Causal Model of Cultural Competence and Behavior among Thai Nurses in International Hospitals

Thanida Khongsamai¹, and Ungsinun Intarakamhang²

Cultural competence is the ability of nurses to take care of patients in accordance with cultural diversity. This study was aimed to examine the causal model and identify the causal variables that could affect cultural competence and cultural care behavior of professional nurses working in international hospitals in Bangkok, Thailand. The study was based on a structural equation modeling analyses of the data collected from 451 registered nurses and the data was obtained using a stratified random sampling technique. The inclusion criteria were registered nurses caring for foreign patients for one year. The data was collected by a set of questionnaires with five instruments, with a confidence level from .67 to .94. The results showed that the assumption of a causal relationship model fits with the empirical data (SRMR = 0.078, RMSEA = 0.072, GFI = 0.97 NFI = 0.97, CFI = 0.97, $\chi^2$/df = 3.35). The cross-cultural experience and cultural attitude had a direct effect on cultural competence, ($\beta = 0.22$, 0.88, $P < .05$). The perceived organizational support and cultural competence had a direct effect on the cultural care behavior ($\beta = 0.11$, 0.63, $P < .05$). This model could explain 84% of the variance in the cultural care behavior. Cultural care behavior can be developed by cultural competence and perceived organizational support. A significant implication that this research could contribute to the development of programs that enhance cultural competence and cultural care behavior.

Keywords: cross-cultural, cultural competence, cultural care behavior, professional nurse, perceived organizational support

Thailand has a strategy to develop into an international medical hub from 2017 to 2026 and there will be increase competition in the medical and wellness industry. As a result, the economy is likely to grow. There is a promotion of medical services and wellness services that has the potential to attract customers and to support the integrated medical industry continues. Currently, there are 68 Joint Commission International (JCI) health services. However, many countries in Asian countries have announced that they are the medical hub of Asia, such as Singapore, South Korea, Malasia etc. Thailand is recognized and ranked in the top 10 in the world in terms of hospitals. The reason for this as Thailand has been accepted due to factors including reasonable price, good quality and international level service, there are specialist and expert healthcare providers, modern technology, hospitality, and beautiful tourist attractions. Thailand is recognized as having the best hospital ranked in the top 10 in the world. In 2019, there was an increased revenue for the country in the past year, there were 3.42 million health-related tourists, earning 28,110 million baht in the country and increase 6.02 percent (Charnverakul, 2019). The International Health Division has received complaints from foreigners since 2014 to 2015 and the Number of patients increase from 10 to 11 cases (0.49% and 0.56%) of the complaints were in the case of surgery such as appendicitis, bone, lasik, abdominal tumor, jaw surgery, and others (Department of Health Service Support, 2015). Some

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nurses stated that caring for patients from culturally diverse patients is a difficult and challenging task because of the unfamiliarity with different cultures and the language spoken by patients, care becomes challenging. The needs of such patients are often more demanding, especially when there is a linguistic gap between nurse and the patient (Amiri & Heydari, 2017).

Cultural factors influence health care treatment, and caregivers must understand the needs of each patient group (Leininger, 1991). Culture is defined as the learning and shared beliefs, values, and lifeways of designated or particular groups that are generally transmitted intergenerationally and influence one’s thinking and actions modes. Nurses are a vital part of the healthcare experience. Therefore, nurses must learn and understand cultural aspects and integrate them into professional care based on the needs of the patients (Leininger, 1991). If the patient feels that a nurse has a bias or prejudice, the patient may not disclose information due to poor communication, a lack of cooperation regarding treatment decisions or changing their behavior because patients have experienced conflict, stress and hopelessness. Nurses need to understand and experience the patients’ different cultures. Nurses with experience influence take as gaining cultural competence requires exposure to caring for patients from various cultures and countries. Nurses with experience have a relationship with cultural knowledge and awareness (Almutairi, Adlan, & Nasim, 2017). Therefore, nurses need competency in nursing culture, which is the ability to express behavior or actions that respond to beliefs, attitudes, traditions and ways of life (Campinha-Bacote, 2002). Caring is included in cultural desire, which is a part of caring that is the core or essence of nursing care. Cultural and social factors influence the values, beliefs and ways of living. Caring is expressed and experienced differently by different cultures. Cultural desire motivates and energizes nurses to develop other components of cultural competence. There are essential cultural competences in caring the patient difference background (Cai, 2017). The study of experienced nurses in caring for foreign patients reported the following problems: 1) problems interacting with patients during care from different cultures; 2) inadequate knowledge of diverse cultures caused a feeling of being desperate and worried, a fear of making mistakes and sometimes chose to avoid patients; 3) needed more attention and took a lot of time for providing good care; and 4) language barrier to communicate with patient and culture (Amiri & Heydari, 2017). In addition to cultural knowledge, nurses must show respect and have positive attitudes toward other cultures (Cai, 2016). Nurses believe that training is important, in order to provide nurses with cultural capabilities, they should be prepared to care in accordance with patients and families. The studies showed that perceived organizational support had an influence on competence (Gunawan, Aungsuroch, & Fisher, 2018). The nurses are trained to have cultural competencies resulting in improved care quality of the health services. There is analyses research which study about evaluate cultural competence training of medical education as 18 Programs in USA from 2000 to 2015 found that the training changed knowledge, skills and attitudes in caring for diversities. (Jernigan, Hearod, Tran, Norris, & Buchwald, 2016)

Multicultural society changes from foreign populations migrating to work study and travel and medical tourism services impact Thailand to be many different ethnic groups together, thus cultural diversity exactly lacks leads to cultural care diversity. Health care providers will encounter a variety of problems in term of technology, politics, law, economy, society, religious practices, values, beliefs and way of life (Leininger, 2001). Cultural care is appropriate care in accordance with the beliefs and lifeways of the patients. In addition, Thai society has problems communicating in foreign languages as misunderstandings so there is communication through an interpreter. The problems while interaction with foreign patients.
found that the service was impolite due to culture differences. Causing the patient a lack of information, disparities, lack of social support and resources (Alpers & Hanssen, 2014). Communication problems and lack of interpreters causes nurses to become frustrated, stress in the service of patients with different cultures (Uzun & Sevinc, 2015, Chiangkhong, Intarakamhang, Duangchan, & Macaskill, 2019). Therefore, nurses need to be culturally competent to provide good care results. Patient-centered care that is important to both patients and their families can participate in decision making on the management of care. Therefore, health personnel should have cultural competencies.

With regard to caring for patients in a multicultural society, Leininger (1991) provided culturally congruent care guidelines which incorporated three-way decision making and nursing care practices. These guidelines highlighted the importance of the following: 1) cultural care preservation and maintenance that help people of a particular culture to retain and/or preserve relevant care values so that they can maintain their well-being, recover from illness, or face handicaps and/or death; 2) cultural care accommodation and/or negotiation that help people of a designated culture adapt to, or negotiate with others for a beneficial or satisfying health outcome with professional care providers; and 3) cultural care re-patterning and restructuring in which patients reorder, change or greatly modify their lifeways for new, different, and beneficial health care patterns. Thus, nurses should learn and understand cultural differences which is important in determining how to care and give appropriate care guidelines for patients with different backgrounds. Culture is importance the resulting in the determination of appropriate methods based on assistive, supportive, facilitative, and enabling acts or decisions that are tailor-made to fit with individual, group, or institutional cultural values, beliefs, and lifeways in order to provide or support meaningful, beneficial, satisfying health care, and well-being services (Leininger, 1991).

There are research studies on cultural competencies and cultural care such as factors affecting the cultural competencies of nurses in Thailand and other countries (Chunrat & Jumpamool, 2018; Ahn, 2017; Preposi, Estacio, Bagtang, & Colet, 2016; Praneed & Siriphan, 2015). However, no study about private international hospitals as tertiary care in Bangkok met the criteria of the joint commissions on international accreditation (JCI) which enable them to take better care of foreign patients. This research questions which factors are the causes of cultural competency and cultural care behavior and factors which effect on cultural care behavior. The findings will be useful in explaining cultural care behavior and any factors effect on cultural competencies and cultural care behaviors in order to be used in the development of health providers and used in the care of multicultural patients at government and private hospital.

**Literature Review and Hypotheses**

**Social Cognitive Theory**

The main theoretical concept used by researchers was the social cognitive theory of Bandura (1986) which explained both the causal factors and the effects of cultural care behavior. The social cognitive theory of Bandura established a basic social learning theory and believes that individual behaviors occur and change due to environmental and personal factors joined together in reciprocal determinism, as shown in Figure 1.
Figure 1: Reciprocal Determinism of Behavioral Factors (Bandura, 1986)

Figure 1 shows the behavior of the person (B), the environment (E) and the personal factors (P) including cognitive factors and other internal factors that affect behavior. These three factors define each other, but this does not mean they are defined equally together. Some factors may have more influence over others, such influences do not occur at the same time, and it takes time for one factor to affect others (Nuchprasop & Intrarakamhang, 2018; as cited in Bandura, 1986). This behavior may not persist because the environment always changes, so both environment and behavior are influenced by each other. In this way, social learning theory explained that a person’s behavior was caused by two main factors: the personal factors that found the important variables that affected cultural care behavior among professional nurses were cross-cultural experiences and culture attitudes. The environmental factors found that the perceived organizational supported the causes and effects on cultural care behavior.

Concept of Cultural Care Behavior

Leininger (1991) defined cultural care as assistive, supportive, and facilitative or enabling acts to maintain good health, improve living conditions, improve way of life or to confront illness, disability or death. Leininger (1999) defined cultural care as appropriate care in accordance with the beliefs and lifeways of the patients. Nurses assess the needs of the patients for health belief using tools such as the Transcultural Assessment Model by Giger and Davidhizar (2002) consisting of six elements: 1) communication; 2) space; 3) social organization; 4) time; 5) environmental control; and 6) biological variations. Language is a tool which can access caring because nurses understand other cultures. Odhiambo, Garcia, & Ackerman-Barger (2019) found that White, African American, philippine, and Hispanic nurses lacked of cultural knowledge and cultural encounter of black Americans then impact to patient. They feel nurse bias and nurse feel frustrate because they didn’t understand when patient explained their health. Therefore, healthcare providers having a bias, without awareness or cultural skill for assessment, may result in different interactions between patients and health care providers and may cause patients to feel stereotyped so nurse need to have component of cultural competence (Cai, 2017). Leininger (1991) provided guidelines for decision-making in nursing care practice and according to the cultural care of patients, allowing patients and family members to participate in the care and negotiate and evaluate outcomes. The factors of cultural competence had an important effect on cultural behavior in terms of nurses caring for patients from different cultures. This study adopted the tools of caring behavior as Wu, Larrabee, &
Putman (2006) defined care behavior as four elements of caring behaviors: 1) assurance of human presence; 2) professional knowledge and skill; 3) respecting the cultures of patients; and 4) positive connectedness. In conclusion, cultural care behavior can be defined as the creative or enabling acts or decisions that are tailor made to fit individuals by maintaining, compromising, and negotiating with patients to satisfy their lifestyles and cultures.

**Conceptual Framework**

Theory used to analyze the causes of cultural competence and cultural care behavior. The development of a causal model of cultural care behavior among professional nurses is essential in this research. Leininger (1991) culture defined as learning share and convey the values, beliefs, norms and way of life of an individual or group that is a guideline for thinking, making decisions, and methods of living things. The culture is very important in health because it is a factor that influences the concept of health beliefs, illness and treatment which is a challenge to caring for patients in a multicultural society. Cultural and social structure dimensions consist of technological, religious and philosophical, kinship and social, cultural values and lifeways, politic & legal, economic, education. Leininger(1991) believed that healthcare system combine 2 systems as folk systems and professional systems. Nurses provide care need to have positive cultural attitudes, cultural competencies are the ability of people in one culture to interact with people from different cultures. Cultural competence concept of Campinha – Bacote, 2002 consists of 1) Culture awareness 2) Cultural knowledge 3) Culture skill 4) Cultural encounters 5) Cultural desire. Leininger cultural care (1991) defined that assistive, supportive, facilitative or enabling acts to maintain good health, improve living conditions, improve way of life which appropriate care in accordance with the beliefs and lifeways of the patients (Leininger,1999). When nurses are aware, they will reduce bias towards other cultures that are different from their own culture. Learn to develop oneself to have knowledge and cultural skills, enables the interaction with other cultures effectively. Causing the practice to express, cares the patients from different cultures. The main theoretical concept used by researchers was the social cognitive theory of Bandura (1986) explained the cause of personal behavior that is caused by two main reasons as personal factor and environmental. When nurses communicate interaction with patients from different cultures leads to awareness and knowledge, causing nurses to change their attitudes as well as reduce bias towards patients with different cultures. The results of self-development as someone who wishes to have cultural competency and cultural care behavior.

From the literature review, the conceptual model of the factors of cultural care behavior and cultural competence were constructed, as shown in figure 1. There were also personal factors, such as cross-cultural experience and cultural attitudes by passing a cultural competence mediator. It was proposed that the environmental factor of the perceived organizational support would have a direct effect on cultural care behavior. In addition, it was proposed that cultural competence would have a direct effect on cultural care behavior, as shown in Figure 2.
There are 9 hypotheses proposed for this research:

H1: Cultural competence have direct effect on cultural care behavior.
H2: Cross-cultural experience have direct effect on cultural competence.
H3: Cultural attitude have direct effect on cultural competence.
H4: Cultural attitude have direct effect on cultural care behavior.
H5: Perceived organizational support have direct effect on cultural competence.
H6: Perceived organizational support have direct effect on cultural care behavior.
H7: Perceived organizational support have indirect effect on cultural care behavior.
H8: Cross-cultural experience have indirect effect on cultural care behavior.
H9: Cultural attitude have indirect effect on cultural care behavior.

Study Design

This study as a cross-sectional design and used structured equation modeling to examine direct and indirect relationships between personal and environmental factors and the cultural competence and cultural care behaviors of professional nurses.

Participants

The participants in this study consisted of 451 people, professional nurses with at least one year of experience caring for foreign patients, aged 20 years and over, working in inpatient or outpatient services at 4 private international hospitals. The participants had to fulfill the following criteria: at least one year of clinical experience of nursing care foreign patients, an understanding of the purpose of the study and consented to participate in the study, exclusion criteria nurse who have experience of nursing care foreign patients less than 1 year and unwilling answer questionnaires, with a sample of between ten to twenty participants per measurable variable (Weiss, 1972, cited in Wiruchchai, 1999). It represented a good population with reliable results. In this study there were 20 participants and the estimated sample size was at least 1:10. According to the requirements, there were at least 400 people. The sample group was nurses who have worked for at least one year from four private international hospitals which derived from proportional stratified random sampling with the ratio between the populations per sample estimated at approximately 2:1. Over 480 questionnaires were
distributed and 451 questionnaires were returned. Ten of these participants were excluded from the analysis due to missing or incomplete data.

**Ethical Considerations**

Ethical approval was granted by the institutional review board (SWUEC/E – 136/2560) duration 14 July 2017 to 14 July 2018. The researcher contacted Nursing departments in each hospital where the data were collected. The participants were informed of the purpose of the survey.

**Measurement**

In this study, using the five instruments, as follows:

1. Cultural care behavior instrument was developed by Wu, Larrabee, & Putman (2006); Leungarun, Wannasonadt, & Chitvibon (2012) adjusted the language to suit the context of the research with 24 items, consisting of 4 elements, including the following aspects: 1) the assurance of human presence; 2) professional knowledge and skill; 3) respecting the cultures of parents; and 4) positive connectedness. Each questionnaire is measure of the value of six levels, ranging from never to always, with a Cronbach's alpha confidence coefficient level of .93. The power of discrimination was between .42 and .79. The confirmed elements were between .26 and .67.

2. Cultural competence instrument: the instrument developed by Phokha (2009) and the Cultural Competence Scale (2012) by Siriphan (2012) was adjusted to language to better suit the context of the research had 21 items, consisting of 5 elements, including: 1) cultural awareness; 2) cultural knowledge; 3) cultural skills; 4) cultural encounter; and 5) cultural desire. Each questionnaire is measured on a six of the value of six levels, ranging from not true at all (one point) to the truest (six points). Cronbach's alpha confidence coefficient was .94. The power of discrimination was between .35 and .77. The confirmed factor analysis were between .32-.72.

3. Cross-cultural experience instrument: the researcher developed from the cross-cultural experience of Bernal and Froman (1993) and the Cross Cultural Experience Scale (Farber, 2015) by adjusting the language to suit the context of the research. There were 7 items, consisting of the following three elements: 1) education experience and learning a foreign language; 2) employment experience; and 3) living and working experience. Each questionnaire is measured as an assessment scale, including the gauge measured the value of ranging from six levels from not true at all (one point) to the truest (six points). The Cronbach's alpha coefficient of confidence coefficients was .90. The power of discrimination was between .54-.86. The confirmed element analysis values were between .53-98.

4. Cultural attitude instrument. The researcher developed this instrument based on a concept of McGuire (McGuire, 1985) and Silaprommas (2004) adjusted the language and created questions to suit the context of the research. There were a total of 11 items consisting of three elements: 1) cognitive components; 2) affective components; and 3) action tendency components. The characteristics of the questions included an assessment scale, with six levels from least (one point) to the maximum (six points). The Cronbach's alpha coefficients of the confidence coefficients was .70. The discriminating power was between .42 and .72, and the confirmed factor analysis was between .27 and .92.

5. Perceived organizational support instrument: this tool was based on the instrument developed by Thiposot (2013) and Pimthong (2014) and the language was adjusted to create more questions to suit the context. There were 26 items, consisting of the following five elements: 1) compensation; 2) knowledge of work and opportunities; 3) job security; 4)
emotional factors; and 5) work practices. Each questionnaire's response format included a six-point Likert scale which ranged from strongly disagree (one point) to strongly agree (six points). The Cronbach's alpha coefficients of confidence coefficients was .96. The power of discrimination was between .56 and .86 and the confirmed factor analysis values were between .29 and .64.

Data collection

The data collection using structured self-report questionnaires between January and March of 2018. The researcher contacted nursing department in four private international hospitals in Bangkok. The researcher explained the purpose of the current study and data collection methods to nursing managers and requested their participation in the study. The eligible participants were recruited as the inclusion criteria. The participants were asked to complete the informed consent form and complete the survey. The questionnaires were sealed in envelopes and sent to the relevant nursing departments for the collection of data. The signed consent forms and completed surveys were collected two weeks later by post.

Data analysis

The data analysis employed an analysis of the basic statistics of the observable variables tested the hypothesized model (Figure 2). The internal reliability of the measurement tool was tested using Cronbach’s alpha. The normality of the data was tested using skewness and kurtosis, and the results satisfied the normality requirement. Therefore, a maximum likelihood analysis was used for an estimate. The correlations between the variables were analyzed using the Pearson’s correlation. The latent variables were confirmed by factor component analysis. An examination of the model was tested using the goodness of fit test. The parsimony fit indices were a Chi-Square ($\chi^2$/df≤5), standardized chi-square test, and the incremental fit index (SRMR≤0.08, RMSEA≤0.08, GFI≥0.90, CFI≥0.90, NFI≥0.90) (Schumacker & Lomax, 2010; Hair et al., 2010).

Results

Demographic Characteristics

The data was collected from four hundred and fifty one professional nurses; including seven men (1.6%), four hundred and forty one women (98.4%); aged twenty to thirty; two hundred and thirty two people (51.4%) aged thirty-one to forty years old; and one hundred and seventy people (37.7%) aged forty one to fifty years of age; forty two people (9.3%), and seven people aged fifty one to sixty years of age (1.6%). In terms of religion, the samples were primarily Buddhists, with a total of four hundred and sixteen (92.2%); twenty six Christians (5.8%); and nine Muslims (2%). In terms of work experience, one hundred and ninety eight of the subjects worked for one to five years (43.5 %); one hundred and thirty six staff members with ten years of work experience and thirty three with eleven to fifteen years (29.5 %); and forty two (42 %); with more than fifteen years(16 %). In terms of their department, fifty staff members (11%) were in the outpatient department; one hundred and sixty six (36.8%) in the out-patient department and two hundred and eighty five in-patient departments (63.2%). The aspect of language proficiency included four hundred and forty one English speakers (91.8%); twenty Arabic speakers (3.5 %); three Chinese speakers (0.7%); as well as other languages, including Cambodian, Lao, Korean, Malaysian, and twenty six speakers of Japanese (5.7%). The test results showed that all observed variables had normal curvature distribution based on the statistical significance test results for both skewness and kurtosis.
Table 1

Correlations among Measured Variables (N= 451)

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Test of Hypothetical Model

The results of the data analysis revealed that the acceptable of fit test SRMR, RMSEA, GFI, NFI, CFI, chi-square correlation ($\chi^2/\text{df}$) were tested for the hypothetical model. The results were SRMR = 0.078, RMSEA = 0.072, GFI = 0.97, NFI = .97, CFI = 0.97, ($\chi^2/\text{df}$) = 3.35 and therefore concluded that the causal model of cultural care behavior was in accordance with the empirical data.

In Table 2, the results found that cultural competence had a direct effect on cultural care behavior, $\beta = 0.63$ ($p<0.05$), cultural attitudes and cross-cultural experience had an indirect effect on cultural care behavior and $\beta = 0.55$ and 0.14 ($p<0.05$) respectively. Variable perceived organization support had a direct effect on cultural care behavior $\beta = 0.11$ ($p<0.05$). These variables explained cultural care behavior coefficient ($R^2$) of 0.84, cultural attitude and cross-cultural experience had a direct effect on cultural competence, and $\beta = 0.88$-0.22 ($p<0.05$), respectively. These variables explained the cultural competence coefficient ($R^2$) of 0.50.
Model of Competence and Behavior

Table 2
Standardized Direct, Indirect and Total Effects of the Model (N=451)

<table>
<thead>
<tr>
<th>Exogenous Variables</th>
<th>Endogenous variables</th>
<th>Cultural competence</th>
<th>Cultural care behavior</th>
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<tr>
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<td>DE</td>
<td>IE</td>
<td>TE</td>
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<tr>
<td>Cultural attitude</td>
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<td>Perceived organization support</td>
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<td>-</td>
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<tr>
<td>Cultural competence</td>
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<tr>
<td>R²</td>
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DE = Direct effect; IE = Indirect effect; TE = Total effect

This study aimed to examine the causal model, cultural competence and cultural care behavior explained the cultural competence and cultural care behavior of nurses, which were found to possess acceptable explanatory power in accounting for 50% of cultural competence scores and 84% of cultural care behavior.

Hypothesis testing: The path coefficient of the final model was evaluated. Among the nine hypotheses in the hypothetical model, six of them (H1-H3, H6, H8, H9) were confirmed to have statistically significant direct, indirect, and total effects which are shown in the table, cultural competence had direct effect on cultural care behavior. Cultural attitude and cross-cultural experience had an indirect effect on cultural care behavior. Cultural attitude and cross-cultural experience had a direct effect on cultural competence according to Hypothesis H2,3 explained that Cross-cultural is a factor effect on cultural competence (Lopes-Murphy & Murphy, 2016) and result in behavior. Perceived organizational support had a direct effect on cultural care behavior according to Hypothesis H6. According to theoretical social cognitive theory of Bandura (1986), It believed that personal factor as cross-cultural experience and cultural
 attitude, environment factor as perceived organization support so cause of personal behavior as cultural care behavior. Furthermore the result showed that cultural competence had strong effect on nurses’ cultural care behavior and according to Kiyomet (2011) found that competence of lecturer effect on value and behavior. Cross – culture experience direct effect on cultural competence according to study of Almutairi, Adlan, & Nasim (2017). Furthermore cross – culture experience and cultural attitude had direct effect on cultural competence according to Ahn (2017). However, the result as perceived organization support have no effect on cultural competence which this result is difference from Ahn (2017). But perceived organization support have effect on cultural care behavior.

Garneu and Pepin (2015) found that when nurses and student nurses were confronted with cultural differences, so they adapted appropriate nursing care for the patients so that they received the effective and quality care. Nurses had positive cultural attitude effects on cultural competence because they were willing to care for culturally diverse patients. Moreover, perceived organizational support directly affected cultural care behavior of nurse’s organization support training, policies, patient information and education material in foreign languages, well as providing interpreters. When they encountered and faced in their nursing practice in a culturally diverse context, they were initially aware of their own culture, so they integrated this difference in their relationships. Nurses and student nurses communicated so that it was at the heart of building relationships and interactions with patients which were appropriate for a culturally diverse context. They received support learning from organizations to build cultural knowledge and understanding health beliefs, values and the life ways of patients. If nurses had cultural competence, then action-based cultural care behaviors, such as respect and good interactions with patients provided the knowledge and skill to take care of patients in accordance with cultural diversity. Therefore, if nurses have cultural competence, they will demonstrate cultural care behaviors. This study could offer a theoretical base to develop a training program on cultural competence and cultural care behavior for foreign patient care. This study can help anyone develop interventions on how to communicate and encounter patients, share previous experiences and adjust their attitudes.

Conclusion

This study review a theoretical model designed to explain the cultural competence and cultural care behaviors of nurses with at least one year of previous experience of caring for foreign patients in private international hospital. The hypothetical model was based on the social cognitive theory of Bandura (1986). The model included a review of the literature, revised CFA and examined causal models of cultural competence and the cultural care behavior of nurses. Furthermore, the model supported the direct and indirect paths proposed in six out of nine hypotheses tested in the present study. The factors that had a direct and indirect impact on the cultural care behavior of nurses were cultural competence, perceived organizational support, cultural attitude and cross-cultural experience. Furthermore, cultural attitude and cross-cultural experience had a direct impact on cultural competence.

The recommendations for this study were to enhance the cultural competence of nurses on cultural care behavior using a development program to improve cultural encounter and cultural desire first. The organization should support employees, in terms of training and opportunity, compensation, job security, emotional factors and work practices.
Limitations of the Study

The measurement tools employed in this study were developed overseas and adjusted according to the context. Moreover, this study collected the data in private international hospitals in Bangkok. Therefore, the research results could not be generalized to all nurses working in government hospitals with foreign patients because of the different contexts.

The study investigated the factors which may influence cultural competency and cultural care behaviors among professional nurses in private international hospitals. Social cognition theory (Bandura, 1986) was used as the conceptual framework which underpinned the research and the influence of people and environmental factors on professional behavior were tested.

The personal factors that assessed and influenced the cultural care behaviors of professional nurses were cross-cultural experience and cultural attitude. These factors were the causes and effects of cultural competence and indirect effects on cultural care behavior. The environmental factor assessed influenced perceived organization support the causes and effects of cultural care behavior.

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