Respect
Listening
Understanding of history/how the society was shaped
Empathy
Communication skills
Equity
Social inclusion
Health inequalities
Acceptance
Communitarianism
Universality
Gratitude
Promotion of common good
Humor
Positivity

Comparison of Instruments and Delphi Results

Items from the IAPCC-R©, CSES, TSET, CCA, CCET, and CCAI were compared to the Delphi items (see Table 12). The CAS (Rew et al., 2003) was too specifically geared to nursing student evaluation of nursing programs to be used for comparison in the current study. All of the cultural competence instruments evaluated, except the TSET, contained less than half of the items identified by the expert panel as important to achieving cultural competence. The CCA (S. Schim, personal communication, January 15, 2008) and the CCAI (Kelley & Meyers, 1987) contained the fewest items with 10, or 13% of the items from the Delphi rounds. The IAPCC-R© (Campinha-Bacote, 2003b) and the CCE (T.L. Freeman, personal communication, June 3, 2007) contained 12 items each or 15% of the items from the Delphi rounds. The CSES (Bernal & Froman, 1993) contained 20 items or 25% and the TSET (Jeffreys, 2006) contained 52 items or 66% of the items from the Delphi rounds.

Table 12. Delphi results compared to cultural competence measurement instruments

	Instruments					
Delphi Item	IAPCC-R	CSES	TSET	CCA	CCET	CCAI
Native culture of participant	No	No	Yes	No	No	No
Education level of participant	No	No	Yes	No	No	No
Dominant language of participant	No	No	Yes	Yes	No	No
Nurse researcher's ability to speak language of participant	No	No	No	No	No	No

Delphi Item	Instruments					
	IAPCC-R	CSES	TSET	CCA	CCET	CCAI
Nurse researcher's ability to read language of participant	No	No	No	No	No	No
Spatial distancing with participant	No	No	Yes	No	No	No
Appropriate eye contact with participant	No	No	Yes	No	No	No
Understanding of facial expressions of participant	No	No	Yes	No	No	No
Use of greetings understood by participant	No	No	Yes	No	No	No
Understanding of participant's cultural orientation in past, present, or future	No	No	Yes	No	No	No
Social meanings of time for participant	No	No	Yes	No	No	No
Appropriate use of touch with participant	No	No	Yes	No	No	No
Acceptable use of names and/or titles with participant	No	No	No	No	No	No
Understanding of gender roles in participant's culture	Yes	Yes	Yes	No	Yes	No
Understanding of child rearing practices in participant's culture	No	Yes	Yes	No	No	No
Understanding of definition of family in participant's culture	No	Yes	Yes	No	No	No
Understanding of importance of family in participant's culture	No	No	Yes	No	No	No
Family involvement in health care in participant's culture	No	No	Yes	No	No	No

	Instruments					
Delphi Item	IAPCC-R	CSES	TSET	CCA	CCET	CCAI
Individual vs. collective viewpoint in participant's culture	No	No	No	No	No	No
Understanding of social status in participant's culture	No	Yes	Yes	No	No	No
Understanding of worldview of participant's culture	Yes	No	Yes	No	No	No
Understanding of head of household in participant's culture	No	Yes	Yes	No	No	No
Knowledge of disease incidence and prevalence in participant's culture	Yes	Yes	No	No	No	No
Common foods in participant's culture	No	Yes	Yes	No	No	No
Knowledge of meaning of foods in participant's culture	No	No	Yes	No	No	No
Food rituals in participant's culture	No	Yes	Yes	No	No	No
Food taboos in participant's culture	No	Yes	Yes	No	No	No
Use of food in illness and wellness in participant's culture	No	No	Yes	No	No	No
Fertility practices in participant's culture	No	No	Yes	No	No	No
Birth control practices in participant's culture	No	No	Yes	No	No	No
Pregnancy practices in participant's culture	No	No	Yes	No	No	No
Views toward pregnancy in participant's culture	No	No	Yes	No	No	No
Death rituals in participant's culture	No	No	Yes	No	No	No

	Instruments					
Delphi Item	IAPCC-R	CSES	TSET	CCA	CCET	CCAI
Bereavement patterns in participant's culture	No	No	Yes	No	No	No
Religious practices in participant's culture	Yes	Yes	Yes	Yes	No	No
Role of prayer in participant's culture	No	Yes	Yes	No	No	No
Role of spirituality in health/illness in participant's culture	No	No	Yes	Yes	No	No
Health care beliefs in participant's culture	No	Yes	Yes	Yes	No	No
Focus of health care (preventive vs. acute) in participant's culture	No	Yes	Yes	No	No	No
Self-medication in participant's culture	No	No	No	No	No	No
Ethnic pharmacology for participant's race	Yes	No	No	No	No	No
Use of herbs in participant's culture	No	No	No	No	No	No
Beliefs about pain in participant's culture	No	No	Yes	No	No	No
Barriers to health care in participant's culture	Yes	Yes	No	Yes	No	No
Status of health care practitioner in participant's culture	No	Yes	Yes	No	No	No
Type of health care practitioner typically consulted (magicoreligious, biomedical, etc.) in participant's culture	No	Yes	Yes	No	No	No

Delphi Item	Instruments					
	IAPCC-R	CSES	TSET	CCA	CCET	CCAI
Explanatory model of illness (biomedical, spiritual, etc.) in participant's culture	No	Yes	Yes	No	No	No
Folk systems of care in participant's culture	No	Yes	Yes	No	No	No
Culturally based physical assessment of participant	No	No	Yes	No	No	No
Caring	Yes	No	Yes	No	No	No
Platonic love	No	No	No	No	No	No
Sacrifice of prejudice and bias	No	No	No	No	No	No
Moral commitment	Yes	No	No	No	No	No
Passion	Yes	No	No	No	No	No
Openness	No	No	No	No	No	Yes
Flexibility	No	No	No	No	Yes	Yes
Awareness of differences	Yes	Yes	Yes	Yes	Yes	Yes
Commitment to build on similarities	No	No	No	No	No	No
Willingness to learn from others	Yes	No	No	Yes	Yes	Yes
Humility	No	No	No	No	No	No
Self-evaluation of biases and prejudices	Yes	No	Yes	Yes	Yes	No
Ethnosensitivity – accepting and valuing differences	No	No	Yes	No	Yes	Yes
Ethnorelativity – use of multicultural frame of reference in decision making	No	No	Yes	No	No	Yes

	Instruments					
Delphi Item	IAPCC-R	CSES	TSET	CCA	CCET	CCAI
Face-to-face encounters	No	No	Yes	Yes	Yes	No
Mutual understanding	No	No	Yes	No	No	Yes
Respect	No	No	Yes	Yes	No	No
Listening	No	No	No	No	Yes	No
Understanding of history/how the society was shaped	No	Yes	No	No	No	No
Empathy	No	No	No	No	Yes	No
Communication skills	No	No	Yes	No	Yes	Yes
Equity	No	No	Yes	No	Yes	Yes
Social inclusion	No	No	No	No	Yes	No
Health inequalities	No	No	Yes	No	No	No
Acceptance	No	No	Yes	No	No	No
Communitarianism	No	No	No	No	No	No
Universality	No	No	No	No	No	No
Gratitude	No	No	No	No	No	No
Promotion of common good	No	No	No	No	Yes	No
Humor	No	No	No	No	No	Yes
Positivity	No	No	No	No	No	No

IAPCC – R©: Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals – Revised, CSES: Cultural Self-Efficacy Scale, TSES: Transcultural Self Efficacy Scale, CCA: Cultural Competence Assessment, CCAI: Cross-Cultural Adaptability Inventory, CCET: Cross Cultural Evaluation Tool, CAS: Cultural Awareness Scale

Cultural Competence Assessment (CCA)

The CCA, seen in Appendix C, (S.M. Schim, personal communication, January 15, 2008) contained 10 of the items that international nurse researchers felt were important antecedents of cultural competence. From the client's perspective, items in the CCA included language, the role of spirituality and religious practices, health care beliefs, and barriers to health care. Other than religious and health care beliefs, the CCA did not focus on specific cultural items such as non-verbal communication, social norms, the role of the family, or pregnancy and nutrition practices. From the nurse's perspective, the CCA considered "awareness of differences," "willingness to learn," "self-evaluation of biases and prejudices," "experience" and "respect." Areas of focus in the CCA that were missing from the Delphi results included the use and documentation of cultural assessments to direct nursing care, resources for seeking information about a culture, and the removal of obstacles for the client.

Cross-Cultural Adaptability Inventory (CCAI)

The CCAI (Kelley & Meyers, 1987) also contained 10 of the items identified as antecedents to cultural competence in the Delphi rounds. The CCAI focused almost exclusively on individual characteristics and considered openness, flexibility, awareness of differences, willingness to learn from others, ethnosensitivity, ethnorelativity, mutual understanding, communication skills, equity and humor to be necessary to adapt to a different culture. The CCAI did not include any items related to culture specific knowledge such as foods, religious beliefs and practices, or health care beliefs and practices. Unlike the Delphi results, the CCAI focused on the ability of the individual to

adjust to the stressors of being in an unfamiliar culture and to maintain personal identity and values in unfamiliar settings.

Cultural Competence Evaluation (CCE)

The CCE (T.L. Freeman, personal communication, June 3, 207) contained 12 of the items from the results of the Delphi rounds. While the instrument addressed gender roles in the target culture, the other common items centered on traits of the individual clinician and included items such as flexibility, awareness of differences, self-evaluation of biases and prejudices, listening, empathy, communication skills, equity, social inclusion, and promotion of common good. Of note were the absence of cultural specific knowledge such as non-verbal communication, the roles of family, religion, food, and maternal-child care. An organizational focus of the CCE was evident in items concerning using cultural strengths to contribute to the organization, resistance of finding cultural scapegoats, and recruitment and selection of minorities. These items did not appear in the Delphi rounds.

Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals – Revised (IAPCC-R©)

The IAPCC-R© (Campinha-Bacote, 2003b) also contained 12 of the items from the results of the Delphi rounds. Like the CCE, the IAPCC-R© identified the importance of gender roles, but also includes items about worldview, disease incidence and prevalence, religious practices, ethnic pharmacology, and barriers to healthcare for the client. Provider attributes included caring, moral commitment, passion, awareness of differences, willingness to learn from others, and self-evaluation of biases and

prejudices. Notable areas that appeared in the Delphi results that did not appear in the IAPCC-R© included: language and non-verbal communication, the role of family and food, pregnancy and death patterns, and cultural beliefs about health and health care. Like the CCA, the IAPCC-R© focused on cultural assessment and the acquisition of knowledge about different cultures through resources such as education, consultation and training, items that were not present in the Delphi results. In addition, numerous items in the IAPCC-R© considered biological, anatomical and physiological variations. In the first round of the Delphi, both "occupation of participant/patient" and "knowledge of drug metabolism by participant's/patient's race" were eliminated from the Delphi list. These two items appeared in the IAPCC-R©. This discrepancy indicated disagreement between the expert panel and Campinha-Bacote (2007).

Cultural Self-Efficacy Scale (CSES)

The CSES (Bernal, 1993) contained 20 items or 25% of the items included in the Delphi results. These items included culture specific knowledge about gender roles, child rearing, the role of family, social status, disease incidence, food practices, religious and health care beliefs, and provider awareness of differences. Unlike the Delphi, the CSES contained a subscale that focuses on general cultural skills and included items such as distinguishing ethnocentrism from discrimination and ethnicity from culture. The CSES also had items that determine self-efficacy with using an interpreter, entering an ethnic community, advocacy, being a participant observer, and obtaining information from a diverse client concerning diet, life history, and a genogram. Like the IAPCC-R©,

the CSES contained items that were removed from the Delphi in the first round: economic style of living and employment patterns.

Transcultural Self-Efficacy Tool (TSET)

The TSET (Jeffreys, 2006) contained the highest percentage of items identified by the international nurse researcher as important antecedents to cultural competence with 52 items or 66% (see Tables 13 and 14). This instrument included topics in the Delphi results such as language, non-verbal communication, gender roles, child rearing, family, social status, foods, pregnancy, death, religion, health care beliefs, practices and inequalities, and culturally based physical assessment. Within the TSET, however, most of these items related to the nurse's comfort level in interviewing a diverse client about these topics. For items related to the clinician, the TSET evaluated awareness of differences, self-evaluation of biases and prejudices, and acceptance, all items identified as antecedents to cultural competence in the Delphi rounds. Items lacking in the TSET that appeared in the Delphi list included language concordance, disease incidence and prevalence, ethnic pharmacology, and provider traits such as willingness to learn, humility and openness. Conversely, the TSET determined the clinician's ability to recognize the need for cultural care preservation/maintenance, accommodation/negotiation, and repatterning/restructuring, decision modes described in Leininger's (2006) Culture Care Theory, in addition to the clinician's ability to advocate for the client. Items that appeared on the TSET that were removed from the Delphi by the international nurse researchers included the impact of political factors, educational background, and economic status.

Table 13. Comparison of Delphi survey findings and Transcultural Self-Efficacy Tool

Delphi Item	Present in TSET	Corresponding TSET Item(s)
Native culture of participant	Yes	Racial background and identity Ethnic background and identity
Education level of participant	Yes	Educational background and interests
Dominant language of participant	Yes	Language preference Level of English comprehension
Nurse researcher's ability to speak language of participant	No	
Nurse researcher's ability to read language of participant	No	
Spatial distancing with participant	Yes	Meanings of space and touch
Appropriate eye contact with participant	Yes	Meaning of non-verbal behavior
Understanding of facial expressions of participant	Yes	Meaning of non-verbal behavior
Use of greetings understood by participant	Yes	Meaning of verbal communication patterns
Understanding of participant's cultural orientation in past, present, or future	Yes	Time perception and orientation
Social meanings of time for participant	Yes	Time perception and orientation
Appropriate use of touch with participant	Yes	Meanings of space and touch

Delphi Item	Present in TSET	Corresponding TSET Item(s)
Acceptable use of names and/or titles with participant	No	
Understanding of gender roles in participant's culture	Yes	Gender role and responsibility
Understanding of child rearing practices in participant's culture	Yes	Role of children Growth and development
Understanding of definition of family in participant's culture	Yes	Role of family during illness Kinship ties
Understanding of importance of family in participant's culture	Yes	Role of family during illness Kinship ties
Family involvement in health care in participant's culture	Yes	Role of family during illness Role of family in providing health care
Individual vs. collective viewpoint in participant's culture	No	
Understanding of social status in participant's culture	Yes	Socioeconomic background
Understanding of worldview of participant's culture	Yes	
Understanding of head of household in participant's culture	Yes	Worldview (philosophy of life)
Knowledge of disease incidence and prevalence in participant's culture	No	
Common foods in participant's culture	Yes	Diet and nutrition
Knowledge of meaning of foods in participant's culture	Yes	Diet and nutrition

Delphi Item	Present in TSET	Corresponding TSET Item(s)
Food rituals in participant's culture	Yes	Diet and nutrition
Food taboos in participant's culture	Yes	Diet and nutrition
Use of food in illness and wellness in participant's culture	Yes	Diet and nutrition
Fertility practices in participant's culture	Yes	Pregnancy Sexuality
Birth control practices in participant's culture	Yes	Pregnancy Sexuality
Pregnancy practices in participant's culture	Yes	Pregnancy Sexuality
Views toward pregnancy in participant's culture	Yes	Pregnancy Sexuality
Death rituals in participant's culture	Yes	Dying and death
Bereavement patterns in participant's culture	Yes	Grieving and loss
Religious practices in participant's culture	Yes	Religious background and identity Religious practices and beliefs
Role of prayer in participant's culture	Yes	Religious background and identity Religious practices and beliefs
Role of spirituality in health/illness in participant's culture	Yes	Religious background and identity Religious practices and beliefs

Delphi Item	Present in TSET	Corresponding TSET Item(s)
Health care beliefs in participant's culture	Yes	Traditional health and illness beliefs Folk medicine tradition and use
Focus of health care (preventive vs. acute) in participant's culture	Yes	Traditional health and illness beliefs
Self-medication in participant's culture	No	
Ethnic pharmacology for participant's race	No	
Use of herbs in participant's culture	No	
Beliefs about pain in participant's culture	Yes	Pain relief and comfort
Barriers to health care in participant's culture	No	
Status of health care practitioner in participant's culture	Yes	Differences in perceived role of nurse
Type of health care practitioner typically consulted (magicoreligious, biomedical, etc.) in participant's culture	Yes	Traditional health and illness beliefs Folk medicine tradition and use
Explanatory model of illness (biomedical, spiritual, etc.) in participant's culture	Yes	Traditional health and illness beliefs
Folk systems of care in participant's culture	Yes	Folk medicine tradition and use Importance of home remedies and folk medicine

Delphi Item	Present in TSET	Corresponding TSET Item(s)
Culturally based physical assessment of participant	Yes	Physical examination
Caring	Yes	Traditional caring behaviors Professional caring behaviors
Platonic love	No	
Sacrifice of prejudice and bias	No	
Moral commitment	No	
Passion	No	
Openness	No	
Flexibility	No	
Awareness of differences	Yes	Differences within own cultural group Differences between cultural groups
Commitment to build on similarities	No	
Willingness to learn from others	No	
Humility	No	
Self-evaluation of biases and prejudices	Yes	Your own biases and limitations
Ethnosensitivity – accepting and valuing differences	Yes	Differences between cultural groups
Ethnorelativity – use of multicultural frame of reference in decision making	Yes	Need for cultural care accommodation/negotiation
Face-to-face encounters	Yes	Interaction with people of different cultures

Delphi Item	Present in TSET	Corresponding TSET Item(s)
Mutual understanding	Yes	Need for cultural care repatterning/restructuring
Respect	Yes	Accept client's refusal for treatment based on beliefs Advocate client's decisions based on cultural beliefs
Listening	No	
Understanding of history/how the society was shaped	No	
Empathy	No	
Communication skills	Yes	Language preference Level of English comprehension Meaning of verbal communication patterns
Equity	Yes	Inadequacies in U.S. health care system
Social inclusion	No	
Health inequalities	Yes	Inadequacies in U.S. health care system
Acceptance	Yes	Accept differences between cultural groups Accept similarities between cultural groups
Communitarianism	No	
Universality	No	
Gratitude	No	
Promotion of common good	No	

Delphi Item	Present in TSET	Corresponding TSET Item(s)
Humor	No	
Positivity	No	

Table 14. Comparison of Transcultural Self-Efficacy Tool and Delphi survey findings

TSET item	Present in Delphi	Corresponding Delphi item
Know and understand ways cultural factors may influence nursing care		
Health history and interview	No	
Physical examination	Yes	Culturally based physical assessment
Informed consent	No	
Health promotion	Yes	Focus of health care Health care beliefs
Illness prevention	Yes	Focus of health care Health care beliefs
Health maintenance	Yes	Focus of health care Health care beliefs
Health restoration	Yes	Health care beliefs
Safety	No	
Exercise and activity	No	
Pain relief and comfort	Yes	Beliefs about pain

TSET item	Present in Delphi	Corresponding Delphi item
Diet and nutrition	Yes	Common foods Knowledge of meaning of foods Food rituals Food taboos Use of food in illness and wellness
Patient teaching	No	
Hygiene	No	
Anxiety and stress reduction	No	
Diagnostic tests	No	
Blood tests	No	
Pregnancy	Yes	Pregnancy practices Views toward pregnancy
Birth	Yes	Pregnancy practices
Growth and development	Yes	Understanding of child rearing practices
Aging	No	
Dying and death	Yes	Death rituals Religious practices
Grieving and loss	Yes	Bereavement patterns
Life support and resuscitation	No	
Sexuality	Yes	Fertility practices Birth control practices
Rest and sleep	No	
Interview clients of different cultural backgrounds about		

TSET item	Present in Delphi	Corresponding Delphi item
Language preference	Yes	Dominant language
Level of English comprehension	Yes	Dominant language
Meaning of verbal communication patterns	Yes	Dominant language Use of greetings Acceptable use of names and/or titles
Meaning of nonverbal behaviors	Yes	Appropriate eye contact Understanding of facial expressions
Meanings of space and touch	Yes	Appropriate use of touch
Time perception and orientation	Yes	Social meanings of time Understanding of cultural orientation in past, present or future
Racial background and identity	Yes	Native culture
Ethnic background and identity	Yes	Native culture
Socioeconomic background	**	**Economic status of participant removed in round 1 of Delphi
Religious background and identity	Yes	Religious practices Role of prayer Role of spirituality
Educational background and interests	Yes	Education level
Religious practices and beliefs	Yes	Religious practices Role of prayer Role of spirituality
Acculturation	No	

TSET item	Present in Delphi	Corresponding Delphi item
Worldview (philosophy of life)	Yes	Understanding of worldview
Attitudes about health care technology	Yes	Healthcare beliefs and practices
Ethnic food preferences	Yes	Common foods Food rituals Food taboos
Role of elders	No	
Role of children	Yes	Child rearing practices
Financial concerns	**	**Economic status of participant removed in round 1 of Delphi
Traditional health and illness beliefs	Yes	Focus of health care Health care beliefs Explanatory model of illness
Folk medicine tradition and use	Yes	Folk systems of care
Gender role and responsibility	Yes	Understanding of gender roles
Acceptable sick role behaviors	No	
Role of family during illness	Yes	Family involvement in health care
Discrimination and bias experiences	No	
Home environment	No	
Kinship ties	Yes	Definition of family
Aging	No	
Awareness of YOUR OWN		

TSET item	Present in Delphi	Corresponding Delphi item
Cultural heritage and belief systems	No	
Biases and limitations	Yes	Self-evaluation of biases and prejudices
Differences within your own cultural group	No	
Among clients of different cultural backgrounds, you are aware of:		
Insensitive and prejudicial treatment	No	
Differences in perceived role of the nurse	Yes	Status of health care provider
Traditional caring behaviors	Yes	Folk systems of care
Professional caring behaviors	Yes	Caring
Comfort and discomfort felt when entering a culturally different world	No	
Interaction between nursing, folk and professional systems	No	
You accept		
Differenced between cultural groups	Yes	Awareness of differences Acceptance
Similarities between cultural groups	Yes	Acceptance
Client's refusal for treatment based on beliefs	Yes	Acceptance Respect

TSET item	Present in Delphi	Corresponding Delphi item
You appreciate		
Interaction with people of different cultures	Yes	Face-to-face encounters
Cultural sensitivity and awareness	Yes	Awareness of differences
Cultural-specific nursing care	No	
Role of family in providing health care	Yes	Family involvement in health care
Client's worldview (philosophy of life)	Yes	Understanding of worldview
You recognize		
Inadequacies in the U.S. health care system	Yes	Health inequalities Equity
Importance of home remedies and folk medicine	Yes	Folk systems of care
Impact of roles on health care practices	Yes	Status of health care provider
Impact of values on health care practices	Yes	Health care beliefs
Impact of socioeconomic factors on health care practices	No	
Impact of political factors on health care practices	**	Politics of participant's native country removed in round 1
Need for cultural care preservation/maintenance	No	

TSET item	Present in Delphi	Corresponding Delphi item
Need for cultural care accommodation/ negotiation	Yes	Ethnosensitivity Ethnorelativity
Need for cultural care repatterning/restructuring	Yes	Mutual understanding
Need to prevent ethnocentric views	**	Ethnocentrism removed in round 2
Need to prevent cultural imposition	No	
You advocate		
Client's decisions based on cultural beliefs	Yes	Respect
Cultural-specific care	No	

Comparison of Model of Ethical Multiculturalism and Delphi Results

In her evolutionary concept analysis of ethical multiculturalism, Harper (2006) integrated the antecedents of cultural competence from Campinha-Bacote's (1999) model of cultural competence and the antecedents identified by Suh's (2004) concept analysis of cultural competence. The Delphi findings were found to be more consistent with Campinha-Bacote's (2003b; 2007) updated model that contains the construct of cultural desire. Therefore, the findings of this research are compared to both Campinha-Bacote's most current model, the Process of Cultural Competence in the Delivery of Healthcare Services, and Suhs' concept analysis (see Table 15).

The Process of Cultural Competence in the Delivery of Healthcare Services (Campinha-Bacote, 2007) contained five constructs: cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters (see Figure 3). Each of these constructs was, in turn, made up of a number of elements. Tables 15 & 16 compare the elements of Campinha-Bacote's model with the results of the Delphi findings from this study.

Table 15. Comparison of Delphi findings, Campinha-Bacote model, and Suh model

Delphi Item	Campinha-Bacote Model (2003)	Suh Model (2004)
Native culture of participant	Cultural skill	Behavioral domain
Education level of participant	Cultural skill	Behavioral domain
Dominant language of participant	Cultural encounters	Behavioral domain
Nurse researcher's ability to speak language of participant	Cultural encounters	Behavioral domain
Nurse researcher's ability to read language of participant	Cultural encounters	Behavioral domain
Spatial distancing with participant	Cultural skill	Behavioral domain
Appropriate eye contact with participant	Cultural encounters	Behavioral domain
Understanding of facial expressions of participant	Cultural encounters	Behavioral domain
Use of greetings understood by participant	Cultural encounters	Behavioral domain
Understanding of participant's cultural orientation in past, present, or future	Cultural skill	Behavioral domain
Social meanings of time for participant	Cultural skill	Behavioral domain

Delphi Item	Campinha-Bacote Model (2003)	Suh Model (2004)
Appropriate use of touch with participant	Cultural skill	Behavioral domain
Acceptable use of names and/or titles with participant	Cultural encounters	Behavioral domain
Understanding of gender roles in participant's culture	Cultural skill	Behavioral domain
Understanding of child rearing practices in participant's culture	Cultural skill	Behavioral domain
Understanding of definition of family in participant's culture	Cultural skill	Behavioral domain
Understanding of importance of family in participant's culture	Cultural skill	Behavioral domain
Family involvement in health care in participant's culture	Cultural skill	Behavioral domain
Individual vs. collective viewpoint in participant's culture		Behavioral domain
Understanding of social status in participant's culture	Cultural skill	Behavioral domain
Understanding of worldview of participant's culture	Cultural knowledge	Cognitive domain
Understanding of head of household in participant's culture	Cultural skill	Cognitive domain
Knowledge of disease incidence and prevalence in participant's culture	Cultural knowledge	Cognitive domain
Common foods in participant's culture	Cultural skill	Behavioral domain
Knowledge of meaning of foods in participant's culture	Cultural skill	Cognitive domain
Food rituals in participant's culture	Cultural skill	Behavioral domain

Delphi Item	Campinha-Bacote Model (2003)	Suh Model (2004)
Food taboos in participant's culture	Cultural skill	Behavioral domain
Use of food in illness and wellness in participant's culture	Cultural skill	Behavioral domain
Fertility practices in participant's culture	Cultural skill	Behavioral domain
Birth control practices in participant's culture	Cultural skill	Behavioral domain
Pregnancy practices in participant's culture	Cultural skill	Behavioral domain
Views toward pregnancy in participant's culture	Cultural skill	Behavioral domain
Death rituals in participant's culture	Cultural skill	Behavioral domain
Bereavement patterns in participant's culture	Cultural skill	Behavioral domain
Religious practices in participant's culture	Cultural skill	Behavioral domain
Role of prayer in participant's culture	Cultural skill	Behavioral domain
Role of spirituality in health/illness in participant's culture	Cultural skill	Behavioral domain
Health care beliefs in participant's culture	Cultural skill	Behavioral domain
Focus of health care (preventive vs. acute) in participant's culture	Cultural skill	Behavioral domain
Self-medication in participant's culture	Cultural knowledge	Behavioral domain
Ethnic pharmacology for participant's race	Cultural knowledge	Behavioral domain
Use of herbs in participant's culture	Cultural knowledge	Behavioral domain
Beliefs about pain in participant's culture	Cultural knowledge	Behavioral domain
Barriers to health care in participant's culture	Cultural knowledge	Behavioral domain
Status of health care practitioner in participant's culture	Cultural knowledge	Behavioral domain

Delphi Item	Campinha-Bacote Model (2003)	Suh Model (2004)
Type of health care practitioner typically consulted (magicoreligious, biomedical, etc.) in participant's culture	Cultural knowledge	Behavioral domain
Explanatory model of illness (biomedical, spiritual, etc.) in participant's culture	Cultural knowledge	Behavioral domain
Folk systems of care in participant's culture	Cultural skill	Behavioral domain
Culturally based physical assessment of participant	Cultural skill	Behavioral domain
Caring	Cultural desire*	
Platonic love	Cultural desire*	
Sacrifice of prejudice and bias	Cultural desire*	Cognitive domain
Moral commitment	Cultural desire*	
Passion	Cultural desire*	
Openness	Cultural desire*	
Flexibility		
Awareness of differences	Cultural desire*	Affective domain
Commitment to build on similarities	Cultural desire*	
Willingness to learn from others	Cultural desire*	
Humility	Cultural desire*	
Self-evaluation of biases and prejudices	Cultural awareness	Cognitive domain
Ethnosensitivity – accepting and valuing differences	Cultural desire*	Cognitive domain
Ethnorelativity – use of multicultural frame of reference in decision making		

Delphi Item	Campinha-Bacote Model (2003)	Suh Model (2004)
Face-to-face encounters	Cultural encounters	Environmental domain
Mutual understanding		
Respect	Cultural desire*	Affective domain
Listening	Cultural encounters	Behavioral domain
Understanding of history/how the society was shaped		Cognitive domain
Empathy	Cultural encounters	
Communication skills	Cultural encounters	Behavioral domain
Equity	Cultural desire*	
Social inclusion	Cultural desire*	
Health inequalities	Cultural desire*	
Acceptance		Affective domain
Communitarianism	Cultural desire*	
Universality	Cultural desire*	
Gratitude		
Promotion of common good	Cultural desire*	
Humor		
Positivity		

Cultural desire: spiritual component, includes motivation to become culturally competent
*(not in 1999 model from which model of ethical multiculturalism was drawn)
Cultural awareness: consciousness of own attitudes and assumptions
Cultural knowledge: cognitive awareness of race/ethnicity specific diseases and response to treatment
Cultural skill: ability to assess
Cultural encounters: interactions with diverse others, includes linguistics

Table 16. Comparison of Campinha-Bacote model with Delphi findings

Campinha-Bacote (2003) model	Delphi item
Cultural Desire (not included in 1999 model)	
Caring	Caring
Love	Platonic love
Recognition of differences	Awareness of differences
Build on similarities	Commitment to build on similarities
Passion	Passion
Sacrifice of bias and prejudice	Sacrifice of prejudice and bias
Moral commitment	Moral commitment
Social justice	Equity/social inclusion Health inequalities Promotion of common good Universality
Humility	Humility
Commitment to be open	Openness
Respect for differences	Awareness of differences Ethnosensitivity – accepting and valuing differences Respect
Willingness to learn	Willingness to learn
Human rights	Communitarianism
Human dignity	Communitarianism
Cultural Awareness	
Recognition of personal biases and prejudices and discriminatory practices	Self-evaluation of biases and prejudices

Campinha-Bacote (2003) model	Delphi item
Respectful attitude	Respect
Cultural openness	Openness
Cultural Knowledge	
Health related beliefs, practices, and values	Health care beliefs Beliefs about pain Barriers to health care Status of health care practitioner Types of health care practitioner Explanatory model of illness
Understanding of worldview	Understanding of worldview
Disease incidence and prevalence	Knowledge of disease incidence and prevalence
Treatment efficacy	
Ethnic pharmacology	Ethnic pharmacology Self-medication
Client use of herbs	Use of herbs
Diagnostic clarity (maintenance of diagnostic objectivity)	
Recognition of intracultural variation	
Cultural Skill	

Campinha-Bacote (2003) model	Delphi item
Cultural assessment (includes all domains in Purnell's model)	Native culture Current residence Education level Temporality Appropriate use of touch Social meanings of time Understanding of gender roles Child rearing Definition of family Importance of family Family involvement in health care Social status Common foods Meaning of foods Food rituals Food taboos Use of food in illness and wellness Fertility practices Birth control practices Pregnancy practices Views toward pregnancy Death rituals Bereavement patterns Religious practices Role of prayer Role of spirituality in health/illness Folk systems of care
Culturally based physical assessment	Culturally based physical assessment
Cultural Encounters	
Linguistic competence	Nurse researchers ability to speak/read language Use of greetings Acceptable use of names/titles Communication skills
Patient's linguistic preference	Dominant language of participant
Use of translators	*Addressed in focus group

Campinha-Bacote (2003) model	Delphi item
Trust	*Addressed in focus group
Health literacy	
Cultural conflict	
Compassion	Empathy
Listening	Listening Communication skills
Attentiveness	Communication skills
Non-verbal cues (facial expressions, gestures)	Appropriate eye contact Understanding of facial expressions
Telephone encounters	* Removed by expert panel
Internet encounters	Internet encounters

Suh (2004) categorized the antecedents of cultural competence along four domains: cognitive, affective, behavioral, and environmental. Campinha-Bacote's (2003b) cultural awareness construct was found within the cognitive domain. Suh also placed cultural knowledge within the cognitive domain. Suh included political, social, historical, and economic components in cultural knowledge whereas Campinha-Bacote did not. Expanding the description of cultural knowledge using Suh's description allowed for the incorporation of the Delphi items understanding of history/how society was shaped and individual vs. collective viewpoints from the Delphi findings of this study. The comparison of the Delphi items with the Campinha-Bacote (2003b; 2007) and Suh

(2004) models indicated that the model of ethical multiculturalism is missing the construct of cultural desire.

Electronic Focus Group Findings

The primary purpose of the focus group was to validate the findings of the Delphi rounds. Seven questions were posed for the group's response.

Focus Group Question One

The first question for the electronic focus group was: Compare the results of the Delphi method with your conceptualization of what makes an international nurse researcher culturally competent. Sixty-nine percent (n = 11) of the focus group participants responded to this question. One respondent indicated that "experience, experience and more experience in-country" is needed, drawing agreement from two other respondents. Seven participants concurred that cultural competence is not achievable and occurs on a continuum. One participant expressed this idea as follows:

> The results of the Delphi survey include most of the skills or attitudes that are important on the road to becoming culturally sensitive (I use that word because I am not sure that anyone becomes truly competent in another culture)…

Gaps in conceptualization identified by the participants included "the continuum on which competence occurs and the specificity of the culture…" and "acknowledging power differences and how they inform our research questions and methods…."

Focus Group Question Two

In the second question of the electronic focus group, participants were asked: Do you disagree with any of the findings of the Delphi portion of the study and if so, why? Fifty-six percent of the focus group respondents (n = 9) answered this query. Of these nine participants, 56% (n = 5) agreed with the findings, 11% (n = 1) disagreed and 33% (n = 3) stated “it depends” on context. A respondent who agreed with the findings stated, “I think this illustrates how many factors come into play when conducting international research.” The individual who disagreed with the Delphi results stated that she disagreed with the removal of “economic status of participant/patient” and “politics of participant’s/patient/s native country.” She stated, “In my experience, you cannot understand a developing or transitional country’s culture if you don’t understand the economic and political issues (present and historical).”

Focus Group Question Three

For the third question in the electronic focus group, respondents were asked: Is there anything you wish you had brought up in the Delphi rounds that we can discuss now? Again, 56% (n=9) of the focus group participants responded to this question. Three topics emerged from the discussion: use of translators (interpreters), culture brokers, and participatory action research. Each of these topics was mentioned by three participants. One individual stated, “Learning to work with translators [interpreters] is an important skill that really will make or break a research study….” Another participant countered, “I believe more focus should be placed on cultural brokers rather than just translators [interpreters].” Then the discussion moved to participatory action research

and one respondent stated, “What part do participants have in determining what is researched in collaboration with the researcher, and are they considered researchers too?”

Focus Group Question Four

In question four of the electronic focus group, participants were asked to identify behaviors that promote the success of a nurse researcher in a culture different from his/her own in the country of the participant. Sixty-nine percent (n = 11) of the focus group participated in this threaded discussion. The most frequent response, given by five respondents, was the ability to earn the trust of authorities and participants. Discussion ensued about the necessity of balancing connections with in-country authorities and research participants. One respondent put it this way: “ …it is equally important not to be too closely connected, particularly to government agencies, in case people feel threatened about responding honestly to research questions.” In addition to earning trust, three respondents cited the importance of having a “willingness to listen and learn” as important behaviors to promote success.

Focus Group Question Five

In question five of the electronic focus group, participants were asked to respond to the following: “Globalization of health care has caused nursing leaders to call for a ‘global nursing ethic.’ How would you conceptualize this ‘global nursing ethic’?” This query elicited responses from ten respondents. Four of these respondents called for standardization of definitions of the terms “international,” “global,” and “cultural,”

indicating that “blurring and interchangeable use” frequently occurs. Two participants concurred that before a “global nursing ethic” can be defined, basic education is needed to help nurses understand the “impact of globalization on health in communities, families, women and children throughout the world.” Other individuals indicated that the “global nursing ethic” may include “respect,” “considering the impact of what we do,” and “keeping participants safe.”

Focus Group Question Six

In question six of the electronic focus group, participants were given the opportunity to discuss the following items from the Delphi survey that achieved consensus but had wide dispersion of responses: “native culture of participant/patient,” “education level of participant/patient,” “dominant language of participant/patient,” “nurse researcher's ability to read language of participant/patient,” “platonic love,” and “universality.” Ten respondents participated in this thread of the discussion. Three participants indicated that “native culture,” “education level,” “dominant language,” and “nurse researcher’s ability to read the language” implied that matching researchers and participants was important. Their low ranking of these items indicated their opinion that matching is not necessary. As one participant stated, “I don’t believe that a person has to be of the same culture, speak the same language, and have the same educational level as participant to understand or appreciate the culture and their traditions.” Respondents also noted that the definition and context of “universality” and “platonic love” were unclear. Lack of clarity of definitions, particularly “platonic love” and

"universality," was a reason given by three participants for the wide dispersion of responses.

Focus Group Question Seven

The final question of the electronic focus group sought to clarify participants' ideas about culture brokers. Respondents were asked, "How do you differentiate between a key informant and a culture broker?" Only one response was obtained to this query. This participant identified a key informant as one who "is knowledgeable about the culture and can help explain it to you." A culture broker is "more of a liaison."

Consensual Thematic Analysis

Consensual thematic analysis of all responses to the online threaded discussion yielded six themes: chimerical, contextual, contact, collaboration, connections, and considering impact (see Table 17).

Chimerical (Unrealistic)

Participants generally referred to cultural competence as an unrealistic goal. Codes found in the chimerical theme include complex and continuum. One participant stated, "Culture is the entire way of life and therefore very complex." Another stated, "Cultural competence occurs on a continuum… even when you believe you are competent, you can always learn more!" Yet another stated, "We can be sensitive and aware, but will never completely understand."

Contextual

Contextual components of cultural competence and culturally competent research were stressed by the participants and included issues such as locale, culture, intracultural differences, the type of research, and the macroenvironment. As one participant explained,

> When referring to cultural competence, it needs to be done in context of a specific culture. For example, you cannot say you are competent in the Hispanic culture… even if you are Hispanic yourself. There are too many subcultures, geographical variations, dialects, etc to make such a generalization.

Subcultures account for intracultural differences and "can be so subtle that the novice may not even notice but it can be extremely significant." Another participant indicated that for research, it may be necessary to only be familiar with "elements of culture that impinge on a particular research topic … without understanding everything about another culture."

Table 17. Consensual thematic analysis of online focus group data

Theme/Components	Participant Comments
Chimerical (unrealistic) Complex Continuum	P2: The results of the Delphi survey include most of the skills or attitudes that are important on the road to becoming culturally sensitive (I use that word because I am not sure that anyone becomes truly competent in another culture). P27: Cultural competence occurs on a continuum…even when you believe you are competent, you can always learn more! P9: I feel that we will never be culturally competent in a culture that is not our own. We can be sensitive and aware, but will never completely understand. P7: I do not disagree with the Delphi findings. I think this illustrates how many factors come into play when conducting international research. P3: Culture is the entire way of life and therefore very complex.
Contact	P2: If you are asking what makes a nurse researcher culturally competent I would say "experience, experience and more experience in-country." P19: I would concur … that experience in the country (living and working) is important before you conduct any research. P16: I agree – in-country experience, the more the better, increases your cultural sensitivity .
Contextual Locale Culture Intracultural differences Type of research Macroenvironment	P27: When referring to cultural competence, it needs to be done in context of a specific culture. For example, you cannot say you are competent in the Hispanic culture…even if you are Hispanic yourself. There are too many subcultures, geographical variations, dialects, etc to make such a generalization. P20: You probably need to be conversant with (or at least willing to learn about) the elements of culture that impinge on a particular research topic and the conduct of research

Theme/Components	Participant Comments
	related to that topic without understanding everything about another culture. P3: Different aspects take on varying importance depending on the situation. P9: As in the United States, there are multiple subcultures in any country and they can be so subtle that the novice may not even notice but it can be extremely significant. P2: In my experience, you cannot understand a developing or transitional country's culture if you don't understand the economic and political issues (present and historical). P36…we need to understand the macro-environment that helps shape health, health behaviors, and access to health care.
Collaboration Gaining entrée Participatory action research Beyond translators/interpreters to culture brokers	P2: Learning to work with translators [interpreters] is an important skill that really will make or break a research study in a non-English speaking country (unless the researcher is fluent in that language). P20: I agree, working with translators/interpreters is a critical issue that can totally invalidate your findings if not addressed at the outset. In participatory action research, community members (subjects) become your culture brokers as well as active participants in the design, implementation, interpretation, (and hopefully, use) of the research. P31: I believe more focus should be placed on cultural brokers rather than just translators [interpreters]. Language is …not the overarching factor to cultural competence. P9: I agree that a cultural broker is essential. Even if you speak the language, you need someone to interpret the culture. P36: Perhaps a critical question is whose research question is it anyway? What part do participants have in

Theme/Components	Participant Comments
	determining what is researched in collaboration with the researcher, and are they considered researchers too? It seems that an approach that is born of what the community wants would be the most culturally competent. P7: I have used translators [interpreters], but instinctively sought out and utilized culture brokers in the process of conducting research. P3: I have to give the foreign team the autonomy to help me plan the study in a culturally acceptable way. P15 … working with data collectors as equal partners in the research process. P16: Maintaining trusting, collaborative relationships over time provides credibility for the researcher, and increases the opportunities for additional research. P25: Because of the …relationships that were formed, access was granted. P21: Without the gate opened up by the authority in our case, the observations and interviews would not have been possible.
Connections Balance between authorities and participants	P2…A major factor in the success of a research study conducted in another country includes being connected and trusted by authorities within the country (be they NGO, government, or health care officials – or all three if possible). This involves the development of trust between the key stakeholders and the researcher and maintaining connections even when you are not in country. P20: However, it is equally important not to be too closely connected, particularly to government agencies, in case people feel threatened about responding honestly to research questions. P7: I have found that you must strike a fine balance between the relationship with governmental officials and your participants. We want to get the most accurate responses, not just what participants think is expected.

Theme/Components	Participant Comments
	P9: I … would add my vote of caution of being careful about the data you share with in-country agency groups. You must be careful to protect the participants. P36: Acknowledging power differences and how they inform our research questions and methods should be part of growing cultural competence.
Considering impact Wholesale import of ideas Ethical considerations	P20: To me this means considering the impact of what we do (in terms of health care and activities of other segments of society, e.g., economics) on the health care of all people wherever they reside. One example that comes to mind is the development of theories of nursing that may be appropriate here in the US and then trying to import them wholesale into other countries and cultures. The same is true of aspects of health care delivery (e.g., use of nurse practitioners or educations of NPs at a doctoral level) that may or may not be appropriate for other parts of the world. The primary ethical directive for nursing practice would be, as I see it, to do good and not to do harm in whatever we do. P36: I think that classical ethics, while it may have something to contribute, is not enough without new ethical frameworks….Certainly keeping participants safe will also be of paramount importance. P35 … showing that the research is not for academic purposes only but also to be applied for the good of all concerned.

Contact

Many participants emphasized the importance of face-to-face encounters or contact within the country of research. “If you are asking what makes a nurse researcher culturally competent I would say ‘experience, experience and more

experience in [a] country [other than one's own]." Another participant stressed the importance of both living and working in the country before conducting research there.

Collaboration

Participants in the electronic focus group identified collaboration as being of prime importance for the culturally competent nurse researcher. Collaboration involved gaining entrée into the country/culture, moving beyond translators/interpreters to culture brokers, and conducting participatory action research. One nurse researcher asserted that "maintaining trusting, collaborative relationships over time provides credibility for the researcher, and increases the opportunities for additional research." Other participants recounted the importance of relationships to gaining access while another emphasized the importance of the "authority" of the gatekeeper. While the participants agreed that "learning to work with translators [interpreters] is an important skill that will make or break a research study in a non-English speaking country (unless the researcher is fluent in that language)," the role of the culture broker was seen as "essential." "Even if you speak the language, you need someone to interpret the culture." The importance of collaboration was demonstrated in the following quote:

> Perhaps a critical question is whose research is it anyway? What part do participants have in determining what is researched in collaboration with the researcher, and are they considered researchers too? It seems that an approach that is born of what the community wants would be the most culturally competent.

> In such participatory action research, community members (subjects) become your culture brokers as well as active participants in the design, implementation, interpretation, (and hopefully, use) of the research.

Connections

Connections were closely related to collaboration. The nurse researchers stressed the importance of striking a balance between in-country authorities and participants. One participant stated:

> … a major factor in the success of a research study conducted in another country includes being connected and trusted by authorities within the country (be they NGO [non-governmental organization], government, or health care officials – or all three if possible). This involves the development of trust between the key stakeholders and the researcher and maintaining connections even when you are not in country.

Another participant cautioned, "…you must strike a fine balance between the relationship with governmental officials and your participants. We want to get the most accurate responses, not just what participants think is expected." Yet another respondent stated that being overly close to government agencies may cause participants to "feel threatened about responding honestly to research questions." Finally, an electronic focus group respondent summarized the importance of connections to cultural competence by stating, "Acknowledging power differences and how they inform our research questions and methods should be part of growing cultural competence."

Considering Impact

The final theme that emerged from the data was considering impact and included the wholesale import of ideas and ethical considerations. One respondent explained:

> …this means considering the impact of what we do (in terms of health care and activities of other segments of society, e.g., economics) on the health care of all people wherever they reside. One example that comes to mind is the development of theories of nursing that may be appropriate here in the US and then trying to import them wholesale into other countries and cultures. The same is true of aspects of health care delivery (e.g., use of nurse practitioners or education of NPs at a doctoral level) that may or may not be appropriate for other parts of the world. The primary ethical directive for nursing practice would be… to do good and not to do harm in whatever we do.

Another respondent called for "new ethical frameworks" while acknowledging that client safety is of "paramount importance." The final ethical consideration identified by the participants was "showing that the research is not for academic purposes only but also to be applied for the good of all concerned."

Research Questions

Research Question One

The first research question was: What are the key attributes of cultural competence? The results of the two Delphi rounds elicited a list of 80 concepts and behaviors that the expert panel identified as important in achieving cultural competence when conducting research with a culture different from their own (see Table 11). The

online threaded discussion validated the results of the Delphi findings. The qualitative data supported the notion that cultural competence is complex and that it is difficult to describe the associated skills. One participant stated, “I think this illustrates how many factors come into play….”

Research Question Two

The second research question was: Do extant instruments that measure cultural competence measure key attributes identified by the expert panel of participants? Of the instruments reviewed, the TSET (Jeffreys, 2006) measured the highest number of attributes identified by the expert panel of international nurse researchers. Tables 13 and 14 show the correspondence between the Delphi items and the TSET items. The TSET, as seen in Appendix B, was formatted to ask about personal perceptions of knowledge, confidence with interviewing, awareness, acceptance, appreciation, and recognition. It was designed to measure self-efficacy in the area of cultural competence.

Research Question Three

The final research question was: Are the antecedents of cultural competence in Harper’s model of ethical multiculturalism consistent with the attributes identified by international nurse researchers? Table 15 shows the comparison of the Delphi results and the Campinha-Bacote (1999) and Suh (2004) models from which Harper (2006) derived the antecedents of cultural competence in her model of ethical multiculturalism. Essentially, the findings of this mixed method approach found that Harper’s model of ethical multiculturalism lacks the antecedent of cultural desire. Cultural desire is an

affective domain that has recently been added to Campinha-Bacote's model (Campinha-Bacote, 2003a, 2003b, 2005, 2007) and that was supported by the findings of this study.

Summary

A mixed methods study using a Delphi survey and an electronic focus group with a sample of international nurse researchers identified 80 antecedents of cultural competence. A comparison of the results of the Delphi to instruments that measure cultural competence found that the TSET contains the most attributes identified by the expert panel in this study. Further comparison of Delphi items to Harper's model of ethical multiculturalism demonstrated that the antecedent of cultural desire is missing from the model. Qualitative results obtained from the electronic focus group validated the Delphi findings and indicated six themes of cultural competence in the international research arena: chimerical, contact, contextual, collaboration, connections, and considering impact.

CHAPTER 5: CONCLUSIONS, DISCUSSION, AND IMPLICATIONS

Globalization has focused the attention of the nursing profession on the development of a “global nursing ethic” (Crigger, 2008). Harper’s model of ethical multiculturalism may provide a beginning framework for this “global nursing ethic” through its identification of the need to balance universal ethical principles within the cultural context of the client (Harper, 2006). Cultural competence is an attribute of ethical multiculturalism.

The threefold purpose of this research was to identify the essential antecedents of cultural competence as identified by international nurse researchers, to compare the content of the extant cultural competence instruments to these antecedents and to potentially identify gaps in their conceptualization. A secondary aim of this research was to initiate validation of Harper’s (2006) model of ethical multiculturalism.

A Delphi method determined the attributes of cultural competence as identified by a sample of international nurse researchers. A comparison of the results of the Delphi to instruments that measure cultural competence found that the TSET contains the most attributes identified by the expert panel in this study. Further comparison of Delphi items to the model of ethical multiculturalism demonstrated that the antecedent of cultural desire is missing from Harper’s (2006) model. Qualitative results obtained from an electronic focus group validated the Delphi findings and indicated six themes of cultural competence in the international research arena: chimerical, contact, contextual, collaboration, connections, and considering impact. The following discussion will

present conclusions reached, further questions raised, and implications of the findings from this study for policy and nursing research, education, and practice.

Can Cultural Competence Be Achieved?

The controversy surrounding the term “cultural competence” is evident from the first Delphi round of this study when a participant did not complete the round, stating the term is “misleading.” Other participants state that nurses could only aspire to be “culturally sensitive.” Yet another participant summarizes the discussion stating,

> …cultural competence does not mean to know everything from A to Z about a culture. I agree with the participants that this goal is impossible to reach. For a nurse or researchers, cultural competence involves the ability to work productively with people of other cultures (not to become like them).

Similarly, Capell, Veenstra, and Dean (2007) argue that the term cultural sensitivity is more appropriate than the term cultural competence to describe the attributes of healthcare professionals. They propose that use of the term cultural competence be limited to care that produces improvement in client outcomes. They further suggest that the cultural sensitivity of healthcare providers may be one component of culturally competent care.

This study highlights the current lack of conceptual consensus for cultural competence described by the Office of Minority Health (Fortier & Bishop, 2004). The expert panel in this study indicates that cultural competence may not be achievable and that at the most a nurse may achieve a high level of sensitivity or awareness. Crigger and Holcomb (2007) disparage the term cultural competence altogether asserting that

the term implies that an individual may understand another culture simply through "study and exposure" (p. 73). They acknowledge that only those who are born into a culture may understand that culture in its entirety. They concede, however, that cultural competence is a process, not an outcome.

Like Crigger and Holcomb (2007), Campinha-Bacote (2007) views cultural competence as a process whose outcome is "the ability and availability to work effectively within the cultural context of the patient" (p. 15). Leininger (2007) refers to this outcome as "culturally congruent care" (p. 9) as do Purnell (2005) and Schim et al. (2007). Likewise, a member of the expert panel in this study summarizes the findings when she states, "…cultural competence involves the ability to work productively with people of other cultures." These views are consistent with the American Academy of Nursing's definition that refers to the outcome of the process of cultural competence as "acceptable cultural care" (Giger et al., 2007a, p. 100).

Given the current recognition of cultural competence as a process with an outcome of providing acceptable care to a person from another culture, the question is not "Can cultural competence be achieved?" but rather "Can nurses provide acceptable care to a person of another culture?" The recipient of care is the one who must answer this question.

In their study of client perceptions of physicians' cultural competence, Thom and Tirado (2006) report a lack of correlation between physician self-reported cultural competence and client perceptions of the physician's cultural competence. In addition, they state that client perceptions were more accurate predictors of outcomes of care than physician perceptions. Similarly, in a qualitative study of nurse and client

perceptions of British nurses' cultural understanding of Pakistani clients' culture, Cortis and Kendrick (2003) report that the perceptions of the nurses and their clients differed with nurses viewing themselves more favorably than the clients. These findings underscore the importance of assessing the perceptions of the recipients of care.

Key informants are essential to conducting culturally competent research, according to the expert panel in this study. One participant states, "A key informant is knowledgeable about the culture and can help explain it to you." Bernard (2006) differentiates a key informant from a specialized informant. A specialized informant has noteworthy knowledge of a particular aspect of the culture. These informants are experts and may provide useful knowledge about the domain of interest. Specialized informants, clients who have extensive knowledge about the medical domain of their cultures, may be the best source to identify what constitutes culturally acceptable care in their particular society.

Measurement of Cultural Competence

Of the instruments reviewed, the TSET (Jeffreys, 2006) measures the most attributes identified by the expert panel of international nurse researchers. Principle component factor analysis with varimax rotation of the TSET reveals nine factors (Jeffreys, 2006; Jeffreys & Smodlaka, 1998): appreciation, self-awareness, communication, awareness of cultural gap, life cycle transitional phenomena, cultural background and identity, professional nursing care, kinship and social factors, and recognition. Many items on the Delphi that do not appear on the TSET are easily conceptualized as relating to one of these factors. For example, Delphi items that may

relate to the communication factor include: the nurse's ability to speak and read the language of the participant/client, the acceptable use of names, and listening. Knowledge of disease incidence and prevalence, ethnic pharmacology, self-medication, and use of herbs may be components of the professional nursing care factor. Individual vs. collective viewpoint, communitarianism, universality, and social inclusion may be seen as kinship and social factors. Platonic love, sacrifice of prejudice and bias, moral commitment, passion, openness, flexibility, empathy, humor, positivity, and humility may all be items that contribute to the self-awareness factor while commitment to build on similarities, willingness to learn from others, and gratitude may be components of the appreciation factor in the TSET. Understanding of history/how the society was shaped may feasibly be conceptualized as relating to the cultural background and identity factor. Research with factor analysis may confirm if these Delphi items fit into the current TSET factors. Based on the findings from this study, two Delphi items are missing from the TSET, barriers to health care in the participant's culture and promotion of the common good, and may represent gaps in its conceptualization.

Of the instruments evaluated in this study, the TSET is the most promising extant instrument for self-assessment of cultural competence. Unfortunately, the length of the instrument, 83 items, presents challenges for its evaluation and use. Since the instrument measures self-efficacy related to cultural competence, research is needed to determine if this variable is associated with cultural competence behaviors. TSET scores must be compared to client perceptions and the assessment of what constitutes culturally competent behaviors by specialized informants, individuals with expertise in a particular aspect of the culture. If transcultural self-efficacy is found to predict culturally

competent behaviors, the TSET could provide a mechanism for evaluation of strategies designed to enhance the cultural competence of students and nurses.

The TSET may prove useful as a tool to help a nurse who is conducting cross-cultural research identify personal strengths and weaknesses. Since cultural competence is an attribute of ethical multiculturalism, nurse researchers ideally should be well advanced in the process of cultural competence to be able to apply fundamental ethical principals in a contextually relevant manner.

A Model of Ethical Multiculturalism

As currently depicted, the base of Harper's (2006) model of ethical multiculturalism contains cultural awareness, cultural knowledge, cultural sensitivity, cultural skills and cultural encounters as antecedents of cultural competence, all of which are supported by the findings of this study. Cultural desire is not included in the original model. Harper (2006) acknowledged that caring and cultural desire may indeed be antecedents of ethical multiculturalism but found insufficient evidence in the literature to support their inclusion in the original model. However, this study supports cultural desire, with caring as one component, as an antecedent of cultural competence. As a result, the model is revised to include cultural desire (see Figure 4).

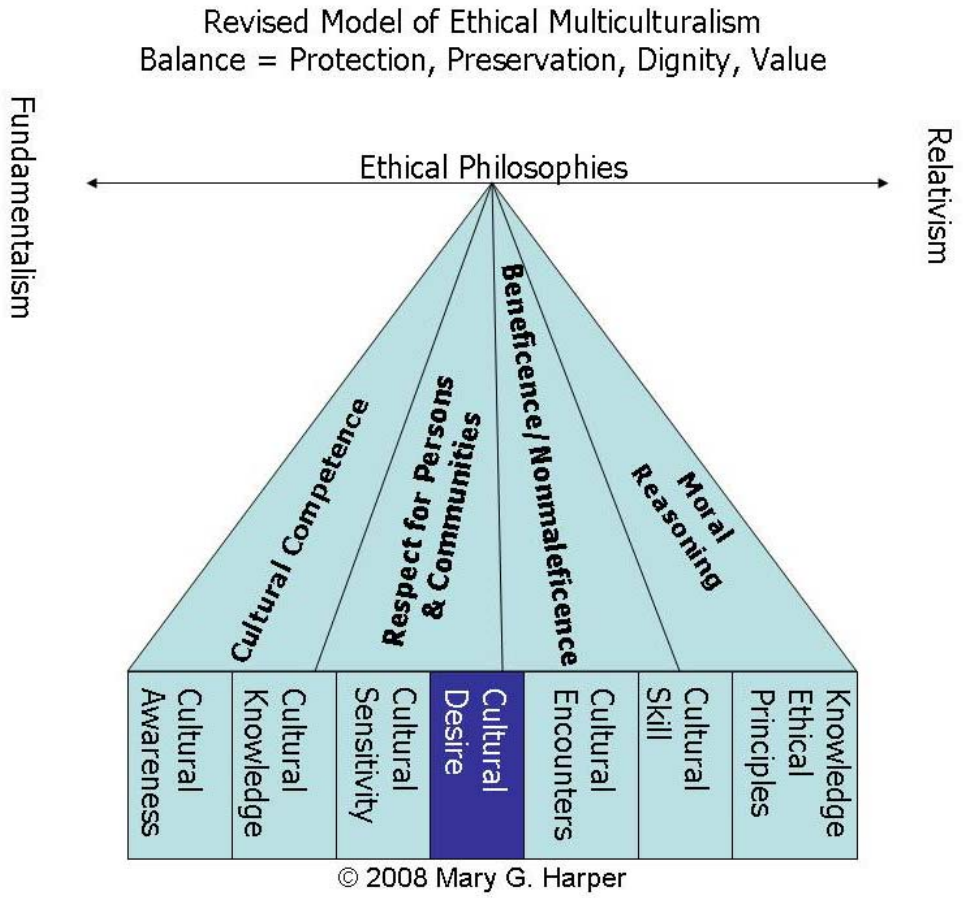


Figure 4. Revised model of ethical multiculturalism

Further research is warranted into Harper's (2006) model of ethical multiculturalism. Delphi items from this study that do not appear in either Campinha-Bacote's (2007) model or Suh's (2004) model from which the base of Harper's model was conceived, include flexibility, ethnorelativity, mutual understanding, gratitude, humor, and positivity. Research may determine if these attributes are included in the domain of cultural desire.

Interviews with international nurse researchers to determine how they balance ethical principles in the context of research are needed (Harper, 2006). Field observation of nurse researchers conducting research with diverse populations may

provide further clarification of if and how balance is achieved in the conduct of research. In turn, that information may lead to a practice framework for transcultural research. The results of such research may inform the development of a global nursing ethic.

Harper's (2006) model of ethical multiculturalism provides a schematic for teaching nurses the contextual nature of ethics, not only in cross-cultural research but also in clinical practice. On one hand, globalization and its resultant diversity of populations has rendered a strictly Western ethical perspective obsolete (Lutzen, 1997). Therefore, ethical principals must be viewed from the context of the culture of the client as this determines beliefs, values, assumptions and expectations (Endicott, Bock, & Narvaez, 2003).

Participatory Action Research

Matching clinician or researcher and clients is one mechanism that has been used in both practice and research in an effort to deliver culturally acceptable care (Sawyer et al., 1995; Ton, Koike, Hales, Johnson, & Hilty, 2005). Matching clients and health care providers on the basis of race, ethnicity, and/or language has demonstrated improvement in health service utilization but not health outcomes (Fortier & Bishop, 2004; Smedley et al., 2003). In research, matching is onerous and often imprecise (Sawyer et al., 1995). Participants in this study do not find matching to be necessary to conduct culturally competent research. One participant states, "I don't believe that a person has to be of the same culture, speak the same language, and have the same educational level as participant to understand or appreciate the culture and their traditions." Another participant states:

> I agree that this can be an advantage to the research, but by itself without the skills and attitudes, cannot guarantee success. There are skills and attitudes that I believe one must cultivate in order to gain insight into a group of individuals.

Sawyer et al. (1995) agree with these participants and offer three criteria for the promotion of culturally competent research: cultural knowledge, cultural sensitivity, and collaboration.

The expert panel in this Delphi study focus on collaboration as an essential component of culturally competent research and advocate the benefits of participatory action research. One participant expresses it in these words:

> Perhaps a critical question is whose research question is it anyway? What part do participants have in determining what is researched in collaboration with the researcher, and are they considered researchers too? It seems than an approach that is born of what the community wants would be the most culturally competent.

One participant points out, "…another overarching competency is the ability to engage 'subjects' in participatory action research on topics that are meaningful to them and on which they are the experts (for both cultural context and content)."

The importance of collaboration and participatory action research with diverse cultures is emphasized by the Work Group on American Indian Research and Program Evaluation Methodology (Caldwell et al., 2005). Recognizing that culture informs every stage of the process, the Work Group suggests that all research conducted with American Indians and Alaska Natives should be participatory research. The Work Group cautions against "culture-centric error" that results when researchers fail to

collaborate with the community, resulting in bias from the researchers' cultural perspectives.

Toward a Global Nursing Ethic

In the electronic focus group, participants in this study discuss how they would conceptualize a "global nursing ethic" that is being promoted by nursing leaders. In addition to recognizing the lack of conceptual standardization of cultural competence, six members of the expert panel in this study call for standardization of the definitions of "international, global, and cultural." One participant states, "I would like to see standardization of the definition of terms (international, global, and cultural) so that we can communicate more effectively on these issues. I have a sense that these terms mean different things to different people." Another reports, "People frequently use global and internationally interchangeably… Definitely more clarity needs to be focused on these topics."

The AAN Expert Panel on Cultural Competence defines culture as "a learned, patterned behavioral response acquired over time and includes explicit and implicit beliefs, attitudes, values, customs, norm, taboos, arts, habits, and life ways accepted by a community of individuals" (Giger et al., 2007a, p. 100). Standardized definitions of global and international have not been found in the nursing literature.

Thirty-eight percent of participants in the electronic focus group indicate the need for standardized definitions of the terms global and international. Another participant calls for more basic education, stating that students are ignorant about current affairs and their impact on health in developing countries. She bemoans, "They cannot explain

the role of the World Bank or the IMF [International Monetary Fund] on health in developing countries. Before we develop a 'nursing ethic' we had better start with some basics." This view is consistent with that of Davidson, Meleis, Daly, and Douglas (2003) who call for the development of a conceptual framework that demonstrates the connections between health and economic globalization. They posit that understanding the effects of globalization on health, in addition to cultural competence, is critical for nurses in order to contribute to global health.

In addition to the need for education for nurses to understand the impact of current events on health, the expert panel in this research identify the need for a multidisciplinary approach to the establishment of a global health ethic. As one participant expresses:

> …I assume that the idea of a global nursing ethic implies that the discipline of nursing would work to reach some consensus on the major ethical issues inherent in the conduct of studies across all settings and the best way of managing these ethical concerns…. I am not sure that 'nursing' needs to do this apart from other disciplines.

This viewpoint is consistent with that of Crigger (2008) who identifies inclusion and balance as qualities that will promote a feasible global ethic. She posits that the formulation of a global ethic must involve individuals from various nations as well as various disciplines in order to obtain a variety of perspectives.

Limitations

This study involves nurse researchers who have conducted at least one investigation involving participants from a country and culture, race, and/or ethnicity other than their own. While Papadopoulos and Lees (2002) posit that the same types of cultural competence are needed for nursing clinicians and nurse researchers, no empirical evidence has been found to support this assumption. The conduct of international research alone does not ensure cultural competence on the part of the investigator.

Participants in this study were limited to international nurse researchers with the ability to read and write English and having Internet access for receiving and responding to the questionnaires and for participation in a threaded discussion. Participants self-selected for this study. Those who chose to join the study may have higher levels of comfort with use of computers and the Internet than those who chose not to take part. Although the focus was not on nurses who are United States citizens, approximately 75% of the participants were either born in or currently reside in the United States. Nearly half of the participants participated in the electronic focus group achieving an acceptable focus group size (Bernard, 2006). However, this cohort from the study sample also self-selected to contribute to the electronic focus group. Thus views of the participants in this study may not be representative of the views of the entire population of international nurse researchers.

Finally, a doctoral candidate with no prior experience with electronic Delphi methods or focus groups conducted this study. This was her second experience analyzing qualitative data (Powel & Harper, 2007) and her initial experience

triangulating qualitative findings with the quantitative data from the two round Delphi survey.

Implications for Nursing

Research

The measurement of cultural competence of health care providers is an area that requires significant research. In a systematic review of 45 instruments measuring cultural competence, Gozu et al. (2007) report that most instruments lack acceptable psychometric properties, are difficult to understand, and may contain items that ask more than one question. In addition, since the majority of the instruments used to measure cultural competence are self-assessments, they are subject to social desirability bias (Capell et al., 2007; Gozu et al., 2007). Extant cultural competence instruments that demonstrate consistent reliability and validity, particularly the TSET with its 83 variables, need further testing for social desirability and to determine if they correlate with culturally competent behaviors or enhanced client outcomes (Capell et al., 2007).

As previously indicated, the perceptions of the recipients of care have been virtually ignored in nursing research. Research is needed to determine client perceptions of culturally acceptable care and its influence on health care outcomes.

Finally, this study has demonstrated the utility of the Internet in bringing together participants from around the world for a Delphi method and an electronic focus group. With increased globalization, electronic communication will become increasingly important in research to ensure the representation of diverse perspectives.

Education

Measurement of cultural competence has been a significant barrier to determining the effectiveness of educational methods for teaching cultural competence (Beach et al., 2005). A variety of methods are described for teaching cultural competence concepts: movies and videos, experiential exercises, reading novels, lectures, textbooks, computer-based self-learning modules, curricular integration, elective courses, service learning, and immersion experiences (Anderson, 2004; Caffrey et al., 2005; Campinha-Bacote, 2007; Evanson & Zust, 2006; Jeffreys, 2006; Koskinen & Tossavainen, 2004; Nokes, Nickitas, Keida, & Neville, 2003; Nokes et al., 2005; Worrell-Carlisle, 2005). A systematic review of studies evaluating the efficacy of cultural competence education reveals that studies are methodologically weak, preventing rigorous evaluation of the best teaching methods (Price et al., 2005). The IOM calls for research to evaluate the most effective teaching methods (Fortier & Bishop, 2004). The results of this study indicate that education aimed at teaching cultural competence must not only emphasize cultural variations, cultural assessments and client preferences, but also the complex nature of cultural competence and that cultural and linguistic competence are processes, not simply outcomes.

In addition to cultural competence, education is needed on the impact of globalization on world health. As one member of the expert panel in the current research states, "…we need to understand the macroenvironment that helps shape health, health behaviors, and access to health care."

An environmental factor that influences access to health care is the current global nursing shortage (International Council of Nurses, Florence Nightingale

International Foundation, & Burdett Trust for Nursing, 2006). Within the United States, the health professions have a shortage of minorities (Betancourt, Green, Carrillo & Ananeh-Firempong, 2003; Pacquiao, 2007; Sullivan Commission, 2004). The Sullivan Commission (2004), formed to address this shortage, posits that increasing minorities in the health professions will increase cultural awareness, enhance client-provider relations, and ultimately improve outcomes. Unfortunately, numerous barriers inhibit minority candidates from pursuing a career in nursing (Andrews, 2003). These barriers include financial limitations; stereotypes; lack of guidance, mentors, and role models, ignorance about the role of nurses, and increasing professional opportunities in other disciplines (American Association of Colleges of Nurses, 2001).

Recruitment of minorities into healthcare professions is needed to achieve the Healthy People 2010 goal of cultural diversity in the healthcare workforce (Agency for Healthcare Research and Quality, n.d.; Lurie, Jung, & Lavizzo-Mourey, 2005; National Advisory Council on Nurse Education and Practice, 2003; Siantz & Meleis, 2007). Several states, including Florida, currently have laws designed to enhance recruitment of minorities (Ladenheim & Groman, 2006). Recruitment initiatives must be aimed at reducing barriers to entry into nursing encountered by minority candidates (Andrews, 2003; National Advisory Council on Nurse Education and Practice, 2003). These recruitment strategies must target children when they are first beginning to set career goals and continue throughout their education (The Sullivan Alliance, 2007). For example, school programs and summer camps may be used to introduce nursing as a career so that students may plan their high school coursework to facilitate nursing program entry (Etowa, Foster, Vukic, Wittstock, & Youden, 2005; Fletcher et al., 2003;

Wieland & Hoerst, 2006; Yates et al., 2003). Campaigns to enhance the image of nursing may be directed at school-aged children (National Student Nurses' Association, 2007). Offering tutors for math and science to students who are interested in attending nursing school may also serve to increase enrollment of minority students and ensure that they are prepared to enter an academically rigorous program (Michigan Center for Nursing, 2006; Noone, Carmichael, Carmichael, & Chiba, 2007). Designating admission quotas may also help ensure adequate representation of minority students in nursing programs (Etowa et al., 2005).

Recruitment efforts have increased the percentage minority students entering nursing school. The American Association of Colleges of Nursing (2007) reports that minority enrollment in entry level bachelor's degree nursing programs was 24.8% in 2006. Recruitment alone, however, will not insure that minority students successfully complete their nursing program and pass the licensure exam. Retention is also important. Minority students face a plethora of barriers to successful completion of a nursing program (Amaro, Abriam-Yago, & Yoder, 2006; National Advisory Council on Nurse Education and Practice, 2003). These barriers include financial challenges, family responsibilities, language, time management, faculty discrimination, and social isolation.

Multiple mechanisms have been identified to address the barriers that minority students encounter while in nursing school. Tutors are one method of promoting retention of minority students in rigorous nursing education programs (Stewart, 2006; Sutherland, Hamilton, & Goodman, 2007; Taxis, 2006). Programs that teach students how to be academically successful and include topics such as study skills and test taking skills may be used (McNeal & Walker, 2006; Stewart, 2006; Sutherland et al.,

2007). Financial support is also helpful to provide tuition and money for personal expenses, thereby eliminating or reducing the need to work (Taxis, 2006). Faculty development, including cultural awareness and how to teach students with a different native language, may also be useful in retaining minority students (Abriam-Yago, Yoder, & Kataoka-Yahiro, 1999; Stewart, 2006). Other retention strategies include family support, mentoring, and culture specific student organizations (National Advisory Council on Nurse Education and Practice, 2003; Taxis, 2006).

While retention strategies found in the nursing literature are primarily anecdotal, Sutherland et al. (2007) evaluated a multifaceted program designed to increase retention, graduation and pass rates for the licensure exam for minority nursing students. Minority students received close faculty mentoring and advisement, tutoring, classes on reduction of test anxiety, use of electronics, and other study skills, and laptop computers with special educational software. Program participation did not significantly influence grades in nursing courses except the final leadership/management course. Ninety-eight percent of the students in the program graduated from the program. Although a statistically significant difference was not found, 65% of the minority students who participated in the program passed the licensure exam compared to 56% of the minority students who did not participate. Further research is needed to determine the effectiveness of initiatives to recruit and retain minorities into nursing school.

Practice

A United States Congressional mandate in 1994 required the OMH to enhance the ability of health care professionals to provide care for diverse cultural and linguistic groups (Office of Minority Health, n.d.). In 1997, the development of national standards was initiated. The resulting Culturally and Linguistically Appropriate Services (CLAS) in Health Care standards were published in 2001 (Office of Minority Health, 2001). Four CLAS standards address the provision of language assistance. However, no federal funds are available for interpreters, leaving the burden of the cost on state and municipal entities (Snowden, Masland, & Guerrero, 2007). As a result, some states and organizations are establishing population thresholds that, when exceeded, require accommodation to language needs. This is consistent with the IOM recommendation that interpretation services, including technology, be used "where community need exists"(Smedley et al., 2003, p.70). Nurses must be prepared to offer language assistance either through interpreters or technological services as the need arises.

CLAS standards also recommend that organizations hire diverse staff who reflect the demographics of the service area in an effort to enhance client-caregiver concordance (Office of Minority Health, 2001). It is imperative that nurse executives support initiatives to recruit and hire minority nurses. Collaboration with colleges of nursing to promote recruitment of minorities may prove effective. In addition, resources may be made available through scholarships and tuition reimbursement programs for current employees to pursue a nursing degree.

As nurses encounter ethical dilemmas in the practice setting, a framework is needed to balance fundamental ethical principles with those of the client. The model of

ethical multiculturalism (Harper, 2006) may provide this framework by illustrating how nurses must use cultural competence, beneficience/nonmaleficience, respect for persons and communities, and moral reasoning to find a balance that is acceptable within the context of the dilemma.

Findings from this study indicate that while nurses are unlikely to achieve cultural competence in cultures different from their own, nurses are able to provide care that is acceptable to clients of another culture. Using local demographic information, organizations may identify ethnic minorities with which nurses are likely to come in contact within a particular work setting. Then, efforts may be focused on obtaining cultural knowledge about these specific minorities to prepare nurses in practice to provide culturally acceptable care.

Implications for Policy

Collection of empirical evidence is hampered by the lack of available data on race, ethnicity, and language from health care providers and insurers (Brach et al., 2005; Centers for Disease Control and Prevention, 2007; Fortier & Bishop, 2004; Goode et al., 2006; Smedley et al., 2003). Lack of standardization of definitions of race and ethnicity and the increasing number of persons who are of mixed races contribute to this barrier. In 2000, the United States Census Bureau expanded racial categories to allow for 63 different categories of race (U.S. Census Bureau, n.d.). Other barriers to collection of standardized data include costs, client privacy, and resistance from health care payers, providers, hospitals, and clients (Lurie et al., 2005; Smedley et al., 2003). Confusion concerning the collection of race, ethnicity and language data exists among

both insurers and health care providers, who fear liability or client resistance despite being given the right to collect this data under Title VI of the Civil Rights Act (Lurie et al., 2005). Without standardized data, evaluation of efforts to reduce health disparities through cultural and linguistic competence will not be feasible (Goode et al., 2006). Therefore, strategic initiatives that require standardized data collection are needed (Mensah & Dunbar, 2006). Since Medicare currently collects data on race and ethnicity, data collection should be expanded to include language (Brach et al., 2005).

In addition to Title VI, several federal policies have been developed to minimize the health disparities of vulnerable populations. For example, the Minority Health and Health Disparities Research and Education Act of 2000 established the National Institutes of Health (NIH) National Center on Minority Health and Health Disparities (NCMHD) as the coordinating agency for research, grants, and strategic planning for health disparities (Institute of Medicine, 2006; Thomas, Benjamin, Almario, & Lathan, 2006). Although the NIH has made health disparities its third highest priority, a review of the NCMHD by the IOM found that a lack of coordination and failure to approve the strategic plan annually as required by legislation has resulted in gaps in research (Institute of Medicine, 2006). The IOM made strong recommendations for the NCMHD to update strategic plans and budgets and to more effectively coordinate research on health disparities. NCMHD compliance with the IOM recommendations must be mandated to ensure coordination of research.

Policies are also needed to promote culturally appropriate informed consent. The purpose of informed consent is to provide information to clients and potential research participants, ensure that they understand the counsel, and to elicit voluntary

participation (Marshall, 2006). Unfortunately, regulatory mandates may conflict with the cultural preferences of communities, both within the United States and internationally. Investigations of research ethics have supported the notion that IRBs should focus on the intent of informed consent rather than the written consent form and consider the social and cultural context of the participant (Davison, Brown, & Moffitt, 2006; Dawson & Kass, 2005; Hyder & Wali, 2006). In a study of international research ethics commissioned by the National Bioethics Advisory Commission, investigators from the United States who carry out research in developing countries indicated that written consent forms excluded the illiterate, made participants uneasy, and did not enhance understanding of the study (Dawson & Kass, 2005). Eighty-seven percent of these investigators felt that more flexibility is needed in the documentation of consent. These findings are consistent with the findings of a survey of researchers from developing countries in which 72% of the participants indicated that non-written formats for informed consent are needed (Hyder & Wali, 2006). The use of non-written formats of informed consent is consistent with Harper's (2006) model of ethical multiculturalism that suggests that balance between fundamental ethical principals and the cultural context of research are needed.

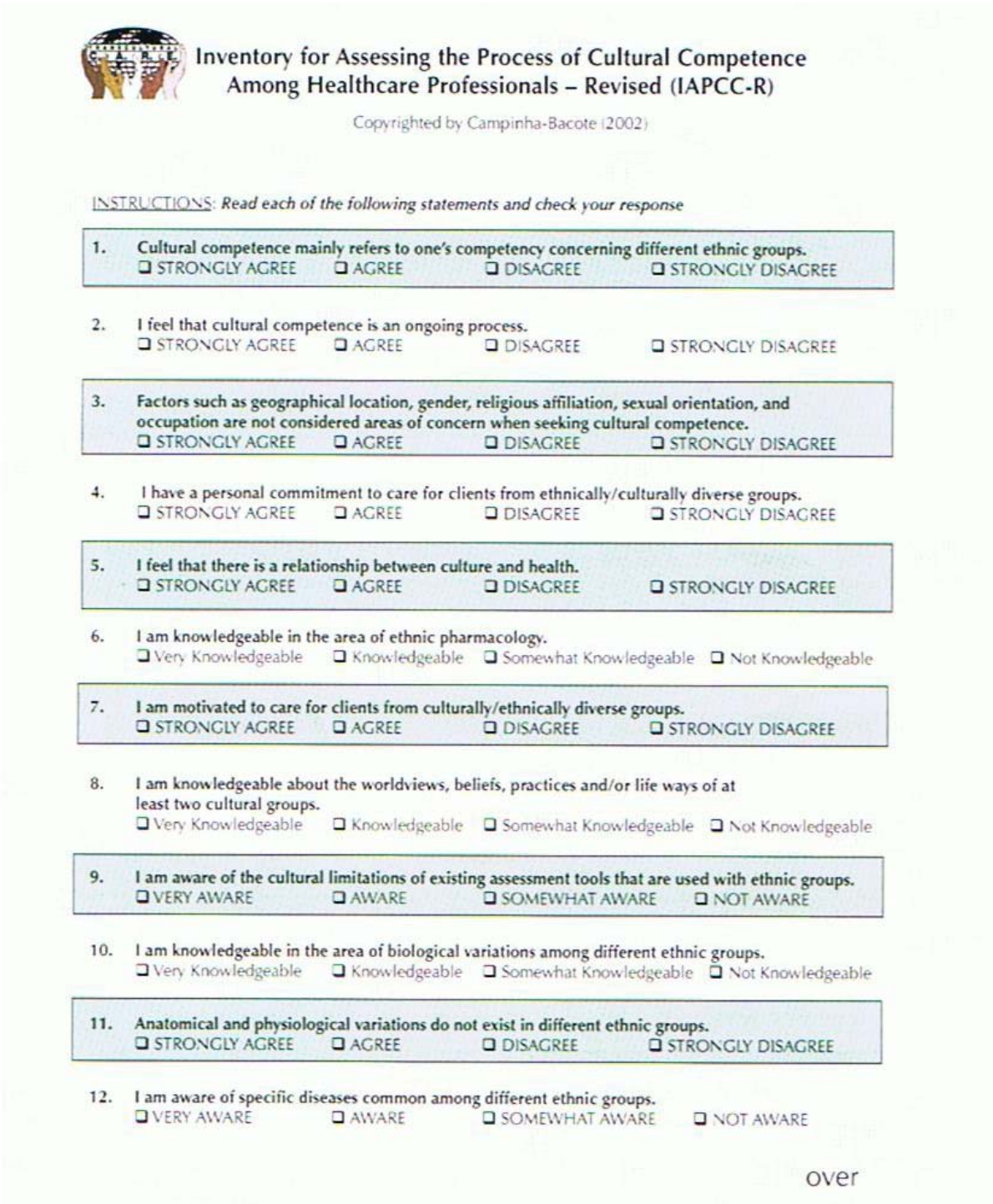
Summary

Globalization is an undeniable force that impacts health and health care. As globalization expands, nurses encounter increasingly diverse clients and conduct research within a variety of cultures. An understanding of how to balance fundamental ethical principles in the context of the client's/participant's culture is necessary. This

balance involves engaging in the complex process of cultural competence in order to "work effectively within the cultural context" of another individual (Campinha-Bacote, 2007, p. 15). Lack of standardized conceptualization and measurement of cultural competence is a barrier to research, education, and practice. This study has contributed to the nursing knowledge base of cultural competence through identification of the antecedents of cultural competence as perceived by a sample of international nurse researchers and a comparison of these antecedents with instruments that measure cultural competence in health care providers.

APPENDIX A
INVENTORY FOR ASSESSING THE PROCESS OF CULTURAL COMPETENCE AMONG HEALTHCARE PROFESSIONALS

Josepha Campinha-Bacote. Copyrighted by Campinha-Bacote (2002). Printed with permission from Transcultural C.A.R.E. Associates.



Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals – Revised (IAPCC-R)

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INSTRUCTIONS: *Read each of the following statements and check your response*

1. **Cultural competence mainly refers to one's competency concerning different ethnic groups.**
   ❑ STRONGLY AGREE ❑ AGREE ❑ DISAGREE ❑ STRONGLY DISAGREE

2. I feel that cultural competence is an ongoing process.
   ❑ STRONGLY AGREE ❑ AGREE ❑ DISAGREE ❑ STRONGLY DISAGREE

3. **Factors such as geographical location, gender, religious affiliation, sexual orientation, and occupation are not considered areas of concern when seeking cultural competence.**
   ❑ STRONGLY AGREE ❑ AGREE ❑ DISAGREE ❑ STRONGLY DISAGREE

4. I have a personal commitment to care for clients from ethnically/culturally diverse groups.
   ❑ STRONGLY AGREE ❑ AGREE ❑ DISAGREE ❑ STRONGLY DISAGREE

5. **I feel that there is a relationship between culture and health.**
   ❑ STRONGLY AGREE ❑ AGREE ❑ DISAGREE ❑ STRONGLY DISAGREE

6. I am knowledgeable in the area of ethnic pharmacology.
   ❑ Very Knowledgeable ❑ Knowledgeable ❑ Somewhat Knowledgeable ❑ Not Knowledgeable

7. **I am motivated to care for clients from culturally/ethnically diverse groups.**
   ❑ STRONGLY AGREE ❑ AGREE ❑ DISAGREE ❑ STRONGLY DISAGREE

8. I am knowledgeable about the worldviews, beliefs, practices and/or life ways of at least two cultural groups.
   ❑ Very Knowledgeable ❑ Knowledgeable ❑ Somewhat Knowledgeable ❑ Not Knowledgeable

9. **I am aware of the cultural limitations of existing assessment tools that are used with ethnic groups.**
   ❑ VERY AWARE ❑ AWARE ❑ SOMEWHAT AWARE ❑ NOT AWARE

10. I am knowledgeable in the area of biological variations among different ethnic groups.
    ❑ Very Knowledgeable ❑ Knowledgeable ❑ Somewhat Knowledgeable ❑ Not Knowledgeable

11. **Anatomical and physiological variations do not exist in different ethnic groups.**
    ❑ STRONGLY AGREE ❑ AGREE ❑ DISAGREE ❑ STRONGLY DISAGREE

12. I am aware of specific diseases common among different ethnic groups.
    ❑ VERY AWARE ❑ AWARE ❑ SOMEWHAT AWARE ❑ NOT AWARE

over

13. I am willing to learn from others as cultural informants.
❑ STRONGLY AGREE ❑ AGREE ❑ DISAGREE ❑ STRONGLY DISAGREE

14. I seek out education, consultation, and/or training experiences to enhance my understanding and effectiveness with culturally and ethnically diverse clients.
❑ STRONGLY AGREE ❑ AGREE ❑ DISAGREE ❑ STRONGLY DISAGREE

15. I am aware of at least 2 institutional barriers that prevent cultural/ethnic groups from seeking healthcare services.
❑ VERY AWARE ❑ AWARE ❑ SOMEWHAT AWARE ❑ NOT AWARE

16. I recognize the limits of my competence when interacting with culturally/ethnically diverse clients.
❑ STRONGLY AGREE ❑ AGREE ❑ DISAGREE ❑ STRONGLY DISAGREE

17. When my values and beliefs "clash" with my client's values and beliefs I become frustrated.
❑ STRONGLY AGREE ❑ AGREE ❑ DISAGREE ❑ STRONGLY DISAGREE

18. I am aware of some of the stereotyping attitudes, preconceived notions and feelings that I have toward members of other ethnic/cultural groups.
❑ VERY AWARE ❑ AWARE ❑ SOMEWHAT AWARE ❑ NOT AWARE

19. I have a passion for caring for clients from culturally/ethnically diverse groups.
❑ STRONGLY AGREE ❑ AGREE ❑ DISAGREE ❑ STRONGLY DISAGREE

20. I am aware of at least 2 cultural assessment tools to be used when assessing clients in a healthcare setting.
❑ VERY AWARE ❑ AWARE ❑ SOMEWHAT AWARE ❑ NOT AWARE

21. It is more important to conduct a cultural assessment on ethnically diverse clients than with other clients.
❑ STRONGLY AGREE ❑ AGREE ❑ DISAGREE ❑ STRONGLY DISAGREE

22. I feel comfortable in asking questions that relate to the client's ethnic/cultural background.
❑ Very Comfortable ❑ Comfortable ❑ Somewhat Comfortable ❑ Not Comfortable

23. I am involved with cultural/ethnic groups outside of my healthcare setting role.
❑ Very Involved ❑ Involved ❑ Somewhat Involved ❑ Not Involved

24. I believe that one must "want to" become culturally competent if cultural competence is to be achieved.
❑ STRONGLY AGREE ❑ AGREE ❑ DISAGREE ❑ STRONGLY DISAGREE

25. I believe that there are more differences within cultural groups than across cultural groups.
❑ STRONGLY AGREE ❑ AGREE ❑ DISAGREE ❑ STRONGLY DISAGREE

APPENDIX B
TRANSCULTURAL SELF-EFFICACY TOOL

Throughout your nursing education and nursing career, you will be caring for clients of many different cultural backgrounds. These clients will represent various racial, ethnic, gender, socioeconomic, and religious groups.

Cultural difference exists in health care needs, caring, and curing practices. Knowing and understanding cultural factors related to client care helps establish a theoretical foundation for providing cultural-specific nursing care.

Part I

Among clients of **different** culture backgrounds, how knowledgeable are **YOU** about the ways cultural factors may influence nursing care? Please use the scale below and mark your response accordingly.

	Not Confident									Totally Confident
	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
You know and understand the ways cultural factors may influence nursing care in the following areas:										
1) health history and interview	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
2) physical examination	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
3) informed consent	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
4) health promotion	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
5) illness prevention	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
6) health maintenance	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
7) health restoration	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
8) safety	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
9) exercise and activity	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
10) pain relief and comfort	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
11) diet and nutrition	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
12) patient teaching	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
13) hygiene	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
14) anxiety and stress reduction	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
15) diagnostic tests	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
16) blood tests	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
17) pregnancy	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
18) birth	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
19) growth and development	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
20) aging	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
21) dying and death	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
22) grieving and loss	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
23) life support and resuscitation	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
24) sexuality	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
25) rest and sleep	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

Part II

The most effective way to identify specific cultural factors that influence client behavior is to conduct a cultural assessment of each client. This is best done by interview.

Right NOW, how confident are **YOU** about **interviewing client of different cultural backgrounds** to learn about their values and beliefs?

Rate your degree of confidence or certainty for each of the following **interview topics**. Please use the scale below and mark your response accordingly.

	Not Confident ①	②	③	④	⑤	⑥	⑦	⑧	⑨	Totally Confident ⑩
Interview clients of different cultural backgrounds about:										
26) language preference	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
27) level of English comprehension	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
28) meaning of verbal communication patterns	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
29) meaning of nonverbal behaviors	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
30) meanings of space and touch	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
31) time perception & orientation	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
32) racial background & identity	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
33) ethnic background & identity	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
34) socioeconomic background	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
35) religious background & identity	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
36) educational background & interests	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
37) religious practices & beliefs	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
38) acculturation	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
39) world view (philosophy of life)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
40) attitudes about health care technology	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
41) ethnic food preferences	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
42) role of elders	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
43) role of children	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
44) financial concerns	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
45) traditional health & illness beliefs	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
46) folk medicine tradition & use	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
47) gender role & responsibility	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
48) acceptable sick role behaviors	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
49) role of family during illness	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
50) discrimination & bias experiences	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
51) home environment	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
52) kinship ties	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
53) aging	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

Part III

As a nurse who will care for many different people, **knowledge of yourself** is very important.

Please rate **YOUR** degree of confidence or certainty for each of the following items. Use the scale below and mark your response accordingly.

	Not Confident ①	②	③	④	⑤	⑥	⑦	⑧	⑨	Totally Confident ⑩
A) About yourself, you are AWARE OF:										
54) **YOUR OWN** cultural heritage and belief systems	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
55) **YOUR OWN** biases and limitations	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
56) differences within **YOUR OWN** cultural group	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
B) Among clients of different cultural backgrounds,										
You are **AWARE OF:**										
57) insensitive and prejudicial treatment	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
58) differences in perceived role of the nurse	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
59) traditional caring behaviors	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
60) professional caring behaviors	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
61) comfort and discomfort felt when entering a culturally different world	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
62) interaction between nursing, folk, and professional systems	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
You **ACCEPT:**										
63) differences between cultural groups	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
64) similarities between cultural groups	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
65) client's refusal of treatment based on beliefs	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
You **APPRECIATE:**										
66) interaction with people of different cultures	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
67) cultural sensitivity and awareness	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
68) cultural-specific nursing care	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
69) role of family in providing health care	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
70) client's world view (philosophy of life)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

	Not Confident									Totally Confident
	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

Among clients of different cultural backgrounds,

You **RECOGNIZE:**

71) inadequacies in the U.S. health care system	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
72) importance of home remedies & folk medicine	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
73) impact of roles on health care practices	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
74) impact of values on health care practices	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
75) impact of socioeconomic factors on health care practices	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
76) impact of political factors on health care practices	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
77) need for cultural care preservation/maintenance	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
78) need for cultural care accommodation/negotiation	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
79) need for cultural care repatterning/restructuring	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
80) need to prevent ethnocentric views	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
81) need to prevent cultural imposition	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

You **ADVOCATE:**

82) client's decisions based on cultural beliefs	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
83) cultural-specific care	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

APPENDIX C
CULTURAL COMPETENCE SURVEY

Cultural Competence Survey

Increasing cultural diversity of people in our communities and workplaces is a fact of life. Diversity among students, co-workers, and organizations is also expanding. Improvements in travel and communication have brought people with different cultures, languages, and customs into contact as never before. A greater variety of people within our communities, schools, and workplaces continue to have an impact on the way that we think, feel, and act.

This survey is designed to explore your knowledge, feelings, and actions when you interact with others in the context of health care and health service environments and in academic settings. *Your answers are strictly confidential.* The researchers will put your answers together with those of others to get an overall profile of group cultural competence and educational needs. We will also use your responses together with those of other people such as yourself to design cultural competency training programs to meet specific needs. Neither your identity nor your individual answers will be shared with anyone.

Questions on this form are intended to gather information about how you personally think, feel, and act. Some questions may not fit your situation exactly depending on the type of study program you are enrolled in or the type of work you do at this time. Please try to answer every question. If you are unsure or have no opinion on an item, use the "No Opinion" or "Not Sure" options. There are no "right" or "wrong" answers.

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 health care environment or workplace? ***Mark 'X' for 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,Vietnamese, or other Asian) ☐
Native Hawaiian / Pacific Islander ☐
Arab American / Middle eastern ☐
Other *(specify)*

_____

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

Hispanic / Latino (including.Mexican, Mexican American,Chicano, Puerto Rican,Cuban, or 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 ___
All other groups combined ___

TOTAL = 100%

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 'X' for all that apply.***

Mentally or emotionally ill ☐
Physically Challenged / Disabled ☐
Homeless / Housing Insecure ☐
Substance Abusers / Alcholics ☐
Gay, Lesbian, Bisexual, or Transgendered ☐
Different religious/spiritual backgrounds ☐
Other *(specify)*

_____

4. In your current environment, what percentage of the total population is made up of people from these racial/ethnic groups? ***Write in percents ; may not total 100%***

Mentally or emotionally Ill ___

Physically Challenged / Disabled ___

Homeless / Housing Insecure ___

Substance Abusers / Alcholics ___

Gay, Lesbian, Bisexual, or Transgendered ___

Different religious/spiritual backgrounds ___

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
☐	☐	☐	☐	☐

For each of the following statements, put an "X' in the box that best describes how you feel about the statement.

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
☐	☐	☐	☐	☐	☐	☐	☐

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

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

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

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

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
☐	☐	☐	☐	☐	☐	☐	☐

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

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

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
☐	☐	☐	☐	☐	☐	☐	☐

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

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

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
☐	☐	☐	☐	☐	☐	☐	☐

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

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

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

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

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

Strongly Agree	Agree	Somewhat Agree	Neutral	Somewhat Disagree	Disagree	Strongly Disagree	No Opinion
☐	☐	☐	☐	☐	☐	☐	☐

For each of the following statements, put an "X' in the box that best describes how often you do the following:

17. I include cultural assessment when I do individual or organizational evaluations.

Always	Very Often	Somewhat Often	Often	Some times	Few times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

18. I seek information on cultural needs when I identify new people in my work or school.

Always	Very Often	Somewhat Often	Often	Some times	Few times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

19. I have resource books and other materials available to help me learn about people from different cultures.

Always	Very Often	Somewhat Often	Often	Some times	Few times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

20. I use a variety of sources to learn about the cultural heritage of other people.

Always	Very Often	Somewhat Often	Often	Some times	Few times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

21. I ask people to tell me about their own explanations of health & illness.

Always	Very Often	Somewhat Often	Often	Some times	Few times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

22. I ask people to tell me about their expectations for health services.

Always	Very Often	Somewhat Often	Often	Some times	Few times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

23. I avoid using generalizations to stereotype groups of people.

Always	Very Often	Somewhat Often	Often	Some times	Few times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

24. I recognize potential barriers to service that might be encountered by different people.

Always	Very Often	Somewhat Often	Often	Some times	Few times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

25. I remove obstacles for people of different cultures when I identify barriers to services.

Always	Very Often	Somewhat Often	Often	Some times	Few times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

26. I remove obstacles for people of different cultures when people identify barriers to me.

Always	Very Often	Somewhat Often	Often	Some times	Few times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

27. I welcome feedback from clients about how I relate to people from different cultures.

Always	Very Often	Somewhat Often	Often	Some times	Few times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

28. I find ways to adapt my services to individual and group cultural preferences.

Always	Very Often	Somewhat Often	Often	Some times	Few times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

29. I document cultural assessments if I provide direct client services.

Always	Very Often	Somewhat Often	Often	Some times	Few times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

30. I document the adaptations I make with clients if I provide direct client services.

Always	Very Often	Somewhat Often	Often	Some times	Few times	Never	Not sure
☐	☐	☐	☐	☐	☐	☐	☐

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 below and decide whether the statement is true or false as it pertains to you personally. Mark you answer with an "X" in the True or False box.

	True	False
31. It is sometimes hard for me to go on with my work if I am not encouraged.	☐	☐
32. I sometimes feel resentful when I don't get my way.	☐	☐
33. On a few occasions, I have given up doing something because I thought too little of my ability.	☐	☐
34. There have been times when I felt like rebelling against people in authority even though I knew they were right.	☐	☐

35. No matter who I'm talking to, I'm always a good listener. True ☐ False ☐

36. There have been occasions when I took advantage of someone True ☐ False ☐

37. I'm always willing to admit it when I make a mistake. True ☐ False ☐

38. I sometimes try to get even rather than forgive and forget True ☐ False ☐

39. I am always courteous, even to people who are disagreeable. True ☐ False ☐

40. I have never been irked when people expressed ideas very different from my own. True ☐ False ☐

41. There have been times when I was quite jealous of the good fortune of others. True ☐ False ☐

42. I am sometimes irritated by people who ask favors of me True ☐ False ☐

43. I have never deliberately said something to hurt someone's feelings. True ☐ False ☐

44. In what year were you born? ☐

45. Using the categories below, what do you consider yourself?
(Choose one or more)

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 group(s) *(specify)* _____

47. What is your highest level of education completed?

Less than high school ☐
Diploma ☐
High school diploma or GED ☐
Associate degree ☐
Bachelors degree ☐
Graduate or professional degree ☐

48. Have you ever participated in cultural diversity training?

Yes ☐
No ☐

49. If you have had prior diversity training, which option below best describes it? (Check all that apply)

Separate college course for credit ☐
Content covered in a college course ☐
Professional Conference or Seminar ☐
Employer Sponsored Program ☐
On-line (computer assisted) Education ☐
Continuing Education Offering ☐
Other diversity training types (Specify)

APPENDIX D
CROSS-CULTURAL EVALUATION TOOL

Terrence L. Freeman, Copyright 1993 Transed, Terrence L. Freeman. Reprinted with permission from T.L. Freeman.

Cross-Cultural Evaluation © 1993 TransEd, Terrence L. Freeman, Ph.D.

We frequently find ourselves in a variety of cross-cultural situations. Sometimes we are members of the dominant culture and sometimes we are the outsiders. Please react as honestly as you can to the statements below by using the numerals adjacent to the following responses:

Always (5) Usually (4) Sometimes (3) Seldom (2) Never (1)

1. I understand that race, gender, physical ability, age and sexual orientation do not predict psychological or cultural traits.
2. I am aware of my values, biases and sensitivities and the limitations they place on my perspective.
3. I realize that people outside my culture may have greater awareness of my cultural idiosyncrasies than I do, so I seek their consul and listen to them when they tell me how my culture affects them.
4. I maintain pride in my culture, take steps to build my self-esteem and know how to reinvigorate my cultural strengths.
5. I utilize my distinct cultural strengths to make positive contributions to my organization.
6. Because I have a philosophy of fairness, I speak out against prejudice and discrimination against other cultures by letting others know about my commitment.
7. I realize that people of other cultures have valuable ideas and perspectives to contribute to the growth of an organization.
8. I am willing to train and coach others on how to succeed in my culture by sharing the unwritten rules and traditions without undervaluing their culture.
9. I am willing to involve myself in multicultural situations in order to increase my awareness and broaden my cultural comfort zone.
10. I am aware of stereotypes and I realize that other cultural groups are not monolithic in values, attitudes or behavior.
11. I seek skills, information and mentors to learn the unwritten rules and traditions necessary to achieve success in an organization or different culture.
12. As I succeed in a dominant culture I maintain contact and share what I learn with others like myself.
13. I interact with all cultural groups in my organization and resist creating a pattern of associating only with members of my culture.
14. Being flexible, empathetic and non-judgmental, I can evaluate other cultures without ethnocentricity and collaborate with them to achieve common objectives.
15. My treatment of people of other cultures is independent of the prejudices and biases of members of my culture and I resist the temptation to seek cultural scapegoats when something goes wrong.
16. I encourage communication with members of other cultures by providing complete accurate information and cultural insight as well as honest and sensitive feedback.
17. I apologize when I have said or done something inappropriate or insensitive that offends members of a different culture.
18. I am willing to modify my attitudes and behavior to achieve harmony and effectiveness within my organization.
19. I actively encourage and support recruiting, selecting, training and promoting people outside the dominant cultural group in order to gain the strengths that diversity and inclusivity may offer.
20. I contribute to a positive organization by being willing to ask or respond to questions and create an atmosphere that encourages the exchange.

To evaluate your **Cross-cultural Interaction Score (CIS)**, Total your score: ☐

95 - 100	Outstanding
85 - 94	Good
75 - 84	Average (work on weaker areas)
Below 75	Needs improvement

African Proverb: *It is through other people's wisdom that we learn wisdom ourselves; a single person's understanding does not amount to anything.*

For more information or permission to use this instrument please contact tfreeman@trans-ed.com

APPENDIX E
CULTURAL AWARENESS SCALE ITEMS

5. The instructors at this nursing school adequately address multicultural issues in nursing.
6. The nursing school provides opportunities for activities related to multicultural affairs.
7. Since entering this nursing school, my understanding of multicultural issues has increased.
8. My experiences at this nursing school have helped me become knowledgeable about the health problems associated with various racial and cultural groups.
9. I think my beliefs and attitudes are influenced by my culture.
10. I think my behaviors are influenced by my behavior.
11. I often reflect on how culture affects beliefs, attitudes, and behaviors.
12. When I have an opportunity to help someone, I offer assistance less frequently to individuals of certain cultural backgrounds.
13. I am less patient with individuals of certain cultural backgrounds.
14. I feel comfortable working with patients of all ethnic groups.
15. I believe nurses' own cultural beliefs influence their nursing care decisions.
16. I typically fell somewhat uncomfortable when I am in the company of people from cultural or ethnic backgrounds different from my own.
17. I have noticed that the instructors at this nursing school call on students from minority cultural groups when issues related to their group come up in class.

18. During group discussions or exercises, I have noticed the nursing instructors make efforts to ensure no student is excluded.
19. I think students' cultural values influence their classroom behaviors (e.g., asking questions, participating in groups, offering comments).
20. In my nursing classes, my instructors have engaged in behaviors that may have made students from certain cultural backgrounds feel excluded.
21. I think it is the nursing instructor's responsibility to accommodate students' diverse learning needs.
22. My instructors at this nursing school seem comfortable discussing cultural issues in the classroom.
23. My nursing instructors seem interested in learning how their classroom behaviors may discourage students from certain cultural or ethnic groups.
24. I think the cultural values of the nursing instructors influence their behavior in the clinical setting.
25. I believe the classroom experiences at this nursing school help students become more comfortable interacting with people from different cultures.
26. I believe some aspects of the classroom environment at this nursing school may alienate students from some cultural backgrounds.
27. I feel comfortable discussing cultural issues in the classroom.
28. My clinical courses at this nursing school have helped me become more comfortable interacting with people from different cultures.
29. I feel that the instructors at this nursing school respect differences in individuals from diverse cultural backgrounds.

30. The instructors a this nursing school model behaviors that are sensitive to multicultural issues.
31. The instructors at this nursing school use examples and/or case studies that incorporate information from various cultural and ethnic groups.
32. The faculty at this nursing school conducts research that considers multicultural aspects of health-related issues.
33. The students at this nursing school have completed theses and dissertation studies that considered cultural differences related to health.
34. The researchers at this nursing school consider relevance of data collection measures for the cultural groups they are studying.
35. The researchers at this nursing school consider cultural issues when interpreting findings in their studies.
36. I respect the decisions of my patients when they are influenced by their culture, even if I disagree.
37. If I need more information about a patient's culture, I would use resources available onsite (e.g., books, videotapes).
38. If I need more information about a patient's culture, I would feel comfortable asking people I work with.
39. If I need more information about a patient's culture, I would feel comfortable asking the patient or family member.
40. I feel somewhat comfortable working with the families of patients from cultural backgrounds different than my own.

APPENDIX F
UNIVERSITY OF CENTRAL FLORIDA INSTITUTIONAL REVIEW BOARD NOTICE OF EXEMPT REVIEW STATUS

University of Central Florida

University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901, 407-882-2012 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Notice of Exempt Review Status

From: **UCF Institutional Review Board**
FWA00000351, Exp. 5/07/10, IRB00001138

To: **Mary Harper**

Date: **July 24, 2007**

IRB Number: **SBE-07-05108**

Study Title: **Evaluation of the Antecedents of Cultural Competence**

Dear Researcher:

Your research protocol was reviewed by the IRB Chair on 7/24/2007. Per federal regulations, 45 CFR 46.101, your study has been determined to be **minimal risk for human subjects and exempt** from further IRB review or renewal unless you later wish to add the use of identifiers or change the protocol procedures in a way that might increase risk to participants. Before making any changes to your study, call the IRB office to discuss the changes. **A change which incorporates the use of identifiers may mean the study is no longer exempt, thus requiring the submission of a new application to change the classification to expedited if the risk is still minimal.** Please submit the Termination/Final Report form when the study has been completed. All forms may be completed and submitted online at https://iris.research.ucf.edu.

The category for which exempt status has been determined for this protocol is as follows:

2. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey or interview procedures, or the observation of public behavior, so long as confidentiality is maintained.
   - (i) Information obtained is recorded in such a manner that the subject cannot be identified, directly or through identifiers linked to the subject, **and/or**
   - *(ii)* Subject's responses, if known outside the research would not reasonably place the subject at risk of criminal or civil liability or be damaging to the subject's financial standing or employability or reputation.

The IRB has approved a **consent procedure which requires participants to sign consent forms**. Use of the approved, stamped consent document(s) is required. Only approved investigators (or other approved key study personnel) may solicit consent for research participation. Subjects or their representatives must receive a copy of the consent form(s).

All data, which may include signed consent form documents, must be retained in a locked file cabinet for a minimum of three years (six if HIPAA applies) past the completion of this research. Any links to the identification of participants should be maintained on a password-protected computer if electronic information is used. Additional requirements may be imposed by your funding agency, your department, or other entities. Access to data is limited to authorized individuals listed as key study personnel.

On behalf of Tracy Dietz, Ph.D., UCF IRB Chair, this letter is signed by:

Signature applied by Joanne Muratori on 07/24/2007 03:49:35 PM EDT

Joanne Muratori

APPENDIX G
INVITATION TO PARTICIPATE/INFORMED CONSENT

(University of Central Florida Institutional Review Board Approved)

Invitation to Participate
Informed Consent

Dear Colleague,

As a doctoral candidate at the University of Central Florida, I am conducting a study of international cross-cultural nurse researchers to determine the most important antecedents of cultural competence. For the purpose of this study, I am defining international cross-cultural research as an investigation involving participants from a country and culture, race, and/or ethnicity different from that of the investigator and that occurs in the native country of the participant.

I obtained your e-mail address from a recent nursing journal publication, university directory, or through a professional organization list-serv. To be eligible to participate in this study, you must be at least 18 years old, you must be a nurse who has conducted at least one international cross-cultural investigation, you must be able to read and write English, and you must have internet access for receipt of e-mail and to participate in an on-line discussion.

Description of the Study
Participation will involve the completion a brief demographic form and two to four questionnaires as part of a Delphi study. The demographic form will take about 10 – 20 minutes to complete. In the first round, you will be asked to rank the importance of a list of attributes of cultural competence I gleaned from the literature. For subsequent rounds, that will occur at roughly monthly intervals, you will be shown how your results compare to the overall group results and you will be asked to rank the importance of the top items from the previous round. It should take approximately 10 - 20 minutes to complete the first round questionnaire and less time for subsequent rounds as the items are narrowed. The number of rounds will be determined by the degree of consensus among the participants.

After consensus is reached from the Delphi rounds, you will be invited to join an on-line threaded discussion to discuss the findings of the study. This will involve logging on to a password protected website and writing your responses to a few open-ended questions and responding to other participants' responses as you deem appropriate. It should take no longer than 10 – 20 minutes to respond to the initial questions. The threaded discussion will be open for participation for three weeks but you need only participate a few times as your schedule allows. You will receive a reminder e-mail if you have not participated after two weeks of the discussion opening. Members of my dissertation committee will have access to the threaded discussion in order to provide expert consultation to me but they will not participate in the discussion. The results of the threaded discussion will be analyzed for content and compared to the findings from the Delphi rounds.

Risks and Benefits of Participation
There are no risks of participation in this study beyond the everyday risks of internet use including the receipt of spam or unwanted discovery of your e-mail address. All group correspondence will be sent to you via blind copy so that your e-mail address is not openly visible to other participants. You may use a pseudonym in the threaded discussion. Participants may choose to reveal information about themselves during the electronic discussions and such revelations will be beyond the control of the investigator.

UCF University of Central Florida IRB
IRB NUMBER: SBE-07-05108
IRB APPROVAL DATE: 7/24/2007

There is no personal benefit for participation in this study other than personal gratification for advancing the science of nursing and the intellectual stimulation of participating in an on-line discussion with other international nursing researchers. Study findings will be made available to you upon completion of the study, if desired.

Confidentiality
Your participation in this study is voluntary and you may withdraw at any time. Your identity will be kept confidential. Your information will be assigned a code number. The list connecting your name to this number will be kept in an excel file in a password protected personal computer with backup on a password protected jump drive. When the study is completed and the data have been analyzed, the list will be destroyed. Your name will not be used in any report. Your e-mail address will be maintained in a private, electronic file by the investigator and will not be distributed to others for any purpose.

Instructions for Giving Consent to Participate
To participate in this study, please affix your electronic signature to document provided to you by echosign.com.

Instructions for Participation
Simply follow the link to SurveyMonkey.com at the bottom of this e-mail to complete the demographic form and questionnaire. Your password is your last name. The first question requests that you acknowledge your informed consent to participate in this study.

Study Findings
If you would like to receive a copy of the study findings, your e-mail address will be maintained in an electronic contact list separate from the survey data. Upon completion of the study, a copy of results will be e-mailed to you, providing the e-mail address remains current.

Contact Information
If you have any questions about this research, please contact me by e-mail at mharper14@cfl.rr.com or by phone at (386) 793-6725. You may also contact my faculty advisor Dr. Jacqueline Byers by e-mail at jbyers@mail.ucf.edu or by phone at (407) 823-6311. Questions or concerns about research participants' rights may be directed to the University of Central Florida Institutional Review Board at the UCF Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826. The phone number is 407.823.3778.

Thank you for your consideration.

Sincerely,
Mary G. Harper, MSN, RN-BC
Doctoral Candidate
University of Central Florida

UCF University of Central Florida IRB
IRB NUMBER: SBE-07-05108
IRB APPROVAL DATE: 7/24/2007

APPENDIX H
SAMPLE ELECTRONICALLY SIGNED INFORMED CONSENT

Please read this consent document carefully before deciding to participate in this study. You must be 18 years of age or older to participate.

Informed Consent Form

Project title: Evaluation of Antecedents of Cultural Competence

Purpose of the research study: The purpose of this study is to determine the most important antecedents of cultural competence.

What you will be asked to do in the study: Participation will involve the completion a brief demographic form and two to four questionnaires as part of a Delphi study. The demographic form will take about 10 – 20 minutes to complete. In the first round, you will be asked to rank the importance of a list of antecedents of cultural competence I gleaned from the literature. For subsequent rounds, that will occur at roughly monthly intervals, you will be shown how your results compare to the overall group results and you will be asked to rank the importance of the top items from the previous round. It should take approximately 10 - 20 minutes to complete the first round questionnaire and less time for subsequent rounds as the items are narrowed. The number of rounds will be determined by the degree of consensus among the participants.

After consensus is reached from the Delphi rounds, you will be invited to join an on-line threaded discussion to discuss the findings of the study. This will involve logging on to a password protected website and writing your responses to a few open-ended questions and responding to other participants' responses as you deem appropriate. It should take no longer than 10 – 20 minutes to respond to the initial questions. The threaded discussion will be open for participation for three weeks but you need only participate a few times as your schedule allows. You will receive a reminder e-mail if you have not participated after two weeks of the discussion opening.

Time required: 10 – 20 minutes per round.

Risks: There are no risks of participation in this study beyond the everyday risks of internet use including the receipt of spam or unwanted discovery of your e-mail address.

Benefits/Compensation: There is no compensation or other direct benefit to you for participation.

Confidentiality: Your identity will be kept confidential. Your information will be assigned a code number. The list connecting your name to this number will be kept in a password protected computer with back-up on a password protected jump drive. When the study is completed and the data have been analyzed, the list will be destroyed. Your name will not be used in any report.

Voluntary participation: Your participation in this study is voluntary. There is no penalty for not participating. You have the right to withdraw from the study at any time without penalty.

Whom to contact if you have questions about the study: If you have any questions about this research, please contact me by e-mail at mharper14@cfl.rr.com or by phone at (386) 793-6725. You may also contact my faculty advisor Dr. Jacqueline Byers by e-mail at jbyers@mail.ucf.edu or by phone at (407) 823-6311.

Whom to contact about your rights in the study: Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (IRB). For information about participants' rights please contact: Institutional Review Board Office, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246. The telephone numbers are (407) 882-2276 and (407) 823-2901. The office is open from 8:00 am to 5:00 pm Monday through Friday except on UCF official holidays.

Consent: By affixing my electronic signature to this document, I affirm that I have read the procedure described above and that I voluntarily agree to participate in the study.

Mary G. Harper (mgh)
e-Signed on 2007-07-21 03:40PM EDT
mary.harper@fhms.org

Document Integrity Verified
Transaction Number: 499Q6H2S2C2Q

Send. Sign. Done. EchoSign. Signed: 2007-07-21

APPENDIX I
DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

This demographic questionnaire should take approximately 10 – 20 minutes to complete.

I acknowledge that I have received and read the consent form for this study.
Yes ☐ No ☐

I consent to participate in this study, with understanding that my responses will be known to the investigator for the purposes of feedback in subsequent Delphi rounds.
Yes ☐ No ☐

I confirm that I am at least 18 years old.
Yes ☐ No ☐

E-mail address:

Have you conducted at least one investigation as the primary investigator or co-investigator involving participants from a country and culture, race, and/or ethnicity different from your own in the native country of the participant?
Yes ☐ No ☐

Year of birth:

Gender: Male ☐ Female ☐

Highest education degree:
Associate ☐ Bachelor's ☐ Master's ☐ PhD ☐ Doctorate ☐
Other, specify:

Highest degree in nursing:
Associate ☐ Bachelor's ☐ Master's ☐ PhD ☐ Doctorate ☐
Other, specify:

Number of years since entry level nursing degree:

Current position:

Have you had formal (course, continuing education) transcultural education? Yes ☐ No ☐

Do you currently teach a course or module on cultural competence? Yes ☐ No ☐

Have you taught a course or module on cultural competence in the past? Yes ☐ No ☐

Country of birth:

Country of current residence:

Length of residence in current country:

Primary language: English ☐ Spanish ☐ French ☐ Thai ☐ Japanese ☐
Filipino/Tagalog ☐ Taiwanese ☐ Chinese ☐ Swedish ☐ Finnish ☐

Other ☐ Please specify:

Other languages spoken/competence level (0 = none - 5 = fluent)

English
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Spanish
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

French
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Thai
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Japanese
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Filipino/Tagalog
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Taiwanese
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Chinese
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Swedish
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Finnish
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Other, specify:
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Number of international research studies as primary investigator:
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more ☐

Please specify number if > 5:

(Provide 5 opportunities to answer the following for each study.)

Study #1
Size of research team supervised:
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more ☐

Please specify number if > 5:
Duration of research activity:

Country/countries in which study conducted:

Did you actually spend time in the country/countries in which the research was conducted?
Yes ☐ No ☐
If yes, how long?
Please describe your contact with indigenous healthcare providers:
Please describe your contact with research participants:

Research funding received: Yes ☐ No ☐
If yes, source of funding:
Government ☐ Non-government organization (NGO); non-profit ☐
Faith-based organization ☐ Other ☐ Please specify:

Have you had other, non-research interactions/contact in this country? Yes ☐ No ☐
If yes, please describe briefly:

Number of international research studies as co-investigator:
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more ☐

Please specify number if > 5:

(Provide 5 opportunities to answer the following for each study.)

Study #1
Size of research team supervised:
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more ☐

Please specify number if > 5:

Duration of research activity:

Country/countries in which study conducted:

Did you actually spend time in the country/countries in which the research was conducted?
Yes ☐ No ☐
If yes, how long?
Please describe your contact with indigenous healthcare providers:
Please describe your contact with research participants:

Research funding received: Yes ☐ No ☐
If yes, source of funding:
Government ☐ Non-government organization (NGO); non-profit ☐
Faith-based organization ☐ Other ☐ Please specify:

Have you had other, non-research interactions/contact in this country? Yes ☐ No ☐
If yes, please describe briefly:

APPENDIX J
ROUND ONE QUESTIONNAIRE

Round One Questionnaire

This questionnaire should take approximately 15 – 20 minutes to complete.

Please rate the following concepts and behaviors on a five-point scale according to their level of importance in achieving cultural competence conducting research with an individual from a culture different from your own.

1 = not important at all 5 = extremely important

Native culture of participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Current residence of participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Economic status of participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Politics of participant's/patient's native country
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Education level of participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Occupation of participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Dominant language of participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Nurse researcher's ability to speak language of participant/patient (language concordance)
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Nurse researcher's ability to read language of participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Spatial distancing with participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Appropriate eye contact with participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Understanding of facial expressions of participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Use of greetings understood by participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Understanding of participant/patient's cultural orientation in past, present, or future (temporality)
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Social meanings of time for participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Appropriate use of touch with participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Acceptable use of names and/or titles with participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Understanding of gender roles in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Understanding of child rearing practices in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Understanding of definition of family in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Understanding of importance of family in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Family involvement in health care in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Individual vs. collective viewpoint in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Understanding of social status in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Understanding of worldview of participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Understanding of head of household in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Knowledge of drug metabolism by participant/patient's race
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Knowledge of disease incidence and prevalence in participant/patient's race
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Common foods in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Knowledge of meaning of foods in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Food rituals in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Food taboos in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Use of food in illness and wellness in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Fertility practices in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Birth control practices in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Pregnancy practices in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Views toward pregnancy in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Death rituals in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Bereavement patterns in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Religious practices in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Role of prayer in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Role of spirituality in health/illness in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Health care beliefs in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Focus of health care (preventive vs. acute) in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Self-medication in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Ethnic pharmacology for participant/patient's race
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Use of herbs in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Beliefs about pain in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Barriers to health care in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Status of health care practitioner in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Type of health care practitioner typically consulted (magicoreligious, biomedical, etc) in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Explanatory model of illness (biomedical, spiritual, etc) in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Folk systems of care in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Culturally based physical assessment of participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

How important are the following in conducting culturally competent research?

Caring
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Platonic love
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Sacrifice of prejudice and bias
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Moral commitment
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Passion
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Openness
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Flexibility
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Awareness of differences
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Commitment to build on similarities
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Willingness to learn from others
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Humility
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Self-evaluation of biases and prejudices
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Ethnosensitivity
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Ethnorelativity
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Ethnocentrism
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Face-to-face encounters
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Telephone encounters
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Mutual understanding
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Respect
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Listening
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Please list other concepts/behaviors that are important to achieving cultural competence:

APPENDIX K
ROUND TWO QUESTIONNAIRE

This questionnaire should take approximately 10 minutes to complete.

Please rate the following concepts and behaviors on a five-point scale according to their level of importance in achieving cultural competence conducting research with an individual from a culture different from your own.

1 = not important at all 5 = extremely important

Native culture of participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Current residence of participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Education level of participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Dominant language of participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Nurse researcher's ability to speak language of participant/patient (language concordance)
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Nurse researcher's ability to read language of participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Spatial distancing with participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Appropriate eye contact with participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Understanding of facial expressions of participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Use of greetings understood by participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Understanding of participant/patient's cultural orientation in past, present, or future (temporality)
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Appropriate use of touch with participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Acceptable use of names and/or titles with participant/patient
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Understanding of child rearing practices in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Understanding of definition of family in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Understanding of social status in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Knowledge of disease incidence and prevalence in participant/patient's race
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Common foods in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Knowledge of meaning of foods in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Food rituals in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Food taboos in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Use of food in illness and wellness in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Fertility practices in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Birth control practices in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Pregnancy practices in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Views toward pregnancy in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Death rituals in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Bereavement patterns in participant/patient's culture

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Religious practices in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Role of prayer in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Role of spirituality in health/illness in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Health care beliefs in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Focus of health care (preventive vs. acute) in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Self-medication in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Ethnic pharmacology for participant/patient's race
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Use of herbs in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Beliefs about pain in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Barriers to health care in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Status of health care practitioner in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Type of health care practitioner typically consulted (magicoreligious, biomedical, etc) in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Explanatory model of illness (biomedical, spiritual, etc) in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Folk systems of care in participant/patient's culture
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Culturally based physical assessment of participant/patient

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

How important are the following in conducting culturally competent research?

Caring
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Platonic love
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Sacrifice of prejudice and bias
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Moral commitment
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Passion
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Commitment to build on similarities
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Ethnocentrism
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Face-to-face encounters
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Mutual understanding
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Listening
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Understanding of history/how the society was shaped
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Empathy
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Communication skills
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Equity
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Social inclusion
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Health inequalities
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Acceptance
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Communitarianism
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Universality
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Gratitude
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Promotion of common good
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Humor
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Positivity
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Internet encounters
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

APPENDIX L
INVITATION TO PARTICIPATE IN ONLINE FOCUS GROUP

Dear (participant's name):

We are ready to begin the last phase of data collection for the Evaluation of the Antecedents of Cultural Competence study. As a nurse who has conducted international research, you possess first hand knowledge of what cultural competence encompasses. Your continued participation during this phase of the research is critical to advance our profession's knowledge about cultural competence.

During this component of data collection, you will participate in an online focus group with the other participants in this study. Your identity will remain anonymous unless you choose to disclose information about yourself during the course of the discussion.

I have posted several questions for discussion. Please respond to as many questions as you can over the course of the next three weeks. In addition, I encourage you to respond to the postings of other participants.

A copy of the results of the Delphi rounds, with your personal responses, is attached to this e-mail. You may want to refer to the results as you respond to the discussion questions.

Please follow the link below to the threaded discussion Web site e-Focus Groups, The Brainchild Forum (you may have to copy and paste in your browser address line):

www.e-focusgroups.com/forum1

At the far right of the horizontal teal bar, click on log-in.

Your user name is: Participant1
Your password is: culture

Please note that the login screen is case-sensitive. You will find further discussion questions on the Web site.

The Web site will remain open from now until December 16. Remember, if you have any questions about this study, please feel free to contact me at this e-mail address or my adviser, Dr. Jacqueline Byers at jbyers@mail.ucf.edu .

Thank you again for your participation.

Mary G. Harper, MSN, RN-BC
Doctoral Candidate
University of Central Florida

APPENDIX M
ONLINE FOCUS GROUP THREADED DISCUSSION QUESTIONS

Threaded Discussion Questions

NOTE: These questions are subject to change based on results of Delphi rounds.

The following antecedents of cultural competence were identified as most important by the participants in this research study: (List results from Delphi rounds)

1. Compare these results with your conceptualization of what makes an international nurse researcher culturally competent.
2. Do you disagree with any of the findings from the Delphi portion of the study and if so, why?
3. Is there anything you wish you had brought up in the Delphi rounds that we can discuss now?
4. Identify behaviors that promote the success of a nurse researcher in conducting research in a culture different from his/her own in the country of the participant.
5. Globalization of health care has caused nursing leaders to call for a "global nursing ethic." How would you conceptualize this "global nursing ethic?"

Further probing questions will be asked as indicated.

APPENDIX N
PERMISSIONS TO USE COPYRIGHTED MATERIALS

1832 South Central Avenue
Flagler Beach, FL 32136
January 13, 2008

Larry Purnell PhD, RN, FAAN
Professor Nursing
University of Delaware
McDowell Hall
Newark, DE 19716

Dear Dr. Purnell,

I am completing my doctoral dissertation entitled "Evaluation of the Antecedents of Cultural Competence" at the University of Central Florida. Pursuant to our recent e-mail communications, I am writing to request written permission to place a reproduction of the Purnell Model for Cultural Competence (Figure 1) from the following:

Purnell, Larry (2005). The Purnell Model for Cultural Competence. *Journal of Multicultural Nursing and Health*, 11(2), pg. 7 – 15.

The reproduction will be from the file that you e-mailed me entitled PurnellModel2.8.05.

The requested permission extends to any future revisions and editions of my dissertation, including non-exclusive world rights in all languages, and to the publication of my dissertation on demand by UMI (formerly University Microfilms). These rights will in no way restrict republication of the material in any other form by you or by others authorized by you. Your signing of this letter will also confirm that you, or your company, owns the copyright to the above-described material.

If these arrangements meet with your approval, please electronically sign this letter as directed by the instructions from the secure Echosign website.

Thank you for your attention to this matter.

Sincerely,

Mary G. Harper, MSN, RN-BC
Doctoral Candidate
University of Central Florida

Larry Dale Purnell (LDP)
e-Signed on 2008-03-16 04:03PM EDT
lpurnell@udel.edu

TRANSCULTURAL C.A.R.E.
Clinical, Administrative, Research & Educational Consultation in Transcultural Health Care

J. Campinha-Bacote,
PhD, MAR, APRN, BC, CTN, CNS, FAAN

Transcultural Healthcare Consultant

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www.transculturalcare.net

11108 Huntwicke Place
Cincinnati, Ohio 45241

Date: January 22, 2008

To: Ms. Mary Harper
From: Dr. Josepha Campinha-Bacote
President, Transcultural C.A.R.E. Associates

RE: Letter of Permission For a Limited Use of My 2002 Model

This letter grants permission to Ms. Mary Harper to copy my 2002 volcano model of cultural competence as it appears on my website at www.transculturalcare.net/Cultural_Competence_Model.htm, for a one-time use in her doctoral dissertation entitled, *"Evaluation of the Antecedents of Cultural Competence"* at the University of Central Florida. This permission extends to future revisions and editions of her dissertation and to the publication of her dissertation by UMI (formerly University Microfilms). However, in her dissertation and in the UMI publication it must clearly state that my model is copyrighted and cannot be used without my permission. Please know that I do not grant permission for my tool to appear in any format outside this purpose dissertation. Ms. Mary Harper agrees to use the following citation when citing my model in this paper:

Copyrighted by Campinha-Bacote (2002);
Reprinted with Permission from
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Clinical, Administrative, Research
& Educational Consultation
in Transcultural Health Care

J. Campinha-Bacote,
PhD, MAR, APRN, BC, CTN, CNS, FAAN

Transcultural Healthcare Consultant

January 17, 2008

To: Ms. Mary Harper
From: Dr. Josepha Campinha-Bacote
President, Transcultural C.A.R.E. Associates

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Please acknowledge Dr. Marianne R. Jeffreys as creator of the TSET instrument.

Best wishes in your research endeavors and commitment to cultural competent care. I would be happy to discuss the TSET with you and maintain correspondence as a consultant.

Sincerely,

Marianne R. Jeffreys

Marianne R. Jeffreys, EdD, RN
Professor, Nursing
jeffreys@mail.csi.cuny.edu
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1832 South Central Avenue
Flagler Beach, FL 32136
February 16, 2008

Stephanie Myers Schim, PhD, RN, APRN-BC
Associate Professor / College of Nursing
Associate Director for Education
Center to Advance Palliative-Care Excellence
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Abriam-Yago, K., Yoder, M., & Kataoka-Yahiro, M. (1999). The Cummings Model: A framework for teaching nursing students for whom English is a second language. *Journal of Transcultural Nursing, 10*(2), 143-149.

Aday, L. A. (2001). *At risk in America: The health and health care needs of vulnerable populations in the United States*. San Francisco: Jossey-Bass.

Agency for Healthcare Research and Quality. (n.d.). *Healthy People 2010: Midcourse Review*. Retrieved April 29, 2007, from http://www.healthypeople.gov/data/midcourse/html/default.htm#FocusAreas

Alpers, R. R. (1996). Comparison of cultural competence and cultural confidence of senior nursing students in a private southern university. *Journal for Nurses in Staff Development, 3*(1), 9-15.

Amaro, D. J., Abriam-Yago, K., & Yoder, M. (2006). Perceived barriers for ethnically diverse students in nursing programs. *Journal of Nursing Education, 45*(7), 247-254.

American Association of Colleges of Nurses. (2001). *Effective strategies for increasing diversity in nursing programs*. Retrieved March 15, 2008, from http://www.aacn.nche.edu/Publications/issues/dec01.htm

American Association of Colleges of Nursing. (2007). *Annual state of the schools*. Retrieved March 15, 2008, from http://www.aacn.nche.edu/Media/pdf/AnnualReport07.pdf

Anderson, K. L. (2004). Teaching cultural competence using an exemplar from literary journalism. *Journal of Nursing Education, 43*(6), 253-259.

Andrews, D. R. (2003). Lessons from the past: Confronting past discriminatory practices to alleviate the nursing shortage through increased professional diversity. *Journal of Professional Nursing, 19*(5), 289-294.

Baker, J., Lovell, K., & Harris, N. (2006). How expert are the experts? An exploration of the concept of 'expert' within Delphi panel techniques. *Nurse Researcher, 14*(1), 59.

Bandura, A., & Locke, E. (2003). Negative self-efficacy and goal effects revisited. *Journal of Applied Psychology, 88*(1), 87.

Beach, M. C., Price, E. G., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A., et al. (2005). Cultural competence: A systematic review of health care provider educational interventions. *Medical Care, 43*(4), 356-373.

Beach, M. C., Saha, S., & Cooper, L. A. (2006). *The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality*: The Commonwealth Fund.

Beech, B. (2001). The Delphi approach: Recent applications in health care. *Nurse Researcher, 8*(4), 38-48.

Bernal, H. (1993). A model for delivering culture-relevant care in the community. *Public Health Nursing, 10*(4), 228-232.

Bernal, H., & Froman, R. (1987). The confidence of community health nurses in caring for ethnically diverse populations. *IMAGE: Journal of Nursing Scholarship, 19*(4), 201-203.
Bernal, H., & Froman, R. (1993). Influences on the cultural self-efficacy of community health nurses. *Journal of Transcultural Nursing, 4*(2), 24.
Bernard, H. R. (2006). *Research methods in anthropology* (4th ed.). New York: Altamira Press.
Betancourt, J. (2006). *Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care*: The Commonwealth Fund.
Betancourt, J., Green, A. R., Carillo, E., & Park, E. R. (2005). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs, 24*(2), 499.
Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*(4), 293.
Brach, C., Fraser, I., & Paez, K. (2005). Crossing the language chasm. *Health Affairs, 24*(2), 424.
Braithwaite, A. (2006). Influence of nurse characteristics on the acquisition of cultural competence, *International Journal of Nursing Education Scholarship* (Vol. 3): Berkeley Electronic Press.
Brathwaite, A. C. (2003). Selection of a conceptual model/framework for guiding research interventions. *The Internet Journal of Advanced Nursing Practice, 6*(1).
Brathwaite, A. C. (2005). Evaluation of a cultural competence course. *Journal of Transcultural Nursing, 16*(4), 361-369.
Brathwaite, A. C. (2006). Influence of nurse characteristics on the acquisition of cultural competence, *International Journal of Nursing Education Scholarship* (Vol. 3): Berkeley Electronic Press.
Caffrey, R. A., Neander, W., Markle, D., & Stewart, B. (2005). Improving the cultural competence of nursing students: Results of integrating cultural content in the curriculum and an international immersion experience. *Journal of Nursing Education, 44*(5), 234-239.
Caldwell, J. Y., Davis, J. D., Du Bois, B., Echo-Hawk, H., Erickson, J. S., Goins, T., et al. (2005). Culturally competent research with American Indians and Alaska Natives: Findings and recommendations of the First Symposium of the Work Group on American Indian Research and Program Evaluation Methodology. *American Indian & Alaska Native Mental Health Research: The Journal of the National Center, 12*(1), 1-21.
Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education, 38*(5), 203-207.
Campinha-Bacote, J. (2001). A model of practice to address cultural competence in rehabilitation nursing. *Rehabilitation Nursing, 26*(1), 8.
Campinha-Bacote, J. (2003a). Cultural desire: The spiritual key to cultural competence. *Journal of Christian Nursing, 20*(3), 20-22.
Campinha-Bacote, J. (2003b). *The Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care*. Cincinnati, OH: Transcultural C.A.R.E.

Campinha-Bacote, J. (2005). A Biblically based model of cultural competence in healthcare delivery. *Journal of Multicultural Nursing & Health 11*(2), 16.
Campinha-Bacote, J. (2007). *The Process of Cultural Competence in the Delivery of Healthcare Services: The journey continues*. Cincinnati, OH: Transcultural C.A.R.E. Associates.
Capell, J., Veenstra, G., & Dean, E. (2007). Cultural competence in healthcare: Critical analysis of the construct, its assessment and implications. *Journal of Theory Construction & Testing, 11*(1), 30-37.
Carnegie Endowment for International Peace. (n.d.). *What is globalization?* Retrieved March 1, 2008, from http://www.globalization101.org/What_is_Globalization.html?PHPSESSID=cbeaca9329f9a51b9f691b1ac53ef050
Centers for Disease Control and Prevention. (2007, April 16). *Eliminating Racial & Ethnic Health Disparities*. Retrieved April 25, 2007, from http://www.cdc.gov/omh/AboutUs/disparities.htm
Clegg, A. (2003). Older South Asian patient and carer perceptions of culturally sensitive care in a community hospital setting. *Journal of Clinical Nursing, 12*, 283-290.
Coffman, M. J., Shellman, J., & Bernal, H. (2004). An integrative review of American nurses' perceived cultural self-efficacy. *Journal of Nursing Scholarship, 36*(2), 180-185.
Cortis, J., & Kendrick, K. (2003). Nursing ethics, caring and culture. *Nursing Ethics, 10*(1), 77-88.
Crigger, N., Brannigan, M., & Baird, M. (2006). Compassionate nursing professionals as good citizens of the world. *Advances in Nursing Science, 29*(1), 15 - 26.
Crigger, N., & Holcomb, L. (2007). Practical strategies for providing culturally sensitive, ethical care in developing nations. *Journal of Transcultural Nursing, 18*(1), 70 - 76.
Crigger, N. J. (2008). Towards a viable and just global nursing ethics. *Nursing Ethics, 15*(1), 17-27.
Crigger, N. J., Holcomb, L., & Weiss, J. (2001). Fundamentalism, multiculturalism and problems of conducting research with populations in developing nations. *Nursing Ethics, 8*(5), 459-468.
Davidson, P., Meleis, A., Daly, J., & Douglas, M. (2003). Globalisation as we enter the 21st century: Reflections and directions for nursing education, science, research and clinical practice. *Contemporary Nurse, 15*(3), 162-174.
Davis, S. L., & Finney, S. J. (2006). A factor analytic study of the cross-cultural adaptability inventory. *Educational & Psychological Measurement, 66*(2), 318-330.
Davison, C. M., Brown, M., & Moffitt, P. (2006). Student researchers negotiating consent in northern Aboriginal communities. *International Journal of Qualitative Methods, 5*(2), 1.
Dawson, L., & Kass, N. E. (2005). Views of US researchers about informed consent in international collaborative research. *Social Science & Medicine, 61*(6), 1211.
de Meyrick, J. (2003). The Delphi method and health research. *Health Education, 103*(1), 7-16.

De Villiers, M. R., De Villiers, P. J., & Kent, A. P. (2005). The Delphi technique in health sciences education research. *Medical Teacher, 27*(7), 639-643.

Dennis, K., Edmonds, A., Weinstein, P. W., & Decker, J. W. (2007). *Life course weight gain, risk factors for cardiovascular disease, and weight loss trajectories in overweight or obese postmenopausal women.* Paper presented at the Sigma Theta Tau International, Theta Epsilon Chapter Fourteenth Annual Research Day, Orlando, FL.

Doorenbos, A. Z., & Schim, S. M. (2004). Cultural competence in hospice. *American Journal of Hospice & Palliative Care, 21*(1), 28-32.

Doorenbos, A. Z., Schim, S. M., Benkert, R., & Borse, N. N. (2005). Psychometric evaluation of the Cultural Competence Assessment instrument among healthcare providers. *Nursing Research, 54*(5), 324-331.

Doutrich, D., & Storey, M. (2004). Education and practice: Dynamic partners for improving cultural competence in public health. *Family & Community Health, 27*(4), 298-307.

Endicott, L., Bock, T., & Narvaez, D. (2003). Moral reasoning, intercultural development, and multicultural experiences: Relations and cognitive underpinnings. *International Journal of Intercultural Relations, 27*, 403-419.

Etowa, J. B., Foster, S., Vukic, A. R., Wittstock, L., & Youden, S. (2005). Recruitment and retention of minority students: Diversity in nursing education. *International Journal of Nursing Education Scholarship, 2*(1), 1-12.

Evanson, T., & Zust, B. (2006). "Bittersweet knowledge": the long-term effects of an international experience. *Journal of Nursing Education, 45*(10), 412.

Fadiman, A. (1997). *The spirit catches you and you fall down*. New York: Farrar, Straus and Giroux.

Faulk-Rafael, A. (2006). Globalization and global health: Toward nursing praxis in the global community. *Advances in Nursing Science, 29*(1), 2-14.

Fletcher, A., Williams, P. R., Beacham, T., Elliott, R. W., Northington, L., Calvin, R., et al. (2003). Recruitment, retention and matriculation of ehtnic minority nursing students: A University of Mississippi School of Nursing approach. *Journal of Cultural Diversity, 10*(4), 128-133.

Fortier, J. P., & Bishop, D. (2004). *Setting the agenda for research on cultural competence in health care*. Rockville, MD: U.S. Department of Health and Human Services Office of Minority Health and Agency for Healthcare Research and Quality.

Genao, I., Bussey-Jones, J., Brady, D., Branch, W. T., & Corbie-Smith, G. (2003). Building the case for cultural competence. *The American Journal of the Medical Sciences, 326*(3), 136-140.

Giger, J. N., Davidhizar, R., Purnell, L., Harden, J. T., Phillips, J., & Strickland, O. L. (2007a). American Academy of Nursing expert panel report: Developing cultural competence to eliminate health disparities in ethnic minorities and other vulnerable populations. *Journal of Transcultural Nursing, 18*(2), 95.

Giger, J. N., Davidhizar, R., Purnell, L., Harden, J. T., Phillips, J., & Strickland, O. L. (2007b). Understanding cultural language to enhance cultural competence. *Nursing Outlook, 55*(4), 212-214.

Goode, T. D., Dunne, C., & Bronheim, S. M. (2006). *The evidence base for cultural and linguistic competency in health care*. Retrieved March 8, 2008, from http://www.commonwealthfund.org/usr_doc/Goode_evidencebasecultlinguisticcomp_962.pdf?section=4039

Goodman, C. M. (1987). The Delphi technique: A critique. *Journal of Advanced Nursing, 12*(6), 729.

Gozu, A., Beach, M. C., Price, E. G., Gary, T. L., Robinson, K. A., Palacio, A., et al. (2007). Self-administered instruments to measure cultural competence of health professionals: A systematic review. *Teaching & Learning in Medicine, 19*(2), 180-190.

Gray, D., & Thomas, D. (2005). Critical analysis of "culture" in nursing literature: Implications for nursing education in the United States. *Annual Review of Nursing Education, 3*, 249.

Gray, D., & Thomas, D. (2006). Critical reflections on culture in nursing. *Journal of Cultural Diversity, 13*(2), 76-82.

Greatorex, J., & Dexter, T. (2000). An accessible analytical approach for investigating what happens between the rounds of a Delphi study. *Journal of Advanced Nursing, 32*(4), 1016.

Gudykunst, W. B., & Kim, Y. Y. (2003). *Communicating with Strangers* (4th ed.). New York: McGraw-Hill.

Gulas, C. J. (2005). Establishing the reliability of using the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals with physical therapy students. *Dissertation Abstracts International*(AAT 3185062).

Gustafson, D. L. (2005). Transcultural nursing theory from a critical cultural perspective. *Advances in Nursing Science, 28*(1), 2-16.

Hagman, L. W. (2006). Cultural self-efficacy of licensed registered nurses in New Mexico. *Journal of Cultural Diversity, 13*(2), 105-112.

Harper, M. G. (2006). Ethical multiculturalism: An evolutionary concept analysis. *Advances in Nursing Science 29*(2), 110-124.

Harper, M. G. (2007, September). *Measurement of cultural competence: A barrier to research and education.* Paper presented at the Transcultural Nursing Society 33rd Annual Conference, Bournemouth, UK.

Hasson, F., Keeney, S., & McKenna, H. (2000). Research guidelines for the Delphi survey technique. *Journal of Advanced Nursing, 32*(4), 1008.

Helman, C. G. (2000). *Culture, health and illness* (4th ed.). Boston: Butterworth Heinemann.

Hughes, K., & Hood, L. (2007). Teaching methods and an outcome tool for measuring cultural sensitivity in undergraduate nursing students. *Journal of Transcultural Nursing, 18*(1), 57.

Hyder, A. A., & Wali, S. A. (2006). Informed consent and collaborative research: perspectives from the developing world. *Developing World Bioethics, 6*(1), 33.

Im, E., & Meleis, A. (1999). Situation-specific theories: Philosophical roots, properties, and approach. *Advances in Nursing Science, 22*(2), 11-24.

Institute of Medicine. (2006). *Examining the health disparities research plan of the National Institutes of Health: Unfinished business.* Washington, DC: National Academies Press.

International Council of Nurses. (n.d.). *About the International Council of Nurses*. Retrieved March 11, 2007, from http://www.icn.ch/abouticn.htm

International Council of Nurses, Florence Nightingale International Foundation, & Burdett Trust for Nursing. (2006). *The global nursing shortage: Priority areas for intervention*. Geneva, Switzerland: Authors.

Jacobson, S. F., Chu, N. L., Pascucci, M. A., & Gaskins, S. W. (2005). Culturally competent scholarship in nursing research. *Journal of Transcultural Nursing, 16*(3), 202.

Jeffreys, M. R. (2000). Development and psychometric evaluation of the Transcultural Self-Efficacy Tool: A synthesis of findings. *Journal of Transcultural Nursing, 11*(2), 127-136.

Jeffreys, M. R. (2006). *Teaching cultural competence in nursing and health care*. New York: Springer.

Jeffreys, M. R., & Smodlaka, I. (1998). Exploring the factorial composition of the transcultural self-efficacy tool. *International Journal of Nursing Studies, 35*, 217-225.

Jeffreys, M. R., & Smodlaka, I. (1999a). Changes in students' transcultural self-efficacy perceptions following an integrated approach to culture care. *Journal of Multicultural Nursing & Health (JMCNH), 5*(2), 6.

Jeffreys, M. R., & Smodlaka, I. (1999b). Construct validation of the Transcultural Self-Efficacy Tool. *Journal of Nursing Education, 38*(5), 222-227.

Jimenez, J. A., Shellman, J., Gonzalez, M. L., & Bernal, H. (2006). The level of cultural self-efficacy among a sample of Spanish Nurses in southeastern Spain. *Journal of Transcultural Nursing, 17*(2), 164-170.

Johnson, R. L., Saha, S., Arbelaez, J. J., Beach, M. C., & Cooper, L. A. (2004). Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. *Journal of General Internal Medicine, 19*, 101-110.

Kardong-Edgren, S. (2007). Cultural competence of baccalaureate nursing faculty. *Journal of Nursing Education, 46*(8), 360-366.

Kardong-Edgren, S., Bond, M. L., Schlosser, S., Cason, C., Jones, M. E., Warr, R., et al. (2005). Cultural attitudes, knowledge and skills of nursing faculty toward patients from four diverse cultures. *Journal of Professional Nursing, 21*(3), 175-182.

Keeney, S., Hasson, F., & McKenna, H. (2001). A critical review of the Delphi technique as a research methodology for nursing. *International Journal of Nursing Studies, 38*(2), 195.

Keeney, S., Hasson, F., & McKenna, H. (2006). Consulting the oracle: Ten lessons from using the Delphi technique in nursing research. *Journal of Advanced Nursing, 53*(2), 205-212.

Kelley, C., & Meyers, J. (1987). *CCAI: Cross-Cultural Adaptability Inventory*. Minneapolis, MN: National Computer Systems.

Knapp, S., Byers, J., & Polizze, J. (2008, February). *Parental perceptions of the NICU experience.* Paper presented at the Graven's High Risk Infant Conference, Clearwater, FL.

Koskinen, L., & Tossavainen, K. (2004). Study abroad as a process of learning intercultural competence in nursing. *International Journal of Nursing Practice, 10*(3), 111-120.
Kraemer, T. J., & Beckstead, J. (2003). Establishing the reliability of using the Cross-Cultural Adaptability Inventory with physical therapist students. *Journal of Physical Therapy Education, 17*(1), 27 - 32.
Kulwicki, A., & Bolonik, B. J. (1996). Assessment of level of comfort in providing multicultural nursing care by baccalaureate nursing students. *Journal of Cultural Diversity, 3*(2), 40-45.
Ladenheim, K., & Groman, R. (2006). State legislative activities related to elimination of health disparities. *Journal of Health Politics, Policy & Law, 31*(1), 153.
Leininger, M. (1997). Overview of the theory of culture care with the ethnonursing research method. *Journal of Transcultural Nursing, 9*(2), 32.
Leininger, M. (2002). Part I. The theory of culture care and the ethnonursing research method. In M. Leininger & M. R. McFarland (Eds.), *Transcultural nursing: concepts, theories, research, and practice* (3rd ed., pp. 71-98). New York: McGraw-Hill.
Leininger, M. (2007). Theoretical questions and concerns: Response from the Theory of Culture Care Diversity and Universality perspective. *Nursing Science Quarterly, 20*(1), 9-15.
Leininger, M., & McFarland, M. R. (2006). *Culture care diversity and universality: A worldwide nursing theory* (2nd ed.). Boston: Jones and Bartlett.
Lim, J., Downie, J., & Nathan, P. (2004). Nursing students' self-efficacy in providing transcultural care. *Nurse Education Today, 24*, 428-434.
Lindsay, J. (2005). Achieving compliance with Title VI of the Civil Rights Act of 1964: a comprehensive approach to ensuring meaningful access to services for limited-English-proficient individuals... Selected proceedings from the 23rd Annual Meeting and Educational Conference of The American Association of Nurse Attorneys, October 28-30, 2004, Orlando, Florida. *Journal of Nursing Law, 10*(1), 47.
Linstone, H. A., & Turoff, M. (1975). The Delphi method: Techniques and applications: Addison-Wesley.
Lipson, J. G., & Desantis, L. A. (2007). Current approaches to integrating elements of cultural competence in nursing education. *Journal of Transcultural Nursing, 18*(1), 10S-20S.
Loustaunau, M. O., & Sobo, E. J. (1997). *The cultural context of health, illness, and medicine*. Westport, CT: Bergin & Garvey.
Lurie, N., Jung, M., & Lavizzo-Mourey, R. (2005). Disparities and quality improvement: Federal policy levers. *Health Affairs, 24*(2), 354.
Lutzen, K. (1997). Nursing ethics into the next millennium: A context-sensitive approach for nursing ethics. *Nursing Ethics, 4*(3), 218-226.
Lynam, M. J., Browne, A. J., Kirkham, S. R., & Anderson, J. M. (2007). Re-thinking the complexities of 'culture': What might we learn from Bourdieu? *Nursing Inquiry, 14*(1), 23-34.
Macklin, R. (2002). Mistaking procedural requirements for ethical standards. *Ethics and Behavior, 12*(4), 378-381.

Magee, K. W., Darby, M. L., Connolly, I. M., & Thomson, E. (2004). Cultural adaptability of dental hygiene students in the United States: A pilot study. *The Journal of Dental Hygiene, 78*(1), 22-29.
Majumdar, B., Keystone, J. S., & Cuttress, L. A. (1999). Cultural sensitivity training among foreign medical graduates. *Medical Education, 33*, 177-184.
Marshall, P. A. (2006). Informed consent in international health research. *Journal of Empirical Research on Human Research Ethics, 1*(1), 25.
McNeal, G. J., & Walker, D. (2006). Enhancing success in advanced practice nursing: A grant-funded project. *Journal of Cultural Diversity, 13*(1), 10-19.
Mead, D., & Moseley, L. (2001a). Considerations in using the Delphi approach: Design, questions and answers. *Nurse Researcher, 8*(4), 24-37.
Mead, D., & Moseley, L. (2001b). The use of the Delphi as a research approach. *Nurse Researcher, 8*(4), 4-23.
Meleis, A. (1996). Culturally competent scholarship: Substance and rigor... based on a keynote speech given at the 11th research conference "Toward Culturally Competent Health Care," Rutgers State University. *Advances in Nursing Science, 19*(2), 1.
Mendias, E., & Guevara, E. (2001). Assessing culturally competent scholarship. *Journal of Professional Nursing, 17*(5), 256.
Mensah, G., & Dunbar, S. (2006). A framework for addressing disparities in cardiovascular health. *Journal of Cardiovascular Nursing, 21*(6), 451.
Meyers, J. (2001). *Test developer profiles*. New York: McGraw Hill.
Michigan Center for Nursing. (2006). *Survey of nursing education programs: 2005-2006 school year*. Retrieved March 15, 2008, from http://www.mhc.org/mhc_images/edprogramsurvey06.pdf
Nápoles-Springer, A., Santoyo, J., Houston, K., Pérez-Stable, E., & Stewart, A. (2005). Patients' perceptions of cultural factors affecting the quality of their medical encounters. *Health Expectations, 8*(1), 4.
National Advisory Council on Nurse Education and Practice. (2003). *Third report to the secretary of Health and Human Services and the Congress*. Retrieved March 15, 2009, from ftp://ftp.hrsa.gov/bhpr/nursing/nacreport.pdf
National Student Nurses' Association. (2007). *NSNA guidelines for planning: 2007-2008 Image of Nursing projects*. Retrieved March 15, 2008, from http://www.nsna.org/pubs/guidelines/image_guidelines.pdf
Nokes, K. M., Nickitas, D. M., Keida, R., & Neville, S. (2003). Using technology to enhance service-learning reflections. *Academic Exchange Quarterly, 7*(2), 86-91.
Nokes, K. M., Nickitas, D. M., Keida, R., & Neville, S. (2005). Does service-learning increase cultural competency, critical thinking, and civic engagement? *Journal of Nursing Education, 44*(2), 65-70.
Noone, J., Carmichael, J., Carmichael, R. W., & Chiba, S. N. (2007). An organized pre-entry pathway to prepare a diverse nursing workforce. *Journal of Nursing Education, 46*(6), 287-291.
Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care: Final report*. Retrieved February 17, 2006, from http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf

Office of Minority Health. (n.d.). *The Office of Minority Health*. Retrieved April 24, 2007, from http://www.omhrc.gov/

Pacquiao, D. (2007). The relationship between cultural competence education and increasing diversity in nursing schools and practice settings. *Journal of Transcultural Nursing, 18*(1), 28S-37S.

Papadopoulos, I., & Lees, S. (2002). Developing culturally competent researchers. *Journal of Advanced Nursing, 37*(3), 258.

Polit, D. F., & Beck, C. T. (2004). *Nursing research: Principles and methods* (7th ed.). Baltimore: Lippincott Williams & Wilkins.

Polit, D. F., & Beck, C. T. (2006). The content validity index: Are you sure you know what's being reported? Critique and recommendations. *Research in Nursing & Health, 29*(5), 489.

Ponce, N. A., Hays, R. D., & Cunningham, W. E. (2006). Linguistic disparities in health care access and health status among older adults. *Journal of General Internal Medicine, 21*(7), 786.

Potter, P. A., & Perry, A. G. (2005). *Fundamentals of nursing* (6th ed.). St. Louis, MO: Mosby.

Powell, C. (2003). The Delphi technique: Myths and realities. *Journal of Advanced Nursing, 41*(4), 376-382.

Powell, L., & Harper, M. G. (2007, November). *Searching for meaning: Men's construction of their illness experience following laparoscopic prostatectomy.* Paper presented at the Sigma Theta Tau International 39th Biennial Convention, Baltimore, MD.

Price, E. G., Beach, M. C., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A., et al. (2005). A systematic review of the methodological rigor of studies evaluating cultural competence training of health professionals. *Academic Medicine, 80*(6), 578-586.

Purnell, L. (1999). Panamanians' practices for health promotion and the meaning of respect afforded them by health care providers. *Journal of Transcultural Nursing, 10*(4), 331.

Purnell, L. (2000). A description of the Purnell model for cultural competence. *Journal of Transcultural Nursing, 11*(1), 40.

Purnell, L. (2001). Guatemalans' practices for health promotion and the meaning of respect afforded them by health care providers. *Journal of Transcultural Nursing, 12*(1), 40.

Purnell, L. (2002). The Purnell model for cultural competence. *Journal of Transcultural Nursing, 13*(3), 193.

Purnell, L. (2005). The Purnell model for cultural competence. *Journal of Multicultural Nursing & Health 11*(2), 7.

Qualitative Research Consultants Association. *e-FocusGroups: The Brainchild Forum*. Retrieved June 12, 2007, from http://www.e-focusgroups.com/brainchild.html

Reeves, J. S., & Fogg, C. (2006). Perceptions of graduating nursing students regarding life experiences that promote culturally competent care. *Journal of Transcultural Nursing, 17*(2), 171-178.

Rew, L., Becker, H., Cookston, J., Khosropour, S., & Martinez, S. (2003). Measuring cultural awareness in nursing students. *Journal of Nursing Education, 42*(6), 249.

Richards, L., & Morse, J. M. (2007). *User's guide to qualitative methods* (2nd ed.). London: Sage.
Salman, A., McCabe, D., Easter, T., Callahan, B., Goldstein, D., Smith, T., et al. (2007). Cultural competence among staff nurses who participated in a family-centered geriatric care program. *Journal for Nurses in Staff Development, 23*(3), 103-111.
Sargent, S. E., Sedlak, C. A., & Martsolf, D. S. (2005). Cultural competence among nursing students and faculty. *Nurse Education Today, 25*, 214-221.
Sawyer, L., Regev, H., Proctor, S., Nelson, M., Messias, D., Barnes, D., et al. (1995). Matching versus cultural competence in research: Methodological considerations. *Research in Nursing & Health, 18*(6), 557-567.
Schim, S. M., Doorenbos, A. Z., Benkert, R., & Miller, J. (2007). Culturally congruent care: Putting the puzzle together. *Journal of Transcultural Nursing, 18*(2), 103-110.
Schim, S. M., Doorenbos, A. Z., & Borse, N. N. (2005). Cultural competence among Ontario and Michigan healthcare providers. *Journal of Nursing Scholarship, 37*(4), 354-360.
Schim, S. M., Doorenbos, A. Z., & Borse, N. N. (2006). Cultural competence among hospice nurses. *Journal of Hospice & Palliative Nursing, 8*(5), 302.
Schim, S. M., Doorenbos, A. Z., Miller, J., & Benkert, R. (2003). Development of a cultural competence assessment instrument. *Journal of Nursing Measurement, 11*(1), 29-40.
Shellman, J. (2006). Development and psychometric evaluation of the Eldercare Cultural Self-Efficacy Scale. *International Journal of Nursing Education Scholarship, 3*(1), 1-15.
Siantz, M. L., & Meleis, A. (2007). Integrating cultural competence into nursing education and practice: 21st century action steps. *Journal of Transcultural Nursing, 18*(1), 86S.
Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academies Press.
Smith-Campbell, B. (2005). Health professional student's cultural competence and attitudes toward the poor: The influence of a clinical practicum supported by the National Health Service Corps. *Journal of Allied Health, 34*(1), 56-62.
Smith, M. C. (2003). Evaluation of middle range theories for the discipline of nursing. In M. J. Smith & P. R. Liehr (Eds.), *Middle Range Theory for Nursing*. New York: Springer.
Snowden, L. R., Masland, M., & Guerrero, R. (2007). Federal civil rights policy and mental health treatment access for persons with limited English proficiency. *American Psychologist, 62*(2), 109.
St. Clair, A., & McKenry, L. (1999). Preparing culturally competent practitioners. *Journal of Nursing Education, 38*(5), 228-234.
Stewart, B. (2006). Enhancing success in BSN nursing education for minority students. *Association of Black Nursing Faculty Journal*, 8-10.
Streiner, D. L., & Norman, G. R. (2003). *Health measurement scales: A practical guide to their development and use* (3rd ed.). New York: Oxford University Press.

Suh, E. E. (2004). The model of cultural competence through an evolutionary concept analysis. *Journal of Transcultural Nursing, 15*(2), 93-102.

Sullivan Commission. (2004). *Missing persons: Minorities in the health professions*: Author.

Sutherland, J. A., Hamilton, M. J., & Goodman, N. (2007). Affirming At-Risk Minorities for Success (ARMS): Retention, graduation, and success on the NCLEX-RN. *Journal of Nursing Education, 46*(8), 347-353.

Tan, J., Low, J. A., Yap, P., Lee, A., Pang, W. S., & Wu, Y. J. (2006). Caring for dying patients and those facing death in an acute-care hospital in Singapore - A nurse's perspective. *Journal of Gerontological Nursing, 32*(5), 17-24.

Taxis, J. C. (2006). Fostering academic success of Mexican Americans in a BSN program: An educational imperative. *International Journal of Nursing Education Scholarship, 3*(1), 1-14.

The Sullivan Alliance. (2007). *Summary proceedings on the National Leadership Symposium on Increasing Diversity in the Health Professions*

Retrieved March 15, 2008, from http://www.aacn.nche.edu/Media/pdf/SullivanJun07update.pdf

Thom, D. H., & Tirado, M. D. (2006). Development and validation of a patient-reported measure of physician cultural competency. *Medical Care Research & Review, 63*(5), 636-655.

Thomas, S., Benjamin, G., Almario, D., & Lathan, M. (2006). Historical and current policy efforts to eliminate racial and ethnic health disparities in the United States: Future opportunities for public health education research. *Health Promotion Practice, 7*(3), 324.

Ton, H., Koike, A., Hales, R., Johnson, J., & Hilty, D. (2005). A qualitative needs assessment for development of a cultural consultation service. *Transcultural Psychiatry, 42*(3), 491-504.

Transcultural C.A.R.E. Associates. (2006, January). *Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised (IAPCC-R)*. Retrieved January 11, 2006, from http://www.transculturalcare.net/

Transcultural C.A.R.E. Associates. (2008, January). *Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals - Revised (IAPCC-R)*. Retrieved January 13, 2008, from http://www.transculturalcare.net/iapcc-r.htm

Transcultural Nursing Society. (2006, April 8). *Transcultural Nursing Society*. Retrieved April 19, 2006, 2006, from http://www.tcns.org/

U.S. Census Bureau. (2004, March 18, 2004). *Interim projections by age, sex, race and Hispanic origin*. Retrieved April 24, 2007, from http://www.census.gov/ipc/www/usinterimproj/natprojtab01a.pdf

U.S. Census Bureau. (n.d.). *Glossary*. Retrieved April 25, 2007, from http://factfinder.census.gov/home/en/epss/glossary_r.html

van Ryn, M., & Fu, S. S. (2003). Paved with good intentions: Do public health and human service providers contribute to racial/ethnic disparities in health? *American Journal of Public Health, 93*(2), 248-255.

Vito, K. A., Roszkowski, M., & Wieland, D. (2005). Measuring cultural competence as a curriculum outcome: What we learned from our experiences with two tools, *National League for Nursing Education Summit*. Baltimore, MD.

Waltz, C. F., Strickland, O. L., & Lenz, E. R. (2005). *Measurement in nursing and health research* (3rd ed.). New York: Springer.

Wieland, D., & Hoerst, B. J. (2006). Increasing the diversity of nursing students for future improved national health outcomes and reduced health disparities: One nursing program's efforts to meet goals of the Sullivan Commission Report. *The Pennsylvania Nurse*, 16-17.

Williams, C. (2006). The epistemology of cultural competence. *Families in Society, 87*(2), 209.

Williamson, E., Allen, B. B., & Coppens, N. M. (1996). Multiethnic experiences enhance nursing students' learning. *Journal of Community Health Nursing, 13*(2), 73-81.

Worrell-Carlisle, P. J. (2005). Service-learning: A tool for developing cultural awareness. *Nurse Educator, 30*(5), 197-202.

Xu, Y., Shelton, D., Polifroni, E., & Anderson, E. (2006). Advances in conceptualization of cultural care and cultural competence in nursing: An initial assessment. *Home Health Care Management & Practice, 18*(5), 386.

Yates, S. H., Bline, K., Bird, C., Bresnahan, E., Couper-Noles, R., Cutler, S., et al. (2003). Start Out: Building healthcare careers for minority teenagers. *Journal of Continuing Education in Nursing, 34*(3), 116-121.

Zoucha, R. (2005). Leininger's Culture Care Theory: Utility with vulnerable populations. In M. de Chesnay (Ed.), *Caring for the Vulnerable: Perspectives in Nursing Theory, Practice and Research*. Boston: Jones and Bartlett.