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Perception Of Cultural Competence in Nurse Practitioners

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Abstract

Purpose: Nurse practitioners are at the forefront in providing quality care to diverse populations and must become cognizant of the importance of cultural competence in caring for diverse patients. The purpose of this study was to examine perceptions of cultural competence and its integration in the delivery of health care in nurse practitioners practicing in a Mexican-American region of South Texas.

Methodology: A descriptive, qualitative design using grounded theory and purposive sampling was utilized for this study. Sixteen nurse practitioners, fourteen females and two males, participated in the study. Qualitative data collection was elicited through individual interviews and a focus group. The selected participants included nurse practitioners who were employed for at least eight hours per week in a primary or acute care setting. The study included a demographic questionnaire and a nine-item interview guide created by the researchers to elicit thoughtful reflection on the participants' perceptions of cultural competence and how cultural competence is integrated in their practice.

Main findings: Data analysis involved grouping of response similarities until no new categories emerged. Affinity among the categories resulted in linkage into four distinct core categories or emerging themes. These themes provided a summary of what the nurse practitioners working with a Mexican-American population perceived as cultural competence and its integration in the delivery of health care. The four emerging themes include: 1) Culture as multifaceted; 2) Communication as empowerment; 3) Cultural dissonance; 4) Influence of myths, traditions, and complementary modalities.

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Principle conclusions: The study findings highlight the importance of advanced practice nurses' efforts to continue to learn and increase their knowledge base and sensitivities to the culture of their clients in all dimensions of health care. The findings also support previous research and strengthen the understanding of the importance of cultural competency in the delivery of care to minority populations.

Key Words: Culture; Cultural Competence; Nurse Practitioner (NP); Advanced Practice Nurse

INTRODUCTION

The United States is the third most populous country in the world and has one of the highest population growths among industrialized nations. The U.S. Census Bureau expects the United States population to increase by 46% by 2050. Hispanics have experienced some of the fastest population growth in the United States in the last decade and are predicted to provide most of the population gains in the future (United States Census Bureau, 2013). Of the Hispanic ethnicities, Mexicans compose the largest group and in 2012 accounted for approximately two-thirds of the United States Hispanic population. In fact, Mexican-Americans account for 11% of the overall United States population (Gonzalez-Barrera & Lopez, 2013). Evidence exists that Mexican-Americans, especially those living in border areas, have more difficulty in accessing quality health care due to factors such as language and cultural barriers (de Heer, et al, 2013). Studies have shown that even if income level and insurance availability are taken in to account, there are still disparities in access to care among racial and ethnic minorities (Mead et al., 2008, p. 44). If disparities continue to exist, many of these individuals will be at risk for disease, chronic illness and overall poor health

The population growth among minorities and the disparities in minority access to health care has increased the complexity in obtaining adequate health care in the United States. In an effort to provide high quality accessibility to health care, the role of the nurse practitioner (NP) has continued to expand over time (Iglehart, 2013). The landmark report *The Future of Nursing: Leading Change, Advancing Health* (Institute of Medicine [IOM], 2010) calls for removal of scope of practice barriers that will lead to major changes in the delivery of health care, changes such as removing regulations preventing NPs from prescribing patient medications and allowing NPs to provide primary care to their patients without physician oversight. *The Future of Nursing* report recommendations also impact health care reform by encouraging the restructuring of the health care delivery system where physicians and nurses will be practicing together to the fullest extent of their training, thus providing better access to care (Iglehart, 2013). As a result of the 2010 Affordable Care Act, which extends health care to millions more than in the past, NPs are now at the forefront in providing safe, cost-effective, quality health care to an increasingly diverse population (Stanik-Hutt et al, 2013). These advanced practice nurses are expected to be culturally competent and deliver culturally congruent care (AACN, 2009). Although there has been some research to measure cultural competence in health care providers (Castro & Ruiz, 2009; Horevitz, Lawson, & Chow, 2013), there is a dearth of existing research on perceptions of cultural competence by practicing NPs. Therefore, the purpose of this qualitative study

was to examine perceptions of cultural competence and its influence on the delivery of health care in NPs practicing in a predominantly Hispanic, Mexican-American region of South Texas. The intent of this study was to add to the limited existing knowledge base regarding perception of culture care and its integration in health care delivery by advance practice nurses.

LITERATURE REVIEW

Literature related to the importance of cultural competence among health-care practitioners is abundant. This literature review primarily relates to minority access to health care, health disparities among racial or ethnically diverse populations, cultural brokering or facilitating and bridging the gap between cultures (Jezewski, 1990), and the need for nurse practitioner programs to include the concepts of culture and cultural competency in its curricula.

Minority Access to Health Care, Health Disparities and Diversity

Lack of access to health care persists and contributes to the quality of care received by racial and ethnic minority groups (AHRQ, 2012). Literature exists that details problems with accessing and obtaining quality health care due to the cultural and ethnic background of clients (Alicea-Alvarez, 2012;AHRQ, 2012). In fact, the AHRQ (2012) *National Healthcare Quality and Disparities Reports* concluded that disparities in access were common, especially among Hispanics and the poor. Findings reported that Blacks, Asians, American-Indians, African-Americans, and Hispanics all had worse access to care than non-Hispanic Whites. Hispanics had worse access than non-Hispanic Whites in 62% of the access factors measured (AHRQ, 2012). There was no significant improvement reported in the disparities associated in accessing quality care for these minority groups compared to previous years.

Cultural competence is defined as “the process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of a client, individual, family, or community” (Campinha-Bacote, 2002, p.54). Cultural competence has been found to be a key factor in increasing access to care and receiving appropriate health care among the culturally diverse (AACN, 2009). Over the last two decades, there has been a national commitment to eliminating health disparities among individuals and families of all cultural backgrounds including differences of gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation (AHRQ 2012). Some of the specific problems that have been identified as contributing to minority inability to access health care include economic disadvantages, lack of insurance, limited English proficiency, and cultural barriers (AHRQ, 2012; Alicea-Alvarez, 2012).

Hispanics have been identified as having worse access to health care as a result of some of those very same problems described above (AHRQ, 2012). According to de Heer et al (2013), Hispanics, specifically Mexican-Americans living along the Texas-Mexico border, face many challenges in accessing health services as a result of language and cultural barriers, lack of transportation, and geographic inaccessibility. Health care providers who develop an awareness of these challenges and who utilize cultural knowledge and are culturally competent can maximize therapeutic interventions and influence positive outcomes (Purnell, 2009). Thus, NPs who have developed cultural awareness are more apt to be culturally competent and provide culturally congruent care that facilitates positive health outcomes, enhances patient and/or client satisfaction, and reduces health disparities (Huerta & Sãnchez, 2009).

Cultural Brokering

Although there are various definitions, cultural brokering in health care refers to bridging, linking, or mediating between individuals, groups, or communities of different cultural backgrounds for the purpose of reducing conflict or to effect change (Jezewski, 1990). Borrowed from anthropology, the concept of cultural brokering is integral for actualizing culturally congruent health care. Nurses, as culture brokers, advocate or intervene in the best interest of their patients who may be disadvantaged or underserved based on their culture or illness (Lerotholi, 2011). Armed with knowledge of the patient's culture, nurses are in the best position to mediate in cases where there are ethnic and racial disparities and to promote change that is congruent with the patient's cultural beliefs and values (Purnell, 2009). According to the American Academy of Nursing (AAN), inequalities in health outcomes may be reduced through the provision of culturally competent care (Expert Panel on Global Nursing & Health, 2010). Thus, as primary health care providers, the ability of NPs to be effective culture brokers is critical to achieving positive health outcomes.

Nurse Practitioner Curricula

A report by the American Association of Colleges of Nursing (AACN) discussed the surge of ethnic and socio-cultural diversity in the United States and the need to prepare NPs to meet the challenges in caring for this population (AACN, 2009). This report underscores the need for clinical practice to reflect leadership at the graduate level and for educational programs to incorporate key concepts in curricula related to the impact of culture on care. AACN's focus on producing a culturally competent graduate nurse workforce led to the development of a tool kit with the specific purpose to assist educators in preparing culturally proficient nursing graduate students for clinical practice and research (AACN, 2009).

Nursing literature supports the importance of including concepts related to culturally congruent and culturally competent patient care in nurse practitioner curricula and for the implementation of these concepts in practice settings (Green-Hernandez, Quinn, Denman-Vitale, Falkenstern, & Judge-Ellis, 2004; Matteliano & Street, 2012). How cultural competency translates into actual nursing practice, however, presents another dimension for nursing research and nursing education. For example, a study of NPs in Australia and New Zealand found that there are dimensions of capability in evaluating NP practice (Gardner, Hase, Gardner, Dunn, & Carryer, 2008). The authors suggest that capability and cultural competence be included when assessing the complex roles inherent in being a nurse practitioner. In another study, advanced practice nurses were interviewed to examine challenges in enhancing their cultural competency in the clinical setting (Ndiwane et al., 2004). Communication, mutual responsibility for health, and cultural assessment were areas identified and subsequently used in developing curricula to enhance cultural competence in advanced practice nursing students. Another study (Castro & Ruiz 2009), involving 15 licensed NPs from 11 different clinics and 218 Latina patients, that explored the degree of NP cultural competence and patient satisfaction, found that the Latina patients reported greater satisfaction with NPs of Latina origin that were Spanish speaking and had received cultural-competence training. The study also found that there were noticeable differences among the NPs' levels of cultural proficiency. The authors concluded that care that includes a cultural focus leads to increased patient compliance, improved patient-provider communication and patient satisfaction with care (Castro & Ruiz, 2009, p. 285). In his extensive work among Mexican-Americans in an East Dallas barrio, Kemp (2005),

a family nurse practitioner, found that understanding culture and being culturally competent was important to providing quality care to his patients and that it was most significant in planning and implementing care.

THEORETICAL FRAMEWORK

Campinha-Bacote's 2002 *The Process of Cultural Competence in the Delivery of Healthcare Services* (PCCDHS) model guided this study. The model depicts cultural competence as an ongoing process that is continuously evolving whereby, through cultural encounters, healthcare professionals view themselves as becoming, rather than being culturally competent. In this model, health care workers are immersed within the cultural context of the patient and must develop purposeful and mindful intercultural communications as opposed to stereotyping. According to Ingram (2011), the PCCDHS model is ideal to use in health care settings because of its practical approach to healthcare. The model's constructs fit well in health care settings where NPs care for ethnically diverse populations and minority groups.

There are five essential constructs in the model. These include cultural encounter, cultural desire, cultural awareness, cultural knowledge, and cultural skills, with cultural desire being the construct that drives the process of becoming culturally competent (Campinha-Bacote, 2002). The construct of desire underscores this study in that NPs acquire general cultural proficiency skills but there is much complexity in using culturally appropriate behaviors. Doing so requires self-awareness, perception of cultural competence, and most importantly desire (Green-Hernandez et al., 2004).

STUDY PURPOSE AND METHODS

The purpose of this study was to investigate perceptions of cultural competence and its integration in the delivery of health care in nurse practitioners practicing in a Mexican-American region of South Texas. A qualitative design using grounded theory and purposive sampling was used for this study and approved by the university Institutional Review Board (IRB). This design was appropriate because the researchers sought to explain the little understood phenomenon of what is perceived as cultural competence in NPs. The design provided a flexible data collection approach that allowed the researchers to focus on perception of cultural competency as an aspect of NP behavior that is not measureable in quantitative terms.

Participant selection criteria included current NP status and employment as an NP for at least eight hours per week in a primary or acute care setting that served the residents of the predominantly Mexican-American and Mexican immigrant community in South Texas. Data was collected by a trained member of the research team through individual semi-structured, face-to-face interviews. NPs for these individual interviews were recruited from attendees at a regional conference for NPs. A target number of 12-20 participants were anticipated before saturation of data.

As a follow-up to the interviews, a focus group was conducted; the focus group was important to further validate and support data from the individual interviews. This form of triangulation provided the researchers with multiple means of data collection to understand the full complexity of the phenomenon under study. Members of a local NP organization were invited to participate in the focus group session. The focus group consisted of some of the previously interviewed participants as well as NPs new to the study. All participants of the study were asked to complete an informed consent for participation as well as consent for audio recording. The participants were given a copy of the informed

consent. A demographic questionnaire was completed to obtain information regarding gender, age, race, ethnicity, time since NP program graduation, years in practice as a registered nurse (RN) prior to becoming an NP, time in NP practice, days in practice per week, and languages spoken. An interview guide created by the researchers was used for the individual interviews and the focus group to provide semi-structure for data collection purposes (Figure 1). The interview guide contained questions designed to elicit thoughtful reflection by the participants on their perceptions of cultural competence and its integration into their practice(s). These questions guided the interviews and the focus group discussions while allowing the participants to direct the discussion and let the discussion related to cultural competency evolve. All participants were provided with a copy of the interview questions used by the researchers to guide the interviews and focus group.

FIGURE 1

Question	Responses*
1. Describe your current practice as a Nurse Practitioner.	
2. Describe your idea of cultural competency.	
3. Provide some examples when you have provided culturally competent care.	
4. Describe cultural factors affecting the health of clients.	
5. How do you evaluate culturally competent nursing care?	
6. Describe the role of the nurse practitioner in providing culturally competent care.	
7. What processes exist in your current practice that facilitate culturally competent care? What hinders it?	
8. How do you perceive culturally competent care in other providers (physicians, PAs), or office personnel and patients themselves?	
9. Describe how you have been prepared to provide culturally competent care.	

*Additional pages may be used for detailed data collection

The study was completed in the Rio Grande Valley located in the southernmost point of Texas and close to the Mexico border. The area is a predominantly Mexican-American, Mexican immigrant, Hispanic region of Texas; therefore, time in practice as an NP in the region and outside the region was also included.

RESULTS

Data Collection

Semi-structured interviews were conducted in a setting and location of the participant's choosing that provided privacy and minimized the potential for interruption. Interview data was collected anonymously via audio recording and interview notes. Individual interview sessions lasted between 45 to 60 minutes. The focus group was held in a private meeting room of a local establishment and lasted approximately 60 minutes. The group discussion was loosely structured allowing for a full range of descriptions of first-hand experiences and expressions revolving around the concept of cultural competency among NPs and their perceptions of its importance to providing quality nursing care.

Demographic Information

A combined total of sixteen nurse practitioners participated in this study. There were fourteen (87.5%) females and two (12.5%) males with a combined average age of 49.6 years. There were ten (62.5%) White-Hispanic participants, two (12.5%) White-Non-Hispanic, two (12.5%) Asian, and two (12.5%) Black-Non-Hispanic NP participants. Of the total NP study participants, 62.5% were of Mexican- American ethnicity and 100% of them were bilingual in English and Spanish. Of the ten Mexican-American NPs, 50% of them indicated that Spanish was their primary language. Two of the six (33%) non-Hispanic NP participants indicated that they spoke some conversational Spanish. Years since graduation from an NP Program revealed six (37.5%) within the past three years, six (37.5%) in the past seven to twelve years, and four (25.0%) twenty years ago. On average, this group had over ten years of practice as a RN prior to becoming a NP. The highest number of years in practice as a NP was 20 years and the shortest was one-half year for a combined average for the total group of approximately ten years. None (100%) had practiced as an NP outside the South Texas region and twelve (75%) indicated the ability to speak two languages, English and Spanish. The majority (87.5%) was currently in practice in clinics; one (6.25%) had a combined practice in a rural clinic and hospital, and another one (6.25%) was employed by a government agency.

Data Analysis

Interview data was reported anonymously with use of pseudonyms and analyzed qualitatively via a constant comparison method. Interviews were transcribed to facilitate coding and analysis of the data. All three research team members were involved in the data analysis. Two research team members are doctorally prepared nurses with expertise in cultural competence and nurse practitioner education, and the third member of the team is a doctorally prepared educational psychologist with expertise in qualitative research and cultural competence. All of the researchers have experience in qualitative research and qualitative analysis.

Using a method of constant comparison, memoing, and sorting in grounded theory research (Glaser, 2001), the three researchers, reviewed the audio recording transcripts and interview field notes to highlight key themes and emerging codes. Repeating ideas gathered through the interviews were compared and contrasted to assure that the participants' perspectives on cultural competence were appropriately conveyed. Focus group transcripts were critically analyzed observing for emerging codes and key themes.

The trustworthiness of this qualitative study was inherent in both the data collection and data analysis. Credibility was established by having NPs who work with culturally diverse patients describe their

perceptions of cultural competence. Confirmability was established because the research team had expertise in qualitative analysis and each of them performed an independent analysis of the data prior to meeting to review the recordings and field notes. Transcript notes were also read multiple times to ensure researchers were fully immersed in the data. Transferability was established because all of the NPs in the study had experience working with culturally diverse patients and it was further established by the thick, descriptive data that emerged. To confirm the consistency and credibility of coding and the validity of the themes, in the final stage of constant comparison, the researchers examined the emerging codes from the total data collected in the interviews and the focus group. Key overarching themes were identified; discussions were held among the researchers to resolve any differing perceptions of the emerging themes. This study produced several themes related to the perceptions of cultural competence in NPs providing care to a predominantly Mexican-American population in South Texas.

Findings

Data analysis involved grouping of response similarities into categories until no new categories emerged. Affinity among the categories resulted in linkage into four distinct core categories or emerging themes. These themes provide a summary of what NPs, working with a predominantly Mexican-American population, perceive as cultural competence and its influence in the delivery of health care. Themes identified include: (1) Culture As Multifaceted; (2) Communication As Empowerment; (3) Cultural Dissonance; and (4) Influence Of Myths, Traditions and Complementary Modalities.

Culture as Multifaceted

The perception that people are never defined by one single determinant of culture and not everyone belonging to a particular group can be said to belong to the same culture was evident in the findings. NPs described culture as being more inclusive than the known major cultural determinants, i.e. ethnicity, race, gender, age, family, language, religion, and nationality. The NPs perceptions of cultural competency in this study did include discussions revolving around the influence of ethnicity, gender, age, language and religion on patient outcomes, thus validating the theme that culture is multifaceted. The NPs, however, shared how being culturally competent required considering the patient holistically to include family influences, cultural beliefs, and individual societal roles. As one NP stated "the role of the NP in providing culturally competent care means that we need to embrace practices that the clients use in their own care. We cannot say 'don't do this or don't do that.' We need to nurture them and work with what they or their family think will work for them and always consider that being culturally competent is a huge part of providing holistic care." Another NP stated that in caring for a client, "we look at the patient holistically because a person's culture has a lot to do with who the person is. We must identify patient cues, recognize family interactions to better understand the whole picture. You have to touch on every factor." Another NP's views of being culturally competent included "understanding the client's background and that of their families including acknowledgement of their social background."

Ethnicity. Both the face-to-face interviews and the focus groups revealed that ethnicity is one of the determinants of culture. The NPs stated that understanding the role that ethnicity plays is important in becoming culturally competent; however, the

majority of the NPs did not perceive the person's ethnicity as being the only concept essential to becoming culturally competent. Development of cultural competence by understanding culture-related areas, not just ethnicity, was a theme echoed by the NPs. For example, one NP stated that "Culture is greater than ethnicity. In practice you need to consider the culture of all people". When asked to describe their idea of cultural competence, most of the NPs described the importance of having a holistic approach when caring for patients rather than considering individual demographic data. One NP stated, "NPs have to be proficient in a lot and need to be aware and have a holistic view of patients of any culture." Another stated that the NP has to "do a really good assessment. Assessment includes both subjective and objective components." The use of a holistic approach in the provision of culturally competent care was further supported in the focus group. As one of the NPs said, "Collecting information does not always include demographics. The NP needs to be an investigator and incorporate all information collected in the nursing plan."

Gender and Age: The NPs included the importance of the roles gender and age play in the Hispanic culture. Understanding how gender and age influence health outcomes was essential to NPs perceptions of cultural competency. For example, there was little variation by the NPs in terms of describing the role of the Hispanic female in the family. Women were perceived as the primary care givers and the persons most responsible for positive health outcomes in the family. As one NP reported "Women are the strong persons in the Hispanic family. Take cues from them." Another NP noted that the Hispanic woman is the caregiver in the family and that "Hispanic women take care of everyone in their homes except themselves." The NPs affirmed that Hispanics have much respect for those of advanced age and that the older Mexican woman such as the grandmother exerts a major influence in the family in terms of health. This influence was especially significant in regard to patient care and teaching. One NP said when describing the influence of older women on the family's health outcomes, "We need to respect them and allow the family dynamics to evolve." Another NP commented that "It is sometimes difficult to teach new mothers because they are prone to go back to what they are told by their mothers or grandmothers." One NP concluded that frequently patients follow the advice of grandmothers rather than the NP's; for example, in "sweeping the body with an egg to rid the body of negative influences or applying Vicks to the bottom of the feet for an upper respiratory infection."

The influence of the Hispanic male in the family was also a topic of discussion when describing the role of the NP in providing culturally competent care. All of the participants agreed that the Mexican male wields a lot of power in the family and is considered the head of the household. One NP who works in a Family Practice Clinic noted that the Hispanic male, originally from Mexico and who is first- generation in the United States, is from a different culture than those born in the U.S. The NP noted that in dealing with Mexican males there is a need to offer respect and acknowledge their role as head of the family. One point of view came from an NP who indicated that although traditionally the male is the head of the family, when it comes to health care concerns "Hispanic men always bring their wives when they come to see the doctor." The consensus among the NPs indicated that understanding the concepts of gender and age and their influence on care is important and that many Hispanic patients seek health care providers of the same ethnicity or gender. The NPs agreed that respect and sensitivity to gender

and generational differences and cultural practices mediates the patient-provider relationship.

Language and Religion: The importance of verbal and nonverbal communication in development of cultural competence was prominent among all of the study participants. The ability to apply active listening, speak the same language, assess non-verbal cues, and use lay terms that are easily understood were considered assets. One NP who was originally from Nigeria and works with Hispanic clients in the area stated, "I do not speak the language but I am an OB nurse and have been with a woman in labor and see her to be in pain. She can see that I feel her pain even if I do not speak her language." Another NP noted that language is a big obstacle in obtaining adequate health care. Religion was also observed to impact patient care. One NP said that most of her patients were Catholics and that "Catholicism impacts Hispanics" and subsequently their beliefs may affect health outcomes. One example provided by the NP was in relation to the patient postponing seeking health care because "As long as I believe in God, I will be okay." Another said that understanding the role religion plays in the patient's life is important to becoming culturally competent. "Religion plays a big part in culture.-mainly Catholic. As an NP, I sometimes suggest prayer if nothing else works."

The NPs considered language and religion to be major cultural determinants thus further validating the theme that culture is multifaceted. A major theme that emerged is that language and ability to communicate effectively empowers patients and affects health care outcomes.

Communication as Empowerment

A common theme echoed by the NPs was that of the importance of the NP being able to communicate with patients in Spanish. The patients' ability to communicate with their health care providers was also described as a facilitator to positive health care outcomes while inability to communicate verbally was described as a barrier. The NPs viewed communication, whether verbal or non-verbal, as vital to creating a trusting provider-patient relationship and identified the qualities of being accepting, compromising, and non-judgmental as facilitators for cultural competency. As one NP stated "the NP should at least try to understand or to speak their language. If patients see that you are making the effort, they will accept the NP as a provider." Another stated "I am Filipino and do not speak the same language, but it is more important to be accepting. This way they trust me."

Most often communicating in the patient's preferred language was seen as a means to empower them. One NP stated, "When I see that my patients understand, I know that they are comfortable and empowered." Language as a component of health literacy was viewed as both a facilitator and a barrier to empowering patients. It was acknowledged that there is a dire need for health literature to be available in Spanish and at the comprehension level of patients. The value of using interpreters was voiced by several NPs as a way to overcome barriers to effective communication. An NP, who cares for pediatric patients, stated that in teaching a parent whose primary language is not English "I use an electronic translator and draw pictures to explain things to her." Another spoke about empowering patients through communication that emphasizes patience and flexibility. "You need to understand where they are in order to be able to explain and educate at their level and in a way that does not put down their culture."

Cultural Dissonance

Data analysis revealed existence of dissonance between some patients and their own culture as well as

between the practitioner and the patient. For example, one NP pointed out that "patients may be from the same ethnicity, but do not always adhere to the same beliefs and or customs" reflecting a dissonance among patients thought to belong to the same culture. The NP further stated that "even though the majority of my patients are from this region, many have lost their roots and do not share the same views. We take care of many people from different countries who are Hispanic, yet even their verbiage and communication styles are different." Another NP in referring to herself as Hispanic, stated that she did not share many of the same views as the Hispanics in the area. When asked how she prepared herself to provide culturally competent care she said "my preparedness comes from growing up as a member of the Hispanic culture in this area; however, I think that I lack some understanding of what it means to be Hispanic because I do not speak Spanish very fluently and have a language barrier myself."

The participants in the study described the need to develop and tailor health care plans for their patients centered on the patients' cultural preferences and backgrounds. Acknowledging differences within individuals in the same cultural group was described as being important in the provision of culturally competent care. The Mexican- American NPs in the study agreed that being of the same ethnicity helped them be more culturally competent but that there were differences even among shared cultural groups and themselves. It was acknowledged that those NPs who are thought to be of the same culture due to their shared ethnicity may be influenced by a variation on beliefs. For example, one of the Hispanic NPs described how some of her Hispanic pregnant "patients wear safety pins to prevent birth defects caused by a lunar eclipse." She said that learning about this practice was new to her because although she is Hispanic, she was raised differently and is "coming from different cultural influences" than her pregnant Hispanic patients.

Language also seemed to play a part when describing the generational and cultural differences among patients of the same ethnicity. One NP indicated that of the Hispanic patients she cared for, some preferred English as their primary language over Spanish, and did not ascribe to the belief system of the culture in which they were born and raised. Some of these preferences were seen as intergenerational changes among younger and older Hispanics.

Cultural dissonance was also perceived as occurring in subcultures of those of Hispanic ethnicity. One NP said, "We have Hispanic patients but some are from the Dominican Republic or Salvador or the Philippines which are not the same as our Hispanic patients from this area. Here there is a subculture of Hispanics." Dissonance among patients and their own culture was reflected in the discussion of intergenerational changes among Hispanics. Potential incongruence among Hispanic beliefs and those of other Hispanics was described. One NP indicated that many of the Mexican-American patients he treats have been impacted by generational changes and also by becoming acculturated. In describing whether he provides culturally competent care, he said "That's difficult to say because many of my patients are now more Americanized and do not ascribe to your typical Hispanic culture."

Study findings also demonstrated that the NPs contributed to cultural dissonance when caring for patients. Interviews revealed that the NPs were aware of the impact that their own beliefs, values, practices, customs, rituals, knowledge, and language had on the ability to deliver culturally competent care. "Being Hispanic we tend to feel that we are culturally competent but that is not necessarily true. I see my culture as

different from many of my patients' culture, especially those not born here." In describing cultural factors that impact the delivery of culturally congruent care, an NP said "There are two cultural factors affecting the delivery of culturally competent care. The main one is the language barrier. Many of us Hispanic nurses use English as our primary language and this becomes a barrier to delivering care. The second factor is the patient's health literacy. Many of the patients treated in this area have no formal education." Cultural dissonance was found among Hispanic NPs, as well as non-Hispanic NPs, who cared for Hispanic patients. For example, one Mexican-American NP indicated that although she limited the number of visitors in the patient's room, she also recognized the importance of being accepting of Hispanic patients' needs. The NP noted that "we need to be more flexible because in Hispanic families, people come from all over to support them and that may mean that they will have a lot of visitors." Some of the NPs voiced ideas on how to reduce cultural clashes among the Hispanic patients and NPs by incorporating the patients' culturally-based beliefs "whether it is in relation to their diets, health care remedies, or traditions." The NPs voiced that as long as the cultural practices do not harm the patient, they are acceptable and should be included in the patient's plan of care.

Influence of Myths, Traditions, and Complementary Modalities

The patients cared for by the NPs in this study were overwhelmingly from a Mexican culture that tends to view health from a holistic perspective where the mind, body, and spirit are interrelated. The study findings reflected the importance of understanding these concepts to achieving cultural competence. There were many instances where the NPs described how an understanding of cultural myths and traditions facilitated and expanded their role. For example, one NP said that his idea of cultural competence meant that the NP has to develop an "understanding of the patient' s beliefs, culture, myths, and taboos in order to provide quality health care." The influence of myths and traditions among those Mexican-Americans seeking health care was verbalized by another NP who stated that it was important to recognize that these patients might not think that health is a primary factor that affects their lives, but rather that "other people cast spells on them such as 'Mal de Ojo' and that these beliefs delay treatment and cause the illness to get worse." One NP cited the importance of understanding the patient's belief system when providing treatment. His experiences with Hispanic patients indicated a strong belief in the effects of hot and cold on health outcomes. He gave the example of one of his patients with Bell's palsy attributing his condition to having "gone out after shaving into the cold weather thus getting partial facial paralysis."

Understanding the use of complementary modalities was also seen as important to achieving cultural proficiency. One NP commented that the use of folk remedies is prevalent among the Mexican-American culture. Another NP said, "Many clients are uninsured and use complementary modalities. Prayer works wonders sometimes. I assess if it's okay to pray and I hold their hand and we pray." Numerous examples of folk remedies were provided by the NPs. For example, the use of teas such as manzanilla (chamomile) to cure evil eye or tummy aches was mentioned. "I go along with that remedy because I know that it is an alternative form of medicine that may help." Another said, "The use of a red string on the forehead of babies is common to cure hiccups. As long as it does not hurt them, it's okay." The finding that myths, traditions, and complementary modalities need to be

understood and are important to positive patient outcomes validated their inclusion in NPs perceptions of cultural competence.

DISCUSSION

Health care providers are individuals with their own diversities integrated into their approach to patient care. The majority of NPs in the United States are non-Hispanic, White females which results in their being overrepresented in research studies of cultural competence (Benkert, Templin, Schim, Doorenbos, & Bell, 2011). The participants in this study, the majority who were Mexican-American, were uniquely able to relate to the cultural issues of their patient population. This study's purpose was to elicit perceptions of cultural competence and its integration in health care delivery among NPs who provide care to a Hispanic population. The study findings were congruent with results from other research studies that looked at cultural beliefs in Hispanic populations. Study findings included the multi-faceted nature of culture, the importance of language and communication in empowering patients, the existence of cultural dissonance, and the influence of myths, traditions, and complementary modalities. These findings validate previous studies (Castro & Ruiz, 2009; de Heer, et al., 2013) that have found that ethnicity, gender, language, religion, age, myths, and traditions are important considerations to the provision of culturally competent care to Hispanic clients.

The perception that cultural dissonance exists among practitioners and patients and patients and their own culture was not surprising. NPs suggested that trying to bridge the gap between the patients' culture and their own was possible by understanding the patients' beliefs and language. This theme supports Matteliano and Street's (2012) findings that NPs play a critical role in bridging professional and patient cultural divides. NPs show their ability to act as cultural brokers by addressing the patient's contextual constraints such as language and beliefs.

Standards of practice for culturally competent care have been introduced by the American Academy of Nursing (Expert Panel on Global Nursing & Health, 2010). The NPs' perceptions of cultural competence in this study were congruent with several of the AAN *Standards of Practice for Culturally Competent Nursing Care* (Expert Panel on Global Nursing & Health, 2010). For example, AAN's standard three describes the importance of transcultural knowledge. This knowledge is attained through the understanding of traditions, values, practices and family systems. Study findings echoed recognition of the role that traditions, practices and family beliefs play in eliciting positive health care outcomes. The finding that communication skills empower patients is also in concert with AAN's standard six relating to patient advocacy and empowerment. NPs in this study described communication as empowering patients and that effective communication is essential in treating Hispanic patients. That assertion supports standard nine that states that nurses should consider the client's verbal and non-verbal language, cultural values, and context.

IMPLICATIONS

The NPs in this study reported emphasis on cultural competence throughout their graduate nursing program curricula. This was a positive finding indicating that the influence of culture on patient outcomes is an important topic in advanced practice nursing education. While these results provide evidence that the NPs in the study were taught the impact of culturally influenced disparities, there may still be a need to have a concerted effort among all educators to infuse cultural concepts in NP curricula. Inclusion of developing technologies

that influence the ability to communicate and educate patients of varying cultures is vital to achieving positive health outcomes. This study's findings support previous research and strengthen understanding of the importance of cultural competency to health care delivery.

There were several limitations in the study; for example, this qualitative study focused primarily on NPs caring for Mexican-Americans residing in South Texas. Generalization cannot be made to other Hispanic groups. The NPs that were included in this study were predominantly Mexican-American (62.5%), had lived in this area for many years, and most had graduated from the same NP program. These facts may have given them greater insight into the concepts of culture among this population. The study was also limited to NPs whose practice was focused in a lower socioeconomic area. Results from this study may not be applicable to patients who are of a higher socioeconomic status. The wide-range differences in the number of years of NP practice may also have affected the findings. Those NPs with many years of practice may have a better understanding of what constitutes cultural competence among this Hispanic population.

CONCLUSIONS

This study highlights the importance of advanced practice nursing education's role and responsibility to engage graduate students in critically evaluating their own cultural heritage, values and beliefs. Such reflective thinking as indicated in AAN *Standards of Practice for Culturally Competent Nursing Care* will increase cultural self-awareness and have a positive impact on the provision of culturally congruent care and health outcomes. As patient advocates, NPs need to continue to learn and increase their knowledge base and sensitivities to the culture of their clients in all dimensions of health care (Alicea-Alvarez, 2012).

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