

JOURNAL OF CULTURAL DIVERSITY

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CULTURE COUNTS

The Surgeon General Executive Summary report U.S. Department of Health and Human Services Center for Mental Health Services concludes the “culture counts” in the care of individuals that are experiencing mental health (DHHS, 2003) or any other physiological problems. This report further underlines the need for an appreciation for the intrinsic diversity within each of the recognized racial or ethnic groups and the implications of that diversity. Race and culture have been identified as barriers to health care. Other barriers include lack of or limited health insurance, lack of financial resources to cover services, lack of a primary health care provider, cultural and spiritual differences, language barriers and issues of discrimination (HP2010). Another barrier is the lack of cultural similar practitioners.

Dr. James Caillier and colleagues investigated the potential of racial discrimination in the delivery of invasive cardiac treatments. Their findings strongly support additional research in the area of medical treatment and minority populations and, further, is an encouragement for further research on potential gender differences in medical care.

Communication discord and insight into cross-racial primary care relationships in a nurse-managed center is offered by Dr. Ramona Benkert, Dr. Joanne Pohl, and Dr. Patricia Coleman-Burns as they explore communication patterns between patients and practitioners.

Maren Coffman, RN, MSN further examines the phenomena of culture with a meta-analysis of qualitative research as it relates to cultural caring in practice. These findings offer strong support for cultural sensitivity and competence in practice. Dr. Merle Kataoka-Yahiro, et al, extend this need for cultural understanding by the health care team in the exploration of the grandparenting caregiving role in Filipino American families. The authors provide sup-

port for education in nursing schools that includes the diverse and complex needs of extended families.

A willingness to decrease ethnocentric behaviors and to become educated about others is the catalyst to cultural knowledge and is a part of nursing curricula. However, the development of cultural competence in schools and colleges of nursing is a struggle because the profession is very homogenous, with approximately 90% white females (National Advisory Council on Nurse Education and Practice [NACNEP], 2000). There is clear evidence to support the work that needs to be done with the current population of practitioners; NACNEP proposes that great energy should be placed on preparing the next generation of nurses (p18). The faculty that prepare this next generation must be knowledgeable of the importance of cultural competency and have an appreciation of the need for and a vision to promote cultural competence. Dr. Ndiwane and his fellow authors address this issue from the curriculum level. Another important way to assure this type of quality cultural education is through the accreditation process of schools and colleges of nursing. Dr. Mary Wawrzynski and Dr. Ruth Davidhizar offer clear suggestions for making the site visit a positive experience for the visitors and the institution.

Our authors in this edition of *The Journal of Cultural Diversity* lend their expertise as they offer insight into to the need to be willing understand and accept other world views, actively listening to patients and families, and in the important role of site visitor at Schools and Colleges of nursing.

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Abstract: *The purpose of this study was to investigate racial and gender differences in the utilization of invasive procedures for cardiovascular treatment. Medical records data of 3,015 patients were abstracted from a Medical System Database from 1999 to 2001. Logit models were used to estimate the adjusted odds in the utilization, referral, and acceptance of invasive procedures, while controlling for confounders (age, race, sex, comorbidity, disease severity, payer type, marital status and family history) simultaneously.*

When considering utilization of invasive procedures, the adjusted odds were lower for African-Americans compared to Caucasians. There was a statistically significant difference ($p < .05$) in Coronary Artery Bypass Graft (CABG) utilization between African Americans and Caucasians. African Americans were less likely than Caucasians to receive a CABG. Although not statistically significant, African-Americans were less likely than Caucasians to receive a cardiac catheterization and Percutaneous Transluminal Coronary Angioplasty (PTCA). Findings failed to yield a statistical significance for gender disparities regarding invasive procedure utilizations.

Key Words: *Race, Gender, Invasive Treatment*

THE EFFECT OF RACE AND GENDER ON INVASIVE TREATMENT FOR CARDIOVASCULAR DISEASE

Cardiovascular disease (CVD) is the leading cause of death among every racial and ethnic group in the United States. An individual's ability to access and use modern cardiac therapy and procedures may have profound implications for improving diagnostic precision, relieving symptoms, and reducing premature mor-

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tality from heart-related conditions. Research to investigate underlying causes, subsequent outcomes and effective interventions is crucial for reducing racial/gender disparities in medical care. Although invasive cardiac procedures have been documented to reduce symptoms and prolong life for those with severe CVD, numerous studies over the past two decades have reported that African Americans are less likely than Caucasians to utilize invasive procedures (Brown, 2002; Ford, Cooper, Castner, Simmons, & Mar, 1989; Giles, Anda, Casper, Escobedo, & Taylor, 1995; Goldberg, Hartz, & Jacobsen, 1992; Hannan, Van Ryn, & Burke, 1999; Kressin & Peterson, 2001; Maynard, Fischer, Passamani, & Pullum, 1986; Watson et al., 2001; Wenneker & Epstein, 1989). Additionally, previous studies have shown that when stratifying by race and sex, African American females are less likely to utilize invasive procedures compared to Caucasians (Ayanian, Udvarhelyi, Constantine, Chris, & Arnold, 1993).

Research has shown that disparities regarding use of invasive treatments remain even after con-

trolling for clinical and socioeconomic factors. There is concern in the medical community that the race and gender of a patient could be prompting differences in physician behavior. Therefore, the purpose of this study was to explore the effect of race and gender on the use of invasive treatment for cardiovascular disease. Accordingly, this study proposed to test the following hypothesis: African-Americans and females will be less likely to receive invasive treatment for cardiovascular disease compared to Caucasians and males, respectively.

METHOD

Design

A retrospective longitudinal review of hospital patient information was conducted using statewide patient data obtained from a Medical System shared by three urban public health hospitals in the state of Louisiana. The use of statewide patient data provided a unique opportunity to examine treatment in the only state in the United States that provides a state system of acute care for its citizens. The vast majority of the persons served by this system are indigent or Medicaid recipients. Data used in the analysis were from July 1998 to July 2000.

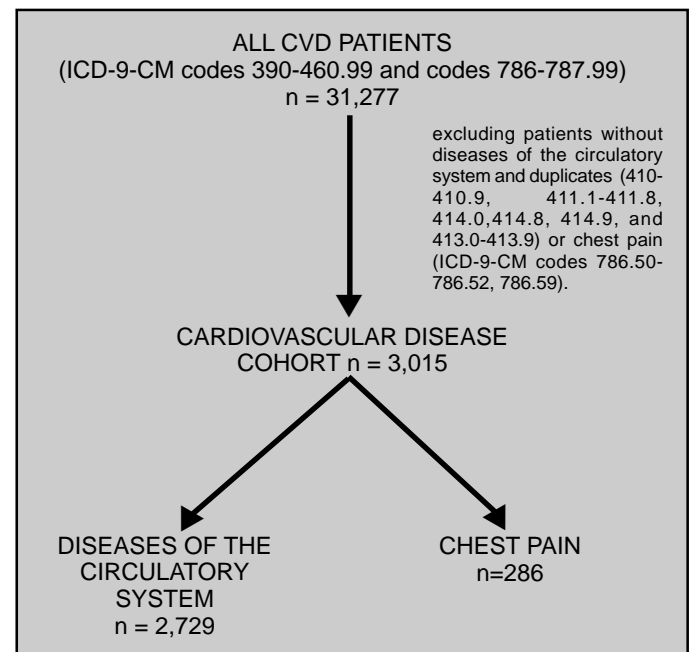
Data was obtained from three public health teaching hospitals, which encompass professional schools in medicine, nursing, and dentistry, as well as allied health vocations. The three hospitals (Hospital A, B, & C) are located in metropolitan areas and serve both rural and urban patients in the southeastern part of the state. Only non-invasive cardiac procedures such as treadmills, echocardiograms, holter monitors, electrocardiograms, stress echograms, and pacemaker insertions are performed at Hospitals A and C. Both non-invasive and invasive cardiac procedures such as cardiac catheterization, (CC), coronary artery bypass grafts (CABG), and percutaneous transluminal coronary angioplasties (PTCA) are performed at Hospital B. Since both hospitals are in the same public health system and are responsible for taking care of the indigent, Hospitals A and C refer all invasive procedures to Hospital B.

Sample

The data set from the three hospitals contained a total of 3,015 CVD patients whose principal diagnoses indicated diseases of the circulatory system (ICD-9-CM codes 390-459) and chest pain (ICD-9-CM codes 786.50 through 786.52). These diagnoses included myocardial infarction, unstable angina, chronic ischemic heart disease, angina pectoris, and chest pain. Patients excluded from the study included those with comorbid diagnoses of stroke, cancer, renal failure, psychiatric illnesses, abuse of drugs and alcohol, Human Immunodeficiency Virus (HIV), cirrhosis, dementia, lung disease, and congestive heart failure

(CHF) because these conditions may influence treatment outcomes, thus reducing the likelihood of these patients being referred for an invasive procedure. Figure 1 displays the selected patient population from the database.

Figure 1. Selected Patient Population From Database



Data Analysis

A multinomial logit technique was used to determine the influence of confounders on invasive procedures such as cardiac catheterization, PTCA, and CABG versus non-invasive treatment. This technique is often used to examine the effect of confounders on a dependent categorical variable with three or more categories. The dependent variable categories were CC, PTCA, CABG and non-invasive procedures. The dataset contained the patient's diagnoses (both primary and secondary), treatment, payer type, gender, race, marital status, and age. To run the analysis, these variables were transformed into categorical and dichotomous variables. For example, procedures were detailed using ICD-9-CM codes. To run the analysis, the dependent variables procedural codes for CC, PTCA and CABG were changed to categorical variables where, CC = 2, PTCA=3, CABG=4, and non-invasive procedures=5. Confounders, such as gender, were coded using dichotomous variables (1 if the patient was male and 0 if the patient was a female).

Protection of Human Subjects

Approval was obtained from the University's Institutional Review Board (IRB) and from the Hospitals' Research Committee. To protect the confidentiality of the patients, no personal identifiers were used in the data sets. A numbering system was used to match the data collection forms to the subjects' medical records.

RESULTS

The final sample included 3,015 patients who were diagnosed with a cardiovascular disease. The sample consisted of nearly equal representation of males (n=1535) (50.9%) to females (n=1480) (49.1%). The majority of the patients (n=1727) (57.3%) were African American between the ages of 41-60 (n=1775) (58.8%). One-third (n=1573) (35.8%) of the patients had two to four secondary diagnoses. The most common diagnosis presented in this patient population was ischemia (n=921) (30.5%). Table 1 presents an overview of the demographic characteristics of the patient population.

Utilization of Invasive Procedures versus Non-Invasive Procedures Based on Race and Gender

There was nearly equal utilization of invasive procedures among the sample (n=1519) (53.4%) compared to non-invasive procedures (n=1496) (49.6%). Of the invasive procedures utilized, more patients had a cardiac catheterization (n=962) (31.9%) compared to PTCA and CABG. However, there was no statistical difference ($p=.141$) in the utilization of cardiac catheterizations between African Americans and Caucasians using the multinomial logit technique.

More males (n=862) (56%) received invasive procedures compared to females (n=657) (44%). There was a statistically significant difference ($p=.00$) in utilization of invasive procedures among males and females. This occurred when gender was the only confounder included in the model. However, when other confounders such as age, race, diagnoses, and comorbidity were added-in and controlled for using a multinomial technique, the significance was eliminated. Thus, there was no difference ($p=.455$) in the utilization of invasive procedures between males and females. Table 2 presents an overview of the cardiac procedures used by the patient population.

Controlling Factors: Cardiac Catheterization Results

The influence of certain variables such as comorbidity, financial status, diagnosis, age, and lifestyle on the utilization of invasive procedures was examined. A comorbid increase of one diagnosis decreased the odds probability ratio between cardiac catheterization and non-invasive procedure when the other confounders were held to their base value (odds

Table 1. Demographic Characteristics of Patient Population

Confounder	Frequency (N)	Percent (%)
Comorbidity		
0	73	2.4%
1	292	9.7%
2	492	16.3%
3	565	18.7%
4	516	17.1%
5	351	11.6%
6	233	7.7%
7	371	12.3%
8	72	2.4%
9	50	1.7%
Financial Class		
Medicaid	648	21.5%
Medicare	456	15.1%
Free Care	787	26.1%
Uninsured	104	3.4%
Insurance	1,020	33.9%
Gender		
Male	1535	50.9%
Female	1480	49.1%
Race		
African-American	1727	57.3%
Caucasian	1202	39.9%
Other	86	2.9%
Age		
0-30	74	2.5%
31-40	171	5.7%
41-50	704	23.3%
51-60	1071	35.5%
61-70	762	25.3%
71-80	167	5.5%
>81	66	2.2%
Diagnoses		
Angina	113	3.7%
Chest Pain	286	9.5%
Acute MI	557	18.5%
Unstable Angina	488	16.2%
Ischemia	921	30.5%
Other CVD Diagnoses	650	21.6%
Sites		
Hospital A	293	9.7%
Hospital B	2,571	85%
Hospital C	151	5%
*Descriptives includes some missing cases		

ratio .77; $P < .000$). Patients with a comorbidity of one had a cardiac catheterization probability of .522, while patients with three and five comorbid diagnoses had a probability of .452 and .370 respectively. When comorbidity increased from one to five, the probability of having a cardiac catheterization decreased by a probability of .152 when other confounders were held to their base. Thus, as the number of secondary diag-

Table 2. Cardiac Procedures Utilized by Patient Population

Procedure	Frequency (N)	Percent (%)
Non-invasive	1496	49.6%
CC	962	31.9%
PTCA	286	9.5%
CABG	271	9.0%
TOTAL	*3015	100.0%

*Note: Some patients had more than one invasive procedure.

noses increased, the probability of undergoing a cardiac catheterization relative to a non-invasive procedure decreased which suggest that patients with fewer secondary diagnoses were more likely to receive a cardiac catheterization than patients with several secondary diagnoses.

When financial class changed from insurance to Medicaid, Medicare, or Free Care, holding the other confounders at their base value, the probability of undergoing a cardiac catheterization decreased (odds ratio 0.43, 0.59 and 0.57, respectively; $p = .00$). Therefore, patients presenting with insurance were more likely to undergo a cardiac catheterization compared to Medicaid, Medicare, and Free Care patients. In fact, when confounders were held to their base, the cardiac catheterization probability for insurance patients was 0.123 higher than Medicaid patients, 0.064 higher than Medicare patients and 0.082 higher compared to Free Care patients. Thus, Medicaid, Medicare, and Free Care patients were 29.6, 15.4, and 19.8 percent respectively, less likely than insurance patients to undergo a cardiac catheterization when other confounders were held to their base. Patients diagnosed with chest pain and other CVD diagnoses were less likely to utilize a cardiac catheterization compared to ischemic patients when other confounders were held at their base values ($P = 0.00$; odds ratio 0.24 and 0.04, respectively). The cardiac catheterization probability for patients with chest pain and other diagnoses was 0.238 and 0.045, respectively, while the ischemic cardiac catheterization; probability is 0.415, when confounders are held to their base. Shifting from ischemia to Acute MI or unstable Angina, while other variables are held to their base values, results in an increase in undergoing a cardiac catheterization (odds ratio 1.82 and 2.17 respectively; $P = 0.00$). When looking at probabilities, patients diagnosed with ischemia were 23 to 25 percent less likely to undergo a cardiac catheterization relative to a non-invasive treatment than a patient diagnosed with an MI or unstable Angina, respectively.

When confounders were held to their base, patients over the age of 81 were less likely, compared to patients younger than 41 years, to have a cardiac cath-

eterization (odds ratio 0.13; $P = 0.00$). When factoring in probabilities, patients over 81 years of age were 68 percent less likely to utilize a cardiac catheterization compared to patients under 41 years.

Lastly, the effects of lifestyle comorbid diagnoses were examined to determine their effects on influencing utilization of invasive procedures. After holding other confounders to their base values, patients with cigarette addiction were more likely than patients without this addiction to utilize a cardiac catheterization ($p < 0.05$; probability 0.460 vs. 0.415), while non-obese patients were less likely than obese patients to utilize a cardiac catheterization ($P < 0.05$; probability was 0.007 greater). Table 3 displays the parameter estimates for cardiac catheterization.

Table 3. Parameter Estimates for Cardiac Catheterization

VARIABLES	B	Std. Error	No. of Procedures	Odds Ratio
Intercept	-4.24**	1.58		
Comorbid	-0.26***	0.03		0.77
Medicaid	-0.84***	0.14	151	0.43
Medicare	-0.52***	0.17	118	0.59
Free Care	-0.56***	0.13	238	0.57
Not Insured	0.84**	0.31	49	2.33
Male	0.09	0.10	540	1.10
Married	0.09	0.18	374	1.09
African-American	-0.16	0.12	505	0.85
Other Races	-0.55	0.30	28	0.57
Ages 41-50	0.15	0.22	245	1.16
Ages 51-60	0.17	0.26	363	1.18
Ages 61-70	0.10	0.30	237	1.10
Ages 71-80	0.09	0.35	55	1.10
Ages over 81	-2.02***	0.61	4	0.13
Acute MI	0.60***	0.14	258	1.82
Unstable Angina	0.77***	0.15	226	2.17
Angina	-0.07	0.23	50	0.93
Chest Pain	-1.41***	0.18	69	0.24
Other				
Diagnoses	-3.27***	0.23	24	0.04
Diabetic	-0.27	0.29	19	0.76
Cigarette	0.43*	0.21	64	1.53
Obese	0.81*	0.37	22	2.25

Note: * $p < 0.05$, ** $p < .01$, *** $P < .00$

Controlling Factors: PTCA Results

When confounders were held to their base, increasing comorbidity by one unit resulted in a decrease in the probability of utilizing a PTCA by 5 percent (odds ratio 0.77; $p = 0.00$). When the number of secondary diagnoses increased, the probability of a patient having a PTCA relative to a non-invasive treatment decreased.

When Financial Class changed from Insurance to Medicaid, Medicare, or Free Care, while holding the

other confounders at their base values, the probability decreased between having a PTCA and a non-invasive treatment (odds ratio 0.45, 0.43, and 0.54, respectively $P = 0.00$). The PTCA rate for patients with insurance was 0.046, 0.064, and 0.04 higher compared to Medicaid, Medicare, and Free Care patients, respectively, when confounders were held to their base. When confounders were held to their base, patients with insurance had PTCA probabilities of 0.165, while uninsured patients had PTCA probabilities of 0.182. Therefore, the insured patients were 9 percent less likely to receive a PTCA than uninsured patients.

Patients diagnosed with chest pain, other diagnoses and angina were less likely compared to Ischemic patients to utilize a PTCA when other confounders were held at their base values ($P < 0.05$; odds ratio 0.03, 0.09 0.39, respectively). Patients presenting with Ischemia had probabilities of 0.154 and 0.125 higher compared to patients with chest pain and other diagnoses, respectively. Therefore, Ischemic patients were 7 percent more likely to undergo a PTCA compared to patients with Chest Pain and 24 percent more likely to undergo a PTCA than patients with Other Diagnoses. On the contrary, shifting from Ischemia to Acute Myocardial Infarction (MI), while other variables were held to their base values, resulted in an increase in PTCA utilization (odds ratio 1.84; $P < 0.05$). Acute MI patients had PTCA probabilities of 0.205 and were 20 percent more likely than Ischemic patient to undergo a PTCA, when confounders were held to their base.

After controlling for other confounders, patients with cigarette addiction were 0.071, or 30 percent, more likely compared to patients without this addiction to undergo a PTCA (odds ratio 1.98; $P < 0.05$). Further, non-obese patients were 0.029, or 15 percent, less likely to undergo a PTCA than an obese patient (odds ratio 2.60; $P < 0.05$). The age variable failed to yield statistically significant results ($P > 0.05$). Therefore, age did not influence PTCA utilization rates in this sample. Table 4 displays the parameter estimates for PTCA.

Controlling Factors: CABG Results

Increasing comorbidity by one and holding the other factors at their base decreased the probability ratio between a CABG and non-invasive treatment slightly (odds ratio 0.87; $P = 0.00$). When confounders were held to their base and comorbidity increased from one to three, the probability increased from 0.088 to 0.098, or 11 percent. However, when comorbidity increased from three to five, the probability decreased by 0.068, or 69 percent. Therefore, as comorbidity increased, the probability of undergoing a CABG relative to a non-invasive treatment decreased.

When financial class was examined, Medicaid, Free Care, and Uninsured variables were significant.

Table 4. Parameter Estimates For PTCA

VARIABLES	B	Std. Error	No. of Procedures	Odds Ratio
Intercept	-8.42***	2.29		0.00
Comorbid	-0.26***	0.04		0.77
Medicaid	-0.81***	0.20	50	0.45
Medicare	-0.84***	0.28	23	0.43
Free Care	-0.62***	0.18	72	0.54
Not Insured	0.74*	0.38	15	2.09
Male	0.11	0.15	165	1.12
Married	0.09	0.24	117	1.09
African-American	-0.19	0.16	147	0.83
Other Races	-0.66	0.46	7	0.52
Ages 41-50	0.11	0.32	76	1.12
Ages 51-60	0.13	0.36	117	1.14
Ages 61-70	-0.07	0.41	67	0.93
Ages 71-80	-0.94	0.60	11	0.39
Ages over 81	-1.55	0.84	2	0.21
Acute MI	0.61***	0.18	91	1.84
Unstable Angina	0.26	0.21	49	1.29
Angina	-0.95*	0.43	7	0.39
Chest Pain	-3.56***	0.60	3	0.03
Other Diagnoses	-2.46***	0.26	19	0.09
Diabetic	0.18	0.39	9	1.20
Cigarette	0.68**	0.28	25	1.98
Obese	0.96*	0.48	8	2.60

Note: * $p < 0.05$, ** $p < .01$, *** $P < .00$

After controlling for other predictors, shifting from Insurance to Medicaid or Free Care resulted in a reduction in the probability of having a CABG relative to having an invasive procedure (odds ratio 0.44 and 0.65, respectively; $p < 0.05$). Patients who were not insured, after controlling for the other confounders and holding them to their base values, had a 0.139 probability of having a CABG. Uninsured patients were 27 percent more likely to receive a CABG than insured patients (odds ratio 2.61; $P < 0.05$).

Several diagnoses posted significant results. Shifting from chronic Ischemia to unstable Angina and Chest Pain resulted in an increase in the expected ratio of having a CABG relative to a non-invasive treatment, while holding other predictors to their base values (odds ratio 2.97 and 0.000, respectively; $P < 0.05$). Ischemic probabilities were 0.072 less than unstable Angina probabilities. Patients diagnosed with unstable Angina had higher CABG probabilities than patients diagnosed with Ischemia (0.173 vs. .101, respectively). Furthermore, obese patients were more likely to undergo a CABG compared to non-obese patients ($p = .00$; odds ratio, 5.26). When confounders are held to their base, obese patients' probabilities were 0.139 higher than non-obese patients. Table 5 displays the parameter estimates for CABG.

Table 5. Parameter Estimates for CABG

VARIABLES	B	Std. Error	No. of Procedures	Odds Ratio
Intercept	-36.53***	2.26		0.00
Comorbid	-0.14***	0.04		0.87
Medicaid	-0.83***	0.22	40	0.44
Medicare	-0.41	0.26	34	0.66
Free Care	-0.43*	0.19	76	0.65
Not Insured	0.96*	0.41	14	2.61
Male	0.13	0.15	157	1.14
Married	-0.12	0.25	92	0.89
African-American	-0.53***	0.17	118	0.59
Other Races	-0.31	0.41	11	0.74
Ages 41-50	0.66	0.48	58	1.93
Ages 51-60	0.72	0.50	115	2.06
Ages 61-70	0.59	0.54	81	1.81
Ages 71-80	0.10	0.64	11	1.11
Ages over 81	-37.03	0.00	*	0.00
Acute MI	0.03	0.21	47	1.03
Unstable Angina	1.09***	0.18	104	2.97
Angina	-0.44	0.37	10	0.64
Chest Pain	-38.13***	0.00	*	0.00
Other Diagnoses	-5.20	1.01	1	0.01
Diabetic	-0.44	0.44	7	0.64
Cigarette	0.01	0.32	6	1.01
Obese	1.66***	0.41	17	5.26

Note: * $p < 0.05$, ** $p < .01$, *** $P < .00$

DISCUSSION

The purpose of this study was to explore the effect of race and gender on invasive treatment for CVD. It was hypothesized that African-Americans and females would be less likely to receive invasive treatment compared to Caucasians and males, respectively. In spite of controlling for insurance, age, comorbidity, diagnoses, gender, ethnicity, diabetes, cigarette addiction, obesity, and marital status, unexpectedly, the population-based analysis failed to validate racial disparities between African-Americans and Caucasians regarding cardiac catheterization and PTCA utilization. However, the analysis did find a statistically significant ($p < .05$) racial difference in CABG utilization probabilities. Therefore, when examining race, findings from this study revealed that African-Americans were less likely to receive a CABG compared to Caucasians. Although, there was a statistically significant difference ($p < .05$) in utilization of invasive procedures among males and females, gender disparities diminished when confounding variables were controlled. Thus, the population-based analysis failed to validate gender disparities between African-Americans and Caucasians regarding cardiac catheterization, PTCA, and CABG utilization.

There are several possible explanations why this study did not find racial disparities regarding cardiac catheterization and PTCA utilization. Most of the patients in the cohort were African-American. Although researchers have not studied this occurrence, the African-American utilization rate may be less when they comprise the majority of patients presenting for care. Several studies have suggested that inequalities in health care are possibly attributable to racial, cultural, and communication barriers between minority patients and Caucasian health care providers (Geiger, 1996; Sullivan, 1991; Weddington, Gabel, & Stewart, 1992; Whittle, Conigliaro, Good, & Joswiak, 1997). Therefore, the utilization disparity between African-Americans and Caucasians may result because clinicians are of a different culture or ethnicity than the patients they serve. Prior studies have demonstrated that African-Americans receive a disproportionate amount of care from racially concordant physicians (Keith, Bell, Swanson, & Williams, 1985; Komaromy, Grumbach, & Drake, 1996; Moy & Bartman, 1995; Xu et al., 1996). Urban hospitals tend to have more African-American physicians than rural and suburban hospitals. Moreover, researchers have found that patients prefer physicians of their own race and rate their experience as more participatory when the physician is of the same race. Patients of the same race as their physician may be more likely to adhere to their treatment decisions because the patients prefer their physicians' decision-making styles. Physicians of the same race as their patients also may be more effective in treating their patients (Cooper-Patrick et al., 1999; Saha, Komaromy, Koepsell, Bindman, 1999).

Although not empirically proven, if African-Americans prefer African-American physicians, then they may also prefer hospitals where they make up the majority. This may account for the narrower utilization rates. As previously mentioned, about 34 percent of the patient population had insurance. These patients could have gone to private hospitals, but instead chose these charity hospitals. Additionally, because the majority of these patients are African-Americans, physicians that are Caucasian may be able to relate better than physicians at hospitals with few African-American patients, causing patients to be participative. This can also lead to reduced utilization differentials between African-Americans and Caucasians.

The sites in the study were academic teaching hospitals, which tend to have more physician oversight than non-teaching hospitals because they serve as a training center for physicians. Furthermore, older and more established physicians supervise recommendations by younger physicians. For example, normally a medical student or a resident is responsible for seeing a patient initially. A staff physician

must approve the recommendations made by the residents. This hierarchy of decision-making and layering of physician management may have an influence on whether a patient receives an invasive procedure or not.

Findings from this study support previous research that found racial disparities in the utilization of CABG despite controlling for socioeconomic status. Wenneker and Epstein (1989) noted that Caucasians underwent twice as many bypass surgeries as African-Americans. This is consistent with the national rate of CABG, which is 27.1 per 10,000 for Caucasians, but only 7.6 for African-Americans (Goldberg, Hartz, & Jacobsen, 1992). Although these differences exist throughout the nation, they were greatest in the southeastern states, particularly in rural areas. Findings from this study also support the findings from Whittle et al., (1997) which reported that Caucasian patients consistently underwent invasive cardiac procedures particularly, CABG more often than African-American patients. Lastly, Peterson, Wright, Daley, & Thibault (1994) indicated that African-Americans were 54 percent less likely to receive CABG than Caucasians.

Additional factors that may contribute to African-Americans undergoing fewer CABG procedures when compared to Caucasians include physician bias and patient preferences. Schulman et al., (1999) reported that physicians may discriminate against African-Americans by referring Caucasians more often for CABG procedures, which results in underutilization of aggressive treatment in African-Americans or overuse in Caucasians.

SUMMARY

Surprisingly, findings from this study failed to support previous studies, which found gender utilization differences in invasive treatment for CVD (Ayanian et al., 1991; Brown, 2002; Giles et al., 1995; Tobin, Wassertheil-Smoller, & Wexler, 1987; Steingart et al., 1991; Udvarhelyi et al., 1992; Watson et al., 2001; Wenneker & Epstein, 1989). These studies reported gender differences despite the fact that they controlled for similar confounding variables. Conversely, this study did validate two other studies that were unable to confirm that invasive procedures were underused in women (Krumholz, Douglas, Lauer, & Pasternak, 1992; Raine, Black, Burke, & Wood, 2002). Krumholz et al., (1992), reported that after controlling for age, females were no less likely to have a cardiac catheterization compared to males and they were as likely as men to be referred for angioplasty after cardiac catheterization.

A limitation in this study was that invasive cardiac procedures were performed at only one of the three hospitals. As a result, patients eligible for an invasive procedure had to be transported to the hos-

pital that offered invasive procedures. However, transportation was provided to these patients by the state of Louisiana. Additional limitations included: the use of retrospective data, whereby some of the medical records were incomplete and the sample was limited to patients in a public health teaching hospital, thereby restricting generalizability to that patient population.

It is recommended that future research attempt to replicate this study focusing on hospitals that are private, non-teaching institutions. Additionally, future research should examine whether the concentration of African Americans in the patient population effects the utilization of invasive cardiovascular treatments. The findings from this study demonstrated that African-Americans were less likely than Caucasians to receive a CABG. It is likely that a mix of patient, provider, and health system factors contributed to disparities in care. However, physicians are often in a position to influence these factors. As a result, physicians play an important role in efforts to understand why disparities occur and in implementing strategies that seek to assure the highest quality medical care for every individual, regardless of race or gender.

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Abstract: *Culturally incompetent communication patterns with providers influence the health disparities of African Americans. Limited knowledge exists on cross-racial nurse practitioner nurse-patient relationships (NP-NPRs). The purpose of this paper is to describe how NPs and patients in cross-racial relationships developed primary care relationships in one nurse managed center (NMC).*

A qualitative design incorporated a social constructivist paradigm and the methodology of Interpretive Interactionism. Twenty cross-racial NP-patient dyads (White NPs and Black patients) participated in individual 1 to 3-hour audiotaped interviews regarding their ongoing relationships and the impact of the NMC.

The analysis uncovered a rich description of the relationship processes from the initial meeting to its current state. Multiple themes for each phase, as well as, four typologies of primary care cross-racial NP-NPRs are described.

Significant relationship work was needed by both partners to overcome communication misunderstandings, contextual aspects of cross-racial interactions and other overt and covert perceptions.

Key Words: *Cross-Cultural, Primary Care Relationships, Nurse-Managed Center*

CREATING CROSS-RACIAL PRIMARY CARE RELATIONSHIPS IN A NURSE-MANAGED CENTER

Racial and ethnic biases have been implicated as a factor in the health disparities of persons of color (Smedley, Stith, & Nelson, 2002). Racial biases are critical to understanding community-based primary care because mutual patient-provider decision-making and planning are dependent on a complex interactive process that is hampered by these biases (van Ryn & Burke, 2000). Numerous

studies have suggested that racial differences influence communication resulting in inadequate diagnostic testing (Canto, Allison, & Kiefe, 2000), miscommunications about etiologies, insufficient treatment plans (Abreu, 1999) and discounting of patient's ideas (Helms & Cook, 1999). Most studies focus on physician providers. Yet, nurse practitioners (NPs) and patients from diverse backgrounds have created relationships in primary care for over 30 years. Despite the considerable research about NPs, few studies focus on the nurse practitioner-nurse patient relationships (NP-NPRs) (Fisher, 1995; Johnson, 1993) and none were found that provide an understanding of cross-racial relationships.

Cross-racial communication during primary care NP-NPRs in a nurse-managed center (NMC) has received little to no attention. Assumptions about care in NMCs are based on the work of non-NP nurses (Morse, DeLuca-Havens, & Wilson, 1997), nursing

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philosophical tenets (Lowenberg, 1994) and studies of NPs in other settings (Brykczynski, 1989). Few studies have explored the perspectives of patients (Scott & Moneyham, 1995), and no study described the perspectives of persons of color. The purpose of the present study was to reconstruct the process of cross-racial primary care relationships between African American patients' and White nurse practitioners from one urban nurse-managed center.

Background

The NP profession has focused most of its research toward professional validation (Bullough, 1995), instead of discovering the source of their successes. Seminal qualitative studies have reported that NPs creatively develop the NP-NPR utilizing a variety of contextually complex relationship skills (Brykczynski, 1989; Fisher, 1995; Johnson, 1993). These researchers argued that to fully understand NP care, and consequently their NP-NPRs, the care must be studied in context and with more depth about the participants and the relationships. Although NPs have been found to excel in nurse-patient interactions, the patients in these studies have been predominately White middle-class women (Johnson) or remain undocumented (Taylor, Pickens, & Geden, 1989). Few studies have provided information on the practice site or other setting specific influences (Campbell, Mauksch, Neikirk, & Hosokawa, 1990). Given that NPs in NMCs service a large proportion of culturally diverse and disenfranchised clients (Reisch, 1992), these NPs, like most nurses, are likely confronting the complexities of cross-cultural relationships. Yet, few studies of these relationships exist.

With the exception of the community health nursing literature, most of the non-NP nurse patient relationship literature is limited in its applicability to NP research due to role distinctions (Morse, et al., 1997), context (May & Purkis, 1995) and autonomy over practice (Lowenberg, 1994). The community health nursing literature suggests that nurses struggle with cross-cultural relationships finding them difficult (Chalmers, 1994), challenging (DeLaCuesta, 1994), and at times mutually dissatisfying (Murphy & Macleod-Clark, 1993). Community health nurses also find that the shift in context from hospital to community settings accentuates the complexities of cross-cultural relationships (Clarke, & Cody, 1994).

A report by the Commonwealth Fund (2001) suggested that cross-racial communication in health care settings have the greatest potential for misinterpretations between providers and patients. Persons of color report cross-racial discrimination as one cause for their service under-utilization and unmet health care needs, but report different views about their private physician and contrast him/her with the systemic discrimination in health care. In contrast, White providers often cite discriminatory behaviors in co-

workers, but not in themselves (Kaiser, 1999). A wealth of physician-patient communication literature exists, but there has been no study of the concept of a sustained cross-racial partnership as advocated in the Institute of Medicine report on primary care (1996). Most studies focus on deficits in these relationships (Cooper & Roter, 2002). These reports substantiate that a problem exists in cross-racial communication but there is limited descriptions about how to sustain cross-racial primary care relationships.

Numerous research studies within the multicultural counseling literature have suggested that racial differences influence provider preferences, interaction processes and outcomes of cross-racial communication. A strong preference for racial concordance exists when the client has a higher Black racial identity (Atkinson & Lowe, 1995). African American clients also describe a cultural mistrust that affects health care processes and outcomes (Whaley, 2001). High levels of cultural mistrust in African American clients have been associated with higher attrition rates in counseling. Counselor race and client cultural mistrust levels have been shown to affect client disclosure, an outcome variable that can affect diagnosis and treatment plans (Atkinson & Lowe). Yet, researchers have only recently applied these concepts to primary care (Smedley, et al., 2002), and few researchers have emphasized the work of patients within these cross-racial encounters (Shapiro, Hollingshead and Morrison, 2002). Earlier research has highlighted the exceptional work of patients to engage in "reciprocal trust" with health care providers (Thorne & Robinson, 1989, p. 156). Yet, little is known about the ethnic backgrounds of the participants.

Much remains to be unraveled in the literature regarding cross-racial primary care relationships. The interconnecting aspects of race, practice style and context have not been described in any depth. Before NPs can make claims of difference in their outcomes of care, especially with African American patients, further study of these relationships is needed.

A qualitative study was conducted to increase understanding of the relationship process between cross-racial NP-patient primary care dyads. The research question in this study was: "How do White NPs and African American patients in a nurse managed center overcome social identity and personal belief disparities to establish sustained relationships in primary care?"

METHODS

This qualitative study used the constructivist perspective of Interpretive Interactionism, which is a reformulation of Symbolic Interactionism (Blumer, 1969), and incorporates multiple philosophical traditions including, critical theory and cultural studies (Denzin, 1989). It emphasizes the illumination of

meanings in problematic and symbolic interactions where language and cultural symbols do not always hold similar meanings. Interpretive Interactionists try to capture the meanings persons give to themselves and their experiences through understanding the intersections of interaction, biography and social structure. Table 1 provides a description of the constructs within Interpretive Interactionism. The framework was used as a guide to ensure qualitative rigor through an epistemological linkage between the paradigm and the methods (Miles & Huberman, 1994). We sought to guard against researcher White privilege by emphasizing issues of race and taken-for-granted meanings in cross-racial health care.

Table 1. Descriptions of Constructs in Interpretive Interactionism

Constructs	Descriptions
Self	The self of a person is seen as a multi-layered construct with several subconstructs (Denzin, 1992). For example, the phenomenological self makes up the inner consciousness of persons.
Epiphany	Epiphany experiences are junctures in life when values held tight by an individual come under threat as they are subject to a more public display (Denzin, 1989). The experiences provide a radical redefinition of the self.
Emotions	A generalized feeling, such as love, hate, fear, anger. Emotions are assumed to be present throughout the interpretive process (Denzin, 1989).
Interaction	Interactions are the symbolic and temporal experiences, which are a joint act interpreted by the actors through subjective and objective reports about their personal experiences, the interaction process, and the social context. Interaction situations may be routine, ritualized, or problematic (Denzin, 1989)
Ensembles	The structural order and social relationships that constrain everyday interaction and exhibits a routine and taken-for-granted meaning (Denzin, 1989). These ideological meanings become taken for granted and affect multiple aspects of health care relationships.

PROCEDURES

The first author was a nurse practitioner (NP) in the site and received agreement to conduct the research at the setting. All NPs had to be women who

self-identified as White or Caucasian heritage with at least one year of NP experience in the NMC and functioning as primary care providers. All patients had to be over 18; self identified either as African American or Black women with no serious mental illness diagnosis that would affect perceptions of self. After institutional review board approval was obtained, maximum variation sampling was performed to secure variations in dyads based on the length of the NP-NPR (Sandelowski, 1999). Thirty-four patients and four NPs were asked to participate; twenty-one patients and four NPs were interviewed. No patients or NPs refused. Thirteen patients were unable to coordinate their schedules with the interviewers, and one patient's tape had mechanical problems.

Data Collection

Since the primary researcher (RB) was a White colleague of the NPs, we chose to use four NP graduate students as interviewers for the study. Two of the students were African American and two were White. They ranged in age from 32 to 54 with a variety of backgrounds. The training consisted of readings, review of the interview guide, four hours of initial meetings and multiple hours of interview guidance during data collection. All interviews were race-concordant and were 45 minutes to 3-hours in length. Each NP was interviewed five times, once for each NP-NPR, and each patient was interviewed once. The interview guide consisted of five primary areas: general background, the NP-NPR process, comparison to other primary care relationships, skills used in the NP-NPR, and the effect of the NMC on the NP-NPR. Each area emphasized a major topic and the relevant constructs of Interpretive Interactionism. For example, the patient participants were asked; "Tell me about your background and exposure to White individuals". This emphasized the general background of African American women including exposure to racism in health care. The constructs of self and interactions were used as further prompts to elicit the women's various views of self and the types of interactions, including routinized, problematic or taken for granted in the primary care arena.

Participants completed a demographic sheet and a socioeconomic measure (Institute for Social Research (ISR), 1997). The demographic tool was developed for this study. Socioeconomic status was measured with an adapted version of the Study of Family Economics (ISR) interview guide that included data such as, hourly income, personal assets, and participant and family educational level and work history.

Data Analysis and Interpretation

The data analysis incorporated processes recommended by Denzin (1989) and other qualitative writers (Miles & Huberman, 1994). The data analysis process included bracketing, construction and

contextualization. During bracketing, the researcher dissected the verbatim transcripts to identify beginning in vivo coding of the phenomenon. The texts were read as an informed reader, as opposed to setting aside one's perspectives (i.e. phenomenology). The construction phase of the process was the most iterative. It involved clarifying and reassembling the relationship phenomenon. The intent of contextualization was to determine how the participant's self-stories and the social structure altered and shaped the relationship.

The analysis was not wedded to the constructs in the framework. Investigator triangulation and peer review guarded against a construct driven analysis process. For example, all participants were asked about epiphany experiences in their relationship process. None were identified. The construct was deemed irrelevant to the analysis. Similarly, staging or major shifts within the NP-NPR progression were deemphasized in the interviews.

Prior to discussion of the findings it is important to note that many participants initially deflected direct questioning about racism. These deflections were evident in the participants' discussions. They stated that they "can't go there" or "I don't know what to say". One woman even reported that these same acts of prejudice were not isolated to "White" providers. No participant used the term, "racism" despite its repeated use by the interviewers. Instead the women used terms like "prejudice", "looking over me cause I'm Black" or used covert terms like "they" to describe a White provider's behaviors or the "white health care system" to imply all health care. The NPs also deflected the term by using "prejudice" terms or stating, "I know where this question is going". Given the qualitative design, we wanted to make clear that the interviewers were direct with the women that a topic of discussion was "racism" in health care, yet it was the participants who did not use these words. The analysis also incorporated linguistic analysis of African American in-group tonal shifts between patients and interviewers (Smitherman, 1975). The analysis was required to better understand the linguistic shifts that occurred between African American race concordant interviews. During segments of the interview, the interviewers and the participants shifted to an in-group linguistic pattern whenever racism or race-related topics proved difficult to discuss by the participants. When the topic of race was concluded, both shifted to a Standard English linguistic pattern. These shifts highlighted the covert terms and underlying contextual pattern of talking about racism in a White dominant society (Smitherman). The analysis process incorporated the use of a qualitative software package, NUDIST V. 4.0® and extensive transcribing processes. The primary researcher performed most of the analysis with investigator triangulation by the two other authors.

Sample

The participants were a purposive sample of 20 dyads, four nurse practitioners and five of their patients, from an urban NMC. The 20 patients ranged in age from 26 to 74 years ($X = 53.5$ years). Ten of the patients had a high school or greater education and thirteen owned their own homes. Patients lived in the predominately Black central city where eight were currently employed. The patients' annual income ranged from \$2,100 to \$25,000. The four NPs ranged in age from 27 to 54 years ($X = 41.8$ years). All NPs had graduate education and one was a doctoral student. Each NP owned her home in an upper middle-income, predominantly White suburb of the central city. Three were employed full-time and the annual incomes ranged from \$55,000 to \$75,000. The NPs had been working at the NMC for 1.5 to 17 years ($X = 7.4$ years, mode = 5.5 years) and patients had been at the NMC for 6 months to 12 years ($X = 4.6$ years).

All but two participants were born and raised in segregated environments. Eighteen patients and three NPs did not have their first substantial encounter with someone similar to their dyadic partner until late adolescence or adulthood. Most NPs and patients described themselves as White and Black, respectively. All but eight participants were born in the Northern US; eight patients were born in the South. All of the patients and none of the NPs were raised in a lower socioeconomic background. Seventeen patients had no family health insurance as a child. All NPs had had health insurance. All patients described an acute awareness of their own skin color, while three out of four NPs were unaware of their own skin color until adulthood.

Findings

The primary care relationships reported here were made up of multiple verbal and nonverbal interactions that resulted in a six month to six-year connection between the members. Each dyad member was asked to describe their initial meetings with each other, what kept the primary care process going and the current state of their connection. No participant described distinct phases in the NP-NPR. The NPs described a "process" used to facilitate the development of a "primary care relationship". Patients were a bit more tentative in their use of the term 'relationships'. Instead they said, they "got along", were "consistent" and "got to know" each other. The following describes how these "consistent" connections evolved.

First meetings

Four themes were identified in the initial meetings between the dyads: a) similar baseline expectations, b) some initial differences, c) color in relations and d) instant trust. For all dyads, baseline expectations outweighed their differences in these initial in-

teractions. This was important since the first meetings were crucial to the patient's decision to remain with the NP.

Similar baseline expectations: Many dyads described similar expectations of their early interactions. Yet, patients and NPs described different reasons for holding the expectations. Eighteen patients preferred a style of care that exhibited "listening" and "caring" skills. These were often linked to female gender since women "live the feelings". During the first few visits, patients described assessing the NP's behaviors for these expectations. These women described expecting an attitude of "true concern" from the NP; these were interaction behaviors of the NP that recognized the patient as an individual.

NPs described the care they delivered in these early interactions as encouraging "the relationship process". The most common NP descriptor of the early interaction behaviors was "hearing their story". All the NPs described an interaction process of creating: "safety through listening", "taking the patient's perspective" into account, and "waiting for the story to unfold". All patients read each of the NPs interactions as "true concern", and seventeen dyads had become a "consistent" connection because of these baseline similarities.

Some initial differences: Despite the similarities, descriptions of the initial visits between dyads exhibited the greatest disparity in perspectives. In eleven dyads each patient's descriptions of the initial phase was clearer than those of the NP. These eleven patients had a clear memory of the beginning NP-NPR and could recall details of the initial encounters. In contrast, the NP's recall of her feelings and thoughts about the early relationship were variable. The common statement from all NPs was a hindsight desire to have reviewed the patient's chart. An example from one patient and her NP is used as an exemplar of the disparity in perspectives. The patient described her initial feelings in the following manner:

When I first met Miss X...yeah, I was wondering if I was gonna like Ms. X as much as I liked Ms. Y. And I kept questioning myself, 'will she be as nice as she was' (barely audible). And then she turned out to be...pretty nice (questioning tone).

The NP's discussion with the interviewer (I) is exemplar of most NPs' comments.

I: Could you tell me a little bit about when you first met Ms. A?

NP: I think I met her pretty soon after I came. I think she was one of the first, I think.

I: Do you have any impressions of the first time you met?

NP: Uhm...Gol [sic] no. Not the first time.

Variability in this pattern also existed. In five dy-

ads, a reversed pattern of recall for these early events occurred with all five patients of one NP. That is the NP had better recall of the early events than her five patients. Four other dyads gave nearly identical descriptions of the initial visits; one was a short-term (< 1 year) dyad. In the other three dyads, one NP described "rocky", "shaky" or "frustrating" experiences in the early visits, which resulted in her recall of early events.

Another difference of these early visits was the perceptions regarding who was in control of the dyad's progression. All four NPs described the patients' "caution" in the early NP-NPR as reflective of the African American woman's poor treatment in health care; subsequently, all four NPs described that the NP-NPR would progress if the NP used the "right skills". In contrast, eighteen patients described their own life history, values and beliefs as the major determinants of their willingness to return. The provider's "attitude" would influence them, but half of the patients believed that the patients' "own attitude" and their perceived "read" of the provider was more influential than the provider's behavior.

Color in Relations: The recognition of skin color differences was another distinct difference in perspective between the dyadic partners. Initially, most patients and NPs described skin color as an unimportant factor in their dyadic relationships. Yet, upon further discussions with interviewers, the patients described, "reading the attitude" of the provider. The NP's "attitude" was a code word for the patient's interpretation of the NP's view on race, which was linked to the NP's potential "prejudice" towards them as Black women. During the initial visits, sixteen patients described, "reading the provider" for her "attitude" through speech tonal qualities, "listening skills" and other nonverbal behaviors, such as touch. The comments about reading the provider's "attitude" made it clear that the provider's race was an important marker to be evaluated in early NP-NPRs. The provider's White skin color appeared to imply that the NP might hold a prejudice against them because of their skin color. In two cases skin color was an issue for the women. A quote from one of the two patients depicts the overt view of these two women and the covert view of the 14 others.

"I've gone to see [my previous provider].and uhm they say 'she gone' and I'm taking her place. I said. [to myself]. Oh God...I got a White lady...you know ...I don't know when I thought that ...I'm thinking ...now you got to be more pacific [sic] and more precise...and know what you sayin [sic]...you know, that's that's [sic] how I felt."

Four patients stated that they were "cautious" with the White NP based on their earlier health care experiences but these four did not describe a distinct assessment based on skin color. Two of these four pa-

tients were adamant that they did not see “color” as the cause for “poor treatment”; it was due to the person’s “skill” or “personal” characteristics.

In contrast, three NPs described not “seeing race” and stated that they used the “same [interaction] process” with all patients. All of the NPs talked about class issues as more important than skin color. They described the importance of equitable care despite class distinctions. These three NPs described skin color as “unimportant” to the process of care, and they stated that they “could count on one hand” the number of times “race” was an interaction issue in the NP-NPR. A quote from one NP exemplifies the common thread of these NPs’ discussions. She stated: “I don’t perceive that [skin color of the patient] I just think I’m seeing another patient today. I almost don’t stop to think about it.”

Two of these NPs contradicted themselves when further depth was obtained regarding their interactions with Black patients. One NP made the following comment in one of her subsequent interviews when questioned by the interviewer about how she could give care without seeing the “race” of patients.

“I don’t go into the visit any different. I think I go in with the same—although I would say that with my African American patients, I always in the back of my mind think [about] Maslow’s hierarchy of needs, making sure I always ask questions, making sure that...or looking into finances, housing, uh, shelter, transportation, kind of the fundamentals, where I don’t know if I am as consciously doing it with my Caucasians.”

Three NPs had years of experience working in communities of color, and they described being able to read early feeling tones of patients. Yet, this skill did not always transfer to reading issues of race. Even with NP experience, self-study, self-reflection and a desire to offer good care, one of the NPs was unaware that race was an overt issue for two of her patients.

Instant trust: In two dyads instant trust was conferred on the NP. One patient developed instant trust due to the NP’s prompt and careful management of her newly diagnosed diabetes. Another process that created instant trust in one dyad was the introduction of the patient to a new NP upon the departure of the previous NP. These transfers of care processes occurred in nine dyads; however, only one NP-NPR resulted in an “instant trust” experience.

Keeping it Going

During discussions of what kept the dyad together, all of the NPs and patients described the themes of time, trust and relationship. Sixteen dyads described complex, yet sustained primary care connections. Power issues affected two dyads, and the length of the relationship and racial ideology affected two dy-

ads.

Time: Time was the most critical element that promoted an ongoing connection. The two other themes, trust and relationship, were dependent on time. The two subthemes of time were “giving time” and “respecting time”. All participants described at length the value they placed on “giving [interaction] time” through longer visits, explanations of treatment plans and calling the patient with test results. Fourteen patients contrasted past health care experiences in which they were given “no time” to the current NP-NPR where time was valued. Patients did not describe time in a linear pattern; rather they described a sense of “not being rushed”, “connecting”, and “listening” time. One patient, a 58-year-old woman who had been with her NP for six years, described this process best. She stated; “Well, she gave me my complete physical and she set up [my treatments and tests]. She took time. She didn’t rush through [the visit]”. Another patient described what she perceived as the NP “giving time”. She stated:

“One thing I like about Ms. Z is that she is very understanding. She really (sic) concerned about her patient, and she will listen to you. She want you [imitating the NP]... ‘when you come in ‘you to tell me everything.”

The amount of time put into the NP-NPR by the NP showed concern for the women beyond a “doctor-patient relationship”. When “time” for an explanation of treatment plans was overlooked, five patients described that it made them feel like a “guinea pig”. The “guinea pig” statement brought comments about the Tuskegee syphilis experiment. Not all patients knew the term “Tuskegee”, yet they knew the implicit meaning of the story, and interestingly provider’s who did not give “time” were linked to this event.

The time given for “listening” was essential to the NPs. All NPs described respecting a time-intensive unfolding process of a patient’s story. One NP’s description is the best exemplar of this time-intensive process. She stated: “She can be very private, so I don’t prod her. Some days she’s very private and doesn’t want to say much. [I] just wait and try to gather what’s happening. Just take her seriously and wait”.

The process of “taking time” was chronologically “time consuming” according to NPs. Two NPs described the dilemma it posed in their attempts to be respectful of the time of “all patients”. These two NPs described being perpetually late with patients’ visits due to the giving of their time to other patients. Yet, both patients and NPs reported that they were expected to show respect for each other’s time, but NPs were expected to negotiate the time for all patients.

Trust: The trust-building elements that kept the connection going took the most time and energy from NPs and patients. Each person worked to develop

trust through the subthemes of a) “trying to understand each other”, b) individualizing and c) “sharing of self”. All of these trust-building processes required mutual flexibility and a give and take process. The subtheme of “trying to get an understanding” began with “intense listening” by the NP. In turn, patients sought to learn more about the NP’s “ways”. The mutual intentional listening was the primary interaction process whereby the NP and patient sought to learn more about each other and how each will respond to the other. For NPs, the skills required to convey these intentional behaviors required experience in the NMC and hard work. Three patients expected the NP to develop an understanding of them first and read their nuances, just as they had learned to “read” providers. Seventeen patients described a mutual process and they appreciated the NP’s work at “trying to get an understanding” of their viewpoint. One young woman who suffered with depression gave this description of the trust theme:

“The first thing she said [during one visit was], what is your concern. Just lay it on the table’. ‘Just tell me a little bit about yourself’. I told her I’m suffering from a depression, I’m not suffering where I want to do suicidal, but she listened. You talkin’ and she listenin’, and lookin’ at me.”

The subtheme of individualizing built upon the “trying to get an understanding” theme. All patients and NPs reported that they worked together to individualize the treatment plan for the patient. Individualizing the plan meant translating medical information and personal beliefs back and forth between patient and NP until they came to a common meaning of a concern. Twelve patients described it as “breaking it down”. Both parties worked at a mutual understanding of medical terminology, symptoms, and other health related treatments. NPs changed their words and communication style of test results, symptom analysis, medical diagnoses and plans for care so that patients could understand the NP. In turn, patients asked questions and corrected misunderstandings. One NP described the process she uses to communicate complex numbers and content and build trust.:

“I just have to work really hard to gain their trust and that this is the right direction to go. And I do that by showing lab work. I’ll take my lab work right out of the chart, put their chart right into their lap and say this is your Hemoglobin A1C, its 12.2 and we want it a lot less than this. The reason you don’t feel good is because it’s high.”

All patients talked about their responsibilities as patients and their need to try and gain an understanding of “her ways”, which included the NP’s interaction styles and the recommended treatment plan. All

of the patients described trying to “work with the NP” to “give her a chance” to learn from them. As long as the NP appeared to be trying, patients would continue, “working together”. Six patients, including the two who felt the race of the NP was a concern, described, “Givin (sic) the NP a chance”. One patient stated:

“I believe in givin (sic) a person a chance. She [the NP], seem like she pretty honest, you know. She seem like she know her job. [So] I give her the chance because it’s like, once you’ve seen one [White provider] it’s better that you keep seeing them; they know more about your situation and perhaps your body.”

Sixteen dyads described working to deepen the relationship through the “sharing of self”. All patients described sharing themselves as a process of trust development. They described the importance of this sharing as a source of information for individualized care. One patient gave voice to the level of emotions often shared with the NP. She stated: “Within two years I told her everything”. The deepest level of sharing described by patients was their beliefs about religion and God. Two patients had shared this part of themselves with providers; yet, the sharing of religion to a health care provider was only important to three patients. Eighteen patients did not feel they could discuss the “religion thing” with their NP. Even within six year NP-NPRs, several patients stated that they “did not go there”.

The trust process was hindered by personality, value or power conflicts. In three dyads, the NP and patient struggled at trust development. One struggle developed over a disagreement regarding a mental health issue of the patient; one occurred over a work-ethic value conflict and one resulted from dissimilarity in beliefs about a treatment plan. Two NPs stated that they did “not like all of their patients”. Most of the time, the dislike was based on a patient’s mental health issues. The two NPs felt that these patients took time; they described these patients as “draining” and often “complex”. According to these NPs, the dislike was about a personality type that did not mesh with NP’s personality and the race or skin color did not matter. Interestingly, only two of these three patients described being aware that the NP was in conflict with their patient concerns.

In turn, eleven patients also described putting limits on their attempts to understand the NP’s ways. In the three dyads described above, the NP and patient did not “get an understanding” of a particular concern. In one dyad, the patient believed she was depressed but did not feel the NP’s treatment plan would be helpful. She sought an alternative opinion.

Relationship: Relationship was the final theme that kept the NP-NPRs on a forward trajectory; the subcomponents of this theme were a) consistency in

a primary care provider, b) unity with each other, and c) equalizing power. Maintaining a consistent provider over time was a similar theme between all of the NPs and patients. Unity with each other and equalizing power in relationship differed in three of the relationships.

Consistency in a primary care provider relationship meant that a provider had predictable behaviors and attitudes that the patient could rely upon over time. The consistency was crucial to all of these patients and NPs. "Getting to know someone" who had compatible ideas about health care treatment plans was a universal description of the value of these NP-NPRs. All patients described not wanting to "go back over the whole thing" [life story] repeatedly. One patient stated that consistency in a primary care provider was important almost to a fault. She stated: "We want to just keep the same doctor because we trust him (sic). We believe in him (sic). He (sic) might not be no good, but this is our belief".

NPs were aware of the value of consistency. All of the NPs described the importance of a long-term primary care relationship with consistency in behaviors. They believed that primary care providers should be consistent in their follow through and consistent in their actions.

"Unity with each other" meant that the NPs and patients shared the responsibility for primary care. Seventeen patients described the mutual sharing of responsibility, but one patient's description incorporated the overall theme, "It's the working together, and pulling together, which I called unity with each other". Fifteen patients suggested that they had a responsibility to acknowledge and understand the plan. One patient discussed it this way. She stated:

"You got to work with yourself, and work with that doctor [NP]. You can't just sit here and say, [to yourself] I ain't gonna do anything, because it just isn't going to work like that. You got to have that strong faith in yourself."

Finally, the relationship theme required some level of power equalizing between the dyad members. The equality was most often achieved through a mutual learning from each other. In eleven relationships, patients and NPs worked to equalize power; however, six dyads worked well despite a traditional hierarchical relationship pattern with episodic mutual learning. The power equalizing interaction process was described as sharing personal selves, admitting frailties, and sharing decision-making; it was a preferred style for most patients.

One aspect of the sub theme was equalizing the position of NP and patient through the NP sharing personal self-stories with patients. Thirteen patients saw the sharing of personal information by the NP as a way to equalize power. When NP talked about

her children and shared a bit of her personal life with patients, these thirteen patients felt the hierarchy of provider and patient disappeared or lessened. One stated it like this:

"I like those off the record talks. Those are nice because, it make me feel like you not like this over me [said with emphasis] like you the queen and I'm just the dumb little patsy."

All NPs advocated admitting frailties and sharing decision making as a process of "letting go of control" in relationships. One NP (Ms W.) described the process of letting go as "equalizing power" in her NP-NPR. She also described a process of deference to the "authority of age" and "life experience". In contrast, three NPs talked about letting patients choose their own course of action. The differentiation between NPs was most evident when NPs talked about their openness to being affected by the values of patients. Ms. W. discussed "letting go of control" as being altered by patients through changes in her values and beliefs, including life values and treatment decision values. She stated:

"Sure every patient always affects you in one way or another. She [one of her patients] probably got me to be even calmer with my family, because she is able to be so calm. She uses her energy wisely. So she's taught me calmness."

Twelve patients and three NPs described honesty with each other in their shared decision-making process. The patients described it as, "being real" with the NP. The patients described the importance of telling the NP about their concerns and the NP was expected to tell the patient about test results and recommendations.

In eight dyads, patients described being able to confront and contradict their provider. The patients described coming in and telling their practitioner their disagreements with the plan of care. Different NPs handled these confrontation situations in different ways, but the two NPs who used a process of "admitting frailties" had patients who described "close relationships" with the NP. One NP in particular had four out of five of her patients give examples of the NP's "admitting her frailties" to them. One patient said it most succinctly: "With her I would [tell her I did not like something] because of her attitude in the first place. She don't have that mightier, holier than you attitude". In turn, this patient's NP expressed a great deal of respect for all her patients. These five dyads had a peculiar pattern of perceived equality by all five patients from the outset of the NP-NPR; this was a sporadic finding with the other dyads.

Not all of the dyads were marked by an equalizing power relationship. Six dyads worked through a mixture of traditional hierarchical relationship pat-

terns and mutual learning patterns; these mixed relationships worked for the patient and NP. Even in the NP-patient dyads where the NP might be imposing her treatment plan, the patients were often satisfied with the care. In fact, one of these patients said it was the “best care she had ever had”.

In three of these hierarchical dyads, the patients described “obeying” the NP’s rules and care management plan, and not being fully “real” with the NP. These patients saw their role as not questioning the NP’s authority. These three patients preferred a relationship in which the NP showed a mixture of learning from the patient and “fussing” at them in a parent-child manner. The fussing was interpreted as caring and demonstrated “true concern”. Two patients valued “obeying” over “being real”. One was an older woman; yet both were raised in the South where there has been a tradition of overt unequal power relationships in society and health care. Birthplace of the patients, however, was not linked to a preferred NP-NPR style. Eight patients were born and raised in the South but only two preferred this style of dyad.

Current State

The current state of relations had seventeen dyads that described a sustained NP-NPR of many years duration; yet, differing perceptions between the members existed in four dyads. Four thematic types of NP-NPRs were developed from the dyad members’ perspectives: family doctor ($n = 12$), familial-friendship ($n = 4$), undetermined ($n = 3$), and separation ($n = 1$).

Family Doctor: The family-doctor theme meant that the NP-NPRs were similar to an earlier “family doctor” relationship in which they had “consistent” primary care providers. The twelve relationships were labeled ‘family doctor’ because both partners described a clear hierarchical distinction between the patient and the NP, as opposed to a familial-friendship process described in another pattern. The family doctor theme was equally subdivided into family doctor-close and family doctor-professional. In the family doctor-close dyads the patients had had an “older Black doctors” who had “taken time” with their patients. Although, these current NP-NPRs varied from six months to six years, the patients described the NP as someone they had been “looking for, for years”. Interestingly, none of NPs in these dyads were aware that these patients had had a long-term primary care doctor.

In the second type, family doctor-professional, the patient and provider worked together well, but in a “business-like” manner. Patients described these relationships as “being treated fairly”; the dyads did not describe the same interpersonal closeness found in the first type. An interesting aspect of these family doctor-professional NP-NPRs is that five of the patients’ earlier physicians were White.

Familial/friendship: In these four dyads, three pa-

tients and two NPs talked about the relationship as being one of deep personal liking and familial or friendship levels of closeness. Both partners described knowing each other beyond a professional relationship. Terms used were “like sisters” “mother-daughter”, and “friends forever”. According to the patients and NPs, they took a special “click” or “bond”. Of note, three out of four of these NP-NPRs were with one NP. The same NP had had all five of her patients describe her style of care as exemplar.

Undetermined: Three NP-NPRs were labeled as undetermined because they were difficult to assess for their sustainability. In one new NP-NPR (< 6 months), the patient was still assessing the NP’s “attitude” and the NP was inaccurate in her perceptions of the patient’s trust level. In the other two undetermined NP-NPRs, the partners described differing perceptions of each other. Both of these NP-NPRs were with one NP. One patient (Judith) had developed a “passive response” to the NP, which the NP described as “irritating”. Another patient (Ms. L), despite a five and one half year NP-NPR was still describing race as an issue in the relationship. She questioned whether she could cross the “race barrier” or work with a White provider on a long-term basis. In contrast, the NP described that she and Ms. L had “a lot in common”.

Separation: During the course of the study one of these dyads separated. The patient and the NP had differing views at the outset of their relationship, which could not be overcome even with time and mutual work due to: 1) a competing NP-patient relationship and 2) fixed perceptions of one another. In ongoing interactions, power rituals between the two members became problematic. After the interview, the patient decided to switch NPs, but not leave the NMC. The woman was the only patient to leave her NP during the study.

DISCUSSION

Primary care within this nurse-managed center provided an opportunity to better understand a sustained connection between White female nurse practitioners and Black female patients through a more informed and reconstructed account of twenty cross-racial relationship trajectories. Even with racial and socioeconomic differences, most dyadic partners worked to achieve sustained NP-NPRs. Yet, significant relationship work was needed by both partners to overcome communication misunderstandings, contextual aspects of cross-racial interactions and other overt and covert perceptions. Sixteen dyads exemplified the flexibility within ambiguity described as the ideal provider-patient relationship needed for our changing health care system (Wuest & Noerager-Stern, 1991). Despite a similarity in country of origin and surface language, Black female patients and their White female NP providers had to work at maintain-

ing their long-term relationships; these relationships required an enormous commitment to make them sustainable NP-NPRs. Consistent with previous research sustaining these relationships required patient skills at reading the attitudes of Whites (Kaiser, 1999), mutual work (Kristjanson & Chalmers, 1990), a give and take process (DeLaCuesta, 1994) and a supportive NMC setting that valued "listening" to the "patient's story" (Scott & Moneyham, 1995).

Similar to the Theory of Human Relatedness (THR) in Nurse-Patient Relationships, as described by Hagerty and Patusky (2003), seventeen dyadic partners worked toward mutuality and reciprocity. In contrast to the theory, these NP-NPRs required time intensive interactions over a period of months and years to develop the level of mutuality and reciprocity described in the theory. Hagerty and Patusky focus was on the inpatient setting with limited time for nurse-patient encounters. In primary care relationships, "taking time" is viewed as the critical element required for deeper levels of trust and alliance (Thorne & Robinson, 1989) and the "reflective negotiated practice" (Fuller, 2003) necessary for intercultural health care. A negotiation of treatment plans across cultural differences took time for both patients and NPs. Similar to the THR, the NP-NPRs in this study did not progress to sustained partnerships through distinct phases. Instead a model of care consistent with the middle range theory of caring (Swanson, 1991), advocacy (Brykczynski, 1989), individualized care (Johnson, 1993), and transcultural nursing skills (Campinha-Bacote, 1998; Leininger, 1991) enhanced these relationships.

Most NPs were able to create these relationships through their use of relationship building skills that included getting to know the patient (Radwin, 1996) and letting go of control (Thorne, 1997). They worked to develop a shared understanding with the women through power sharing and a give and take process of interaction. The NPs had gained skill at cross-racial relationship building after years of experience at the NMC.

Most patients facilitated the relationships through their skill at "reading" White individuals. They described clarifying and separating the qualities of this White NP provider through individualizing the NP. In contrast to the NPs, the patients had gained skill at cross-racial relationships through their lifelong exposures to prejudice and segregation in a White dominant society. These life skills likely created an astute ability to quickly assess the perspectives of providers within the first few visits (Helms & Cook, 1999). The skill helped these women to understand the "NPs' ways" and opened up the option to share themselves in deeper manner. No study has focused on this skill in health care relationships. Emphasis has been placed on race-concordance between pro-

vider and patient when the verbal and nonverbal exchanges are the actual proxy measures of cultural competence (Shapiro, et. al., 2002).

Earlier findings on cultural mistrust in health care were expanded. The reading of "attitudes" as a measure of potential prejudicial treatment made 16 out of 20 patients wary of the White NP in the initial interactions, and in two dyads, the patients remained unsure about their willingness to over ride their own beliefs about working with a White provider despite the NP's relationship skills. The impact of this finding on health care utilization and ultimately health disparities deserves greater study. It is likely that the intersection of ethnic matching (Atkinson & Lowe, 1995), Black racial identity (Helms & Cook, 1999), and cultural mistrust (Whaley, 2001) in health care relationships may mimic earlier research from multicultural counseling. The combined effects of cultural mistrust and Black racial identity, as well as, racial concordance might help to explain the impact of clinical uncertainty on health disparities. It is possible that these important consumer variables and the clinical uncertainty of health care treatment plans interact to dissuade African American patients from pursuing further care out of fear of being another "Tuskegee experiment". A more complex understanding of patient (and provider) variables could help providers and systems better service the African American population.

Expert practice, defined as learning more about the history of individuals, reaching out, and being affected by patients, was particularly evident with one NP (Benner, Tanner & Chesla, 1996). Even more significant, the analysis suggests that two NPs were still limited by their race and social class views and despite years of practice were not performing at an expert practice level. These two NPs used a history taking style that at times linked Black race to lower social class. Despite having worked in communities of color for years, these NPs might have benefited from more self-reflection on the diversity within the Black community. Yet, the findings are consistent with Frankenberg's (1993) research on White women and race in which she argues that White women who work in communities of color with limited understanding of their multiple privileges of color, class and role are at risk of re-enacting the hegemonies of race and class in the US.

The lessons from this study supported and contradicted the work of Fisher (1996). Fisher suggested that the equality in relationships perspective found in the ethical writings on caring was not possible. She argued that it might be more strategic, especially in culturally diverse encounters, to highlight that NPs provided time for alternative problem management and allowed patient's to counter their recommendations. In short, NPs acknowledge and support alter-

native definitions to the socially constructed ideology of primary care relationships. Most NP-NPRs in our study did exhibit a resistance to the ideology of traditional provider-patient relationships and supported a power equalizing process. Consistent with Fisher and Reutter and Ford (1997), all NPs described patients as being in control of their health care decisions. In contrast, to Fisher, a few NP-patient dyads enacted the hegemony of traditional primary care relationships and not all NPs were comfortable with patients' countering their recommendations. In addition, even when a NP did support an alternative provider-patient relationship style, two of the patients' views about racial and power hierarchies impacted their views of the relationships. The renegotiation of the hierarchies and belief disparities in most of the NP-NPRs suggested that cross-racial relationships in health care can be successful but the renegotiation is dependent upon each member's willingness and ability to override racial and medical hegemony. Both parties need to support a renegotiation process or implicitly agree to a hierarchical arrangement in order for the relationship to be sustained. In all cases, mutual work was necessary for a sustained NP-NPR.

Until now, there have been no reported studies of the concept of sustained cross-racial primary care relationships as a prototype for NP-NPRs in NMCs. The primary care relationships in this study that incorporated differing social identities of race, ethnicity, and class were found to be complex processes that challenged even the most experienced practitioners. Nursing has long emphasized the knowledge needed to work with diverse cultural groups and has urged us to become aware of our biases; yet, the complex reality of nursing practice within the cultural mosaic of US society requires more emphasis on the deeper elements of power, oppression and history (Resnicow, Soler, Braithwaite, Ahluwalia, & Butler, 2000). Effective cultural and racial competence in health care will mean constructing a focus on the centrality and intersections of the experiences of dominant-group nurses in concert with the experiences of minority-group patients, particularly patients of color.

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Abstract: *The number of qualitative studies regarding the experience of nurses caring for patients from cultures other than their own has increased, yet there remains a limited understanding of the meanings derived from this work. Using the methodology of Noblit and Hare's meta-ethnographic comparative method, the main themes and concepts from 13 qualitative studies are reduced to six overall themes that describe over 1,000 nurses' experience caring for patients from other cultures. The themes include: (a) connecting with the client, (b) cultural discovery, (c) the patient in context, (d) in their world, not mine, (e) road blocks, and (f) the cultural lens.*

Keywords: *Nursing Practice, Cultural Caring, Meta-Synthesis Qualitative Research*

CULTURAL CARING IN NURSING PRACTICE: A META-SYNTHESIS OF QUALITATIVE RESEARCH

Minority populations continue to grow at an unprecedented rate in the U.S. The Hispanic population is the fastest growing minority with over 35.3 million (12.5%) persons residing in the U.S. This largely Spanish speaking group has become the majority minority as of the year 2000 census. The African American population is slightly less than the Hispanic population at 34.6 million persons or 12.3%. In addition, there are 10 million Asian Americans or about 3.6% of the total U.S. population and 2.4 million American Indians that comprise 0.9% of the population (U.S. Bureau of the Census, 2002).

While the U.S. population has become increasingly diverse, nurses have remained a homogeneous group. Approximately 90% of all Registered Nurses are Caucasian; 4.2% are African American; 3.4% are Asian or Pacific Islander; and 1.6% are Hispanic (Minority Nursing Statistics, 2001). The only nurse population that mirrors the U.S. population is Asian American. The degree of uniformity of nurses compared to the U.S. population begs the question: Are we prepared to care for the increasingly multicultural patient?

Definition and purpose

According to Leininger, culture is a process of "learned, shared, and transmitted values, beliefs, norms, and life practices of a particular group that guides thinking, decisions and actions in patterned ways" (1988, p. 156). This article focuses on the ex-

perience of providing care to patients from other cultures. More specifically, other cultures refers to the experience of health care providers caring for a patient from a culture that is perceived as different than their own. This may include the patient having a different language, ethnicity, religion or any other life practice.

As society becomes increasingly diverse, transcultural care has become an important aspect of health care. The need for clinicians to become more sensitive to cultural differences and gain an understanding of transcultural concepts has been repeatedly stressed by Leininger (1988) who stated "the use of transcultural care knowledge is essential for accurate, reliable health care" (p. 159). As the health care community recognizes the need for increased cultural understanding, the number of qualitative studies regarding the experience of clinicians caring for different cultural groups has increased. Though there is increased interest and research, there remains a limited understanding of the meanings derived from this work since the work that has been done has not been summarized in a meaningful way. To further the applicability of the work, it is essential to synthesize individual studies into more concise findings. Further, a review of the literature revealed no published meta-synthesis on health care clinicians' experience caring for patients from other cultures. This represents a gap in the knowledge and need for synthesis of studies that address health care provider's views. The aim of this article is to closely examine and integrate the qualitative work in this area of study through meta-synthesis.

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Meta-synthesis can be defined as “the theories, grand narratives, generalizations, or interpretive translations produced from the integration or comparison of findings from qualitative studies” (Sandelowski, Docherty & Emden, 1997, p. 366). According to Jensen and Allen (1996, p. 553), meta-synthesis is essential “in order to advance knowledge and influence practice.” A meta-synthesis that summarizes the experience of clinicians caring for patients from a variety of cultural backgrounds will enhance the overall understanding of the issues and concerns. By utilizing a comprehensive synthesis of information, limitations in the research emerge and future research can be fine-tuned and applied to practice.

METHOD

The methodology chosen for the meta-synthesis is Noblit and Hare’s (1988) meta-ethnographic comparative method. This method allows for “substantive interpretations” that can be derived from ethnographic and interpretive studies (Noblit & Hare, 1988, p.9). This approach allows the researcher to “compare and analyze text, creating new interpretations in the process” (Noblit & Hare, 1988, p. 9). The seven step process is outlined throughout the article and in Table 1.

Table 1. Noblit and Hare’s Meta-Ethnographic Comparative Method

Phase 1: Getting started. This step involves finding an area of interest in need of synthesis.
Phase 2: Deciding what is relevant to the initial interest. This phase involves conducting a literature search based on sample criteria.
Phase 3: Reading the studies. This involves reading and re-reading the studies and noting interpretive metaphors in each.
Phase 4: Determine how the studies are related. In this step, the studies are “put together” and relationships between the studies are forged. It is suggested that a list of key metaphors, phrases, ideas and concepts are made for each study. The metaphors are then compared and juxtaposed. Three different relationships are possible: a direct comparison using reciprocal translations; a refutational comparison where studies oppose each other; and a grouping of studies that represent a line of argument.
Phase 5: Translating the studies into one another. Simply stated, the metaphors and themes are compared with each other while leaving the central metaphors intact.
Phase 6: Synthesizing translations. This step requires the researcher to make the parts of each study into a whole through synthesis of the information
Phase 7: Expressing the synthesis. The final step requires the researcher to write up and report the results.
(Noblit & Hare, 1988, pp. 26-29)

Phase one and two involved deciding on a research topic of interest and locating a sample. The content of the research articles selected for inclusion in the analysis must be related to each other and directly comparable. Initially, research articles were subject to two criteria for inclusion in the meta-synthesis: first, the focus of the research was on health care providers caring for patients from different cultural backgrounds and second, the research design was qualitative. The studies included in this meta-synthesis were located through an extensive search of literature databases including CINAHL, Medline, PsychINFO, ERIC, Sociological Abstracts and Dissertation Abstracts Online for all available dates. Key words used in the literature search included; culture, cultural bias, minority, cultural competence, experiences, as well as providers, nurses, clinicians, physicians, therapists, health care professionals and social workers. Initially, all studies found from any health discipline were within the predetermined inclusion criteria. An effort was made to include a variety of qualitative methods, as well as other cultural backgrounds, settings and participant experiences.

Following the literature review, the next phase of the comparative method consisted of meticulous reading and re-reading the studies selected for possible inclusion. Originally, 18 studies were found in the literature related to the overall phenomenon of health care provider’s experience caring for patients from other cultures. The initial objective was to include a wide variety of health care providers. Examination of the research revealed 3 studies that focused on the physician’s experience and 14 studies on the nurse’s experience. As a result, the inclusion criteria were narrowed to the experience of nurses as there was not adequate research using other health care providers.

The final sample consisted of 13 articles published between 1990 and 2001. One study was eliminated (Bates, Rankin-Hill & Sanchez-Ayendez, 1997) as the researcher interviewed the patients but used observation methods only to study the providers. Eleven of the studies were published in nursing journals, one (Lipton et al., 1998) was published in a multi-disciplinary health journal and the remaining study was an unpublished doctoral dissertation (Emerson, 1995). All were published in English, nine were conducted in the U.S. while the remaining four were conducted in the U.K. and Canada. Sample size of the studies included in the meta-synthesis ranged from 7 to 767 participants, the large numbers resulting from two studies using triangulated methods though the quantitative data was not included in the current analysis. A total of 1054 nurses participated in the studies (noting that one study accounted for 767 of the total number of participants). The ethnicity of the nurses as well as the patients they cared for varied, however, five studies did not report the ethnicity

Table 2. Demographic Characteristics of the participants of the Individual Studies Included in the Meta-Synthesis

Study	Country	Sample	Ethnicity of nurses	Study setting	Research design	Data collection	Data analysis
Boi, 2000	UK	7	Not specified	Hospital	Descriptive	Interview	None specified
Murphy & Clark, 1993	UK	18	Not specified	Hospital	Descriptive	Interview	None specified
Kirkham, 1998	Canada	8	1 Asian, 7 Caucasian	Hospital	Interpretive descriptive	Interview	Lincoln and Guba
Bernal, Pardue & Kramer, 1990	USA	12	RNs caring for Hispanic patients	VNA	Descriptive	Questionnaire	None specified
Bengiamin, Downey & Heuer, 1999	USA	22	Caucasian, Asian & Native American	Students	Descriptive	Questionnaire	None specified
Labum, 2001	USA & Canada	27	RNs caring for Vietnamese	Clinics, Hospital	Grounded Theory	Interview, theoretical memos	Dimensional analysis
Lipton et al., 1998	USA	24 total, 7 RN's	13 Hispanic, Caucasian & Asian American	Clinics	Descriptive	Focus groups	None specified
Weaver, 1999	USA	40	Native American RN's and students	Not specified	Exploratory	Questionnaire	None specified
St. Clair & McKenry, 1999	USA	80	Not specified	Students	Exploratory, triangulated	Analysis of journal entries	None specified
Baldonado et al., 1998	USA	767	70% Caucasian	250 Students 517 RN's	Exploratory, triangulated	Questionnaire	Lincoln and Guba
Canales & Bowers, 2001	USA	10	Hispanic	Nursing professors	Grounded theory	Interviews	Constant comparative method, dimensional analysis
Ryan et al., 2000	USA	9	Not specified	Varied	Grounded theory	Interviews, focus group analysis	Constant comparative method, dimensional
Emerson, 1995 (dissertation)	USA	30	Not specified	Community health	Descriptive	Interviews, observation	None specified

of the nurses. Study settings, where specified, included nurses that worked in hospitals, clinics and community health settings. Research methods ranged from descriptive qualitative, exploratory and grounded theory. A synopsis of the studies used in the metasynthesis can be viewed in Table 2.

RESULTS

Phase four of Noblit and Hare's (1988) seven step method included looking at how the ideas and concepts in the sample are related. To do this, a detailed table was constructed that included all of the key metaphors, phrases, idea, themes and concepts that emerged from the research articles. As a result of the large quantity of data extracted from the pool of articles, the most central data from each of the studies is summarized in Table 3.

The fifth phase of the process involved translating the key concepts from the pool of studies into one another and then synthesizing these translations into an encompassing whole. This is done while maintaining the central themes from each of the original studies. The themes can be related as either reciprocal translations, meaning they are similar and can be

compared directly, as a refutation or opposites of each other, or in a line of argument.

In phase six of the method, the research brings the clustered data together to make a whole. Through this process, an initial clustering of metaphors into 13 categories were reduced to 6 overall themes that described the nurses' experience caring for patients from other cultures. The six reciprocal translations as outlined in Table 3 include: (a) connecting with the client, (b) cultural discovery, (c) the patient in context, (d) in their world, not mine, (e) road blocks, and (f) the cultural lens. Step seven involved expressing the findings in written format.

Connecting with the Client

Communication was seen as an over-encompassing issue and emerged in all but two of the studies included in the synthesis. Communication included both spoken language, the use of interpreters, body language as well as other issues. Nurses often felt that cultural and language barriers made it difficult to relate to the patient. Kirkham (1998) stated that "cultural beliefs and practices of the culturally diverse client, along with the language barrier, presented the

Table 3. Individual study metaphors as related to six themes

	Boi, 2000	Murphy & Clark, 1993	Kirkham, 1998	Bernal, 1990	Bengiamin, Downey & Heuer, 1999	Labun, 2001
Connecting with the Client	Communication	Communication	Connecting with the client – overcome through communication	Limitation – nurses' limited Spanish Reward – nurses able to use/learn Spanish		Connecting through the use of interpreters
Cultural Discovery	Nurses' lack of knowledge of cultural differences Nurses' education and training	Nurses' lack of knowledge	Importance of foundation of education	Reward – nurses able to learn about and from another culture	Nursing students able to learn from experience	Process of cultural discovery – Nurses "expanded their horizons"
Patient in Context	Patient's relatives	Issues relating to relatives	Working with the family	Strong sense of family		Seeing the patients in context of family
In Their World, Not Mine			Three steps to accommodate practice		Accommodating meanings of care within cultures	Changing views of health to accommodate patients views of health
Road Blocks				Client's non-compliance Over-reliance on the nurse for care Poverty of the pts.	Poor socio-economic status of the patients	
The Cultural Lens		Nurses' feeling stressed and frustrated working with other cultures	Nurses' lack of commitment to caring – resistant or generalist care Presence of racism Negative colleagues Lack of support from institutions	High demand on nurses Through experience nurses less willing to stereotype	Students able to become open-minded through experience	Discovering that other cultures are not so different Bonding with the patients you are taking care of

Table 3. Individual study metaphors as related to six themes (cont.)

	Lipton 1999	Weaver, 1998	St. Clair & Mckenry, 2001	Baldonado et al., 1998	Canales & Bowers, 2001	Ryan et al., 2000	Emerson, 1995
Connecting with the Client	Communication as a barrier to care	Communication skills and understanding language	Communication	Language and communication a challenge	Connecting students to multiple communities	Learning to communicate differently	Verbal and non-verbal communication Use of interpreters
Cultural Discovery		Nurses' need to know about cultural issues Know culture to gain trust, "Go slow."	Students' increased awareness of cultures through immersion	Nurses' need for transcultural knowledge	Teaching students to connect with minority patients	Nurses' learning about differences in cultures	Nurses' commitment to learning
Patient in Context	Treating family members. Pts take recommendations of family/friends	Seeing patients within their nations/history		Gender and family roles			Knowledge of family roles & relationships
In Their World, Not Mine	Use of folk remedies	Cultural health beliefs, healing practices, medicine men		Nurses' need to accept and allow for pt differences Nurses need to modify care. Hot/cold, diet	Caring for others from the others perspective	Strategies to provide care "in their world, not mine."	Nurses' need to respond to cultural differences, flexible, open
Road Blocks	Patients resisting treatment Poverty and low literacy of pts.			Patients are stereotyped Minority patients get different care	Minorities are oppressed, marginalized and discredited		
The Cultural Lens	Nurses able to develop trusting relationship	Nurses open- minded and non-judgmental Importance of caring and compassion		Nurses' cultural bias & ignorance	Being a voice for the community		Nurses' attitude of empathy for the clients

nurse with variables not typically encountered in the development of a helping relationship" (p.133). Language was one of the most widely recognized barriers to delivery of quality health care. Without effective communication, the nurse found that only superficial nurse-patient relationship was formed (Boi, 2000).

The nurses described the process of connecting with the client through the use of translators and their own communication efforts (Boi, 2000; Kirkham, 1998). Nurses used such methods as "hand signs" and tried to show objects to the patient to attempt to convey a message (Murphy & Clark, 1993). Other nurses stated that body language techniques such as touching, pointing and smiling helped them to connect with their patients (Baldonado et al., 1998). Emerson's (1995) study of public health nurses described the impact of verbal and non-verbal communication patterns the nurse used while caring for patients in the community. The nurses observed the consequence that cultural knowledge and awareness had on communication effectiveness to improve the care of ethnic clients.

Too often, the resources nurses felt were needed to communicate with the client, such as interpreters, were not available. One nurse described seeing her client "really upset and crying and his wife crying and him looking so worried. You can't get an interpreter in time when you need them most" (Murphy & Clark, 1993, p. 444). A nurse working to prepare patients for surgery stated, "The interpreters would arrive after the patients have already been sent down for surgery limiting the amount of preoperative teaching that can be completed" (Boi, 2000, Pg 386).

Nurses felt that illiteracy of ethnic patients and lack of resources made minority patients more difficult to teach. One study noted the lack of educational materials in Spanish (Lipton et al., 1998). Nurses indicated that the patients would nod, agree or would even say "yes" even when they did not understand what they were being told (Baldonado et al., 1998). A student nurse reported an experience she had with a non-English speaking client stating, "Language barriers are difficult. I was discharging a Vietnamese woman who spoke very little English. She wanted to be taught how to change the dressing over her breast which was from what she thought was a biopsy. When the dressing was removed, she was shocked to find out that she had a mastectomy" (Baldonado et al., 1998, p. 21)

Several of the articles presented the experience of nurse participants that spoke foreign languages. These nurses felt that they benefited from speaking foreign languages in their ability to connect with and develop relationships with patients (Baldonado et al., 1998; Bernal, Pardue & Kramer, 1990; Emerson, 1995). The benefits of having a bilingual staff was expressed

by a Spanish speaking nurse who stated, "You need to understand the language for that particular group. A Spanish speaking woman told me 'I have ants on my face' during labor. I knew she meant tingling because she was hyperventilating. But what if a non-Spanish speaking person were taking care of her? How would they find out that problem she was having?" (Baldonado et al., 1998, p. 21). Fortunately for this client, her nurse was able to understand the symptoms that the patient was describing and intervene appropriately.

Cultural Discovery

Nurses expressed that they lack the education necessary to effectively care for a diverse mix of patients from other cultures. The nurses verbalized a desire to continue to gain knowledge and "expand their horizons" (Labun, 2001) with regard to other cultures in order to practice effectively. All but two of the studies referred to education as a major theme within the experience of caring for patients from other cultures.

Many nurses expressed a need for transcultural knowledge to enable them to deliver culturally sensitive nursing care (Baldonado et al., 1998). The participants felt that their own educational training did not give them the foundation that they needed (Baldonado et al; Boi, 2000; Kirkham, 1998). This sentiment was expressed by one participant who felt she was "not at all [prepared in training to care for culturally different patients]. When I came to England I had never actually cared for anyone from a different background." (Boi, p. 386).

The nurses stated that they enjoyed learning about different cultures from the patients themselves. "I learnt so much from looking after people. I found it so interesting and would want to know more" (Murphy & Clark, 1993, p. 448). Bernal et al. (1990), reported that nurses felt rewarded by working with Hispanic patients and listed the "nurse's opportunity to learn from a generous population" (p. 22) as a benefit of their work.

Not all of the participants in the studies demonstrated as much interest in learning about other cultures. One student nurse described the resistance she perceived from the nurses she had observed during shift reports. She felt that "with an increasing number of patients with different ethnic backgrounds, I have found that many people in the health care field are not aware of different belief systems and do not really care to learn" (Baldonado et al., 1998, p. 20).

The study participants gave the researchers suggestions to improve cultural understanding. The participants wanted to learn the specific skills and facts needed to care for other cultures. However, as well as learning the facts, the nurses expressed a need to gain an understanding of strategies such as collaboration and working with translators (Kirkham, 1998). One respondent paraphrased, "a need I perceive as

being unique to groups of different cultures is religion. Religion is so important to many of the different cultures we encounter during our health care career, yet we get very little of it in our educational experience. I know very little about other religions and don't believe I could be much help to anyone outside the Catholic religion." (Baldonado et al., 1998, p. 20). Additional methods to increase transcultural knowledge were the need for inservices regarding other cultures, taking time to learn from the patients themselves and the value of being exposed to a variety of clients in the clinical setting (Kirkham, 1998; Murphy & Clark, 1993).

Two described the impact that living in another country had on their educational knowledge and nursing practice. These studies (Ryan et al., 2000; St. Clair & McKenry, 1999) reported that students who had participated in cultural immersion experiences were able to learn about cultural practices and gain an understanding about cultural sensitivity by living outside of the U.S. St. Clair and McKenry (1999) analyzed the journals of nursing students who lived abroad. An overall sentiment expressed by the students was that they were able to learn more by living in foreign communities than by studying transcultural nursing in the classroom. One student wrote regarding living in another country, "this experience has made me rethink what is important in life, what I value, how I relate to others, how I understand and am sensitive to others, what I need to do to be culturally competent." (p. 232).

Patients in Context

Families and relatives emerged as a theme in nine of the studies. Families were seen as both a positive and negative influence on the care of the patient and affected the patient's health. The importance of understanding the meaning and role of the family was essential in order to build a caring relationship.

Families provided a great deal of support, assurance and caring to an individual who was ill and in need of healthcare services. One nurse expressed that "our concept of family is a lot different than their concept of family" (Ryan et al., 2000, p. 405). In addition to the distinction of familial concepts between cultures, patients from other cultural backgrounds were described by the nurses as having a "strong sense of family" (Bernal et al., 1990, pp. 21-22).

Nurses agreed it was helpful to have family members present when the patient had little or no understanding of English. Families were often used as a source of information for nurses gathering patient histories (Boi, 2000). Astute nurses stated that they could learn about the patient's background just by meeting the family members. "They are a sign of what the patient's environment is actually like at home... watching them interact with the family can often show quite a few different things" (Boi, p. 386).

Families were also useful when translators were not available though this practice was not always seen as the ideal circumstance when sensitive information needed to be shared (Murphy & Clark, 1993). Nurses also relied on family members to provide cultural food or diets to clients could not be accommodated by the hospital (Boi).

Support from family was not always seen as positive by the nursing staff. Only one nurse stated that having the family at the bedside for long periods of time in the hospital was useful (Murphy & Clark, 1993). The overwhelming majority of nurses (Baldonado et al., 1998; Boi, 2000; Lipton et al., 1998; Murphy & Clark, 1993) however felt that the large number of visitors that came in with minority patients was difficult to deal with and impacted patient care. "...When they visited, they came in large numbers. I did find it hard to deal with 10 visitors and the patient" (Boi, p. 386). Another nurse stated that there would often be so many visitors, that she "felt apprehensive going into the patient's room. There would be a whole crowd of people in there and it was hard everybody looking at you trying to get through to (the client)" (Murphy & Clark, p. 446).

Nursing staff who gained a deeper understanding of family accommodated their practice to meet the needs of the patriarchal and matriarchal order to provide cultural care. One nurse stated that as she began to learn about family dynamics, she "taught the patient's husband, who then gave me permission to teach the patient" (Baldonado et al., 1998, p. 23). Another nurse reports, "One black patient I had was younger and had no questions regarding his condition. When his mother visited, she had many. From then on, I would wait for his mother to come in and talk with them together, understanding how the mother in black families is often dominant and the center of the family (Baldonado, p. 23).

More experienced nurses who adapted their care treated family more respectfully in order to gain trust (Kirkham, 1998). The nurses did this by allowing the family to actively participate in the care of the patient (Baldonado et al., 1998), as well as provide health care service, when appropriate, to family members free of charge in order to gain needed respect and trust (Lipton et al., 1999). As nurses learned to modify their nursing practice to meet the needs of the patient, they found that they were able to build trusting relationships with families and foster improved outcomes with the patients.

In Their World, Not Mine

The title of this theme was borrowed from Ryan et al. (2000) as strategies nurses used to care for clients "in their world, not mine" (p. 403). Kirkham (1998) discussed three levels of nurses in her study. She found that nurses were either resistant, meaning that they ignored or resented the cultural diversity of their

patients, generalist nurses who were respectful but had not given a lot of thought to the issue of cultural and last, the most experienced nurses who were impassioned. These impassioned nurses expressed a high degree of personal commitment to providing culturally sensitive care. Many of these nurses described having had an "awakening" to the importance of culturally sensitive care through having lived in another country or being a minority themselves at some time in their life. The impassioned nurses were those who were most effectively able to accommodate for the cultural needs of the patient and see beyond their own worlds into that of the patient.

Concern about the cultural needs of patients included gaining an understanding and accommodating for non-medicinal therapies, rituals, home remedies and religious practices. "The Vietnamese culture has its own way of looking at health and looking at appropriate treatment and the whole concept of Eastern and Western medicines very much an issue and that can easily be misinterpreted" (Labun, 2001, p. 878). Native Americans were described as having very specific rituals that were meaningful to them. These patients expected that nurses be "knowledgeable of the local cultural beliefs and traditions, any currently practiced health care rituals, and/or medicine men or women in conjunction with Western alternative health practices." (Weaver, 1999, p. 200).

Nurses spoke of the influence of folk medicine on health beliefs. The health care providers in the clinics felt that their Latino patients would seek care from folk remedies and *curanderos* first, and then if those remedies were not successful, the patients would come to the clinic for care. This would often mean a delay in treatment as the client did not access care until complications had set in (Lipton et al., 1998). Accommodating nurses who worked with American Indian patients recognized the role of medicine woman and men in providing health care to their clients (Weaver, 1999).

Religious and spiritual rituals were considered an essential element in providing culturally sensitive care. Many nurses spoke of the importance of accommodating for these practices in terms of providing privacy, respect and taking the time to understand the issues. Nurses and student nurse reported remarkable outcomes with regards to these aspects of nursing care. For example, one student stated "I had a Mormon patient, an 18 year old woman with little hope for survival, at best total paralysis. Church members came to the ICU late one night to say a blessing. The patient not only survived but has only slight short-term memory loss" (Baldonado et al., 1998, p. 22).

Road Blocks

Areas that have an impact on the quality of patient care that is given to patients from other cultures

include; being an outsider, the socioeconomic status of the patients, adherence and health beliefs of the patients. Also included are factors that contribute to whether patients receive the health care they need and how they view the health care system.

Unfortunately, many of the most vulnerable members of our society are also the most economically at risk. Nurses were aware of the impact that one's socioeconomic status has on individual health status and expressions and meanings of care. One student nurse felt that "it is the failure of society to accept the socioeconomic diversity among people, that causes most of our problems today. We fear that which we do not understand. If people would just take time to learn and explore the differences maybe they would appreciate each and every individual" (Bengiamin, Downey & Heuer, 1999, p. 63).

An example from the studies involved the impact poverty has on the patient as they fear having to ask for help. Patients who have a lot of pride and self-reliance are sometimes unwilling to accept the help offered to them in the form of government subsidized medications and medical care. Some patients believed that if they accepted help, they would someday, be required to pay for the costs. Immigrant patients, who did not have the proper U.S. visas and paperwork, feared seeking medical care believing that accepting free medical care would jeopardize their chances of gaining U.S. Citizenship. This seemed to contribute to delays in accessing care and choosing to use home remedies (Lipton et al., 1998).

Many cultural groups were viewed by health care providers as failing to maintain prescribed medical treatments. While some nurses in outpatient clinics understood the need to allow patients to continue with home remedies as a means to improve adherence to prescribed treatments (Lipton et al., 1998), other nurses found the use of healer and alternative health practices to be a source of frustration.

Cultural Lens

The "cultural lens" related to the way nurses, institutions, colleagues and the health care system at large view patients from other cultures. These areas include the positive and negative attitudes of nurses, support from nurses' colleagues, the role of the institution and stereotyping that made care inequitable. An essential characteristic that nurses needed in order to care for culturally different patients was a non-judgmental attitude. This quality was noted by an overwhelming portion of the studies. Most of the nurses that were interviewed felt that they were in the process of learning to care for patients without being biased. One student who took a course on culture stated "I now feel more open toward diversity not only in health care but in life itself. Because of this class I have been exposed to a great variety of

alternative health practices and ideas" (Bengiamin, Downey & Heuer, 1999, p. 64).

Many nurses still seemed to maintain biases against culturally different patients. Though none of the nurses in the studies felt that they were biased, they indicated that many of their nurse colleagues held negative attitudes towards some patients that influenced care. One nurse described having to work with a group of negative, complaining nurses that discouraged others in their efforts to care for culturally different patients (Kirkham, 1998). One student perceived that "more than once on shift reports, nurses have criticized patients and families for differences rather than conveying understanding and accepting differences" (Baldonado et al., 1998, p. 20). It was suggested by some nurses, that a diverse group of colleagues and experience working with clients with different cultural backgrounds was helpful as it increased flexibility and openness in nurses (Bernal et al., 1990; Kirkham, 1998).

The health care setting was included in several studies as an issue in caring for patients. Many nurses felt that the heavy workloads they were expected to carry prevented them from spending the time that they needed to meet the special needs of diverse patients. The nurses felt that they did not have the time to communicate effectively or build rapport with the patients from other cultures (Kirkham, 1998). Other nurses reported feeling frustrated at the circumstance that they were in regarding limited support from the institution.

The nurses perceived that many minority clients were stereotyped and often received inequitable treatment when compared to non-minority populations. Though the nurses didn't always claim to understand why, many made suggestions. One student nurse stated that "the care minorities receive is below standard perhaps because the nurses providing the care are the majority" (Baldonado et al., 1998, p. 21). Another student agreed stating that "some patients (Hispanics, blacks) are treated as if they cannot understand or are inferior in intelligence when they are not" (Baldonado et al., 1998, p. 21).

DISCUSSION

A strength as well as a limitation of this meta-synthesis was the diversity of the participants sampled and the wide variety of cultural groups that they care for. The diversity of experiences allowed for a wide variety of experiences but also made direct comparison more difficult. Another limitation was the lack of reporting in many of the studies related to the demographics of the study participants. Adherence to the research methodology allows for credibility of the findings despite these limitations. Mixing the experience of nursing students with nurses provided an etic perspective of the nurses' weaknesses. Many students described their interpretations of nurses actions

related to cultural caring. The students were able to observe the nurses' behaviors, reluctance and resistance related to caring for patients from other cultures. This finding was confirmed by other nurses in the studies who felt that they were able to care for all patients, but described their colleagues' biases.

Suggestions for further research include continued meta-synthesis of more narrow topics as the body of qualitative research continues to expand. Given an adequate number of studies in the future, separate meta-synthesis could be conducted related to specific practice settings, cultural groups and practice concerns. In addition, further qualitative studies are needed not just on the experience of nurses and nursing students caring for patient from other cultures, but on that of others who work within the health care system.

Meta-synthesis of the qualitative articles that have been completed regarding nurses caring for minority cultures have shown the positive and negative impact that diversity has on the health care system. A meaningful summary of the studies demonstrates the experience of nurses caring for diverse cultures and allows for expression of the nurse's issues. Overall, nurses voiced concern related to the barriers, lack of support and resources encountered when caring for cultural groups. Nurses stated that they did benefit from learning about other cultures and found satisfaction in caring for gracious ethnic patients. On the other hand, nurses were concerned that due to limited resources including teaching materials and translators, they were challenged with finding other ways to overcome barriers to best meet the client's health care needs.

Culture is an essential element of the human race and will continue to be an enduring part of the health care system. Leininger (1991) identifies the genuinely interested practitioner as one who has a positive interest as well as a sincere desire to know and serve a variety of people. Since nurses are in a position where they are expected to provide intimate and individualized care to individuals, it is essential that nurses and other health care professionals come to understand and respond to the patient's cultural needs. The most effective way to accomplish this is to increase awareness and become enlightened to the cultural differences of those we serve.

Implications for practice

The qualitative findings outlined through this meta-synthesis mirror those of quantitative findings suggesting that nurses lack a level of comfort and ability to perform transcultural skills and tasks when caring for patients from other cultures. The information contained in prior quantitative studies suggests that nurses lack confidence when caring for all ethnic minorities and are the least comfortable caring for Asians and Hispanics, due primarily to the lan-

guage barriers that are present (Bernal & Froman, 1987, 1991; Jeffries & Smoldlaka, 1999; Lipton et al., 1996; Rooda, 1993).

In fact, communication has been cited as the primary barrier to providing culturally sensitive care and without adequate and meaningful interaction, only superficial relationships are developed between clinicians and clients. In addition, communication is not only language, but encompasses all of the methods we use to share information with each other. Nurses are a critical element in quality health care and communication is essential in order for the nurse to advocate and care for their patients in a meaningful way.

Many nurses in the studies perceive that they lack the necessary training to adequately care for their patients' cultural needs. Nurses recommend additional education and inservices on culture in order to increase their level of confidence and knowledge of transcultural skills. Other ways that nurses can improve cultural competence is through immersion experiences, living in another country or learning another language. Nurses and students reported the effect this type of experience has on their ability to relate to and care for diverse patient populations.

Cultural competence has become a new imperative in a world that is looking more like a salad bowl than a melting pot. It is interesting to note that the majority of the studies used in the sample have been completed since 1995. This alone speaks for the urgent need for health care clinicians to expand their care practices. Continued research needs to be done in to enhance the knowledge base of nurses and others and qualitative work and intervention studies are needed to determine approaches and experiences that are effective and meaningful.

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Abstract: *The purpose of this preliminary study was to explore the Filipino American grandparent caregiver role of grandchildren. This descriptive qualitative study utilized three data collection methods: demographic information sheet, focus group, and field notes. The Filipino American grandparents were recruited from a church in Honolulu, Hawaii. Thematic analysis was used to analyze narrative data. Filipino American grandparents view the grandparenting caregiving role as a normative process rather than a burden in which families take on responsibilities as part of cultural beliefs and norms such as pakikisama, utang na loob, and authoritarianism. Pakikisama is family unity and closeness and Utang na loob is mutual reciprocity "the give and take" and obligation in relationships.*

Keywords: *Grandparent Caregivers, Filipino-American Families*

GRANDPARENT CAREGIVING ROLE IN FILIPINO AMERICAN FAMILIES

Approximately 6 million grandparents are living with their grandchildren (U.S. Census Bureau, 2000a). For many grandparents, caring for their grandchildren has become a full-time responsibility that has created multiple stressors and major life changes (Davidhizar, Bechtel, & Woodring, 2000; Kelley & Damato, 1995). Filipino immigrants to the U.S. have the highest percentage (27%) of Asian American grandparents who are living with their own grandchildren under 18 years of age and who are responsible for their grandchildren (28%) (U.S. Census Bureau, 2000b,c). When the members of the Filipino nuclear family or extended family migrate to the U.S., they usually live together because the family is a major source of emotional, moral, and economic support. Many elders become surrogate parents and homemakers for their grandchildren when both parents are employed (Philippine Nurse=s Association of America, 2000). The family collectively provides a unique system of care for family members from birth to end of life (Barringer, Gardner, & Levin, 1995; Lantican & Corona, 1992; Santos, 1983). Filipinos strongly identify with their nuclear and extended family and the needs and welfare of the fam-

ily come before those of the individual (Espiritu & Wolf, 2001; Jones, 1996; Tompar-Tiu & Sustento-Seneriches, 1995).

The majority of Filipino Americans currently living in the U.S. are first-generation Americans challenged with the difficulties of acculturation (Lee, 1997). Often there is a cultural gap between grandparents and grandchildren which may result in intergenerational conflicts when the children become more assertive about their Western acculturation towards individuality (Tompar-Tiu & Sustento-Seneriches, 1995).

Although Filipino American grandparents play an integral role as caregivers to their grandchildren, they may also care for grandchildren at the expense of their own health. Filipino American elders have a higher incidence of diabetes and higher risk factors for coronary heart disease such as hypercholesterolemia and hypertension compared with Whites (Ryan, Shaw, Pliam et al., 2000). They also have a higher percentage of cases of schizophrenia as a diagnosis compared with other Asian groups (Bjorck, Cuthberston, Thurman et al., 2001). This article will (a) discuss the limited literature related to caregiving role among Asian Americans, in general, and Filipinos specifically, (b) describe a preliminary study which examines the role of Filipino grandparents as caregivers for their grandchildren, and (c) relate the findings of these grandparent caregivers from a cultural context.

Literature Review

The literature on the caregiving role among Asian Americans is very limited. The only published study of Asian American grandparents to date that the authors are aware of is by Tam and

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Detzner (1998). They explored the role of Chinese American grandparents and found that grandparents typically provided child assistance. Grandmothers were a source of child care when both parents were working and many acted as substitute parents. Some parents did not perceive the grandparent involvement in childrearing as positive because of their acculturation and assimilation to American values.

The majority of the caregiving studies investigating Asian American or Filipino American families, however, have focused on the women's caregiving for their elderly parents. In Goodman's study (1990) of three women of Japanese and Chinese descent, identified the common themes of family centrality, balance of multiple obligations, and norms of reciprocity and competence. Jones (1995) explored cultural influences on the caregiving role among Filipino American women who cared for their elderly parents and found that respect and honor were central components for the caring for and providing for types of care. She identified categories such as gratitude, indebtedness, obligation, responsibility, reciprocity, satisfaction, and paying back which contributed to the core category of paying respect.

Another study (Jones, 1996) investigated the relationship between role identity, role integration, sense of coherence, coping strategies, and perceived health in ten Chinese and ten Filipino American women who cared for elderly parents. This research reported a significant relationship between role identity and psychological well-being and between role integration, total physical symptoms, and psychological well-being. She concluded the balance between stress and satisfaction associated with their roles influences the caregivers' health.

Role involvement, role integration, and perceived health were examined in 29 Chinese and 21 Filipino American women caregivers of elderly parents (Jones, Jaceldo, Lee, Zhang, & Meleis, 2001). Role integration was positively associated with perceived health in the Filipino group but not the Chinese group. Role satisfaction was consistently high in both groups, and role satisfaction and psychological well-being were significantly correlated for the combined group and for the Filipino caregivers. Total role stress was significantly correlated with overall health in the combined group. They concluded that support may be more effective than efforts to decrease the extent of role involvement. In general, studies of Asian American caregiving role (Dilworth-Anderson, Williams, & Gibson, 2002) are rare and, more specifically, studies on Filipino American grandparenting caregiving role are nonexistent.

Purpose

When the literature is very limited about a topic and no adequate theories exist to explain the behavior of a particular group, an inductive approach is appropriate to explore how a group of people defines

their reality. Our goal was to investigate and uncover previously unarticulated problems for Filipino American grandparent caregivers and to explain the variation within the group. Preliminary exploration of a problem approaches the problem from the ground up or from practice to theory. The purpose of this descriptive qualitative study was to explore the cultural context of the Filipino American grandparent caregiving role of grandchildren and its affect on their health. A goal of this study was to discover what the relevant issues were related to the grandparent caregiving role of grandchildren and their health as perceived by six Filipino American grandparents. These questions were based on the personal experience of two of the three researchers and information found in the literature. The interview explored the following questions:

1. What are reasons for caring for your grandchildren on a full-time basis?
2. What are the various ways that you are involved in caring for your grandchildren?
3. What satisfies you as a grandparent?
4. What is difficult about being a grandparent?
5. What type or kind of behavioral problem do you observe while caring for your grandchildren?
6. How has caring for your grandchildren affected time for yourself?
7. How has caring for your grandchildren affected your health (ie. emotional and physical health)?

METHODOLOGY

Method/Design.

This is a descriptive qualitative study design to be considered as preliminary work leading to an expanded qualitative study.

Informants.

Filipino American grandparents were recruited into the study from a church in Honolulu, Hawaii. The eligibility criteria included Filipino American grandparents (a) who cared for their grandchildren on a routine basis (more than 30 hours per week), (b) who spoke English and or Ilokano, (c) who were biological grandparents to their grandchildren, (d) who were born in the Philippines and immigrated to the U.S., and (e) whose grandchildren were born in the U.S. and were between the ages of 0 to 18 years of age with no previous history of medical or psychiatric problems.

The researchers planned to have two focus groups with six to eight grandparents, however, after several months of recruitment, the researchers settled for one focus group of six due to time and budgetary constraints. Six grandparents did not or could not participate because (a) they were busy caring for their grandchildren, (b) the time was not conducive, (c) transportation to the interview site was difficult, or (d) they were not comfortable participating in a research study. The sample size is a limitation to this

Table 1. Grandparent Demographics

Category	Number of Grandparents	Percentage of Total Group
Gender		
Male+	1	16.7%
Female	5	83.3%
Marital Status		
Married	5	83.3%
Widowed	1	16.7%
Age		
50-59	1	16.7%
60-69	5	83.3%
Education		
8 th grade or less	1	16.7%
some high school	1	16.7%
vocational training	1	16.7%
college degree	3	49.9%
Religion		
Christianity/Catholic	6	100.0%
Employed		
Retired	3	50.0%
Working Part time	1	16.7%
Unemployed	2	33.3%
Household Income		
10,000 - 19,999	2	33.3%
20,000 – 29,999	1	16.7%
over \$50,000	3	50.0%
Own House		
Yes	4	66.7%
No	2	33.3%
Living with Children		
Yes	2	33.3%
No	4	66.7%
How Many People Live in Household?		
6	2	33.3%
7	3	50.0%
10	1	16.7%
How Long Lived in U.S.		
0-5 years	1	16.7%
21-30 years	3	50.0%
41-60 years	2	33.3%

study and the results should therefore be considered as preliminary work. This exploratory focus group interview is a first step for an expanded qualitative study. The findings from this preliminary study will guide the development of a second phase including in-depth case studies with participant observation and one to one interviews with grandparents.

The informants of this study were six Filipino American grandparents who cared for their grandchildren on a full-time basis ranging from 30 hours to 80 hours per week. All of the grandparents were born in the Philippines, immigrated to the U.S., and were able to speak and converse in both English and

Ilokano. The majority owned their own homes and resided with their grandchildren in a three-generational household. Their ages ranged from 58 to 69 years of age, most were married or widowed, and Catholic or Christian. They lived in the U.S. between three to 41 years, were retired or unemployed, and most had some high school or college education. The annual household income ranged from \$10,000 to \$50,000 with an average income of approximately \$30,000. The number of people living in each household ranged from six to ten.

They were biological grandparents to their grandchildren and cared for two to eight grandchildren at

a time. These grandparents had seven to twelve grandchildren in all and more likely were related to their grandchildren through their daughter rather than son. The grandchildren were between the ages of six months to eighteen years of age, and they were all born in the United States. There were more female grandchildren than male, and their parents were either married, separated, divorced, or not married.

Data Collection Procedures.

This study utilized three methods for data collection (a) a demographic information sheet, (b) a focus group, and (c) field notes. The grandparent demographic information included the number of grandchildren cared for, living arrangements, time spent with grandchildren, relation to grandchildren, their age, how long lived in the U.S., marital status, employment, number of people in the household, religion, annual household income, and education. The information regarding grandchild(ren) included gender, age, and the marital status of grandchildren's parents.

A focus group guide constructed by the researchers consisted of seven questions related to caregiving role and health status. The consent form, demographic information sheet, and questions for the focus group were translated and back-translated (Brislin, 1970; Jones & Kay, 1992) to assure cross-cultural equivalence. Forward translation from English to Ilokano dialect was done by a bilingual, bi-literate translator followed by back-translation from Ilokano to English by a different bilingual, bi-literate translator. Field notes were used to record comments made by the researcher and two research assistants before, during, and after the focus group (Roper & Shapira, 2000) to help confirm and supplement narrative data.

A church priest and key informant at a church in Honolulu, Hawaii assisted the researchers to recruit six grandparents who expressed interest in the study in response to clergy announcements. Prior to the focus group, the eligibility criteria and consent form were read to the potential informants. Those who agreed to be part of the study signed the consent form, and completed the demographic information sheet. Each participant received a gratuity of \$20.00.

Two researchers and two research assistants conducted the focus group. The researcher who conducted the interview was of the same ethnicity as the grandparents and could converse fluently in both English and Ilokano. The focus group, which took approximately one hour, was audio-taped, transcribed to a typed manuscript by the researcher, and the text was audited for accuracy. Questionable portions of transcript were read while simultaneously listening to the recorded interviews and examining the recorded notes. Transcriptions were corrected. Although the interviewer was prepared to conduct the focus group in either English or Ilokano, the informants preferred to have the discussion in English.

Data Analysis

Qualitative thematic analysis was used to analyze narrative data and identify themes and patterns in the data. The unit of analysis for this research was thematic units which are phrases, sentences or groups of sentences with a unifying meaning or theme. Related phenomena and themes were grouped into categories and given a conceptual name, a procedure common in qualitative research (Strauss & Corbin, 1998).

The three researchers initially read and analyzed the transcripts of the interviews independently. The principles described by Strauss and Corbin (1998) guided the data analysis. The three authors did line by line reading of the text. Rationale and examples to guide themes into specific categories were developed as data were analyzed. The overall process was a constant comparison of data and emerging themes. Through the coding procedures, significant data were given labels denoting categories. The researchers focused on the key issues (themes) that emerged from the data and became categories of interest. After the initial analysis, the researchers used a group process for thematic analysis and to refine the conceptualization of the informants' experiences. Intercooder reliability was evaluated to reduce subjectivity and enhance consistent interpretation by discussion and debate of common themes among the three authors.

Findings

Consistent with the literature, the majority of the Filipino American grandparents in this study were less acculturated than their grandchildren and this contributed to the challenges of parenting and disciplining by the grandparents. The households were large and included several generations. The grandparents had preexisting health problems such as asthma, diabetes, hypertension, and cardiac problems.

A major theme that emerged in this study was the view of the informants that the grandparent caregiving role was a "natural role expectation." Three sub-themes that arose were based on Filipino cultural beliefs and norms namely (a) *Pakikisama* – family unity and closeness (b) *Utang na loob* – mutual reciprocity "the give and take" and obligation in relationships, and (c) authoritarianism (being responsible role models, elders are highly valued, and respect for authority figures) (Espiritu & Wolf, 2001; Goodman, 1990; Jones, 1995; Lee, 1997; Leininger, 1991; Teruya & Wong, 1975; Tompar-Tiu & Sustento-Seneriches, 1995). Health issues that came into existence during the time of caring for their grandchildren were back problems, sleep deprivation, and stress.

Pakikisama (Family Unity and Closeness)

An important theme expressed by the informants was that caring for their grandchildren was a positive and natural role expectation that brings family unity and closeness. A Filipino American grandmother explained that she is a caregiver in order to help my daughter cause I have to help because I am there. I am the grandmother. It's natural that I do.

Another grandparent described the closeness by stating both parents are working so nobody can take care of children...and cannot hire babysitters...It is so expensive now a days...If you retire too it is good...have someone to play with...it is a joy. Similarly, another grandparent agreed that when you see them happy...then you are happy [and] that will be love.

Utang na loob (Reciprocity and Obligation)

The Filipino American grandparents were very involved with the grandchildren's daily care to the extent that their caregiving role was seen as reciprocity and obligation to the family. The Filipino American grandparents in this group were involved in child care including activities of diapering, feeding, helping with school work, playing, driving them to activities, shopping, washing clothes, and giving money or buying things (ie. clothes, shoes). One grandparent stated:

"Please don't feel bad about taking care of your grandchildren. I have eight grandchildren...five live with me and three are from my other daughter. She is a nurse and works night shift...so I take care [of them during] night time...When she comes home...I take care [of them] because she has to go to sleep, huh?...All [I] take care of them...cook for them, wash the clothes...I drive them around...It's an obligation...It's my daughter, so I guess, if your daughter cannot accept you...yeah...who will help them?"

Authoritarianism (being responsible role models, elders are highly valued, respect for authority figures) Grandparents in this study, felt a need to contribute to their grandchildren's development and future. This group obtained great satisfaction by making a contribution to the children's development and their future and the opportunity of being a role model. They indicated that contributing to their growth, the ability to see them grow-up, and seeing their achievement were great sources of satisfaction.

This cultural norm has created differences in perception and expectations between grandparents and grandchildren. Adhering to the cultural norm of authoritarianism, the grandparents in this study expected the grandchildren to be respectful, obedient, and appreciative. They expressed difficulties related to parenting and disciplining (ie. sibling fights, providing emotional support, finding time to satisfy the

needs and completing all the tasks for all the grandchildren, use of the television, setting limits, handling demanding behavior, and delaying immediate gratification).

Parenting and Disciplining

Several informants described the difficulties of parenting and disciplining. One area of concern was sibling fighting as one grandparent stated:

"...Well [the] difficulty is fighting with each other...You don't know where to go [to take sides]...or all kids [are] deciding to kick somebody...Take each side with explanation...Your opinion is right...and so is yours...You have [to make] the same decision again...Otherwise they will be confused."

Providing emotional support was an important parenting role assumed by these grandparents. As one of the grandparents explained that:

"It is kind of hard sometimes but one particular grandson...He is the closest to me...He cannot leave the house without hugging me...He is the one that tells me his problem[s] and doesn't tell mom. However, he often needs emotional support. I have to give him extra pep talk...he is so difficult...When he is good he is good. He wants to be the boss of all the brothers and sisters...He is the one that answers [back] to the grandpa, too..."

This grandmother was worried about the child's tendency to be controlling and disrespectful but yet required a great deal of emotional support.

In addition, juggling the parenting roles was challenging as one suggested:

"Sometimes they get angry with each other...and I know it...but I cannot do two things at the same time...I also cook their food...and [they say] I like this one...I like that one..."

This grandmother appeared frustrated at not being able to meet the needs of all her grandchildren at the same time.

The majority of the informants had conflicts regarding the use of the television. One grandparent expressed views similar to others:

Yes, watching TV...They like to watch their own programs...before you stop them...they go to the other TV."

Everyone joined in laughter and nodded their heads. One grandparent described an issue of setting limits:

"...Even [when] you tell them come home early [They say]...yes, mom [grandma]...Oh my God, they come home 10 o'clock p.m...11 o'clock p.m...They go out...That's our problem...We don't know what happened to them...outside the house

[and]...We have a hard time now they are teenagers already..."

She shook her head and her eyes looked down as she expressed her frustration. Another grandparent described her grandchildren's demanding behavior and her dilemma about the grandchildren wanting the same things:

"[Grandma] if you give that to _____[grandchild], you have to give [it to] me also..."

This grandmother replied "Can you wait until the paycheck come[s]?"

Another grandmother explained demanding behaviors related to using money as:

"You do this one and I give you money...You never do anything...ah...that is not fair you know...but you have to do something too so I can give you money...The other one [problem is]...the clothes...I cannot buy all one time you know...How many of you...[There are] three of you. How much [does] one pair of shoes [costs]?...Because they want \$100 shoes...\$80 shoes...I cannot afford that one...yeah... You like [these shoes] now?...No...No...So you better wait [on the shoes for] ...two or three months...I say...These [are] good \$20.00 shoes."

This grandmother shook her head. She wanted her grandchildren to appreciate the value of hard work. Her frustration also resulted from her grandchildren wanting expensive things that she could not provide. The grandparents were concerned that their grandchildren were being spoiled, wanting things immediately, and not being able to delay their gratification. One of the grandparents explained:

"They ask for something...you like to give them [things immediately] right away...huh...They tend to be spoiled...yeah...and when they want the same thing again next time...You say no they tend to get some kind of frustration because they tell [ask] you again...I think that will affect them when they grow up"

The grandparent sat there with a concerned look and paused for a moment.

Consequences of Grandparent Caregiving Role

Consequences of grandparent caregiving role relate to maintaining their health and having time for self. These grandparents did not perceive their health and having time for themselves to be significantly altered or affected as a result of caring for their grandchildren. One described the difficulty of managing to find time for self:

"We take time for ourselves when the kids are sleep [asleep]...not when they are awake...especially the six month old...[He] already like [likes] to

crawl...[and] like [likes] to discover the corner of the house...We have to watch him when he is awake...As soon as the baby goes to sleep...I take care of myself... fall asleep, too...I hear [a] cry...OK...I pick up the milk...I change the diaper...The other kids want to go to this place the other one want [wants] to go to that place...so you have to portion your time...I am trying to make the time for everybody...The other one has to go to music class...the other one goes to the hula class...the other one goes to karate class..."

Overall they felt that they did have time for themselves. The favorite past times of the grandmothers in this study were shopping and watching a Filipino Television Channel. Grandparents felt they needed to be assertive to gain some time to watch television. A grandmother reported:

"...If I am watching TV [TFC - Filipino Channel]...[I tell them] you cannot change the channel...laugh...They get mad at me [and say to me]...[It's] Filipino [show]time again...They can watch TV...when I am not around."

Filipino American grandparents in this study already had predisposing health problems including asthma, hypertension, diabetes, and cardiac problems before taking care of the grandchildren. They do not attribute their present health status to caring for their grandchildren. Health issues that came into existence during the time of caring for their grandchildren were back problems, sleep deprivation, and stress. Several grandmothers in this study made it clear to others in the group that their illness came before caring for their grandchildren and that their grandchildren were not the cause of their health problems. One indicated I have already sickness...I have irregular beating of heart beat ever since [then] that is why I retired early...You know...I feel weak, but I working...I still [am] working now...I have medications.

Another stated "No, because...I have a heart murmur, too. I got my diabetes since [in] 19__...I got the stroke, huh...from the diabetes...That is why I retired early. The third indicated her belief that just because you get [a] problem...[It is] not the grandchildren's fault."

DISCUSSION

Filipino American grandparents reported experiences that were similar to other grandparents in previous studies (Dowdell, 1995; Kelley & Damato, 1995; Minkler, Roe, & Price, 1992; Strawbridge, Wallhagen, Shema, & Kaplan, 1997). Similar experiences were decreasing energy levels, incidences of stress and illness, and symptoms of aging.

Although the grandparents in this study were taking care of two to eight grandchildren at a time on a full-time basis, their overall response to their caregiving role of their grandchildren was positive.

They were very involved in caring for their grandchildren and described the difficulties in caring for their grandchildren. It is likely that these grandparents were stressed based upon the large number of hours caring for their grandchildren, the described difficulties of parenting and disciplining, and their preexisting and existing health needs. However, it is amazing that their overall reaction to caregiving role was not perceived to be a burden. They did not believe that their caregiving role compromised their overall health status and expressed being satisfied with their grandparent caregiving role. Even in stressful and demanding situations, the reaction/perception of an individual to the situation is many times culturally determined (Hurme, 1997). In previous studies when roles are more satisfying than stressful, they tend to exert a more positive affect on health (Douglas, Meleis, & Paul, 1997; Jones, 1995; Meleis, Norbeck, & Laffrey, 1989; Meleis, Norbeck, Laffrey, Solomon, & Miller, 1989). In summary, Filipino American grandparents view the grandparenting caregiving role as a normative process rather than a burden. Families take on responsibilities as result of their cultural beliefs and norms such as *pakikisama*, *utang na loob*, and *authoritarianism*.

The family is greatly valued in the Filipino culture and the persons' concept of self is strongly identified with his or her nuclear and extended family. Enriquez (1990) stresses that shared identity (ie. sensitivity to and regard for others, respect and concern, helping out, understanding and making up for other's limitations, rapport and acceptance) is a central core value of all Filipino values. These cultural beliefs and norms were clearly evident in this analysis.

Implications for Nursing Research, Education, and Practice

Nursing research. Further research is needed to understand the cultural meaning and significance of the grandparent caregiving role and its impact on their health (Burnette, 1999). Future caregiving research should address issues such as cultural beliefs, values, and norms, acculturation, and assimilation and its impact on the caregiving role and health status at the same time there is a need to improve on the theoretical and methodological approaches in this area (Dilworth-Anderson, Williams, & Gibson, 2002).

Nursing education. Nurses would benefit from a comprehensive understanding of emerging ethnically diverse family systems that include grandparents. The curriculum in nursing schools should consider the health and psychosocial needs of grandparents caring for their grandchildren and include both a family and individual approach to nursing care.

Nursing practice. Consideration of the level of acculturation is essential in determining culturally sensitive interventions for populations experiencing

health disparities. By targeting and tailoring specific interventions based on level of acculturation health care providers may provide culturally sensitive care. An individual and family life-span developmental perspective would enhance nursing service for ethnically diverse families. Public policies that promote access and services for families in addition to individuals are required (Minkler & Fuller-Thomson, 1999). Health professionals in hospitals and the community can initiate and facilitate culturally-sensitive support groups and parenting and stress management programs (Whitley, White, Kelley, & Yorke, 1999). Public health departments, community mental health centers, divisions of child and family services should include the needs of ethnically diverse grandparents and their grandchildren in their routine community needs assessment (Thomas, Sperry, & Yarbrough, 2000). An understanding of the needs and development of resources for grandparents in ethnically diverse families is essential to facilitate bridging the gap of health disparities among vulnerable populations in the United States.

CONCLUSIONS

One very interesting finding that emerged from this study was that in spite of the great demands of energy required by the caregiving role and the grandparents own health difficulties, all of the grandparents expressed that it was a joy to provide care. One expressed this as *Alt is fun to be a grandma and grandpa...good experiences...we are lucky that we are grandparents*. This conclusion should not deter health professionals from considering that this group does not require support. On the contrary, it requires health care professionals to further ask the questions "Are we missing something? How does culture have an impact on actual versus perceived health? Should we be asking more culturally appropriate questions in regards to both family and individual needs?" Are there culturally sensitive approaches to research and practice that we should be addressing based on cultural beliefs and norms? Based on the scope and budget, this study was limited by the small sample size, therefore, it is difficult to make any generalizations from the findings. The findings should be treated as preliminary work leading to more contextual work in this area of study. However, it provides some beginning insight to Filipino American grandparent caregiving role of their grandchildren and their health status.

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Abstract: *Shifting population demographics will have a major impact on the practice of advanced practice nurses (APNs). The ethnic composition of people in this country is becoming increasingly diverse. Massachusetts and, in particular, the city of Worcester is also experiencing changes in the diversity of its population. These trends testify to the great need for APNs who are sensitive to and competent to care for culturally diverse populations. To address these changes, specific curricula enhancements focused on ethnically diverse populations were implemented for the nurse practitioner specialties at the Graduate School of Nursing (GSN), University of Massachusetts Worcester. The processes used for this project included visiting community and clinical sites, identifying key curricular components, and evaluating existing didactic and clinical learning experiences. The GSN faculty developed a systematic plan for integrating these components into the graduate nursing core, advanced practice core, and specialty courses of the respective curricula. A major outcome of this project was the enhanced preparation of APN students to meet the multifaceted needs of ethnically diverse patients, families, and communities.*

Key words: *Cultural Competence, Advanced Practice Nurse*

ENHANCING CULTURAL COMPETENCIES OF ADVANCED PRACTICE NURSES: HEALTH CARE CHALLENGES IN THE TWENTY-FIRST CENTURY.

The United States is becoming more culturally and ethnically diverse because of the influx of immigrants from other countries. Nationally, non-white residents made up 30.9% of the total population in 2002, up from 24.4% in 1990 (U.S. Census Bureau, 2001). By comparison, minorities and other ethnic and racial groups also

increased at a rate of 43.2% over the last decade, versus a 3.5% growth rate for whites during the same period (U.S. Census Bureau, 2001). By 2030, these demographics are projected to shift even more, leading to a 10% decrease in the proportion of White Americans (U.S. Census, 2000).

The city of Worcester site of the Graduate School of Nursing (GSN) is strategically located in central Massachusetts. It has an underserved immigrant community that is becoming more culturally and ethnically diverse. The total percentage of Hispanics, Blacks and Asians is 26.7%, far exceeding the statewide data of 16.1% (U.S. Census Bureau 2000). These data illustrate the need to prepare Advanced Practice Nurses (APNs) to provide culturally competent care to diverse ethnic clients. Many of these

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THE PROCESS OF CULTURAL COMPETENCE IN THE DELIVERY OF HEALTHCARE SERVICES

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immigrants have limited access to health care, speak English as a second language, and economically have incomes below the federal poverty guidelines (MassCHIP Health Status Indicator Report 2000). As these people access health care systems, they will need culturally competent care from their health care providers. Advanced practiced nurses have frequently been the primary providers of care to the medically underserved and ethnically diverse populations.

Given the ethnic composition of the surrounding community, the GSN faculty felt it was imperative to enhance the cultural components of the curricula, particularly for the nurse practitioner specialties. The Faculty's goal was to train a cadre of APNs who could provide culturally competent care, for the growing, ethnically diverse population in central Massachusetts. This goal was also consistent with the GSN's mission to promote excellence and innovation in advanced nursing education and practice to meet the unique needs of culturally diverse and medically underserved populations.

Cultural Competency Model

Campinha-Bacote, (1996) defined cultural competence as "a process, not an end point, in which the nurse continuously strives to achieve the ability to effectively work within the cultural context of an individual, family or community from a diverse cultural/ethnic background" p.6. The attain-

ment of cultural competence is viewed as a process that links cultural awareness, cultural knowledge, cultural skill, cultural encounter and cultural desire. The GSN faculty used Campinha-Bacote's (2002) model of cultural competence for integrating cultural competency contents into the APN curricula. This model is depicted as a volcano here.

According to Campinha-Bacote's (2002) cultural competency model, cultural awareness is a process involving the examination of one's own biases as a preliminary attempt to be sensitive and appreciative of others' cultures. The attainment of cultural knowledge involves seeking and obtaining diverse cultural information and education, in order to understand the clients' perspectives. Developing cultural assessment skills are necessary to collect relevant cultural data using a culturally sensitive approach. In cultural encounters, the health care provider engages the client in cultural interactions. The health care provider may also engage the client in multiple interactions in order to ensure an in-depth understanding of the client's values and beliefs, thus, enhancing culturally competent practice. Cultural encounters also provide APN students with the opportunities to learn and appreciate the norms and uniqueness of clients from diverse cultures. Cultural desire has been identified as a "pivotal spiritual construct that provides the energy source and foundation for one's journey towards cultural competency" (Campinha-Bacote, 2002, p.244). The model is depicted as a volcano, to symbolically represent a person's readiness and desire to engage in the process of cultural competence. When cultural desire erupts, it stimulates the process of cultural competence (Campinha-Bacote, 2002).

Integrating Cultural Concepts Into APN Curricula:

The GSN faculty divided the process of enhancing the cultural curricula of the AP specialties into four components: 1) evaluating existing didactic and clinical learning experiences, 2) visiting community/agency clinical sites, 3) identifying key curricular components, and 4) systematically integrating key components into the graduate core, AP core and specialty courses of respective curricula.

As a first step, key cultural content areas were identified as necessary concepts for the graduate curricula. The graduate curricula were thoroughly evaluated to identify existing gaps and duplication in cultural content. The core curricula content was to accurately reflect the surrounding multicultural community. This review found few content areas pertaining to culturally based health care and limited examples of cultural concepts threaded throughout the curriculum.

The next step involved visiting community agencies and health care facilities within the Worcester community. The purpose of these visits were to obtain information from nurse practitioners and other

health care providers about the challenges they felt in providing care to a multicultural patient population. These visits also enabled the faculty to identify key didactic content to address the cultural health needs of the community. This knowledge base was useful in restructuring the existing curriculum and educating the APN students.

While in the community settings, faculty was also able to observe some clinical sites where students could develop their Community Service Learning (CSL) projects. These CSL components fulfilled a dual need. First, they met the needs of an identified target group within the community, and secondly, they provided a practical learning experience for the students. Some projects that the APN students completed included diabetes education, setting up and managing immunization clinics, data collecting and preparing a plan for disaster. The students planned, implemented and evaluated these projects with the guidance of the faculty and health care providers at the respective agencies. These experiences enhanced their understanding of the community being served, the beliefs, values, and norms of its members, and barriers to the provision of quality health care. The students also developed a poster presentation from their CSL projects, at the end of their clinical practicum.

After reviewing curricular contents, the APN curricula were enhanced with the integration of cultural didactic contents into the graduate core, advanced practice core, and specialty courses. The targeted courses were GN 603 Societal Forces, GN 605 Research and Theory, GN 615 Advanced Physical / Health Assessment and two Advanced Nursing Science specialty courses. Two hours were allotted for didactic presentation of cultural components in each course.

In the GN 603 course, some cultural attributes such as, universality, stability, uniqueness, and variability were defined and operationalized within the cultural competency framework selected. Case scenarios that incorporated the constructs of cultural awareness, knowledge, skills, and cultural encounter were presented in class, and student responses were elicited on how they would address each scenario in a real life clinical situation. An added component to enhance communication and understanding of the patient's perspective, particularly during the interview process was adapted from Berlin and Fowkes' (1983) classic LEARN model. Listen - understand your clients from his/her perspective; Explain your rationale for asking health/personal questions; Acknowledge differences as well as similarities; Recommend an action/treatment plan; and Negotiate consensus that takes into account the patient's cultural norms.

This model is interdisciplinary and provides the health care provider a mnemonic device for keeping

in mind the patient's perspective about his/her health problems. It also enables an understanding of positive/negative factors that affect the patient's abilities to attain health, and allows for the establishment of a shared plan of care, thus, a mutual responsibility for health.

A second model introduced in the GN 603 course was the Sociolinguistic theory. Sociolinguistics is the part of the discipline of linguistics concerned with the use of language as a social and cultural phenomenon (Trudgill, 2001). A mnemonic device for the Sociolinguistically SPEAKING Model (Hymes, 1974) was adapted as follows: Setting referred to the time and place of the speech; Participants referred to the speakers and audience; Ends referred to the purpose, goals and outcomes of the speech event; Act sequence was the form and order of the speech; Key referred to the cues of the speech; Instrumentalities was the forms and styles of the speech; Norms was the social roles governing the event, the participants' actions and reactions; and Genre was the kind of speech act or event. This model was useful as an organizing framework for performing a cultural assessment and plan of care for culturally diverse populations. A Culturological Assessment Guide (McNeal, 2000) was also adapted for APNs utilization in home and diverse clinical settings.

In GN 605 (Theory and Research course), a tool, to assess cultural competency was introduced. This instrument, the Inventory to Assess the Process of Cultural Competency (IAPCC; Campinha-Bacote, (1998) can be utilized to collect cultural data and measure cultural competency among professionals. The IAPCC is a 20-item instrument that measures the constructs of cultural awareness, knowledge, skills, and cultural encounter, with five statements addressing each construct. The strength of this tool is in its theoretical conceptualization, which adds to its construct validity (Campinha-Bacote, 1998). The students were not able to use this tool, given the relatively short time frame for this course. However, in order to translate theory into practice, they were encouraged to use this instrument in their clinical research practice in the future.

A third course, GN 615 (Advanced Health Assessment), integrated techniques for conducting a cultural assessment and collecting cultural data during a health assessment. The importance of communication and the use of qualified interpreters to facilitate the patient/nurse interaction were emphasized. Students were introduced to the "CLAS Standards", a mnemonic for National Standards for Culturally and Linguistically Appropriate Services. CLAS provides a federally-recommended guideline for health care organizations that receive federal funds. The three main areas of CLAS that were emphasized were: the importance of implementing cultural competency in health care practice, the provision of language access

services to patients with limited English proficiency and the need for organizational support for staff who implement components of cultural competency in their practice (U.S.D.H.H.S., O.M.H., 2000).

Enhancing cultural competency skills for APNs is imperative to meet the health care challenges of an increasingly diverse population. An effective approach involve curricula enhancement of the graduate nursing and APN core courses through the integration of cultural competency components. Nurse educators need to work with students to ensure that students possess cultural awareness, knowledge and cultural skills necessary to apply appropriately in the clinical setting. Cultural desire requires self-motivation and a commitment to care for all patients regardless of cultural beliefs and values. Health care organizations should be committed, willing and supportive of their staff to ensure the attainment of a culturally competent work environment.

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Table 1. Projected Growth in Diversity of U.S Population

Ethnic Group	Year 2000	Year 2030
White	70%	60%
Black	12%	13%
Hispanic	13%	19%
Asian/ Pacific Islander	4%	7%
North American/ Alaskan Native	1%	1%
Source: U.S. Census Bureau, 2000		

Table 2. Percent Comparison of Ethnic Composition in Worcester County Versus State

Ethnic Composition	Worcester, MA	Statewide
White-Non Hispanic	73.1%	83.9%
Hispanic	15.2%	06.8%
Blacks	06.5%	05.3%
Asians	05.0%	04.0%
Other	00.2%	00.0%
Source: MassCHIP Health Status Indicators Report. U.S. Census Reports for 2000.		
(Figures in bold exceed state rates)		

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Abstract: *In much of nursing academe the words “self-study” and “accreditation site visit” are enough to squeeze the coronary arteries of nurse administrators and faculty. Such words conjure up images of months of labor intensive work, anxiety and concerns that all might not go well and that the program’s accreditation will be placed in jeopardy. Both the completion of a self-study, designed as a self-assessment of program strengths and weaknesses, and preparation for the on-site visit are an addition to the normal tasks of nurse administrators and thus often result in overtaxing resources allotted to maintenance of the program.*

Key Words: *Accreditation, Site Visitor Chairperson, National League for Nursing Accrediting Commission (NLNAC)*

THE EXPERT SITE VISITOR CHAIRPERSON: SUPPORTIVE, EFFECTIVE, EFFICIENT

It is a recognized fact that nursing education accreditation visits are important to ensure the quality of programs and services and that, in the worst case scenario, the outcome of the site visit can result in closure of the nursing program (Burke, 2003). Accreditation is seen as an indication of a program’s competence, excellence, and quality thus increasing its viability (Burke, 2003). The acquisition of accreditation when a program is initiated and the continuation of accreditation by ongoing reassessment is critical for many programs. Accreditation enables institutions to apply for federal, corporate, and foundation funds, aids the department in competition for campus resources, and for students since there is higher status associated with a degree from an accredited institution (Burke, 2003).

How can fears of the nurse administrator and faculty be calmed by the site visitor chairperson so that the program can be showcased in a positive light? The evaluation site visit team chairperson plays a central role in the process of lowering the stress of the nursing program and increasing the productivity of an accreditation visit. There are a number of ways the chairperson can be effective, efficient, and supportive before, during, and following the site visit. A professional, ethical manner is critical in the implementation of the accrediting body’s guidelines. The chairperson of a National League for Nursing Accrediting Commission (NLNAC) team can also

be assisted by noting the outline of the responsibilities of team chairperson and members which can be found in the current NLNAC *Accreditation Manual and Interpretive Guidelines by Program Type*(2002) (See Table 1).*

Prior to the Visit

Planning prior to the visit involves both the site visitor team members and the nursing administrator of the program. Strategic elements are involved in planning with both the team and the nursing administrator if the team and nursing administrator are to feel mentored and supported. The first step begins with the team chairperson’s contact with members of the site visit team and the nurse administrator of the program to be visited.

Planning with the Team

The initial call to team members should include setting a collegial tone, establishing e-mail communication, obtaining information on areas of expertise, discussing travel plans, dividing responsibilities for the standards in the site visit report, and soliciting input into the agenda (see Table 2).

It is the responsibility of the site team member chairperson to set the tone for the meeting and to facilitate a collaborative attitude. The tone should be professional yet collegial to put team members at ease. Setting the tone begins with the first contact. In spite of the availability of e-mail a personal phone call is more likely to set a positive tone and should be used for the first contact.

Utilizing e-mail connections early on in the process to facilitate communication among the chairperson and team members as well as between the chairperson and the nurse administrator at the nursing program is a wise choice today. Technology has

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Table 1. Responsibilities of Team Chairperson

1.	Act as official spokesperson
2.	Set agenda with nurse administrator
3.	Coordinate planning with team members
4.	Make logistical arrangements with program
5.	Allocate responsibilities of team members
6.	Request information from program as necessary for preparing for visit
7.	Conduct periodic conference with nurse administrator
8.	Arrange exit meeting
9.	Collate and edit Program Evaluator Report
10.	Submit completed Program Evaluator Report
11.	Be available during the Evaluation Review Panel meeting
12.	Assume responsibilities of team member to prepare for the visit, collaborate with team members on site, and retain materials until the panel review.

Adapted from the NLNAC (2002) *Accreditation Manual and Interpretative Guidelines by Program Type*, NLNAC, New York, NY.

Table 2. Initial Call to Team Members

1.	Set a collegial tone
2.	Establish e-mail communication
3.	Obtain information on areas of expertise
4.	Discuss travel plans
5.	Divide responsibilities for the standards in the site visit report
6.	Solicit input on agenda

changed the context of how work gets done and e-mail easily fosters collaborative work across borders (Pulley, Sessa & Malloy, 2002). The traditional skills associated with leadership such as communication, motivation and direction setting remain valuable, but e-leadership done on e-mail requires sensitivity to how messages are worded and responded to. Tact and sensitivity is essential when e-mail communication is used. Since it is done without face-to-face contact there is no opportunity to read the non-verbal body language that accompanies the message. An expert chairperson compensates for this through special care in wording of responses as well as the timeliness of his/her responses to the team and the nurse administrator.

The determination of areas of expertise and experience enables the chairperson to plan ahead. For example, if a team member has only made one or two site visits, the chairperson can anticipate that some time will need to be spent on mentoring this member as she/he grows in this new role. On the other hand, if a member is a seasoned visitor, the chairperson can expect that this member will most likely move the productivity of the team along. Hearing the expertise of each team member helps the chairperson determine

how to efficiently divide up the pre-visit and on site work. For example, if the team member is a Nurse Practitioner (NP) and the site visit involves a master's level program, then logically the NP member could be responsible for reviewing the master's level curriculum, graduate faculty vitae, and student policies. The NP would then logically be assigned to write-up these aspects of the site visit report. If a team member comes from a baccalaureate only nursing program, then review of the undergraduate aspects of the curriculum, policies, students and faculty would probably be the best use of his/her talents. The division of labor usually does not occur with the initial phone call. Rather it is done democratically sometimes prior to the visit with last minute assignments to be done the night before the actual site visit when everyone on the team is physically present. The expert chairperson can guide this discussion and decision making process with keen awareness of strengths and levels of expertise.

In a sense, the experienced chairperson serves as mentor to the professional nursing colleagues on the team who have less experience. This provides ongoing career development and fosters leadership development in the team members as they are groomed for their responsibilities as accreditation site administrators. The expert chairperson links mentoring to achieving the goals of the site visit team and thus fosters a successful visit while at the same time facilitating personal development of novice team members. The chairperson who is able to do this listens as a mentor not a problem solver (Perrone, 2003). The chairperson empowers the team members to handle their own aspects of the site visit assignment. This provides the team members with support as well as challenge before and during the site visit. A successful visit raises the level of professional accomplishment in each of the team members who meet that challenge (Perrone, 2003).

During the initial phone call to the members, the chairperson also determines each member's tentative plans for arrival and departure for the visit and establishes an e-mail internet connection for the site visit team. The internet connection enables the team to communicate easily, efficiently, and most effectively. Discussion can be held on-line to facilitate pre-visit planning and confirmation. The chairperson can determine if the team member can arrive at the hotel early in the afternoon the day before the site visit takes place. If yes, then plans can be made to review materials such as committee minutes, from the department of Nursing to be visited, at the hotel. This will decrease the stress on the visitors regarding review of the materials on site in a tight time frame of the visit and increase the preparedness of the team before the visit.

The chairperson should work with the team to decide on the strategy for dividing the self-study report. Each member should be assigned responsibility for

standards. For example if there are two members and a clinician reviewing a BSN program for the NLNAC one member may be responsible for I (Administration and governance), VI (Integrity) and VII (Educational Effectiveness), another IV (Curriculum and instruction) and II (Faculty) while the clinician may do V (Resources) and III (Students). It is essential to determine who has experience and feels comfortable with the standards before they are assigned.

Before the Visit

Before the visit the chairperson should telephone the nurse administrator of the program of nursing to be visited early on. The purpose of this early phone call is to set a reassuring, tone, provide direction for the agenda, provide direction for the visit, review travel, computer, hotel, and visitor needs, and provide direction for preparation for the site visit (see Table 3).

A collegial, professional manner establishes open communication with the nurse administrator and communicates a tone of collaboration. The chairperson should convey interest in the program as well as offer assistance in clarifying questions or concerns. By the time this telephone call arrives, thousands of hours of labor have already been invested in preparations for the site visit. Such positive acknowledgement heartens the nurse administrator and the faculty as they finish preparations for the site visit.

Obtaining the tentative agenda early on, including the schedule of classes and clinicals, enables the team to make appropriate travel plans and to determine how best to consolidate meeting times on the agenda so that the on-site work is completed in a timely, thorough fashion. If the agenda is not done or even if it is the chair should provide direction for preferences in organization and direction on how time can best be utilized. The chairperson should provide information on where the tentative agenda can be e-mailed or faxed and the procedure for having the team review and approve it so final arrangements can be made. The chairperson can advise the nurse administrator that proposed changes will be discussed and negotiated so that both the team's preferences and the program's needs can be met. Planning the agenda well in advance helps the program reduce the stress of last minute changes. A carefully developed agenda maximizes the best use of time on site. This in turn increases efficiency and productivity.

Table 3. Initial Call to Nurse Administrator

1. Set a collegial tone
2. Provide direction on agenda
3. Provide direction for visit
4. Review travel, computer, hotel, and visitor needs
5. Provide direction for preparation for site visit

In the initial telephone discussion the chair can clarify when the self-study will be sent to the team members. Requesting that the administrator send the school catalogs, student and faculty handbooks to each member also facilitates pre-visit preparation by the team. Early review of materials provides an opportunity for the team chair to notify the nurse administrator if parts are missing. For example, if the organizational chart is missing from the self-study materials, then the chairperson can discuss this with the nurse administrator and request that this be available on site in the resource room upon their arrival. This is supportive to the nursing program and gives them time to comply with overlooked or omitted requirements in a lower stress time frame.

The chair should be aware that many programs have sent representatives to self-study preparation forums since these are readily available to programs preparing to write self-studies (Abbe, 1997). Programs can also receive assistance by familiarity with literature which describes aspects of the accreditation process (Felton, Abbe, Gilbert, & Ingle, 2000; Overbay & Aaltonen, 2001; Van Ort & Townsend, 2000) and how a program can prepare for an accreditation visit (Vance & Davidhizar, 1998), or by seeking consultation. Chairpersons may be asked questions to clarify the directions for preparation of the self-study provided by the *Accreditation Manual and Interpretive Guidelines by Program Type* (NLNAC, 2002) and the NLN Web site, www.nlnac.org. Other services available to facilitate the site visit process are workshops for site visitors which are regularly held by the NLNAC staff to orient, update, and mentor site visitors into the role of a successful site visit as well as telephone conferences with site visitors before a visit occurs. Perrone (2003) notes that successful mentoring programs always provide formal training regarding the special mind-set and skill set required. This model is used by the NLNAC by these services to assist site visitors.

Additional information the Chair needs from the nurse administrator in the first pre-visit phone call is travel and computer related. The name of the closest airport, distance from the School, is car rental necessary or will the school provide local transportation and necessary pieces of information. Also necessary is the name and telephone number to the hotel so the team members can make their own reservations. The accommodations should include single rooms for each member with a desk, telephone, and restaurant facilities within the hotel or nearby. If laptop computers are desired by the team members the chairperson may ask the nurse administrator if these can be provided on-site or if team members will need to bring their own. If computers of the program being visited will be used it is important to ensure that the computers have the capability of handling the type of disk preformatted by the accreditation body. If reading materials are desired in the hotel the evening before the

visit to gain advance review time, the chairperson should explain to the nurse administrator what materials, for example, minutes of the Curriculum Committee, Nursing Faculty Committee, and Program Evaluation materials, are desired.

A brief meeting the day or evening before the visit with the Nurse Administrator can provide additional opportunity for gaining rapport before the visit actually begins. It provides the nurse administrator an opportunity to meet the team chair and sometimes the members are a day early and in a relaxed setting. This often decreases anxiety of the nurse administrator and facilitates the review process of site materials for the Team. Requesting these materials at the beginning of the process gives the school plenty of time to get them together and make plans for delivery.

During the Visit

During the visit a crucial role of the site visit team chairperson is the ongoing establishment and maintenance of the report. As each new group is encountered it is up to the chair to set the tone. It is the chairperson's responsibility to orient each individual and group encountered throughout the visit to the role of the visitors and to represent the accrediting commission. A simple orienting comment is helpful, for example, "We are not employees of the accrediting commission but colleagues from programs similar to yours. It is our role to verify, clarify, amplify the extensive work your nursing faculty have done putting the self-study together and to try to showcase your program in our report by providing additional data which will enhance the report." (Author) While team members are unpaid volunteers, to persons encountered on site, site visitor team "becomes" not simply represents the accrediting commission. An attitude of professionalism and fairness, should be clearly communicated. The chairperson must set the tone of being pleasant yet focused. A chairperson who is too light hearted may be perceived as not serious enough to be giving the program a careful evaluation. A chairperson who is too serious may appear stern and rigid.

The team chair has the responsibility for keeping the team focused and for the most part, sticking with the pre-established agenda. In this respect the team chair may serve as the time keeper. A comment such as, "Thank you very much for your helpful informative comments. We do appreciate it" can serve to draw closure to a meeting when the time frames on the agenda indicate that it is time to move on. In most cases individuals being visitors will not want to "close" a meeting so this responsibility generally falls to the chairperson.

Most team members have constructed questions related to the self-study report which will facilitate meetings with individuals and groups. A seasoned site visitor chairperson will have a personal repertoire of questions for individuals and groups who are routinely on a site visit agenda so that collecting the nec-

essary data to address the criteria and standards can be done efficiently. Thus the chairperson's generic list of questions can be tailored to the questions generated by the program's self-study to meet the needs of the site visitors' report which is being drafted.

Following the Visit

Following the visit the chairperson of the team should be appropriately grateful for the efforts of the program in hosting the visitors. An e-mail to the nurse administrator thanking the administrators and faculty for graciousness during the visit is appropriate, for example, "We really appreciated the gracious hospitality provided by you and the faculty during the site visit. We do appreciate all your efforts to take care of us and make the visit pleasant. Your responsiveness to our requests made our work easier." Comments regarding special efforts to entertain or to provide hospitality should be noted, for example, "The quick tour of Notre Dame by your faculty member on the way to the airport made our visit extra special."

SUMMARY

Seasoned site visitor chairpersons have "tricks of the trade" that enable them to facilitate an accreditation visit for the nurse administrator and team members. This paper has reviewed some of the activities that a site visitor chair can do to facilitate a visit and enable it to go smoothly and with decreased stress for all involved.

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* This paper is primarily related to the experiences of the authors with the NLNAC accreditation processes. However, many of the comments can be applied to the other accrediting body for nursing education programs, the Commission on Collegiate Nursing Education (CCNE) or other health related accreditation processes.

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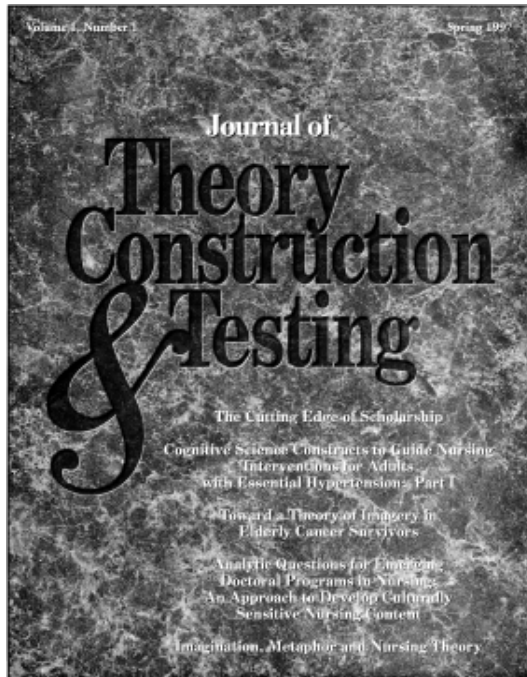
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