ORIGINAL ARTICLES

Factors affecting nursing cultural competency in private hospitals at Bangkok, Thailand

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ABSTRACT

Background: Cultural competency is particularly important in healthcare industry nowadays, where cultural beliefs have a significant impact on care access, treatment choices, effectiveness of nursing care, and other aspects of patient care. This study aimed to explore the level of cultural competency and the factors affecting the cultural competency of nurses, from two medium-size private hospitals in Bangkok, Thailand with similarity in therapeutic specialties and other characteristics in three categories: multi-cultural knowledge, attitude towards different cultures and cultural practice in nurses.

Methods: This was cross sectional study by interviewing 166 nurses in two hospitals of Bangkok in December 2014. The samples were selected using proportional simple random sampling (SRS) method. The data was collected using a validated, piloted and reliable self-administered questionnaire and analyzed in SPSS 16.0 using descriptive statistics, regression and Chi-square analyses.

Results: The analysis showed that the overall level of cultural competency of nurses was classified as low to moderate (75.9% of all nurses scored low multicultural knowledge competency while 63.3% and 71.7% of all nurses scored moderate attitude towards different cultures and cultural practice respectively). It was found that knowledge of different cultures was affected by responsibility, age and level of confidence of the nurses ($p < .05$) while attitude towards different cultures was affected by work shift, level of confidence and marital status of the nurses ($p < .05$). Further study showed that the level of confidence in communication and nursing care towards foreign patients and the level of attitude towards foreign patients significantly associated with the quality of cultural practice ($p < .05$). It was found that level of confidence and attitude had positive correlation with the cultural practice.

Conclusions: Study has concluded that the good quality of cultural practice was primarily driven by the positive confidence and attitude while the expedience factors, level of knowledge and other background marginally affected the quality of cultural practice.

Key Words: Cultural competence, Private nursing, Cross-cultural nursing, Knowledge, Attitude, Practice

1. INTRODUCTION

Health has now become one of the top priorities of people around the world. Whilst in some developed countries such as UK, Japan, USA, Canada and countries in Europe or Middle East, the cost of medical treatment is very expensive and the waiting time for medical treatment is often long, other developing countries such as Brazil, Bolivia, Costa Rica, Hungary, Poland, Belgium India, Cuba, Jordan, Lithuania, Malaysia, Israel, Singapore and South Korea offer state of the art medical services at a much cheaper price with short

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waiting time. As a result, the term "medical tourism" explains the movement of tourists travelling to other countries to obtain cheaper, higher quality or more accessible medical services, such as surgical care, dental or other health facilities/services.

In Thailand, the international patient inflow has increased every year and this country become one of the world's top destinations for medical tourism, balancing a combination of low labor costs and highly advanced medical services and technologies.[1] Major sources of medical tourists to Thailand include Japan, the United States, Europe, and the Middle East. With medical tourists spending an additional $ 1,000 per visit compared to other tourists, this niche segment is a high value development opportunity for Thailand. Private hospitals, which are allied to international medical schools and accredited by international agencies, provide the majority of this care.[2] However, Thailand is not alone in this market – countries including India, Singapore, and Malaysia also have active medical tourism industries. As a result, Thailand needs to maintain its competitiveness in the medical sector. One area where Thailand can develop a competitive advantage is in culturally competent care. Culturally competent care includes knowledge, attitudes, and practices that support caring for people across various languages and cultures.[3,4] Knowledge consists of awareness of the cultural base, shared traditions and values of the patient group. Attitude refers to the ability to accept and work with these traditions, even where different from one's own. Practices, or skills, consist of communication competence - not just language skills, but being able to communicate ideas effectively across cultural boundaries.

Culturally competent nursing care combines best practices of nursing with cultural knowledge, attitudes, and practices appropriate to the culture of the patient.[5] There is extensive evidence in the literature that cultural competence is essential for nurses, along with other healthcare providers, in order to provide care and overcome cultural barriers to healthcare.[6] The growing diversity of patient populations has increased the need for cultural competence in cultural practices in many areas. However, this study have also shown that many nurses do not have significant cultural competence or experience with multicultural or transcultural contexts.[7] The consequences of this gap in skills can include ethnocentric attitudes, inappropriate communication, based diagnoses, and ineffective intervention and care.[8] In many ways, a nursing staff is the ideal part of the hospital in which to study cultural competency and its effect on patient treatment where they involve constantly with patients on many levels.[9] Nurses are expected to be culturally competent, support institutional cultural knowledge, and develop services with cultural competency in mind.[10]

Thailand, one of the world's premier medical tourism destinations, particularly at accredited private hospitals, has a unique need for the knowledge, attitudes and practices associated with cultural competency in its nursing staffs. The present study was to determine the level of cultural competency in three main classifications: knowledge, attitude and practice and the factors influencing the level of cultural competency in nurses, particularly, the cultural practice.

2. METHODS

This cross-sectional study was conducted to assess the cultural competency in nurses at two purposively selected medium-size private hospitals in Bangkok with similar therapeutic specialties and other characteristics. The samples were selected using proportional simple random sampling (SRS) method (n = 166), 83 nurses from each hospital working in different departments. The study aimed to explore a minimum of 40% of total nurses working in both hospitals out of 350. Only full-time permanent nurses with a work experience at shift job of more than 1 year were included in this study while part-time nurses, nurses with a work experience at shift job of less than 1 year or nurses who were in the third trimester of pregnancy were excluded. Ethical clearance was sought from both of the participating hospitals as well as an approval from College of Public Health Science, Chulalongkorn University review board. Participants were informed both verbally by the researcher and in written form of their right to refuse or terminate participation without penalty. Submission of the questionnaire to the researcher implied consent to participate. No identifying information appeared on the questionnaire. A self-administered questionnaire was modified and used to gather data about age, gender, marital status, religion, education, position, responsibility, work experience, salary, work shift, language skills and feeling and confidence in communication and nursing care towards foreign patients and cultural competency. The questionnaire consisted of 4 parts like; demographic and experience factors (15 questions), knowledge of different culture (116 knowledge questions in food, greeting, religions, belief, dress code, language, manner, healthcare, tradition and social), attitude towards cultural competency (14 questions): and practice of cultural competent nursing care (10 questions). Bloom's criteria were used to classify level of knowledge.[16] The levels of attitude and practice were classified using mean and standard deviation. Prior to collecting the data from samples, the questionnaire was tested for its validity and reliability: 1) reliability was tested by distributing 30 sets of questionnaires to 3rd hospital with similarity in therapeutic specialties and other characteristics and 2) validity of

the contents was approved by five experts in different fields, *e.g.* experts in cultural competency, experts in international cultural competency and expert from private sectors.

Table 1. Demographic characteristics

	N (166)	%
Sex		
Male	4	2.4
Female	162	97.6
Age (years) Range = 22-59 ($\bar{x}$ ± SD = 33.0 ± 8.7)		
22-30	81	48.8
31-40	50	30.1
More than 40	35	21.1
Marital status		
Single	97	58.4
Married	63	38
Divorced/widowed	6	3.6
Highest education		
Bachelor degree	153	92.2
Master degree	13	7.8
Level of seniority		
Junior nurse (initial 2 years of job experience)	9	5.4
Nurse (2-5 years of job experience)	104	62.7
Senior nurse (5-10 years of job experience)	7	4.2
Supervisor (more than 10 years of job experience)	39	23.5
Others (no experience)	7	4.2
Experience as nurse (years) Range = 1-39 years ($\bar{x}$ ± SD = 9.9 ± 8.6)		
0-3	44	26.5
4-10	65	39.2
11-20	38	22.9
More than 20	19	11.4
Experience as nurse at this hospital (year) Range = 1-30 years ($\bar{x}$ ± SD = 5.6 ± 5.1)		
0-3	76	45.8
4-10	67	40.4
11-20	23	13.9
Current monthly salary (Baht) (32-34 THB = 1 USD at time of study)		
15,000-20,000	12	7.2
20,001-30,000	43	25.9
30,001-40,000	64	38.6
40,001-50,000	36	21.7
More than 50,001	11	6.6
Unspecified		
Current responsible areas (last three months)		
Out-patient department	32	19.3
In-patient department	72	43.4
Emergency room	15	9.0
Operation room	23	13.9
ICU	13	7.8
Others	11	6.6
Work shift (last three months)		
Day shift	77	46.4
Night shift	89	53.6
Experience with foreign patients		
Yes	122	73.5
No	44	26.5
Feeling towards foreign patients		
Welcoming	82	49.4
Shy	5	3.0
Afraid	10	6.0
Excited	54	32.5
Stressed	10	6.0
Enjoying	5	3.0
Confidence towards foreign patients (communication and nursing care)		
0 = unconfident at all	6	3.6
1 = quite unconfident	7	4.2
2 = relatively unconfident	24	14.5
3 = relatively confident	94	56.6
4 = quite confident	28	16.9
5 = fully confident	7	4.2

The data was analyzed in SPSS 16.0. The analysis includes descriptive statistics, regression analysis and Chi-square analysis. Multiple linear regression was used to identify the factors (if any) that had a significant relationship to knowledge, attitudes and practice while Chi-square was used to test for association between two categorical variables. Significance was assessed at $p < .05$ for all tests.

3. Results

The demographic characteristics of the samples were reported in Table 1. The samples from the two hospitals consisted of 166 nurses. Subjects were primarily females with wide age range (22-59 years of age). The largest group was in their 20 years (48.8%). Majority of the subjects were single (58.4%) and Buddhism (95.2%). Almost all have a Bachelor degree (92.2%). Most of subjects were nurses (62.7%). A wide range of work experience (1-39 years) was observed. The subjects also came from a number of different areas, though the largest group (43.4%) was from the inpatient department. Work shifts were split between day and evening. About three-quarters (73.4%) has experience with foreign patients. Common feelings towards foreign patients were welcoming (49.4%) and excited (32.5%). Only few participants reported feeling shy, afraid, or stressed (15% in total). Majority of the subjects had moderate confidence (level 2-4) towards foreign patients (88%).

Participants were asked about their foreign language skills, focusing on three common languages for Thai foreign medical patients – English, Chinese, and Yawee (Muslim language). The highest level of language skill was show for English, where 84.9% self-assessed their competence as Average or Good. Much lower language skill was shown for Chinese (Poor = 94%) and Yawee (Poor = 96.4%). This indicated that while English language skill was good, other languages were not as strong.

Although the result shows that most of the subjects had little knowledge about cultures (75.9%), most of them had moderate attitude towards cultural competency (63.3%) and practice of cultural competent nursing care (71.7%). This indicates that while knowledge was relatively low, attitudes and practices were relatively strong. However, it should be recalled the study was a self-assessment and could involve mis-self-identification (see Table 2).

Table 2. Cultural competency

Category	Low	Moderate	High
Knowledge[*]	126 (75.9%)	40 (24.1%)	0 (0%)
Range = 39%-69% ($\bar{x}$ ± SD = 52% ± 8%)			
Attitude[#]	30 (18.1%)	105 (63.3%)	31 (18.7%)
Range = 42.8%-100% ($\bar{x}$ ± SD = 75.7% ± 11.4%)			
Practice[&]	22 (13.3%)	119 (71.7%)	25 (15.1)
Range = 20%-100% ($\bar{x}$ ± SD = 69.8% ± 14.6%)			

Note. Cultural competency scores were converted into percentage-based system for direct comparison; [*]Bloom's cut off criteria for knowledge: low < 60%; ≥ 60% moderate ≤ 80%; and high ≥ 60%; [#]Standard deviation cut-off criteria for attitude: low < 64.3%; ≥ 64.3% moderate ≤ 87.1%; and high ≥ 87.1%; [&]Standard deviation cut-off criteria for practice: low < 55.2%; ≥ 55.2% moderate ≤ 84.4%; and high ≥ 84.4%

Chi-square tests were used to determine whether any of the demographic, experience factors or cultural competency had significant differences in corresponding cultural competency. Further, the use of linear regression was used to validate the relationship of these factors and cultural competency (see Table 3). Marital status was significantly associated with a difference in knowledge ($\chi^2 = 3.915$, df = 1, $p = .048$). Single participants had a lower level of knowledge than others. Work shift had a significant difference in distributions of attitudes ($\chi^2 = 5.450$, df = 1, $p = .020$). Day shift nurses were more likely to have positive scores (higher than an average), while night shift nurses were more likely to have negative scores (lower than an average). The third significant differences was in Practice, when grouped by confidence towards foreign patients ($\chi^2 = 8.403$, df = 2, $p = .015$). For this difference, those with low confidence scores were more likely to have low practice scores (lower than an average), while those with high confidence scores were more likely to have high practice scores (higher than an average). Those with moderate confidence and practice scores were approximately evenly distributed. While the effect of Marital Status on knowledge is surprising, the differences in work shift and practice may be more explainable. Work shift could have an impact because night shift nurses may have less interaction and engagement with foreign patients. It is also reasonable to assume that confidence towards foreign patients and effective culturally competent cultural practice would be associated. However, these connections were not proved in the present study.

The result shows that the knowledge in different cultures was associated with responsibility, age and confidence level

of the participants; attitude towards patients with different cultures was associated with work shift, confidence level, and marital status of the participants; and cultural practice was associated with confidence level of the participants. It is interesting that the level of confidence has an impact on all three variable of cultural competency where high level of confidence positively affects the level of knowledge, attitude and practice of nurses (see Table 4).

Table 3. Summary of Chi-square outcomes for knowledge, attitude and practices for culturally competent nursing care

Outcome variable	Value	Df	Asymp. Sig. (2-sided)
Knowledge and marital status			
Pearson Chi-square	3.915	1	0.048
Continuity correction	3.221	1	0.073
Likelihood ratio	3.872	1	0.049
Fisher's exact test			0.065/0.037*
Linear-by-linear association	3.892	1	0.049
Attitude and work shift			
Pearson Chi-square	5.450	1	0.020
Continuity correction	4.748	1	0.029
Likelihood ratio	5.481	1	0.019
Fisher's exact test			0.029/0.015*
Linear-by-linear association	5.417	1	0.020
Practice and confidence			
Pearson Chi-square	8.403	2	0.015
Likelihood ratio	8.735	2	0.013
Linear-by-linear association	6.782	1	0.009
Attitude and practice			
Pearson Chi-square	21.766	1	0.000
Continuity correction	20.339	1	0.000
Likelihood ratio	22.276	1	0.000
Fisher's exact test			0.000/0.000*
Linear-by-linear association	21.635	1	0.000

Note. *2-sided and 1-sided Fisher's exact test; Some data was regrouped for Chi-square analysis including the level of confidence (1 = unconfident at all, quite unconfident and relatively unconfident; 2 = quite confident; 3 = fully confident), attitude (1 = lower than average; 2 = higher than average), practice (1 = lower than average; 2 = higher than average) and marital status (1 = single; 2 = married, divorced and widowed) of the nurses

4. DISCUSSION

Cultural competency is particularly important in healthcare industry patients with different cultures where cultural beliefs have a significant impact on care access, treatment choices, effectiveness of nursing care, and other aspects of patient care; especially in Thai medical tourism where there are patients with diverse background and cultures. The present study showed that the overall levels of cultural competency can be described as low to moderate. In general, nurses have positive and welcoming feelings toward foreign patients. However, language skills are low, with only English language skills being moderate for most participants. Knowledge competency of different cultures is low, although attitude towards foreign patients and cultural practice are somewhat higher. Stepwise regression showed that a maximum variance of 7.5% in knowledge, attitude and practice of cultural competency from the demographic characteristics and experience factors. The findings of this study support many of the previous works related to cross-cultural competence in nursing care. In particular, the study does support the idea that many nurses do not have strong cultural competency skills, despite the awareness that cultural competency is a prerequisite for successful cross-cultural nursing care.[1,3,7,8]

Although the knowledge in different cultures alone did not improve cultural competency of nurses, the present study found that confidence is the key to an improved knowledge, attitude and practice of nurses. The study showed that nurses with a higher level of confidence had higher level of knowledge, attitude and practice. The present study did not find the direct relationship between the cultural knowledge and cultural practice but the indirect relationship between them.

In other words, knowledge was somehow related to the level confidence of nurses where cultural practice was associated with the level confidence of nurses. Hence, the cultural practice was indirectly associated with the level of knowledge. This was in agreement with the previous study that knowledge of cultural diversity is vital for cultural practice and it enabled nurses to be more effective in diagnosis assessments and serving patients.[11]

Table 4. Summary of linear regression outcomes for knowledge, attitude and practices for culturally competent nursing care

Outcome variable	Predictor variables	Adj. R-squared (Std. error of estimate)	F	Sig.
Knowledge	Responsibility	0.027 (9.14)	5.502	0.020
	Age	0.046 (9.05)	4.938	0.008
	Confidence	0.065 (8.96)	4.822	0.003
Attitude	Work Shift	0.036 (7.82)	7.075	0.009
	Confidence	0.058 (7.73)	6.043	0.003
	Marital Status	0.076 (7.66)	5.537	0.001
Practice	Confidence	0.019 (7.25)	4.179	0.043
	Attitude	0.342 (0.59)	86.745	0.000

Further, the present study also found factors such as responsibility and age of nurses apart from their confidence level associated with the level of knowledge while nursing experience was not significantly correlated with the level of cultural knowledge. This agrees with the previous finding that experience alone does not equip nurses with adequate knowledge for intercultural symptom assessment and culturally competent treatment and care.[12] Instead, it was suggested that the level of education was significantly correlated with knowledge.[13] However, the present study did not capture the relationship between education level and knowledge as nurses' education recruited in the present study was not diverse (92.2% of total samples hold their bachelor degree). It was suggested that cultural attitude must be incorporated within the nursing education considered to enhance the cultural competence of nurses and, in turn, cultural practice. Failure to acknowledge one's attitude toward cultural diversity may lead to negative behaviors towards culturally diverse population.[14] Teaching cultural competence in nursing and health care. In fact, exposure to diversity of cultures improves cultural knowledge and attitude towards different cultures. Findings suggest that cultural exposure experiences enhance the level of confidence, knowledge and attitudes toward people from different cultures.[15]

The present study showed that whilst the level of cultural knowledge was not significantly associated with the cultural practice, the level of confidence in communication and nursing care towards foreign patients and the level of multicultural attitude were significantly associated with the cultural practice. It was found that high level of confidence and positive attitude resulted in competent cultural practice. It was suggested that the good quality of cultural practice was primarily driven by the positive confidence and attitude while the experience factors, level of knowledge and other background marginally affected the quality of cultural practice. This agrees well with the previous study that Confidence is one of the factors influencing professional cultural practice as well as career satisfaction and career advancement.[16] However, it was suggested that overconfidence and low confidence behaviors must be avoided to avoid cultural pain.[17] Also, awareness of cultural attitudes, values and beliefs promotes effective engagement/practice with culturally diverse patients. Cultural competence in nursing care will help nurses understand different approaches to medication, different theories of disease, and different ways of expressing discomfort, pain, or other difficult emotions. It is known to reduce communication barriers and improve understanding of how patients perceive and receive medical advice.[14] One way to improve the cultural competency is training and exposing nurses with multicultural patients, it is known to improve knowledge, confidence and attitude and influence practices of nursing staff.[18]

Limitations

Funding constraints and inclusion of male nurses in this study might affect the actual results and response rate in this study.

5. Conclusion

Study has concluded that the good quality of cultural practice was primarily driven by the positive confidence and attitude while the expedience factors, level of knowledge and other background marginally affected the quality of cultural practice. Hence, it is recommended that the regular education and training in cultural competency for both qualified nurses and student nurses should be given.

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