Government agencies and health insurance companies have looked at cultural competence as a way to improve quality of health care and to decrease health disparities among minority populations (Betancourt, Green, Carillo, & Park, 2005; Burchum, 2002). In spite of efforts to increase providers’ cultural competence and decrease disparities, the Agency for Health Research and Quality (AHRQ, 2010) reports that the Hispanic population continues to show little improvement in the core measures being monitored regarding disparities including effectiveness, patient safety, timeliness, patient centeredness, efficiency, and access to care. Approximately 16.3% of the total U.S. population is made up of persons self-identifying as Hispanic and this ethnic group has contributed to 56% of the nation’s total growth over the last decade (Pew Research Center, 2011). Hispanics have been reported as having disparities regarding access to preventive health care for many common chronic diseases such as cardiovascular disease, diabetes, cancer, end stage renal disease, as well as maternal and pediatric health care services (Cristancho, Garces, Peters, & Mueller, 2005; Burchum, 2002).
Taking that into consideration, it is important to determine the degree to which Hispanic immigrants perceive that they are receiving culturally competent care. This paper examines current nursing and other health related literature pertaining to cultural competence from the perspective of the Hispanic immigrant patient in order to determine what is known regarding this topic and what gaps in the research still exist.

Scope of the Question

Do Hispanic immigrant patients consider the care they are receiving to be culturally competent? The U.S. Department of Health and Human Services Office of Minority Health (OMH) has defined cultural competence as, “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations” (OMH, 2005). Developing cultural competence is a process consisting of many stages including cultural desire, cultural awareness, cultural knowledge, cultural understanding, cultural sensitivity, cultural interactions or encounters, and cultural skill (Burchum, 2002; Campinha-Bacote, 2006). Research has shown that unless nurses and other healthcare providers develop some measure of cultural competence, the risks of clients being non-compliant with treatment regimens, having low satisfaction with the care provided, and ultimately having poor patient outcomes are intensified (Castro & Ruiz, 2009; Taylor, 2005).

Organizations such as the OMH and the American Nurses’ Association have published standards and continuing education courses designed to assist healthcare providers in becoming more culturally competent (Campinha-Bacote, 2006). The National Standards on Culturally and Linguistically Appropriate Services (CLAS standards) published by the OMH in 2001 focused on culturally and linguistically appropriate healthcare for every patient (OMH, 2007). Four of the fourteen standards are currently federal mandates for health care organizations that receive any type of federal funding. The remaining ten standards are being recommended as mandates (OMH, 2007). In response to these types of federal initiatives, state lawmakers from across the nation have begun to initiate legislation requiring cultural competence components to be integrated into healthcare education. Some states have even considered making cultural competence education a requirement for licensure (Graves, Like, Kelly, & Hohensee, 2007).

Current Knowledge

In spite of the amount of attention the topic of cultural competence has received in health care over the last two decades, the issues of measuring cultural competence and the perspective being studied are two areas of concern. First, a research review by Gozu et al. (2007) investigating cultural competence tools in the literature found 45 unique instruments for measuring cultural competence from the perspective of the health care provider. The authors reported that within the articles studied, they were unable to find information regarding the reliability and/or validity for 67 percent of the instruments (Gozu et al, 2007). In addition, the multitude of tools demonstrated a lack of consensus on how to measure the concept of cultural competence objectively (Barone, 2010).

Only recently has a tool been developed to measure cultural competence from the viewpoint of the patient regarding their interactions with physicians. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Cultural Competence item set is a 44 item survey focusing on collecting information from the patient’s perspective over five areas dealing specifically with cultural competence. The five areas
include language access (15 items), patient-provider communication and alternative medicine (16 items), shared decision-making (5 items), experiences of discrimination (2 items), and trust (6 items) (Hurtado, Weech-Maldonado & Weidmer, 2010). At this time, the tool is specifically focused on patient and physician interactions and does not take into account other health care providers leaving a large gap still to be covered.

A second area of concern is the perspective being studied. According to some studies, the focus on cultural competence ratings is viewed from the perspective of the health care provider, rather than from the patient’s perspective. In other words, instead of asking the patient if the care they received was culturally competent, researchers ask the practitioner if the care they gave was culturally competent. Additionally, models of cultural competence in health care are often associated with self-assessment tools for measuring some components of cultural competence and are used extensively in nursing and medical education as well as in practice (Burchum, 2002; Capell, Veenstra, & Dean, 2007; Fernandez, Schilling, Grumbach, Rosenthal, Stewart, Wang, & Perez-Stable, 2004; Jirwe, Gerrish, & Emami, 2006; Ladson, Linn, Flores, & Magrane, 2006; Nokes, Nickitas, Keida, & Neville, 2005; Sargent, Sedlak, and Martosof, 2005; Suarez-Balcazar, Balcazar, Taylor-Ritzler, Portillo, Rodakowski, Garcia-Ramirez, & Willis, 2011; Starr & Wallace, 2009).

A search of nursing and other health care literature regarding cultural competence from the patient perspective was undertaken to determine the state of the science. The Cumulative Index for Nursing and Allied Health Literature (CINAHL) and Web of Science databases were searched using the terms Hispanic, Mexican, immigrant, cultural competence, perceptions of care, patient perspective, and U.S. healthcare individually and in combination. Articles were initially selected based on title and perusal of abstracts. Those that appeared to be about some aspect of cultural competence from the Hispanic patient perspective were then scanned for applicability. The search produced 31 promising articles of which nine were applicable to the query. A second search of Web of Science was further refined re-using the terms “Mexican immigrants” and “U.S. healthcare” which provided four articles, two of which were applicable. A further search using the terms “Hispanics” OR “Mexican immigrants” AND “cultural congruence” AND “health care” AND “perceptions” and further refined using the term “perceptions of care” revealed 86 results. Of those 86 articles, an additional six article were identified as applicable. Reference lists from the applicable articles were also searched for additional studies.

Twenty-two articles were finally selected and deemed representative of current research providing pertinent information about health care encounters from the Hispanic immigrant patient’s perspective related to cultural competence. The studies included two case studies (Barone, 2010; Derose, 2000), ten qualitative studies using interviews or focus groups (Bergmark, Barr, & Garcia, 2010; Carbone, Rosal, Torres, Goins, & Bermudez, 2007; Clark & Redman, 2007; Collins, Villagran, & Sparks, 2008; Cristancho, Garces, Peters, & Mueller, 2008; Frazier, Garces, Scarinci, & Marsh-Tootle, 2009; Harari, Davis, & Heisler, 2008; Keller, 2008; Nailon, 2004; Warda, 2000); a descriptive correlational study (Castro & Ruiz, 2009); three reviews of the literature (Cooper & Ballard, 2011; Mayo, Sherrill, Sunareshwaran, & Crew, 2007; Padilla & Villalobos, 2007); five studies using survey data (Gonzalez, Vega, & Tarraf, 2010; Johnson, Saha, Arbelaez, Beach & Cooper, 2004; Riffe, Turner, & Rojas-Guyler, 2008; Sorkin, Ngometzger, & DeAlba, 2010; Wallace, DeVoe,
While the majority of the selected studies focused on the patient’s perspective, only a few studied cultural competence as a whole (Barone, 2010; Carbone, Rosal, Torres, Goins, & Bermudez, 2007; Nailon, 2004). The majority of studies focused on investigating aspects affecting cultural competence including themes such as barriers to health care (Bergmark, Barr, & Garcia, 2010; Collins, Villagran, & Sparks, 2008; Cristancho, Garces, Peters, & Mueller, 2008; Derose, 2000; Frazier, Garces, Scarinci, & Marsh-Tootle, 2009; Harari, Davis, & Heisler, 2008; Lassetter & Baldwin, 2004), cultural sensitivity and congruence in health promotion and care (Cooper & Ballard, 2011; Keller, 2008; Padilla & Villalobos, 2007), language issues (Bergmark, Barr & Garcia, 2010; Cristancho, Garces, Peters, & Mueller, 2008; Gonzalez, Vega, & Tarraf, 2010; Harari, Davis, & Heisler, 2008), discrimination (Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Sorkin, Ngo-Metzger, & DeAlba, 2010), expectations (Clark & Redman, 2007), and patient satisfaction or quality of care (Castro & Ruiz, 2009; Gonzalez, Vega, & Tarraf, 2010; Sorkin, Ngo-Metzger, & DeAlba, 2010; Wallace, DeVoe, Rogers, Protheroe, Rowlands, & Fryer, 2009).

Barone’s (2010) case study identified four major themes found to contribute to the culturally competent care given at an outpatient health clinic in Omaha, Nebraska. The clinic was developed to meet the needs of Indian American and Hispanic populations in the area and both practitioners and patients were interviewed for the case study. The themes identified that contributed to culturally competent care included physical space, culture and language, community involvement, and the practicing of cultural medicine (Barone, 2010). Since these themes encompassed most of the themes listed previously, modifications of these categories were used to organize the information from the above research in determining the state of the science. The following sections summarize the information gained from these research studies.

**Physical Environment**

The environment that a patient walks into for health care can have a huge impact on their overall perception of the encounter. Barone (2010) found that when an environment is welcoming and facilitates interactions between patients and providers, patients have a better perception of the facility. Warda’s (2000) qualitative study to determine important aspects of cultural competence from the Hispanic patient’s perception reported that dissatisfaction by Hispanic patients was associated with the physical environment coupled with a perceived lack of caring evident in the attitudes of health care providers.

Wait times were also negatively associated with perceptions of health care by Hispanic immigrants. Having to wait up to 12 hours or more for an appointment has been shown to be a barrier to accessing care in this population (Cristancho, Garces, Peters, & Mueller, 2008; Derose, 2000; Nailon, 2004; Sorkin, Ngo-Metzger, & DeAlba, 2010) as the expectation is often for timely care with treatments that provide rapid results (Clark & Redman, 2007). Castro and Ruiz (2009) in their study comparing nurse practitioner levels of cultural competence with Latina patient satisfaction scores found that longer wait times were associated with lower satisfaction scores. A primary reason cited by the authors was that the patients often have to bring their children with them to an environment not conducive to the energy and exuberance of children (Castro & Ruiz, 2009).
Communication

Communication is at the center of every health care encounter. Effective communication is important for the exchange of important information regarding wellness, illness, and treatment. Language discordance is often one of the greatest barriers to Hispanic patients receiving health care, culturally competent or otherwise, and many studies focused specifically on the communication aspect of care. Bergmark, Barr, and Garcia (2010) in their study to determine why Mexican immigrants return to Mexico for health care reported that many do so due to language barriers. Other studies have shown that a practitioner’s ability to speak Spanish improves the perception of the care received while an inability to speak Spanish poses barriers to access and adequate care for the patient (Castro & Ruiz, 2009; Clark & Redman, 2007; Cristancho, Garces, Peters, & Mueller, 2008; Derose, 2000; Frazier, Garces, Scarinci, & Marsh-Tootle, 2009; Gonzalez, Vega, & Tarraf, 2010; Harari, Davis, & Heisler, 2008; Keller, 2008; Mayo, Sherrill, Sundareswaran, & Crew, 2007; Nailon, 2004; Sorkin, Ngo-Metzger, & DeAlba, 2010). Keller (2008) found in studying Mexican parents’ perceptions regarding their relationships with rural clinic nurses that the race and ethnicity of the practitioner is not as important as their ability to speak in the patient’s language.

Another aspect of communication that has been found to be extremely important in a culturally competent encounter with Hispanic immigrant patients is the concept of personalismo. Warda (2000) described this concept as a “formal friendliness” where adequate time is taken to visit with patients openly and in a caring manner. The concept of personalismo has been repeatedly found as an important element in culturally competent encounters (Clark & Redman, 2007; Cooper & Ballard, 2011; Keller, 2008). The idea of spending time visiting with a patient on a more personal level and making sure they understand what they need to during each visit often goes against the more time constrained clinical aspects of health care appointments in the U.S., but for the Hispanic immigrant, relationship building and fostering a respectful and sympathetic connection between provider and patient is at the heart of culturally competent health care (Bergmark, Barr, & Garcia, 2010; Castro & Ruiz, 2009; Clark & Redman, 2007; Cristancho, Garces, Peters, & Mueller, 2008; Keller, 2008; Lassetter & Baldwin, 2004; Nailon, 2004; Padilla & Villalobos, 2007; Wallace, DeVoe, Rogers, Protheroe, Rowlands, & Fryer, 2009).

The use of interpreters has also received much attention in the literature. With language services being one of the governmental mandates associated with the CLAS standards (OMH, 2007), studying the use and effectiveness of interpretation services or other means of interpretation has abounded. Almost without fail, cultural competence is perceived as being greater when health care practitioners are able to speak Spanish or when there are adequate interpretation services available (Barone, 2010; Castro & Ruiz, 2009; Clark & Redman, 2007; Sorkin, Ngo-Metzger, & DeAlba, 2010). Often times, Hispanic immigrants consider interpretation services to be inadequate and they question the accuracy of the information being translated (Cristancho, Garces, Peters, & Mueller, 2008; Derose, 2000; Harari, Davis, & Heisler, 2008; Nailon, 2004). This often leads to the use of family members or community members as translators (Barone, 2010; Derose, 2000) or becomes an additional barrier to health care access when such resources are not available (Cristancho, Garces, Peters, & Mueller, 2008; Harari, Davis, & Heisler, 2008; Johnson, Saha, Arbalaez, Beach, & Cooper, 2004).
Family and Community Involvement

The Hispanic culture has been said to be community oriented rather than being as individualistic as found in U.S. culture. Hispanic patients value input from family and community into their health care, a recurring theme found in a literature review by Cooper and Ballard (2011) to determine best educational practices for osteoporosis in this population. Culturally competent health care for the Hispanic patient is often facilitated by community leaders or contacts working as cultural brokers (Barone, 2010; Harari, Davis, & Heisler, 2008; Padilla & Villalobos, 2007). It is also very important that family members be included in health care encounters as they provide a large measure of support to patients (Bergmark, Barr, & Garcia, 2010; Carbone, Rosal, Torres, Goins, & Bermudez, 2007; Lasseter & Baldwin, 2004; Mayo, Sherrill, & Sundareswaran, & Crew, 2007; Nalon, 2004; Riffe, Turner, & Rojas-Guyler, 2008; Warda, 2000). Derose (2000) found in a study to determine the barriers to access Latina patients face and what they do to overcome the obstacles, that English speaking family or community members are heavily relied upon for even gaining entry into the health care system.

Equally important to including family and community members in the care of the patient when needed or desired, is an appreciation of the gender roles within the family as this is often important when delivering health education. Women are often perceived as the care-givers, dispensing medicines to other family members and in control of the dietary intake of the family (Carbone, Rosal, Torres, Goins, & Bermudez, 2007; Collins, Villagran, & Sparks, 2008). However, men are considered the leaders of the family and are often deferred to for decision-making (Collins, Villagran, & Sparks, 2008).

Practicing Cultural Medicine

The practice of cultural remedies or the use of traditional healers is another area where cultural competence in U.S. health providers appears to be lacking. Many Hispanic immigrants will use home remedies prior to accessing traditional care (Frazier, Garces, Scarinci, & Marsh-Tootle, 2009; Harari, Davis, & Heisler, 2008; Mayo, Sherrill, Sundareswaran, & Crew, 2007). If they are able, some will even return to Mexico (if that is where they are from) to get medicines stating that medicines from Mexico work better and are cheaper (Bergmark, Barr, & Garcia, 2010). Additionally, the services of curanderos, or lay healers, may be used in addition to more advanced medicine (Collins, Villagran, & Sparks, 2008; Cooper & Ballard, 2011; Padilla & Villalobos, 2007).

Cultural medicine in the Hispanic culture is also closely linked with spiritual beliefs and characterized by a fatalistic attitude known as fatalism (Carbone, Rosal, Torres, Goins, & Bermudez, 2007; Cooper & Ballard, 2011; Warda, 2000). It must also be understood that there are often culturally based beliefs about what may be causing an illness, something that must be assessed during a health care encounter (Lasseter & Baldwin, 2004).

Other

In spite of the information found in the research on what can aid nurses and other health care providers in caring for Hispanic immigrant patients in a culturally competent manner, evidence of bias and discrimination toward this population continues to be reported (Bergmark, Barr, & Garcia, 2010; Cristancho, Garces, Peters, & Mueller, 2008; Derose, 2000; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Sorkin, Ngo-Metzger, & DeAlba, 2010). Perceived discrimination has been negatively associated with perceptions of quality of care and level of cultural competence (Sorkin, Ngo-Metzger, &...
DeAlba, 2010). It becomes important to ask why the health disparities that exist within this population are not decreasing. The next section reporting the gaps that exist within the research may help to answer this question.

Gaps in Nursing Science
As was pointed out earlier, there is a major lack of consensus on how cultural competence is measured (Barone, 2010). There is also a lack of measuring cultural competence from the patient perspective as well as comparative measures between patients and providers (Johnson, Saha, Arbalaez, Beach, & Cooper, 2004; Nailon, 2004). There has been little research to date on the health literacy aspect of this population including learning preferences (Carbone, Rosal, Torres, Goins, & Bermudez, 2007). Having standardized measures that are well validated and proven reliable and that measure and compare practitioner and patient perspectives are needed. Measures for determining health literacy also need to be incorporated into research.

Due to the family-oriented nature of the Hispanic populations in these studies, further research should be aimed at determining the effectiveness of community-based interventions that meet health care prevention, promotion, and maintenance needs (Cristancho, Garces, Peters, & Mueller, 2008; Derose, 2000). Further investigation into how to incorporate cultural beliefs of the population being served with biomedical care is also needed to enhance cultural competence (Nailon, 2004; Padilla & Villalobos, 2007; Warda, 2000).

The point that makes the case for studying cultural competence from the perspective of the Hispanic immigrant patient, however is that a problem faced by researchers originates from the multiple origins for people who identify as Hispanic. Even those from the same country of origin may have significant biological and cultural differences (Collins, Villagran, & Sparks, 2008; Cooper & Ballard, 2011). Furthermore, continuing waves of immigration often hinder progress toward cultural competence as cultural differences can abound, requiring further research for each subgroup (Collins, Villagran & Sparks, 2008; Harari, Davis, & Heisler, 2008; Padilla & Villalobos, 2007; Wallace, DeVoe, Rogers, Protheroe, Rowlands, & Fryer, 2009). Continuing needs assessments with Hispanic communities and families is important to delivering culturally competent care (Lassetter & Baldwin, 2004; Wallace, DeVoe, Rogers, Protheroe, Rowlands, & Fryer, 2009). Obtaining input from Hispanic immigrant patients on how health care is being or should be delivered is perhaps the only avenue for changes to take place and a measure of cultural competence to be achieved.

Conclusion
Providing culturally competent care continues to be a challenge for nurses and other health care workers as rates of migration and immigration continue to increase changing the demographic face of the United States. Lack of knowledge about cultures and lack of exposure to certain cultures often limit members of the health care team in providing culturally competent care. Lack of culturally competent care serves as a barrier for many immigrant patients to access and receive effective care. It is crucial to develop relationships and open communication with local Hispanic communities in order to determine their needs, expectations, and improve cultural competence in health care. In order to ensure that healthcare providers are culturally competent, interventions and health promotion models need to be implemented and their effectiveness needs to be evaluated. With this combination of research and practice, it is hoped that one day the health disparities present
in the Hispanic immigrant population will decline.

**References**


Gonzalez, H., Vega, W., & Tarraf, W., (2010). Health care quality perceptions among foreign-born Latinos and the importance of speaking the same language. Journal of the American Board of Family Medicine, 23(6), 745-752.


