

Incorporating Multiculturalism Into Oncology Nursing Research: The Last Decade

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Purpose/Objectives: To use the Oncology Nursing Society's cultural competence guidelines to review research studies conducted by oncology nurse researchers with racial and ethnic minorities and published in the *Oncology Nursing Forum* during 1990–2000.

Data Sources: Using selected key words (e.g., cultural competence, cultural diversity, multiculturalism, minorities, African American/Black American, Hispanic/Latino, Asian/Pacific Islander, Native American/Alaskan Natives) the authors identified 27 studies that met the inclusion criteria for review. Case studies, sponsored lectureships, review articles, commentaries, editorials, and the like were excluded.

Data Synthesis: Within the context of the cultural competence guidelines, the primary strengths included sufficient background information and literature to establish the existence of the problem in the targeted culture, use of conceptual and theoretical frameworks to guide the study, identification of salient study limitations, and recommendations for dissemination of the findings to a general audience. Limitations included discussion of culture beyond the background and literature review, consideration of potential ethical concerns the target population may have about the methods to be used, inclusion of racial and ethnic minorities in the design and implementation of the study, and implications for oncology nursing education.

Conclusions: Although much has been gleaned from previous oncology nursing research published from 1990–2000, more fully incorporated content related to cultural competence is needed. This is needed particularly in studies specifically targeting racial and ethnic minority populations.

Implications for Nursing: Including cultural competence when designing and reporting research has a greater potential to inform oncology nursing practice, design future research studies, strengthen existing nursing curricula, and help to shape health policy related to racial and ethnic minority populations. The *Oncology Nursing Society Multicultural Outcomes: Guidelines for Cultural Competence* provides guidance for enhancing the next generation of oncology nursing research with ethnically and culturally diverse populations.

As oncology nurses strive to transform cancer care during the 21st century, the current shift in demographics coupled with the cancer profile of racial and ethnic minority populations will warrant special attention. Oncology nurse researchers, in particular, will be challenged to conduct research that will promote the provision of culturally compe-

Key Points . . .

- ▶ Demographic trends reveal that growth will be tremendous in racially and ethnically diverse populations in the 21st century.
- ▶ The current shift in demographics underscores the need for and interest in cultural competency in oncology nursing research.
- ▶ The *Oncology Nursing Society Multicultural Outcomes: Guidelines for Cultural Competence* provides guidance for the conduct and reporting of oncology nursing research with racial and ethnic minority populations.
- ▶ The use of these guidelines, when designing and reporting oncology nursing research, may enhance the provision of culturally competent cancer care and the creation of health policies that will improve the health outcomes of racial and ethnic minority populations.

tent care and the creation of health policies that will improve the cancer outcomes of racial and ethnic minority populations. The increased need for and interest in cultural competency in oncology nursing research is influenced, in part, by a number of factors, including (a) the projected changes in demographic trends in the United States; (b) the continuing disparities in cancer incidence, mortality, and survival among racial and ethnic minority populations; (c) the Oncology Nursing Society's (ONS's) commitment to diversity and quality cancer care; and (d) the increased emphasis on the need to include racial and ethnic minority populations in federally funded research. To this end, the purposes of this article were twofold: to examine oncology nursing research published in the *Oncology Nursing Forum* from 1990–2000 using an adapted

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version of the *ONS Multicultural Outcomes: Guidelines for Cultural Competence* and to highlight implications for strengthening future oncology nursing research with racial and ethnic minority populations.

Multiculturalism can encompass various aspects of diversity including, but not limited to, sexual orientation, age, socioeconomic status, disability, lifestyle choices, and religious practices. However, for purposes of this article, the focus is on the inclusion of racial and ethnic minority populations in oncology nursing research. These populations include African Americans, Native Americans/Alaskan Natives, Asian/Asian Pacific Islanders, and Hispanics/Latinos.

Demographic Trends

Demographic trends reveal a tremendous growth in racial and ethnic minority populations by the year 2020. To illustrate, in 2000, America's population was 71.4% white, 11.8% Hispanic/Latino, 12.2% black, 3.9% Asian and Pacific Islander, and 0.7% Native American. This compares with the 2020 projections of 63.8% whites, 17% Hispanics/Latinos, 12.8% blacks, 5.7% Asian and Pacific Islanders, and 0.8% Native Americans/Alaskan Natives (U.S. Census Bureau, 2001).

Disparities in Cancer Incidence, Mortality, and Survival

Despite the advances in cancer diagnosis, treatment, and survival, many minority populations suffer disproportionately from cancer. Disparities exist in cancer incidence, mortality, and survival among racial and ethnic minorities, including African Americans, Asian and Pacific Islanders, Native Americans and Alaskan Natives, and Hispanics and Latinos. For example, current data show that African Americans are more likely to develop cancer than any other racial or ethnic group (American Cancer Society [ACS], 2002). Similarly, African Americans are approximately 33% more likely to die of cancer when compared to their Caucasian counterparts and twice as likely to die from cancer when compared to Asian and Pacific Islanders, Native Americans, and Hispanics (ACS, 2002). Hispanic women experience a 40% higher death rate from cervical cancer when compared with non-Hispanic women (ACS, 2001).

The disparities in cancer outcomes are even more striking among the socioeconomically disadvantaged. The five-year survival rate for this group is approximately 10%–15% lower than those who are not socioeconomically disadvantaged (Freeman, 1989). Although poor socioeconomic status has been linked to poor cancer outcomes, regardless of race or ethnicity, minority populations are disproportionately represented among the socioeconomically disadvantaged. A number of behavioral risk factors and the lack of access to and underutilization of state-of-the-art cancer services, to name a few, have been associated with poverty and hence are related to a higher cancer incidence and poorer cancer outcomes (Freeman).

Inclusion of Minorities in Federally Funded Research

The documented gaps in knowledge regarding a multitude of minority health issues influenced the creation of the National Institutes of Health (NIH) Revitalization Act of 1993. In brief, this mandate calls for the inclusion of women and

minority groups as subjects in clinical research and for NIH-defined phase 3 clinical trials. See http://grants.nih.gov/funding/women_min/women_min.htm for a more detailed discussion of the NIH Policy amended in October 2001. In 1999, NIH expanded these guidelines calling for the inclusion of children (age 21 and under) in federally funded research (<http://grants.nih.gov/grants/funding/children/children.htm>). Investigators seeking federal funding are required to address the recruitment and retention of minorities, women, and children in their research applications. Applications are assessed carefully during the review process for the inclusion of these populations. When these populations are not included, the principal investigator must provide a compelling justification supporting why inclusion is inappropriate or lacking. After the initial review, the principal investigator may be contacted to provide additional information regarding the adequate recruitment and retention of these populations. The inclusion of these populations in NIH-supported research is essential to ensure that research has relevance to diverse segments of the populations (Harden & McFarland, 2000; NIH, 1994)

Oncology Nursing Society Role

The mission and values outlined by ONS reflect the Society's ongoing commitment to addressing the needs of diverse populations. ONS values cultural, ethnic, and racial diversity and has adopted strategies to ensure a culturally diverse organization that is responsive to the needs of its members and the populations they represent and serve. Reflecting the need to facilitate cultural competency in oncology nursing, ONS published the *ONS Multicultural Outcomes: Guidelines for Cultural Competence* (ONS, 2000). These guidelines were developed to address cultural competence in oncology nursing practice, education, and research. The guidelines for addressing cultural competency in oncology nursing research, in particular, were adapted from original items developed by Porter and Villarruel (1993) and Kagawa-Singer (1994) and were designed to assist investigators during each stage of the research process. The research guidelines were expanded further to encompass a variety of issues germane to cancer care and cancer outcomes, particularly for racial and ethnic minority populations.

Defining Cultural Competence in Nursing Research

Numerous authors have provided direction for enhancing cultural competence in nursing research. Although a detailed description of these guidelines is beyond the scope of this article, readers are referred for a more detailed discussion related to achieving cultural competence in nursing research and conducting research with racial and ethnic minority populations (Campinha-Bacote & Padgett, 1995; Cohen, Phillips, & Palos, 2001; Flaskerud & Nymathi, 2000; Henderson, Sampelle, Mayes, & Oakley, 1992; Kagawa-Singer, 2000; Loue, 2000; Marin & Marin, 1991; Meleis, 1996; Napholz, 1998; Porter & Villarruel, 1993; Tripp-Reimer, 1999).

For the purposes of this article, the authors used the definition of cultural competence proposed by the ONS Multicultural Advisory Council in 1994. According to this definition, cultural competence is "being sensitive and responsive to issues related to culture, race, ethnicity, gender, age, socioeconomic status, and sexual orientation. Cultural competence

indicates a translation of cultural sensitivity and awareness into credible behaviors and actions” (ONS, 2000, p. 3). Regarding research, cultural competence must be an integral part of the entire research process. Thus, the *ONS Multicultural Outcomes: Guidelines for Cultural Competence* were designed to assist a research team and evaluate community involvement throughout all phases of the research process.

In 1993, Porter and Villarruel offered guidelines for conducting research with African American and Hispanic populations. These guidelines include questions for consideration during each phase of the research process. Major areas addressed in these questions include the conceptual framework, sample, measurement, investigator, analysis, and discussion. Designed to promote the conduct of culturally sensitive research, several examples of these questions include the following. Is there evidence that the identified theoretical or conceptual framework or concepts are relevant to the populations included in the study? Is the instrument specifically developed for the population under study? Are there links made among theory development, research, and practice implications for African Americans and Hispanic populations in particular or racial and ethnic minority populations in general?

Kagawa-Singer (1994) stressed that to achieve cultural competence in research, researchers first must conduct a personal assessment of their own personal beliefs and values. This assessment is essential to identify how one’s cultural views influence judgments and interpretations related to the research process. Further, Kagawa-Singer (1994) emphasized the need for cultural knowledge to transform the entire research process beginning with planning the research and continuing through the interpretation phase. Kagawa-Singer (1994) contended that an infusion of cultural knowledge throughout all phases of the research process aids in ensuring cross-cultural validity and reliability.

The need for cultural competence in nursing research has received increased attention in recent years. The projected shifts in demographics, the continuing disparities in cancer outcomes among racial and ethnic minorities, ONS’s commitment to diversity, along with the federal mandate to include minority populations in federally funded research will help shape the future of oncology nursing research.

Selection of Studies for Review

An adapted version of the guidelines for cultural competence in nursing research was used to critique research articles published from 1990–2000 in the *Oncology Nursing Forum*, an official ONS journal (see Figure 1). Twenty-seven of the original 41 articles were used in the current critique to identify a set of minimal reporting standards related to conducting research with racial and ethnic minority populations. Although the guidelines were developed in 1999, a current assessment of previous research and reporting trends is needed to identify future directions for oncology nursing research with racial and ethnic minority populations. Using selected key words, the authors conducted a 10-year literature search of PubMed and ONS Online (www.ons.org) to identify relevant studies. Articles were located by using the key words “cultural diversity, cultural competence, multiculturalism, minorities, African American/Black Americans, Hispanic/Latino, Asian/Pacific Islander, and Native Americans/Alaskan Native.” These key words were coupled with the wording “Oncology Nursing Society.” Studies were selected for inclu-

sion and critique if one or more of the key words appeared in the title or the specific aims or purpose, or if 25% or more of the study population included one or more of the previously mentioned populations. Case studies, sponsored lectureships (e.g., the Mara Mogenson Flaherty Memorial Lectureship, Schering Oncology/Biotech Clinical Lectureship), review articles, commentaries, editorials, studies solely targeting healthcare professionals or foreign populations in foreign settings, and studies not specifically identifying the minority composition of the sample were excluded. Finally, a total of 27 articles were selected for inclusion in this critique (see Figure 2). Figure 3 lists research designs, sample populations, conceptual frameworks, study instruments, and the cancer focus of the various articles included in this critique.

1990–1995

Studies published between 1990–1995 that met the inclusion criteria will be discussed in the aggregate. A total of eight studies published during this time period met the criteria. The majority of studies ($n = 6$) employed some type of quantitative approach (e.g., descriptive, correlational, survey, comparative), and qualitative approaches were used in two studies (e.g., analysis of testimony, focus groups). All studies contained useful information that has contributed to knowledge development related to cancer and ethnic and racial minorities. Nevertheless, each study had its own particular strengths and limitations, which will be discussed using the format outlined in the adapted guidelines explicated in Figure 1.

Knowledge

Knowledge was assessed on the basis of whether the studies reflected an authentic awareness of the cultures of the sample groups and the significance of the problems to be studied. All eight studies published dealt with significant problems for the group under study.

The eight studies reflected awareness of the culture of the target group. Determination of the degree to which that awareness was authentic, in part, depends on the researchers’ definition of “authentic.” According to *Merriam-Webster’s Collegiate® Dictionary* (1997), to be authentic is to be fully trustworthy, “worthy of acceptance or belief as conforming to or based on fact” (p. 77). Although this definition is not part of the guidelines set forth in Figure 1, it is used in this article to aid in examination of the authenticity of cultural awareness in the studies reviewed. Using this definition, authentic awareness of culture should be reflected in all areas (e.g., literature review, background, purpose, sampling, instrumentation, study procedures, analysis, interpretation, discussion, conclusions).

Those studies that provided sufficient background information to support the existence of the problem in the culture but had little integration of the culture in other areas of the study (e.g., purpose, instrumentation, study procedures) were viewed as having low authenticity of cultural awareness ($n = 6$). Two studies included specifics related to culture in the background, purpose, sampling, instrumentation, and study procedures. In addition, the perception of the problem or question was discussed by members from the specified cultural group. However, culture was not explicitly addressed in the other areas. Thus, these two studies were viewed as dem-

Knowledge

- Does the question reflect an authentic awareness of the culture?
- Is this a significant problem for the group to be studied?

Method

- Are the methods adequately described to enable others to replicate the study?
- Have the measures been tested or adapted for use with this group?
- Are the measures valid and reliable for this group?

Theoretical framework

- Have the theoretical or conceptual frameworks or concepts been applied appropriately or modified for use with the particular population?
- If the theoretical or conceptual framework or concepts have not been demonstrated to be valid in the population of interest, has a rationale for its application been provided and evidence presented to support its use?
- How have the investigators operationalized the concepts of ethnicity, culture, and race?
- How does the theoretical or organizing framework incorporate the concepts of ethnicity (culture) and race (color)?
- Are these definitions and operationalizations consistently used in the research design?

Sample

- What is the makeup (diversity) of the sample (e.g., ethnic population, acculturation, socioeconomic differences)?
- How have the researchers delineated their population to control for the diversity in or among the sample(s) by, for example
 - Ethnicity
 - Acculturation
 - Socioeconomic status
 - Regional variation
 - Gender?
- How have the researchers justified heterogeneity or homogeneity of the sample on the parameters identified?

Measurement and instrumentation

- Is the instrument reliable and valid for the target population?
- Have the health beliefs, values, and practices of the target population been incorporated into the measurement tools?

Analysis

- Does the data allow for subgroup and among subgroup analyses?
- Are the principles guiding the aggregation and analyses of data specified?

Interpretation

- Are the meanings congruent with the culture of the target population?
- Does the identification of limitations of the study design speak to cultural factors that influence the extent to which the data can be understood?
- Were the explanatory frameworks informed and verified by the participation (i.e., were insiders involved in data interpretation)?
- In what ways were the insiders involved?
- Who was involved in data interpretation?
- How was the participation in the research team selected?

Discussion and interpretation

- Are links made among theory development, research, and practice implications for the target populations?
- Are implications discussed in a manner that would be applicable to culturally based oncology nursing?
 - Education
 - Practice
 - Research

Dissemination and education

- What are the plans to disseminate the research or project findings to participants, community groups, and professional audiences?
- Are the contributions of participants acknowledged during dissemination and education?
- Who benefits from the dissemination and education?
- How can findings be used by the members of the target population to enhance their level of cancer awareness and health behavior throughout the cancer continuum—from prevention to rehabilitation or end-of-life care?

Figure 1. Guidelines for Cultural Competence in Oncology Nursing Research

Note. Based on information from the Oncology Nursing Society, 2000.

onstrating only a moderate degree of authentic awareness of culture.

The moderate level of integration of culture was most evident in studies conducted by investigators from racial and ethnic backgrounds and those targeting a specific racial or ethnic population. For example, in a comparative study examining religiousness and hope in Hispanic and Caucasian women with breast cancer, the investigators provided background information regarding the prevalence of the phenom-

enon in both the Hispanic and Caucasian cultures and discussed the perception of the variables in each culture (Mickley & Soeken, 1993).

Theoretical or Conceptual Framework

Six of the eight studies reviewed during this time period identified and used a conceptual or theoretical framework. The Health Belief Model (HBM) was used in two studies. In other studies ($n = 4$), conceptual models were developed us-

1990

Millon-Underwood, S., & Sanders, E. (1990). Factors contributing to health promotion behaviors among African American men. *Oncology Nursing Forum, 17*, 707-712.

1993

Mickley, J., & Soeken, K. (1993). Religiousness and hope in Hispanic and Anglo American women with breast cancer. *Oncology Nursing Forum, 20*, 1171-1177.

O'Hare, P.A., Malone, D., Lusk, E., & McCorkle, R. (1993). Unmet needs of black patients with cancer posthospitalization: A descriptive study. *Oncology Nursing Forum, 20*, 659-664.

1994

Underwood, S.M., Hoskins, D., Cummins, T., Morris, K., & Williams, A. (1994). Obstacles to cancer care: Focus on the economically disadvantaged. *Oncology Nursing Forum, 21*, 47-52.

1995

Douglass, M., Bartolucci, A., Waterbor, J., & Sirles, A. (1995). Breast cancer early detection: Differences between African American and white women's health beliefs and detection practices. *Oncology Nursing Forum, 22*, 835-837.

Gelfand, D., Parzuchowski, J., Cort, M., & Powell, I. (1995). Digital rectal examinations and prostate cancer screening: Attitudes of African American men. *Oncology Nursing Forum, 22*, 1253-1255.

Powe, B.D. (1995). Cancer fatalism among elderly Caucasians and African Americans. *Oncology Nursing Forum, 22*, 1355-1359.

Sensiba, M.E., & Stewart, D.S. (1995). Relationship of perceived barriers to breast self-examination in women of varying ages and levels of education. *Oncology Nursing Forum, 22*, 1265-1268.

1996

Morrison, C. (1998). Determining crucial correlates of breast self-examination in older women with low incomes. *Oncology Nursing Forum, 23*, 83-93.

Tomaino-Brunner, C., Freda, M.C., & Runowicz, C.D. (1998). "I hope I don't have cancer": Colonoscopy and minority women. *Oncology Nursing Forum, 23*, 39-44.

1997

Collins, M. (1997). Increasing prostate cancer awareness in African American men. *Oncology Nursing Forum, 24*, 91-95.

Jennings, K.M. (1997). Getting a Pap smear: Focus group responses of African American and Latina women. *Oncology Nursing Forum, 24*, 827-835.

Lovejoy, N.C., Roche, N., & McLean, D. (1997). Life stress and risk of precancerous cervical lesions: A pretest directed by the Life Stress Model. *Oncology Nursing Forum, 24*, 63-70.

Zimmerman, S. (1997). Factors influencing Hispanic participation in prostate screening. *Oncology Nursing Forum, 24*, 499-504.

1998

Hunt, L., Voogd, K., Akana, L., & Browner, C. (1998). Abnormal Pap screening among Mexican-American women: Impediments to receiving and reporting follow-up care. *Oncology Nursing Forum, 25*, 1743-1749.

Weinrich, S.P., Weinrich, M.C., Boyd, M.D., & Atkinson, C. (1998). The impact of prostate cancer knowledge on cancer screening. *Oncology Nursing Forum, 25*, 527-534.

1999

Facione, N.C. (1999). Breast cancer screening in relation to access to health services. *Oncology Nursing Forum, 26*, 689-696.

Jennings-Dozier, K. (1999). Perceptual determinants of Pap test up-to-date status among minority women. *Oncology Nursing Forum, 26*, 1327-1333.

Lauver, D.R., Kane, J., Bodden, J., McNeel, J., & Smith, L. (1999). Engagement in breast cancer screening behaviors. *Oncology Nursing Forum, 26*, 545-554.

Phillips, J.M., Cohen, M.Z., & Moses, G. (1999). Breast cancer screening and African American women: Fear, fatalism, and silence. *Oncology Nursing Forum, 26*, 561-571.

Powe, B.D., & Weinrich, S. (1999). An intervention to decrease cancer fatalism among rural elders. *Oncology Nursing Forum, 26*, 583-588.

Schulmeister, L., & Lifsey, D. (1999). Cervical cancer screening knowledge, behaviors, and beliefs of Vietnamese women. *Oncology Nursing Forum, 26*, 879-887.

2000

Champion, V.L., Skinner, C.S., & Foster, J.L. (2000). The effects of standard care counseling or telephone/in-person counseling on beliefs, knowledge, and behavior related to mammography screening. *Oncology Nursing Forum, 27*, 1565-1571.

Han, Y., Williams, R.D., & Harrison, R.A. (2000). Breast cancer screening knowledge, attitudes, and practices among Korean American women. *Oncology Nursing Forum, 27*, 1585-1591.

Kim, K.K., Yu, E.S., Chen, E.H., Cross, N., Kim, J., & Brintnall, R.A. (2000). Nutritional status of Korean Americans: Implications for cancer risk. *Oncology Nursing Forum, 27*, 1573-1583.

Smiley, M.R., McMillan, S.C., Johnson, S., & Ojeda, M. (2000). Comparison of Florida Hispanic and non-Hispanic Caucasian women in their health beliefs related to breast cancer and health locus of control. *Oncology Nursing Forum, 27*, 975-984.

Taylor, E.J. (2000). Transformation of tragedy among women surviving breast cancer. *Oncology Nursing Forum, 27*, 781-788.

Figure 2. Oncology Nursing Forum Articles Included in This Review

ing the study variables. Two studies used qualitative and survey approaches, with no specific conceptual framework identified. The rationale for use of the conceptual or theoretical models was discussed in all eight studies. However, information regarding strategies used to adapt the model(s) for use

with the target population was reported in only one of the studies (Douglass, Bartolucci, Waterbor, & Sirles, 1995). Discussion of the intraethnic differences and their implications for instrumentation and interpretation of findings was absent from all but one of the studies.

Research designs

- Qualitative (e.g., grounded theory, focus groups)
- Quantitative (e.g., correlational, descriptive, quasi-experimental, experimental, survey, repeated measures, retrospective longitudinal)

Sample populations

- African American men and women
- Hispanic men and women
- Korean men and women
- Mexican American women
- Vietnamese women

Conceptual and theoretical frameworks

- Champion's Health Belief Model^a
- Health Belief Model
- Health Locus of Control
- Leninger's Transcultural Nursing Theory
- Life Stress Model
- PRECEDE Model
- Self-Regulation Theory
- Social Marketing
- Theory of Care Seeking Behavior
- Theory of Planned Behavior
- Theory of Reasoned Action
- Transtheoretical Model

Study instruments

- Attitudes Toward Digital Rectal Screening and Prostate Cancer
- Attitudes Toward Mammography Scale
- Audit of Complex Problems
- Breast Cancer Knowledge Test
- Breast Cancer Screening Belief Scale^a
- Breast Self-Examination Survey^a
- Brief Symptom Distress Scale
- Checklist of Unmet Needs
- Colorectal Knowledge Questionnaire^a
- Family APGAR
- Feagin's Intrinsic/Extrinsic Scale
- Habits of Health Services Utilization^a
- Health Habits and History Questionnaire^a
- Health Screening Questionnaire^a
- HIV Symptom Distress Scale
- Inforced Social Dependency Scale
- McCorkle Symptom Distress Scale
- Melnyk's Barriers Scale
- Nowotny Hope Scale
- Oral Testimony Transcripts
- Perceived Access to Health Services^a
- Perceived Barriers Questionnaire Subscale
- Perceptions of Prejudice^a
- Powe Fatalism Inventory^a
- Profile of Mood States
- Squamous-Cell Intraepithelial Lesions of the Cervix Risk Factor Inventory
- Spiritual Well-Being Scale
- The Knowledge of Prostate Cancer Screening^a
- The Pap Smear Questionnaire^a

Cancer foci

- Breast cancer, breast self-examination, colon cancer, nutrition, prostate cancer

Figure 3. Selected Characteristics of Articles Reviewed

^a Modified or adapted for use with target population

All of the studies reviewed involved adult populations ranging in age from 18–85 years. The specific racial and ethnic populations are identified in Figure 3. Two studies focused exclusively on men, three focused only on women, and three focused on both men and women. Four of the eight studies examined minority populations from middle-income backgrounds, and most were convenience samples.

Measurements and Instruments

Measurements and instruments were assessed based on the inclusion of information about whether the target group recognized the measures as ethical (i.e., were their health beliefs, values, and practices incorporated into the measurement tool), an adequate description of the instruments in terms of their sensitivity was present to detect the problem (e.g., barriers to breast self-examination practice, health beliefs, religiousness, hope, fatalism, obstacles to cancer care), and testing to determine their validity and reliability for the cultural group was present.

Based on the information provided in the eight studies reviewed, no activities were undertaken to determine whether the target population recognized the instruments to which they were asked to respond as ethical. This criterion has considerable importance at a time when many members of racial and ethnic populations are reticent to participate in research studies, particularly clinical trials. This, in part, is related to the exposure of the Tuskegee Experiments, which were replete with unethical methods (“Knowledge of the Tuskegee Syphilis Study,” 2001). Therefore, investigators must identify strategies to enable access to information about concerns members of the target population may have about instruments to be used. Attention to this criterion will increase the target population's participation in the research process.

Clear descriptions of instruments were included in all eight studies. Three of the eight studies discussed the prior use of the instruments with the target group. The reliability of the instruments was discussed in all eight of the studies, and three studies addressed the prior use of the instruments with the target population.

Analysis

Two of the studies reviewed during this time period were comparative (i.e., African American and Caucasian women, Hispanic and Caucasian women). Four studies focused on homogeneous minority groups. The other two studies focused on disadvantaged groups that included racial and ethnic minorities but in small numbers, precluding subgroup analyses. Across all studies using quantitative approaches, investigators provided information about data analysis, rationale, type of statistics used, and detection of significance. The studies using qualitative approaches included limited information regarding the data analysis plan (e.g., approach used, data-sampling frame).

Interpretation

Although findings were discussed in considerable detail across all studies, six of the eight studies did not discuss interpretation of findings within the context of the particular culture. For example, in the studies that included samples from two or more groups, most of the interpretation focused on successive discussion of findings relative to each group without use of cultural context to enrich and add meaning to the

findings. In one study of health promotion behaviors among African American men, the authors concluded that despite widespread advertising of the acrostic CAUTION, which was used to remind subjects of the early warning signs of cancer (e.g., changes in bowel or bladder habits, sores that do not heal, unusual bleeding, thickening or lumps on the body, indigestion, obvious changes in warts or moles, nagging cough), the majority of African American men still were uninformed (Millon-Underwood & Sanders, 1990). Within a cultural context, the question might be raised as to whether acronyms are the most effective way to communicate this information to the target population. In the studies that focused on specific racial or ethnic groups, culture tended to be used more often in the interpretation and discussion of findings. For example, culture was used to aid in understanding the finding of higher mean levels of religiousness in Hispanics compared to Caucasians (Mickley & Soeken, 1993). Specifically, some Hispanics reported viewing illness as “God’s will” and something to be simply endured. Within this cultural context, the investigators concluded that for some Hispanics, religiousness may serve as a risk factor, particularly in stress-related illnesses or emotional problems (Mickley & Soeken).

Study limitations were acknowledged in all studies. Limitations identified included limited generalizability, small sample sizes, limited reliability and validity of instruments, and moderate response survey rates. Not one of the studies indicated that any of the study limitations were considered within the context of cultural factors. The involvement of members of target population (insiders) in the interpretation of findings was not discussed in any of the studies.

Discussion

In the studies that employed the HBM, some discussion of the way in which the conceptual or theoretical framework helped to explain the findings was included. The links between findings and the organizing framework were less well discussed in studies that did not utilize specific conceptual or theoretic frameworks. Although most studies included implications, only two linked theory, practice, and research in the discussion. Implications of the findings from the studies relative to patient education generally were not addressed in the studies reviewed for the 1990–1995 time period. Culture was not well integrated into the discussion of implications in any of the studies reviewed.

Dissemination and Education

Although not explicitly stated, indications were implicit that findings would be shared in varied venues. Whether any of the venues would be located in the communities of the target populations was unclear. No discussion was included of how and when the findings would be shared with the participants once the study was completed. Although it was unclear where the programs would occur, several studies discussed the need for education programs designed to address common beliefs and concerns identified by participants in the study. The way in which members of the target population might use findings from the studies reviewed rarely was discussed.

1996–2000

Based on the criteria for inclusion, a total of 19 articles published in the *Oncology Nursing Forum* during 1996–2000

were included in the final analysis. The majority of studies ($n = 14$) employed some type of quantitative approach (e.g., descriptive, correlation, quasi-experimental, experimental), and six studies reported using a qualitative approach (e.g., focus groups, grounded theory) to examine a wide range of cancer-related topics. Although all of the studies highlighted a number of important findings and implications for future oncology nursing research, the majority of the studies indicated a number of strengths and weakness. These strengths and weaknesses are discussed next. The following discussions follow the format outlined in the adapted guidelines depicted in Figure 1.

Knowledge

In most cases, an authentic awareness of the culture was perhaps best reflected in the study’s purpose or objectives versus the actual research question(s). When the criterion, “Does the question reflect an authentic awareness of the culture?,” was applied across all studies, evidence of cultural knowledge was reflected in other areas of the published reports including the literature review, sampling, instrumentation, and study procedures (e.g., language translation, focus group interviews). This was most evident in studies that targeted a specific racial or ethnic minority population as opposed to studies including representative samples of racial and ethnic minorities. Notably, 15 of the 19 studies emphasized differences or implications related to socioeconomic status, culture or ethnicity, and race in the purpose(s) or objective(s). Finally, all 19 studies posed significant research questions that were relevant to racial and ethnic minority populations. These questions focused on cancer-related knowledge, beliefs, behaviors, prevention, screening and detection, and adaptation to the cancer experience.

Theoretical or Conceptual Framework

Most of the studies reviewed during this time period identified a conceptual or theoretical framework. Four studies did not include an organizing framework, and one study’s use of grounded theory precluded the use of an organizing framework. The HBM ($n = 5$) followed by the PRECEDE Model ($n = 2$) and the Theory of Planned Behavior ($n = 2$) were the most frequently cited frameworks or models in published research. All studies utilizing a framework or conceptual model provided a rationale for its use based on a review of the literature. In many instances, researchers described links between their conceptual frameworks and instruments that included cultural beliefs, norms, and attitudes in contrast to modifying or adapting a conceptual framework or model to incorporate these variables. To illustrate, one researcher conducted focus groups to help operationalize variables outlined in the Theory of Planned Behavior (e.g., salient referents, social norms, control beliefs) specific to a sample of African American and Latino women (Jennings-Dozier, 1997).

All of the studies reviewed included adults ranging in age from 17–99 years. The racial and ethnic minority populations studied are displayed in Figure 3. Two authors noted stratifying according to racial and ethnic identity to ensure the most homogenous sample. The overwhelming majority of studies utilized minority populations from low-income backgrounds. Three articles reported sampling according to socioeconomic status (i.e., low versus middle income).

Measurements and Instrumentations

When using established instruments or investigator-developed tools, the majority of the investigators provided details related to the psychometric properties of their instrument(s). Reported Cronbach alpha coefficients ranged from 0.56–0.63, and test-retest reliability estimates ranged from 0.30–0.70. The majority of researchers reported established validity (e.g., construct, content, face) when using well-known or newly developed tools. Researchers using interview guides or open-ended questionnaires consistently reported developing items based on a literature review or focus group discussions. Researchers targeting exclusive samples of racial and ethnic populations were more likely to address practices and issues, such as acculturation, literacy, and specific cultural beliefs, compared to researchers including representative samples of minority populations. Discussions related to ethical issues and conduct of research with racial and ethnic minority populations were very limited.

The majority of researchers used bilingual interviewers when targeting Hispanics. In studies targeting racial and ethnic populations, participants were offered a chance to be interviewed in their preferred language (e.g., English, Spanish, Korean, Vietnamese).

Analysis

For the most part, studies conducted during this time period tended to include homogenous samples of minority and nonminority populations or did not include samples that were large enough to allow for subgroup distinction or subgroup analysis. In a study on cervical cancer screening, Jennings-Dozier (1999) provided subgroup data on African American and Latino women. African American subgroups were identified as African American with Native American (12%) and West Indian (2%) ancestry. One woman was a Nigerian immigrant. In contrast, the majority of Latina participants reported being Puerto Rican (81%). Other Latina subgroups included Dominicans (9%), Cubans (6%), Colombians (1%), Guatemalans (1%), Hondurans (1%), and Ecuadorians (1%). However, across all of the studies, investigators included information regarding data analysis, rationale, and procedures regardless of sample composition. When two or more racial and ethnic minority populations were included, investigators conducted data analysis to discern differences according to racial and ethnic background accordingly.

Discussion

Interpretation: When items related to interpretation were applied across studies, 10 researchers offered specific explanations or insights related to culture. Most of these studies tended to include exclusive samples of racial and ethnic minority populations. For example, several researchers commented on fatalism and machismo as potential cultural barriers related to appropriate cancer screening (Phillips, Cohen, & Moses, 1999; Powe, 1995; Powe & Weinrich, 1999; Zimmerman, 1997). Similarly, one investigator targeting Vietnamese women offered issues on modesty and preference for female healthcare providers as a barrier to cervical cancer screening for this population (Schulmeister & Lifsey, 1999). In a study targeting African American women, issues such as fatalism, spirituality, and community silence were cited as specific cultural barriers to breast cancer screening for this population (Phillips et al.).

Study limitations were acknowledged in all studies. Limitations related to sample selection, small sample size, limited generalizability, geographic and demographic distribution, and instrumentation (e.g., poor reliability) were acknowledged consistently. The authors of the current study did not identify any studies that specifically indicated insider involvement in data interpretation.

Implications: All investigators offered implications for oncology nursing research and practice with the exception of one study. Of interest, one researcher noted a need for reimbursement policies to increase access to cancer-screening services for underserved women (Lauver, Kane, Bodden, McNeel, & Smith, 1999). Sorely lacking across studies were discussions related to oncology nursing education. Overwhelmingly, authors provided little to no information regarding implications for nursing education. Only two studies identified implications for oncology and healthcare professionals' education. These researchers called for the inclusion of cultural aspects in healthcare professions' curricula, and one investigator called for the recruitment of Hispanics into nursing to aid in developing culturally appropriate interventions targeting Hispanic populations.

Dissemination and Education

Although researchers did not specifically describe venues or plans for the dissemination of research findings, one would hope that the findings were shared with diverse audiences during presentations and other scholarly activities. Several study participants offered suggestions for their respective communities. These suggestions included increasing the involvement of community leaders in cancer control efforts, showing compassion and extending support to other breast cancer survivors, utilizing Hispanics and African Americans to develop promotional messages, and promoting survivorship and inspiration as potential strategies to effectively target culturally diverse communities.

Conclusions and Future Recommendations for Oncology Nursing Research

The researchers of the current study examined articles published in the *Oncology Nursing Forum* from 1990–2000 using an adapted version of the *ONS Multicultural Outcomes: Guidelines for Cultural Competence*. Although all of the studies reflected a number of important findings and implications for future oncology nursing research, the majority shared a number of strengths and limitations. Within the context of the cultural competence guidelines, the primary strengths were the (a) inclusion of sufficient background information and literature to establish the existence of the problem in the targeted culture, (b) use of conceptual and theoretical frameworks to guide the study, (c) identification of salient study limitations, and (d) recommendations for dissemination of the findings to a general audience. Limitations shared by the studies largely were related to (a) little discussion of culture beyond the background and literature review, (b) lack of consideration of potential ethical concerns the target population may have about the methods used, (c) failure to include racial and ethnic minorities in the design and implementation of the study, and (d) failure to identify implications for oncology nursing education.

Based on the findings from this critique, the current study's researchers offer the following recommendations for use when conducting and reporting on research with racial and ethnic minority populations. These recommendations are not listed in any particular order and are not meant to be inclusive or restrictive. Rather, they are highlighted to strengthen the conduct and reporting of oncology nursing research with racial and ethnic minority populations, identify implications for future oncology nursing research with racial and ethnic minority populations, and aid in reducing the disparities in cancer noted among culturally diverse and underserved populations.

For the Oncology Nursing Society

- Evaluate and refine the guidelines for cultural competency in oncology nursing research for use when planning, conducting, reporting on, and disseminating qualitative and quantitative research conducted with racial and ethnic minority populations.
- Integrate the guidelines into existing publication guidelines for authors, editors, and reviewers of the *Oncology Nursing Forum*.
- Articulate minimal reporting requirements for potential authors seeking publication in the *Oncology Nursing Forum*.
- Identify issues and opportunities for developing cultural competence in oncology nursing research.
- Assess the overall applicability and generalizability of the guidelines for use in critiquing oncology nursing research conducted with racial and ethnic minority populations.
- Revise and strengthen the guidelines to enhance their effectiveness for review and critique of oncology nursing research with racial and ethnic minority populations.
- Highlight the guidelines and their instrumentality in facilitating ONS in meeting the needs of its members and the patients and clients the Society serves.

For Future Oncology Nursing Researchers

- Strive to establish and maintain collaborative research partnerships with culturally diverse populations.
- Develop psychometrically sound and culturally appropriate instruments for use when conducting oncology nursing research with racially and ethnically diverse populations.
- Expand the current body of oncology nursing research with racial and ethnic minorities by conducting studies in areas

such as genetics, survivorship, family adaptation, quality of life, and decision making, to name a few.

- Increase the number of effective cancer intervention studies targeting minorities and their subpopulations.
- Increase the number of qualitative studies with understudied racial and ethnic minority populations.
- Continue to develop cultural competence in oncology nursing research.
- Expand, refine, and evaluate new and existing conceptual and theoretical foundations for use in studies with racial and ethnic minority populations.
- Increase the number of oncology nursing studies with minority males, children, and families across the life cycle.
- Share experiences and lessons learned related to conducting research with culturally diverse populations.
- Facilitate the widespread dissemination of research findings and outcomes to study participants and targeted communities, in addition to public and professional audiences.
- Include members of targeted racial and ethnic minority populations (insiders) in the design, implementation, and interpretation of research findings of oncology nursing research conducted with these groups.
- Develop focused strategies to aid in accessing knowledge about ethical concerns that racial and ethnic populations may have about participating in oncology nursing research.
- Strengthen the authentic awareness of culture by oncology nurse investigators conducting research with racial and ethnic minority populations.

Summary

The members of ONS are positioned ideally to conduct, strengthen, and disseminate the next generation of oncology nursing research with racial and ethnic minority populations. Given its commitment to diversity and quality cancer care for all, ONS stands ready to assist its members in this endeavor. The authors hope that this preliminary review of previously published research provides guidance for incorporating multiculturalism into oncology nursing research in the future.

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For more information . . .

- ▶ California State University: Center for Multicultural and Gender Studies
www.csuchico.edu/mcgs
- ▶ Centers for Disease Control and Prevention: Recent Trends in Mortality: By Ethnicity
www.cdc.gov/mmwr/preview/mmwrhtml/mm5103a1.htm
- ▶ Oncology Nursing Society: Multicultural Guidelines
www.ons.org/Documents/Library/ONSPublications/multicultural.pdf

These Web sites are provided for information only. The hosts are responsible for their own content and availability. Links can be found using ONS Online at www.ons.org.
