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Relationship Between Nurse Educators' Cultural Competence and  
Ethnic Minority Nursing Students' Recruitment and Graduation

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A dissertation

presented to

the faculty of the College of Nursing

East Tennessee State University

In partial fulfillment

of the requirements for the degree

Doctor of Philosophy

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by

Pearl N. Ume-Nwagbo

December 2008

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Keywords: Ethnic Minorities, Cultural Competence, Nurse Educators,  
Nursing Students, Under-Representation

## ABSTRACT

### Relationship Between Nurse Educators' Cultural Competence and Ethnic Minority Nursing Students' Recruitment and Graduation

by

Pearl N. Ume-Nwagbo

The purpose of this exploratory study was to measure the cultural competence of nurse educators in accredited baccalaureate (BSN) nursing programs in Tennessee (TN) and investigate the relationship, if any, between nurse educators' cultural competence and the percentage of minority nursing students recruited into and graduated from these schools in the previous 5 years.

With the rapid rise of the minority population in the United States, more minority healthcare providers, including nurses, are needed to provide culturally congruent care in underserved communities. Literature has implied that nurse educators' lack of cultural competence and sensitivity regarding minority nursing students' educational needs could be a contributing factor to minority nurses' underrepresentation.

Nurse educators in 9 accredited colleges of nursing in TN completed the "Cultural Diversity Questionnaire for Nurse Educators." Some of the participating schools and the American Association of Colleges of Nursing Research Data Center provided the percentage of students recruited and graduated in each school by ethnicity.

The findings revealed that the majority of respondents were at least moderately culturally competent. There was no correlation between Tennessee schools' mean cultural competence scores and their percentages of minority students recruited into BSN programs in the past 5 years. But there was a significant statistical correlation between Tennessee schools' mean cultural competence scores and their percentages of minority students graduated from BSN programs in the past 5 years ( $p = .015$ ). There was a statistically significant difference between the mean cultural competence score of respondents who had lived in a culture different from the United States and those who had not ( $p = .01$ ). There was also a statistically significant difference between the mean cultural competence score of respondents who had attended multicultural education seminars in the past 5 years and those who had not ( $p = .0005$ ).

The researcher recommended that nursing faculty engage in activities that would increase their cultural competence, enabling them assist students from diverse cultural backgrounds stay in school and graduate.

## DEDICATION

To my husband Ebele and our children, Nwabundo, Osita, and Ndubisi

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## CHAPTER 1

### INTRODUCTION

This chapter provides information on the rapid increase of the ethnic minority population, health of the minority population, barriers to minority healthcare access, underrepresentation of minority nurses and nursing students, and reasons for minority nurses' underrepresentation. Also presented in this chapter, are the significance of the study, statement of the problem, study variables, research questions, and hypotheses.

The ethnic minority population in the United States (U. S.) is underrepresented in the nursing profession despite the rapid increase of ethnic minorities in the general population. For the purpose of this paper, the term ethnic minority population is used synonymously with minority population and defined as American Indians and Alaskan Natives, African Americans and Africans, Asians, Hispanics, and Native Hawaiians and Pacific Islanders residing in the United States. See Appendix A for definition of ethnic. Minority underrepresentation in the nursing profession exists when the percentage of ethnic minority individuals in the nursing profession is lower than the percentage of ethnic minority groups in that population. As ethnic minority groups continue to grow, the number of minority clients needing healthcare services will also continue to rise. It is important to increase the number of minority students recruited and graduated from nursing programs to provide culturally congruent care to clients from diverse backgrounds. The number of minority nursing students admitted and graduated directly impacts the number of minority registered nurses available to provide care in underserved communities. The limited number of minority graduates also impacts the number of minority nurses available to pursue graduate education, resulting in a paucity of minority nursing faculty.

Several studies have implied that nurse educators' lack of cultural awareness, sensitivity, and competence could be a possible contributing factor to underrepresentation of minority nursing students (Gardner, 2005a; Kirkland, 1998; Yoder, 1996). See Appendix A for definition of nurse educator. The premise of this study is that nurse educators who are culturally competent are more likely to be sensitive to the needs of minority students and help them progress and graduate from the program. Cultural competence is defined as "the process in which the healthcare provider [nurse educator] continuously strives to achieve the ability to effectively work within the cultural context of a client [student], individual, family, or community" (Campinha-Bacote, 1998, p.6). This study will measure the levels of cultural competence among nurse educators in Tennessee accredited baccalaureate nursing programs and investigate the relationship, if any, between nurse educators' levels of cultural competence and the percentage of minority nursing students recruited and graduated from these schools in the past 5 academic years.

#### Shift in Minority Population

The ethnic minority population in the U. S. has increased from 21% in 1980 to 28% in 2000 (U. S. Census Bureau, 2008). It is projected that by 2020 the percentage of ethnic minority residents will rise to 36% of the total U. S. population (U. S. Census Bureau, 2008); by 2050 the U. S. ethnic minority population will comprise 50% of the total U. S. population (U. S. Census Bureau, 2004). This rise in ethnic minority population is likely to result in increased numbers of minority clients needing healthcare services. According to Andrews (1992), members of some minority groups demand culturally relevant healthcare to accommodate their specific beliefs and practices. In addition, not all clients from diverse minority groups are comfortable with Western healthcare practices, thus, necessitating modification in the traditional delivery system or finding

ways to increase their comfort level. Thomas (1991) hypothesized that as diversity increases, individuals begin to show pride in their differences and become unwilling to assimilate to the dominant values and healthcare practices. In addition, members of some minority groups do not speak English and have beliefs, values, and healthcare practices that are different from those of the dominant culture. In order to meet the healthcare needs of this culturally diverse population, more minority nurses are needed. Nurses spend more time with clients than any other healthcare provider (Cannon, 2006) and as such nurses are in a better position to assess and identify the cultural needs of their clients. For example, hospitals are structured so that of all healthcare providers only nurses are physically present with clients 24 hours a day, 7 days a week. The other healthcare providers are on call or summoned to the client's bedside only when their services are needed. Similarly, in home health settings, each client is assigned a nurse who visits the client on a regular basis, while other healthcare providers such as physical and respiratory therapists are called in only when their specialty is needed.

#### Health of the Minority Population

Several reports suggest the healthcare needs of ethnic minority groups in the nation have been underserved, and the health status of ethnic minorities continues to be lower than Caucasians. The Institute of Medicine (IOM, 2002) reported that several studies found that ethnic minorities receive lower quality healthcare than their Caucasian counterparts, even when insurance, income, age, and severity of health-related conditions were similar. This report also indicated that U. S. ethnic minorities are less likely to receive routine healthcare services than Caucasians.

*The Report of the Secretary's Task Force on Black and Minority Health* revealed large and persistent gaps in health status among Americans of different racial and ethnic groups



(Office of Minority Health, 2004a). Additionally, minorities have less access to and availability of mental health services and are less likely to receive needed mental health services. When these services are available, they tend to be of lower quality (Office of Minority Health, 2004b).

Not only are minorities underserved, they have been identified as having higher morbidity and mortality rates than Caucasians. Infant death rates among African Americans, American Indians, and Alaskan Natives are more than double that of Caucasians. Death rates due to heart disease are more than 40% higher in African Americans than Caucasians and the death rates for all cancers are 30% higher in African Americans than for Caucasians. Hispanics living in the United States are more likely to die from diabetes than Caucasians (Office of Minority Health, 2004a). Because of these health and healthcare disparities, the federal government has issued a call to improve the health of the ethnic minority population in the U. S. (U. S. Department of Health and Human Services, 1998; U. S. Department of Health and Human Services, 2000).

### Improving Minority Health

In an effort to improve the health status of underserved populations, including ethnic minorities, the U. S. Department of Health and Human Services created the Office of Minority Health in 1985. The Centers for Disease Control and Prevention (CDC) created its own Office of Minority Health in 1988; and Congress passed the “Disadvantaged Minority Health Act of 1990” (Office of Minority Health, 2004a). The second goal of *Healthy People 2010* is to eliminate health disparities among different segments of the population, e g., by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation (Office of Minority Health). The IOM (2002) report stated that more ethnic minority healthcare providers, including nurses, are needed because they are more likely to serve in minority and medically underserved

communities than their Caucasian counterparts. In reaction to the rising ethnic minority population, *Healthy People 2010* (U. S. Department of Health & Human Services, 2000) called for an increase in the number of health profession degrees awarded to underrepresented ethnic minority groups. It is believed that more minority healthcare providers will offer better access to care and improved quality of care for minority populations (IOM; McLean & Graham, 2003; U. S. Department of Health & Human Services, 2000).

### Barriers to Minority Healthcare Access

#### *Language Difficulty and Healthcare*

Limited English proficiency has been cited as one reason ethnic minority clients do not seek healthcare services. Johnson, Roter, Powe, and Cooper (2004) studied the quality of client-physician communication during visits and found that physicians were more verbally dominant and tended to be less client-oriented in their approach to African American clients than Caucasians. Gerrish (2001) studied district Caucasian nurses who provided care to South Asian clients, some of whom had limited English proficiency. She found that those clients with limited English proficiency received lower quality healthcare than those who understood English. McLean and Graham (2003) reported that many Latino participants in their study said that having healthcare providers who understand both their language and culture would make a difference in their interactions with physicians. The participants described “effective communication as more than just accuracy in translation,” and that “[G]ood communication involves a deeper understanding of cultural values....” (p. 1). Murphy and Clark (1993) also identified language difficulties as a major cause of low quality healthcare provided to ethnic minority clients. The respondents stated that language difficulty was one of the main deterrents to providing quality healthcare because without effective communication clients could not

understand their health problems and how to manage these problems themselves. Cook, Kosoko-Lasaki, and O'Brien (2005) found that for some minority clients communication barriers created problems when seeking healthcare services, and that healthcare providers did not have adequate knowledge about clients' ethnicity and culture. The authors commented that lack of cultural understanding and sensitivity by providers contributes to problems with communication, trust, and satisfaction.

Bischoff et al. (2003) found that language barriers prevented nurses who assessed asylum-seekers in Geneva, Switzerland from adequately referring these clients for psychiatric services. When there was client-nurse language concordance, more adequate referrals resulted; but when client-nurse language demonstrated discordance, fewer adequate referrals were made. In their literature review, Ferguson and Candib (2002) found consistent evidence that race, ethnicity, and language influenced the quality of relationships between clients and physicians. They found that minority clients, especially those with limited English proficiency, were less likely to elicit empathy from their physicians. Also, they were less likely to establish rapport with their physicians, receive sufficient information about their presenting problem, and participate during visits with their physicians than nonminority clients. The authors commented that building rapport using empathy and effective communication skills was important in forming effective and trusting relationships between healthcare providers and clients. As mentioned before, nurses spend substantial time with clients and much of this time is spent building rapport and forming warm, therapeutic relationships with clients. Both Henderson (1966) and Peplau (1952) developed their nursing theories around this professional relationship.

If language difficulties result in failure to access care and receipt of poorer quality healthcare, it stands to reason that increasing the number of minority healthcare providers could

reduce communication barriers and increase access to quality healthcare among ethnic minority populations. Having healthcare providers who speak a client's language is preferable to having nonhealthcare interpreters who may not be proficient in healthcare terminology or able to give accurate information to clients. Elderkin-Thompson, Silver, and Waitzkin (2001) examined the accuracy of interpretations provided by nurses who were not trained in health-related interpretation but had excellent bilingual skills. They found that approximately two thirds of uncomplicated cases contained no errors that jeopardized the diagnosis and treatment of clients. However, one third of the uncomplicated cases and two thirds of the complicated cases had communication problems that resulted in errors or significant omissions in clients' charts.

#### *Race Concordance and Healthcare*

Race concordance between clients and healthcare providers has also been found to be more satisfactory to clients. LaVeist and Nuru-Jeter (2002) and LaVeist and Carroll (2002) found that among their respondents, those who were race concordant reported greater satisfaction with their healthcare providers compared with respondents who were not race concordant. Several studies have also shown that racial concordance between clients and healthcare providers affects clients' satisfaction with the healthcare they received (Cooper et al., 2003; Cooper-Patrick et al., 1999; Malat, 2001; Saha, Komaromy, Koepsell, & Bindman, 1999). Ethnic minority clients were more likely than their Caucasian counterparts to report that 1) they would receive better care if they belonged to another race or ethnicity; 2) healthcare providers treated them unfairly or with disrespect because of their ethnicity; and 3) healthcare providers were unfair to them or showed no respect to them on the basis of how well they spoke English (Johnson, Saha, Arbelaez, Beach, & Cooper, 2004). van Ryn and Burke (2000) found evidence that healthcare providers display bias toward and stereotype their clients in the absence of client-healthcare provider race

concordance. See Appendix A for definition of stereotype. Cooper-Patrick et al. argued that healthcare providers and clients belonging to the same race or ethnic groups are more likely to share similar cultural beliefs, values, and experiences that might enable them to communicate more effectively and feel more comfortable with each other. If clients are more satisfied with healthcare providers of similar race and ethnicity, as studies have indicated, it is likely that having more minority healthcare providers could result in clients seeking timely treatment, overall improvement in health, fewer health problems and less healthcare disparity.

### *Lack of Trust in Healthcare*

Lack of trust in the healthcare system by ethnic minorities has been listed as a reason for minorities to not seek timely healthcare services. Whetten et al. (2006) found mistrust of the healthcare community prevented both ethnic minority and nonminority clients in their study from seeking healthcare services. The authors commented that this finding, members of nonminority groups being distrustful of providers and the government, was new to the trust and health literature, suggesting that ethnic minority clients' mistrust of healthcare providers and government is not new. LaVeist, Nickerson, and Bowie (2000) and Doescher, Saver, Franks, and Fiscella (2000) found that ethnic minorities in their studies reported more mistrust of their physicians than Caucasians. One study found that nearly 40% of minority clients compared to 24.1% of Caucasian clients believed that hospitals often asked too much information about clients' personal affairs (LaVeist et al.). The minority groups were almost twice as likely as Caucasians to agree or strongly agree, "hospitals have sometimes done harmful experiments on patients without their knowledge" (p. 152). LaVeist et al. also found that ethnic minority clients perceived more racism in the healthcare services they received than Caucasian clients did. With more minority nurses and other healthcare providers, it is possible that ethnic minority clients

might reestablish trust in the healthcare system thereby empowering them to seek additional services, improve their health status, and reduce health disparities. If providing more ethnic minority healthcare providers, including nurses, resulted in increased access to healthcare services, improved quality of healthcare and increased trust in the healthcare system for the minority population, their health status would improve with resulting reductions in health and healthcare disparities. The problem is minority healthcare providers, including nurses, are consistently underrepresented.

#### Underrepresentation of Minority Nurses

Ethnic minorities have provided care to sick individuals since before nursing schools were established in the United States (Carnegie, 1995); and minorities have attempted to increase their numbers in the nursing profession since formal training was established in the U. S., (Davis, 1999). However, little progress has been made. The National Association of Colored Graduate Nurses (NACGN) was the only professional association to recruit African American nurses and students on a national scale (Carnegie). Admission of minority students was restricted by quotas when nursing schools were first established in the U. S. (Carnegie). For example, when the New England Hospital for Women and Children was opened in Boston, (1863), only one African American and one Jew were admitted in each class (Carnegie). Mary Eliza Mahoney, the first African American professional nurse, Martha Minerva Franklin, and Adah Belle Samuels Thoms (Davis) were African American women who fought for equal opportunities for minority nurses and made considerable efforts to increase the number of minority nurses in the early 20th century without success. Franklin actively campaigned against racial discrimination and founded the NACGN in 1908 to promote working standards for African American nurses (Carnegie). Thoms

fought for African American nurses to be accepted as members of the American Red Cross as well as equal rights for minority nurses in the U.S. Army Nurse Corps (Davis).

Several other attempts were made to increase the number of minorities in higher education, including nursing schools. The Sealantic Project, funded by the Sealantic Fund established in 1938 by John D. Rockefeller, aimed to increase the number of minority students admitted and graduated from nursing schools (Carnegie, 1995). The Civil Rights Act of 1964 prohibited racial segregation in institutions of higher learning; and the Nurse Training Act of 1964, with its subsequent revisions, provided funding to increase the number of ethnic minority nursing students (Miller, 1985). The Higher Education Act of 1965 provided monies not only to help low-income students but also for the admission and support of ethnic minority students. In 1965, Breakthrough to Nursing, a project of the National Student Nurses' Association (NSNA), was established with the goal of increasing the number of minority healthcare providers (National Student Nurses' Association, 2004).

Other attempts were made through both privately and federally funded projects to increase minority representation in the nursing profession (Carnegie, 1995). The American Nurses Association (ANA) Minority Fellowship Program (MFP) secured a grant in 1974 to increase the number and quality of ethnic minority nurse researchers and provide scientific data to increase the quality of mental healthcare services for ethnic minority clients (Carnegie; MinorityNurse.Com, 2004). The W. K. Kellogg Foundation provided grants for Project LEAD (Leadership Enhancement And Development) to support schools of nursing at historically black colleges and universities and to increase nursing leadership training in these schools (American Nurses Foundation, 2008). The Clara Lockwood Fund was originally initiated to encourage

American Indians to secure nursing education, but in 1983 the interest accruing from the Fund was approved to support graduate education for all ethnic minority nurses (Carnegie).

In spite of these efforts, minority underrepresentation in the nursing workforce remains a reality. Buerhaus and Auerbach (1999) reported that the percentage of ethnic minority registered nurses (RNs) had grown from an estimated 6.3% in 1977 to 9.75% in 1996 – a meager growth of 3.4% in 20 years. A survey by the federal Health Resources and Services Administration (HRSA) revealed that the number of ethnic minority RNs had risen to 12 % of all RNs in 2000 (Spratley, Johnson, Sochalski, Fritz, & Spencer, 2001). Minority underrepresentation in nursing is attributed to the high attrition rates, 15 % to 85% of minority nursing students (Rodgers, 1990), rather than attrition of minority registered nurses. According to the HRSA survey, of all ethnic minority nurses, 86% were employed, while only 81% of all Caucasian nurses were employed. Additionally 77% to 86% of employed ethnic minority nurses worked full time compared to just 70% of employed Caucasian nurses (Spratley, Johnson, Sochalski, Fritz, & Spencer). In 2003, ethnic minority nurses comprised approximately 19% of the registered nurse workforce (U. S. Department of Labor, 2005). In Tennessee, minority groups represented 8.3% of the registered nurse workforce in 1986 and by 2000 the percentage had grown to 9.4% (Tennessee Center for Nursing, n.d.). Despite these increases, Caucasians continue to dominate the nursing profession with 81.8% in the workforce in 2004 (Steiger, Bausch, Johnson, Peterson, & Arens, 2004); while comprising only 67.9% of the U. S. population at that same time (Health Resources and Services Administration, 2004).

Not only are ethnic minority nurses underrepresented in the workforce, research findings also report that ethnic minority nursing students are underrepresented. According to the National League for Nursing (1996), only 15.75% of all enrolled students in Registered Nurse (RN)



programs in 1993 were minority students. A survey by the Southern Regional Education Board (SREB) reported that ethnic minority nursing students comprised approximately 30% of all enrolled students in baccalaureate nursing programs in the 2000-2001 academic year (Pearcey, Corder, Dennis, Wilson, & Uriri, 2001). The American Association of Colleges of Nursing (AACN, 2006a; AACN, 2006b) reported that in the state of Tennessee, Caucasians outnumbered ethnic minority students in both RN to baccalaureate programs and generic baccalaureate nursing programs during the fall of 2005, 80.9% and 82.6% respectively. One way of improving the health and healthcare of the minority population is to increase the number of ethnic minority nursing students recruited, retained, and graduated, increase the number of minority nurses in the nursing workforce, and provide culturally acceptable healthcare services for the increasing number of ethnic minority clients. For this reason, it is necessary to address the issue of ethnic minority students' underrepresentation in nursing programs.

#### Underrepresentation of Minority Nursing Students

Many factors have been identified as contributing to the underrepresentation of ethnic minority students in nursing programs. Martin-Holland, Bello-Jones, Shuman, Rutledge, and Sechrist (2003) identified financial difficulties, poor educational preparation, lack of minority faculty role models, language difficulties, and differences in cultural beliefs as some of the barriers to success among minority nursing students in their study. Kirkland's (1998) study identified financial difficulties, family conflicts, time management, lack of minority faculty role models, poor interactions with Caucasian faculty, lack of social support, and perceived insensitive attitudes from Caucasian nurse educators and peers as barriers to the success of ethnic minority nursing students. Kirkland suggested that nurse educators learn about the culture and

needs of minority nursing students and provide advisement and mentoring to promote retention and graduation of these students.

Manifold and Rambur (2001) and Gardner (2005a) identified difficulties speaking, understanding, and writing English as barriers to success among the ethnic minority nursing students they studied. The authors suggested that a program to help students use English effectively could enable students to stay in the program and succeed. Gardner also identified loneliness, isolation, cultural differences, absence of acknowledgement of individuality from nurse educators, peers' lack of understanding and knowledge about cultural differences, lack of support from teachers, and coping with insensitivity and discrimination as barriers experienced by minority nursing students in their educational pursuits. Gardner suggested that by understanding students' experiences and perspectives, nurse educators might meet the educational needs of minority nursing students and increase their graduation rates.

Hassouneh-Phillips and Beckett (2003) found that racism, nurse educators' lack of interest in cultural diversity, unwillingness of nurse educators and Caucasian students to challenge racist behaviors of others, and pressure to conform to the traditional method of European education were barriers to success encountered by minority nursing students in their study. See Appendix A for definition of racism. Weaver (2001) reported perceived racism and stereotyping, culture shock, cultural differences, isolation, and assumptions about their cultural identity as barriers identified by minority nursing students in the study. See Appendix A for definition of culture shock. The author remarked that while many participants in her study did not identify any struggles in their educational pursuit, some respondents identified many problems; she urged all nursing programs to consider the type of situations American Indian

students experience in nursing schools and develop educational programs to respond to the needs of students from diverse populations.

Yoder (1996) reported that nurse educators who had low levels of cultural competence did not meet the educational needs of culturally diverse students, while educators with higher levels of cultural competence were better able to identify and meet the educational needs of culturally diverse students. The deans and directors in Grossman's et al. (1998) study reported that lack of cultural knowledge, sensitivity, and awareness were the most critical issues related to diversity in their schools. Literature suggests that by increasing nurse educators' levels of cultural awareness, sensitivity, and competence, the needs of culturally diverse nursing students would be identified and met, which in turn could result in increased retention and graduation rates of ethnic minority nursing students.

Literature has shown that faculty cultural competence impacts minority students' success. Therefore, this study measures nurse educators' levels of cultural competence and investigates the relationship, if any, between nurse educators' levels of cultural competence and the percentage of minority nursing students recruited and graduated in accredited colleges of nursing in the state of Tennessee in the past 5 academic years.

#### Significance of the Study

More minority nurses are needed to effectively care for the increasing number of minority clients. Additionally, nurse educators are expected to adequately prepare all nurses to provide culturally congruent care for their clients. Yet, literature has shown that nurse educators' low levels of cultural competence are possible contributors to the low retention and graduation rates of ethnic minority nursing students (Gardner, 2005a; Yoder, 1996). It is important to measure nurse educators' levels of cultural competence and investigate the

relationship between cultural competence and the percentage of ethnic minority students recruited and graduated to:

1. establish nurse educators' levels of cultural competence;
2. reveal a relationship, if any, between nurse educators' levels of cultural competence and the percentage of minority students recruited and graduated.

#### Statement of the Problem

In summary, literature supports that ethnic minority populations in the United States are increasing (U. S. Census Bureau, 2004; U. S. Census Bureau, 2008), and they have poorer health status than the dominant population (IOM, 2002). These individuals have a lower trust of and satisfaction with healthcare services provided by healthcare providers who have little understanding of their clients' cultures (LaVeist et al., 2000; LaVeist & Nuru-Jeter, 2002). Minorities are underrepresented in the nursing workforce (U. S. Department of Labor, 2005), among nursing faculty, and among nursing students (Southern Regional Education Board, 2001). Also, previous studies indicated above agree that it is imperative to increase the number of ethnic minority nurses in the healthcare workforce to provide more effective healthcare services to underserved groups.

Although it has not been conclusively shown, previous studies suggested that increasing both the cultural competence of nonminority faculties and the percentage of minorities in nursing faculties could lead to increased numbers of minorities graduating from nursing schools and entering the nursing workforce (Kirkland, 1998; Yoder, 1996). This in turn could lead to improved healthcare for minorities. However, the connection between cultural competence of nurse educators and increasing the number of minority nursing students recruited and graduated has not been established.

Unfortunately, few studies have addressed the issue of cultural competence among nurse educators. Ruiz (1981) investigated the relationship between nursing faculty's ethnocentrism and their attitude towards culturally diverse clients. See Appendix A for definition of ethnocentrism. Yoder (1996) investigated how nurse educators teach students from diverse ethnic groups. Sealey (2003) examined the cultural competence of nurse educators teaching in baccalaureate nursing programs in Louisiana, and Kardong-Edgren et al. (2005) examined faculty attitudes, perceived cultural knowledge, and cultural skill in caring for clients from four ethnic groups. These researchers generally found that nurse educators with high cultural sensitivity and competence were more likely to meet the needs of culturally diverse nursing students and feel more comfortable providing nursing care to clients from diverse cultural backgrounds. However, they did not address the vital issue of the relationship between nurse educators' levels of cultural competence and the percentage of ethnic minority nursing students recruited and graduated. In particular, there was no published study found on the relationship between nurse educators' cultural competence and the percentage of ethnic minority students recruited and graduated from nursing schools. It is critically important to establish the relationship between the cultural competence of nursing faculty and the retention and graduation of ethnic minority nursing students. Therefore, the purpose of this study was to investigate nurse educators' levels of cultural competence and correlate it with the percentage of ethnic minority students recruited and graduated from accredited baccalaureate nursing programs in Tennessee. Information gathered from this study will be valuable to the nursing profession, a profession that has advocated for nurse educators to become culturally competent and to act as role models for its diverse student bodies.

## Study Variables

The variables used in this exploratory study were based on reviewed literature.

Literature asserts that nurses need to be culturally competent and sensitive to meet the healthcare needs of clients from diverse cultural backgrounds (Leininger & McFarland, 2002; Purnell & Paulanka, 2003). Literature has also suggested that culturally competent nurse educators would be likely to meet the educational needs of nursing students from diverse backgrounds (Gardner, 2005a; Yoder, 1996). Meeting the educational needs of nursing students from diverse cultural backgrounds could result in increasing the number recruited and graduated; and meeting the educational needs of nursing students from diverse cultural backgrounds would require nurse educators who are culturally competent and able to demonstrate sensitivity to these needs, assisting students to stay in school and graduate. Several effective methods have been identified to increase individuals' levels of cultural competence. For example, cultural immersion experiences (Koskinen & Tossavainen, 2004; Ryan & Twibell, 2002), continuing education in transcultural nursing (Sealey, 2003), cultural interventions, and cultural projects (Anderson, 2004) are some of the methods shown to result in increasing levels of cultural competence. The study questions were derived from the linkages of the study variables; nurse educators' levels of cultural competence, living and practicing in a culture different from the United States, continuing education in transcultural nursing, and the percentage of minority nursing students recruited and graduated.

## Research Questions

1. What is the distribution of Tennessee baccalaureate (BSN) program's mean nurse educators' cultural competence score?

2. What is the distribution of cultural competence scores among nurse educators in Tennessee BSN programs?
3. Will Tennessee schools' mean nurse educators' cultural competence scores correlate with their percentages of minority nursing students recruited into BSN programs in the past 5 years?
4. Will Tennessee schools' mean nurse educators' cultural competence scores correlate with their percentages of minority nursing students graduated from BSN programs in the past 5 years?
5. Does experience living in a country with a culture different from the United States increase nurse educators' cultural competence scores?
6. Does attendance at multicultural education seminars during the past 5 years increase nurse educators' cultural competence scores?

#### Hypotheses

1. The majority of Tennessee BSN programs have a mean nurse educator cultural competence score under 130.
2. The majority of nurse educators in Tennessee BSN programs will have low cultural competence scores. Low is defined as under 130.
3. There will be a significant positive correlation between Tennessee schools' mean nurse educators' cultural competence scores and their percentages of minority nursing students recruited into BSN programs in the past 5 years.
4. There will be a significant positive correlation between Tennessee schools' mean nurse educators' cultural competence scores and their percentages of minority nursing students graduated from BSN program in the past 5 years.

5. Nurse educators who have had experiences living in a country with a culture different from the U. S. will have significantly higher cultural competence scores than those who have not.
6. Nurse educators who have attended multicultural education seminars during the past 5 years will have significantly higher cultural competence scores than those who have not.

### Assumptions

Participants in this study will be honest in their responses to the study questionnaire. Becoming culturally competent is important to the nursing profession. Many nurses would like to learn about their clients' cultural beliefs, values, and worldviews. To promote a trusting relationship between nurses and their clients, each client's cultural beliefs and values should be respected, even if they are not understood. The healthcare environment will be more satisfying to clients if nurses are knowledgeable about clients' cultural values, beliefs, worldviews, and healthcare practices.

### Summary

The ethnic minority population is rapidly increasing in the United States, but this change is not reflected in the composition of the nursing profession. Despite all efforts to resolve this problem, minority underrepresentation in nursing continues to be a reality. Nurse educators' lack of cultural competence has been suggested as contributing to this problem. The need to increase the number of minority nurses to provide better healthcare services to minority populations creates an imperative for nurse educators to be culturally competent. Cultural assessment could assist in ascertaining if faculties are sufficiently culturally competent to meet the needs of minority students, thus increasing the number of minority nursing students and



minority nurses in the profession. This study may also support or refute literature claims that nurse educators' lack of cultural competence contributes to the low number of minority nursing students.

## CHAPTER 2

### LITERATURE REVIEW

The previous chapter discussed the underrepresentation of ethnic minority groups in the nursing profession though ethnic minority populations in the U. S. continue to increase rapidly. Despite the need to increase the number of minority healthcare professionals, including nurses, and the efforts that have been made by several organizations to increase the number of minority nurses, the problem remains. Some studies have identified nurse educators' behaviors that may promote or impede retention and graduation of ethnic minority nursing students. Other studies have revealed that minority clients perceive healthcare services received from healthcare providers of similar race and ethnicity as more satisfactory than healthcare received from providers of different race and ethnicity.

This chapter provides an overview of culture and discusses situations that could cause stress and misunderstandings among individuals from various cultural backgrounds. Other topics include cultural competence in healthcare and other disciplines, cultural competence in the nursing profession, cultural competence and nurse educators, and strategies for increasing cultural awareness, sensitivity, and competence.

#### Culture

In the 19th century, culture was identified with the past and linked to fine arts and literature. A cultured person was described as one whose mind had been improved and enriched by the humanities (Zaragoza, 1993). In the 20th century, culture assumed a more anthropological meaning, when, at the World Conference on Cultural Policies held in Mexico City in 1983, culture was defined as “the whole complex of distinctive spiritual, material,

intellectual, and emotional features that characterize a society or group” (Zaragoza, p. 1). Currently, culture refers not only to knowledge of the arts, but also to modes of life, to the fundamental rights of the human being, value systems, traditions, and beliefs. Leininger and McFarland (2002) define culture as “patterned lifeways, values, beliefs, norms, symbols, and practices of individuals, groups, or institutions that are learned, shared, and usually transmitted intergenerationally over time” (p.83). Culture impacts and shapes individuals’ lives, including beliefs, values, worldviews, attitudes, emotions, behaviors, and lifestyles (Cheung, Shah, & Muncer, 2002); and lack of cultural knowledge, sensitivity, and competence can result in gross misunderstandings among individuals from different cultural backgrounds (Lemon, 2002; Maldonado-Duran, Munguia-Wellman, Lubin, & Lartigue, n.d.).

#### Effects of Cultural Blindness

Cultural blindness, often responsible for cultural incompetence, is the belief that one is unbiased, color or cultures make no difference, and that all individuals are alike (Ford & Whiting, 2007). Fadiman (1997) reported that Hmong parents have been arrested and imprisoned for child abuse because they used folk healthcare practices to treat their children. These incidents resulted from Caucasian healthcare providers’ limited understanding of Hmong cultural beliefs about illness and treatment. Healthcare providers have also failed to provide adequate pain relief to their clients because they did not understand how pain and discomfort were expressed in their clients’ cultures (Andrews, 1992). Individuals have been incorrectly diagnosed with schizophrenia and institutionalized due to healthcare provider’s ethnocentrism (Andrews).

#### *Cultural Differences*

Cultures differ in a variety of ways. Some cultures are not time-conscious and do not place emphasis on punctuality. A manager from a culture that is particularly time-conscious

might label an employee with an opposing view as “lazy and irresponsible,” a detrimental label for advancement in the organization. Some African countries associate the left hand with toileting; so, using the left hand to give or receive things is unacceptable. Nurses from Western cultures might label clients from these cultures “non-compliant,” if they refuse to accept medications, food, or treatments given to them by the nurse using the left hand. The client, on the other hand, might regard the nurse as rude and insolent.

Maintaining eye contact may also be a source of misunderstanding between clients and their healthcare providers. Clients from Western cultures may be disturbed if Chinese nurses avoid eye contact with them. Similarly, a Chinese client in the United States might be shocked by the boldness of young American nurses looking directly into clients’ eyes. One way to avoid these misunderstandings is if both clients and healthcare providers are knowledgeable about each other’s cultural beliefs. Lemon (2002) reported that an American nurse was shocked to hear a laboring Latino woman request to take her baby’s placenta home. The nurse wondered how the infection control supervisor would react to the request. The nurse’s reaction resulted from her lack of knowledge regarding some Latinos’ cultural beliefs about placentas; some Latinos expect to bury the placenta soon after it is born to ensure that a wild animal does not eat it. If this tradition is not followed and an animal eats the placenta, it is believed the woman will be unable to have more children in the future.

Some Chinese and Latino cultures consider the colostrum to be stale and dirty, and so discard it. Nurses from Western cultures, who regard colostrum to be nutritious, and beneficial to the baby, may label women who discard their colostrum, as “non-compliant.” Some Chinese cultures also advise breastfeeding mothers to eat a high salt diet encouraging the production of breast milk (Traditional Health Beliefs, n.d.). If women have high blood pressure and are being

treated with a low salt diet, adding extra salt to food might lead nurses who do not understand Chinese breastfeeding and diet beliefs to label these women “non-compliant.”

A sunken fontanelle in an infant is an indication of dehydration in Western culture. However, in some Latino cultures, sunken fontanelles are attributed to sudden removal of the nipple from the baby’s mouth or frightening the baby. To rectify this problem, parents may hold the baby upside down and gently tap the soles of the feet or apply upward pressure to the roof of the mouth (Kay, 1993; Kirhofer-Hansen, 1997). An American healthcare provider witnessing either treatment might conclude the baby is being abused.

An American physician scolded a Latino woman for breastfeeding her new baby in front of her 5-year-old. The physician told the mother that breastfeeding in front of the 5-year-old might be seductive for the child. The mother, on the other hand, was bewildered as to why her child would be disturbed by breastfeeding; after all, the child had often been witness to her mother and others breastfeeding their young ones (Maldonado-Duran et al., n.d.). This misunderstanding occurred because neither the physician nor the client was aware of the other’s cultural beliefs about breastfeeding. As a result, the woman stopped taking her child to the physician. These short narratives illustrate how the cultural awareness, sensitivity, and competence of healthcare providers, clients, and managers could be a major source of comfort and understanding, or stress and inaccurate conclusions, among people of diverse cultures.

#### Cultural Competence in Health Care and Other Disciplines

With the nation’s population becoming increasingly diverse, all individuals are encouraged to develop cultural awareness, sensitivity, and competence to successfully interact with residents from diverse cultures. Unfortunately, nurse educators, as well as other professionals, do not always have opportunities to develop cultural competence. It was reported

that nurse educators who scored high on ethnocentric measures also had negative attitudes toward clients from diverse cultural backgrounds. In addition, nurse educators who were open-minded viewed clients from four different cultural groups as less annoying and superstitious than nurse educators who were closed-minded (Ruiz, 1981). See Appendix A for definition of open-minded. Nurse educators who learn about different cultures should not only increase their cultural awareness and competence but also demonstrate sensitivity to the needs of clients from multicultural backgrounds and tailor their teaching strategies to each student's needs. In a 1996 study, Yoder found that some nurse educators demonstrating high levels of cultural awareness adapted their teaching strategies to meet the needs of culturally diverse nursing students. Other nurse educators demonstrating high levels of cultural awareness were able to identify the special needs of culturally diverse nursing students but did not show sensitivity to or respond to these needs. A third group of nurse educators displayed low levels of cultural awareness and did not identify that culturally diverse students had any special needs. One way to rectify this problem is to teach nurse educators to respond to multicultural nursing students in a culturally sensitive manner (Yoder).

The deans and directors of nursing programs in Florida stated that the promotion of cultural diversity in their programs was of moderate importance. However, they reported the lack of cultural knowledge, sensitivity, and awareness as the most critical issue associated with cultural diversity in their schools (Grossman et al., 1998). Among the types of assistance needed to integrate cultural diversity in their schools were: statistics and success stories about cultural diversity, curriculum development, educational materials, and knowledge of minority nursing students' learning styles. Other possible remediation strategies suggested were workshops and programs on culture with expert speakers.

Sealey (2003) examined the level of cultural competence among nurse educators in Louisiana nursing programs. Analysis revealed that continuing education in transcultural nursing in the past 5 years was associated with increased cultural knowledge, skills, desire, and overall competence among respondents. Presence of minority students in the program was associated with increased overall cultural competence among nurse educators, and practicing in women's health, childbearing, and community health was found to be significantly associated with increasing an individual's cultural competence. The author recommended that dialogue among nurse educators in the above specialties and those in other specialties be initiated to share teaching practices and develop teaching strategies to promote cultural competence among all nurse educators. The study also revealed that respondents agreed that they were knowledgeable about transcultural nursing. The author concluded that with increased training in transcultural nursing, these respondents will be able to "strongly agree" rather than just "agree" that they are capable of teaching students how to provide culturally congruent care to clients from diverse cultural backgrounds (Sealey).

Ochoa, Evans, and Kaiser (2003) noted that medical students are entering a field in which recognition of healthcare disparities is inescapable. It is the responsibility of medical schools to provide students with skills to limit or eliminate those disparities. One of the ways to address this problem is to teach medical students knowledge, skills, and attitudes necessary to be culturally competent because a clinician's knowledge could be rendered useless when confronted with communication or cultural barriers. Resident physicians' preparation to provide cross-cultural care was found to be well behind preparation in other areas. Even though participants noted the importance of cross-cultural care, they reported insufficient clinical time during residency to address cultural care appropriately. They also reported too little training, formal evaluation, or

role modeling in this area (Weissman et al., 2005). The authors suggested substantial improvement in cross-cultural education to limit or eliminate healthcare disparities.

Clients who reported their physicians instructed them to modify their diets, exercise, or lose weight also reported physician behaviors that indicated high cultural competence. Physicians who referred their clients for nutrition and exercise counseling had higher cultural competency scores than those who did not. Physicians, whose clients reported modifying their diets, exercising, losing weight, or checking blood glucose at home, also had high cultural competence scores (Thom & Tirado, 2006).

A study to investigate predictors of culturally competent care among San Diego County physicians revealed that mere knowledge of cultural factors and simple exposure to Mexican Americans in practice did not promote culturally competent care. Rather, culturally appropriate care was better predicted by awareness that cultural factors are relevant to health care, and negative preconceptions about other cultures can diminish service efforts (Reimann, Talavera, Salmon, Nunez, & Velasquez, 2004). The authors concluded that physicians must perceive cultural information as valuable before they will apply it in their practice.

Spanish-speaking diabetic clients were more likely to report positive interpersonal relationships with primary care physicians when physicians rated themselves high in language ability and cultural competence (Fernandez et al., 2004). According to the authors, the study's results provide evidence that language and cultural competence are important in the primary healthcare of Spanish-speaking clients.

Napoles-Springer, Santoyo, Houston, Perez-Stable, and Stewart (2005) found that providing quality healthcare to clients from diverse cultural backgrounds requires cultural flexibility enabling providers to elicit and respond to cultural factors. They concluded that



interventions aimed at reducing healthcare disparities in the United States must focus on cultural factors affecting the quality of healthcare encounters.

Two thirds of respondents in Valadian, Chittleborough, and Wilson's (2000) study reported their staff encountered problems concerning treatment compliance, communication, and cultural differences while working with Australian Aboriginal clients. Most of the respondents (87%) reported that cross-cultural education specific to the Australian Aboriginals would enhance the skills and knowledge needed to work with these clients. The authors remarked that increasing cultural awareness among providers may enhance intercultural interactions, resulting in more satisfying healthcare services for clients.

Occupational therapy students rated themselves as possessing relatively low levels of cultural awareness. They reported that cultural factors are important in occupational therapy because such factors could affect assessment and treatment results. The respondents emphasized the need for more information about diverse cultures and methods of minimizing barriers (Cheung et al., 2002). All the occupational therapists in Scott's (1997) study reported difficulty in accurately interpreting clients' behaviors in cross-cultural clinical experiences. They also noted that assisting clients to identify their needs and then providing proper interventions were complicated when caring for non-English speakers. Additionally, they saw the need to understand not only the cultural and physiological implications of clients' illnesses but also the social and economic environments in which clients and their families reside.

A study by the Interdisciplinary Multicultural Patient Care Team at the University of Wisconsin Hospital and Clinics and Children's Hospital, found that 83% of the 872 hospital and clinical staff respondents needed assistance in working more effectively with clients from diverse cultural and religious backgrounds. Some of the respondents suggested more interpreters,

especially during off hours and weekends, more culturally diverse personnel willing to act as cultural brokers, more information about different cultures, and how to communicate better with clients from diverse cultures (Peterson, Whitman, & Smith, 1997).

Zweber (2002) stated that as the nation's population becomes increasingly diverse, cultural competence in pharmaceutical practice is crucial. According to the author, pharmacists must in addition to understanding drug actions, metabolism, and the economics of prescriptions, also understand the cultural components of how Americans arrive at healthcare choices. Pharmacists are often confronted by client's use of home remedies such as herbs, foods, traditional healing practices, and rituals. The author advised, provided they do not pose harm to the client, that integrating these treatments with conventional treatment could encourage clients to maintain some control while learning to accept Western treatments. The author also suggested that pharmacists examine their own cultural backgrounds, learn about the cultures they serve, and show sincere interest in their clients' cultures to increase the quality of care provided.

Gardenswartz and Rowe (2001) commented that culture underlies all human behavior at work, e. g., how loud employees speak, how close they stand to other individuals, how they handle conflict, and even how they behave in a meeting. The authors stressed the importance of managers learning about the cultures of their employees, because managers who are knowledgeable about cultural norms are less likely to misinterpret employees' behaviors.

Kushner (1990) noted it is critical for nonprofit human-service agencies to show cultural sensitivity because awareness of cultural differences improves communication among employees and between the agency and the populations it serves. The author suggests employers need to identify their own values, goals, and perceptions to demonstrate sensitivity to diverse cultures

before they can understand the ways of other individuals. Nonprofit managers must also learn about their employees' cultural values and beliefs to create a culturally aware organization.

Bonvillian and Nowlin (1994) commented that when U. S. workers are employed in other countries, they try to make favorable impressions and do their best to be professionals. However, some behaviors, comments, time orientation, social practices, and etiquette that Americans regard as proper professional behavior may be considered arrogant, insensitive, overconfident, or aggressive by another culture. This incongruity can result in individuals being perceived as insensitive to other cultures and negatively impact their working relationships with their international counterparts. The authors suggest that business professionals understand specifics of the cultures in which they work. For example, they need to know the language, communication methods, time orientation, personal space, greetings, and beliefs about eye contact, religion, social behavior, and intercultural socialization of the countries in which they reside.

In summary, nursing faculty who scored high on ethnocentrism had negative attitudes toward clients from diverse cultural backgrounds (Ruiz, 1981). Nursing faculty who demonstrated high levels of cultural awareness identified and met the needs of culturally diverse nursing students (Yoder, 1996). Lack of cultural knowledge, sensitivity, and awareness reduced student diversity in some nursing schools (Grossman et al., 1998). Continuing education in transcultural nursing, presence of minority students in nursing programs, and practicing in women's health, childbearing and community health were associated with increasing nursing faculty's levels of cultural competence (Sealey, 2003). Even though resident physicians acknowledged the importance of cross-cultural care, they reported inadequate preparation in this area (Weissman et al., 2005). Physicians with higher cultural competency scores had better client

health outcomes (Thom & Tirado, 2006) and better client and healthcare provider interpersonal relationships (Fernandez et al., 2004). Also, healthcare providers from the dominant culture reported encountering problems, e.g., communication and interpreting client's behaviors accurately, when providing healthcare services to clients from ethnic minority groups (Peterson et al., 1997; Scott, 1997; Valadian et al., 2000). The above studies and literature suggest that many disciplines are recognizing the importance of cultural awareness, sensitivity, and competence in service delivery and are making efforts to deliver culturally competent services.

### Cultural Competence in the Nursing Profession

The concept of transcultural nursing has existed since modern nursing began. Florence Nightingale, who showed concern about the fate of Australian Aboriginal individuals, is considered the first transcultural nurse in modern history (Hagey, 1988). Concern for the health needs of clients from diverse cultural backgrounds was also demonstrated throughout the 19th century. In 1890, Linda Richards became the first U. S. nurse to practice international nursing when she established a school of nursing in Japan under the guidance and support of the American Board of Missions (Andrews, 1992). Additionally, at the turn of the century, Lillian Wald, Lavinia Dock, and other public health nurses provided healthcare services to European immigrants (Andrews), many of whom lived in the slums of New York City.

In the 1960s and 1970s, many culturally diverse groups, especially African Americans and Hispanics, demanded civil rights, raising the consciousness of the American public to cultural diversity. Influenced by this consciousness, the nursing profession responded with increased sensitivity to individual attitudes, values, beliefs, healthcare practices, illness experiences, and caring among multicultural clients; and developed a specialty in transcultural nursing. It was during this period that Leininger wrote her book *Nursing and Anthropology: Two*

*Worlds to Blend* (1970). She noted in this book that the nursing profession supports the concept of comprehensive client care and providing total nursing care to clients. She argued that to deliver total nursing care, clients' cultural backgrounds must be considered as well as their physical and psychological status; cultural aspects of behavior are as crucial to the successful treatment of clients' health needs as are the physical and psychological aspects of clients' illnesses (Leininger). Understanding client cultures is crucial as U. S. residents become more diverse. In the 1960s, some nurses with doctoral degrees in anthropology began to examine areas of common interest between nursing and anthropology and established the Council on Nursing and Anthropology (Andrews, 1992) within the American Anthropological Association. Madeleine Leininger founded the Transcultural Nursing Society in 1974 with the aim of meeting the cultural healthcare needs of clients worldwide by nurses prepared in transcultural nursing. Today, nurses are expected to learn about their clients' cultural values, beliefs, worldviews, and healthcare practices to provide culturally congruent care.

#### Cultural Competence and Nurse Educators

Nurse educators are expected to develop their own cultural awareness, sensitivity, and competence, enabling them to act as role models for all students and attend to the needs of culturally diverse students (Alpers & Zoucha, 1996; Chrisman, 1998; Crawford & Olinger, 1988; Gardner, 2005a). Nurse educators are also expected to incorporate cultural diversity into nursing curricula (American Academy of Nursing, 1992; Crawford & Olinger). Campbell and Davis (1996) commented that commitment by both minority and nonminority nurse educators is the major factor in the academic success of minority nursing students. Such commitment could lead to support programs and services that promote minority nursing students' success. Nurse educators must respect and be receptive to the views, values, and patterns of different cultures

(Campbell & Davis) because acceptance communicates to minority students that they belong and encourages them to fully participate in campus life and activities as well as the nursing profession.

Several studies have identified nurse educator behaviors that contribute to the success of minority nursing students. Some students identified nursing program characteristics and nurse educator behaviors that were instrumental in their success including flexible programs i.e., evening and weekend programs (Villarruel, Canales, & Torres, 2001), supportive nurse educators who acted as formal and informal mentors (Amaro, Abriam-Yago, & Yoder, 2006; Hassouneh-Phillips & Beckett, 2003; Martin-Holland, Bello-Jones, Shuman, Rutledge, & Sechrist, 2003; Villarruel et al.), and faculty who make themselves available, always willing to help students and answer their questions (Amaro et al.; Villarruel et al.). Other nurse educator behaviors that assist minority nursing students succeed were encouragement from faculty members (Gardner, 2005a; Kossman, 2003; Martin-Holland et al.), and working with students who earned low grades, supervising remediation plans (Martin-Holland et al.).

Nurse educators who made an effort to get to know students (Dickerson & Neary, 1999; Gardner, 2005a; Kossman, 2003) and made students feel valued contributed to the success of minority nursing students. Nurse educators who identified and attended to the educational needs of students from diverse cultural backgrounds were also instrumental in their program success (Kossman). Additionally, minority nursing students reported that nurse educators who treated students as unique individuals with specific needs and desires, were approachable and patient, and assisted students in feeling comfortable around nurse educators also helped them progress in their programs (Gardner). Nurse educators who endeavored to identify students' learning styles, spent extra time with students assisting them in their studies, and modified nursing curricula and

teaching methods to accommodate students also promoted the success of minority nursing students (Dickerson & Neary).

Studies have also identified nurse educator behaviors that impede retention of minority nursing students. Some minority students identified discrimination by nurse educators based on faculty being unsupportive, lacking flexibility in scheduling and advisement, and treating students as inferiors because of accents and inability to speak English fluently as barriers to their success in nursing programs (Amaro et al., 2006; Kossman, 2003; Villarruel et al., 2001). Some nurse educators exerted pressure on minority students to conform to traditional European-style education and ignored or discouraged any discussion of non-European cultures. Other nurse educators stated interest in diversity while maintaining policies that supported only Euro-American dominance in education and showed little or no reaction to obvious racist remarks or behaviors directed toward minority nursing students (Hassouneh-Phillips & Beckett, 2003). The authors commented that “Until faculty are willing to be challenged by difference and to be made uncomfortable by the pain and anger associated with racist and ethnic oppression, diversity among faculty in nursing schools is unlikely to increase” (p. 264).

Some students who were English Language Learners reported experiencing prejudice and impatience from nurse educators due to their accents and communication difficulties (Amaro et al., 2006). The students expressed the need for nurse educators to understand the consequences of students’ language and communication problems; without language and communication proficiency, students feel alienated from their peers. Similarly, nurse educators who were unapproachable, uncommunicative, disrespectful, intimidating, and prone to ignore students as individuals caused stress and were barriers to student success (Gardner, 2005a). Nurse educators’ lack of racial understanding, lack of interest and concern about students’ problems, devaluing

students as individuals, and bias and stereotyping caused stress and anxiety for students (Kossman, 2003).

Behaviors and attitudes listed above suggest that some nurse educators lack cultural awareness, sensitivity, and competence while others are culturally aware, competent, and sensitive. Those who are culturally competent show sensitivity to the needs of culturally diverse students and support their success in school. Those who lack cultural competence do not identify the special needs of students from diverse cultural backgrounds and, subsequently, are not sensitive to them. Rew (1996) stated, “Faculty who have knowledge about other cultures and societies are sensitive to the nuances of language and customs that differ and that may seem strange or frightening when viewed from a different perspective” (p.312). Without this knowledge, faculties tend to teach in ways that are meaningful only to the majority of students, leaving some minority students confused and lost (Rew).

#### Factors Affecting Recruitment and Retention of Minority Nursing Students

##### *Faculty Role Models*

Lack of faculty role models is a contributing factor to the underrepresentation of minority nursing students (Martin-Holland et al., 2003; Mills-Wisneski, 2005; Robinson, 1972). Robinson reported that a minority applicant sent a note to the only minority faculty member on a panel that interviewed the student. The student expressed in her note how happy she was to see the minority nurse faculty on the interviewing panel. Mills-Wisneski investigated minority students’ perceptions concerning the presence of minority nurse educators. Analysis of quantitative measures revealed that the absence of minority nurse educators was rated: 51%, very important, 20.2%, important, 10.1%, somewhat important, 5.8%, not important, and 11.6%, not sure. The analysis of the open-ended question revealed that 71.2% of the respondents provided information



on the importance of having minority nurse educators both in the classroom and in clinical areas. Lack of minority faculty was perceived as a barrier to successfully completing the nursing program; several of the participants sought support and role modeling from minority nurses outside the nursing program. Strategies that provide teaching experiences for minority nurse educators at various levels could increase the number of minority faculties both in the classroom and clinical areas, and more minorities in the classroom and clinical areas provide mentors and role models for minority nursing students (Mills-Wisneski).

#### *Increasing Cultural Awareness, Sensitivity, and Competence*

The researcher developed a framework from reviewed literature to guide this exploratory study. See Appendix B. From the literature reviewed, it is clear that nurses must be culturally competent to meet the healthcare needs of clients from diverse backgrounds (Leininger & McFarland, 2002; Purnell & Paulanka, 2003). Nurse educators also need to be culturally competent to meet the educational needs of multicultural nursing students. It is hypothesized that cultural competence of nursing faculty will increase recruitment, retention, and graduation of minority nursing students. Several methods have been identified to assist individuals increase their cultural awareness, sensitivity, and competence. Short international immersion experiences (Koskinen & Tossavainen, 2003; Koskinen & Tossavainen, 2004; Ryan & Twibell, 2002), cultural diversity training (Sealey, 2003), cultural interventions, and cultural projects (Anderson, 2004) are some of the methods found to be effective in increasing cultural competence. Studying (Kitsantas & Meyers, 2001), living, and practicing abroad (Cross, 1998) have also been identified as promoting cultural awareness, sensitivity, and competence.

### *Short International Immersion Experiences*

Short international immersion experiences have been identified as beneficial in promoting individuals' cultural awareness, sensitivity, and competence (Ryan & Twibell, 2002; Sandin, Grahn, & Kronvall, 2004; St. Clair & McKenry, 1999; Walsh & DeJoseph, 2003; Woods & Atkins, 2006). St. Clair and McKenry compared the cultural competence of nursing students who stayed in the United States and those who participated in short international immersion experiences. They found that living in a culture different from one's own challenged the participants' beliefs and values and increased their awareness of self and others and their understanding of alternative worldviews, especially the impact of prejudice, politics, and oppression. Living in another country also helped students realize what it means to be in the minority, to be misunderstood, to have no control, and to recognize their own ethnocentrism. The authors noted that not all participants achieved the same level of transformation from ethnocentrism to ethno-relativism. Additionally, none of the journals of students who stayed in the U. S. reflected the cultural transformation that manifested in the journals of those who took part in the immersion program.

Some participants in Koskinen and Tossavainen's (2004) study of a short international immersion program demonstrated an increase in cultural competence, and others did not. The authors identified three types of adjustment to the host culture. Type one adjustment involved recognizing and respecting the differences and consequently changing behaviors in response to the differences in intercultural encounters. Participants with type two adjustment perceived cultural differences as less important than the similarities; to this group the meaning of the immersion experience was to recognize that people and healthcare were similar worldwide. Students with type three adjustment viewed the differences as threats and responded by

evaluating the experience negatively; they emphasized the superiority of their own culture and healthcare. The authors commented that the three types of cultural adjustment were compatible with the intercultural awareness at the stages of acceptance, minimization, and defense.

Similarly, Koskinen and Tossavainen (2003) found several reactions to a short international immersion program in their study participants. Some participants overcame their culture shock and language barrier, adjusted well to the stress encountered in the host country and demonstrated tremendous intercultural competence. Other participants could not overcome the culture shock and language barrier, so the intercultural transformation did not occur.

### *Cultural Interventions*

Cultural interventions have also been shown to be effective in improving individuals' cultural awareness, sensitivity, and competence (Hill & Augoustinos, 2001; Napholz, 1999; Smith, 2001). Smith compared the cultural competence of registered nurses who participated in a culture school and registered nurses who participated in a nursing informatics class and found that participants in the culture group demonstrated significantly more cultural self-efficacy and cultural knowledge than the other group. The author concluded that nursing education interventions could increase the cultural competence of participants. Similarly, Napholz compared one group of nursing students who received the traditional method of integrating cultural diversity into a course by university faculty (control) with another group that received three 2-hour onsite consultations from an expert in transcultural nursing in addition to the traditional method of learning cultural competence (experimental). The experimental intervention was effective in enhancing the self-efficacy of the experimental group to a higher level than that achieved by the control group.

### *Cultural Projects*

Use of cultural projects has also been effective in increasing participants' cultural awareness, sensitivity, and competence (Anderson, 2004; Keime, Landes, Rickertsen, & Wescott, 2002). Prior to the project, participants in Anderson's study wrote a 1-to 2-page paper on 1) a personal situation where they had to make a decision whether to adhere to a treatment regimen or not, and 2) a situation in which a Mexican American client fails to follow diabetic instructions. Then they read assigned portions of the book *The Spirit Catches You and You Fall Down* together with other readings that address course concepts. Participants then wrote a 1-to 2-page response to questions that connected these concepts to the story. After reading the entire book, they responded again to the two previous vignettes. Participants completed two questionnaires before and after reading the book. One questionnaire assessed participants' responses to transcultural healthcare situations; the other asked participants to rate their agreement with statements describing Western and non-Western values. The author found that participants demonstrated newly acquired cultural awareness and competence in responding to clients from diverse cultures.

Keime et al. (2002) used an action research project to increase the cultural awareness of elementary and high school students; the increase was more noticeable at the elementary school level. The authors concluded that it is easier to change values at a younger age than after individual attitudes are formed. A combination of a cultural project and experiential learning was also effective in increasing nursing students' cultural awareness and cross-cultural sensitivity (Lockhart & Resick, 1997). Similarly, Flannery and Ward (1999) found that a combination of multicultural education and community-based service learning moved students beyond cultural awareness toward the development of cultural competence.

### *Living, Studying, and Practicing Abroad*

Studying (Kitsantas & Meyers, 2001), living, and practicing abroad (Cross, 1998) were effective in increasing students' cross-cultural awareness. Kitsantas and Meyers compared the cultural awareness of students who studied abroad and those who studied in the United States. They found that the study abroad group scored significantly higher on the Cross Cultural Adaptability Inventory Test. The authors concluded that studying abroad enhanced students' cultural awareness. Returned Peace Corps teachers who had lived and taught in foreign countries ranked the Peace Corps experience as instrumental in enhancing their cultural awareness and self-efficacy (Cross).

### *Cultural Diversity Training and Higher Education*

Previous cultural diversity training was found to increase nurses' cultural competence (Doorenbos, & Schim, 2004; Schim, Doorenbos, & Borse, 2005; Sealey, 2003). Higher education was also found to correlate with cultural competence (Doorenbos & Schim; Schim et al.). Doorenbos and Schim suggested that the correlation between higher education and cultural competence could be due to the inclusion of multicultural courses in health curriculum or the correlation could be the result of exposure to individuals from diverse cultures due to a combination of higher education, reading, the arts, and travel opportunities. It has also been reported that overall experience as social workers correlated significantly with respondents' perceived levels of cultural competence; similarly, the level of social work licensure correlated significantly with respondents' perceived levels of cultural competence (Teasley, Baffour, & Tyson, 2005).

### *Cultural Competent Model*

Use of a model has been reported to increase nursing students' cultural competence (Fahrenwald, Boysen, Fischer, & Maurer, 2001). The authors used Campinha-Bacote's cultural competence model to design a course for nursing students caring for the Hutterites. The model consisted of five constructs (cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire). Students read and engaged in in-depth discussions of selected literature about the Hutterite culture to increase their cultural awareness. To achieve cultural knowledge, students learned about Hutterite lifeways, folkways, worldviews, religious beliefs, communication patterns, childrearing and childbearing practices, nutritional practices, and health concerns and researched and discussed the health-related needs of agricultural communities. Students acquired cultural skills by conducting health assessments of Hutterite community members. To address the cultural encounter construct, faculty planned clinical time for students to have multiple encounters with Hutterite individuals. Asking students about their feelings, thoughts, and actions throughout the course provided the means for assessing their cultural desire. The authors concluded that the model was effective in increasing students' cultural competence and suggested that the use of cultural models to guide student learning could also be applied to other cultures.

Transcultural "food habits" travel courses were developed to teach cultural diversity to dietetic and hospitality students (Kuczmarski & Cole, 1999). Dietetic and hospitality students along with faculty traveled to the Hawaiian Islands where students were exposed to a variety of cuisines from diverse origins. Students tasted and completed sensory evaluations of 15 food items unfamiliar to them. Other instructional strategies included group discussions and storytelling, study groups, experiential learning, and research. Three of the chefs who prepared

the cuisines were guest speakers. The students rated the effectiveness of the project in stimulating interest in transcultural food habits from 3.64 to 3.94 with 4.0 being outstanding and satisfaction with the cultural aspects of the project from 4.57 to 4.75 with 5.0 as very satisfied. They rated the project as excellent (3.71 to 3.91 with 4.0 being excellent). Based on the evaluations at the end of the program, the authors concluded that the project achieved its objectives.

### *Cultural Diversity Courses*

Cultural diversity courses also have been beneficial in increasing students' cultural competence (Crandall, George, Marion, & Davis, 2003; Jeffreys, 2002). Crandall et al. described a yearlong culture and diversity-training course for medical students. The course used interactive lectures, videos, simulation, demonstration, role-plays, workshops, client interviews, community-based service-learning, and online problem-based learning. The course consisted of 20 two-to-three hour sessions presented by local, national, and international experts on cultural influences on health. The evaluation revealed the course was effective in improving cultural knowledge, attitudes, and skills of medical students. The course also resulted in a positive change in the medical school's approach to cultural competency training.

### Summary

Lack of cultural awareness, knowledge, sensitivity, and competence could result in stress and misunderstandings among individuals from varied cultural backgrounds (Fadiman, 1997; Lemon, 2002). Fortunately, several disciplines are recognizing the effects of cultural competence in their service delivery and attempting to incorporate cultural competence and sensitivity in services provided. Transcultural nursing began with Florence Nightingale and was revived in the 1960s by Leininger who argued that nurses must be culturally competent to provide culturally

congruent care to multicultural clients. Since then, nurses have been urged to develop cultural awareness, knowledge, sensitivity, and competence. Several studies have identified nurse educators' behaviors that help minority nursing students successfully complete nursing programs (Amaro et al., 2006; Kossman, 2003; Villarruel et al., 2001) as well as behaviors that create barriers to minority nursing students' success (Gardner, 2005a; Hassouneh-Phillips, & Beckett, 2003). Several methods that have been instrumental in increasing individual's cultural awareness, knowledge, sensitivity, and competence were also discussed.



## CHAPTER 3

### METHODOLOGY

The previous chapter provided an overview of culture and discussed situations that could cause stress and misunderstandings among multicultural individuals. Other topics presented included cultural competence in healthcare and other disciplines and strategies for increasing individual's cultural competence. This chapter discusses the research design, population and sample, setting, ethical considerations, instrumentation, data collection, and analyses used in this study.

#### Research Design

This study used a descriptive, correlational, nonexperimental survey design to assess the extent to which Tennessee nurse educators are culturally competent and compared their levels of cultural competence with the percentage of minority nursing students recruited and graduated in Tennessee baccalaureate nursing (BSN) programs from the 2001-2002 to 2005-2006 academic years. Some participating school officials reported the number of students recruited and graduated in their schools in the past 5 years, while other schools' data were obtained from the American Association of Colleges of Nursing Research and Data Center.

Nurse educators' levels of cultural competence were collected through a survey. A survey study identifies the characteristics of a particular group, measures attitudes of a population, and elucidates relationships among variables in a population (Polit & Beck, 2004; Zikimund, 2003). The survey method has several advantages: 1) it is an effective and efficient method of collecting data; 2) it can be flexible and broad in use in that it can be used to gather information on a wide range of topics; and 3) it can be used for many purposes (Polit & Beck; Zikimund). Ruiz (1981)

examined the relationship between ethnocentrism of nursing faculty and their attitudes toward culturally diverse clients. Alpers and Zoucha (1996) compared the cultural competence and confidence of senior nursing students who received cultural content in their education with those who did not. Cross (1998) used the survey method to investigate the effect of Peace Corps experiences on teachers' self-efficacy and cultural awareness. A survey was used to examine the cultural competence of nurse educators in Louisiana (Sealey, 2003). The survey method was, therefore, appropriate for this study because a questionnaire was used to measure personal characteristics and levels of cultural competence among Tennessee nurse educators.

#### Population, Sample, and Setting

The sampling frame for this study included nurse educators teaching in accredited BSN programs in the state of Tennessee. In this study, nurse educators were defined as individuals who teach in nursing schools. All nurse educators currently active in teaching, regardless of age, gender, or educational level, were included in the sampling frame. The list of accredited nursing programs in the state was secured from the American Association of Colleges of Nursing (AACN) web site and the National League for Nursing (NLN) web site. The researcher wrote to the deans and directors of all identified nursing programs to explain the study and request permission to include their schools in the study. Following approval by the East Tennessee State University (ETSU) Institutional Review Board, the deans and directors who gave permission to include their schools in the study were contacted and asked to provide the names and e-mail addresses of current nurse educators teaching in their BSN programs. Deans and directors were also asked to provide recruitment and graduation data for ethnic minority students in their schools for the past 5 academic years: 2001-2002, 2002-2003, 2003-2004, 2004-2005, and 2005-2006. All identified nurse educators (100%) were included in the study.

## Ethical Considerations

Before seeking participants for this study, the ETSU Institutional Review Board (IRB) approved the research study. See Appendix C. Using the prospective respondents' e-mail addresses, the researcher explained the overall goals of the study and assured prospective respondents that the data collected would be used for research purposes only. Faculty respondents received a description of the data collection process. At the completion of the study, all information and records linking the participants to their code numbers were destroyed. All information and records from the study are locked in a file cabinet in the Research Office, ETSU College of Nursing, for a period required by law (10 years). The researcher or her substitute will destroy the documents after the time required by law. A copy of the study results was made available to each participating school.

## Instrumentation

The instrument for this study was the "Cultural Diversity Questionnaire for Nurse Educators" (Sealey, 2003). The researcher obtained permissions to use the instrument and to publish it in the dissertation document. See Appendices D and E. The instrument, which can be completed in 20 minutes, was designed specifically to measure the cultural competence of nurse educators and it encompasses five constructs: cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire. The reliability coefficients for the five constructs are, 0.63, 0.82, 0.69, 0.68, and 0.76, respectively. A panel of four experts chosen by the instrument's author established content validity (Sealey).

The instrument has two sections. The first section of 55 items includes 12 cultural awareness, 14 cultural knowledge, 12 cultural skill, 6 cultural encounter, and 11 cultural desire statements. Responses to these items are measured on a five-point Likert scale. The second

section includes 14 demographic items, e.g. years of teaching experience, age, and ethnic origin. All data were collected via the questionnaire. For each Likert-type item on the questionnaire, respondents were asked to indicate their degree of agreement or disagreement. A numerical value was assigned to each response: 5 = strongly agree, 4 = agree, 3 = undecided, 2 = disagree, and 1 = strongly disagree. Twelve questions were reverse coded so that 1= strongly agree, 2 = agree, 3 = undecided, 4 = disagree, and 5 = strongly disagree (items 1, 4, 5, 8, 9, 11, 15, 31, 34, 38, 45, and 49). In regularly coded items, “strongly agree” was the best answer corresponding to a high level of cultural competence. In reverse coded items, “strongly disagree” represented a high level of cultural competence. Scores were computed by adding the assigned value of each response; the higher the number, the more culturally competent the person: 55 – 130 = low level, 131 – 201 = moderate level, 202 – 275 = high level. The following are examples of five statements from the instrument. 1) What I believe about health, illness, and preventive health is strictly based on science, 2) I am knowledgeable about variations in drug metabolism among specific cultural groups, 3) I am personally and professionally committed to teaching how to provide nursing care that is culturally competent, 4) I feel confident in using a variety of cultural assessment tools in the health care setting, 5) I attend holiday celebrations within culturally, racially, and ethnically diverse communities (Sealey, 2003). See Appendix F.

#### Data Collection Procedure and Analyses

The data were collected using the Internet version of the questionnaire on an ETSU web site. Before the survey was sent to prospective respondents, the survey was sent to eight nurses who did not participate in the study to pilot the survey and identify any potential problems. The respondents also verified that respondents could access the web site containing the survey without difficulty. Seven of the nurses to whom the survey was sent successfully completed the

survey without difficulty in accessing or completing the survey. The eighth person did not complete the survey.

To solicit prospective respondents, the researcher identified 21 accredited Colleges of Nursing in the state of Tennessee and wrote to their deans and directors via e-mail, requesting permission to include their schools' faculty in this study. See Appendix G. The research prospectus was attached to the letter to the deans and directors. See Appendix H. Four deans and directors gave permission to include their schools. One dean declined stating that the school was new and did not meet the criteria for the study. Three weeks after the e-mail, the researcher contacted the deans and directors, who did not reply to the e-mail by telephone to remind them of the e-mail message. Following the telephone call one dean gave permission. Two deans declined due to busy schedules: one was in the process of moving and one was scheduled for accreditation. Another dean replied stating that the researcher would need approval from the school's Institutional Review Board. One week after the telephone reminder, the investigator sent a second e-mail to the deans and directors who had not replied. Following the second e-mail, four deans and directors gave permission; two deans and directors declined, one due to being new and one stated time constraints. Another dean also stated the researcher would need approval from the school's Institutional Review Board prior to receiving permission. Five deans and directors did not reply at all. Altogether, 10 deans and directors gave permission to include their schools in the study, but one school was unable to participate in the study due to a busy schedule. Therefore, nurse educators from nine accredited Colleges of Nursing in the state of Tennessee participated. All participating school's IRBs approved the study.

Following this process, the researcher collected the names and e-mail addresses of nurse educators who teach in the baccalaureate (BSN) programs where deans and directors gave

permission to include their nursing faculty in the study. This yielded 173 names and e-mail addresses. Advance notice letters were sent via e-mail to these prospective respondents. See Appendix I. The advance notice letter explained the purpose of the study and requested participation by the respondents. The advance notice letter also explained the value of the study to the respondents, the importance of their participation and the estimated time for completion of the questionnaire. The informed consent was attached to the advanced notice letter, and the respondents were instructed that completing and submitting the questionnaire was their consent to voluntarily participate in the study. See Appendix J. Three days after the advance notice letters were sent, prospective respondents were contacted again via e-mail and provided with a URL and instructions on how to access the web site. See Appendix K. Each respondent was assigned a code number and instructed to insert it in the space provided in the questionnaire. The respondents were assured that the code numbers were used to enable the researcher to contact nonrespondents. One week following the e-mail about web site access, respondents were sent another e-mail reminding them of the survey. See Appendix L. Two weeks following the reminder e-mail, a last e-mail was sent to nonrespondents reminding them of the survey. See Appendix M. They were again provided with the web site to access the questionnaire. Each nonrespondent's code number was also included in this e-mail with instruction to enter it in the space provided.

Seven e-mails were undeliverable and two surveys were not completed because they were sent to staff members whose names were mistakenly included in the faculty list by one of the participating schools. Seven prospective participants declined participation with such reasons as "no reason," "swamped with work," and "illness in the family." The response rate was 53 %. Of the 164 e-mails delivered, 87 were returned completed; 11 of these were excluded from data

analysis because they indicated they taught in graduate programs only. Seventy-seven respondents did not return the survey. No further data were collected on the nonrespondents. Seventy-six completed surveys were included in the data analyses. Some schools did not supply a list of nurse educators who taught in the BSN program; therefore, the researcher secured some of the prospective respondents' names from the Internet; but it was unknown whether they taught in undergraduate or graduate programs. The nonresponse rate was 47%. The numbers and percentages of ethnic minority nursing students recruited and graduated in the past 5 academic years from the participating schools were obtained from the American Association of Colleges of Nursing Research and Data Center and from some of the participating schools.

The data were collected in a Microsoft Office Front Page database and transported to Microsoft Excel. From Microsoft Excel, data were transported to SPSS for Windows for analysis. Prior to analysis, data were cleaned by the following procedures: In question 44, where a respondent entered "144" under months for length of teaching, the 144 months was converted to 12 years. In the columns containing "ON" and blanks, "ON" was replaced with a "1" and blanks were replaced with a "0." In question 66 "If (item 65, above, is yes), how many have you attended?" "6-10" was replaced with an "8," "CE" was replaced with a "blank," "3-4" was replaced with a "4," and "3+" was replaced with a 3. Where a respondent entered "10 credits of transcultural nursing in a university" was replaced with a "blank." Question 67 asked respondents to estimate the percentage of seven ethnic groups in their nursing schools, some respondents inserted "%" in the columns; these "%" signs were deleted. Where individuals inserted "<" (less than), the "<" sign was deleted. The ">" (greater than) sign was also deleted. For example, "< 5" was converted to 5 and "> 99" was converted to 99. The response "7-10" was converted to "9," and "1-2" was replaced with 2. Missing values were replaced with serial

means. According to George and Mallery (2003), missing values sometimes make data files difficult to analyze. The authors suggested replacing missing values with serial means, mean of nearby points, or median of nearby points.

The scores were treated as interval level data and descriptive statistics, e. g., frequencies and percentages, were used to analyze information on race and ethnicity, age group, whether or not respondents had resided in another country with a different culture from their own, and whether participants had attended continuing education on transcultural nursing or cultural competence. Frequencies and percentages were also used to analyze data on whether respondents assess how their students' cultural beliefs and values influence their attitudes toward education and learning and their learning styles. Pearson's Product Moment correlations, Spearman rho correlations, and Student t-tests were computed to answer research questions and hypotheses. The Confidence Interval (CI) for all computations was set at 95%.



## CHAPTER 4

### FINDINGS

The previous chapter provided information on the research design, population, sample and setting, ethical considerations, instrumentation, data collection procedure, and data analyses used in this investigation. This chapter presents the findings of this exploratory study that investigated the relationship between nurse educators' cultural competence and the recruitment and graduation of ethnic minority nursing students in accredited Colleges of Nursing in the state of Tennessee.

#### Demographic Characteristics

Most (n = 68, 89.5%) of the respondents were Caucasians; African Americans comprised the next largest ethnic group (n = 5, 6.6%); only one American Indian (1.3%) was included in the sample. One (1.3%) respondent did not provide his or her race and the remaining 1.3% (n = 1) was of Alaskan and Caucasian ethnicity (Figure 1).

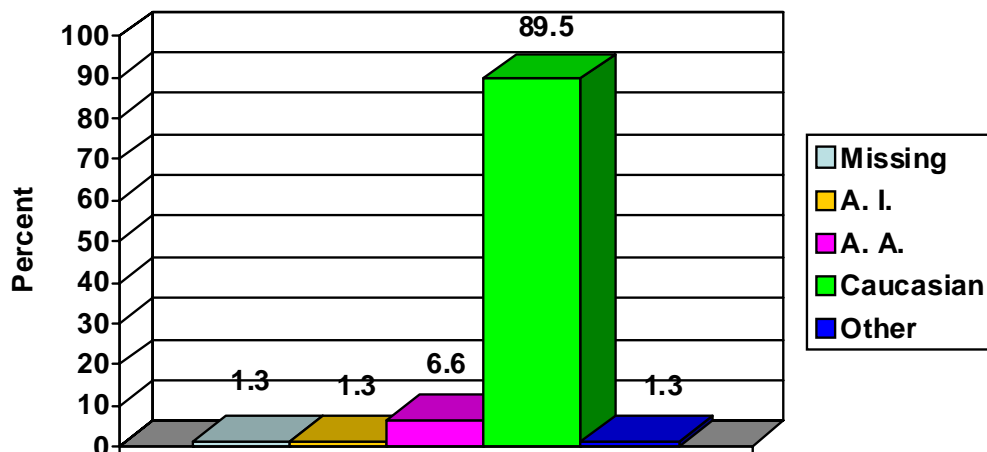


Figure 1. Race of Respondents

Nine Colleges of Nursing participated in this study, yielding 76 respondents. Seventy-four participants (97.4%) provided their school affiliation and 2(2.6%) refrained from doing so. Respondents were asked to specify their specialty areas. Many participants reported specialty in more than one area. The following specialty areas were provided by respondents: Adult Health (n = 32, 42.1%), other specialties (for example; Fundamental Nursing, Holistic Nursing, Education, Leadership, Primary Care, Family Practice, Simulation Labs, Peri-operative Nursing, Pediatric Nurse Practitioner, Rehabilitation, and Hospice) (n = 15, 19.7%), Childbearing (n = 12, 15.8%), Community Health (n = 11, 14.5%), Psychiatric Nursing (n = 10, 13.2%), Child Health and Illness (n = 9, 11.8%), Gerontology (n = 9, 11.8%), Women’s Health (n = 8, 10.5%), Nursing Administration (n = 5, 6.6%), and Transcultural Nursing (n = 5, 6.6%) (Table 1).

Table 1.  
*Respondents' Specialty Areas*

Variable	Number	Percentage (%)
Specialty:		
Adult Health	32	42.1
Other	15	19.7
Childbearing	12	15.8
Community Health	11	14.5
Psychiatric Nursing	10	13.2
Child Health and Illness	9	11.8
Gerontology	9	11.8
Women’s Health	8	10.5
Nursing Administration	5	6.6
Transcultural Nursing	5	6.6

The largest number of respondents was between the ages of 51 and 60 (n = 32, 42.1%); while the smallest number of respondents was between the ages of 20 and 30 (n = 4, 5.3%) (Figure 2).

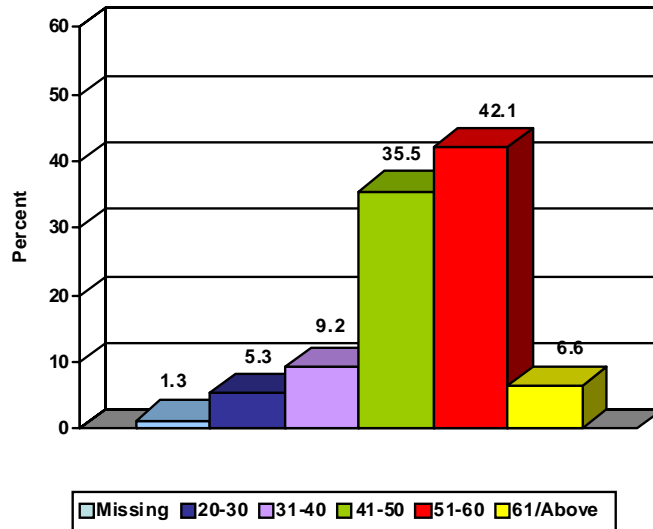


Figure 2. Age of Respondents

Respondents were asked whether they had resided for more than 6 months in another country with a different culture other than their own. The findings are displayed in Table 2.

Table 2.

*Resided in Another Country*

Variable	Number	Percentage (%)
Did respondents reside in another country with a different culture?		
Yes	9	11.8
No	67	88.2

Table 3 shows the responses on whether participants had attended multicultural education seminars in the past 5 years.

Table 3.

*Attended Multicultural Education*

Variable	Number	Percentage (%)
Did respondents attend multicultural education seminars?		
Yes	39	51.3
No	34	44.7

Respondents were asked whether they assess how their students' cultural beliefs and values influence their attitudes toward education, learning, and learning styles. Respondents' replies are displayed in Tables 4 and 5.

Table 4.

*Faculty Assessment of How Cultural Beliefs and Values Influence*

*Attitudes Toward Education and Learning*

Variable	Number	Percentage (%)
Do faculty assess how cultural beliefs and values influence attitudes toward education and learning?		
Yes	43	56.6
No	31	40.8

Table 5.

*Faculty Assessment of How Cultural Beliefs and Values Influence*

*Learning Styles*

Variable	Number	Percentage (%)
Do faculty assess how cultural beliefs and values influence learning styles?		
Yes	38	50.0
No	38	50.0

Participants were also asked to identify at what level of nursing education they teach and the highest degree earned. Frequencies and percentages were used for these analyses. Tables 6 and 7 show participants' responses.

Table 6.

*Degree Programs Faculty Taught*

Variables	Number	Percentage (%)
Level/Taught:		
BSN	76	100
Masters	35	46.1
Doctorate	6	7.9

Table 7.

*Highest Degree Earned*

Variables	Number	Percentage (%)
Highest Degree Earned:		
BSN	0	0
Master's	40	52.6
Doctorate	36	47.4

The participants reported teaching experience ranging from 2 months to 39 years, with a mean of 13.58 years (SD = 10.13).

The respondents were asked to estimate the percentages of students from different ethnic groups in their nursing programs. According to their responses, the mean percentage of Caucasian students was 85.13% (SD = 15.84), African American students were the next largest group at 9.59% (SD = 11.1). The mean for the “other” category was 0.95% and included students from India, the Middle East, and Nigeria. Figure 3 displays the mean percentages provided by the respondents.

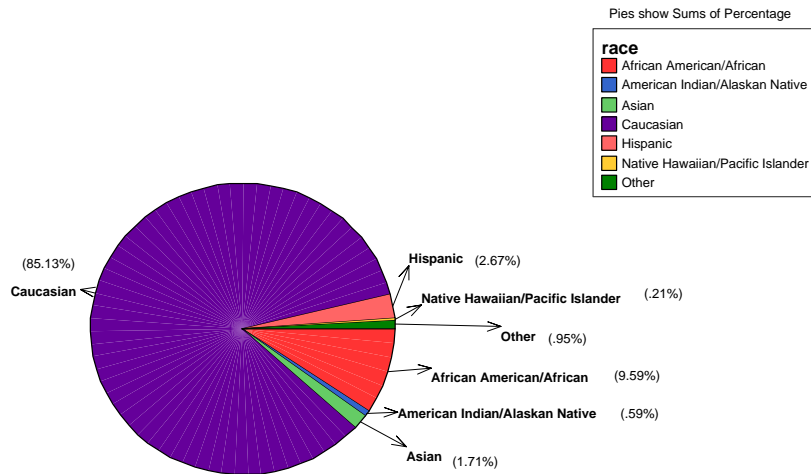


Figure 3. Mean Percentages of Students' Ethnicities

### Research Questions and Hypotheses

Question 1: What is the distribution of Tennessee baccalaureate (BSN) program's mean nurse educators' cultural competence score?

Hypothesis 1: The majority of Tennessee BSN programs have a mean nurse educator cultural competence score under 130.

The mean nurse educator cultural competence score for each school was computed.

The mean cultural competence score for the nine schools (Table 8) ranged from 199.7 to 229.8 (55 – 130 = low; 131 – 201 = moderate; and 202 – 275 = high). The majority of BSN schools' mean faculty cultural competence scores did not fall below 130 as expected; hypothesis 1 was not supported. Respondents who participated in this study were more culturally competent than the researcher hypothesized, assuming that respondents were accurate in the responses they provided in the survey. This finding is consistent with Kardong-Edgren's (2007) study, but

contrary to Kardong-Edgren's et al. (2005) finding that nursing faculty lacked cultural competence.

Table 8.

*Schools' Mean Cultural Competence Scores*

Variable	Mean	N	SD
School 1	205.3	7	16.8
School 2	205.2	9	14.2
School 3	203.9	4	16.8
School 4	199.7	20	18.9
School 5	202.7	3	12.7
School 6	212.3	12	21.5
School 7	219.0	2	1.4
School 8	229.8	6	30.0
School 9	209.5	11	12.7

Question 2: What is the distribution of cultural competence scores among nurse educators in Tennessee BSN programs?

Hypothesis 2: The majority of nurse educators in Tennessee BSN programs will have low cultural competence scores. Low is defined as under 130.

Each respondent's total cultural competence score was computed to determine the distribution and if the majority of the scores were under 130. This computation showed that the respondent's total cultural competence scores ranged from 168 to 262 (Figure 4).



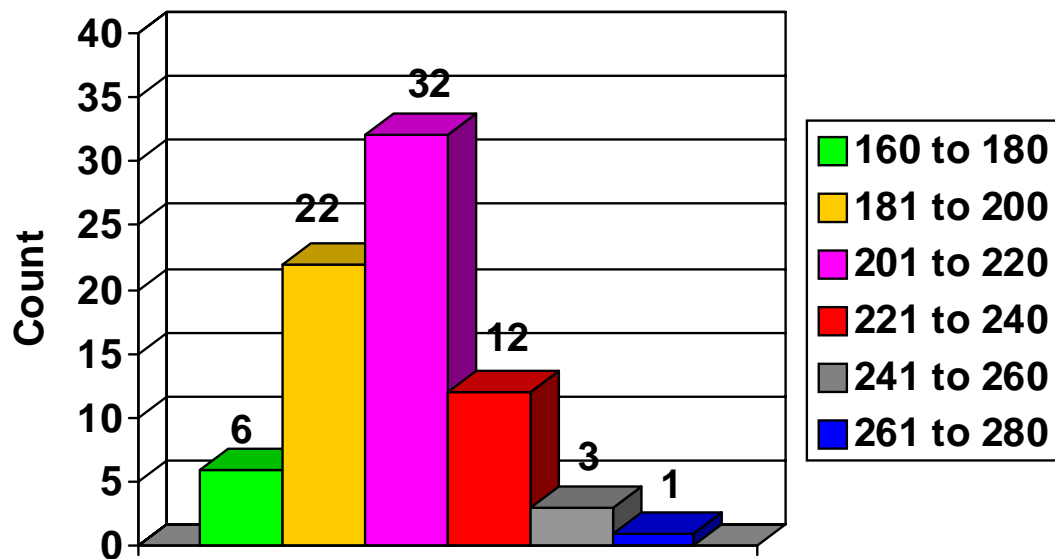


Figure 4. Respondents' Total Cultural Competence Scores

The majority of nurse educators in Tennessee BSN programs did not have a cultural competence score under 130. Therefore, the researcher's hypothesis was rejected.

Question 3: Will Tennessee schools' mean nurse educators' cultural competence scores correlate with their percentages of minority nursing students recruited into BSN programs in the past 5 years?

Hypothesis 3: There will be a significant positive correlation between Tennessee schools' mean nurse educators' cultural competence scores and their percentages of minority nursing students recruited into BSN programs in the past 5 years.

The data for this analysis did not have a normal distribution; it was positively skewed, so Spearman rho correlation was computed to answer question 3 and hypothesis 3. Data that are

positively skewed have a greater number of small values than large values. According to Field (2000), when data are not normally distributed, Spearman rho correlation is recommended. The result showed a positive trend toward a correlation between Tennessee schools' mean nurse educators' cultural competence scores and their percentages of minority nursing students recruited into BSN programs in the past 5 years ( $p = .103$ ). (Table 9) The study's hypothesis was not supported.

Question 4: Will Tennessee schools' mean nurse educators' cultural competence scores correlate with their percentages of minority nursing students graduated from BSN programs in the past 5 years?

Hypothesis 4: There will be a significant positive correlation between Tennessee schools' mean nurse educators' cultural competence scores and their percentages of minority nursing students graduated from BSN program in the past 5 years.

For this question and hypothesis, Spearman rho correlation was also computed, because the data were positively skewed. A significant positive correlation between Tennessee schools' mean nurse educators' cultural competence scores and their percentages of minority nursing students graduated from BSN programs in the past 5 years was found ( $p = .015$ ). This finding supported the study's hypothesis (Table 9).

Table 9.

*Spearman rho Correlation Between Mean Nurse Educators' Cultural Competence Scores and the Percentages of Minority Nursing Students Recruited and Graduated*

		Percentage of minorities recruited	Percentage of minorities graduated	Mean nurse educators' cultural competence scores
Percentage of minorities recruited	Correlation coefficient	1.000	.667*	.467
	Sig (1-tailed)	.	.025	.103
	N	9	9	9
Percentage of minorities graduated	Correlation coefficient	.667*	1.000	.717*
	Sig (1-tailed)	.025	.	.015
	N	9	9	9
Mean nurse educators' cultural competence scores	Correlation coefficient	.467	.717*	1.000
	Sig (1-tailed)	.103	.015	.
	N	9	9	9

\* Correlation is significant at the 0.05 level (1-tailed)  
 All data are based on 9 participating schools

Question 5: Does experience living in a country with a culture different from the United States (U. S.) increase nurse educators' cultural competence scores?

Hypothesis 5: Nurse educators who have had experiences living in a country with a culture different from the U. S. have significantly higher cultural competence scores than those who have not.

This question and hypothesis were answered using a one-tailed independent t-test to compare the mean cultural competence score of respondents who have lived in a country with a culture different from the U. S. (n = 9) with respondents who have not (n = 67). The Levine's Test for equality of variances was not significant ( $p = .940$ ); therefore the t-test for equal variances assumed was used. The analysis demonstrated a statistically significant difference between the two groups ( $p = .01$ ). (Table 10)

Table 10.

*t-test Comparing the Mean Cultural Competence Scores of Respondents Who Have Had Experiences Living in a Country With a Culture Different From the U. S. and Those Who Have Not*

Did faculty reside in another culture?	n	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Yes	9	221.44	18.0	2.38	74	.010
No	67	205.75	18.64			

Cross (1998) and Kitsantas and Meyers (2001) also found that living and practicing abroad increased participants' cultural competence. For Hypothesis 5, the study's hypothesis was supported because a statistically significant difference between the mean cultural competence scores of the two groups was found.

Question 6: Does attendance at multicultural education seminars during the past 5 years increase nurse educators' cultural competence scores?

Hypothesis 6: Nurse educators who have attended multicultural education seminars during the past 5 years have significantly higher cultural competence scores than those who have not.

Student's independent t-test (one-tailed) (95% confidence interval) was used to compare the mean cultural competence score of respondents who have attended multicultural education seminars in the past 5 years (n = 39) and those who have not (n = 34). The Levine's Test for equality of variances was not significant ( $p = .222$ ); therefore, t-test for equal variances was used. A statistically significant difference between the mean cultural competence score of nurse educators who attended multicultural education seminars in the past 5 years and those who did not was found ( $p = .0005$ ). (Table 11)

Table 11.

*t-test Comparing the Mean Cultural Competence Scores of Respondents*

*Who Have Attended Multicultural Education Seminars and Those Who Have Not*

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Did faculty attend continuing education?

	<u>n</u>	Mean	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Yes	39	214.6	20.2	3.45	71	.0005
No	34	199.7	15.6			

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This finding is consistent with past research (Schim et al., 2005). This finding supports the study's hypothesis because a statistically significant difference was found between the mean cultural competence score of respondents who have attended multicultural education seminars in the past 5 years and those who did not.

Question 6 and Hypothesis 6 revealed that nurse educators who have attended multicultural education seminars during the past 5 years achieved statistically significant higher cultural competence scores than those who have not. To discover whether there was a correlation between the number of multicultural education seminars attended and total cultural competence scores of respondents, Pearson's Product Moment correlation was computed and the confidence interval (CI) was set at 95%. The number of multicultural education seminars attended ranged from one to nine. The total cultural competence scores of respondents who attended multicultural education seminars ranged from 168 to 262. The result showed a significant positive correlation between the number of multicultural education seminars attended and cultural competence scores ( $p = .000$ ). Though a significant positive correlation between the number of multicultural education seminars attended and cultural competence scores was found, the correlation coefficient was weak at .452.

#### Respondents' Comments

Respondents were asked to comment on this survey and 21 participants responded to this request. One respondent had concerns about reporting his or her school affiliation and asked why this information was needed. School affiliation was needed to answer Research Questions 3 and 4 and Hypotheses 3 and 4. These questions and hypotheses aimed to discover a correlation between Tennessee schools' mean nurse educators' cultural competence scores and the percentages of ethnic minorities recruited and graduated in BSN programs in the past 5 years. Another respondent commented that questions in the survey focused on clinical teaching and were not appropriate for teaching doctoral students. One respondent thought that "content" was not the best method to improve nurse educators' cultural competence. This individual recommended stories, discussion, interaction, personal reflection, and opportunities to

experience other cultures as critical in achieving this goal. One respondent commented that the survey was too long and that some questions could be better answered with “something other than the choices given.” Another respondent stated she or he did not teach in the undergraduate program and as such, the responses provided by this respondent might not apply to this study. Appendix N contains a verbatim report of all the respondents’ comments.

## CHAPTER 5

### SUMMARY, DISCUSSION, AND RECOMMENDATIONS

Cultural competence in this study was defined as “the process in which the healthcare provider [nurse educator] continuously strives to achieve the ability to effectively work within the cultural context of a client [student], individual, family, or community” (Campinha-Bacote, 1998, p. 6). A framework developed from the literature by the researcher guided this study. The research sample included BSN faculty in nine accredited Colleges of Nursing in the state of Tennessee. The data were collected using the Internet version of the questionnaire, “Cultural Diversity Questionnaire for Nurse Educators” (Sealey, 2003).

This exploratory study had six purposes:

1. To discover the mean cultural competence scores for participating schools,
2. To determine the distribution of cultural competence scores among respondents,
3. To investigate the correlation, if any, between Tennessee schools' mean nurse educators' cultural competence scores and their percentages of minority nursing students recruited into baccalaureate nursing programs in the past 5 academic years.
4. To correlate Tennessee schools' mean nurse educators' cultural competence scores with their percentages of minority nursing students graduated from baccalaureate nursing programs in the past 5 academic years,
5. To discover whether living in a country with a culture different from the United States increased nurse educators' cultural competence scores, and
6. To determine whether attending multicultural education seminars during the past 5 years increased respondents' cultural competence scores.



## Summary of Findings and Discussion

The majority of the respondents were Caucasian (n =68, 89.5%), and the largest number of respondents was between the ages of 51 and 60 years (n =32, 42.1%). Nine (11.8%) participants had resided for more than 6 months in a country with a culture different from the United States, and 39 (51.3%) respondents had attended continuing education programs on transcultural nursing or cultural competence in the past 5 years. The number of continuing education programs on transcultural nursing or cultural competence attended by respondents ranged from one to nine. Forty-three (56.6%) respondents reported assessing how their students' cultural beliefs and values influence students' attitudes toward education and learning; 38 (50%) reported assessing how cultural beliefs and values influence students' learning styles. The majority (n = 40, 52.6%) of participants reported earning a master's degree in nursing. The mean percentages of Caucasian and African American nursing students in their schools were 85.13% and 9.59% respectively. The faculty's nursing specialties most cited by respondents were Adult Health (42.1%), Childbearing (15.8%), Community Health (14.5%), Psychiatric Nursing (13.2%), Child Health and Illness (11.8%), Gerontology (11.8%), and Women's Health (10.5%).

Research question 1 was, what is the distribution of Tennessee baccalaureate (BSN) program's mean nurse educators' cultural competence score? The finding revealed that the mean cultural competence score for nurse educators in each of the nine BSN schools ranged from 199.7 to 229.8; the majority of BSN school's mean faculty cultural competence scores did not fall below 130 as predicted by the researcher. Hence, research hypothesis 1 was rejected.

Research question 2 was, what is the distribution of cultural competence scores among nurse educators in Tennessee BSN programs? The data related to research question 2 showed that the cultural competence scores among respondents ranged from 168 to 262. The study's hypothesis

was rejected, because none of the respondent's cultural competence scores fell below 130. The study finding that nurse educators are culturally competent is supported by other studies in the literature (Sargent, Sedlak, & Martsof, 2005). Measuring cultural competence levels of 1st year and 4th year students and faculty, (Sargent et al.) demonstrated that nursing faculty achieved higher cultural competency scores than 1st and 4th year nursing students. Kardong-Edgren (2007) also measured the cultural competence of nursing faculty. This study revealed that nursing faculties were culturally competent; however, nursing faculties teaching in states with fewer immigrants were less culturally competent than faculties teaching in states with higher immigrant populations.

In contrast, the findings of this study were inconsistent with the results of other studies. Sealey, Burnett, and Johnson (2006) measured the cultural competency of nursing faculty in Louisiana and found that the cultural competency reported by the respondents fell below what would be expected among individuals charged with preparing nurses to care for clients from diverse cultural backgrounds. Kardong-Edgren et al. (2005) found a lack of cultural competence in nursing faculty. The inconsistency in this finding could be attributed to various factors. Nurse educators who were culturally competent could have had opportunities to reside and practice in a culture different from the United States and could also have been attending multicultural education seminars, thus increasing their cultural competence. Residing and practicing abroad and attending multicultural education seminars have been shown to increase individuals' cultural competence (Doorenbos & Schim, 2004; Kitsantas & Meyers, 2001; Koskinen & Tossavainen, 2004). Location of nursing schools where studies were conducted could have had an influence on the levels of cultural competency reported by respondents. Kardong-Edgren (2007) found that faculties teaching in states with large immigrant populations were more culturally competent

than faculties teaching in states with few immigrants. It could also mean that some Colleges of Nursing are demonstrating more commitment to cultural diversity than others by providing opportunities for faculty to improve their cultural competence.

Research question 3 was, will Tennessee schools' mean nurse educators' cultural competence scores correlate with their percentages of minority nursing students recruited into BSN programs in the past 5 years? The findings revealed no correlation between Tennessee schools' mean nurse educators' cultural competence scores and their percentages of minority nursing students recruited into BSN program in the past 5 years. Subsequently, the study's hypothesis was rejected.

Question 4 was, will Tennessee schools' mean nurse educators' cultural competence scores correlate with their percentages of minority nursing students graduated from BSN programs in the past 5 years? Hypothesis 4 was supported; question 4 and hypothesis 4 analyses showed a significant positive correlation between Tennessee schools' mean nurse educators' cultural competence scores and their percentages of minority nursing students graduated from BSN programs in the past 5 years. This is the first time this issue has been systematically investigated. No published studies were found on the relationship between minority nursing students' graduation rates and nurse educators' levels of cultural competence. The literature does suggest that nurse educators who are culturally competent are more likely to identify and meet the educational needs of ethnic minority nursing students, which could in turn increase the number of ethnic minority nursing students recruited and graduated (Gardner, 2005a; Yoder, 1996). Gardner commented that by understanding minority nursing students' experiences, nurse educators might better meet students' educational needs and increase their graduation rates. However, suggestions and comments are unsuitable as justification for establishing new

initiatives and programs. The fact that this systematic study has now established a clear relationship between faculty cultural competence and graduation rates of minority nursing students has an importance that cannot be over emphasized. The higher graduation rates of minorities could be explained by a tendency of schools with culturally competent faculty to admit more minority nursing students. However, this cannot explain the present finding. The relationship between nurse educators' cultural competence score and admission rates for minority nursing students was both lower and not statistically significant. This indicates that culturally competent faculty specifically enhance graduation rates regardless of admission rates. The finding demonstrates the importance of faculty cultural competence on the experience, understanding and support of minority nursing students during their educational pursuit.

Research question 5 was, does experience living in a country with a culture different from the United States (U. S.) increase nurse educators' cultural competence scores? Analysis of research question 5 showed that nurse educators who have lived in a country with a culture different from the U. S. had a statistically significant higher cultural competence scores than those who have not. Hence, hypothesis 5 was supported. This finding is similar to those of other studies. Cross (1998) and Kitsantas and Meyers (2001) found that living and practicing abroad increased participants' levels of cultural competence. This finding underscores the importance of encouraging both nursing faculties and students to travel abroad whenever possible. Travelling abroad provides opportunities for faculty and students to meet and interact with individuals from diverse cultural backgrounds, a necessary step to becoming culturally sensitive and competent.

Question 6 was, does attendance at multicultural educational seminars during the past 5 years increase nurse educators' cultural competence scores? The findings revealed that nurse educators who had attended multicultural education seminars in the past 5 years achieved

significantly higher cultural competence scores than those who had not. Hypothesis 6 was also supported. This finding is also consistent with previous studies (Schim et al., 2005; Sealey, 2003). This finding stresses the importance of encouraging nursing faculty and students to seek opportunities to attend multicultural education seminars to increase their cultural competence. In addition, because becoming cultural competence is important to the nursing profession, Colleges of Nursing could offer yearly multicultural education seminars to their faculties and students to enhance nursing faculties' and students' cultural competence.

#### Limitations

Several limitations in this exploratory study have been identified. This study used convenience samples of both schools and nurse educators, so generalizability is limited to these schools and nurse educators. Because data were collected at one point in time with no follow-up questions or clarifications, trends or cyclic changes over time are not visible. Only accredited baccalaureate nursing programs in the state of Tennessee were surveyed, so findings cannot be generalized to other schools that are not accredited or prepare nurses at the baccalaureate level. Internal validity, as for all nonexperimental studies, is low. Recent nurse educators' cultural competence scores were correlated with the percentages of ethnic minority nursing students recruited and graduated in the past 5 academic years; these findings cannot be taken as evidence of causation because cultural competence scores were measured in the present while the recruitment and graduation of minority nursing students occurred in the past.

Another limitation was a low response rate of only 53%. Response bias is likely because this study used a self-report tool, giving respondents the opportunity to give socially acceptable answers, thereby manipulating the scores through their responses. Additionally, the reliability of

the instrument used in this study is relatively low, ranging from 0.63 to 0.82 for the five constructs.

Although the framework and assumptions for this study posit that faculty who are culturally competent promote greater success among ethnic minority nursing students, the investigator cannot rule out two other technical possibilities because this was a correlational (nonexperimental) study. The first possibility is that schools in which minorities are more successful tend to attract and retain faculty who are culturally competent. The second possibility is that faculty cultural competence does not "cause" higher graduation rates among minority nursing students. However, the two may be connected due to a third hidden intervening variable. For example, higher minority graduation rates might be caused by the financial condition of a school, such that abundant money permits more resources for minority nursing students and more resources for hiring potentially more expensive, culturally competent faculty. Several other variables other than finances are also candidates for intervening variables.

Unfortunately, it was not feasible, and may not even be possible to conduct a randomized experimental design. So, regardless of how unlikely the above two possibilities appear, the reader must keep them in mind when reviewing the data and findings in the present study.

### Recommendations

Research question 1 revealed that nurse educators who participated in this study were culturally competent. It is noteworthy to mention that though this study's participants were culturally competent, it does not mean that all nurse educators are culturally competent. Of the 164 e-mails that were sent, 77 were not returned. It is possible that nursing faculty who were not culturally competent chose not to participate in this study, and only those who were culturally competent chose to participate. Additionally, this study used a self-report instrument;

participants may have given socially acceptable responses, thereby, manipulating the study's findings. It should also be noted that among the 76 respondents in this study, almost 40% had total cultural competence scores that were in the moderate level category. This is not adequate. All nurse educators need high levels of cultural competence to identify and meet the needs of culturally diverse nursing students and to prepare nurses who are capable of providing culturally satisfying care to multicultural clients. Engaging in activities that enhance individuals' cultural competence could help these respondents improve their cultural competence.

It is imperative that nursing faculty become culturally competent and sensitive, enabling them to meet the needs of culturally diverse clients and students and also prepare nurses capable of providing culturally congruent care to multicultural individuals (Alpers & Zouchers, 1996; Chrisman, 1998; Leininger & McFarland, 2002). To provide culturally congruent and satisfying healthcare services to clients from different cultures, healthcare providers, including nurses, must become culturally competent. According to the U. S. Census Bureau (2008), the ethnic minority population in the U. S. has increased from 21% in 1980 to 28% in 2000. It is projected that by 2050 the U. S ethnic minority population will represent 50% of the total U. S. population (U. S Census Bureau, 2004). This increase will also result in more ethnic minorities needing healthcare services. Fortunately, the average cultural competence scores in this study indicate that most faculties are at least moderately culturally competent.

For nursing faculty who are not culturally competent or those who wish to improve their levels of cultural competence, published research has identified many strategies to increase individuals' cultural sensitivity and competence. Studying (Kitsantas and Meyers, 2001), living, and practicing abroad (Cross, 1998) have been shown to increase individuals' cultural sensitivity and competence. Even though these strategies are effective in increasing cultural sensitivity and

competence, it may not be feasible for all nursing students and faculty to live abroad due to cost and time factors. Short international immersion experiences have also been identified as instrumental in promoting cultural sensitivity and competence (Koskinen & Tossavainen, 2004; Ryan & Twibell, 2002; Sandin et al., 2004; Walsh & DeJoseph, 2003; Woods & Atkins, 2006). Cultural projects, e.g., assigning students to work with communities that have cultures different from the students' own or having students read literature on different cultures (Anderson, 2004; Keime et al., 2002), are strategies also known to promote cultural sensitivity and competence. Another strategy shown to be beneficial in increasing cultural sensitivity and competence is cultural diversity training (Doorenbos & Schim, 2004; Schim et al., 2005; Sealey, 2003).

Because cultural competence and sensitivity are important to the nursing profession, Colleges of Nursing could conduct annual multicultural education seminars for faculty. However, the nursing profession should not be solely responsible for producing nurses who are culturally competent and sensitive. Federal, state, and local governments should support Colleges of Nursing financially in offering cultural immersion experiences for nursing faculty and students. Living, studying, and practicing abroad, whether semester-long or immersion experiences, give nurses opportunities to meet and interact with individuals from diverse cultural backgrounds and to learn about other perspectives and beliefs. This is consistent with Campinha-Bacote's concepts of cultural desire, cultural encounter and cultural knowledge, essential in promoting cultural sensitivity and competence. Similarly, by attending multicultural education seminars, an individual demonstrates cultural desire. Multicultural education provides opportunities for individuals to interact and learn from and about other cultures. Cultural immersion experiences could also be achieved locally. Nursing faculty and students could visit or stay with segregated groups in the community, e.g., the Mennonites, American Indians living



on reservations, and the Amish. Caucasian faculty and nursing students could also reside at predominantly Black colleges for a semester or more. Such experiences would provide cultural encounters for faculty and students and also provide opportunities to experience being in the minority and sometimes misunderstood. This is a necessary step for individuals to become aware of other cultures and to appreciate and respect cultural differences. The State Boards of Nursing could also mandate yearly multicultural education seminars as part of licensure renewal to insure that once nurses and nurse educators become culturally competent and sensitive, they continue to improve in this area.

Several cultural models have been developed for nurse educators who want to increase their cultural competence. Purnell and Paulanka (2003) developed *Purnell's Model for Cultural Competence* to aid healthcare providers in gaining knowledge about their clients by assessing the ethno-cultural attributes of clients and their families. This framework consists of 12 domains. See Appendix O. The investigator obtained permissions to use and include the "12 Domains of Culture" of the Model in the dissertation document. See Appendices P and Q. Collecting information on some or all of these 12 domains enables nurse educators, nurses, and nursing students to increase their cultural knowledge, sensitivity, and competence.

Overview, inhabited localities, and topography includes becoming familiar with the ethnic group's origin, where they reside, factors that motivated them to immigrate, and the economic or political factors that influenced their acculturation. When assessing a group's communication, the following need to be identified: discover the group's main language and other languages they speak, what touch means to them, what degree of personal space is used during face-to-face communication, use of eye contact, the meaning of body language, and how much importance the group places on punctuality. To assess a cultural group's family roles and

organization, a healthcare provider must identify the types of decisions made by various members of the family, gender roles for men and women in this group, and appropriate versus inappropriate behaviors for various members.

Assessing workforce issues includes identifying educational levels, cultural issues regarding professional autonomy, superior or subordinate control, religious issues and gender in the workforce. These issues also include exploring factors influencing patterns of acculturation for this group. Exploring problems or concerns posed by the group's skin color for healthcare practitioners, identifying risk factors for this group, recognizing hereditary or genetic diseases that are common to this group, and identifying endemic diseases specific to this group would enable healthcare providers to learn about clients' biocultural ecology. Assessing high-risk behaviors includes exploring the use of alcohol, tobacco, and recreational drugs and identifying the usual health-seeking behaviors for this group. Nutrition assessment includes identifying the meaning of food, food preparation practices, enzyme deficiencies or food intolerances within this group, and native food limitations in the new country that might induce special health problems.

By exploring cultural views and practices about fertility and prescriptive, restrictive, and taboo practices toward pregnancy, the birthing process, and the post partum period, nurses learn the best ways to approach childbearing experiences in each cultural group. Similarly, exploring each cultural group's death rituals, responses to death and grief, and the meaning of death enables nurses to provide culturally congruent care when clients experience death in their families and communities.

Spirituality may be important in a cultural group's behavior toward life. To assess a group's spirituality, nurses need to explore the influence of the group's main religion on their healthcare practices, including how this group uses prayer and meditation. It is also important to

identify what gives life meaning for this group and what constitutes the source of members' strength. Some of the areas nurses need to assess in regard to healthcare practices are identifying the predominant beliefs that influence healthcare practices, magico-religious, folk, and traditional beliefs, and barriers to healthcare access for each cultural group. Nurses also need to explore the types of healthcare practitioners to whom each cultural group is accustomed. This is important because some cultural groups may prefer one type of healthcare provider over another (Purnell & Paulanka, 2003).

Campinha-Bacote's (2003) *Cultural Competence in the Delivery of Healthcare Services* also provides healthcare practitioners with a process for becoming culturally competent including five constructs: cultural awareness, cultural knowledge, cultural encounters, cultural skill, and cultural desire.

Cultural awareness involves continuous examination of one's own prejudices and biases about other cultures and exploration of one's own cultural background. This is intended for healthcare providers to acknowledge and respect differences between beliefs, values, and healthcare practices of individuals from diverse cultural backgrounds, thus preventing healthcare providers from imposing their beliefs, values, and healthcare practices on clients. Cultural knowledge involves obvious effort by the healthcare provider to seek information on the worldviews of individuals from several cultures. Cultural encounter is the process of face-to-face meeting and interaction with individuals from diverse cultures; cultural encounters refine or modify healthcare providers' beliefs about these cultural groups, preventing possible stereotyping. Cultural skill involves collecting relevant cultural information and conducting physical examinations that are culturally specific. This can be achieved by using assessment tools designed specifically for cultural assessment. Cultural desire is having the motivation to

learn about other cultures, an important step in the process of becoming culturally competent because without desire individuals cannot be forced to become culturally competent. Fahrenwald et al. (2001) reported using Campinha-Bacote's Cultural Competence Model to increase nursing students' cultural competence.

The framework that guided this study outlined the following strategies that are beneficial in promoting cultural sensitivity and competence in individuals: living, studying, and practicing abroad (Kitsantas & Meyers, 2001), cultural immersion experiences (Koskinen, 2004), cultural diversity training (Doorenbos & Schim, 2004; Sealey, 2003), cultural interventions (Smith, 2001), and cultural projects (Anderson, 2004). Living, studying, and practicing abroad and cultural immersion experiences increase encounters and interactions with individuals from diverse cultural backgrounds. Interactions help both visitors and hosts become aware of other cultural beliefs, values, worldviews, and practices, and enable them to realize how their individual beliefs, values, worldviews, and practices affect others. With this knowledge, they become receptive to and respectful of other cultural beliefs, values, worldviews, and practices. This knowledge also enables them to change their behaviors to accommodate individuals from diverse cultural backgrounds, hence increasing their cultural sensitivity and competence. Interactions with multicultural individuals assist healthcare providers refine or modify their existing beliefs about other cultures as they identify differences among individuals from the same race and ethnic groups, thereby preventing stereotyping.

Cultural diversity training uses various educational strategies, e.g., on-line learning, face-to-face workshops, presentations, group discussions, role-play, and videos. Diversity training provides participants with knowledge about other cultural beliefs, values, worldviews, and practices. It also assists participants in learning new skills essential for behavior changes to

accommodate multicultural individuals. Changing behaviors to accommodate other cultural beliefs, values, worldviews, and practices promotes a more diverse and respectful workplace.

Cultural intervention, through information on different cultural beliefs, values, worldviews, and practices, aims to increase the target group's knowledge, awareness, and understanding of these cultures. Cultural interventions could be implemented through workshops, films, discussions, and lectures. It is hoped that with increased knowledge, awareness, and understanding of other cultures, participants will appreciate and respect other cultures, thus increasing their cultural sensitivity and competence.

Cultural projects also help individuals increase their knowledge about other cultures. These projects could be developed through reading literature on different cultures or working in a community with different cultural beliefs, values, worldviews, and practices. These strategies also help individuals increase their cultural sensitivity and competence.

It is hypothesized that culturally competent nursing faculty are more likely to identify and meet the educational needs of students from diverse cultural backgrounds. The idea is that meeting the needs of culturally diverse students encourages students to stay in school and graduate, thus increasing the number of minority nursing students graduated and entering the workforce. Because Hypothesis 4 was supported, the first empirical support for the link between faculty cultural competence and the graduation rates of minority students was demonstrated.

One strategy for providing culturally congruent care to culturally diverse individuals is to increase the number of ethnic minority nursing students recruited and graduated. More ethnic minority healthcare providers, including nurses, are needed because they are more likely than their Caucasian peers to serve in minority and underserved communities (IOM, 2002; U. S. Department of Health & Human Services, 2000). The Tennessee Center for Nursing's (TCN)

New Nursing Education Master Plan Report (TCN, 2008) has called for an increase in the number of prelicensure minority registered nurse graduates to mirror the state population. Several strategies have been used to increase the rate of ethnic minority nursing students' recruitment and graduation (Guhde, 2003; Martin-Holland et al., 2003; Stewart, 2005; Yurkovich, 2001).

It is also important to increase the number of ethnic minority healthcare providers, including nurses because previous studies have shown that racial concordance between clients and healthcare providers affects clients' satisfaction with the healthcare they receive (Cooper et al., 2003; Cooper-Patrick et al., 1999; Malat, 2001). Cooper-Patrick et al. argued that healthcare providers and clients belonging to the same race or ethnicity are more likely to share similar cultural beliefs, values, and experiences that might enable them to communicate more effectively and feel more comfortable with each other.

#### Recruiting and Educating More Ethnic Minority Nurses

Though nursing is the most trusted profession in the United States, the public image of nursing is not favorable (Nevidjon & Erickson, 2001). The public hears about the nursing shortage, the long hours nurses work, medication errors resulting in client deaths, and infections that spread among hospital patients. These issues result in the public view of nursing as unsafe, unstable, and unpredictable (Nevidjon & Erickson). Studies conducted with high school students and new nursing students of diverse cultural backgrounds revealed that the younger generation has a negative image of nursing and does not view nursing as an ideal career choice (Brodie et al., 2004; Rossiter & Yam, 1998), resulting in ambivalence about nursing as a career choice. These findings suggest that recruiting, retaining, and graduating more ethnic minority nursing students will require substantial commitment by nurse educators.

### *Recruitment Strategies*

To recruit more ethnic minority nursing students, nursing faculties must be more visible in high schools. Visiting area high schools to talk to students about the nursing profession, explaining what nurses do, and describing the benefits of becoming a nurse are all part of a comprehensive minority recruitment strategy. Another strategy is conducting health fairs in ethnic minority neighborhoods to promote nursing. One strategy to assist young people commit to nursing as a career is to create or sponsor hospital immersion experiences where high school students who show an interest in nursing are given opportunities to work in hospitals observing what nurses actually do. Additionally, faculty and students could organize summer camps for minority high school students to promote the positive image of the nursing profession. It is also important that minority nursing faculty be part of the recruitment team because making minority nurse educators visible to minority high school students might be an incentive that could bolster the students' confidence that they could also successfully become nurses.

The nursing staff at Memorial Medical Center in Springfield, Illinois, and the nurse educators at Mennonite College of Nursing at Illinois State University collaborated to host a 4-day “Teen Camp” to increase the interest of high school students in the nursing profession (Redding, Reich, & Prater, 2004). The campers participated in simulated learning experiences, classroom activities, post clinical conferences, and hands-on experiences in hospital units. According to the authors, on arrival all the campers stated that coming to the camp was something interesting to do for the summer; at the completion of the program, all participants stated interest in becoming nurses. The Teen Camp is an example of a successful approach that should be emulated.

Studies have shown that minority nursing students are often inadequately prepared for the academic rigors of nursing programs, leading to fewer students recruited and retained (Allen, Nunley, & Scott-Warner, 1988; Britten, Elander, Collins, & Updegraff, 1993; Browne-Krimsley, 1996). To overcome this problem, nursing faculty must assist ethnically diverse students to prepare for the highly competitive application process through academic counseling, tutoring, and remedial courses earlier in their education to improve the acceptance rate for this population. Precollege programs could also be used to bridge students from general education to the professional aspects of the nursing curriculum as recommended by Allen et al.; Britten et al.; and Browne-Krimsley. Once the students are recruited, minimizing or removing some or all of the factors that contribute to attrition could promote higher graduation rates. For example, providing scholarships, grants, work-study, and summer jobs to minority students who show interest in nursing but who may be financially unable to pay for the ever-increasing tuition, room, and board could increase recruitment rates and minimize attrition.

### *Retention Strategies*

Conducting comprehensive orientation programs to thoroughly acquaint students with curriculum requirements and available services, including how and when to access these services, would promote retention of ethnic minority nursing students and increase their graduation rates (Kirkland, 1998). It is important that once minority nursing students are recruited, faculty advisors and mentors are assigned to each student. Britten et al. (1993) argued that a strong relationship between faculty and students aids students academically and professionally. To build strong relationships, the authors suggest minority students be acquainted with advisors and oriented to the benefits of the relationship. Britten et al. also suggest that an early assessment of minority students' academic progress be conducted to



identify those needing assistance with coursework. Yurkovich (2001) and Villarruel et al. (2001) found that having role models and mentors facilitated minority nursing students' pursuit of nursing education. Gardner (2005b) and Stewart (2005) described mentoring programs in their schools that were instrumental in promoting the retention of minority nursing and prenursing students.

To further promote retention and graduation of minority nursing students, each College of Nursing could initiate tutoring and remedial plans including reading improvement, writing skills, studying skills, and test taking skills to help all students, especially ethnic minority students. Britten et al. (1993) found notable characteristics among minority nursing students that created obstacles to pursuing nursing education, including inadequate attention to detail and relying on rote-mode learning and memorization. Additional characteristics were inadequate problem solving and decision-making skills and deficiencies in test taking, note taking, and study skills. Such programs have been shown to be beneficial in promoting retention and graduation of ethnic minority nursing students (Guhde, 2003; Martin-Holland et al., 2003). Remedial plans that include reading improvement, writing skills, and study and test taking skills benefited minority nursing students who cited inability to read and understand the English language as a barrier to pursuing their education (Gardner, 2005a; Guhde). Salamonson, Everett, Koch, Andrew, and Davidson (2008) found that academic performance among nursing students who are English Language Learners is related to their degree of English-language acculturation.

Communication is central to nursing practice. Without English competency, nurses are unable to communicate effectively with their English-speaking clients and other healthcare providers. Assisting ethnic minority nursing students improve their English language competency has multiple benefits. English competency helps students stay in school and

graduate; become more competent healthcare providers; provide effective communication and care for clients who only speak English, and contribute substantially to quality healthcare, hence decreasing the nursing shortage the nation is currently experiencing.

Providing financial aid and flexible programs, e.g. evening and weekend, as recommended by Villarruel et al. (2001), is strongly suggested to help minority nursing students stay in school and graduate. Another recommendation for promoting retention and graduation of minority nursing students is to provide support groups. Ethnic minority students have had high attrition rates, estimated between 15% and 85% (Rodgers, 1990). Several factors have been identified as contributing to this problem: social isolation and loneliness (Gardner, 2005a); lack of self-esteem and stress (Buchanan, 1999); and perceived prejudice and discrimination (Amaro et al., 2006; Gardner; 2005a; Villarruel et al.). Participants in Yurkovich's (2001) study reported that forming peer support groups reduced feelings of loneliness and isolation, increased socialization, and substituted for absent family members. Formation of minority student support groups has also been reported to help students overcome the psychological problems students may encounter in higher educational systems (Gardner, 2005b). Minority support groups helped students express their concerns, form friendships with peers, and provide emotional support (Gardner, 2005b). Shelton (2003) found that nursing students who continued in nursing programs from their first clinical course to their final semester reported significant perceived psychological and functional support from faculty compared to students who withdrew either voluntarily or due to academic failure. Psychological support provides a caring atmosphere, while functional support, e.g., presenting information clearly, providing helpful feedback and helping with problem identification and resolution increases learning, thereby, promoting student persistence. The author argued because nursing education focuses on a holistic approach to client care,

nursing faculty also need to extend this holistic approach to caring for and nurturing nursing students.

The key question is, "Do the qualities of nursing faculty affect minority nursing students' graduation rates; if it does, to what extent?" The present study is the first to show by scientific methodology that faculty cultural competence is linked significantly to graduation rates but not admission rates of minority nursing students. This finding demonstrates that faculty cultural competence is not necessarily associated with schools that recruit a high percentage of minority nursing students. Instead, faculty cultural competence is connected with high graduation rates, showing a specific effect of nurse educators' cultural competence on the success of minority nursing students. This finding demonstrates that enhancements of nursing faculty cultural competence will result in student success. The present study did not determine the exact reason or reasons for this connection, but several possibilities are worthy of consideration.

Strategies that increase graduation rates of ethnic minority students have one thing in common. They recognize and appreciate that the upbringing, values, beliefs, and worldviews of ethnic minorities and Caucasians are different. Some minority students, if not all of them, have been exposed to situations where they did not feel welcome and are sometimes discriminated against. Nurse educators must welcome all students, become acquainted with students on a personal level (Gardner, 2005a; Kossman, 2003), communicate enthusiasm, and explain that minority nurses are needed in the profession. Knowing students on a personal level helps nurse educators gain insight into students' family situations, cultural values and influences, educational adequacy, and work situations. This attention conveys sincere interest in students and assures them of the teachers' willingness to support them, which in turn enhances their confidence and encourages them to persevere in school to graduation.

Using various teaching strategies has also been shown to retain minority nursing students (Choi, 2005). Choi stated that whereas many Caucasian students have been taught to think in an independent, linear, and competitive way, other cultures' learning styles may differ. For example, American Indian students prefer group work and do not need to compete with peers.

Lastly, Rew (1996) commented, "Faculty who have knowledge about other cultures and societies are sensitive to the nuances of language and customs that differ and that may seem strange or frightening when viewed from a different perspective" p. 312). Without this knowledge, faculties tend to teach in ways that are meaningful only to the majority of students, leaving some minority students confused and lost (Rew).

Regardless of why faculty cultural competence improves minority nursing students' graduation rates, the main point of this study is that faculty cultural competence absolutely, positively does matter.

#### Future Research

Most of the literature on the underrepresentation of minority nursing students in nursing schools reported a lack of ethnic minority faculty role models as one of the reasons. To date only one published article, Mills-Wisneski (2005), has reported on the importance of ethnic minority faculty role models for the retention of ethnic minority nursing students. This study should be replicated to further understand how ethnic minority faculty role models influence minority nursing students.

The literature has implied that low levels of nurse educator cultural competence leads to low recruitment and graduation of minority nursing students. This study demonstrated that nursing faculty respondents were culturally competent, yet the

number of minority students in these schools was low. More research is needed to explore why minority students continue to be underrepresented in schools of nursing and the reasons culturally competent faculty promote academic success in minority nursing students.

Researchers have also suggested that meeting the needs of ethnic minority nursing students could increase recruitment and graduation rates. More investigation is needed to identify how to meet their needs.

Salamonson et al. (2008) found that academic performance among students who are English Language Learners was related to the degree of English language acculturation by the students. Programs must be established to help minority nursing students improve their English language competence and investigate the effect of such programs on academic performance.

A qualitative study of successful minority nursing graduates could identify nurse educator actions that were beneficial to students' program success.

Nursing faculty in this study appears to be culturally competent. A qualitative study is needed to investigate whether being culturally competent means that nursing faculty members are able to meet the educational needs of culturally diverse students.

### Summary

The ethnic minority population is rapidly increasing with a similar rise in the number of ethnic minority clients needing healthcare services. It is recommended that nurse educators engage in activities to increase their levels of cultural competence and meet the needs of culturally diverse nursing students. Faculty must prepare nurses capable of providing culturally congruent care to multicultural individuals. It is also suggested that Colleges of Nursing adopt some or all of the strategies identified to promote the recruitment, retention, and

graduation of minority nursing students. Nurse educator behaviors that promote retention and graduation of minority nursing students should be adopted in working with all students.

This descriptive correlational nonexperimental study surveyed a “convenience” sample of nurse educators from nine accredited baccalaureate nursing programs in the state of Tennessee. The analyses revealed that respondents in this study were culturally competent; however, almost 40% of them scored at a moderate level of cultural competence. The study also revealed a relationship between nursing faculties’ cultural competence and graduation rates of minority nursing students. Additionally, the study analyses revealed that living in a country with a culture different from the United States and attending multicultural education seminars increased nurse educators’ cultural competence scores. More research is needed in this area to replicate these findings.

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## APPENDICES

### Appendix A

#### Definition of Terms

The following definitions apply to this study:

1. Acculturation is the “cultural modification of an individual, group, or people by adapting to or borrowing traits from another culture” (Merriam-Webster’s Collegiate dictionary (10<sup>th</sup> ed.), (2000, p. 8).
2. Alien resident is “a foreign-born resident who has not been naturalized and is still a subject or citizen of a foreign country” (Merriam-Webster’s Collegiate dictionary (10<sup>th</sup> ed.), (2000, p. 28).
3. Assimilation is the state in “which individuals disregard their own cultural tradition in favor of the tradition of another culture” (Klyukanov, 2005, p. 66).
4. Citizen is “a native or naturalized person who owes allegiance to a government and is entitled to protection from it” (Merriam-Webster’s Collegiate dictionary (10<sup>th</sup> ed.), (2000, p. 208).
5. Culture is defined as “patterned lifeways, values, beliefs, norms, symbols, and practices of individuals, groups, or institutions that are learned, shared, and usually transmitted intergenerationally over time” (Leininger & McFarland, 2002, p. 83).
6. Cultural awareness is “the understanding of the similarities and differences between various cultures as they relate to what people do, how they express themselves, and their value and belief systems” (Monroe, 1995, p.4).
7. Cultural competence is “the process in which the healthcare provider [nurse educator] continuously strives to achieve the ability to effectively work within the cultural



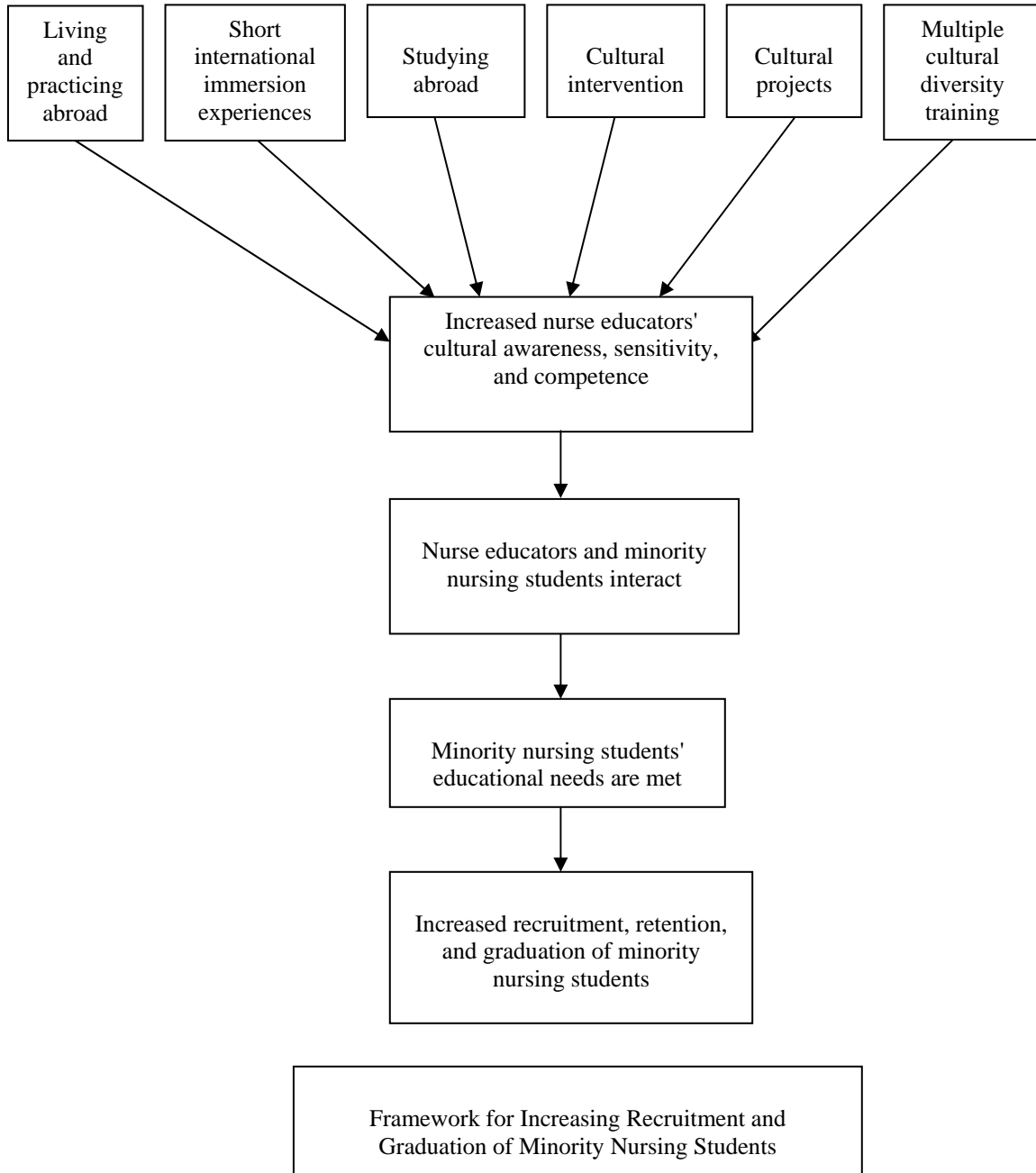
context of a client [student], individual, family, or community” (Campinha-Bacote, 1998, p.6).

8. Cultural desire is “the motivation of the nurse to ‘want to’ engage in the process of cultural competence (not the ‘have to’)” (Campinha-Bacote, 2003, p. 60).
9. Cultural encounter is “the process that encourages nurses to engage directly in cross-cultural interactions with clients from culturally diverse backgrounds” (Campinha-Bacote, 2003, 58).
10. Cultural knowledge is defined as “learning the elements of culture and their role in shaping and defining health behavior” (Wells, 2000, p.191).
11. Cultural skill is “the ability to collect relevant cultural data about the client’s health history and health problems, as well as to accurately perform a culturally-specific physical assessment” (Campinha-Bacote, 2003, p.58).
12. Culture shock is a “sense of confusion and uncertainty sometimes with feelings of anxiety that may affect people exposed to an alien culture or environment without adequate preparation” (Merriam-Webster’s Collegiate dictionary (10<sup>th</sup>. ed.), (2000, P. 282).
13. Open and closed mindedness is the extent to which a person can receive, evaluate, and act on relevant information received from the outside on its own merits without being bothered by irrelevant factors arising from within the person or outside (Rokeach, 1960).
14. Ethnic groups have members who believe they have a common descent because of similarities of physical type, customs, or both (Alba, 1990).

15. Ethnocentrism is “the tendency for human beings to think that our own ways of thinking, acting, and believing are the only right, proper, and natural ones and to believe that those who differ greatly are strange, bizarre, or unenlightened” (Purnell & Paulanka, 2003, p.353).
16. Immigrant is a “person who comes to a country to take up permanent residence” (Merriam-Webster’s Collegiate dictionary (10<sup>th</sup> ed.), (2000, p. 578).
17. Naturalization means admittance to citizenship (Merriam-Webster’s Collegiate dictionary (10<sup>th</sup> ed.), (2000).
18. Racism is “the tendency by groups of institutional and cultural power to use that power to oppress members of groups who do not have access to the same kinds of power” (Calloway-Thomas, Cooper, & Blake, 1999, p.100).
19. Stereotype is when “we take a category of people and make assertions about the characteristics of all people who belong to that category, such that the differences among the members of the group aren’t taken into account” (Calloway-Thomas, Cooper, & Blake, 1999, p.94).
20. Socialization is the process whereby “from infancy, members of a culture learn their patterns of behavior and ways of thinking until most of them become internalized and habitual” (Samovar & Porter, 2004, p. 34).
21. Nurse educator is any individual who teaches in a baccalaureate nursing program.

## Appendix B

### Framework Guiding This Study



Appendix C  
ETSU IRB Permission



East Tennessee State University

Office for the Protection of Human Research Subjects • Box 70565 • Johnson City, Tennessee 37614-1707 • (423) 439-6053  
Fax: (423) 439-6060

**APPROVAL**  
**Initial Exempt Review**

September 20, 2007

Pearl Ume-Nwagbo  
1558 Colony Park Drive  
Johnson City, TN 37604

**Re:** Relationship between Nurse Educators' Cultural Competence and Ethnic Minority Nursing Students' Recruitment and Graduation

**IRB#:** c07-035e

**ORSPA #:** None

The following items were reviewed:

- Form 103
- Narrative (8/20/2007)
- CV
- Conflict of Interest Form (no potential conflict of interest identified)
- Letter to Non-Respondents
- Letter to Deans and Directors of TN Baccalaureate Nursing Program
- Advance Notice Letter
- Participant Letter
- Letter of Website access to the Questionnaire
- Questionnaire
- Reminder letter (7/13/2007)
- Permission letters from outside institutions

On September 20, 2007, a final approval was granted in accordance with 45 CFR 46. 101(b)(2). It is understood this project will be conducted in full accordance with all applicable sections of the IRB Policies. No continuing review is required. The exempt approval will be reported to the convened board on November 1, 2007.

**Make sure you provide the Graduate Office with a copy of this letter for their records.**

Unanticipated Problems Involving Risks to Subjects or Others must be reported to the IRB (and VA R&D if applicable) within 10 working days.



*Accredited Since December 2005*

## Appendix D

### Permission to use Research Instrument

---

**From:** Lorinda J. Sealey [mailto:lsealey@selu.edu]  
**Sent:** Thu 3/30/2006 11:43 PM  
**To:** Ume-Nwagbo, Pearl Ngozika  
**Subject:** research instrument

Dear Ms. Ume-Nwagbo,  
I received your letter today. As I stated in my previous mail to you, I am pleased to grant you permission to use my instrument "Cultural Diversity Questionnaire for Nurse Educators" for your doctoral research. You may modify the instrument to suit the needs of your study and certainly feel free to contact me if you have any further questions concerning my research. In case you need a more formal response (besides this electronic message), I have also written you a letter and sent it by regular mail. You should receive it in a few days.

Best Wishes,  
Lorinda Sealey

Lorinda J. Sealey, Ph.D., RNC  
Assistant Professor  
School of Nursing  
Southeastern Louisiana University  
4849 Essen Lane  
Baton Rouge, LA 70808  
(225) 765-2324

## Appendix E

### Permission to Publish Instrument in the Dissertation Document

**From:** lsealey@selu.edu [mailto:lsealey@selu.edu]  
**Sent:** Sun 6/29/2008 5:15 PM  
**To:** Ume-Nwagbo, Pearl Ngozika  
**Subject:** RE: research instrument

Dear Pearl,

I am pleased to learn that you have completed your dissertation. You may certainly publish my instrument in your dissertation, as long as it is appropriately cited. Did you make any changes to the instrument? I am curious about the psychometrics (e.g., factor analysis, reliability) and your findings in general. Congratulations on completing your research and best wishes.

Lorinda J. Sealey

On Saturday, June 28, 2008 2:45 PM, Ume-Nwagbo, Pearl Ngozika wrote:

>

>Date: Sat, 28 Jun 2008 15:45:23 -0400

>From: Ume-Nwagbo, Pearl Ngozika

>To: "Lorinda J. Sealey" <lsealey@selu.edu>

>cc:

>Subject: RE: research instrument

>

>Dear Dr. Sealey,

>

>It seems such a long time since I obtained your permission to use your instrument in my dissertation study. I want to thank you again for giving me that permission. I have completed my dissertation. I am asking your permission to include your instrument in my dissertation document. I hope to hear from you soon.

>Thank you again, Pearl

## Appendix F

### Cultural Diversity Questionnaire for Nurse Educators

The following statements are about your clinical and teaching practices, and your beliefs and attitudes regarding caring for culturally, racially, and ethnically diverse clients. Statements about teaching relate only to your activities with undergraduate nursing students. Please circle the term that most accurately reflects your level of agreement with each statement. Client could be an individual, family, group, or community.

1. What I believe about health, illness and preventive health is strictly based on science.  
Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
2. Some cultural groups believe that supernatural forces can cause illness.  
Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
3. I feel confident in using a variety of cultural assessment tools in the healthcare setting.  
Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
4. It is more important for my students to conduct cultural assessments on ethnically diverse clients than on other clients.  
Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
5. I do not have time to include cultural competence in my course content.  
Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
6. I am involved socially with cultural/racial/ethnic groups, different from my own, outside of my teaching role and healthcare setting.  
Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
7. Caring for clients who are culturally, racially, or ethnically diverse is a challenge that I welcome.  
Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
8. Individuals of different cultural/racial/ethnic groups have perceptions of health, illness, and preventive health that are no different from my own.  
Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
9. The same approach should be followed when caring for all patients, regardless of culture, race, ethnic or religious background, or worldview.  
Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
10. I am knowledgeable about variations in drug metabolism among specific cultural groups.  
Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

11. Determining the degree of acculturation of culturally diverse clients is a desirable but not essential part of conducting a cultural assessment.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

12. I avail myself of professional development and training opportunities to enhance my knowledge and skills in the provision of health care services to culturally, racially, and ethnically diverse groups.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

13. I am aware that biological variations exist in different cultural, racial, and ethnic groups.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

14. I use the appropriate communication style and protocol to communicate with clients who are of different cultural, racial, and ethnic backgrounds.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

15. There is no difference in food digestion among ethnic, racial, and cultural groups.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

16. My students are required to seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to culturally, racially, and ethnically diverse groups served by our program.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

17. When I care for a client, I consider how the difference between our perceptions of health, illness and preventive health could affect the outcome of my care.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

18. I am knowledgeable about biological variations that exist among specific cultural, racial, and ethnic groups.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

19. I am knowledgeable of keywords and phrases needed to communicate effectively with the major groups with limited English language proficiency that are served by our program.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

20. I seek out clinical opportunities for my students to care for clients who are culturally, racially, and ethnically diverse.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

21. I am knowledgeable about diseases that have a high incidence among cultural, racial, and ethnic groups in our service area.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

22. I am in contact with individuals, who provide health services to groups that are culturally, racially, and ethnically diverse.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree



23. I require that students be knowledgeable about diseases that have a high incidence among clients in our service area, from diverse cultural, racial, and ethnic groups.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
24. I am aware of some of the stereotyping attitudes and preconceived notions and feelings that I have towards members of other cultural, racial, and ethnic groups.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
25. I have a clear understanding of the difference in meaning of the following terms: acculturation, assimilation, and socialization.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
26. I am confident that I possess the necessary skills and experience to select and work with appropriate translators as needed to care for clients with limited English language proficiency.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
27. I keep abreast of the major health concerns and issues of culturally, racially, and ethnically diverse client populations residing in my program's service area.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
28. I attend holiday celebrations within culturally, racially, and ethnically diverse communities.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
29. My students are expected to demonstrate knowledge of their clients' worldviews, beliefs, and practices by incorporating this knowledge in their plans of care.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
30. I am knowledgeable about diseases that are common in the countries of origin of recent immigrants to our service area.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
31. When working with clients of limited English language proficiency, family members are most preferable for providing interpretation services.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
32. I have spent extended periods of time (i.e., at least seven consecutive days) living among people from cultural/ethnic/racial groups different from my own.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
33. I screen books, movies, and other media sources for negative cultural, racial, or ethnic stereotypes before using them in my courses or sharing them with clients cared for by me, or by my students.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

34. I am interested in becoming culturally competent because it is the politically correct thing to do.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
35. I am personally and professionally committed to providing nursing care that is culturally competent.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
36. I am personally and professionally committed to teaching how to provide nursing care that is culturally competent.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
37. I advocate for the review of my program's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural and linguistic competence.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
38. The administrators of my program should be the ones responsible for seeking out clinical experiences with culturally, racially, and ethnically diverse groups in our service area.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
39. I teach my students that the client's culture is a determining factor in the client's perception of health and illness and in his or her adherence to the prescribed treatment regimen.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
40. I am knowledgeable about the socio-economic and environmental risk factors that contribute to the major health problems of culturally, ethnically, and racially diverse populations served by my nursing program.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
41. I patronize business in my service area that are owned by people who are culturally, racially, and ethnically diverse.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
42. I encourage my students to examine their attitudes, preconceived notions and feelings towards members of other cultural, racial and ethnic groups.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
43. I know the prevailing beliefs, customs, norms, and values of the cultural, racial, and ethnic groups, other than my own, residing in our service area.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
44. I teach my students to recognize presenting signs and symptoms as they are manifested in individuals who are culturally, racially, and ethnically diverse.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
45. Additional content on cultural competence is not necessary in my program's curriculum.
- Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

46. The cultural assessment tool that I use elicits information about client's dietary practices, health beliefs, and social organization.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

47. There are more differences within cultural groups than across cultural groups.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

48. I am knowledgeable about the population percentages of the major ethnic groups living in my service area.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

49. I do not feel comfortable asking questions that relate to the client's cultural/racial/ethnic background.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

50. I teach my students that when working with clients who are culturally, racially, or ethnically different, they should become familiar with (each client's) indigenous beliefs and practices.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

51. I believe that failure to explore my own culture's influence on the way I think and behave may lead me to impose my own values and beliefs on my clients.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

52. What I believe about health, illness and preventive health is influenced by my culture.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

53. I have a clear understanding of the difference in meaning of the following terms: immigrant, alien resident, and citizen.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

54. I accept that male-female roles may vary significantly among different cultures and ethnic groups.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

55. I am confident that I can effectively assess conditions such as pallor, jaundice, and cyanosis in clients of a race or ethnicity different from my own.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

**Please, provide the following information about yourself:**

56. How long have you been teaching nursing? If less than a (one) year, please give the number of months.

1. \_\_\_\_\_ Months

2. \_\_\_\_\_ Years

57. What is your age group?

1. \_\_\_\_\_ 20 to 30 years
2. \_\_\_\_\_ 31 to 40 years
3. \_\_\_\_\_ 41 to 50 years
4. \_\_\_\_\_ 51 to 60 years
5. \_\_\_\_\_ 61 and above

58. At what level in your nursing school do you teach? (Please, indicate all that apply).

1. \_\_\_\_\_ Associate
2. \_\_\_\_\_ Baccalaureate
3. \_\_\_\_\_ Master's
4. \_\_\_\_\_ Doctorate

59. Have you resided in a country (of different culture from your own) for more than six months?

1. \_\_\_\_\_ Yes
2. \_\_\_\_\_ No

60. If yes, name of country \_\_\_\_\_

61. What is your racial/ethnic background classification?

1. \_\_\_\_\_ American Indian/Alaskan Native
2. \_\_\_\_\_ African American/African
3. \_\_\_\_\_ Caucasian
4. \_\_\_\_\_ Hispanic
5. \_\_\_\_\_ Asian
6. \_\_\_\_\_ Native Hawaiians/Pacific Islander
7. \_\_\_\_\_ Other (Please specify) \_\_\_\_\_

62. What is the highest degree you have earned?

1. \_\_\_\_\_ Bachelor's
2. \_\_\_\_\_ Master's
3. \_\_\_\_\_ Doctorate

63. With which school are you affiliated? \_\_\_\_\_

---

64. What is your nursing specialty area? (Please check all that apply)

1. \_\_\_\_\_ Adult Health
2. \_\_\_\_\_ Community Health
3. \_\_\_\_\_ Child Health and Illness
4. \_\_\_\_\_ Childbearing
5. \_\_\_\_\_ Psychiatric Nursing
6. \_\_\_\_\_ Women's Health
7. \_\_\_\_\_ Nursing Administration

- 8. \_\_\_\_\_ Trans-cultural Nursing
- 9. \_\_\_\_\_ Gerontology
- 10. \_\_\_\_\_ Other (Please list, if necessary) \_\_\_\_\_

65. Have you attended /completed any continuing education program on trans-cultural nursing/cultural competence in the past five years?

- 1. \_\_\_\_\_ Yes
- 2. \_\_\_\_\_ No

66. If (item 64, above, is) yes, how many have you attended?

\_\_\_\_\_

67. Estimate the percentage of each of the following groups in your nursing program:

- 1. \_\_\_\_\_ American Indian/Alaskan Native
- 2. \_\_\_\_\_ African Americans/Africans
- 3. \_\_\_\_\_ Asian
- 4. \_\_\_\_\_ Caucasian
- 5. \_\_\_\_\_ Hispanic
- 6. \_\_\_\_\_ Native Hawaiians/Pacific Islander
- 7. \_\_\_\_\_ Other (Please specify) \_\_\_\_\_

68. Do you assess how your student's cultural beliefs and values influence their attitudes towards education and learning?

- 1. \_\_\_\_\_ Yes
- 2. \_\_\_\_\_ No

69. Do you evaluate how your students' cultural beliefs and values influence their learning style?

- 1. \_\_\_\_\_ Yes
- 2. \_\_\_\_\_ No

Comments

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**Thank You Very Much!**

## Appendix G

### Letter to Deans and Directors of Tennessee Baccalaureate Nursing Programs

My name is Pearl Ume-Nwagbo and I am a doctoral candidate (and faculty) at East Tennessee State University (ETSU) College of Nursing. I believe it is imperative to increase the number of ethnic minority students admitted to and graduated from colleges of nursing to care for the increasing numbers of clients from diverse cultural backgrounds. As ethnic minority groups continue to grow in the United States, the number of clients needing healthcare services also continues to rise; yet, ethnic minorities are grossly under-represented in the nursing profession. The number of minority nursing students admitted and graduated directly impacts the number of minority registered nurses available to provide care in underserved communities. The limited number of minority nurses also impacts the number of minority nurses pursuing graduate education; and the resulting paucity of minority nursing faculty, a major contributing factor to the under-representation of minority nursing students.

My dissertation area is under-representation of minority students in nursing programs. Literature has implicated nurse educators' lack of cultural competence regarding ethnic minority students' unique educational needs as a possible key contributing factor in this situation. I intend to measure the levels of cultural competence among nurse educators teaching in baccalaureate nursing programs in the state of Tennessee and correlate each institution's average cultural competence score with the percentage of ethnic minority students admitted and graduated in each institution during the past five years: 2001-2002, 2002-2003, 2003-2004, 2004-2005, 2005-2006.

There are two parts to this study:

Part one involves completion of a web-based cultural competence questionnaire by faculty. Part two is providing the number of students admitted and graduated (by ethnic group) during the past five years for each school.

I have attached the study abstract to provide additional clarification of the proposed study.

In preparation for this study, I am completing documents necessary for ETSU Institutional Review Board (IRB) approval. I am requesting and hoping that you grant me permission to include your school in my study. Will your university/college require that I seek IRB approval from your campus or will it accept ETSU IRB approval? Would you be willing to write a letter of permission to conduct the study in your school after I obtain ETSU IRB approval?

If you agree to participate in the study, I will send you a copy of the IRB approval as soon as it is granted.

I look forward to hearing from you in the next few weeks. Your participation in this study will provide valuable information as all Tennessee nursing schools attempt to increase the number of minority students and faculty to better meet the needs of our diverse clients.

Yours sincerely,

Pearl N. Ume-Nwagbo

## Appendix H

Research Prospectus Sent to Deans and Directors of Tennessee Baccalaureate Nursing Programs.

**Background:** *The minority population in the United States continues to grow rapidly resulting in a larger proportion of minority citizens needing healthcare services; yet the minority population is grossly under-represented both in the nursing workforce and nursing schools. Studies have found the existence of racial and ethnic disparities in healthcare; and recommendations have been made to increase the number of minority healthcare providers, including nurses, to provide culturally competent care in underserved communities. Several attempts have been made to increase the number of minorities in the nursing profession; but little progress has been made. Literature has implied that nurse educators' lack of cultural competence regarding minority nursing students' unique educational needs could be a key contributing factor to this problem. The purpose of this study is to measure the levels of cultural competence of nurse educators teaching in accredited baccalaureate nursing programs in the State of Tennessee (TN).*

**Methodology:** *Nurse Educators teaching in accredited colleges of nursing in TN will be asked to complete the "Cultural Diversity Questionnaire for Nurse Educators." The number of students admitted and graduated in each school by ethnic group in the past five years will also be obtained.*

**Data Analysis:** *Descriptive univariate statistics and inferential multivariate statistics will be computed and interpreted. Each school's average cultural competence score will be correlated with the percentage of minority nursing students admitted and graduated in the past five years. The findings from this study will help Tennessee nursing schools learn how culturally competent their faculty members are; which may assist them in providing effective faculty development activities to increase the cultural competence of nurse educators as they meet the many needs of culturally diverse students. The findings may also refute or support literature claims that nurse educators' lack of cultural competence could be a contributing factor to the under-representation of minority nursing students in Tennessee schools of nursing.*

## Appendix I

### Advance Notice Letter

Dear Colleague,

I am a doctoral student (and faculty) at East Tennessee State University in Johnson City Tennessee. This is an advanced notice letter to inform you about a study I intend to conduct in the near future. I am requesting your participation in this study on nurse educators' cultural competence, in partial fulfillment of the requirements for my degree.

I believe it is imperative to increase the number of ethnic minority students admitted to and graduated from colleges of nursing to care for the increasing numbers of clients from diverse cultural backgrounds. Studies have found the existence of racial and ethnic disparities in healthcare; and recommendations have been made to increase the number of minority healthcare providers including nurses to provide culturally competent care in underserved communities. Several attempts have been made to increase the number of minorities in the nursing profession; but little progress has been made. Literature has implicated nurse educators' lack of cultural competence regarding ethnic minority students' unique educational needs as a possible key contributing factor in this situation. I am therefore interested in measuring nurse educators' levels of cultural competence.

I am requesting and hoping you will participate in this study by completing and submitting the "Cultural Diversity Questionnaire for Nurse Educators" on line. It will take 20 minutes to complete the questionnaire. Completing and submitting the questionnaire is your indication of consent to voluntarily participate in this study. Even though your responses to all items on the questionnaire would be beneficial in assessing nurse educators' levels of cultural competence, you do not have to answer every question ; and you may terminate participation at anytime even after you have started. The codes on the questionnaire are only for continued communication with non-respondents. Your responses will be confidential and stored in a locked cabinet in the investigators' office. Information, about your school affiliation, is only for computation purposes. All data will be reported anonymously.

Your participation in this study and the candor of your responses are of utmost importance in understanding the issue under study. You will be receiving another e-mail in a few days to instruct you on how to access the questionnaire. If you have any questions regarding this study, please, do not hesitate to contact me by e-mail at [umenwagb@etsu.edu](mailto:umenwagb@etsu.edu) or by telephone at (423) 434-0290 or (423) 439-4083. Thank you very much for your time and I look forward to hearing from you.

Sincerely Yours,

Pearl N. Ume-Nwagbo

Please see attached informed document.



## Appendix J

### Informed Consent

Dear participant:

My name is Pearl Ume-Nwagbo, I am a graduate student at East Tennessee State University. I am working on my doctoral degree in Nursing. In order to finish my studies, I need to complete a research project. The name of my research is “Relationship between Nurse Educators’ cultural competence and recruitment and graduation of ethnic minority nursing students”.

The purpose of this study is to measure the levels of cultural competence of nurse educators in accredited colleges of nursing in the state of Tennessee and correlate each institution’s average cultural competence score with the percentage of ethnic minority nursing students recruited and graduated in these schools during the past five academic years. I would like to give a brief survey questionnaire to nurse educators teaching in accredited baccalaureate nursing programs in the state of Tennessee. It should take about 20 minutes to complete. You will be asked questions about your clinical and teaching practices, and your beliefs and attitudes regarding caring for culturally, racially, and ethnically diverse clients. Since this project deals with diverse cultures, it might cause you minor stress. However, I hope you will feel satisfied knowing that by completing this questionnaire, you are part of a team providing information that could help Tennessee nurse educators become more culturally competent. This study will benefit Tennesseans by providing information on what nurse educators need to know to increase their levels of cultural competence.

This method is completely confidential. In other words, there will be no way to connect your name with your responses. Although your rights and privacy will be maintained, the Secretary of the Department of Health and Human Services, the ETSU Institutional Review Board (IRB) and personnel particular to this research (Pearl Ume-Nwagbo and her dissertation committee members) have access to the study records.

If you do not want to complete the survey, you will not be affected in any way. There are no alternate procedures except to choose not to participate in the study.

Participation in this research experiment is voluntary. You may refuse to participate. You can also withdraw at any time. If you withdraw or refuse to participate, the benefits to which you are otherwise entitled will not be affected.

If you have any research-related questions or problems, you may contact me, at (423) 434-0290. I am working on this project under the supervision of Dr Joy Wachs. You may reach her at (423) 439-4549. Also, the chairperson of the Institutional Review Board at East Tennessee State University is available at (423) 439-6055 if you have questions about your rights as a research subject. If you have any questions or concerns about the research and want to talk to someone independent of the research team or you cannot reach the study staff, you may call the IRB Coordinator at (423) 439-6055 or (423) 439-6002.

Sincerely

Pearl N. Ume-Nwagbo

## Appendix K

### Letter of Web Site Access to the Questionnaire

Dear participant,

A few days ago, you received an advanced notice letter via e-mail from me telling you about a study “Relationship between nurse educators’ cultural competence and recruitment and graduation of ethnic minority nursing students,” I am conducting. I am still soliciting your help in completing the questionnaire. Please remember that completing this survey is totally voluntary and that you may choose not to complete it, and you may withdraw from the study process any time without penalty. Completing and submitting the survey is an indication of your voluntary consent to participate in the study. If you choose to complete the questionnaire, you can access it by following this website address <http://faculty.etsu.edu/umenwagb/CulturalDiversity.asp> Your code number is 01; kindly enter it in the space provided. The questionnaire contains the instructions for completion. Once you have completed the survey, you just click on the submit button to return it to me. Thank you very much for taking the time to participate in this important study.

Yours sincerely,

Pearl N. Ume-Nwagbo

Please let me know if you are unable to access the web site

## Appendix L

### Reminder Letter

Dear Participant,

My name is Pearl Ume-Nwagbo. I am a graduate student at East Tennessee State University, completing my doctoral degree in nursing. I had previously requested your help in completing my survey. One week ago, I sent you an e-mail with a web site access to the “Cultural Diversity Questionnaire for Nurse Educators.” This e-mail is just to remind you of the survey.

If you are willing to participate in the study, you can access the survey from <http://faculty.etsu.edu/umenwagb/CulturalDiversity.asp> or you can access it by copying and pasting the link on the Internet address. Your code number is 0 , kindly insert it in the space provided.

Completing and submitting the questionnaire is your consent to voluntarily participate in the study. You may refuse to participate in the study, and you may withdraw from the study at any time without penalty.

If you have any research-related questions or problems, you may contact me, at (423) 434-0290. I am working on this project under the supervision of Dr. Joy Wachs. You may reach her at (423) 439-4549. Also, the chairperson of the Institutional Review Board (IRB) at East Tennessee State University is available at (423) 439-6055 if you have any questions about your rights as a research subject. If you have any questions or concerns about the research and want to talk to someone independent of the research team or you cannot reach the study staff, you may call the IRB Coordinator at (423) 439-6055 or (423) 439-6002.

If you have already completed and submitted the survey, thank you! Please excuse the inconvenience and disregard this e-mail.

Sincerely,

Pearl N. Ume-Nwagbo

## Appendix M

### Letter to Non-Respondents

Dear Participant,

My name is Pearl Ume-Nwagbo. I am a graduate student at East Tennessee State University, completing my doctoral degree in nursing. I had previously requested your help in completing my survey. Two weeks ago, you received a reminder letter from me regarding the completion and submission of my survey “Cultural Diversity Questionnaire for Nurse Educators.”

If you are willing to participate in the study, you can access the survey by copying and pasting this link: <http://faculty.etsu.edu/umenwagb/CulturalDiversity.asp> on the Internet. Your code number is 0 , kindly insert it in the space provided. Completing and submitting the questionnaire is your consent to voluntarily participate in the study. You may refuse to participate in the study, and you may withdraw from the study at any time without penalty.

If you have any research-related questions or problems, you may contact me, at (423) 434-0290. I am working on this project under the supervision of Dr. Joy Wachs. You may reach her at (423) 439-4549. Also, the chairperson of the Institutional Review Board (IRB) at East Tennessee State University is available at (423) 439-6055 if you have any questions about your rights as a research subject. If you have any questions or concerns about the research and want to talk to someone independent of the research team or you cannot reach the study staff, you may call the IRB Coordinator at (423) 439-6055 or (423) 439-6002.

If you have already completed and submitted the survey, thank you! Please excuse the inconvenience and disregard this e-mail.

Sincerely,

Pearl N. Ume-Nwagbo

Please let me know if you cannot open the link.

## Appendix N

### Verbatim Report of Respondents' Comments

1. "There is way too much emphasis by outside factors on culturalism. Students should be taught nursing and health based up hard science. People from other cultures can leave our country if they are not comfortable. My grandparents immigrated and did not request or obtain special treatment. Let's spend our time on research that has meaning."
2. "In clinical and through written assignments. One group has to do presentations on different cultural experiences."
3. "Consider Appalachians as a culture also ... there are many ethnic groups but most Appalachians are Native American/Caucasian or European/Caucasian. However the culture of the Native people is well known."
4. "#68-69: I do this individually."
5. "Note that I was dean for 15 years and an associate dean for 4 years of the past 29 years."
6. "I would love to know the results of your study and how you plan to use the results."
7. "A great tool – it even reveal areas that I need more information. Good Luck!"
8. "Good job"
9. "I teach Health Assessment. Culture, beliefs, attitudes, behaviors, acculturation, etc. are emphasized."
10. "In #67, did you mean number of students of different culture groups? # of faculty and staff would be different. # of patients would be different."

11. “Our program includes an elective international studies course in the Dominican Republic.”
12. “I do not teach undergraduate students. Therefore, my responses may not apply to your study. My graduate Health Policy Course includes a module on disparities in which I introduce students to 3 different cultural belief assessment tools. I also have a program of research in disparities for people with disabilities. Good luck with this project.”
13. “Good luck”
14. “I have concerns about reporting my school affiliation. Why was this needed?”
15. “In my opinion, many of these questions reflect clinical teaching and are inappropriate for teaching doctoral students.”
16. “Some questions do not apply to my teaching and were therefore difficult to answer accurately. I do NOT believe that CONTENT is the best method to improve cultural competence. Stories, discussion, interaction, personal reflection and opportunities to EXPERIENCE (even a sample) of other cultures is critical if perceptions are to be questioned or changed.”
17. “Thank you for giving me the opportunity to re-visit my priorities. I look forward to seeing more exploration of how I can become more culturally competent and the CON.
18. “I do not use an assessment tool to obtain this information, but am cognizant of the different ethnic groups within the classroom.”

19. “In my current classes I do not evaluate this; however in my doctorate training I just finished a course on how to do a learning style inventory and methods and strategies of how to integrate cultural awareness and sensitivity training in the classroom, which I hope to apply now that I have acquired this knowledge from this course.”
20. “Outstanding research! What I find challenging is what I do as an individual faculty versus what the faculty as a whole value and what is demonstrated in the curricular process. Additionally, a university and school of nursing may have vision and mission statements related to diversity; however, there may not be evidence of those values and beliefs in the program execution itself. Thank you!”
21. “Survey too long. Some questions would be better answered with something other than the choices given.”

## Appendix O

"The 12 Domains of Culture" of *Purnell's Model for Cultural Competence* (Purnell & Paulanka, 2003)

- Overview, inhabited localities, and topography,
- Communication,
- Family roles and organization.
- Workforce issues,
- Biocultural ecology,
- High risk behaviors,
- Nutrition,
- Pregnancy and childbearing practices,
- Death rituals,
- Spirituality,
- Health-care practices and,
- Health-care practitioners



Appendix P

Permission to Publish "The 12 Domains of Culture"

From: Betty Paulanka [mailto:paulanka@UDel.Edu]  
Sent: Thu 7/10/2008 10:43 PM  
To: Ume-Nwagbo, Pearl Ngozika  
Cc: lpurnell@UDel.Edu  
Subject: Re: Permission to publish "The 12 Domains"

Permission granted Dr. Betty J. Paulanka

Ume-Nwagbo, Pearl Ngozika wrote:

> Dear Dr. Purnell,

>

> My name is Pearl Ume-Nwagbo, a faculty at East Tennessee State University College of Nursing, Johnson City, Tennessee. I have just defended my dissertation and I am in the final stages of submitting my finished document. In my dissertation, I described several methods of increasing an individual's cultural competence and one of them was " The 12 Domains of Culture" in The Purnell Model for Cultural Competence (Transcultural Health Care , 2nd. ed.).

>

> I would appreciate your permission to publish the "12 Domains" in my work.

>

> Yours sincerely, Pearl

>

>

--

Betty J. Paulanka, EdD, RN  
Dean, College of Health Sciences  
University of Delaware  
345 McDowell Hall  
Newark, DE 19716  
Tel: 302-831-8370  
Fax: 302-831-3490  
Web: www.udel.edu/health

## Appendix Q

### Permission to Publish "The 12 Domains of Culture"

From: Larry Purnell [mailto:LPurnell@UDel.Edu]  
Sent: Fri 7/11/2008 4:31 AM  
To: Ume-Nwagbo, Pearl Ngozika  
Subject: Re: Permission to publish "The 12 Domains"

You have permission to use the 12 domains in your work. Best of successs in yur career.

Larry Purnell PhD, RN, FAAN  
Professor Nursing  
University of Delaware  
Home 410-438-3826

----- Original message -----

>Date: Thu, 10 Jul 2008 21:10:44 -0400  
>From: "Ume-Nwagbo, Pearl Ngozika" <UMENWAGB@mail.etsu.edu>  
>Subject: Permission to publish "The 12 Domains"  
>To: <lpurnell@UDel.Edu>, <paulanka@UDel.Edu>  
>  
>Dear Dr. Purnell,  
>  
>My name is Pearl Ume-Nwagbo, a faculty at East Tennessee State University College of Nursing, Johnson City, Tennessee. I have just defended my dissertation and I am in the final stages of submitting my finished document. In my dissertation, I described several methods of increasing an individual's cultural competence and one of them was " The 12 Domains of Culture" in The Purnell Model for Cultural Competence (Transcultural Health Care , 2nd. ed.).  
>  
>I would appreciate your permission to publish the "12 Domains" in my work.  
>  
>Yours sincerely, Pearl  
>

## VITA

### PEARL N. UME-NWAGBO

- Personal Data: Date of Birth: February 27, 1944  
Place of Birth: Achi-Ahani, Nigeria  
Marital Status: Married to Ebele Ume-Nwagbo May 9, 1970
- Education: Public Schools: Igbo-Ukwu, Nigeria  
A. D. N., University College Hospital, Ibadan, Nigeria 1968  
State Certified Midwife, Halifax General Hospital, Halifax, England 1969  
B. S. N., A & T State University, Greensboro, North Carolina 1981  
M. S. N., East Tennessee State University, Johnson City, Tennessee 1994  
PhD. in Nursing Science, East Tennessee State University, Johnson City, Tennessee 2008
- Professional Experience: Registered Nurse, University College Hospital, Ibadan, Nigeria 1968  
Midwife, Chippenhan Maternity Home, England 1970 -1971  
Registered Nurse, Our Lady of Lourdes Hospital, Camden, New Jersey, 1972 – 1978  
Registered Nurse, Moses H. Cone Memorial Hospital, Greensboro, North Carolina, 1978 – 1981  
Supervisor/Instructor, Bishop Shanahan Hospital, Nsukka, Nigeria, 1981 – 1985  
Matron, Apex Group Specialists (Nigeria Limited), Igbo-Ukwu, Nigeria, 1985 – 1992  
Family Nurse Practitioner, Woodridge Psychiatric Hospital, Johnson City, Tennessee, 1994 – 1997  
Family Nurse Practitioner, East Tennessee State University, College of Nursing Downtown Clinic, Johnson City, Tennessee, 1997 – 2000  
Family Nurse Practitioner, East Tennessee State University, Student Health Clinic, Johnson City, Tennessee 2000 – Present  
Instructor, East Tennessee State University, College of Nursing, Johnson City, Tennessee, 1997 – Present
- Publications: Ume-Nwagbo, P. N., DeWan, S. A., & Lowry, L. W. (2006). Using the Neuman Systems Model for Best Practices. *Nursing Science Quarterly*, 19(1), 31-35.

Honors and Awards: 1969 The Emblim Rose Bowl Award, Halifax General Hospital, Halifax, England  
1969 Student-of-the-Year Award, Halifax General Hospital, Halifax, England  
1981 Dean's List, A & T State University, Greensboro, North Carolina  
1993 Outstanding Scholastic Achievement Award, East Tennessee State University, Johnson City, Tennessee  
1994 Outstanding Scholastic Achievement Award, East Tennessee State University, Johnson City, Tennessee  
2000 Who's Who Among America's Teachers, 2000 (6th Edition).