Cabezonas con Suenos:
Assets Latina/o Nursing Students Used to Overcome Obstacles

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Abstract

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Assets Latina/o nursing students used to overcome obstacles

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This study used critical ethnography to explore and document the institutional, personal, and cultural assets that Latina/o nursing students and recently graduated Latina/o RNs used to surmount obstacles to successfully navigate an accredited U.S. nursing program. Six nursing students and seven recently graduated RNs were interviewed in focus groups and semi-structured interviews about their experiences in nursing school. The data were divided into seven categories--1) personal assets, 2) social assets, 3) cultural assets, 4) institutional obstacles, 5) cultural obstacles, 6) racism, and 7) institutional assets --from which two themes were extracted-- *assets used for overcoming and resistance* and *obstacles to be overcome.* The findings were congruent with most previous research conducted, and a new understanding of the importance of the cultural assets of stubbornness and determination was gained. Participants were committed to maintaining family and cultural ties and carrying out family responsibilities. Findings regarding racism within nursing education are also reported. Recommendations for nursing educators include gaining an understanding of the issues faced by Latina/o and other racialized students and learning about antiracism, which is signified by an acknowledgement that White people will never know what it is like to be a racialized person in the United States, a commitment to overtly fighting racism, and a recognition of the significant effects of racism. Further steps include integrating anti-racism into nursing curricula by teaching about both racial oppression and White privilege, as

well as teaching Whites students how they contribute to institutional racism, and how they can become antiracist "allies." Additional recommendations are that nursing education include more content on social disparities in health; create more flexible, culturally-appropriate nursing programs; increase flexibility in admissions; remove academic barriers; and implement mentoring support for racialized students once they enter a nursing program.

**Stubborn (headstrong) women with dreams*

TABLE OF CONTENTS

LIST OF FIGURES

Figure Number Page

LIST OF TABLES

Table Number Page

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DEDICATION

Mostly to Steve;

also to Nicholas, Beth, and "Ladybug";

to Jayna and Jonathan;

to Nathan.

"And what does the Lord require of us?
To act justly and to love mercy
and to walk humbly with your God."

Micah 6:8

Introduction

Latina/o and other racialized populations are underrepresented in the nursing profession. A high demand and a low availability of Latina/o registered nurses (RNs) becomes a social justice issue of access to culturally appropriate health care and culturally appropriate education. This is in light of the fact that Latina/o RNs could be expected to practice with greater cultural appropriateness than non-Latina/o White RNs (Manifold & Rambur, 2001) who now comprise the majority of the RN workforce. The high demand for Latina/o RNs is also a social justice issue of lack of access to nursing education for Latina/o students.

The perspectives of Latina/os and other RNs are necessary to help policy makers, employers, and educators gain a greater understanding about the changes that would effectively remove obstacles to racialized students wishing to enter and complete nursing programs (Buerhaus & Auerbach, 1999). Multiple issues–such as financial obstacles, lack of traditional academic preparation, and cultural differences–are at play. Yet, little is known about these and other issues from the perspective of Latina/o nursing students. Issues such as social justice, culturally-appropriate nursing care, social disparities in health, racism in nursing and nursing education, and how curriculum is designed and presented to nursing students are also factors that may contribute to the lack of Latina/o RNs.

The purpose of this study was to explore and to document, through the use of critical ethnography, the experiences of Latina/o nursing students and recently

graduated Latina/o RNs, and the institutional, personal, and cultural assets, i.e. resources, attributes, and advantages, they used to surmount obstacles and thus successfully navigate an accredited U.S. nursing program. The following review of the literature addresses demographic data regarding diversity in nursing focusing on Latina/o students; concepts such as social disparities in health, Whiteness, and racism in nursing education; and studies conducted with racialized nursing students about their experiences in nursing programs.

Review of Literature

A review of the literature was conducted using CINAHL, ProQuest, PubMed, and Social Science Abstracts databases. Additionally, the American Federation of Teachers, Center for Health Workforce Studies, the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, GeographyIQ, the National Cancer Institute, the U.S. Census Bureau, and the United States Department of Health and Human Services Web sites were searched. The library catalogs of the University of Washington and its Summit Consortium affiliates were also searched. The search was limited to peer-reviewed literature, books, and government reports from 1993 to the present. Key words included *Hispanic, Latina/o, nursing education*, and *racism*. Eighty-one salient sources were selected. The literature found was integrated into demographics; social disparities in health; racism; academic obstacles (such as a lack of culturally-appropriate nursing care and education and the effects of Whiteness on nursing education); and institutional, personal, and cultural obstacles and assets. A brief discussion of the literature follows.

Demographics

Latina/os now comprise 14% of the population of the United States and continue to be the fastest growing racialized group in the United States, with an expected increase in the Latina/o population size to 24% of the U.S. population by the year 2050 (U.S. Census Bureau, 2006). *Racialized groups* are people of color

who are identified by the dominant group, and often by other minority groups, first by their races and ethnicities and the dominant stereotypes of their races and ethnicities before being identified as groups of human beings with unique assets, including cultural identities. The U.S. Census Bureau counts their numbers using a narrow list of imposed racial categories, rather than by people's own self-identifiers. Racialized groups are generally seen to be homogenous by those in power. In contrast to this opinion, the Latina/o population is quite heterogeneous, including multiracial and multiethnic groups who display a wide variance in educational and socioeconomic status.

With all the Latina/o groups, such as Mexican American, Puerto Rican, and Latin American combined, only 2.0% of the nation's population of registered nurses (RNs) are Latina/o. This percentage has changed very little in the past ten years (Center for Health Workforce Studies, 2004; Goba, 2001). In fact, the numbers of Latina/o RNs have grown more slowly than in other racialized groups (Buerhaus & Auerbach, 1999). Thus Latina/os, comprising the fastest growing racialized group in the United States, are one of the most underrepresented in the nursing profession. While 31% of the U.S. population is non-White, only 13% of registered nurses are non-White (U.S. Department of Health and Human Services [USDHHS], 2000), and only 2% are Latina/o (Center for Health Workforce Studies, 2000). Greater gains have been made by some racialized groups, but there is still clear under-representation in all racialized groups within the nursing

profession. Thus, nursing does not mirror the general population, and the growth in the numbers of Latina/o nurses is not keeping pace with the growth in population of Latina/os. The under-representation of Latina/os in nursing has important ramifications for the health of the Latina/o population.

In a study of key biographical, educational, and employment trends of racialized RNs, Buerhaus and Auerbach (1999) used a longitudinal analysis of U.S. Census Bureau data and data from the National Sample Surveys of the Population of Registered Nurses. They found that while the percentage of racialized nurses had dramatically increased between 1977 and 1996 (from 6.3 % to 9.7 %), the actual number of racialized RNs remained small and still at a much lower proportion than the percentage of racialized people in the U.S. population (13 per 100 RNs vs. 31 per 100 people). Additionally, data from the study demonstrated that increasing numbers of RNs were educated by associate degree (ADN) programs and fewer by diploma programs. Latina/os and American Indians earned a higher proportion of associate (ADN) degrees than baccalaureate (BSN) degrees (Buerhaus & Auerbach). Buerhaus and Auerbach concluded that little was known about the factors such as racism, discrimination, and alternative career options for women, and that there was a perception that healthcare organizations and nursing programs were (and are) unwelcoming of racialized students; these factors might serve to inhibit racialized students from choosing a career in nursing. Buerhaus and Auerbach further concluded that there was sufficient evidence to begin to devise

new strategies to address the problem and that continuing the recruitment and retention strategies of the past 20 years held little to no hope of increasing the numbers of minority nurses. Seven years later, new thinking and new strategies are still needed.

Workforce demographics have demonstrated that there is a disproportionate representation of racialized people, particularly African Americans and Latina/os, in the lower-skilled, lower-waged facets of nursing, such as nursing assistant and practical nurse (Glazer, 1991). In fact, there are twice as many nurses of color who are licensed practical nurses (LPNs) as there are licensed as RNs (Center for Health Workforce Studies, 2004). This is due to racialized people being directed into the less academically challenging high school courses and thus into lower skilled nursing roles by high school teachers and counselors (Abrums & Leppa, 2001) and by college counselors (American Federation of Teachers, 2004), thus fulfilling White economic expectations for a low-paid labor force of brown women. This disparity between racialized LPNs and RNs also fulfills the purpose of segmenting nursing practice in a way that limits the opportunities of lower-skilled nurses, often of color, to advance in the profession. The result is that RNs rise to higher positions and leave the more labor-intensive nursing work to LPNs and nurses' aides. Table 1 illustrates the differences in proportions, by race and ethnicity, of LPNs and RNs. In all categories, except White and Asian/Pacific Islander, there are at least twice as many LPNs as RNs.

Moreover, educational level may be related to patient outcomes. In a cross-sectional study of staff nurse educational levels and patient deaths, Aiken (2003) examined outcome data from over 200,000 surgical patients in 168 hospitals. Aiken's findings indicated that the use of ADN-prepared nurses rather than BSN-prepared RNs was associated with an increase in patient mortality. A limitation of the study was that BSN-degree-only nurses were grouped together with advanced practitioners, so that the effect of having a BSN only was not measured. Aiken

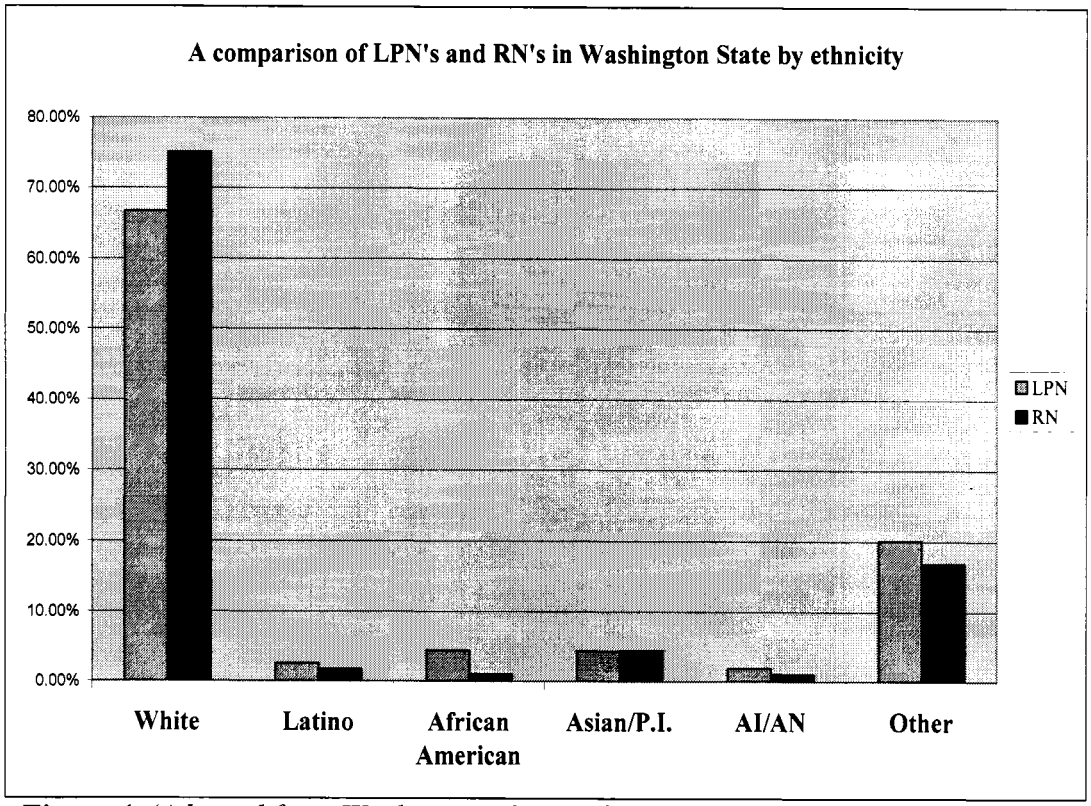

Figure 1 *(Adapted from Washington Center for Health Workforce Studies, 2004)*

called for an increase in BSN education, but noted that BSN-completion programs were also an effective means of increasing the numbers of BSNs.

While the importance of a BSN education cannot be overstated, insisting that it be the exclusive means of becoming an RN continues class differentiation in nursing in light of the higher numbers of racialized students who enroll in ADN programs and who might be excluded from BSN programs. A further examination of the demographic data concerning racialized students and nursing education has demonstrated that 49.4% of American Indian, 43.1% of Latina/o, and 37.3% of African American RNs initially earn an ADN (Spratley, Johnson, Sochalski, Fritz, & Spencer, 2000). With these data, it is not difficult to understand why the National Black Nurses Association (NBNA) has opposed the American Nurses Association (ANA) position that the BSN be the entry point into the nursing profession. According to Barbee (1993), The NBNA does not trust that BSN programs will enroll African-American students. While the ANA calls for increasing the diversity in nursing (American Nurses Association, 2002), the emphasis in current practice and curricula on research-based practice which supports the call for BSN-educated (and higher) nurses (American Nurses Association, 1997), may inadvertently perpetuate ethnic/racial stratification. While patient outcomes seem to be related to educational attainment (Aiken, 2003), certain groups of nurses are denied entry to higher levels of education based on race or ethnicity; improving access to higher levels of education could improve patient outcomes.

For racialized college students, in general, there is a lower college enrollment rate at all levels of higher education and a greater attrition rate. These

two problems--of low enrollment and high attrition--may share some of the same causes (Klisch, 2000; Lockie & Burke, 1999; Perna, 2000), such as lack of educational preparation before college and lack of support while in college. At the same time, appeals and attempts have been made by numerous organizations--including the Robert Woods Johnson Foundation, the W. K. Kellogg Foundation, and the American Nurses Association--to increase the numbers of minority RNs as a means of meeting national standards for providing culturally- and linguistically-appropriate care (Xu, 2001). Since many racialized students begin their nursing educations in ADN programs and then transfer into BSN completion programs, it makes sense from a perspective of social justice (for nurses as well as for patients) to promote BSN completion for ADN-prepared RNs while continuing to recruit racialized students at both ADN and BSN levels.

The demographic data tell us that there is disparity in the numbers of racialized RNs compared to White RNs; the data do not tell us why the disparity exists. The following sections outline several factors that are possible reasons for this disparity among RNs. They include social disparities in health, racism, and academic barriers such as a lack of culturally-appropriate nursing care and education, and the effects of Whiteness on nursing education. Additionally, personal, cultural, and institutional barriers and assets identified by racialized nurses in the literature will be discussed.

Social Disparities in Health

The term *social disparities in health* refers to those unequal burdens of greater morbidity and mortality that are carried by non-dominant, racialized groups in comparison to the dominant (White) culture. Thus, while race is often considered to be a factor in social disparities in health, it is more accurate to state that the impact of the dominant culture on racialized groups is the greater factor (Baldwin, 2003). The twin issues of social disparities in health and care disparities regarding health, whereby marginalized clients receive a lower quality of health care than Whites, are documented to be more than 200 years old (Baldwin; Krieger, 2003). It has been demonstrated that social disparities in health may be decreased when people are cared for by nurses who share their culture and ethnicity (Management Sciences for Health, 2003). Therefore, it is important to examine not only healthcare access, but healthcare access to providers who share culture and ethnicity with clients.

Socioeconomic status. Lower socioeconomic status, i.e. economic disadvantage and educational inequality, is a factor contributing to social disparities in health. For example, the Latina/o population has a high school graduation rate of 60% and a college completion rate at the bachelor's degree level of 11% (USDHHS, 2005). This means that Latinas/os are less likely than many others to complete the education necessary to either access healthcare or to become healthcare providers.

Continuing, those with a lower socioeconomic status have fewer available opportunities to practice a healthy lifestyle, such as eating adequate amounts of nutritious food, exercising, and managing stress. They also have reduced access to health insurance and health care as a result of poverty. Latina/os earn less, proportionately, than any other racialized group and are more likely to live in poverty; 21.8% of Latina/os live in poverty, i.e. less than 200% of $20,000 per annum for a family of four, compared to 8% of Whites (USDHHS, 2006). People living in poverty, then, have dual barriers to overcome to gain admittance to a culture of healthcare, be it for personal access or for educational access to become providers. Baldwin (2003) has pointed out that healthcare disparities occur due to lack of providers (such as caused by the current nursing shortage), a lack of knowledge by providers as to how to provide culturally-appropriate care, and racism.

Provider-client relationships. The relationship between providers and clients may also contribute to healthcare disparity. When already marginalized clients perceive low- or lower-quality care, provider discrimination or bias, or discriminatory care, they tend not to return; thus, they do not receive routine preventive care nor necessary follow-up health care (Baldwin, 2003). The result is that if Whiteness were to be de-centered and the US compared to other developed countries, it would be clear that social disparities in health are greater in the US than in Europe, even though the US spends more money per capita--$5670 per

capita, $1.7 trillion overall (Centers for Medicare and Medicaid Services, 2005)--on health care than any other nation on earth (Baldwin, 2003), while doing poorly on health outcomes, such as infant mortality (ranked 35th) (Geography IQ, 2005). So, when there is a lack of providers of color, such as Latina/o nurses, then access to health care is decreased, and the burden of social disparities in health remains on non-White groups rather than being shared (Baldwin, 2003). This again demonstrates the importance of increasing the numbers of Latina/o and other nurses of color as one means of addressing social disparities in health.

Care differentiation. Racialized groups are less likely to receive health services even when controls are in place for such variables as income and insurance status (The Providers' Guide to Quality and Culture [PGQC], 2003). Racialized people often receive different care for the same illnesses/conditions as Whites and have worse health outcomes than White patients. For example, African-American men receive fewer cardiac catheterizations for the same symptoms as White men (PGQC). Also, African-American women receive fewer diabetic interventions than White women, and Latina/os receive less medication for pain than Whites (PGQC). Stereotyping, cultural bias, and uncertainty by providers all adversely affect clinical decision-making and contribute to unequal treatment of patients in the margins (PGQC). The most common results of social disparities in health for Latina/os and other racialized groups are increased cardiovascular disease, diabetes, and cancers, and these result in greater morbidity and mortality rates than for White Americans.

The leading cause of death for Latina/os is cardiovascular disease, followed by cancers (PGQC, 2003). Both of these diseases also occur at higher rates than in Whites. The next most unequally prevalent health concerns when compared to the White population are unintentional injuries, homicide, and HIV/AIDS. In addition, Latina/os are twice as likely to die from diabetes as their White counterparts and have higher incidence of hypertension, obesity, and tuberculosis (PGQC). Latina/o children suffer more asthma, diabetes, and unintentional injuries when compared to Whites or other racialized groups (Flores & Zambrana, 2001). The epidemiologic paradox of Latina/o women having a lower incidence of low birth weight (LBW) infants is often noted in the literature. However, when statistics for individual sub-groups of Latina/os are examined, some Latina/o groups-- such as Puerto Ricans-- have a high incidence of LBW infants compared to their White counterparts (USDHHS, 2005b). Thus, for numerous kinds of healthcare needs, Latina/os are less likely to receive necessary health services. One must question whether these differentials would continue if patients were to be treated in a culturally-appropriate manner, especially if the healthcare providers were from within their racial or ethnic communities.

Racism and health. The effect of racism on health is also a factor in social disparities in health (Krieger, 2003). While this phenomenon has not been well studied, the very nature of racism, along with stress, lack of access to services, and lack of trust in providers can be linked to diseases such as hypertension and

diabetes (Krieger). Institutional racism that limits access to health services and basic resources--such as nutritious food, safe neighborhoods, adequate housing, reliable child care, and well-paying jobs--has been cited as the actual difference in social disparities in health, rather than cultural or economic differences (Krieger). Institutional racism is sometimes called *covert racism* and refers to those policies and practices of institutions, such as government or employers, whose members systematically provide Whites with advantages while simultaneously marginalizing members of racialized groups. Often, Whites are not aware of how certain practices, which become institutionalized or common, serve to privilege them and to exclude racialized people from opportunities afforded to Whites. So, racism at its most ingrained precludes access to both health care and to healthcare education.

Impact of social disparities in health. When social disparities in health and disparities in health care are viewed more broadly than simply the results of lack of access to healthcare, and are expanded to include lack of access to culturally-appropriate health care, the need for increasing the numbers of Latina/o nurses becomes evident. If lack of access, which is actually a proxy for poverty, were the only problem, then the solution would be to create more clinics or to offer universal health care, for examples. Clients of a particular race or ethnicity tend to seek health care from similarly-oriented providers, yet 43% of Latina/os do not have a regular provider (National Cancer Institute, 2003). However, the responsibility for positively addressing social disparities in health in marginalized and racialized

communities does not belong exclusively to providers of color. Finding ways to increase the numbers of racialized healthcare providers is a responsibility that belongs to all of us. Since many racialized providers tend to work with vulnerable and underserved populations (Barbee, 1993), one of many purposes for increasing the numbers of racialized nurses is to address social disparities in health of underserved racialized populations by providing linguistically- and culturally-appropriate health care.

Racism

Many of the reasons for a lack of representation of Latina/os in nursing may be tied to racism within our institutions and within the nursing profession (Barbee & Gibson, 2001). Further, race is a socially-constructed, not a biological, phenomenon. Racism can be defined as those practices by both individuals and institutions that create and reinforce systems of oppression and restriction toward those against whom they discriminate (Krieger, 2003; Western States Center, 2003). Many studies in the areas of genetics and anthropology have demonstrated that there is no set of genes that determines race (Krieger, 2003). The concept of race is constructed based on skin color, and is significant and meaningful in its social and political contexts only as a means of unequally distributing resources (Andersen & Collins, 1997). The use of race and color to privilege some over others, especially in resource allocation, is a practice that nursing education must address. White students must also be taught that they cannot remain oblivious to

White privilege and think that they will be able to provide culturally-appropriate care. However, racism may be difficult to identify because it has been reframed and thus minimized in White society (Bonilla-Silva, 2003).

The topics of discrimination, racism, and White dominance, and their effects on health and nursing education (let alone their insidiousness in the nursing profession), are rarely discussed in nursing literature. Yet a recent survey of over 5000 nurses by the American Nurses Association (ANA) reported that half of the racialized nurses who responded believed that barriers to their progress in the nursing profession existed and that these barriers were related to race or ethnicity (Chwedyk, 2002). If nursing students are to learn about politics, society, cultures, and the economy, they must also be educated on the process and effects of racial discrimination. If we are to be intellectually honest in nursing research, then we must address the role that racism plays in social disparities in health.

Gonzalez, Marin, Figueroa, Moreno, and Navis (2002) conducted an auto-ethnographic study of 6 Latina/o doctoral students. The narratives of the doctoral students revealed that racism was pervasive in academic programs and that sometimes it was overt, at other times covert, and always present. In a classic article on nursing and racism, Barbee (1993) noted that there were several issues that made racism difficult to discuss in nursing. One was, and is, the professional value of nursing as a caring profession. If nurses care, then it would be logical to assume that caring people cannot be racist; thus, White nurses deny the very racism

that racialized nurses encounter and battle on a daily basis. Also, nursing culture and the stated philosophy behind many curricula posit that a caring nurse should treat all people the same. Treating people "the same," rather than with equity, parity and like sensitivity, leaves no room for an analysis of the institutions or environments that contribute to differential access, differential treatment, and poor health. Treating everyone the same, i.e. "the color-blind perspective" (Barbee, p. 351), does not mean that the nurse is providing appropriate care. Barbee stated that when cultural diversity is discussed in nursing education, racism gets hidden behind such concepts as ethnocentrism in a way that allows a criticism of ethnocentricity, but that rarely looks at how racism influences nursing and nursing care. Because racism is not typically addressed overtly in nursing, a more critical look at what is being taught as "cultural diversity" is required. In a later article, Barbee and Gibson (2001) called for nursing education on cultural diversity and culturally-appropriate care to include a long, hard look at racism in society and in the nursing profession. They stated that racism cannot continue to be masked behind terms such as "diversity" and "cultural competence" (p. 243). Nor can White nurses continue to refuse to see the institutionalization of racism in nursing or continue to call it an "individual attribute" (Barbee & Gibson, p. 243).

In a study if immigrant nurses' experiences with racism, Hagey et al. (2001) found that nursing education programs and organizations need to look at recruitment and retention efforts and then confirm the usefulness of these strategies

with racialized students and nurses. As a result of their findings, Hagey et al. suggested that a broadened concept of caring, to include anti-oppression, be taught as one means of explicitly addressing racism.

Racism is also present inside of nursing programs. Using critical hermeneutics, Byrne (2001) examined three nursing fundamentals textbooks for racial bias specific to African Americans. She found that racial bias was prevalent in the textbooks, for example the word "normal" being used in the nursing textbooks to describe White skin color or hair (Byrne). The portrayal of African Americans was also biased according to the findings. An emphasis on Eurocentric norms, which included a covert curriculum of euro-centricity that tended to negate perspectives and experiences from racialized groups, was also found. Thus, White culture as emphasized in most nursing curricula (Byrne) resulted in numerous barriers for racialized students to complete a nursing education program. A suggestion that arose from the study was that culturally-appropriate nursing care be taught through increasing the awareness of racial discrimination.

Barbee and Gibson (2001) asked White nursing students why they believed there were fewer racialized RNs than White RNs. The White students frequently responded that it was because racialized people lacked finances or received inadequate educational preparation and that racialized nurses do better in lesser-skilled nursing roles because they were not as bright as White students (Barbee & Gibson, 2001). These statements demonstrate that White nursing students carried

negative stereotypes about racialized groups that could be addressed within a culturally-appropriate, antiracist nursing curriculum.

Academic Obstacles

A number of obstacles exist for Latina/os that contribute to a lack of representation in nursing programs. They include cultural issues, a lack of culturally appropriate care and education, and the effects of Whiteness on nursing education.

Cultural issues and nursing education. Culture cannot be observed and reported from a single standpoint, nor does one perspective of culture fully represent the culture that was/is being constructed (Allen, 1996). Knowing one representation of a particular culture, such as Latina/o, does not mean that for all Latina/os the same kind of nursing care is appropriate. Since there are dozens of cultures within the broad label of *Latina/o*, such as Mexican American, Latin American, Puerto Rican, and Cuban, it would be practically impossible to know exactly what culturally competent care looks like for such a wide variation of people. *Culturally-appropriate care* communicates the idea of providing care that is appropriate to the individual patient, based on his/her own cultural preferences, rather than imposing assumed health practices on people of color based on stereotypes or lists of "typical" health practices. Further, *competence* is not something arrived at; it is a process that begins with a close and clear look at racism and how it affects social disparities in health. It is important to note that the

term and concept of *culturally-competent care* has been used extensively to disguise racism in nursing (Barbee & Gibson, 2001). The concept of "cultural competence" has been used as nothing more than a list of procedures or preferences by racial or ethnic groupings. Instead, cultural competence must include analyzing the contexts within which each person lives and reflecting on how to change one's own practices to fit that which best serve the client, including those cultural beliefs and practices related to health that have been beneficial to the client in the past (St. Clair & McKenry, 1999). If an increase in the numbers of racialized nurses enhances nursing practice as well as the health of the non-White population, then an increase in the numbers of racialized students and faculty could create a more socially just nursing education (Terenzini, Cabrera, Colbeck, Bjorkland, & Parente, 2001). However, an issue that has been repeated frequently in the literature as potential reason for lack of enrollment or completion of nursing school is the lack of culturally-competent or culturally-appropriate nursing education (e.g. Barbee, 1993; Barbee & Gibson, 2001). Therefore, nursing curricula will require adjustment in order to recruit and retain additional racialized students in nursing programs.

Goba (2001) made a point that the provision of culturally-appropriate care is lacking, not only within the profession of nursing, but in nursing schools as well– in content, in pedagogy, and in how nursing faculty members relate to racialized students. Using a Euro-centric curriculum diminishes the values and importance of

racialized health practices that contribute to health and health care. For example, when nursing students are taught only about how to care for the skin and hair of the White majority, it not only does not benefit the racialized client, it also gives a message that difference (i.e. non-White) is not valued. Goba suggested that instruction be included in nursing education programs about diet and personal care for racialized patients, as well as the adoption of a multicultural perspective in nursing programs, demonstrating respect for all students. A final recommendation was to decrease the high school dropout rate of racialized students by working with school counselors, parents, and students to provide adequate preparation so that more racialized students would have the opportunity to enter nursing programs.

In a compelling article, Arredondo (2002) spoke to the problem that culture can pose for Latina/o women who wish to pursue higher education. For instance, the cultural value of caring for the family may be at odds with the value of education. She commented that the male dominance that has traditionally been a part of Latina/o cultures is also a problem, although it is changing as more Latina/o women enter the workforce and as their educational levels slowly increase. A question not pursued in this literature review, nor in this study, is how the *machismo* of Hispanic cultures and educations intersects, confounds, or creates a paradox with the patriarchic dominance of White culture and education under the umbrella of racialization.

Culturally-appropriate nursing care and education. Culturally-appropriate nursing care is enhanced by presence of racialized RNs. Clair and McKenry (1999) used a triangulated design with 200 senior and graduate-level nursing students to explore the relationship among cultural self-efficacy, cultural competence, and international clinical nursing experiences. They found that nursing units are more able to provide culturally-appropriate care when there is increased representation of racialized RNs on that unit. This is important to note since, as discussed earlier, health and health care of racialized populations is improved when care is delivered by providers of similar racial or ethnic backgrounds.

Barbee and Gibson (2001), as well as Abrums and Leppa (2001), questioned the benefits of teaching culturally appropriate nursing care without first recognizing and then addressing the pervasive issue of racism both within nursing schools and the nursing profession. One cannot provide culturally-appropriate care unless the issues of racism and discrimination that are also present are addressed (Abrums & Leppa). Yet, little is taught in nursing education programs about how race, class, and gender affect health.

Whiteness and nursing education. It is important to look at culture in relationship to the dominant (White) U.S. culture and in the context of power and privilege. How this relationship and its effects shape the experiences of oppression are more important than just knowing about different cultures for the sake of information (Andersen & Collins, 1997). Not taking time to understand the

relationship of Whiteness to racialized cultures can result in further marginalization (Madrid, 2001). The dominance of White culture in the United States has had a negative effect on both population health and nursing education. When the question of diversity arises in conversations about the racial or ethnic composition of students in nursing education programs, the focus often turns to a lack of gender diversity rather than racial or ethnic diversity (Barbee & Gibson, 2001). While gender diversity is an important issue in the nursing profession (Meadus, 2000), it should not be used as a diversion from racial or ethnic diversity.

According to Phillips (2000), in a conceptual article on language use and multicultural education, one must begin by looking at the issues of White power and privilege, not just within colleges and universities, but within nursing education programs. It is important to keep in mind that a White educator can engage students in examining issues related to diversity, but unless the educator realizes the privileged position of choosing to acknowledge their privilege or not, White students will remain oblivious to their own privilege, a privilege that racialized students do not have. It has been noted that being oblivious to White privilege is also a carefully protected "privilege" of being White (McIntosh, 1997). A White American can choose to state his/her different ethnicity and race or not; he/she can even choose which ethnicity to acknowledge; a racialized person is in the position of having no choice but being forced to acknowledge her/his "brown" ethnicity (Waters, 1997).

In an article on multicultural education, Howard (1999) suggested that a new identity of Whiteness as a non-dominant group identity needed to be disseminated. We Whites need to acknowledge that we have been racist, meaning we have benefited from power and privilege. This acknowledgement, along with the realization of the reality that Whites will no longer be the dominant group in terms of population numbers in the United States within a few years (Molina, Molina, & Zambrana, 2001), can help to shape a new location for Whiteness in society, including in the area of nursing education--long a White, middle-class, female-dominated profession. Howard has called for a move forward "from dominance to diversity" leading to multicultural, antiracist nursing education.

Institutional, Personal, and Cultural Obstacles and Assets

In addition to the societal issues discussed earlier, there are multiple institutional, personal, and cultural obstacles as well as assets for racialized students entering or completing nursing education. In a phenomenological study, Dickerson, Neary, and Hyche-Johnson (2000) conducted focus groups with 11 American Indian graduate nursing students to find out about the learning experiences of these American Indian nursing students who all attended the same university. Four themes emerged: a shared common unwritten knowledge, being unaccustomed to a rigid academic environment, barriers between students and faculty and strategic survival by American Indian students. The investigators concluded that a more flexible learning environment would be a major factor in

promoting student success. They also suggested that racialized nursing students be given more informal knowledge about the academic setting and that nursing faculty members examine their institutions for barriers that may leave nursing students of color feeling alienated and isolated.

In a review of the academic records of 150 American Indian practical nursing students, Manifold and Rambur (2001) found that older students had a greater chance of academic success in nursing programs, but that students with low math scores tended to have a greater chance of not completing a nursing program. Grade point average was not found to be a significant predictor of successful completion. They also found that the central concept of caring in nursing actually provided a means for nurses to continue to discriminate against others without having to challenge their self-images as non-racist (Manifold & Rambur). A limitation of the study was that it examined only information about practical nursing students at one college. However, the study did point out the importance of maturity, academic preparation, and clear instruction regarding the concept of caring for American Indian students to be successful in nursing programs.

Yurkovich (2003) interviewed 18 American Indian BSN students to explore assets that supported educational success and identified several student success factors for completing a nursing program. These included students being focused on the goal of completing their programs, adjusting to the dominant culture, maintaining their own cultures, investing in self-assessment, establishing support

groups, and becoming socialized into the roles of student and nurse. Success factors related to faculty included that faculty were compassionate and nurturing, accepting of cultural differences, believed in student capabilities, were able to create informal and interactive learning environments, and were friendly, intellectually challenging, and supportive of the personal, holistic growth of the students (Yurkovich). The sense that they were not perceived to be as bright or as prepared as White students contributed to American Indian students' perceptions of a lack of support from academic institutions and feelings of alienation. These negative experiences lead to increased stress and adjustment difficulties in the American Indian students (Yurkovich).

Villaruel, Canales, and Torres (2001) conducted 6 focus groups with 37 Latina/o RNs throughout the United States to discover what they called *barriers* and *bridges* that existed for the educational mobility of Latina/o nurses. *Educational mobility* refers to LPNs being able to move into RN education, associate degree RNs being able to move into BSN programs, and BSN RNs being able to study for a Master's degree. Villaruel's et al. (2001) concept of *bridges* differed from *assets* in that bridges was used to refer to those factors that helped nurses to continue in their educations after they had completed at least one "rung" in the educational ladder, for example moving from being an LPN to becoming an RN. Assets were those factors that helped students to complete whatever piece of

their education they were currently in and referred most specifically to assets that assisted racialized students to complete an RN nursing program.

Four categories of barriers and bridges were identified: financial, institutional, cultural/personal, and language (Villaruel et al., 2001).

Financial barriers included the high cost of a BSN education compared to an associate degree (ADN) education, and the need to work throughout their education, often resulting in students taking longer to complete their studies than more economically-privileged students.

Under the category of *institutional barriers* were included unsupportive faculty, perceptions of discrimination, and poor or no advisement beginning in high school when guidance counselors directed students of color toward two-year or technical colleges rather than helping the students do what was necessary to gain entrance into a four-year university (Villaruel et al., 2001).

Cultural barriers included conflict between cultural expectations for Latina/o women and a desire to pursue an education, limited family support, and having to choose between educational and family responsibilities (Villaruel et al., 2001).

Language barriers were two-fold. When English was the second language, there were issues with proficiency. However, many participants reported that having an accent, no matter how well they spoke or understood the English language, put them at a distinct disadvantage, and that faculty and other students

viewed the presence of an accent as evidence of a lack of intelligence or preparation (Villaruel et al., 2001).

Financial bridges, such as financial aid and tuition reimbursement and *institutional bridges,* such as supportive faculty, support, mentorship, and role modeling of faculty or peer group members were cited frequently as critical factors in educational mobility (Villaruel et al., 2001). C*ultural/personal bridges* were supportive family and professional aspirations, such as becoming an RN as a means of improving the health of Latina/o communities.

Based on the findings, Villaruel et al. (2001) made several conclusions and suggestions. They concluded that the ADN degree should be offered as a step on a career ladder toward higher degrees and that flexibility in course offerings for working adults may be an effective means of increasing the educational status of Latina/o nurses. They also concluded that peer and faculty support needed to be developed and supported by institutions. Further, institutions must take into account the centrality of the family and become more inclusive of family in the education of Latina/o students by assisting families to value a family member becoming an RN as an asset to their communities. Finally, they suggested that faculty members take time to plan how to best support Latina/o nursing students and be held accountable for harmful behavior that is detrimental to student learning.

Evans (2004) identified numerous obstacles to successful completion of nursing programs in a phenomenological study of 7 American Indian and Latina/o RNs. The obstacles included: a) limited recruitment and retention efforts, b) nursing education programs being unfamiliar with the concept of multicultural education, c) inflexible learning environments, d) false assumptions by faculty about ethnic differences, e) detachment and distancing by nursing faculty, f) misunderstanding of "cultural competency," g) evidence of racism in nursing texts, h) threats to ethnic identity, i) student loneliness and isolation, and j) family obligations.

Weaver (2001) also studied the educational experiences of 40 American Indian RNs and reported similar findings such as little support for Indian culture and little cultural content in the nursing programs they attended. Racism, stereotyping, and isolation were described as common occurrences, which caused struggles during their nursing education. Weaver called for replication of this study with additional groups of racialized RNs, including Latina/os.

Evans (2004) suggested implementing a nurturing, caring environment, where the different assets all students bring to nursing school are recognized, as a replacement for the more hostile environments many racialized nursing students have described.

Table 1 ***Barriers and Assets Identified in the Literature***

	Positive	Negative
Institutional Factors	-Flexible learning environment -Financial aid -Ethnic diversity in faculty and students -Mentors -Student support groups -Supportive faculty -Role models -Limited recruitment efforts	-Lack of sufficient financial aid -Rigid academic environment -Hostile, unsupportive faculty -Perception that students not bright enough -Perceptions of discrimination -Racism -Poor advisement -Lack of culturally appropriate education -Lack of support for cultural identity --Stereotyping
Personal Factors	-Maturity (age) -Focus on a goal -Persistence	-Low math scores -Work obligations -Loneliness -Isolation -Family obligations
Cultural factors	-Ability to adjust to dominant culture -Maintaining own cultural identity -Family and community support	-Cultural expectations of woman as caregiver -Limited family support -Low English proficiency -Presence of an accent

Discussion of Literature

The literature makes clear that the numerous social disparities in health experienced by Latina/os point out the need for increasing the numbers of Latina/o nurses. It is also evident from that literature that racism remains an obstacle both for students in nursing programs as well as for Latina/o nurses attempting to advance their educations and careers. Evans (2004), Yurkovich (2003), Villaruel et al. (2001), and Weaver (2001) have brought to light many obstacles, as well as potential solutions, to the recruitment and retention of Latina/o and other racialized nursing students. There are institutional obstacles common in academics as well as obstacles specific to nursing education, such as a lack of culturally-appropriate nursing education. Personal and cultural obstacles often involve family

responsibilities or a lack of understanding and support of racial or ethnic identity. Although the fact that change must occur was evident in the literature, few specific strategies were offered.

Evans (2004) and others have called for the implementation of a "caring curriculum" for nursing programs as one means of addressing some of the obstacles to completion of nursing education by Latina/o students. However, without addressing the issue of racism, caring curricula carry the danger of continuing "color blindness" in nursing. Teaching about racism, as well as promoting instructional methods that address the diversity in learning styles and cultural values of Latina/o students, will also address some of the barriers evident in the literature (AFT, 2004). An example is Bevis and Watson's (2000) caring curriculum for nursing that is based on the basic tenet of human freedom, with an emphasis on mutual respect and mutual caring between faculty members and students. This can be difficult when a faculty adheres to a hierarchical model and/or is oblivious to White privilege.

This review of the literature demonstrates numerous obstacles for racialized nursing students, some potential assets that help them to be successful, and an interest in increasing the numbers of racialized nursing students. Most of the work published to date concerns American Indian nursing students, yet there has been little research conducted on strategies to specifically address the low numbers of Latina/o students and Latina/o RNs. Thus, little is known about the changes

needed within nursing education to diminish obstacles and to promote assets necessary for success. This is particularly important in light of the increasing numbers of Latina/os in the United States compared to the small numbers of Latina/o RNs, as well as the lack of access to health care, let alone culturally-appropriate health care, that Latina/os experience.

To date, there have been no studies published that exclusively sought the perspectives of Latina/o nursing students about the assets and structures they believe are necessary to be successful in a nursing program. The knowledge gained will provide information about how to integrate Latina/o cultural content into nursing education, as well as how to increase supports and diminish obstacles for Latina/o nursing students. The ultimate goal is to increase the representation of Latina/os in nursing. Consequently, this study explored the experiences of Latina/o registered nursing students and Latina/o RNs in order to document what personal and cultural assets are needed by Latina/o students to successfully navigate nursing education (Villaruel et al., 2001), as well as what institutional assets nursing education programs must create or utilize to increase the numbers of Latina/o students completing registered nursing programs. This information will provide policy makers, institutions, and educators with information to create effective strategies to increase the numbers of Latina/o RNs. It will further serve to bring to light those areas of power imbalance, racism, and discrimination that may be experienced by Latina/o nursing students.

Methodology

Critical scholarship focuses on power relationships and exposes oppression in society with the goal of increasing social justice. When applied to nursing scholarship, critical thought examines those factors that prevent people from reaching their full health potential because of oppression, racism, and dominance by a particular group or groups. Additionally, in critical scholarship, research participants are not the subjects of research; rather they are the willing sources of knowledge (Boutain, 1999). Critical ethnography was appropriate to this study because I sought, through the voices of Latina/o nursing students, to make connections between health and society, between nursing programs and racialized nursing students, and ultimately between the nursing profession and racialized RNs. Long term goals are to increase the numbers of Latina/o nursing students by reducing the barriers in nursing education that serve to keep Latina/o students from being fully represented and to enhance assets that will allow Latina/o students to successfully complete a registered nursing program. This, in turn, will address social disparities in health that Latina/o communities experience as more Latina/o RNs become available to provide culturally-appropriate care to these communities.

Critical Ethnography

Critical ethnography has its roots in conventional ethnography, defined as form of cultural inquiry involving description and analysis through interpretation of meanings (Thomas, 1993). Ethnography is any form of inquiry that has as its aim to

describe and interpret the ways people in a group, organization, community, or a cultural group experience and make sense of their lives and their world (Bentz & Shapiro, 1998; Chambers, 2000). In this definition, ethnography is more heavily defined by the subject matter of culture than by any particular set of methods. Before the 1960s, traditional ethnographers attempted to simply describe cultures other than their own while attempting to remain both invisible and neutral (Bentz & Shapiro, 1998). As ethnography evolved, it began to include observation of behavior as it is constructed in societies, giving attention to moral and social rules and how systems of ideas interact with individuals (Bentz & Shapiro, 1998). The results then have come to include accounts, descriptions, representations, and interpretations of people's lives that are situated both historically and politically, as well as personally (Tedlock, 2000).

Traditional ethnography moved toward contemporary ethnography by expanding from strictly participant observation, whereby the meaning was in the method (Thomas, 1993), to using additional sources of data such as words, texts, gestures, and art forms. The purpose of ethnography changed from description to interpretation, moving toward dialog and communications rather than exclusively cultural descriptions (Denzin & Lincoln, 2000, p. 300). Additionally, conventional ethnography relies upon grounded theory whereby the theory "emerges" from the data. Critical ethnography has shifted toward analyzing unequal power relations and emancipatory theory building (Lather, 1991, p. 55).

In the 1960s, a group of U.S. researchers began to do "urban ethnographies" (Thomas, 1993, p. 11) of marginalized populations in Chicago. From these, critical ethnography began to emerge as researchers attempted to be more reflexive in their ethnographic writings in the 1980s and 1990s, embracing critical social theory. During this same time critical social theory challenged traditional ways of defining truth and the metaphors and theories associated with "truth" (Thomas).

Critical ethnography can be considered a subset of conventional ethnography. The two methodologies share a number of commonalities, but they are also different in significant ways. Both conventional ethnography and critical ethnography share qualitative interpretation of the data collected. While conventional ethnography displays meanings through interpretation, critical ethnography involves making judgments about meanings through a process of choosing between various conceptual alternatives (Thomas, 1993). The purpose of critical ethnography is to challenge the status quo of such things as research, policy, and other social activities where power differentials are present. This is done for the purpose of building a more equitable society (Lather, 1991). Therefore, critical ethnography goes beyond describing or interpreting culture, to changing it (Thomas). Critical ethnography is a form of critical scholarship that employs a form of analysis requiring reflection as well as judgments, while conventional ethnography is a description of culture along with analysis (Thomas). Both are concerned with culture, but critical ethnography examines culture, knowledge and

action in a reflective manner. It is as though critical ethnography takes a further step to complete what conventional ethnography has begun, because critical ethnography has an agenda beyond describing a culture and speaking for a particular group. Rather it is a political form of inquiry that requires one to act upon values in a political context (Thomas). Further, critical ethnography reveals hidden agendas, rather than describing what is overt. It is concerned with power because it reveals and analyzes power issues such as where the power does and does not lie, as well as how it is used and misused socially, economically, technologically, and culturally to emancipate, oppress, exploit, and/or dominate (Bentz & Shapiro, 1998). It also challenges commonly held assumptions that may be forms of unacknowledged oppression.

A focus on context is essential in critical ethnography, since it focuses on how cultural dynamics, i.e. the parts, intersect to construct a social system (Denzin & Lincoln, 2000, p. 281). To effect change (a major goal of critical ethnography) the context may need to be changed. These ideas about context point to a focus on debunking "common sense" understandings and pointing to alternate understandings of a particular area of society. Critical ethnography asks how the greater social system reproduces itself through a particular phenomenon (Bentz & Shapiro, 1998). The low percentage of Latina/o RNs compared to the total percentage of Latina/os in the United States is an example of the dominance of Whiteness in society that is reproduced in the nursing profession.

Over the past 40 years, critical ethnography has changed to a decreased focus on truth and toward greater interest in positionality. Critical ethnography stems from a desire to find out what there is to know on a deeper level than mere description, moving to the level of meanings that affect how power and resources are distributed and how people are labeled and put into class levels (Thomas, 1993). Critical ethnography encompasses a concern for social justice along with a desire to make positive changes in society (Carspecken, 1996). It includes a desire to examine and delve into how cultural meanings affect one's existence or into injustices, social control, allocation of resources (Thomas) and, most importantly, how power is used to privilege or disadvantage members of society.

My role as critical ethnographer was to take an insider approach, whereby I was neither neutral nor impersonal. Instead, I attempted to work within the same culture as that of the participants, rather than my own. There are some very important reasons for this. First of all, critical ethnography is personal, since it began with a desire to address an injustice or inequity in society. Additionally, I attempted to work as an insider in order to do critique, and to do so required identification with the norms, standards, and values of the culture with which I was concerned (Bentz & Shapiro, 1998). Critiquing points to what is, and then asks what could be (Thomas, 1993). In other words, I, as the critical ethnographer, would not accept the dominant discourse. I have a vested interest in what was learned and how it can be used to facilitate change. It is important to note as well

that while I may have and may voice my agenda, I also needed to be careful that I did not set out to prove a point, in case the information gathered did not lead to that end (Thomas). Instead, the participants and I were active together in constructing and validating meanings (Lather, 1991). Data sources were multiple (triangulation) in order to get the most relevant and comprehensive information. Data came from people, observation, and my own experiences (Thomas).

In summary, critical ethnographic research affirms my role of researcher as an engaged insider, who was required to critically reflect on the insider role and examine how my values and involvement affected data generation, analysis, and discussion. Through the process of critical reflection, I became more aware of my own thought processes (Thomas, 1993), which required that I recognize that I have a position that frames how I see the world. Like all research, this critical ethnography was not a neutral endeavor; there were personal and political reasons why I chose the research topic that I did. Finally, the goal of critical ethnography is to contribute to human emancipatory activities. While this was not accomplished within the time frame of the study, the goal must remain a part of the research endeavor (Bentz & Shapiro, 1998). As a critical ethnographer I remain an optimist, seeing what can be rather than only what is.

Purpose

The tenets of critical ethnography informed the questions that were asked in the focus groups and individual interviews. Since assets must be viewed in light of

the barriers frequently encountered by racialized nursing students, I was explicit about the obstacles when asking about assets. The questions I asked (see Appendix B) included asking about issues related to power differentials since many of the obstacles involve inequitable allocation of resources, racism, cultural differences, and areas where power is used implicitly and explicitly.

By entering nursing programs at either the BSN or ADN level, Latina/o nursing students are also entering into the culture of nursing education, while bringing their own culture(s) with them. Nursing education reproduces many of our U.S. preconceived notions about Latina/os, such as that they are lazy or less intelligent than Whites. Latina/os are poorly represented in nursing. A critical stance is needed in order to challenge the status quo of nursing education through the stories and experiences of those who are marginalized in nursing education. Power differentials always exist between nursing instructors and students, and little is known about the impact of these unequal power relations from the perspective of a Latina/o student.

Thus, the purpose of this research was to document the institutional, personal, cultural, or other assets, i.e. resources, attributes, and advantages, that Latina/o nursing students used to be successful in a nursing program.

Design

A critical ethnographic interpretive research design, using observation, focus groups, and in-depth interviews, was used to generate data on the

institutional, personal, cultural, and other assets Latina/o students used to be successful in their nursing programs. Data on obstacles were also gathered. This study was retrospective, which is not unusual in ethnography (Thomas, 1993).

Sample

Participants were recruited from undergraduate ADN and BSN programs in the Pacific Northwest using a convenience sampling technique. Human subjects approval for the study was obtained from the University of Washington, Human Subjects Division prior to recruitment. Informed consent and the opportunity to drop out of the study were built in to the methodology of the study. Participants were provided transportation and child care as needed, as well as food during the sessions and a $20.00 gift card to a local department store.

Two RN focus groups and one student focus group were conducted. The two RN focus groups had three participants each; the student focus group had four participants. One participant was asked from each focus group to participate in a semi-structured interview to gain additional information as well as to clarify and confirm my understanding of what was discussed in the focus groups. Additionally, three individual interviews were conducted with participants who either could not or were not willing to participate in a focus group, but who were interested in participating in the study. Total participants were 13.

Descriptive Statistics

The demographics collected provide descriptive statistics for this ethnographic study. All participants self-identified as Hispanic, Latina, or Latino. All 6 student participants spoke English, understood spoken and written English, and were enrolled in the last two quarters or last semester of an ADN or BSN RN program. All 7 RN participants spoke English, understood spoken and written English, and had completed an ADN or BSN RN program within the past three years. Of the participants, one self-identified as male, and 12 self-identified as females.

Of the RNs, two had earned a Bachelor of Science in Nursing (BSN), and five had earned an Associate degree in Nursing (ADN). Two had also previously earned other degrees. Two students were enrolled in BSN programs, and the other four were in ADN programs. One of the students had previously earned a degree. Participant ages ranged from 22 to 40 years old. Ten worked 16 to 35 hours per week while attending school. The majority of RNs were employed full time in hospitals, and 2 worked in community clinics. Nine participants had children in the home while they were in school, and the number of children ranged from 1 to 4. Of the total participants, 9 spoke English as their first language, and 4 spoke Spanish as their first language. Eleven were born in the US, and two were born outside the US in Mexico. Eleven identified themselves as Mexican-American; 1 Cuban and 1 Puerto Rican were also represented in the sample.

Table 2 ***Descriptive Statistics***

Gender:	
Females	12
Male	1
Age range:	
22-40 years old	
Nursing degree type:	
BSN	4
ADN	9
Work hours while in school:	
16-35 hours per week	10
10 hours or less per week	3
Children in the home while in school:	
1-4 children at home	9
0 children at home	4
First language:	
Spanish	4
English	9
Country of family origin:	
Mexico	11
Puerto Rico	1
Cuba	1
Birthplace	
United States	11
Mexico	2

Data Analysis

I transcribed all of the focus group and individual interviews as a means of being fully immersed in the data. Once each interview or focus group was transcribed, it was analyzed individually with code words highlighted and then defined in a code book (Appendix A). A master transcript composed of all the transcripts was created and again was analyzed for codes. Throughout the analysis process, attention was paid to power imbalances that may have been taken for granted as "normal" as well as to who benefited from the way things were done.

This was a repetitive process as I kept returning to the data and rereading the transcripts to consider and reconsider what I believed I had gleaned; I then took time to think about it in additional ways. Because I was so familiar with the tape recordings due to transcription, I often remembered how the participants had used tone, emotion, and inflection. "Is there another way to view this?" was a question I asked repeatedly. I also attended to what was not said, as well as to what was said, to discover what power differentials or constraints were in place that may have disadvantaged the Latina/o participants to the advantage of others (Thomas, 1993).

Trustworthiness. Trustworthiness of the data was maintained through the use of the focus group participant individual interviews and by requesting that participants confirm my understanding of what they were saying as the focus group took place. I was also able to share my findings with Latina/o nurses not involved in the study, who confirmed that I was accurately reflecting some of their own experiences as Latina/o nursing students. Additionally, the information gathered made sense in light of previous research and in light of the experiences and understandings of the participants. Thus, I was comfortable that I had a clear and accurate understanding of what the participants were telling me.

As an integral part of the data analysis, and as another means of maintaining trustworthiness, I spent numerous hours reflecting (systematic reflexivity) on the interviews and asked how they were the same or different from what had been previously reported in the literature. Was I gaining an accurate understanding?

How did the questions I asked affect the answers? Who had I not attended to? What was I missing? These questions led me back to the data again and again. As I poured over the transcripts, it became clear that the obstacles the participants described to me were the same as those previously described in the literature.

A final way of maintaining trustworthiness was to be explicit about my position, my privilege, and my objectives to the Latina/os with whom I spoke. Often, they did not want to begin the focus group until they had a clear picture of who I was and what motivated me. They wanted to hear my story before they shared theirs. Once they felt comfortable, we could proceed. This provided me with a means of continual reflexivity as I had to vocalize who I was and how my background influenced my work.

Morse and Field (1995) provided the approach to data reduction I used in this study. They described the iterative process whereby data are first coded, then collapsed into categories, then organized around broad themes.

The data were divided into seven categories from which two themes were extracted. The categories included: 1) institutional obstacles, 2) cultural obstacles, 3) racism, 4) institutional assets, 5) personal assets, 6) social assets, and 7) cultural assets. The two broader themes that describe these categories were: *obstacles to be overcome* and *assets used for overcoming and resistance.* The first three categories fell under the theme of *obstacles to be overcome,* and the fourth through seventh categories fell under the theme of *assets used for overcoming and resistance.*

Table 3 ***Categories and Themes***

Theme: Obstacles to be overcome

Categories:

Institutional obstacles:
"I was accepted into nursing school but then told I had to wait but that was not true. Our people (Latinos) get robbed because we don't know we have other choices" (Elena)

Cultural obstacles:
"It's tough to balance the expectations of my culture because I have tons of homework and don't always have time for family gatherings..." (Lupe)

Racism:
"I see myself as less than others (Whites) culturally. When I walk into a classroom I feel that I am lower than the other students." (Liliana)

Theme: Assets used for overcoming and resistance

Categories:

Institutional assets

Personal assets
"I wanted to be a nurse since I was small. I think about the fact that every day is a little closer to the sueño (dream). That is what keeps you going; it is a vision for yourself or your family." (Amalia)

Social assets
"There were some strong voices in our class, and I did not have to say anything, but I would back them up. If the class didn't like something, we said something." (Gloria)

Cultural assets
"I also have a good personal trait and that is called *cabezona* in Spanish and that means stubborn." (Gloria)

Findings

Obstacles to be Overcome

The theme of *obstacles to be overcome* describes the numerous obstacles, or barriers that the participants described as being in place that slowed or could have prevented their progress. One participant also described obstacles as *blockades.*

Institutional obstacles. Numerous *institutional obstacles* were faced by participants. Power differentials between faculty, staff, and students were clearly expressed by the participants, and they were clearly embedded in the institution and its structures.

Some participants also described that just the fact of being in a nursing program was intimidating, knowing that it was a difficult program. Others felt that being intimidated was a role they had to take on as a part of being a nursing student. Another participant felt that intimidation was an intentional component of the nursing program where she attended.

> "I just think that it's my role to be intimidated, so I just accept that they are the teacher and know more. If they choose to ask me questions that they know I don't know, that's not my fault. Eventually, I will know. I just accept it or act like I get it when I don't." (Carmela)

Another participant spoke of her fear of speaking up about an instructor whose insensitivity was believed by students to have contributed to an Asian nursing student's suicide.

> "...Then 2 weeks before graduation she made a mistake with insulin. She had the instructor check her, which is what every RN does, and the dosage was wrong. She didn't give it, but the instructor told her 'go home now and never come back.' They knew she [the student] was on antidepressants but they made her go home alone. That night she committed suicide. I had a fear that I couldn't win so I decided to wait until after graduation to speak up about it. Graduation was too important to me to risk getting kicked out, so I waited. I felt bad about that." (Matilde)

When access is limited by certain criteria, *gate keeping* occurs. It results in fear and intimidation. In admissions, gate keeping includes minimum grade point average (GPA) standards, prerequisite courses, and standardized test scores. In a nursing program, gate keeping includes attitudes, power differentials, and the inherent rules of mainstream university culture.

The statements of one participant, "It would be easier if I were White" and "sometimes I just wish I were White" (Maria), demonstrate that it is difficult being a Latina in a nursing program and that she saw greater advantages to being White when it came to achieving success. Some noted that they had less power than their instructors and thus expressed a fear of speaking up:

> "They used fear to intimidate us. They had no tolerance for accents, or ESL students. They use mistakes in punctuation to 'filter out' people, especially ESL students. All the students were scared of the instructors in

> the nursing program. The instructors set out to intimidate us. Now in nursing school, I was essentially told 'you are nothing.'" (Matilde)

Cultural obstacles. Cultural obstacles are the incongruencies between what is taught and the expectations of students coming from racialized cultures. These students expect that certain norms of their culture will be followed. Institutions and faculty expect that all students, reasonably or not, will conform to the norms of the current academic culture into which they have been accepted.

Students spoke of incongruence between what was taught and what was practiced. An example is the student who was told that her family was important and should come first, but when she attempted to put her family first in a particular instance, she did not expect the response she received.

> "One of the professors got irritated with me when I stayed home with my daughter when she got sick. She said I was irresponsible... I told her my values were family then school, and she supported that, but when it came down to it, it was a different story." (Silvia)

Cultural obstacles were also described as familial. Family resonated with all participants as an integral part of Latino culture and as having major impact and influence on their nursing education. As an obligation or responsibility, family could be an obstacle, since the responsibilities of family tended to fall to the women. For many, family obligations required balancing.

> "Being Latina [in a nursing program] was more of a struggle for me… because of the cultural expectations [of women]. Other friends or activities may be laid aside for school but not the family." (Liliana)

Another said:

> "It's tough to balance the expectations of my culture because I have tons of homework and don't always have time for family gatherings, which we have a lot of! This causes conflict. So the message I get is that I probably won't succeed, that family is more important than school." (Lupe)

A nod to family or family members as a support often unleashed stories of family members as an obstacle, especially along gender lines. One participant discussed her Latino husband:

> "At the same time he was supportive saying, 'you've made it this far; carry through with it'… he was also making it hard for me saying 'Hey, look at the house, are you gonna wash me any pants?' or 'I'm hungry, my stomach is growling.' Being Latina made it harder because you're the mom, the wife, the cook, and you don't have the guy for help and if you ask them, you're being 'a White girl.'" (Gloria)

Another participant stated:

> "My husband was not supportive at all, but my co-workers, my parents, and even my husband's aunts were very supportive and watched the baby. So now my husband realizes that I am not going to let him stop

> me anymore, so he is much nicer to me. I should have listened to my sisters, because they married White guys, and they told me you could just give them Hamburger Helper, and they'll be happy. Well, little did I know I had to be frying tortillas and making tacos, which is all time consuming stuff." (Lydia)

Participants discussed what families thought about their choices to become nurses, and what kinds of support and encouragement family was able to provide and not provide: "I didn't have my parents' support for an education. It was not important to them" (Lupe).

They also talked about feeling an obligation as well as a conflict regarding their new ability to improve their families' economic condition.

> "The thing is, it is a big threat for the female to make more money than the male. I think it's that way in all cultures but especially for Hispanics. They want to be macho, they want to be the caregiver and their machismo plays a role. They're the man and they should be able to take care of the family and everything." (Gloria)

Thus, participants appreciated the support and encouragement of family, while realizing and expressing the burdens placed on them by family.

Further, a lack of Latina/o role models was a cultural obstacle that many participants noted. "Something I would like to see is more role models. Children of immigrants have a very hard time succeeding because they do not have role

models" (Amalia).

Racism. Institutional racism, cultural racism, and personal racism, along with internalized oppression, an effect of racism, were all described by the participants. An example of the presence of *institutional racism* was demonstrated through the process of admissions. *Admissions* refers to the processes students must go through to gain acceptance to college and/or a nursing program. All along the pathway of nursing education, from entering college to acceptance into a nursing program, participants described how they had to deal with racism. One student related her experience with the director of a nursing program she had hoped to attend, but was directed to go elsewhere before talking:

> "So just by looking at me she thought I should go to [a different college]. So that was racist. I bet there are millions of Hispanics trying to get in, but she'll look at you and because you are Hispanic she'll write you off." (Carmela)

Other participants told of being given different information than that given to their White counterparts concerning requirements for admission into the nursing program, such as being told to take different prerequisite courses or being told that there was a waiting list when there was not.

Cultural racism is when assumed stereotypical practices of a group of people are believed to be static and are then used to rationalize why the group is not as successful as the dominant culture; success being defined by dominant cultural

norms, values, and beliefs (Bonilla-Silva, 2003). Cultural racism comprises the expectation that because students are from a particular culture, they will behave and succeed or not succeed according to preconceived patterns. Participant descriptions of cultural racism included comments about ethnicity and color, such as "Hispanics aren't that smart." One participant described being intimidated as a result of cultural racism, saying,

> "I did feel intimidated by faculty. It's very uncomfortable when it happens because I think first that is it because I am Hispanic. Some teachers, with their body language and the way they look, intimidate me." (Carmela)

Another participant stated, "Don't kid yourselves; it makes a difference what color you are" (Amalia).

Many spoke of feeling different and thus isolated in nursing programs where there were few Latinas.

> "When you are Hispanic, you can't help knowing that you are the only person who is Hispanic. Sometimes I feel uncomfortable like I have to prove myself because it's that there are no Hispanics, and people perceive that they are uneducated, lazy, and don't achieve anything. It's constant. It's always on my mind that I am Hispanic." (Anabel)

Another participant stated: "Unfortunately, the world we live in is not equal, and if you think we are equals, it's ridiculous" (Liliana).

Additionally, students discussed racism from instructors as well as from fellow students. "They [instructors] had no tolerance for accents or ESL students. They used mistakes in punctuation to filter out people, especially ESL students…They are tougher on these students who aren't doing as well because they [instructors] feel they have to have the heavy hand, and many of these are the minority students." (Luis)

The following two quotes describe the insensitivity and cultural dissonance participants encountered with peers in their nursing programs:

> "This quarter we had *Pan Dulce* in the home so I thought I'll just bring some to class. So I brought it to class; I packed it, and I didn't think anything of it. I just thought everyone could have some bread. I said 'Everyone, have some bread,' and they all said, 'No thank you.' I was heartbroken; I was like 'You know what? Try it!!' Just a little, so I could see them put it in their mouth. Anglos, when you offer them something, always say, 'Oh I'm fine…' These girls [Latinas] are like, 'Yeah, give me some bread.' I couldn't believe these people. I couldn't believe they wouldn't take my bread. I thought if I had brought donuts, they all would have grabbed one. And then I was like, 'Calm, down; just dump it after class.' It was heart breaking. They are going to meet Hispanic families, and if they offer you something, you better take it or they will not let them back in their home." (Carmela)

Another student stated,

> "I am 4th generation so I am pretty acculturated, but in that first class I didn't hear anything. But they didn't have to say anything; it was facial expressions or gestures or just not having enough time [for you] if you're Hispanic. So there is racism, but I don't think I could ever prove it. They just act like they think you're retarded and need to just go work in the fields or something… It's [as if] they think you can't figure it out or maybe it is because of your color." (Eugenia)

This student understood that her professors might not recognize or name their own acts of cultural racism.

The same student also spoke about how cultural racism was revealed at work and how it would affect her professional practice:

> "…I work in a hospital and I notice a lot that doctors will write off a patient in pain as having 'Hispanic syndrome.' They ask if he is in actual pain or Hispanic pain. I see that all the time. There are traits but you can't write off people as being hysterical without digging in and finding out. Hispanics get accused of faking it. When I am that person's nurse, I hope I am able to be better than that. I see this a lot. People having an idea of what a culture is like and writing people off like that." (Eugenia)

This quote demonstrates the necessity of improving access to culturally-appropriate care. Participants experienced cultural racism from instructors, fellow students, and

practitioners. The barrier of cultural racism was pervasive and noted by participants in every interview and focus group.

Personal racism is similar to cultural racism in that it involves individuals making and enacting generalizations about a group or individual based on appearance. It tends to be enacted by an individual against an individual, rather than against a group (Bonilla-Silva, 2003).

One participant described the challenge of having an instructor who did not think she would make it, but when through determination she did succeed against the odds, the instructor expressed pride in the participant's accomplishments:

> "It's tough when you have an instructor who doesn't like you… he didn't have the time for me, didn't explain anything, and never gave me any encouragement. But at our pinning ceremony he told me he was proud of me." (Gloria)

Another participant told how, "There were one or two instructors at the beginning who did not think I would make it, but after one year they were all helpful" (Amalia).

Internalized oppression is when one begins to believe the negative attitudes of the dominant group toward their racial or ethnic group and begins to see him/herself as less than, simply because of race or ethnicity (Bonilla-Silva, 2003), sometimes confounded by gender. Students expressed internalized oppression through putting pressure on themselves, through defensiveness in tone, through

feeling intimidated or lower, and through examining facets of themselves as flaws. "I see myself as less than others (Whites) culturally. When I walk into a classroom I feel that I am lower than the other students" (Liliana). In this student's case, the student was also internalizing institutional racism, whereby the norms and practices of the dominant culture are favored over that of the non-dominant culture.

Internalized oppression created stress and pressure to succeed. "I put a lot of pressure on myself," said one participant, "...so there's another pressure right there to succeed" (Anabel). Another student said, "So right now it is really stressful, but I can see the light at the end of the tunnel!" (Carmela). And yet another said,

> "The college thing...since I am Hispanic, I am the only one who succeeded. I am the only person in my whole extended family to go to college. Most of my cousins did not even finish high school. I don't care. [becoming defensive] I am going somewhere" (Liliana).

Moreover, participants described feeling intimidated by either the students or instructors, or both.

> "I feel intimidated in front of the class with the majority being Anglo. I feel intimidated asking questions in front of the class, but I can go to the instructors privately and ask them questions or by email" (Maria).

Another participant relates a story of being the only Latina in class and how she experienced racism this way:

> "It was hard being the only Hispanic in my class. Because when you talk and to say a word in Spanish, they don't understand. It was difficult …I had this student who had this mentality that because I did not have a big vocabulary that she would always automatically give me the definition. She would say, 'You probably don't know what this means.' I don't think she means any harm, but one of these days, I will tell her. In her environment she hasn't been around anyone like me." (Lupe)

But she was becoming impatient and beginning to resist, as she said, "One of these days, I will tell her" (Lupe).

Assets Used for Overcoming and Resistance

"When I think about how my family struggled to get here, I don't want to throw it all away after all the hard work they have done for me" (Carmela).

Nearly every participant spoke of wanting to quit at some point in their nursing programs, but they resisted the desire to quit in the face of adversity. One spoke of going from being a farm worker to being a nurse, which was a great motivator for her. For many, the thought of what their families had endured to get to the United States was an inspiration that kept them going. Some of the assets they used to overcome the obstacles they faced were peer support, family support, encouragement from family, seeing the possibilities, and seeing that they could go somewhere.

When discussing *institutional assets*, participants discussed more about

what was lacking. However, the two most frequently mentioned institutional assets, i.e. resources available to them through the academic institution or nursing program, were financial aid and instructor support. A few participants received financial aid in the nursing program, but all had no financial aid left by the time they had been accepted into a nursing program. Additionally, participants spoke of instructor support and encouragement in the forms of extra help with coursework, words and gestures of encouragement, and stating an appreciation for Latino culture. Only three of the participants described their nursing instructors as being supportive or encouraging.

Personal assets are those internal personal features, abilities, and attributes such as motivation, determination, care for others, and spirituality that one may possess. One participant described the asset of having goals and dreams saying,

> "I wanted to be a nurse since I was small. I think about the fact that every day is a little closer to the *sueño* [dream]. That is what keeps you going; it is a vision for yourself or your family." (Amalia)

Since all of the participants had completed at least their first year of nursing school or were already RNs, they were able to reveal how they overcame the obstacles they encountered. Some of the participants' motivation came from their own desire to succeed: "I would remember working in the fields and remind myself that I didn't want that anymore" (Maria). Determination was the most frequently discussed trait. Having goals and dreams was also described as a means to

overcome. Some participants described how they wanted to help their own families as well as the Latino community and wanted more choices for themselves and their children.

> "I was tired of being out in the fields. I wanted my kids to see that I could finish something. My mom said, 'You don't have to live the same life we do. You can do better than this…that's why we came here.' So, I tell my children to do something with their lives." (Amalia)

Many turned to prayer when things became especially difficult. "Prayer helps me. I feel confident that there is a path and a purpose in this for me." (Lupe); and "I use a lot of prayer. When I could not find a way, I would get down on my knees and pray" (Matilde). Others used positive self-talk, such as "You can do this" or chose to learn to say "No" to traditional obligations or to things they deemed not necessary for success. "I didn't want to be the typical Hispanic wife who stayed home. I was raised to want more" (Liliana).

Figuring out a way to get "a foot in the door" (Anabel) was a strategy some employed. Many participants believed that once they could get inside, they could achieve. For these participants, "getting in" posed a challenge that they strategized to overcome.

> "I figured this is what I want to do and this is how I am going to get there. Since most of the schools used a grade point system, you were

allowed points for your GPA, so I decided to excel at each of the classes." (Anabel)

Social assets. Social assets are social support and social networks that can be counted on for helpful resources. These may include family members, friends, community, and peer groups. Some participants related a desire to give back to the communities that had encouraged them, "That is something we need to take into consideration, that if you are going to move away from your community you have to find a way to give back" (Anabel).

Participants overwhelmingly described how having a supportive group of peers was critical to their success. "...having good friends in the program really helped and studying together and encouraging each other. That was like having a family in itself. Because school is like your home away from home" (Lydia). This participant likened her peers to family.

So important was peer support that one participant attributed failing her nursing program the first time to not having a supportive nursing student peer group:

> "I didn't get the support because everyone had their own little cliques. It was either you fit in or you didn't. I didn't get the support at all... and I did not feel accepted. So that's part of why I dropped out." (Gloria)

This participant highly valued a social connection with peers and was able to articulate the consequences of not having that connection.

Cohesiveness in the class also was cited as a social asset that helped the participants to achieve. They viewed this as a means of being able to collectively stand up to instructors who were intimidating in order to get what the class needed. Referring to intimidating instructors, one participant said, "You only have to put them [instructors] in their place once and then they don't talk like that anymore" (Lydia). Several participants described feeling that while they believed that they themselves had little personal power, they benefited from the power of the collective when they experienced a sense of belonging with other students who were able to vocalize concerns about unjust policies, or what they viewed as inappropriate or inadequate teaching in their nursing programs. While not all participants described themselves as being vocal, many were supportive of their classmates who spoke up against what the class perceived as injustices.

> "There were some strong voices in our class, and I did not have to say anything, but I would back them up. If the class didn't like something, we said something." (Gloria).

Participants were not accustomed to working in a vacuum, and wanted the support of others. They also had a sense of wanting to give support by wanting to give back to their communities as well.

Cultural assets are resources and advantages that one has as a result of belonging to a particular culture. These assets may include shared values, cultural pride, and the ability to speak a common language (Spanish) that are shared by a

particular culture and that can be useful tools for achievement. While each participant employed many different strategies, one asset that came from her culture, and that nearly all spoke of, was that of determination or stubbornness. Being stubborn and wanting to prove that they could do it also was a driving force toward success. "I was stubborn. If I wasn't, I wouldn't be here" (Sylvia). One participant spoke for many when she stated,

> "I also have a good personal trait and that is called *cabezona* in Spanish and that means stubborn. If I wasn't stubborn, I wouldn't have finished nursing school" (Lupe).

This idea of stubbornness or determination was discussed across all interviews and focus groups.

Those who spoke Spanish viewed it as a strong cultural asset in today's health care world. "As a nurse I will be able to help them (other Latinos) because I am Hispanic and speak Spanish" (Anabel). The few who did not speak Spanish expressed some shame or regret that they either did not remember or did not learn Spanish because they had been encouraged to learn and speak English. They viewed not being able to speak Spanish as a loss of their culture.

When speaking about culture, the participants spoke about the centrality of the family in Latino cultures with family support and family encouragement being instrumental in their success. Family support was defined by participants as help with child care, cleaning, doing laundry, and cooking. Family encouragement was

defined as words and gestures of affirmation, praise and encouragement. Both were considered to be critical to the participants' success. Family served as a point of inspiration as well; particularly the children of the participants. Many voiced that they could not have made it without their family behind them. One said:

> "Family; I could not have made it without my family. My dad and my step mom, and I got a really good boyfriend towards the end of the program. But having the two kids and trying to work and to have my family back me up and tell me 'you can do this… you can do this.' My dad was my biggest support. He was there encouraging me and my step mom was taking care of the kids even though they were working fulltime. They aren't very old, and they helped me out a lot." (Lydia)

Having at least one additional Latina/o in the nursing program was a cultural asset that was highly valued by the participants. "I didn't feel so isolated there because there were other Hispanics and other cultures. I did not feel so guarded all the time like here where there are just Anglos… and me" (Anabel). Participants who were the only Latina/os in their class were acutely aware of it, expressing a sense of isolation. Participants who were not the only Latina/os in their classes found comfort, support, and strength in having a cultural peer.

Pride in being Latina/o was another cultural asset that students used to be successful. They used it as a means of providing themselves encouragement and motivation. For example:

> "I am a Mexican-American and proud of it! I was used to hard times as a Mexican American, and I knew there would be some more. I had seen my culture go through a lot, and I knew it would be better at the end. I knew my people would be with me whether I succeeded or failed." (Matilde)

Culture and cultural values, such as stubbornness, the family, Latina/o peers, and pride in being Latina/o, were used by these participants as assets to achieve success.

Summary of Findings

In summary, this ethnographic design using focus groups and individual interviews resulted in two broad themes that were extracted from the data using a qualitative coding method for analysis: *obstacles to be overcome* and *assets used for overcoming and resistance.* Within these themes participants describes numerous obstacles they had faced as they entered and subsequently participated in their nursing programs. A persistent obstacle was that of racism in multiple forms. Participants also described the many assets that they employed to be successful, with particular emphasis on the asset of determination or stubbornness, as well as other cultural assets, including the family.

Discussion/Analysis

A critical approach to analysis involves a focus on power relationships and exposes oppression in society with the goal of increasing social justice. When applied to this study, a critical approach examines the factors of oppression, racism, and dominance that Latina/o nursing students reported as well as the assets they used to be successful. This section includes analysis of each of the major findings and compares these findings to the current literature. As a critical ethnography, particular attention is paid to both the Latina/o culture and the nursing education culture.

From the findings, it is clear that this group of Latina nurses and nursing students was tenacious, determined, and willing to work around and push through the numerous obstacles they encountered. It is also clear that for none of them was the path easy. Information from the interviews and focus groups demonstrates that professional nursing education can be a structure that oppresses. My background can attest to this. As a nursing program director for two years and as a nursing program faculty member in four different nursing programs, interacting with directors and faculty from nursing programs around the country, I have observed many instances where the more traditional and rigid expectations of faculty concerning curriculum, content delivery, and class scheduling were in force, rather than creating a more flexible learning environment wherein students from diverse backgrounds could thrive. This is in direct contrast to findings in the literature that

have suggested a more flexible learning environment as a means of fostering success in racialized students (Dickerson, Neary, & Hyche-Johnson, 2000; Evans, 2004). Additionally, the literature has pointed out that even though there are many calls and suggestions for moving nursing program curricula toward a more caring model, little has been done to make that happen (Bevis & Watson, 2000; Evans).

A key goal of this critique is to remove the focus from simply being about Latina/o nurses and nursing students and their assets and attributes, toward the deeper questions about why they are required to employ so many strategies for success, strategies that in many cases exceeded those that a White person would have to use. The following section will discuss these assets in light of the obstacles and possible reasons behind the numerous obstacles that that participants faced.

Since an emphasis was placed on what assets Latina/o nurses and nursing students used to be successful, participants spoke of the many kinds of assets they used to surmount the numerous obstacles they faced. However, the participants realized that, as Latinas/os, they were burdened with unearned disadvantages, although they did not always name them as racism. Institutional racism is defined as societal structures that are in place to keep power with the dominant (White) group and to provide differential (less) access to jobs, housing, and education for members of the non-dominant (racialized) group (Bonilla-Silva, 2003; Western States Center, 2003). Early on, some of the disadvantages came as a result of poor counseling in high school whereby some participants in this study were directed

away from college preparatory classes. This corresponds to literature that has shown that misdirecting of racialized students into less challenging courses continues to occur (e.g., Abrums & Leppa, 2001; Villaruel et al., 2001). Additional unearned disadvantage was present because the participants' parents were not educated, and while parents were usually very encouraging of the participants' hopes and dreams of moving beyond farm work, their parents did not know how to help their children to achieve their dreams. Thus, participants were faced with having to discern independently the institutionalized norms and standards of a White academic institution and then those of the White culture of nursing in the United States. While institutionalized racism was not named as such, all described it in varying ways as a major obstacle they were forced to overcome.

Obstacles to be Overcome

This section analyses the impact of institutional and cultural obstacles on Latina/o students. Using the concept of institutional racism, the impact of admissions practices, program design, and gate keeping on racialized students is also analyzed.

Institutional obstacles. The obstacles that require the most effort for Latina/o students to overcome are widespread within the same institutions and programs that express a desire to increase their enrollments of Latina/o and other racialized students. While images of racialized students are shown in nursing-program recruiting materials, Latina/o students discussed admission information

and procedures as being designed to exclude them. Standardized tests, such as the SAT or the Nursing Entrance Test (NET), employed by most nursing programs (Crow, Handley, & Morrison, 2004) to predict success and admit students, favor students with traditional middle-class backgrounds and educations and result in less racialized students being admitted (IOM, 2004). Further, studies have shown that standardized tests, such as the SAT, are not reliable predictors of overall college success (Hoffman & Lowitski, 2005; Hoover, 2004), although they are more reliable predictors of success on the NCLEX-RN exam. Nursing programs with higher numbers of Latina/o students had lower NCLEX-RN pass rates since Latina/o students are not typically well prepared for standardized tests (Crow et al., 2004), nor are the tests culturally appropriate (McQueen & Zimmerman, 2004). Thus, White students, who do better on standardized tests, are advantaged to the detriment of racialized students who are admitted in fewer numbers, and programs that admit more students of color are disadvantaged when comparing overall NCLEX pass rates with nursing programs with lower proportions of Latina/o students.

Some participants, when asked about the admissions process, spoke of getting different or less helpful information and guidance than White students. This tells students that the institutions do not want, or do not want to accommodate, racialized students. This finding was consistent with several studies that cited a lack

of, or poor, guidance in high school and college (e.g., Klisch, 2000; Lockie & Burke, 1999; and Perna, 2000.)

Furthermore, the design and culture of most nursing programs is one that to benefits White middle-to-upper class students with few family obligations. Classes are usually held during the day, several days per week. Study participants frequently complained that class schedules were changed with very short notice, creating havoc for those needing to arrange child care. The current design of most nursing programs, i.e. with rigid schedules and expectations, benefits nursing instructors who do not have to adjust curriculum or scheduling practices to fit the unique needs of racialized students and/or economically disadvantaged students.

Participants also noted a lack of cultural understanding among nursing program faculty that ranged from ignorance to hostility. Ignorance and hostility can only be maintained when, structurally, the attitudes are support by the status quo. An additional structural issue of nursing programs is that of the range of prerequisite courses that must be taken prior to acceptance into a nursing program.

Most nursing programs require several courses prerequisite to applying to the nursing program. These courses are "gatekeeper" courses that must be taken prior to application, usually no more than twice. These courses, typically in math and science, use "objective" tests and are a detriment to Latina/o students who may be dealing with issues of language and unfamiliarity with, or even a clash with, the culture of White academic institutions. Additionally, the majority of nursing

programs admit new students using a heavy weighting of grade point averages (GPAs) for selection of nursing students, along with standardized tests scores, such as from the SAT, and entrance tests specific to nursing (Crow et al., 2004). These practices persist despite many studies demonstrating that standardized tests are poor predictors of success. Admission decisions based mostly on GPA pose an obstacle (closed gate) to students who are denied adequate high school preparation for college, particularly in the areas of science and math. It further poses an obstacle for students who, because of heavy financial and family responsibilities, do not have the time required to earn an "A" in a course.

As this research shows, for Latina/os, the common act of attending college becomes a symbol of struggle for equal access and then for equal treatment. Not only do Latinas/os struggle to gain admission to a nursing program, there is a struggle between those who have power (instructors) and those who do not (students). Latina/o nursing students have a more difficult time than most White students with the struggle because they do not know the "rules" of White nursing education and are often at a disadvantage by being the only Latina/o in the group. This is the most subtle form of gate keeping.

Optimally, Latina students should be taught the "rules of the game" in high school as the White population is taught; however, racialized people often must work under different rules than Whites or without being aware of rules that are often known by the dominant culture but hidden from outsiders (Corley, 2003).

Cultural obstacles. In action, institutional and structural racism, especially gate keeping, are made manifest in the experiencing of cultural obstacles and cultural racism. The Latina women who participated in this study all spoke of their family responsibilities as an obstacle to success. While several spoke of being encouraged and supported in practical ways by their families, the issue of what was expected of them culturally as women reveals another critical element; that of the double bind of being both Latina and women. The women with families encountered many obstacles that, as Latino men, they would not have faced, such as the responsibility to cook, clean, and care for the family. The participants expressed closeness with and care for their families, but did realize that they were bound to unequal burdens as a part of being Latina. While the discourse of many husbands/partners was positive toward nursing education, the lack of action of picking up the traditional female workload shows that the support is not materially there. This explains why two participants expressed a preference for being "Americanized," i.e. giving up traditional Latina women's roles, as well as a preference for "White boys," whom they perceived to be less demanding.

Additionally, the structure of the nursing programs applied pressure on Latina/o students to give up at least some of their cultural norms in order to succeed. Participants spoke of faculty penalizing students for being five minutes late to class, fostering a climate of competition, and naming as "irresponsible" students who missed a day of class to care for a sick child. These are all examples

that participants gave of cultural conflicts they faced, which corresponds to literature (e.g., Abrams & Leppa, 2001; Barbee & Gibson, 2001). They were pressed towards adopting the ways that nursing education has always been accomplished, which usually require that non-White cultural ways be abandoned. This pressure to give up one's culture is itself is a form of racism in that it favors White students while not explicitly excluding racialized students (McQueen & Zimmerman, 2004).

Racism. While students are struggling to understand the system and to navigate between two distinct cultures, Latina/o and nursing, they are also hearing many messages both inside and outside of their nursing programs that are examples of cultural racism. *Cultural racism* is defined as racism that uses stereotype about cultures to explain why certain racialized groups do not have or achieve what the dominant (White) group achieves (Bonilla-Silva, 2003). The participants in this study both heard and felt many instances when they were viewed as less capable simply because they were Latina. For example, Latinas were congratulated once they "made it" but were often not encouraged along the way by faculty or others inside the institution. Cultural racism, as a manifest form of institutional racism, is at play here since those holding the power offer no alternative possibilities to Latina/o students other than being thought of as less than their White counterparts.

Acts of *personal racism*, defined as those actions or assumptions made against a racialized person or group by an individual (Bonilla-Silva, 2003), were

described frequently by the study participants. One participant described how an instructor used his power to fail Latina/o students:

> "I heard a professor say once about Hispanics, 'I don't think they are that smart. I give them really hard work right away to weed out the weak ones'" (Liliana).

Another participant spoke of a nursing instructor who was unwilling to help when she had difficulty understanding some content in the nursing program. However, when she graduated, the instructor expressed admiration for the student. The expression of admiration implied, not subtly, that the instructor did not expect him/her to succeed. Admission rates might be higher for Latinas/os if these students were given the same educational advantages as their White nursing student peers and if standardized testing and gatekeeper courses were adjusted or eliminated.

Participants described being targets of overt expressions of dislike for their food or cultural practices from others, particularly White students in their classes, who would react to Latino cultural practices regarding health as "weird" or "wrong." Unfortunately, with the exception of one program, participants reported that their nursing programs did little if anything to try to create a multicultural, antiracist environment. It was not enough that some instructors were supportive, defined by the participants as providing help, encouragement, and expressions of belief that the student had the ability to succeed, since other instructors were "allowed" to make racially insensitive statements that got explained away as a part

of someone's intimidating personality. Participants felt that faculty members had a responsibility to educate White students to appreciate multiculturalism and to challenge their assumptions and stereotypes. This finding is supported several places in the literature, such as Barbee and Gibson's (2001) finding that White nursing students carried many unchallenged misconceptions about why there were so few nurses from racialized cultural backgrounds.

Participants made comments that demonstrated that self-images include negative, racist input from society. This *internalized oppression* occurs when stereotypes become ingrained, i.e. internalized, and result in multiple negative feelings. For example, when a participant said, "I feel lower than the other students" (Liliana), she meant she was inferior to the White students, being unworthy of being in the nursing program as a Latina. Participants also struggled with internalized oppression in the form of self-doubt or powerlessness when they talked about how many times they were not sure they would make it through the nursing program. Some participants made negative comments about their own culture, such as, "I have heard that Hispanics, when they get to the top, they want to keep the other person down. I don't know I am like that but I hear that about my culture" (Anabel), which further demonstrates a degree of internalized oppression. Three participants had been in abusive partner relationships, another form of oppression that results in internalized, negative self-worth. Finally, fear of reprisal

kept at least one participant from speaking up against injustices she observed and experienced in the program she attended.

Assets used for Overcoming and Resistance

Participants reported expending a great deal of time and effort to overcome the obstacles they faced. The most difficult obstacles involved institutional racism because it was difficult for the participants to pin down and name. However, when a participant said, "I don't know; maybe it was racist" (Gloria), it means that she did perceive the behaviors as racist, but out of fear or internalized oppression, she was unwilling to definitely name the incident as racist.

In spite of all the obstacles that they faced, participants in this study used several assets in order to succeed. Of particular note is that the participants in this study managed to hold onto their cultural assets, such as valuing family, being a part of the collective, stubbornness or determination, and *personalismo* (the valuing of personal relationships and valuing people over tasks). They also succeeded in their programs. This finding is in contrast to a recent study in which Latina nurses reported that they had to abandon family obligations in order to succeed (Doutrich, Wros, Valdez, & Ruiz, 2005). None of the Latina/os interviewed in this study expressed a willingness to abandon their family obligations, even though their duties as mother, cook, and caregiver made attending nursing school very difficult at times. They did learn to adjust to the dominant culture without caving in to it, as found in Yurkovich's study (2004), which described the asset of cultural flexibility.

Participants engaged in *active resistance* as many participants made deliberate decisions to care for family, to create support/study groups, to not compete, and to live as a Latina/o in the midst of the dominant White nursing culture. Participants related how much they valued and appreciated their culture, as well as how much they appreciated the support they received from their families and communities. Acts of resistance provide clues as to how and why participants were able to hold onto their culture in the face of pressure to assimilate.

Another form of active resistance was to resist cultural norms regarding Latina women's roles. Participants chose to go to school in spite of the hardships of managing family obligations in pursuit of a better life for themselves and their children. Those participants who had been in abusive relationships actively resisted by leaving the abusive partner and choosing to attend school. Latina/o students banded together, then joined their White peers, and acted as a collective within the classroom to actively resist what they believed to be unjust practices. Discussing these actions gave energy to the participants as they used the focus group as a venue to support and encourage each other.

The attribute of stubbornness, as discussed by every participant, also illustrates active resistance. When described as a cultural trait, along with solidarity with the greater Latino community who one participant described as having "gone through a lot," this reveals a concept of resistance that has long been a part of Latino history both in this country as well as throughout the Americas.

One participant described a form of *passive resistance*. He spoke of his relationships with nursing instructors in this way, "Sometimes unknown to them, our relationship was not as good as they thought it was. It was just that I was able to handle them" (Luis).

Had the numerous obstacles mentioned not been present, less time and energy would have been spent clearing hurdles and breaking through blockades. More time and energy would have been available to be spent on learning and, as a result, filling the need for diversity in nursing. Furthermore, while it is admirable that the participants in this study were able to find ways to overcome a myriad of obstacles, the fact that these Latina/os had to work harder than their White counterparts perpetuates social injustice. Nursing education programs that do not examine practices that are forms of institutional, cultural, and personal racism will have little success in changing their demographics through intensive recruitment. Thus, the face of nursing practice will remain White and privileged. Access to culturally-appropriate health care can only happen, and thus reduce the social injustice of lack of access, by changing the face of nursing education (physically and metaphorically). There are not enough Latina/o nurses providing health care because of the difficulties encountered as Latina/os attempt to navigate the White currents of nursing education.

Inflexibility (Evans, 2004), racism (Barbee & Gibson, 2001) and family obligations (Villaruel et al., 2001) emerged from several studies, causing the

authors to call for culturally-appropriate nursing education. While this may help to move nursing education forward, a greater step must be taken–that of implementing multicultural, antiracist nursing curricula. Further, although persistence paid off for students, it is a chosen mode of being. To master any skill, one must be persistent. However, for the Latinas/os in this study, they both had to use a cultural trait of stubbornness, even willfulness, and risk being stereotyped and discriminated against because they revealed their cultural trait.

In this study, resistance was a form of stubbornness, a refusal to give up culture; it was an act of civil disobedience towards oppression and an act of empowerment towards social justice. This study adds new information that elucidates assets for success not previously seen in the literature, such as stubbornness and a refusal to give up one's culture. It also affirms the Latina/o cultural norm of valuing the collective over the individual, which the participants reported they nurtured themselves. Latina students used resistance and the collective to overcome the many obstacles they faced. Additionally, the pervasiveness and effects of racism as described by these participants further informs the academy and provides evidence to catalyze institutional and academic cultural change.

Strengths, Weaknesses, and Limitations

Because this study focused on the stories of a small group of nurses and nursing students, these findings cannot be generalized to all Latina/o nurses and nursing students in the United States. However, as a critical ethnography, the intent is not to generalize but to highlight areas of injustice as experienced by these Latina nurses and students. It is highly likely that these injustices, including institutionalized racism, are repeated in many locales due to the fact that nursing programs are predominantly White, middle-class, and female. These findings, when combined with information from a number of previous studies (e.g., Evans, 2004; Yurkovich, 2001) help to create a clearer picture of what must be changed in nursing education if we are to attract, retain, and successfully graduate increasing numbers of Latina/o and other racialized students.

As a White researcher working with Latina/o participants, I realize that there may be stories that were not told, or stories that were told to me in ways that they would not be told to a Latina/o researcher. However, my background and ability to speak Spanish helped to establish some level of trust so that participants did express feeling comfortable to speak freely. Two limitations of the study were that more men were not represented and that participants were predominantly from associate degree nursing programs. Although attempts were made to recruit from BSN programs, there are few Latina/os represented in BSN programs in the Northwest. A strength of the study was that I was able to interview students who

were currently enrolled in a nursing program and nurses who had recently graduated. This allowed for an understanding of how nursing programs are currently structured for Latina/o students.

Implications/Recommendations for Nursing Education

Nursing, the "caring profession," (McQueen & Zimmerman, 2004) has historically favored White, middle-class women. Now nursing must rethink recruitment of Latina/os and other racialized groups (McQueen & Zimmerman).

> "The ethical practice of caring as a central role of the nurse in health care and nursing education is a professional commitment to all clients regardless of their race, ethnicity, or background. Paradoxically, the practice of care in nursing has assumed the masculine traits of competing for a place on the team and exclusion of some has become a predominant theme in nursing school." (McQueen & Zimmerman, p. 53)

The American Black Nursing Faculty's (McQueen & Zimmerman) call for awareness on the part of nursing educators about the obstacles that Latina/o students face must be acknowledged; flexibility in admissions and strong mentoring support for racialized students once they do enter a nursing program must be implemented.

Implementing a multicultural, antiracist nursing curriculum is imperative if we truly intend to increase the numbers of Latina/o nurses. It is the responsibility of program directors and administrators to monitor, educate faculty and staff, and yes, even terminate employment of those who choose not to gain an understanding of the issues faced by racialized students. Further, culturally-appropriate nursing education needs to be instituted in all nursing programs and comprise more than

one required course on "diversity," which is not enough to adequately teach antiracist practices. The concept of culturally-appropriate, antiracist care needs to be woven throughout the curriculum and taught as a part of total nursing competence rather than how "cultural competence" has been in the past (Canales & Bowers, 2001). This will allow students to learn to care for all kinds of clients, including those who are racially or culturally different from themselves (Canales & Bowers).

Structural barriers need to be eliminated in order to create opportunities for Latina/o students to enter and succeed in nursing programs. Bi-lingual admissions materials and flexible admission policies that consider more than grade point and test scores need to be instituted. Flexibility in course scheduling to allow for work and family obligations must take place.

Cultural obstacles, as observed in many nursing curricula, can be overcome if curricula are threaded with multicultural perspectives throughout and if faculty members are re-educated and re-purposed to teach a multicultural, antiracist nursing curriculum. This includes teaching both sides of racism; racial oppression and White privilege (Martinas, 1998). White nursing students can learn how they contribute to institutional racism, and how they can become antiracist "allies" (Western States Center, 2003, p. 54). This means acknowledging that they will never know what it is like to be a racialized person in the United States, being committed to overtly fighting racism (Western States Center), and recognizing the

significant effects of racism (Bonilla-Silva, 2003). In addition, nursing education must include more content on social disparities in health so that students will enter the nursing profession with a deeper understanding of the clients for whom they will care as well as a greater understanding of their racialized classmates.

Future Directions/Conclusion

There is a great deal of work to be done in the form of antiracist work in nursing education. Additional study is needed to learn more about cultural assets in Latina/o communities and how assets--such as valuing family, being a part of the collective, determination and *personalismo*--can be esteemed and incorporated into nursing education to support student. The study described here could be expanded to include a nationwide sample through the National Association of Hispanic Nurses.

Finally, I would ask the reader to consider the following and imagine with me a world in which racialized students' success does not have to be so difficult to attain because institutional racism has been dismantled.

Imagine a Latina student who was admitted to a nursing program based on her achievements in many areas, not solely on grades. She is valued because of her determination, unique cultural perspective, and strong work ethic. She is well-advised in high school and directed into college preparatory courses. She hears the same information as do other applicants, and she also has the opportunity to read and understand the admissions information in Spanish. She never fears that she will be targeted or weeded out because she is Latina. She is able to obtain sufficient financial aid so that she does not have to work during school. Childcare is funded and available on site, and decisions about when classes are offered take into consideration student needs over faculty preferences. Laptops are provided to all

students, and many of the courses are available online and accessible from remote sites at any time. If family needs take the student away for a day or two, she is allowed to make up the time and is not penalized. Imagine that nursing classes are taught by faculty, who as a group, have training in and understanding of, multicultural, antiracist nursing curricula. At least one of the faculty is Latina, others are from other racialized groups, and all have a great understanding of Whiteness and how it has affected their past nursing education practices, either as White or as racialized persons. This faculty also understands that nursing education is a practice that embodies the ethic of caring. Therefore, they treat each of their students with the utmost respect and dignity as human beings and future fellow colleagues. They are available as partners and mentors in learning. Competition between students is discouraged, and collaborative work is encouraged. There are always at least two Latina/os in each cohort, and peer support groups are an integral part of the process of learning. White students learn how their unearned advantage has affected them and their racialized peers, and they learn how to function in a multicultural world. Stereotypes and racism are challenged, and no one is asked to lay aside her culture to succeed in nursing.

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Appendix A

Code Book
(Includes major themes, categories, and codes)

Major Theme #1: *Obstacles to be overcome*

Three Categories:

1. *Institutional Obstacles*

   Definition: Those attitudes, actions, policies, and structures related to academia that act as barriers for students to enter and/or succeed in a nursing program.

   "I was accepted into nursing school but then told I had to wait but that was not true. Our people (Latinos) get robbed because we don't know we have other choices." (Elena)

   Code words and definitions

   - Admissions (refers to admission policies and procedures)
   - Blockades (speaks to intentional line of defense. Also means "to deny access to")
   - Poor counseling (guidance counseling in high school and college)
   - Gate Keeping (prerequisites courses and requirements)
   - Lack of professional role models
   - Nursing program structures (inflexibility, cultural dissonance)
   - Nursing program curriculum
   - Lack of knowledge of the system (rules, differing information re: entrance requirements)
   - Lack of financial aid
   - Power differentials (between faculty and students)
   - Lack of accurate information about the program (how to get in, what to expect)
   - Lack of accurate information about each course (when items due, what to expect)
   - Lack of multicultural curriculum (lack of content including recognition of other cultures as clients and of other cultures in the class. Also lack of inclusion and recognition of Latina family.)
   - Lack of instructor/program flexibility

(allowing for family and work obligations without penalty)
- Lack of relevant instructional methods
  (instruction that is immediately useful, and that takes into consideration the cultural learning style of many Latinas, i.e. group work)

2. *Cultural Obstacles*
   Definition: Those attitudes, actions, norms, and/or values that are culturally-based that act as barriers to enter or be successful in a nursing program.

   "It's tough to balance the expectations of my culture because I have tons of homework and don't always have time for family gatherings..." (Lupe)

   Code words and definitions:
   - Inability of parents to guide them *(because of immigrant status, or lack of education)*
   - Family responsibilities
   - Differing norms that White academia
   - Familial obstacles
     1. Husband/partner obstacles
        Expectations
        Economics
     2. Gender obstacles
   - Cultural expectations (related to men's and women's traditional roles in Latino culture that would frown on a male nurse or a woman working. Also related to Latino concepts of success and that being a nurse is not being enough)
   - Nursing culture vs. Latino culture
   - Being the only Latina in the class

3. *Racism*
   Definition: Institutional, personal, and cultural forms of racism, and internalized oppression.

   "I see myself as less than others (Whites) culturally. When I walk into a classroom I feel that I am lower than the other students." (Liliana)

Code words and definitions:

- Intimidation
  ("it's my job to be intimidated")
- Negative perceptions by others
- Poor counseling
  (guidance counseling in high school or college pre-nursing)
- Having to prove self
  (working harder because of ethnicity)
- Lack of respect
- Labeling
  ("Hispanics are stupid")
- Poor treatment because of being Hispanic
- Internalized oppression (impact of racism)
  1. Feeling alone, feeling different
     (being the only Latina/o in the class)
  2. Being vulnerable, sensitive
  3. Pressure
  4. Stress
  5. Depression
  6. Feeling lower than White students

Major Theme # 2: ***Assets used to resist and overcome***

Four categories:

1. *Institutional Assets*
   Definition: resources available to participants through the academic institution or nursing program

   Code words and definitions:
   - Financial aid
     (Financial aid from the college)
   - Instructor support, encouragement
     (words of affirmation, help with questions, hugs)
   - Being appreciated for being Latina
     (verbal recognition of importance of Latina/o nurses)

2. *Personal Assets*
   Definition: Internal personal features, abilities, and attributes such as motivation, determination, care for others, and spirituality that one may possess.

"I wanted to be a nurse since I was small. I think about the fact that every day is a little closer to the sueno (dream). That is what keeps you going; it is a vision for yourself or your family." (Amalia)

Code words and definitions:

- Having goals and dreams (not material goals but personal goals)
- Motivation
- Desire to give back to community
- Desire for a better life for themselves and family (
- Prayer
- Positive self talk
- Determination
  (not quitting, even when it's really hard; trying hard)
- Stubbornness

3. *Social Assets*

   Definition: Social support and social networks and that can be counted on for helpful resources. These may include family members, friends, community, and peer groups.

   "There were some strong voices in our class, and I did not have to say anything, but I would back them up. If the class didn't like something, we said something." (Gloria)

   Code words and definitions:

   - Peer support
     (Knowing that peers are behind you and with you)
   - Solidarity; Cohesive class
     (classmates stand up for each other and help each other to succeed)
   - Family support
   - Family encouragement

4. *Cultural Assets*

   Definition: resources and advantages that one has as a result of belonging to a particular culture. These assets may include shared values, cultural pride, and the ability to speak a common language (Spanish) that are shared by a particular culture and that can be useful tools for achievement.

"I also have a good personal trait and that is called cabezona in Spanish and that means stubborn." (Gloria)

Code words and definitions:

- Family support
  (practical help such as child care, cleaning, cooking, laundry)
- Family encouragement
  (words of praise and encouragement to keep going; showing an interest and valuing the education they were getting)
- Valuing the collective
  (working well in groups, supporting and encouraging each other. They were going to succeed together)
- Having other Latinas in the cohort
- Cultural pride
  (viewing being Latina/o as a positive asset for being able to succeed)
- Latina role models
- Religion, prayer
  ("On my knees"; feasts, holidays, prayers for help)
- Speaking Spanish
- Stubbornness; determination
  (not letting anything stop you, especially other people)

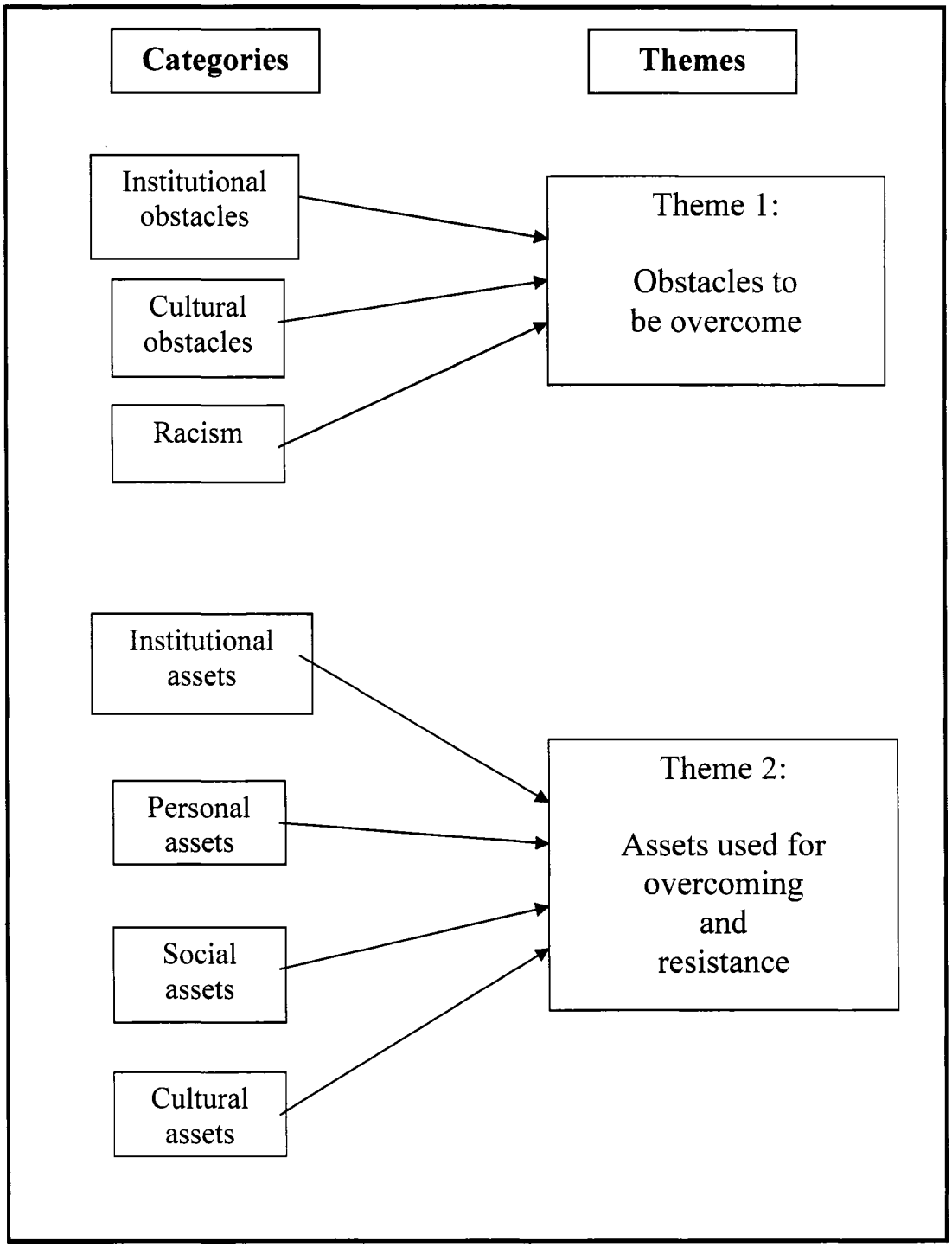

Figure 2: *Categories and Themes*

Appendix B

Sample Questions for Focus Groups and Interviews

1. *Experiences entering nursing school.*

    - Please describe what occurred as you were trying to get into nursing school.

2. *Experiences during nursing school.*

    - Everyone has different experiences in school. Some are positive, and some are negative.
    - Please describe what it was/is like for you to attend nursing school.

3. *When you think about the nursing program in general:*

    - What kinds of interactions, support offered, types of instruction, and assignments were most helpful to you? In what ways?
    - What kinds of things were least helpful? In what ways?

4. *Experiences with the institution.*

    - Please describe how you feel/felt about being at the college or university?
    - Describe occurrences that were helpful/not helpful and why.

5. *Experiences with faculty.*

    - Without using any names, how would you describe your interactions with the nursing program faculty?
    - What kinds of interactions, support offered was most helpful to you? In what ways?

6. *Experiences with fellow students.*

    - What kinds of interactions, support offered was most helpful to you? In what ways?
    - Without using any names, how would you describe your interactions with other students in the nursing program?

7. *Instances of racism and how participants succeeded.*
    - Sometimes students might notice that there are instances of racism or discrimination because of a student's race or ethnicity.

- Without stating any names, did you ever feel that you experienced racism in your nursing program?
- Since the focus of this investigation is on assets you used to be successful, please elaborate on what assets you used to carry on and be successful in the midst of that experience.

8. *Instances of feeling intimidated.*

- Sometimes students might feel intimidated by faculty members, fellow students, or by the nursing program in general for many reasons.
- Without stating any names, did you ever feel intimidated during your educational experience?
- Since the focus of this investigation is on assets you used to be successful, please elaborate on what assets you used to carry on and be successful in the midst of that experience.

9. *Strategies employed to be successful.*
   - Please highlight the "things" that helped you to be successful, whether it was other people, your own personal characteristics, your culture, external support, or other things.
   - What of these was the most important for your success? Why?

10. *The role of family.*

- How would you describe your family in relationship to your educational goals?

11. *The role of personal attributes.*

- How has your personality or goals helped you to succeed?

12. *The role of culture.*

- How has being Latina/o affected your success in the nursing program?
- What advise would you give to other Latina/os who are in nursing school right now or who want to be nurses?

VITA

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