CULTURAL COMPETENCE LEVELS OF
OHIO ASSOCIATE DEGREE NURSE EDUCATORS

A Dissertation

Presented to

The Graduate Faculty of The University of Akron

In Partial Fulfillment

of the Requirement for the Degree

Doctor of Philosophy

Vivian M. Yates

December, 2008
CULTURAL COMPETENCE LEVELS OF
OHIO ASSOCIATE DEGREE NURSE EDUCATORS

Vivian M. Yates

Dissertation

Approved:  
Advisor  
Dr. Susan J. Olson

Accepted:  
Department Chair  
Dr. Bridgie A. Ford

Committee Member  
Dr. Susan N. Kushner Benson

Dean of the College  
Dr. Cynthis F. Capers

Committee Member  
Dr. Sandra Spickard Prettyman

Dean of the Graduate School  
Dr. George R. Newkome

Committee Member  
Dr. Cheryl S. Sadler

Date

Committee Member  
Dr. Lynn A. Smolen
ABSTRACT

This study examined the cultural competence levels of nursing faculty teaching in associate degree nursing programs in Ohio and determined the extent to which transcultural concepts are included in the associate degree nursing curricula. Campinha-Bacote’s (2003) Process of Cultural Competence in the Delivery of Health Care Services Model provided the organizing framework for the study. A revised version of Sealey’s (2003) Cultural Diversity Questionnaire for Nurse Educators was used for the study.

Out of an accessible population of 503 nurse educators teaching in associate degree nursing programs in four types of educational institutions in Ohio, 137 responded to the questionnaire. The forty-one item Likert type questionnaire along with eleven questions regarding demographic and professional characteristics was administered via the Internet over a three week period.

The findings from this study indicated that associate degree nurse educators in Ohio “agree” that they possess cultural awareness, cultural knowledge, cultural skill, and culture desire and are undecided regarding their level of engagement in cultural encounters. The findings also indicated that the participants “agree” that their teaching behaviors reflect cultural competence. The study results provide direction for professional development programs for nurse educators in the area of cultural diversity and support for hiring and retaining a culturally diverse nursing faculty.
ACKNOWLEDGEMENTS

I thank God for the strength and the perseverance to accomplish and endure all things. I thank my advisor, Dr. Susan Olson and my dissertation committee, Dr. Susan Kushner Benson, Dr Cheryl Sadler, Dr. Sandra Spickard Prettyman, and Dr. Lynn Smolen for the knowledge and expertise that they so willingly shared and for their enthusiasm toward cultural diversity. I thank my family for their love and support through three decades of pursuing higher education; especially my husband Edward for his encouragement to always aim high and achieve the best, my parents James and the late Nellie Shores for instilling in me the value of education, and my children who finally have a mother that is not a student.
# TABLE OF CONTENTS

## LIST OF TABLES

Page viii

## CHAPTER

### I. INTRODUCTION TO THE STUDY

- The Problem Defined ......................................................... 1
- Explanations for the Health Disparities .............................. 9
- Culturally Competent Care .................................................. 10
- Multicultural Education ..................................................... 11
- Cultural Education for Nurses .............................................. 12
- Purpose of the Study .......................................................... 20
- Research Questions ........................................................... 20
- Conceptual Framework ....................................................... 21
- Significance of the Study .................................................... 21
- Operational Definition of Terms ......................................... 23

### II. REVIEW OF LITERATURE

- Epidemiologic Considerations ............................................. 30
- Multicultural Education .................................................... 40
- Approaches to Cultural Diversity Education in Nursing .......... 43
- Differentiation of Nursing Education and Nursing Practice .... 50
### LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Entry Levels into Professional Nursing</td>
<td>52</td>
</tr>
<tr>
<td>2.2</td>
<td>Comparison of Registered Nurses and Licensed Practical/Vocational Nurses</td>
<td>57</td>
</tr>
<tr>
<td>3.1</td>
<td>Accessible and Responding Ohio Associate Degree Nurse Educator Population by Institution Type</td>
<td>94</td>
</tr>
<tr>
<td>3.2</td>
<td>Demographic Characteristics: Race/Ethnicity and Age of Participating Ohio Associate Degree Nurse Educators</td>
<td>95</td>
</tr>
<tr>
<td>3.3</td>
<td>Professional Characteristics: Highest Academic Degree, Academic Rank, and Years Teaching in Nursing Education</td>
<td>96</td>
</tr>
<tr>
<td>3.4</td>
<td>Participants by Type of Institution in Which Program is Located and Program Level Taught</td>
<td>97</td>
</tr>
<tr>
<td>4.1</td>
<td>Cronbach’s Alpha Coefficient for the CDQNE-R and Subscales</td>
<td>102</td>
</tr>
<tr>
<td>4.2</td>
<td>CDQNE-R Subscale Scores of Ohio Associate Degree Nurse Educators</td>
<td>103</td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION TO THE STUDY

The diversity of the American population may be one of this nation’s greatest assets. However, with this diversity comes a range of health improvement challenges. As our nation continues to become more racially and ethnically diverse, health status challenges increase. Health status and health care continue to be characterized by disparities that have been linked to membership in certain racial and ethnic groups.

The Problem Defined

Healthy People, a national health initiative and planning process led by the United States Department of Health and Human Services (USDHHS), began in 1979 with the purpose of improving the overall health of our nation (United States Department of Health and Human Services, 2000). The initiative clearly presents a series of objectives to increase the health status of all people living in the United States and to measure progress over time. Healthy People 2010, the most recent ten year health objective plan of the initiative, focuses on the development of comprehensive national health objectives to address concerns of the twenty first century. It challenges clinicians, individuals, communities, businesses, and scientists to use both traditional and innovative approaches to improve the health status of our nation. One of the major goals of Healthy People 2010 is to address the diversity of our nation’s population and eliminate the health disparities that occur by race or ethnicity.
According to the USDHHS (2000), many aspects of the health status of our nation have improved. However, significant racial and ethnic disparities continue to exist across a wide range of health measures. Health status can be measured by (a) birth and death rates; (b) life expectancy; (c) quality of life; (d) morbidity from specific diseases; (e) health risk factors; (f) use of ambulatory care and inpatient care; (g) accessibility of health personnel and facilities; and (h) financing of health care and health insurance coverage (United States Department of Health and Human Services, 2000). Healthy People 2010 targets six major health problems that disproportionately affect minority groups in this country which include infant mortality, diabetes, cancer screening and management, heart disease, HIV/AIDS, and immunizations. These six health problems reflect health disparities known to affect multiple racial and ethnic groups at all life stages.

In 2006, the nation’s minority population reached 100.7 million with about one in three United States residents being a minority (United States Department of Commerce, 2007). Definitions and categories of race and ethnicity have evolved over time resulting in inconsistencies across data sources. In 1977, the Office of Management and Budget (OMB) issued Race and Ethnicity Standards for Federal Statistics and Administrative Reporting to improve uniformity and comparability of data among federal data systems and to better reflect the diversity of the nation’s population (United States Department of Health and Human Services, Centers for Disease Control and Prevention, 2007). The 1977 Standards required the federal government data systems to classify individuals into four racial groups; (a) American Indian or Alaskan Native, (b) Asian or Pacific Islander, (c) Black, and (d) White; plus the category of “some other racial group”. Depending on
the data source, the classification by race was based on either self-classification or on observations by the interviewer or other person completing the questionnaire.

In 1997, revisions were made in the classification of individuals by race within the federal government’s data systems (United States Department of Health and Human Services, Centers for Disease Control and Prevention, 2007). The revised standards include five racial groups; (a) American Indian or Alaskan Native, (b) Asian, (c) Black/African American, (d) Native Hawaiian or Other Pacific Islander, and (e) White; plus the category of “some other race”. The new standards also provide an opportunity for respondents to select more than one of the five racial groups providing multiple race categories that did not previously exist. Federal data systems were required to comply with the 1997 standards by the year 2003. Due to the reclassification of race and the multiple possibilities of combined racial categories, standards for the data years 1999 and beyond and are not strictly comparable with data from earlier years.

The federal statistical system considers race and Hispanic or Latino origin to be separate and distinct concepts. Hispanic or Latino origin is defined by the United States government as persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture of origin (United States Department of Health and Human Services, Centers for Disease Control and Prevention, 2007). Although they share many aspects of common heritage such as language and emphasis on extended family, persons of Hispanic or Latino origin can be of any race and the culture of the various subgroups varies significantly by country of origin. The terms Hispanic and Latino are used interchangeably by the government. However, experts who have studied their meaning purport that the terms can be traced to the original bloodlines of two different Spanish
speaking populations in opposite parts of the world. Hispanics derive from the mostly White Iberian Peninsula, while Latinos are descended from the indigenous Indians of Central America and the Caribbean (Houghton Mifflin, 2000). Consequently, issues related to the classification and diversity of Hispanic or Latino origin must be considered when interpreting health related statistics from this group.

Differences in terminology, data collection procedures, perceptions of group identity, and changing demographics, all present challenges in the process of classifying individuals and identifying health disparities according to race and ethnicity. The United States population exhibits a complicated and diverse pattern of racial and ethnic backgrounds that defy simplistic labeling. For these reasons, the population morbidity, mortality, and health disparity statistics presented are all derived from the Centers for Disease Control and Prevention Office of Minority Health and Health Disparities and the United States Census Bureau using the 1997 United States Census classifications for race and ethnicity. Ethnicity may or may not be indicated with race classification.

The Hispanic/Latino Population

According to national and state estimates, Hispanics/Latinos of all races represent 14.8% of the United States population, about 44.3 million individuals (United States Department of Commerce, 2007). The Census Bureau projects by the year 2040 there will be 87.5 million Hispanic/Latino individuals comprising 22.3 % of the population.

Health disparities among those of Hispanic/Latino origin living in the United States can vary significantly by country of origin (Centers for Disease Control Office of Minority Health and Health Disparities, 2007). Overall, Hispanic/Latinos are 1.9 times more likely to have Type Two diabetes than White Americans of similar age. More
specifically, Mexican Americans are two times more likely to have Type Two diabetes than White Americans of similar age. From 1998-2002, Hispanic/Latino women had an incidence rate for cancers of the cervix that was 1.8 times higher than that for White American women. Hispanic men and women have higher incidences and mortality rates for stomach and liver cancer than White American men and women.

Puerto Ricans living on the mainland suffer disproportionately from HIV/AIDS (Centers for Disease Control Office of Minority Health and Health Disparities, 2007). In 2003, the HIV/AIDS death rate was 2.7 times higher for Hispanic/Latino males than for non-Hispanic/Latino White males, and 4.5 times higher for Hispanic/Latina females than for non-Hispanic/Latina White females. Puerto Ricans living on the mainland also suffer disproportionately from asthma and infant mortality.

The Black/African American Population

Those who identify themselves as Black or African American surpassed 40 million in 2006 and constitute approximately 12.9% of the population (United States Department of Commerce, 2007). The Census Bureau projects that by 2050, there will be more than 60 million Black/African Americans comprising 14.6% of the population.

In 2003, Black/African Americans had the highest age adjusted death rate of all races/ethnicities (Centers for Disease Control Office of Minority Health and Health Disparities, 2007). Heart disease and strokes are the leading causes of death for all racial and ethnic groups in the United States. However, in 2000, rates of death from heart disease were 29% higher among Black/African American adults than among White American adults and death rates from strokes were 40% higher. Black/African Americans have the highest rate of high blood pressure of all groups and tend to develop
hypertension at a younger age than other racial/ethnic groups. Black/African Americans are two times more likely to have Type Two diabetes than White Americans of similar age and have higher rates of diabetes-related complications such as kidney disease and amputations.

Although deaths caused by breast cancer have decreased among White American women, Black/African American women continue to have higher rates of mortality from breast cancer and cervical cancer (Centers for Disease Control Office of Minority Health and Health Disparities, 2007). Black/African American women are more than twice as likely to die of cervical cancer as White American women and are more likely to die of breast cancer than are women of any other racial or ethnic group. Men in the Black/African American population also have more cancers of the lung, prostate, colon, and rectum than do White men. Overall, Black/African Americans have more malignant tumors and are less likely to survive cancer than the general population.

During 2001-2004, 68% of all women living in the United States reported with AIDS were Black/African American (Centers for Disease Control Office of Minority Health and Health Disparities, 2007). Among men, 44% of new cases of HIV/AIDS were in Black/African American men.

The Asian American Population

Asian Americans are the fastest growing and most diverse population in the United States (Centers for Disease Control Office of Minority Health and Health Disparities, 2007). Those who identify themselves only as Asian American reached 14.9
million in 2006 and comprise 3.6% of the population (United States Department of Commerce, 2007). The Asian American population is estimated to grow to 37.6 million by the year 2050 comprising 9.3% of the population.

Although Asian American women have the highest life expectancy of any other racial/ethnic group living in the United States, Asian Americans are most at risk for cancer, heart disease, stroke, unintentional injuries (accidents), and diabetes (Centers for Disease Control Office of Minority Health and Health Disparities, 2007). Asian Americans in general suffer disproportionately from certain types of cancer, tuberculosis, Hepatitis B, HIV/AIDS, and chronic obstructive pulmonary disease. Vietnamese women living in the United States have an incidence rate of cervical cancer five times higher than White American women.

The American Indians and Alaskan Native Population

The Census Bureau estimates that as of July 2004, 4.5 million people living in the United States are American Indian or Alaskan Native alone or in combination with one or more other races, making up 1.5% of the total population (United States Department of Commerce, 2007). The Census Bureau projects modest growth by American Indian/Alaskan Native communities over the next few decades, topping 5 million individuals by the year 2065. There are currently over 500 federally recognized American Indian/Alaskan Native tribes; each with its own culture, beliefs, and practices (Centers for Disease Control Office of Minority Health and Health Disparities, 2007).

According to the Centers for Disease Control Office of Minority Health and Health Disparities (2007), American Indians and Alaska Natives are 2.6 times more likely to have diagnosed Type Two diabetes than White Americans of similar age and are
diagnosed at a rate of 1.7 times the rate for all populations in the United States. Approximately 15% of American Indians/Alaskan Natives twenty years of age and older receiving care from the Indian Health Service (IHS) have been diagnosed with diabetes. American Indians and Alaskan Natives also have higher rates of diabetes-related complications such as kidney disease and limb amputations. After Black/African Americans, American Indians/Alaskan Natives had the highest diabetes death rate in 2003.

American Indians/Alaskan Natives also had the highest death rate from chronic liver disease and cirrhosis, 2.4 times higher than the rate for all populations living in the United States (Centers for Disease Control Office of Minority Health and Health Disparities, 2007). In 2001, they had the highest rate of Sudden Infant Death syndrome of all racial/ethnic groups, 2.2 times higher than the rate for all populations. The rate of AIDS diagnoses among American Indian/Alaskan Native adults and adolescents was the third highest in the country after Black/African American and Hispanic adults and adolescents. Additionally, American Indian/Alaskan Natives suffer disproportionately from depression and substance abuse.

The Native Hawaiian and Other Pacific Islander Population

Native Hawaiian and Other Pacific Islanders comprise 0.1% of the American population or almost 400,000 individuals (United States Department of Commerce, 2007). Prior to 2000, Native Hawaiian and Other Pacific Islanders were grouped with Asian Americans for race and ethnicity data collection purposes. For the 2000 Census they were assigned as a distinct category for the first time. Consequently, there are no
population growth projections for Native Hawaiian and Other Pacific Islanders at this time (Centers for Disease Control Office of Minority Health and Health Disparities, 2007).

Native Hawaiian and Other Pacific Islanders generally experience poorer health than the American population as a whole (Centers for Disease Control Office of Minority Health and Health Disparities, 2007). They are the most at risk for developing and dying from cancer, heart disease, diabetes, and other diseases. Native Hawaiians in particular are 2.5 times more likely to have diagnosed Type Two diabetes than White American residents on Hawaii of similar age. They also have a disproportionately high prevalence of Hepatitis B, tuberculosis, and HIV/AIDS.

The anticipated demographic changes over the next forty to fifty years related to the growth of racial and ethnic populations magnify the importance of addressing disparities in health status. With the projected growth rate of many of the racial/ethnic groups living in the United States that are experiencing poorer health status, the future health status of our country is compromised.

*Explanations for the Health Disparities.*

Current information about the biologic and genetic characteristics of Hispanics/Latinos, Black/African Americans, Asians, American Indians and Alaska Natives, and Native Hawaiians and Other Pacific Islanders living in the United States does not explain the health disparities experienced by these groups when compared with the White American population in the United States (United States Department of Health
and Human Services, 2001). The health disparities are believed to be the result of the complex interaction among genetic variations, environmental factors, specific health behaviors, and sociologic factors.

In a review of over 100 studies that assessed the quality of health care for various racial and ethnic minority groups in the United States, The National Academy of Sciences Institute of Medicine (2002) sought to determine what factors contributed to the health disparities among racial and ethnic groups. Results of the review revealed that health disparities were attributed to two sets of factors. The first set of factors involved responses to illness and treatment and addressed three components; health seeking behaviors, preferences for and attitudes toward treatment, and the climate of the health care system related to factors such as cultural and linguistic barriers and fragmentation of health care. The second set of factors stemmed from clinical encounters and included three mechanisms from the provider’s side including clinical uncertainty, the implicit nature of stereotypes shaping expectations and affecting interpersonal interactions, and health care provider prejudice or bias. The National Academy of Sciences Institute of Medicine (2002) reported that “although myriad sources contribute to these disparities, some evidence suggests that bias, prejudice, and stereotyping on the part of health care workers may contribute to differences in care” (p. 1).

**Culturally Competent Care**

It has become imperative for the health care profession to confront these health disparities and address the culturally diverse health issues and health care needs of all clients through the provision of culturally competent care. Culturally competent care is defined by Giger and Davidhizar (2008) as a dynamic, fluid, and continuous process of
finding meaningful and useful care delivery strategies based on knowledge of cultural
heritage, beliefs, attitudes, and behaviors of those to whom care is rendered. According
to Health Resources and Services Administration, United States Department of Health
and Human Services (2001) cultural competence has been found to (a) allow the health
care provider to obtain more specific and complete information to make more appropriate
medical and nursing diagnoses; (b) facilitate the development of treatment plans that are
actually followed by culturally diverse clients and supported by the families; (c) increase
the utilization of health care services by culturally diverse populations and reduce delays
in seeking care; (d) enhance communication and clinical interaction between health care
providers and culturally diverse clients; and (e) enhance the compatibility between
western health practices and traditional cultural health practices.

In order for culturally competent care to be implemented, health care
professionals must be cognizant of the health disparities that exist in our multicultural
society as well as the contributing factors and solutions to decrease or alleviate the
disparities. Nursing, as the largest health care profession, must adequately address
cultural diversity issues in the nursing curriculum and provide a multicultural education
to prepare graduates to develop the knowledge, skills, and attitudes required to provide
culturally competent care.

Multicultural Education

To meet these educational challenges, nurse educators must possess the
multicultural knowledge, skills, attitudes, and behaviors that appropriately respond to
issues of diversity. They must have a clear understanding of how strategies for teaching
cultural diversity content can be incorporated into the curriculum to achieve cultural
program outcomes. J. Banks, a leading international authority and proponent of multicultural education, emphasizes the importance of educating students to live in a pluralistic society (Banks, 2006). Multicultural education is frequently defined in the literature as the provision of educational equality among students from diverse racial, ethnic, and social class groups (Gay, 1994). However, a major goal and purpose of multicultural education is to facilitate the development of knowledge, attitudes, and skills in students that is linked with social commitment and action in a culturally diverse environment (Banks, 1996). Attaining this goal requires changes in the curriculum, teaching strategies, and teaching materials as well as changes in the attitudes, perceptions, and behaviors of the teachers. To meet the goals of multicultural education, faculty must attain new knowledge and skills that will allow them to design and implement effective teaching strategies that reflect diversity.

According to Banks (2006), education in this country falls short of providing the critical and transformative multicultural education that is needed to prepare students to function in a complex and diverse world. Many school and university faculties have a limited conception of multicultural education and view it primarily as the inclusion of racial, ethnic, and cultural content in the curriculum. The various dimensions of multicultural education; content integration, knowledge construction, prejudice reduction, an equity pedagogy, and an empowering school culture and social structure; are not well understood among most school educators.

*Cultural Education for Nurses*

Nursing education must embrace the goals and purposes of multicultural education if nurses are to be prepared to confront the health disparity issues this country
faces. Nursing education occurs on various levels in the United States and in the state of Ohio. Nurse educators in programs at all levels have been faced with the challenge of finding the most effective methods to implement a curriculum that promotes an awareness, acceptance, and affirmation of cultural diversity.

The associate degree and diploma nursing programs prepare graduates for a well-defined technical scope of practice requiring nursing theory and technical proficiency (American Nurses Association, 2004). The baccalaureate degree programs prepare graduates for a broader scope of professional nursing responsibilities and a knowledge base necessary for advanced education in nursing. The masters in nursing programs prepare graduates for an advanced role in nursing administration, academia, or clinical practice. Doctoral programs in nursing are designed to prepare experts in specialized advanced nursing practice (practice focused doctorate) or as nurse scientists and scholars (research focused doctorate). Regardless of the level of nursing education and nursing practice, all nurses require cultural competence, making it imperative that a wide range of nursing educators in all program types become prepared to teach and model cultural competence. Faculty must develop moral cognizance and adequate preparation to appropriately teach students to interact with and care for the clients from the diverse cultures they will encounter (Brown, 2006).

Cultural competence is imperative to conducting an accurate client assessment and providing culturally appropriate nursing interventions. Also of importance are culturally competent interactions between health care professionals from different cultural and ethnic backgrounds. Commitment to one’s own cultural beliefs, values, and practices and differing cultural expectations can result in underlying tensions or overt
conflicts between the groups. Recognizing the value and importance of culturally appropriate care and interactions is necessary for nurses to become effective care agents in our changing demographic society.

Two different types of cultural diversity training discussed in the nursing literature include valuing diversity and managing diversity. Valuing diversity includes focusing on learning about oneself in relation to others who are different and the development of respect for others. It encompasses the recognition of personal biases toward and assumptions regarding culturally diverse individuals. Managing diversity includes acquiring knowledge of cultural groups and developing interaction skills, conflict resolution skills, and multicultural creativity. It is essential that a nursing curriculum includes both elements of valuing diversity and the actual interpersonal skills and knowledge needed to be culturally competent (Davidhizer & Giger, 2001).

Although there are many factors involved in cross cultural knowledge, skills, and interactions, Giger & Davdhizer (2008) have identified six cultural phenomena that are evident in all cultural groups that can affect interactions between health care providers and clients as well as interactions among health care professionals. These dimensions include communication, the use of space, perceptions of time, social interactions, perceptions of environmental control, and biological variations.

**Communication**

Language differences and recognizing the complexity of language interpretation are important aspects of becoming culturally competent (Giger & Davidhizar, 2008). An awareness of racial and cultural factors that may affect communication when nurses interact with clients from cultures different from their own is key to cultural competence.
Language barriers between the nurse and the client can cause feelings of alienation and helplessness on both sides. The physical healing process may actually be impaired when communication is impaired. Effective communication of health information is essential for culturally diverse clients to attain and maintain optimal health.

Communication among nurses and other health care professionals can also be affected by cultural differences. Power dynamics have been identified as a potential contributor to conflict when health care professionals from different cultures interact (Lowenstein, 1995). Nurses possessing different cultural values may interpret managerial actions and decisions differently. For example, the superior/subordinates communication process between nurses from different cultural backgrounds can be affected by each person’s cultural interpretation of a demand versus a request. These types of miscommunications can lead to alienation, disputes, distrust, anger, and verbal attacks.

Use of space

Although individual variations occur, dimensions and perceptions of inner and outer personal space and response to touch are largely determined by culture. Outer personal space is the area that surrounds a person’s body and the objects within that space. Inner personal space is defined as invisible lines of demarcation that are divided into four areas consisting of (a) the inner spirit core, (b) an area of thoughts and feelings perceived as unacceptable, (c) an area of thoughts and feelings perceived as acceptable, and (d) an area of superficial public feelings. Each individual needs to defend his/her personal space against invasion by others and will experience discomfort when personal
space is invaded. Actions that may be considered an act of kindness or concern by some cultures may be perceived as a threatening invasion of personal space by others.

In a clinical setting, violation of a client’s personal space is unavoidable. However, nurses need to have an understanding of culturally appropriate behaviors in relationship to personal space. The nurses’ response to the spatial requirements of the client is an important factor in the client’s emotional comfort. If the client is in a place where a feeling of control over his or her personal space is experienced, the client will feel safer, less threatened, and less anxious.

Interpersonal communication between health care professionals that are from different cultural backgrounds can be affected by use and perceptions of space (Preston, 2005). The proximity of people to one another when they interact, the configuration of work areas, and preferred meeting environments send messages that may be interpreted differently by different cultures. It is as important to develop sensitivity to unspoken messages of distance and proximity of professional peers.

Perceptions of time

The awareness of time is a cultural phenomenon (Giger & Davidhizar, 2008). In the provision of culturally competent care, it is important for nurses to understand how time is viewed and managed from a cultural point of view. Understanding how persons from different cultures view time can help nurses to avoid the misunderstanding and misreading of issues that involve time. Cultural adherence to present orientation perceptions versus future orientation perceptions can provide information about a cultural group’s potential for change and likelihood of adhering to a treatment regimen. Cultures adhering to present orientation perceptions believe that the present takes precedence over
the future and whatever is occurring at the precise moment takes precedence over potential future events. Cultures adhering to future orientation perceptions defer gratification of personal pleasure until some future objective has been met. These perceptions of time have a significant impact on the values held by both the client and the health care provider.

Social organization

Patterns of cultural behavior are learned through the process of enculturation through social organizations (Giger & Davidhizar, 2008). Social organizations are structured groups such as family, religious, ethnic, and racial groups. Patterns of behavior and a set of norms, beliefs, and values evolve through interactions with these social organizations. Awareness of and sensitivity to the social organizations that are important to the client’s culture or ethnicity is essential when providing care to clients. For example, the role of gender may influence decision making processes regarding health care in cultures where the females allow the males in the family to make decisions. Assigning nurses of the same gender may be required for patients from cultures where touch or direct eye contact is only permitted between members of the same sex.

Cultural issues related to the role of gender can also have a significant impact on male/female interactions in the professional work environment (Giger & Davidhizar, 2008). In some cultures nursing is considered a low status occupation. Male health care professionals from these cultures may refuse to acknowledge and accept the female nurse in a role of authority.
Environmental control

The values and beliefs of a person influence health care behavior and consequently health status (Giger & Davidhizar, 2008). Some cultural groups believe that health status is determined by luck, chance, fate, or is under the control of “others”. Persons who subscribe to this external locus of control tend to be more fatalistic about health and illness and are less likely to seek medical advice or follow a treatment regimen prescribed by the health care system. The culturally competent nurse must be able to recognize the client who subscribes to an external locus of control and attempt to modify the client’s behavior while maintaining respect for and appreciation of their beliefs.

Biological differences

Biological differences exist among people from various racial, ethnic, and cultural groups (Giger & Davidhizar, 2008). Most baseline biological data in the United States is based on the White race and do not reflect biological variations among different racial groups. Uniracially normed values such as growth and development patterns, nutrition, and susceptibility to disease may be inappropriate when applied to African Americans, Asians and American Indians. Assessment data related to skin color, drug interactions and metabolism, and susceptibility to disease is affected by race and ethnicity. Knowledge regarding biological variations is detrimental to providing culturally competent care.

Culture and ethnicity have been strongly associated with how a person perceives and communicates pain (Cleland, Palmer, & Venzke, 2005). A variety of cultural and ethnic factors have been linked to the experience of pain including pain expression, remedies for pain, how one labels pain, social roles and expectations related to pain, and
the cultural context of suffering. Recognizing individual and cultural meanings of pain is an important step in managing pain for clients of all cultures.

**Professional Nursing Organizations’ Endorsement of Culturally Competent Care**

It has only been over the past thirty years that nursing began to develop an appreciation for the importance of incorporating culturally appropriate approaches to nursing care. The American Nurses Association (ANA) published its purpose and objectives for a culturally diverse curriculum along with strategies and approaches for development of a culturally diverse nursing curriculum in 1986. The National League for Nursing (NLN) resolved that innovative nursing curricula be developed that recognize multicultural/multiracial perspectives in 1989. Since that time, the literature has been proliferated with goals, objectives, and strategies for incorporating cultural diversity into the nursing curriculum of all nursing program types including diploma, associate degree, and baccalaureate and higher degree nursing programs.

The National Council Licensure Examination for Registered Nurses (NCLEX-RN) incorporates questions on providing culturally competent nursing care (National Council State Boards of Nursing, 2007). The current test plan includes cultural diversity objectives that require the nurse graduate to (a) assess the importance of client culture/ethnicity when planning, providing, and evaluating care; (b) incorporate client cultural practices and beliefs when planning and providing care; (c) respect the cultural background and practices of the client; (d) recognize cultural issues that may impact clients, families, or significant others’ understanding and/or acceptance of diagnoses; and (e) use appropriate interventions to communicate with non-English speaking clients and their families/significant others. Additionally, the National League for Nursing
Accrediting Commission (NLNAC), the national accrediting body for associate degree nursing programs, in its revised 2008 standards and criteria, is mandating that the nursing curriculum include cultural, ethnic, and socially diverse concepts that may also include experiences from regional, national, or global perspectives (NLNAC, 2008).

The utilization of creative and innovative strategies by nursing faculty can develop and improve cultural competence in nursing students (Eschleman & Davidhizer, 2006). Although nursing literature addresses numerous strategies for teaching cultural diversity concepts, there is a paucity of research that critically examines nursing faculty readiness and preparation for implementing strategies necessary to effectively teach cultural diversity concepts.

**Purpose of the Study**

This study examines the cultural competence levels among nursing faculty teaching in associate degree nursing programs in Ohio and to determines the extent to which transcultural nursing concepts are included in the associate degree nursing curricula. Associate degree nursing programs were chosen for the study because they comprise 51% of the nursing programs in Ohio and graduates from associate degree nursing programs comprised 53% (n=3158) of the new nursing graduates in Ohio from 2005-2006 (Ohio Board of Nursing, 2007).

**Research Questions**

The research questions for this study are as follows.

1. What is the level of cultural competence of the nursing faculty teaching in associate degree nursing programs in Ohio as measured by the scales of the Cultural Diversity Questionnaire for Nurse Educators - Revised?
2. To what extent does nursing faculty teaching in associate degree nursing programs in Ohio include transcultural nursing concepts in the courses they teach as measured by the scales of the Cultural Diversity Questionnaire for Nurse Educators- Revised?

Conceptual Framework

Campinha-Bacote’s (2003) Process of Cultural Competence in the Delivery of Healthcare Services Model provides the organizing framework for this study. The model summarizes the elements described in the literature as essential components of cultural competence. According to the model, the process of cultural competence consists of five interrelated constructs representing an interdependent relationship. The key construct of the model is cultural desire, an intrinsic motivation that is essential to the process of becoming culturally competent. Cultural desire leads to seeking cultural awareness - examining and recognizing one’s own biases, prejudices, and assumptions regarding individuals who are different and knowledge of health care disparities, cultural skills - the ability to systematically collect culturally relevant information about the client’s health and interpret the information for the purpose of culturally congruent interventions, cultural knowledge - seeking and obtaining information regarding world views, biological variations, health conditions and other meaningful cultural data, and cultural encounters - face to face interactions with clients from culturally diverse backgrounds.

Significance of the Study

The development of cultural competence among nurse educators is essential in the preparation of culturally competent graduates (Sealy, Burnett, & Johnson, 2006). The literature addresses a shortage of nursing faculty with appropriate transcultural nursing
knowledge, attitudes, and behaviors that can respond to issues of diversity in health care and teach culturally competent nursing care effectively (Grant & Letzring, 2003; Ryan, Carlton, & Ali, 2000; Wells, 2000). National and statewide nursing faculty shortages at all levels will have an effect on the number of faculty qualified to teach cultural competence in nursing education programs.

Additionally, there is a shortage of minority nursing faculty representing the racial and ethnic minority groups living in the United States (National League for Nursing, 2006). Although it should not be assumed that racially/ethnically diverse faculty members are resident experts on cultural diversity, minority nurses serve as leaders in the development of models of care that address the unique needs of racially and ethnically diverse populations (Bednash, 2003). The presence of a racially and ethnically diverse faculty increases the probability of culturally competent nursing education (Drayton-Hargrove, 1997). A diverse faculty creates a culturally sensitive teaching learning environment which facilitates the realization of goals related to preparing culturally competent nurses (Glanville, 2000). The presence of a diverse faculty can offer students a rich environment for cultural encounters as well as role modeling of cultural awareness, knowledge, and skills. Greater diversity among health care professionals has been associated with better educational experiences for all students while in training (The Institute of Medicine, 2004).

In a metasynthesis of qualitative research, Coffman (2004) suggests that nurses lack a level of comfort and ability to perform transcultural skills and tasks when caring
for patients from other cultures. Many nurses in these studies perceived that they lack the necessary educational background to effectively care for clients from diverse cultural backgrounds.

This study contributes to the current body of nursing literature by assessing trends in the levels of cultural competence among associate degree nursing faculty in Ohio. It also contributes to the assessment of nursing faculty’s professional development needs in the area of cultural diversity through evaluating faculty strengths and identifying areas of needed growth. Additionally, the study further develops the Cultural Diversity Questionnaire for Nurse Educators related to reliability.

**Operational Definitions of Terms**

Different terms are used by various sources in discussions of race, ethnicity, health care, nursing education, and multicultural education. The following definition of terms applies to this study.

**Racial and Ethnic Groups**

The following terms depict racial and ethnic groups residing in the United States and are used within the federal government’s data systems.

*American Indians and Alaskan Natives* – people having origins in any of the original peoples of North and South American and who maintain tribal affiliation or community attachment (Centers for Disease Control Office of Minority Health and Health Disparities, 2007).

*Asian Americans* – people having origins in any of the original peoples of the Far East, Southeast Asia or Indian Subcontinent (Centers for Disease Control Office of Minority Health and Health Disparities, 2007).

Hispanic or Latino – persons of Mexican, Puerto Rican, Cuban, Central and South American, and other or unknown Latin American or Spanish origins. Persons of Hispanic origin may be of any race (Centers for Disease Control Office of Minority Health and Health Disparities, 2007).

Native Hawaiian or other Pacific Islanders (NHOPI) – people having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands – even if they do not live in the Pacific Islands (Centers for Disease Control Office of Minority Health and Health Disparities, 2007).

White Americans – Americans of white European descent, including those with origins in countries of the Iberian Peninsula – Spain and Portugal (Centers for Disease Control Office of Minority Health and Health Disparities, 2007).

Educational Institutions

The following depicts educational institutions of higher learning in the state of Ohio in which associated degree nursing programs are located.

Colleges and universities - post-secondary institutions with teaching and research facilities constituting an undergraduate division that awards bachelor's degrees and graduate and professional schools that award master's degrees and doctorates (Houghton Mifflin, 2000). Colleges and universities offer associate, baccalaureate, masters, or doctoral degrees in nursing.

Community colleges - institutions of higher learning often emphasizing career rather than academic programs. This type of institution offers associate degrees and
certificates of proficiency in a variety of fields generally not exceeding a time frame of two years and not leading to a baccalaureate degree. Associate degree nursing programs and practical/vocational nursing programs are offered in community colleges (American Association of Community Colleges, 2007).

*Hospital affiliated nursing schools* - single purpose hospital based educational institutions that prepare graduates to practice as professional nurses. They may be affiliated with a college or university for the fulfillment of general education requirements or they may be self contained. These institutions offer either associate degree nursing programs or diploma nursing programs.

*Private career training institutions* - post-secondary education institutions that offer short-term, intensive, practical education in various fields. These institutions provide instruction and training in the knowledge and skills required for employment in specific occupations. Associate degree nursing and practical nursing programs are offered in private career training institutions.

*Technical colleges* - institutions of higher learning providing technical education programming for the occupational or general educational benefit of adult persons. These colleges offer associate degrees and certificates of proficiency in a variety of fields generally not exceeding a time frame of two years and not leading to a baccalaureate degree. Associate degree nursing programs and practical/vocational nursing programs are offered in technical colleges.

*Nursing Education Program Types*

The following nursing educational program types depict the various educational levels at which professional nurses are prepared for entry into practice.
**Associate degree nursing education** - a two year entry level nursing program offered primarily at community or junior colleges preparing graduates as generalists (American Association of Colleges of Nursing, 1996).

**Baccalaureate degree nursing education** – a four year entry level nursing program (assuming two years of general education and two years of nursing major) offered at colleges and universities, preparing graduates for leadership, management, and more independent roles (American Association of Colleges of Nursing, 1996).

**Diploma nursing education** – a three year entry level nursing program provided in hospital settings, usually affiliated with a community or junior college, preparing graduates as generalists (American Nurses Association, 2008).

*Health and Health Care*

The following terms depict concepts used in health care related to services, client behaviors, client outcomes, and health care statistics.

**Health care** – the continuum of services provided in traditional health care settings including public and private clinics, hospitals, community health centers, nursing homes and other health care facilities including home based care. These include services provided by a range of health care professionals including physicians, nurses, physician’s assistants, psychologists, and other licensed professionals (United States Department of Health and Human Services, 2000).

**Health care services** – the provision of preventative, diagnostic, rehabilitative, and/or other therapeutic or medical health services to individuals or populations (United States Department of Health and Human Services, 2000).
Health disparities – gaps in the quality of health and health care across racial and ethnic groups; population specific differences in the presence of disease, health outcomes, or access to care (United States Department of Health and Human Services, 2000).

Health seeking behaviors – behaviors related to the recognition of symptoms, presentation to health care facilities, and compliance with effective treatment; actions to prevent, screen for, or control ill-health conditions (Dressler, Oths, & Gravlee, 2005).

Infant mortality rates – the number deaths occurring during the first year of life per 100,000 live births (McKinney et al., 2005).

Morbidity rates – the number of ill persons or cases of disease in relationship to a specific population (United States Department of Health and Human Services, 2000).

Quality of care – a general sense of happiness and satisfaction with one’s life and environment including health, recreation, culture, rights, values, beliefs, aspirations, and the conditions that support a life containing these elements (USDHHS, 2000).

Cultural Diversity

The following terms depict concepts related to cultural diversity, culturally specific care, and cultural education.

Culture – a patterned behavioral response that develops over time as a result of imprinting the mind through social and religious structures. Culture is shaped by values, beliefs, norms, and practices that are shared by members of the same cultural group (Giger & Davidhizar, 2008).
Cultural diversity – differences in race, ethnicity, language, nationality, or religion among various groups within a community, organization, or nation (Centers for Disease Control Office of Minority Health and Health Disparities, 2007).

Culturally competent care - a dynamic, fluid, and continuous process of finding meaningful and useful care delivery strategies based on knowledge of cultural heritage, beliefs, attitudes, and behaviors of those to whom care is rendered (Giger & Davidhizar, 2008).

Ethnicity - A social grouping based on common national origin or common language designed for collecting data on the race and ethnicity of broad population groups in this country. It is not anthropologically or scientifically based (Centers for Disease Control Office of Minority Health and Health Disparities, 2007).

Ethnic group – large groups of people classified according to national origin or common language (Centers for Disease Control Office of Minority Health and Health Disparities, 2007).

Minority group – a racial, ethnic, religious, political, national, or other group thought to be different from the larger group of which it is a part and having little power or representation to other groups within the society (Giger & Davidhizer, 2008).

Multicultural education – the provision of educational equality among students from diverse racial, ethnic, and social class groups (Gay, 1994). Facilitation of the development of knowledge, attitudes, and skills in students that is linked with social commitment and action in a culturally diverse environment (Banks, 2006).
Race – a population of people who share distinguishing physical features such as skin color, bone structure or blood groups and primarily mates within itself (Giger & Davidhizer, 2008).

Transcultural nursing – a culturally competent practice field that is client centered and researched focus. The delivery of culturally sensitive care that is free of inherent biases based on race, ethnicity, gender, or religion (Giger & Davidhizer, 2008).

Content integration - the extent to which teachers use content from a variety of cultures and groups to illustrate key concepts, generalizations, and issues (Banks, 2006).

Nursing faculty – registered nurses, full time, part-time or adjunct, teaching nursing courses in an associate degree nursing program in a classroom, laboratory, or clinical setting.
CHAPTER II
REVIEW OF LITERATURE

The review of literature addresses epidemiologic considerations theorizing causes of health disparities among racial and ethnic minorities in the United States, multicultural education, approaches to cultural diversity education in nursing, differentiation of nursing education and nursing practice, faculty attributes required for teaching cultural competence effectively, barriers to teaching cultural competence, and research on the cultural competence levels of nursing faculty. A detailed description of The Process of Cultural Competence in the Delivery of Healthcare Services Model and the Cultural Diversity Questionnaire for Nurse Educators are also presented.

Epidemiologic Considerations

Disparities in health status have been noted between racial and ethnic minority groups residing in the United States and their White American counterparts (United States Department of Health and Human Services, Centers for Disease Control and Prevention, 2007). Hispanics, African Americans, Asian Americans, American Indians/Alaskan Natives, and Native Hawaiians and Other Pacific Islanders have marked disparities related to infant mortality, diabetes, cancer, heart diseases, HIV/AIDS and many other health conditions. Epidemiologists addressing these disparities are concerned not only with the distribution of diseases in specified populations, but also the determinants of diseases and the causes of the disparities in the distribution of the
diseases. According to epidemiologic principles, most diseases do not occur randomly, but are related to environmental and personal characteristics that vary by race, time, and subgroup (The National Academy of Sciences, Institute of Medicine, 2002).

Epidemiologists have examined many underlying factors among the racial and ethnic minority population in the United States that place them at higher risks for poorer health outcomes. However, the causes of these health disparity issues are complex and not well understood. There are four models in the literature that attempt to explain the racial and ethnic disparities in health status and health care; the Racial Genetic Model, the Health Behavior Model, the Socioeconomic Model, and the Psychosocial Stress Model.

The Racial Genetic Model

The Racial Genetic Model attributes disparities in health status to genetic factors related to race (Dressler, Oths, & Gravlee, 2005). This model depicts racial differences in health status as inevitable and normal. The genetic model rests on the basic assumption that the genes which determine race are linked to the genes which affect health and that the health of any community is mainly the consequence of the genetic constitutions of the individuals of which it is composed. Although there are a few diseases for which a clear-cut link of genetics and race/ethnicity is established such as sickle cell anemia in persons of African descent and Tay Sachs Disease which has a high incidence among people of Eastern European and Askhenazi Jewish descent, they have a small impact on the health of the minority population as a whole. These diseases are used by some researchers to support genetic explanations of racial differences in the major
diseases of the twentieth first century such as heart disease, stroke, and cancer. However, genetic explanations for heart disease, strokes, and cancer have not been proven and no current evidence exists to justify this inference.

The Health Behavior Model

The Health Behavior Model hypothesizes that health disparities are caused by differences in health related risk factors and health seeking behaviors that are experienced more commonly among certain racial and ethnic groups (Dressler, Oths, & Gravlee, 2006). Health related risk factors are discrete behaviors voluntarily adopted by individuals such as high caloric intake, decreased physical activity, smoking, and excessive alcohol intake. Although these types of behaviors can be great contributors to disease, there is little evidence that the behaviors, alone or in combination, can explain racial and ethnic differences in disease occurrence.

Health seeking behaviors are behaviors related to the recognition of symptoms, presentation to health care facilities, and compliance with effective treatment as well as actions to prevent, screen for, or control ill-health conditions. Individuals vary in health seeking behaviors and some racial and ethnic groups may be more likely than White Americans to delay or avoid seeking health care. Causes for the delay or avoidance in seeking health care among many racial and ethnic minority groups may be due to a mistrust of health care providers or negative experiences during previous clinical encounters (The National Academy of Sciences Institute of Medicine, 2002). Differences in the likelihood of rejecting medical services are only 3-6% more likely in Black/African Americans than White Americans. The Institute of Medicine (2002) suggests that racial
differences in patient’s attitudes, such as their preference for treatment, do not vary greatly and cannot fully explain racial and ethnic disparities in health care.

The Socioeconomic Status (SES) Model

Link & Phelan (1995) posit that finding the underlying causes of the disparities in health status requires looking beyond the proximal or individually based risk factors as causes of disease and focusing more on social factors which tend to be more distal causes of morbidity and mortality. Recognizing the “multifaceted and dynamic sociological processes” that influence health status and length of life is essential in determining the causes of the disparities. Link & Phelan (1995) argue that the reasons for the disparities are largely reflected in socioeconomic differences, differences in access to health care, and direct and indirect consequences of discrimination. The Socioeconomic Status (SES) Model views racial and ethnic health disparities confounded with SES disparities in health (Dressler, Oths, & Gravlee, 2006). Race and SES are correlated and some argue that controlling for SES will either reveal the “true” effect of race or ethnicity or, if secondary to SES disparities, cause racial disparities to disappear.

Income and education. A link between poverty, low educational attainment, and poorer health outcomes with increased morbidity and mortality has been well established (United States Department of Health and Human Services, 2000). Inequalities in income and education underlie many of the health disparities among racial and ethnic minorities in the United States. In general, population groups that suffer the worst health status also have the highest poverty rates and the least education. Disparities in income and educational levels are associated with differences in occurrences of diseases such as heart disease, diabetes, obesity, and low birth weight.
Higher income affords increased access to medical care and the opportunity to engage in health promoting behaviors (United States Department of Health and Human Services, 2000). The weighted average poverty threshold in the United States for the year 2006 was $10,488 for one person and $20,614 for a family of four (United States Department of Commerce, 2006). In 2006, the Black/African American poverty rate was 24.3%; nearly three times the poverty rate of 8.2% for non-Hispanic Whites. Among Hispanics of all races living in the United States, 20.6% (9.2 million) were living in poverty. The Asian poverty rate was closest to the non Hispanic White poverty rate at 10.3%.

More years of education usually translate to more years of life (United States Department of Health and Human Services, 2000). Higher levels of education may increase the likelihood of obtaining and understanding health related information needed to develop health promoting behaviors and beliefs in prevention. Among people aged 25-64 years in the United States, the overall death rate for those with less than 12 years of education is more than twice that for people with 13 or more years of education (United States Department of Health and Human Services, 2000). Regarding educational attainment, non-Hispanic Whites had the highest proportion of adults with a high school diploma or higher (91%), followed by Asians (87%), African Americans (81%) and Hispanics (59%) (United States Department of Commerce, 2007).

There are complicated interrelationships between race, ethnicity, and socioeconomic status that may result in healthcare disparities. While sufficient data exist
about health disparities by race and ethnicity, it is difficult to sort out the individual contributions of race, income, or education to these differences (The National Academy of Sciences, Institute of Medicine, 2002).

Health insurance coverage. Income levels are closely related to health insurance coverage. Black/African Americans, Asian Americans, American Indians and Alaskan Natives and Hispanics living in the United States are less likely to have health insurance and consequently have more difficulty getting health care (United States Department of Commerce, 2006). The number of uninsured remained statistically unchanged in 2006 for non-Hispanic Whites at 21.2 million (10.8%). For Black/African Americans, the number of uninsured was 7.6 million (20.5%) in 2006. The number of uninsured Asians in 2006 was 2 million (17.2%) and the number of uninsured Hispanics was 15.3 million (34.1%). Based on a three-year average (2004-2006), 31.4% of people who reported American Indian and Alaska Native as their race were without coverage. The three-year average for Native Hawaiians and Other Pacific Islanders was 21.7%.

The possibility exists that many minorities with health insurance coverage are disproportionately enrolled in lower cost health plans that place greater per-patient limits on healthcare expenditures and available services (The National Academy of Sciences, Institute of Medicine, 2002). Racial and ethnic minorities are more likely to be beneficiaries of publicly funded health insurance such as Medicaid and when insured, may face additional barriers such as high insurance co-payments (United States Department of Commerce, 2006).
Residence. Poverty is also very closely related to residency (Timberland & Michael, 2006). Over one-half of Black/African Americans live in inner cities, areas often typified by poverty, poor schools, crowded housing, unemployment, exposure to pervasive drug culture, street violence, and a generally higher level of stress. Hispanic and American Indian families continue to be exposed to dramatically higher rates of neighborhood poverty than their White American counterparts. Over 40% of Hispanic and American Indian families resided in neighborhoods with poverty rates in excess of 20% in the year 2000 (Timberlake & Michael, 2006). Neighborhood poverty has been linked to poorer health status and decreased life expectancy (Schultz, Williams, Israel, & Lempert, 2002).

Schultz et al. (2002) purport that race-based residential segregation is a fundamental cause of racial disparities in health status. They suggest eradicating racial disparities in health status through examining the economical and political processes that spatially separate the races. Schultz et al. (2002) concluded that racial segregation and the subsequent withdrawal of economic resources from poor Black/African American neighborhoods have had a negative effect on the physical environment and consequently the health of the residents. When there is a concentrated area of poorer people, it is likely that they will not have the political and economic resources to influence decisions regarding land use and public safety services. The relative scarcity of health care providers and health care facilities in minority communities also has an effect on the health status of the residents living in those neighborhoods (The National Academy of
The economically deprived neighborhoods face a greater likelihood of closed health care facilities and pharmacies resulting in less access to health care and medications (Schultz et al., 2002).

The Psychosocial Stress Model

The Psychosocial Stress Model addresses stress associated with actual or perceived institutional and interpersonal racism as a cause for the health disparities (Dressler, Oths, & Gravlee, 2006). The Institute of Medicine was asked by Congress to assess the extent of racial and ethnic disparities in health care independently of income, education, insurance status, residence, or other factors that affect access to care (The National Academy of Sciences, Institute of Medicine, 2002). This charge included evaluating the potential sources of the disparities including the role of bias, discrimination, and stereotyping at the individual, institutional, and health system level.

The National Academy of Sciences, Institute of Medicine (2002) reviewed over 100 studies to assess the quality of health care for various racial and ethnic groups controlling for potential confounding factors such as access related factors, severity or stage of disease progression, the presence of co-morbid illnesses, the type of health care facility in which the client was treated (public or private), and other patient demographic variables such as age and gender. Research findings consistently indicated that even with equivalent access to care, racial and ethnic minorities living in the United States receive a lower quality of health services and are less likely than White Americans to receive needed services. Needed services include clinically necessary procedures for a number of diseases such as cancer, cardiovascular disease HIV/AIDS, diabetes, and mental illness. These studies concluded that factors contributing to health disparities may
emerge from clinical encounters that involve bias against racial and ethnic minorities, greater clinical uncertainty when interacting with racial and ethnic minority patients, and stereotypical beliefs held by the health care provider regarding the behavior or the health of racial and ethnic minorities.

*Healthcare Provider Prejudice or Bias.* Prejudice is defined as an unjustified negative attitude based on a person’s group membership. Research suggests that among White Americans, prejudicial attitudes remain more common than not (The National Academy of Sciences, Institute of Medicine, 2002). While there is no evidence that provider biases affect the quality of care for minority clients, research does suggest that healthcare providers’ diagnostic and treatment decisions are influenced by patients’ race or ethnicity. It has been speculated that if patients convey mistrust, refuse treatment, or comply poorly with treatment, providers may become less engaged in the treatment process and patients are less likely to be provided with more vigorous treatments and services.

Some researchers suggest that there may be subtle differences in the way members of certain racial and ethnic groups respond physiologically to treatment, particularly with regard to some pharmaceutical interventions. Consequently, these differentiated responses indicate that some forms of treatment may be justified on the basis of patient race or ethnicity. However, the majority of the studies reviewed by The National Academy of Sciences, Institute of Medicine (2002) found disparities in clinical services that are equally effective for all racial and ethnic groups.

*Health Care Provider Stereotyping.* Stereotyping, the process by which social categories are used to acquire, posses, and recall information about others, continues to
evolve, persist, and shape expectations in this country (The National Academy of Sciences, Institute of Medicine, 2002). Stereotypes are perceived by some to provide greater confidence in the ability to understand a situation and respond in more efficient and effective ways. However, when stereotyping takes place in the clinical setting, health professionals may make judgments about client conditions and decisions about treatment without complete and accurate information.

**Health Care Provider Clinical Uncertainty.** New information about patients along with prior expectations is used to make decisions concerning a patient’s diagnosis and course of treatment. Any degree of uncertainty a health care provider may have relative to the condition of a patient causes greater emphasis to be placed on prior expectations, including stereotypes, contributing to disparities in treatment (The National Academy of Sciences, Institute of Medicine, 2002).

**Perceived discrimination.** Perceived discrimination is the conscious perception of discriminatory acts and practices and the distress associated with that perception (Williams, Neighbors, & Jackson, 2003). Research suggests that the subjective experience of racial bias is associated with multiple indicators of poorer physical and mental health status. These perceptions may be a neglected determinant of health and a significant contributor to health disparities associated with race and ethnicity.

The complexity of the theorized causes of the health disparities among racially and ethnically diverse groups in the United States warrants an assessment of current education trends in health care curricula. Multicultural education and teaching students the provision of culturally competent care entails more than teaching health care delivery strategies that address the cultural needs of clients and families. It encompasses
promoting an awareness of the disparities in health and health care, recognizing and
addressing the causes of the disparities, and promoting a professional and social
commitment to alleviating the disparities.

**Multicultural Education**

A major goal and purpose of multicultural education is to facilitate the
development of knowledge, attitudes and skills in students that is linked with social
commitment and action (Banks, 2006). Possessing an awareness of the potential
biological, sociological, psychological, and political contributors to disparities in health
status and health care is essential to providing holistic culturally competent care.
Meeting these multicultural goals requires a careful assessment of the curriculum and
well planned educational strategies and opportunities.

It is generally agreed upon among scholars of multicultural education that for
multicultural education to be implemented successfully, changes in the curriculum,
teaching materials, and teaching styles as well as the attitudes, perceptions and behaviors
of teachers and administrators are necessary (Banks, 2006; Gay, 1994; Byrne, 2003.)
Advocates of multicultural education agree that the content should include ethnic
identities, cultural pluralism, unequal distribution of resources and opportunities, and
other sociopolitical problems stemming from long histories of oppression (Gay, 1994).
Many faculties in schools and universities continue to have a limited conception of
multicultural education and view it primarily as a restructuring the curriculum to include
information about racially, ethnic, and culturally diverse groups (Banks, 2006).

Banks (2006) describes multicultural education as having several dimensions that
are needed to create comprehensive multicultural education practices. Two of those
dimensions, content integration and the knowledge construction process, are appropriate
to the discussion of multicultural education in the nursing curriculum. A general
description of these four approaches is provided in this section. Applications of these
approaches to nursing education are discussed in the next section.

Content integration

Content integration in multicultural education is described by Banks (1996) as the
extent to which teachers use examples and content from a variety of cultures and groups
to illustrate key concepts, generalizations, and issues within a subject area or discipline.

Four approaches to multicultural curriculum reform, according to Banks, are: the
contributions approach, the additive approach, the transformative approach, and the
decision making and social action approach.

The contributions approach. The contributions approach to multicultural content
integration, cited as the most popular yet the least effective of the methods, involves
inserting isolated facts about cultural and ethnic heroes and heroines into the curriculum
without changing the actual structure of the lesson plans (Banks, 2006). Multicultural
groups are only recognized during certain holidays or in relationship to historical figures
that have contributed to the progress of our country. The contributions approach, which
is the easiest approach for teachers to use to integrate multicultural content into the
curriculum, has substantial limitations. Issues such as racism, poverty, and oppression
tend to be avoided with this approach. The results are often trivialization of ethnic
cultures and reinforcement of existing stereotypes and misconceptions.

The additive approach. The additive approach to multicultural content integration
involves adding content, concepts, themes, and perspectives of ethnic or cultural groups
to the course or curriculum without changing the inherent structure or purpose of the
course (Banks, 2006). While this approach is an improvement over the contributions
method, it falls short of providing the critical and transformative multicultural education
that is needed to prepare students to function in a complex and diverse world. A major
shortcoming of the additive approach is that it usually results in viewing ethnic content
from the perspectives of mainstream writers utilizing Eurocentric criteria.

*The transformative approach.* The transformative approach differs fundamentally
from the contribution and additive approaches to integration of multicultural content
(Banks, 2006). This approach brings content about cultural, racial, and ethnic groups to
the center of the curriculum by incorporating concepts, issues, themes, and problems
viewed from the perspective and the experiences of groups from different social-class,
racial, and ethnic groups. The transformative approach requires substantial faculty time,
effort, and training to rethink the curriculum purpose and goals and to implement new
teaching strategies.

*The decision making and social action approach.* The decision making and social
action approach includes all elements of the transformative approach with the addition of
components that require students to make decisions and take actions related to the
concepts and issues studied (Banks, 2006). Students are required to gather pertinent data
regarding the issue, analyze their personal values and beliefs regarding the issue,
synthesize their knowledge and values, identify alternative courses of action, and make
decisions on actions that should be taken to address the problem.

These approaches to integrating cultural diversity content into the curriculum are
often mixed and blended in actual teaching situations (Banks, 2006). It is realistic to
expect an educator to begin at the more basic levels using the contributions and additive approaches and progress gradually and cumulatively toward the transformative and decision making and social action approaches.

Knowledge construction

In the support of transformative education, Banks (2006) purports that teaching strategies should be used to promote students’ understanding of the influence of authors’ and researchers’ assumptions, perspectives, and biases related racial, ethnic, and social class position on the construction of knowledge. Understanding that the formulation of conclusions, generalizations, and principles in any discipline is influenced by cultural assumptions, perspectives, and frames of reference is crucial. A transformative curriculum enables students to question and critically analyze knowledge and to view concepts, issues, themes, and problems from diverse cultural and ethnic perspectives.

Approaches to Cultural Diversity Education in Nursing

Two major educational approaches to teaching cultural diversity in nursing education currently exist. They include the essentialist approach and the transformative approach.

Foundations of Multicultural Education in Nursing

The first theory in nursing that focused on culture and care was Madeleine Leininger’s (2002) Cultural Care Theory. The theory was launched in the mid 1950s and reflects an anthropological view of culture as an influence and a determiner of health and illness states. Leininger (2007) theorized that cultural care was essential to nurture quality of life and health as well as to prevent illness or disabilities. From the beginning, the theory conceptualized culture care by searching for diversities as well as
universalities or the commonalities of care among cultures. The central purpose of Leininger’s Culture Care Theory is to discover and explain socio-structural factors that influence health, well being, illness, and death of individuals or groups. These factors include religion, politics, economics, worldview, cultural variables, history, language, lifespan, values, kinship, philosophy of living, and geo-environmental factors.

Some basic assumptions of Leininger’s theory include (a) every human culture has lay (generic, folk, or indigenous) care knowledge and practices and usually some professional care knowledge and practices which vary transculturally; (b) culture care values, beliefs, and practices are influenced by and tend to be embedded in the worldview, language, philosophy, religion (and spirituality), kinship, social, political, legal, educational, economic, technological, ethnohistorical, and environmental contexts of cultures; and (c) a client who experiences nursing care that fails to be reasonably congruent with his/her beliefs and values will show signs of cultural conflict, noncompliance, stress, and ethical or moral concerns. According to Leininger’s theory, these assumptions should be used to guide nurses and other health care providers to use culturally based care values, beliefs, and practices to assure and maintain culturally competent care and to guide nurses away from using largely inappropriate, unsafe, traditional, or destructive actions that failed to be acceptable to diverse cultures.

The Essentialist Approach to Cultural Diversity Education

Leininger’s theory remains the preeminent culturally focused theory of nursing in the United States (Gray & Thomas, 2005) and has been a major contribution to the establishment and maintenance of the discipline of transcultural nursing (Leininger, 2002). The Culture Care Theory has served as the prototype for subsequent more recent
models that focus on cultural competence and its application such as Giger & Davidhizar’s (2008) Transcultural Assessment Model, Purnell’s (1998) Model for Cultural Competence, and Spector’s (2008) developmental dimensions of Cultural Foundations, Domains of Health, and Panoramas of Health. These models and approaches to teaching cultural diversity concepts and values to nursing students use traditional educational principles that are embedded in anthropology and an essentialist philosophy of education.

Giger & Davidhizar (2008) and others using this approach, promote culturally competent care through cultural assessments and interventions. Through the nursing process, a problem solving method which includes assessment of client needs; identification of client problems; outcome/goal setting; planning and implementation of client care; and evaluation of outcomes, culturally competent care is incorporated. From this approach, understanding about the client’s culture and recognition of the value and importance of culturally competent care is paramount. The theorists attempt to avoid promoting the package approach by virtue of race or ethnicity, and recognize the variations within and among certain racial and ethnic groups. They believe that culturally diverse nursing care is the key to ensuring that all people have equal access to high quality culturally competent care.

The essentialist educational approach to teaching cultural diversity meets the American Nurses Association’s and the National League for Nursing’s objectives of preparing students to provide culturally competent care to clients from diverse backgrounds (Duffy, 2001). This approach acknowledges that the nursing profession requires transcultural knowledge and skills for effective practice. The current theories
and models that exist for teaching transcultural theory and concepts using the traditional approach can be utilized in a variety of clinical settings. These models and theories help nurses to discover and understand what health care means to various cultures.

Critics of this traditional form of cultural education purport that nursing education strategies and goals remain focused on changing the individual rather than society and that the challenge of confronting competing attitudes and ideologies is often avoided. Underlying social conditions such as economical and political factors and processes that contribute to the health disparities are not addressed (Duffy, 2001).

**The Transformative Approach to Cultural Diversity Education**

Many advocates of cultural diversity education in nursing suggest that cultural education in nursing has not evolved to meet the demands of a multicultural global society and are embracing transformative approaches to education (Henderson & Hawthorne, 2000). Transformative education is an alternative means of teaching that focuses on changing the underlying beliefs and social structures of the learner and conveys the idea of continuous growth through inquiry. It is a process of getting beyond gaining factual knowledge alone to instead become changed by what one learns in some meaningful way. It involves questioning assumptions, beliefs and values, and considering multiple points of view while always seeking to verify reasoning. It encourages creative problem solving, nurtures critical thinking, and works to include multiple perspectives. It is grounded in continuous self and social examination.

Duffy (2001), an advocate for curriculum reform regarding transcultural education in the nursing curriculum, argues that innovative transformative approaches to cultural education are needed. Duffy (2001) agrees that students should learn the basics
from a theoretical base, but proposes that faculty and students should then incorporate the principles of transformative learning that instigate critical reflection, stress inquiry, critique presumptions, and encourage reflection upon beliefs. This type of education promotes investigation of alternative approaches to problem solving at both a personal and social level. Alternative ideas are encouraged along with the development of sensitivity to the thoughts, feelings, and needs of individuals and society as a whole.

Transformative education seeks to cultivate moral and ethical accountability through becoming aware of deep, interrelated, and controversial issues of equity, diversity, and civility. This helps the students to see themselves as active, lifelong, informed decision makers and teaches them to become active and responsible members of a pluralistic society (Henderson & Hawthorne, 2000).

From the transformative point of view, major goals of a multicultural curriculum in nursing include the development of a multicultural perspective that acknowledges oneself as a cultural being and accepts culture as being multileveled, dynamic, and relative (Duffy, 2001). Transformative education promotes active learning, critical reflection, and confrontation of self and one’s own culture. Perceptions, understandings, and feelings about oneself, others, and the world are brought to the surface and examined and reformulated. The evaluation focus in transformative education is on how students connect and integrate new ideas and forms of analysis and criticism into a larger construction of knowledge (Henderson & Hawthorne, 2000).

A limitation of transformative education is that it is frequently difficult for faculty to engage in dialogue with students that presents them with challenges and draws attention to contradictions, misunderstandings, and “why” questions (Duffy, 2001).
These challenges can lead to an environment of conflict, uncertainty, and debate as students are encouraged to take risks and live with some degree of psychological discomfort during this process of acquiring knowing and gaining new insights (Taylor, 2007). According to Mezirow (2003), effective participation in dialogue in the transformative learning process requires emotional maturity, awareness, empathy, management of one’s own emotions, and the recognition of emotions in others. Some learners engaging in the transformative process may not possess these attributes, making it difficult to establish and maintain a degree of decorum in the classroom during discussions pertaining to racial/ethnic issues. Little is known about how to effectively engage emotions in practice and the role of particular feelings such as anger, shame, or happiness in relationship to transformative learning (Taylor, 2007).

Byrne (2003), incorporating the principles of transformative education and Bank’s (2006) dimension of content integration, developed The Multicultural Inclusion Model, a multidimensional approach to cultural diversity education in nursing. Byrne (2003) stresses that the goal of attaining cultural competence in nursing must be considered by the faculty from a multidimensional approach throughout the educational process in order for culturally competent care to become a reality. The Multicultural Inclusion Model identifies Bank’s (2006) four approaches to content integration as used by nursing faculty in to infuse cultural diversity into the nursing curriculum.

The contribution approach, the most basic of the approaches, may involve including information on African American nurses’ contribution to the foundations and history of nursing or recognizing ethnic holiday celebrations such as the Mexican communities’ celebration of Cinco de Mayo. With this insufficient approach to teaching
cultural diversity concepts, the curriculum is void of any pertinent health care related
information that would contribute to positive health care outcomes for ethnically diverse
clients. Sociologic issues such as bias and racism in health care are also omitted from the
curriculum using this approach.

With the second level approach, the additive approach, nursing faculty design the
curriculum to include health related cultural diversity content at a basic level (Byrne, 
2003). Learning objectives may include discussing the prevalence of hypertension
among African Americans or recognizing the child rearing practices of Native American
tribes. Although information is disseminated and knowledge is acquired, limited skills
are developed regarding the provision of culturally competent care. The perspectives of
marginalized groups related to health and health care are not addressed.

The third level approach incorporates a transformative approach to cultural
education in nursing (Byrne, 2003). From the transformative view, cultural knowledge is
extended, incorporating the understanding and application of equality, valuing diversity,
and recognizing and challenging bias and racism in health care. The focus is on changing
underlying beliefs and social structures of the learners related to the health and health
care of diverse groups.

The highest level approach for incorporating cultural diversity concepts into the
curriculum, the decision making and social action approach level, extends the
transformative curriculum and enables students to pursue projects and activities that
allow them to take personal, social, and civic actions related to cultural diversity issues in
health care. Curricula designed at this level offer a range of possible outcomes rather than
a set of prescribed outcomes. It promotes the development of students who are able to argue effectively on social, political, and economical issues (Cortis, 2004.)

Throughout the nursing education process, faculty should be able to guide students through thinking critically about cultural diversity issues, forestalling or reducing bias in health care and cultivating acceptance of racially and ethnically diverse clients. Nurse educators must possess these attributes in order to pass them on to students (Maze, 2005; Paccione, 2000).

\textit{Differentiation of Nursing Education and Nursing Practice}

Professional nurses are prepared for entry into practice at various levels. Incorporating principles of multicultural education in nursing is essential at all levels of nursing education in preparation for the multiple roles in which they will practice. However, approaches to incorporating multicultural content into the nursing curriculum may vary based on the level of the nursing education program and the expected roles of the graduates.

The various methods of educational preparation for nurses and the subsequent roles that nurses are prepared to take can be perplexing. To clarify the roles, the American Association of Colleges of Nursing (AACN) in conjunction with the National Organization for Associate Degree Nursing (NOADN) developed a nursing care delivery model that differentiates scope of job responsibility based on education, clinical experience, and defined competence and decision making skills. Educational experiences are organized and academic expectations are established according to the nursing degree. Differentiated nursing practice acknowledges the qualities and conditions that distinguish nursing education program types and include aspects such as (a) the complexity,
intensity, and length of the program of study; (b) the amount and extent of general education; (c) the amount of scientific knowledge; (d) ethical and clinical judgment and decision making skills; (e) interpersonal and technical skills integral to nurses’ clinical expertise, roles, and scopes of nursing; (f) the concentration on research and the spirit of inquiry; (g) the identification, formulation, and evaluation of possible solutions to a broad range of societal issues; and (h) the legally defined scope of practice for which the graduates are prepared (NLNAC, 2005).

The entry pathways into professional nursing include associate degree nursing education, diploma nursing education, baccalaureate degree nursing education, and direct entry graduate programs. Upon graduation, individuals from all types of entry level programs sit for the NCLEX-RN to obtain a license to practice registered nursing. The professional roles for which they are prepared are directly related to their level of education. Table 2.1 provides the entry levels into professional nursing in Ohio and nationally and summarizes the educational preparation, role expectations, and licensing examination requirements of each level.

*Associate Degree Nursing Education*

An associate degree nurse (ADN) completes a two-year program, granting an Associate of Applied Science Degree or an Associate of Science in Nursing Degree, which prepares individuals for a defined technical scope of practice. Set in the framework of general education, the clinical and classroom components prepare nurses for roles that require nursing theory and technical proficiency. Associate degree nursing programs were born out of the need to alleviate a critical shortage of nurses in the 1950s by decreasing the length of nursing education to two years and placing nursing
Table 2.1

Entry Levels into Professional Nursing

<table>
<thead>
<tr>
<th>Entry level</th>
<th>Educational preparation</th>
<th>Role expectations</th>
<th>Licensing examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Degree Nurse (ADN)</td>
<td>Two year Associate of Applied Science or Associate of Science in Nursing Degree</td>
<td>Health care generalists working primarily in staff positions; posses a well defined technical scope of practice.</td>
<td>NCLEX-RN passage required to apply for licensure as a registered nurse</td>
</tr>
<tr>
<td>Diploma Nurse</td>
<td>Three year Diploma in Nursing</td>
<td>Health care generalists working primarily in staff positions; posses a well defined technical scope of practice.</td>
<td>NCLEX-RN passage required to apply for licensure as a registered nurse</td>
</tr>
<tr>
<td>Baccalaureate Degree Nurse (BSN)</td>
<td>Bachelor of Science in Nursing Degree</td>
<td>Designs and facilitates comprehensive plans of care in a variety of health care settings; prepared for a broader scope of health care practice.</td>
<td>NCLEX-RN passage required to apply for licensure as a registered nurse</td>
</tr>
<tr>
<td>Masters Degree Nurse – Direct Entry Program (MSN)</td>
<td>Bachelor’s degree in a field other than nursing, combined with a basic and advanced nursing education.</td>
<td>Advanced practice in a clinical specialty, nursing research, nursing administration, or nursing education.</td>
<td>NCLEX-RN passage required to apply for licensure as a registered nurse</td>
</tr>
</tbody>
</table>

programs in community colleges (American Association of Community Colleges, 2007).

The number of associate degree nursing programs in the United States has grown from 7 in 1958 to more than 940 in 2007, with over 600 being located in community colleges.

According to the American Nurses Association Workforce Survey (2004) there are 2.9 million registered nurses in the United States. The initial educational preparation for the largest proportion of registered nurses in this country is the associate degree.
The survey results showed that 1,227,256 (42%) received their initial nursing education in an associate degree program and associate degree nursing programs were 58.9% of all entry level programs in the country. Ohio currently has 40 associate degree nursing programs located in community/technical colleges, four year colleges and universities, hospital affiliated schools, and private career training institutions (Ohio Board of Nursing, 2007).

Associate degree nurses function primarily in staff positions as health care generalists; predominantly at the bedside in an institutional setting and in less complex client care situations (American Association of Colleges of Nursing, 1996). Care rendered by the associate degree nurse is based on activities that provide comfort, physiological stabilization, or assistance to a peaceful death. The guiding principles of the associate degree nurse’s work are found in nursing standards, protocols, and pathways.

*Diploma Nursing Education*

Diploma nursing programs are usually associated with a hospital, combining classroom and clinical instruction over a three year period. Although once a common educational route for registered nurses, diploma programs have diminished steadily to 4% of all basic registered nursing education programs in the United States as nursing education has shifted from hospitals to academic institutions (American Nurses Association, 2008). Ohio currently has six hospital affiliated diploma nursing programs (Ohio Board of Nursing, 2007). The diploma nurse’s role is commensurate with that of the associate degree nurse’s role.
Baccalaureate Degree Nursing Education

The baccalaureate degree nurse has a university based Bachelor of Science in Nursing (BSN) degree. This degree provides the nursing theory, sciences, humanities, and behavioral science preparation necessary for the full scope of professional nursing responsibilities. The course work enhances the student's professional development, prepares the graduate for a broad scope of practice, and provides the nurse with a better understanding of the cultural, political, economic, and social issues that affect patients and influence health care delivery. Additionally, the degree provides the knowledge base necessary for advanced education in specialized clinical practice, research, or primary health care.

In 2005, 573 colleges and universities in the United States offered the BSN degree. Most often, supervised clinical practice is obtained during the last two years of the program in hospitals, nursing homes, and community settings (ANA, 2004). Currently, Ohio has 29 baccalaureate degree nursing programs that are located in four year colleges and universities (Ohio Board of Nursing, 2007).

The guiding principles for the Bachelor in Science in Nursing role go beyond the needs addressed in established nursing standards and pathways. The role requires collaboration with other disciplines and agencies to design and facilitate a comprehensive well prepared discharge from the health care system based on the unique needs of the client and family (American Association of Colleges of Nursing, 1996).

Direct Entry Graduate Nursing Programs

A nontraditional entry into professional nursing is offered in the form of direct entry graduate degree in nursing programs for individuals with a baccalaureate degree in
another field (American Association of Colleges of Nursing, 2005). This option provides a more streamlined pathway to advanced practice nursing for those who have not had previous nursing education. It combines preparation in basic nursing with advanced preparation in a clinical specialty and nursing research. Currently, three direct entry graduate programs exist in Ohio; two leading to a master of science in nursing, and one leading to a doctor of nursing practice.

Additional Nursing Education Pathways

Although not entry level positions, two other types of nursing education/roles exist in the United States; the advanced practice nurse and the licensed practical nurse. The advanced practice nurse (APN) role, based on the Master’s of Science in Nursing (MSN), provides a continuum of care across all settings working with the client and family throughout wellness, illness, or until death. Based on a perspective supported by in depth education in physiology, physical assessment, pharmacology, and a broad health care system perspective, the MSN creates and defines protocols and pathways and assists with the development of standards on emerging new health phenomena (American Association of Colleges of Nursing, 1996).

In the state of Ohio, an advanced practice nurse may be certified as registered nurse anesthetist, performing pre-anesthesia preparation and evaluation and post-anesthesia care; a clinical nurse specialist or certified nurse practitioner, providing preventive and primary health care services; or a certified nurse midwife, providing health care to women during uncomplicated pregnancy, childbirth, and recovery, as well as gynecological care to non-pregnant women (Ohio Board of Nursing, 2007).
Licensed practical nurses (LPNs), also called licensed vocational nurses (LVNs) in some states, are not professional/registered nurses. LPNs/LVNs have completed a one year post-high school educational certificate program, offered at technical and community colleges, that focuses on basic nursing care (United States Department of Labor, 2008). The practice of nursing for the LPN is defined by the state of Ohio as providing nursing care requiring the application of basic knowledge of the biological, physical, behavioral, social, and nursing sciences at the direction of a licensed professional such as a physician, dentist, podiatrist, optometrist, chiropractor, or registered nurse (Ohio Board of Nursing, 2007). LPNs/LVNs also must pass a national licensing exam (NCLEX- PN) to obtain a license to practice. Table 2.2 summarizes the differences between professional and licensed practical/vocational nursing in Ohio and nationally.

Cultural diversity education is imperative at all levels of nursing education and in all areas of nursing practice. The breadth and depth of liberal education as well as the complexity, intensity, and length of the course of study varies according to educational program type. Therefore, the level of cultural diversity content integration in the nursing curriculum will vary based on the program type. Associate degree nursing program graduates have had limited exposure to models and theories for understanding the dynamics of the nurse-client relationship, epidemiology, interdisciplinary interventions, and systematic approaches to problem solving and decision making. To be adequately prepared in the area of cultural competence, it is imperative that faculty members teaching in associate degree nursing programs are adequately prepared with the awareness, knowledge, and skills needed to effectively teach cultural competence.

56
Table 2.2

Comparison of Registered Nurses and Licensed Practical/Vocational Nurses

<table>
<thead>
<tr>
<th>Nursing level</th>
<th>Education</th>
<th>Role expectations</th>
<th>Licensing examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional/Registered Nursing</td>
<td>Associate of Applied Science or Associate of Science in Nursing Degree, Diploma, Bachelor’s of Science in Nursing Degree, or Masters of Science in Nursing Degree</td>
<td>Ranges from generalists in a defined scope of practice to advanced practice nursing in independent settings.</td>
<td>NCLEX-RN</td>
</tr>
<tr>
<td>Licensed Practical/Vocational Nursing</td>
<td>One year educational certificate in practical/vocational nursing.</td>
<td>Provides basic nursing care under the direction of a licensed professional.</td>
<td>NCLEX-PN</td>
</tr>
</tbody>
</table>

*Faculty Attributes Required for Teaching Cultural Competence*

Knowledge of curriculum design, theory, standards, and practices is essential to effectively develop, implement, and evaluate curriculum. It is imperative that educators also possess the knowledge, skills, and sensitivity to successfully implement a culturally diverse perspective into their programs. Faculty must serve as role models and demonstrate behaviors that are consistent in illustrating cultural sensitivity. Additional faculty attributes that are germane to teaching and promoting cultural competence in nursing education include the ability to promote self inquiry, facilitate dialog, and manage conflict.
Promotion of Self Inquiry

Providing culturally competent nursing care involves an understanding of one’s own value system and biases while valuing diversity and the uniqueness of others (White, 2003). Nursing faculty should create an atmosphere reflecting an acceptance of and a respect for cultural differences. Cultural proficiency in nursing education is demonstrated through the provision of a learning environment which encourages both students and faculty to “unearth, examine, and challenge” their own cultural biases (Wells, 2000). Becoming aware of one’s own culture and the effect that it may have on others is essential to effectively respond to issues of diversity (Robins, Lindsey, Lindsey, & Terrell, 2006). When teaching/learning strategies are used that address feelings, attitudes, relationships, and problem solving, faculty must possess the ability to guide students through coping with the emotions and negative feelings that may be generated in the process (Shearer & Davidhizer, 2003).

Kleiman (2006) purports that self understanding, experiential awakening, and dialogic openness are necessary in order to achieve a sense of cultural awareness, cultural sensitivity, and cultural competence. In order for educators to raise the students’ cross cultural cognizance and cultural diversity sensitivity, they must first be able to objectively examine and reflectively clarify their own cultural frames of reference that have subconsciously evolved over their lifespan (Brown, 2006). To provide culturally competent nursing care requires an understanding of one’s value system and biases while valuing diversity and the uniqueness of others (Maze, 2005).

Self inquiry and reflection around racial, cultural, and ethnic issues can be daunting because of the potential for self disclosure of undesirable thoughts and feelings.
Critical self reflection uncovers and deconstructs inconspicuous beliefs, perceptions, and experiences, aiding in the understanding of one’s own covert values and biases not previously in the forefront of one’s thinking. Confronting potentially unpleasant values, beliefs, and assumptions may prove to be disturbing to some students causing them to become guarded or protective of their perceptions and opinions ultimately affecting the learning process (Terhune, 2006). Faculty must possess the knowledge and skills to guide the student through the difficult emotions and responses that may surface following such exercises and prepare students to recognize their own personal resistance and defensiveness in caring for culturally diverse individuals. Guidance through the processes of self awareness, reflection, and inquiry will enable students to recognize barriers to culturally competent care and adopt strategies that motivate clients (Baldwin, 1999).

Facilitation of Dialog

Dialog in the classroom can be an effective strategy in the teaching/learning process regarding cultural diversity. Dialog can be used for the purpose of learning from one another through discussion and debate (Sommer, 2001). Freire (2003) considers dialogue more than a mere conversation or technique and stresses that it requires the engagement of issues at a deep and thoughtful level. Creative use of conflict in a cooperative learning setting is a useful educational tool in promoting dialogue about multiculturalism. It can provide an opportunity for students to learn that conflict is unavoidable and can be a constructive and useful tool in providing an avenue for creative problem solving (Sommer, 2001).
The process of engaging the students in dialogue and identifying areas of agreement can be very effective in supporting group members and preventing feelings of guilt, resistance to participation, and feeling threatened. Faculty should be able to promote constructive actions that focus on learning new skills, changing attitudes and behaviors, building relationships, and developing complex problem solving skills. The ultimate goal should be to expand individual knowledge, level of awareness, personal insight, and appreciation of significant differences (Terhune, 2006).

Managing Conflict

It is not possible to provide culturally competent care without examining and confronting issues of racism and discrimination. Communications around these issues can be complex, polarizing, and uncomfortable requiring teachers to maintain a delicate balance between challenge and support (Abrams & Leppa, 2001). Spratlen (1998) acknowledges that there will be discomfort and negative reactions when diversity and racism are explored during frank and open discussions in the classroom. Confronting values, beliefs, and assumptions may prove disturbing for faculty and/or students. According to Baldwin (1993), difficult dialogs are encountered when academia includes the experiences of white women, women of color, and men of color into the curriculum. These dialogs may lead to feelings of discomfort and uneasiness among both faculty and students.

Robins et al. (2006) purport that it is the mismanagement of conflict rather than the conflict itself that causes most problems. They view conflict as a natural part of life and faculty needs to develop skills to manage conflict effectively. Faculty should be able to stimulate candid discussions and curiosity about diverse cultural groups, and alleviate
any stress, anxiety, or isolation that may be felt by students as a result of these conversations (Brown, 2006). The outcome should be a constructive and powerful learning experience.

Nurse educators teaching on the topics of race and class often find themselves in the midst of discussions that cause students to experience frustration, anger, hurt, yelling, silence and withdrawal (Friedman, 1998). Educators must focus on providing a safe place for these dialogues that reflect a deep sense of mutual respect and regard for those involved (Terhune, 2006). The ultimate goal is to increase students’ self awareness regarding issues of discrimination in health care and at the same time create a safe space for open dialogue (Abrums & Leppa, 2001).

**Barriers to Cultural Competency**

Without a clear and established commitment by the faculty to cultural diversity issues, legitimate cultural competence efforts will be frustrated. To be effective as an instructor from a culturally proficient perspective, a reflection on the barriers to cultural proficiency is essential (Robins et al., 2006). Chief barriers to cultural competency include; a shortage of nursing faculty, a lack of awareness of the need to adapt to diversity, a sense of entitlement, systems of oppression, faculty bias and lack of commitment toward providing culturally competent care, and under-preparation of faculty to teach cultural diversity issues.

**Faculty Shortages in Nursing Education**

The shortage of faculty in nursing programs is a continuing and expanding problem (American Association of Colleges of Nursing, 2005). The nursing faculty shortage in baccalaureate and masters degree nursing programs is one of the major causes
cited for declining numbers of students being admitted to baccalaureate and masters degree nursing programs. These shortages ultimately affect the numbers and quality of faculty available to teach in associate degree nursing programs. The NLN’s 2005 National Nursing Education Database Survey found that the number of qualified nurses available to teach nursing students continues to decline. In 2005, schools of nursing were forced to reject more than 147,000 qualified applicants, an increase of 18 percent over previous years.

According to a Special Survey on Vacant Faculty Positions released by the American Association of Colleges of Nursing in July of 2007, a total of 767 faculty vacancies were identified at 344 nursing schools with baccalaureate and/or graduate programs across the country for the academic year 2007-2008 (American Association of Colleges of Nursing, 2007). Ohio’s baccalaureate and higher degree nursing programs reported 23 faculty vacancies during 2004 with a projection of 95 vacancies over the next five years (Ohio Board of Nursing, 2007). Associate degree nursing programs in Ohio reported 16 faculty vacancies with a projection of 64 vacancies over the next 5 years. With the supply of potential nursing faculty decreasing in masters, baccalaureate, and associate degree nursing programs, the problem of acquiring and maintaining qualified nursing faculty is expected to increase.

Embedded in the overall nursing faculty shortage is a shortage of minority faculty members teaching in schools of nursing. According to the NLN 2006 Faculty Census Survey, disparities exist between the number of minority nursing faculty members and the number of minorities in the general population. This is, in part, due to an under-representation of minorities graduating from baccalaureate and masters degree nursing
programs. The number of minority nursing faculty is dependent on the number of minority nursing graduates who pursue graduate degrees and return to institutions of higher learning as faculty.

Commensurate with national statistics, there are alarmingly low numbers of racial and ethnic minorities graduating from master’s in nursing programs in Ohio and consequently prepared to teach in schools of nursing. Of 573 graduates from masters in nursing programs in Ohio during the period from 8/1/05 through 7/31/06, only 9.7% were of a minority race or ethnicity (American Association of Colleges of Nursing, 2007).

The shortage of minorities in the nation’s health care work force is an ongoing contributor to the nation’s racial and ethnic health disparities (Sullivan Commission, 2004). A culturally and racially diverse nursing faculty increases the probability of culturally competent nursing education and contributes to the improvement of health care delivery services to less advantaged and underserved populations (American Association of Colleges of Nursing, 2002; Drayton-Hargrove, 1997).

A Lack of Awareness of the Need to Adapt to Diversity

Failure to make personal and organizational changes in response to the diversity of the people in the environment or encompassing the belief that changes need to occur in “others - the ones who are not like us” is a barrier to cultural competence (Robins et al., 2006). Cultural awareness allows the nurse to gradually become more sensitive to cultural diversity and modify biased attitudes and beliefs related to clients from cultures different from their own (Campinha-Bacote, 2005).

Bennett (1993) defines the concept of cultural awareness in the Developmental Model of Intercultural Sensitivity. The model depicts cultural awareness as evolving
along a continuum ranging from an ethnocentric to an ethnorelative perspective. Ethnocentric is defined by Bennett (1998) as the perception that one’s own culture is experienced as central to reality in some way. Giger and Davidhizer (2004) define ethnocentrism as the perspective that one’s own worldview is best and the ideas of others are ignorant or inferior. According to Bennett’s model, the first three stages are levels of the ethnocentric perspective and include (1) denial of the existence of cultural differences and avoiding other cultures by maintaining psychological and/or physical isolation from the differences; (2) protection from or defense against cultural differences in which one’s own culture is experienced as the superior culture and all others are regarded as inferior; and (3) minimization of cultural differences in which elements of one’s own cultural worldview are experienced as universal and other cultures are trivialized.

The ethnorelative perspective of the Developmental Model of Intercultural Sensitivity toward cultural diversity involves realizing that western medicine is limited and beginning to respect and accept different world views. The levels of the ethnorelative perspective include (1) acceptance of, but not necessarily an agreement with, cultural differences during which one’s own culture is experienced as just one of a number of equally complex worldviews; (2) adaptation to cultural differences during which one’s worldview is expanded to include constructs from other worldviews and the ability to look at the world through different eyes; and (3) integration of cultural differences in which one is easily able to move in and out of different cultural world views.

Campinha-Bacote (2003), based on the works of educational psychologist W. Howe, describes cultural awareness as occurring along a continuum raging from
unconscious incompetence to unconscious competence. Unconscious incompetence is defined as being unaware that one is lacking cultural knowledge. The nurses are unaware of cultural differences between themselves and the client and of differences across and within cultural groups. Conscious incompetence involves being aware that one is lacking knowledge about other cultural groups. The person possesses the “know that” knowledge but not the “know how” knowledge (Purnell, 1998). Conscious competence is the process of learning about the client’s culture, verifying generalizations, and providing culturally competent care. They are overly conscious about doing or saying the right thing. Encounters are limited and interactions are not comfortable. Unconscious competence is the ability to spontaneously provide culturally responsive care to clients from diverse cultures. They easily and effectively communicate in cross cultural encounters.

Gaining cultural awareness is an important early step in becoming culturally competent. Cultural awareness includes gaining insight into one’s own cultural values as well as recognizing cultural differences between self and others. A continuous process of cultural awareness should be demonstrated among those who render care to and teach the care of culturally diverse clients.

A Sense of Entitlement

A sense of entitlement creates barriers and oppression for some groups of people (Robins et al., 2006). Because language reflects power in our society, faculty’s use of language may serve to objectify or dehumanize certain groups of people. Terms of oppression such as culturally deprived, minority, disadvantaged, or different implies that there is something wrong with the person and that they need to be “fixed”. The use of
oppressive terms to describe certain groups gives permission to view others differently and frees faculty from considering institutionalized oppression to which the persons may be subjected. Exposure to oppressive language used by faculty members may affect how the students subsequently view and care for clients from other cultures.

**Systems of Oppression**

Systems of oppression are institutionalized racism where no overt rules or policies preventing differential treatment exist, yet members of certain groups experience subtle but profound discrimination (Robins et al., 2006). To be oppressed is to be socialized into a world view that is less than optimal and leading to a fragmented sense of self. The oppressed are left feeling vulnerable and insecure because their self worth is based primarily on external validation. The result is a feeling of powerlessness where power and responsibility are placed outside of self (Meyers, Speight, Highen, Cox, Reynolds, Adams, & Hanley, 1991).

Nursing faculty must be comfortable addressing issues of sociological and political inequalities that face racial and ethnic groups with respect to power relationships in society. Consideration of the relationship between knowledge and power and an analysis of the relationship between prejudice and discrimination and health care provisions should be openly discussed in the classroom and recognized in practice.

**Faculty Bias and Lack of Commitment**

Faculty biases are likely to affect perceptions, attitudes, and behaviors toward clients, students, and colleagues from diverse backgrounds (Wells, 2000). Educators bring to the classroom their personal experiences, biases, prejudices, and expectations and, as authority figures, have a major impact on student learning. The ways in which
faculty present diversity concepts can have far reaching consequences and may influence the emphasis that the learners ultimately place on diversity once they begin their professional practice (Leonard, 2006). If faculty presents diversity as an important concept, then graduates are more likely to respect the diversity of their clients and colleagues.

Byrne (2003) discusses categories of bias found in teaching when faculty members are not adequately qualified. These categories include (1) invisibility – utilizing texts and illustrations where particular groups are omitted or not represented, teaching people from nondominant cultures that they are less important and less significant in society than people from dominant cultures, (2) stereotyping – oversimplification or untruths about the traits and behaviors common to an entire group of people, denying the reality of individual differences and inhibiting people’s understanding of diversity and complexity, (3) imbalance and selectivity – an exclusive and culturally privileged perspective of an issue leading to an imbalanced account of a situation thus limiting students’ knowledge of situations, (4) unreality – occurring when instruction materials ignore controversial, unpleasant, or negative facts resulting in students lacking the information to recognize, understand, or change circumstances that plague society, (5) fragmentation and isolation – non-dominant cultural groups are presented physically or visually separate from mainstream content, and (6) linguistic bias - language and metaphors depicting certain groups as primitive or exotic, dehumanizing and defining people only as they relate to the dominant groups.
Underpreparation of Faculty

Several researchers have attributed the low levels of cultural competence among nursing students as well as practicing nurses to faulty approaches to teaching cultural competence. Byrne (2003) discusses commonly occurring faults that occur when untrained faculty teaches cultural diversity concepts. These faults include (1) faculty generalizations that occur when a subgroup of a culture is represented, but the content is generalized to all people in that cultural group (2) circular reasoning when a norm or idea is based on an exclusive category, usually defined from a dominant White male perspective, (3) mystified concepts – occurring when ideas, notions, and categories are so embedded in cultural norms that they are rarely questioned, and (4) partial knowledge resulting from the first three errors – supporting only part of a group of people without representing or including the whole group. These types of instructional bias must be interpreted and continually challenged and alleviated through the use qualified teaching faculty.

Research on Nursing Faculty’s Cultural Competence Levels

Few research studies dedicated to determining the level of cultural competence among nursing faculty were found. Of the five studies found, four addressed only baccalaureate and higher schools of nursing.

Sealy, Burnett, & Johnson (2006) examined the level of cultural competence of faculty members teaching in baccalaureate nursing programs in Louisiana. Cultural competence was measured by the scales of the Cultural Diversity Questionnaire for Nurse Educators (CDQNE). The basic organizing framework of the instrument is Campinha-Bacote’s model of cultural competence and includes items to measure cultural awareness,
cultural knowledge, cultural skills, cultural encounters, and cultural desire. The instrument also includes items that measure transcultural teaching behaviors as well as other concepts in the literature related to acceptance and acknowledgement of cultural differences.

The instrument uses a five point Likert scale for an overall measurement of cultural competence and six subscale scores including cultural awareness, cultural knowledge, cultural skills, cultural encounters, cultural desires, and cultural teaching behaviors. Respondents were asked to express their level of agreement on a five-point Likert-type scale regarding statements that addressed components of cultural competence. The interpretation of the response categories include: < 1.50 = strongly disagree; > 1.50 – 2.50 = disagree; >2.50 – 3.50 = undecided; >3.50 – 4.50 = agree; and > 4.50 = strongly agree.

Out of a sample population of 313 faculty members, 172 questionnaires were returned and 163 questionnaires were deemed usable. Data analysis revealed the following mean scores: cultural awareness M = 4.14, SD =.36; cultural desire M = 3.67, SD=.42; cultural knowledge M= 3.65, SD=.50; cultural skill = M=3.65, SD=50; cultural encounters M= 3.56, SD=.62; transcultural teaching M= 3.97, SD=.43, and overall cultural competence rating = 3.73, SD=.38.

Although the mean scores were relatively high, a closer look at the items on the subscales indicated undecided responses (M=3.0) in some areas. The cultural knowledge (M=3.65), desire (M=3.67) and skill indexes (M=3.65) indicated that the respondents agreed that they were competent in those areas. However, skills when communicating with patients with limited English language proficiency and selecting and working with
translators scored lower. The cultural encounter index (M= 3.56) was on the lower end of the “Agree” response category and was the lowest of the subscore indexes. The transcultural teaching index (M=3.97) indicated that the participants in the study responded favorable to almost all items regarding teaching transcultural nursing, but they did not strongly agree or strongly disagree with any of the items. They responded least in agreement with “I screen books, movies, and other media sources for negative cultural, racial, and ethnic stereotypes before using them…”.

Sealey et al. (2006) acknowledge that a study limitation was that data obtained are based solely on self report of the respondents. Additionally, the sample was limited to baccalaureate nursing faculty teaching in Louisiana and can only be generalized to that population. Further investigation was warranted to include nursing faculty teaching in associate and diploma nursing programs in other areas of the country.

Grossman, Massey, Blais, Geiger, et al. (1998) surveyed deans and directors of nursing programs in the culturally diverse state of Florida to determine how they promote and integrate cultural diversity. A survey questionnaire was mailed to the deans or directors of all academic nursing programs in the state. Of the 90 surveys mailed, 46 were returned. Respondents represented practical, associate, baccalaureate, and masters degree programs in nursing.

The instrument, which is described but not titled in the article, consisted of nine open ended questions and five forced choice questions. The deans and directors were asked questions related to the ethnic composition of the students and faculty, the importance of cultural diversity content in the nursing curriculum, critical issues related to cultural diversity, instructional activities on cultural diversity, barriers to and strategies
for the recruitment of ethnically diverse faculty and students, and program needs related
to cultural diversity. The instrument was examined for content validity by a panel of
experts in nursing education and transcultural nursing. Inter-rater reliability was
determined by estimating the percentage of agreement between two data coders. The
mean percentage of agreement was 90%.

The ethnic composition of the nursing students and the nursing faculty were
disproportionate with that of the Florida population. The largest discrepancy was in the
Hispanic population. The proportion of Hispanics residing in Florida at the time of the
study was 12%. However the only 5% of the students and 2% of faculty were Hispanic.
African Americans comprised 13.6 % of the state’s population, 11% of the students, and
8.2% of the faculty.

The study results revealed that although the majority of the respondents indicated
cultural diversity is reflected in their program’s philosophy, mission statement, and
conceptual framework, a lack of cultural knowledge, sensitivity, and awareness related to
cultural diversity in their programs were among the most critical issues perceived by 41%
of the respondents. In response to the question on barriers to recruiting ethnically
diverse faculty, the majority of the respondents (29%) cited an insufficient number of
qualified faculty available for recruitment as the major barrier. Major barriers to
recruitment of ethnically diverse students were cited as a lack of educational preparation
(n=14, 30%), language barriers including reading and comprehension problems (n=11,
23%), and insufficient numbers of eligible students (n=11, 23%). Grossman et al. (1998)
recognize that the data suggest that research is needed to evaluate the effectiveness of current methodology and strategies used by the nurse educators in teaching cultural diversity content.

Ryan, Carlton, & Ali (2000) conducted a descriptive research study on baccalaureate and higher degree National League for Nursing Accrediting Commission (NLNAC) accredited schools in the United States. The study examined the level of faculty preparation, development, and support in relation to culturally competent nursing care, curricular content, and cultural experiences available. Inquiries were made into the number of qualified faculty members with formal education to teach culturally competent nursing care, nursing curricula content in relation to transcultural nursing, cultural experiences that were available to the students, and the type of preparation that was done for students for transcultural field experiences.

A researcher designed questionnaire, Transcultural Nursing Care Experiences in Schools of Nursing, was used for the study. The 29 item questionnaire was reviewed by a panel of experts for content validity and scale construction. The questionnaire was also reviewed by M. Leininger, internationally recognized expert in transcultural nursing. The instrument consists of three parts; Transcultural Nursing: Approaches to Teaching, (11 items), inquiring about modules and courses along with types of preparation and follow up of students for field experiences; Transcultural Nursing: Faculty Development, (6 items) queries the frequency of faculty development programs in transcultural nursing, faculty qualifications, and preparation in transcultural nursing for teaching and guided field experience; and demographic information (9 items).
A total of 610 surveys were mailed to the deans and directors of the schools. Of the 610 surveyed, 217 (36%) responded to the survey. Of the 163 respondents to the question of whether they have sufficiently prepared faculty in transcultural nursing, 36 schools (22%) replied positively and 127 schools (78%) replied that they did not have sufficient faculty prepared in the area of cultural competence. Some 201 schools (98%) did not have specific faculty positions earmarked for teaching transcultural nursing. Of the 210 schools responding to the question on faculty development programs, 69 (33%) had conducted seminars, courses, or faculty exchange programs focused on faculty development in transcultural care in the previous five years.

Limitations of the study presented with respect to findings on faculty preparation to teach transcultural nursing courses included the small sample size, the potentially wide variations in the interpretation of faculty preparation by the respondents, and the variation in the interpretation of transcultural nursing theory.

Kelly (1991), as part of a larger study on transcultural nursing, used a descriptive research design to obtain information on faculty from colleges and universities with baccalaureate degree and higher nursing programs. The research questions included: Are nurses sufficiently prepared to have confidence in caring for ethnically diverse clients? A descriptive survey was used to collect the data. Although a copy of the instrument is included in the research report, no information regarding the development of the instrument or reliability and validity data of the instrument are available.

Forty percent of the 400 colleges and university nursing education programs in the United States were included in the sample. The survey questionnaire was sent to 160 randomly selected faculties of which 108 responded. One of the questionnaires used in
the study included questions regarding the transcultural preparation of the faculty. Questions referred to the percentage of faculty that were transculturally prepared, the type of transcultural education obtained by faculty, questions regarding foreign travel and languages spoken by the faculty, and the amount of socialization that the faculty members have had with members of minority groups.

Results of the study showed that 44% of the colleges and universities surveyed stated that they had faculty prepared in transcultural nursing. Of those faculty, 73.1% were academically prepared. Kelly (1991) acknowledges that the sample size and response rates are limitations of the study.

A descriptive study describing the cultural competence levels of nursing faculty in a Midwestern baccalaureate nursing program was conducted by Sargent, Sedlak, and Martsolf (2005). The convenience sample consisted of 51 nursing faculty members of whom most were White American (90.2%) and female. Campinha-Bacote’s Inventory for Assessing the Process of Cultural of Competence (IAPCC), a 20 item Likert scale questionnaire, was used to measure the level of self reported cultural competence. The instrument is based on Campinha-Bacote’s 1994 Culturally Competent Model of Care measuring cultural awareness, knowledge, skill, and encounters. The total score can range from 20 - 80 with a higher score depicting a higher level of cultural competence. Scores ranging from 75 – 80 indicate cultural proficiency, 60 – 74 indicate cultural competence, 40 – 59 cultural awareness, and 20 – 39 indicate cultural incompetence. The reliability of the instrument was not reported in the study. Content validity was
established through a review of the instrument by transcultural health care experts. Construct validity was established by linking the IAPCC with Campinha-Bacote’s cultural competence model.

Faculty scores on the IAPCC ranged for 43-76 (M=59.08, SD=6.957). Of the 51 faculty members, 29 (56.9%) achieved cultural awareness, 20 (39.2%) were culturally competent, and 2 (3.9%) were culturally proficient. Analysis of the instrument as used in the study indicated a Cronbach Alpha of .756.

The researchers acknowledged the use of a convenience sample within only one college of nursing was a significant limitation of the study. Also cited as limitations of the study were the homogeneity of the nursing faculty and the use of self reported cultural competence being the only measure of cultural competence.

Minimal research has been done on the cultural competence levels of nursing faculty. Research on the cultural competence levels of associate degree nursing faculty is almost nonexistent. Given the large numbers of practicing registered nurses with associate degrees as their highest level of education, it is imperative that they are adequately prepared by qualified faculty to provide culturally competent nursing care.

*The Process of Cultural Competence in the Delivery of Healthcare Services Model*

Campinha-Bacote’s Process of Cultural Competence in the Delivery of Healthcare Services Model, an integrated model approach to cultural competence for healthcare professionals, will serve as the theoretical framework for the study. The model, originally developed in 1990, blends the works of Madeline Leininger in the area
of transcultural nursing with Campinha-Bacote’s integrated knowledge from transcultural nursing, medical anthropology, multicultural counseling, transcultural psychiatry, biocultural ecology, and theology (Campinha-Bacote, 2005).

Assumptions of the Model

Assumptions of the Process of Cultural Competence in the Delivery of Healthcare Services Model include:

1. Cultural competence is a process, not an event;
2. The process of cultural competence consists of five inter-related constructs: cultural desire, cultural awareness, cultural knowledge, cultural skills, and cultural encounters;
3. The key and pivotal construct of cultural competence is cultural desire;
4. There is more variation within cultural groups than across cultural groups;
5. There is a direct relationship between health care professionals’ level of cultural competence and their ability to provide culturally competent health care services; and;
6. Cultural competence is an essential component in rendering effective and culturally responsive care to all clients.

According to the model, in order to demonstrate cultural competence, there must first exist an intrinsic motivation or cultural desire to engage in the process of cultural competence (Campinha-Bacote, 2005). Campinha-Bacote recognizes culture as a complex concept that includes knowledge, belief, arts, morals, law, custom and other habits acquired by members of a society. This model recognizes the broader definitions of culture that encompass not only racial classification and national origin but also
physical size, gender, sexual orientation, age and many others as faces of cultural diversity. Cultural competence is viewed as a process that is an essential component in rendering effective and culturally responsive care to all clients.

Constructs of the Model

Five interrelated constructs of cultural competence were identified by Campinha-Bacote (2005) representing an interdependent relationship. The key and pivotal construct of the model is cultural desire, an intrinsic motivation that is essential to the process of becoming culturally competent. Cultural desire leads to seeking cultural awareness, cultural skills, cultural knowledge, and cultural encounters.

Cultural desire. In order to demonstrate cultural competence, there must first exist an intrinsic motivation or willingness and desire from within to engage in the process of cultural competence (Campinha-Bacote 2003). There must be a genuine and authentic motivation of the health care professional to “want to” as opposed to “have to” engage in the process of becoming culturally aware, culturally skilled, culturally knowledgeable, and to seek cultural encounters. Cultural desire is the spiritual and pivotal construct of cultural competence that provides the energy source for and foundation of culturally competent care. This motivation involves the commitment to care for all clients regardless of their cultural values, beliefs, customs, or practices. It involves the commitment of personal sacrifice of one’s prejudice and biases toward culturally different clients.

Cultural awareness. Cultural awareness is the process of conducting a self examination and in-depth exploration of one’s own cultural background (Campinha-Bacote, 2003). It involves the recognition of one’s biases, prejudices, and assumptions
about individuals who are different. Without being aware of the influences of one’s own cultural values, there is a risk that the nurse may engage in cultural imposition, the tendency to impose one’s own cultural beliefs, values, and patterns of behavior upon others of a different culture. Cultural awareness also involves acquiring an awareness of the existence of documented racism and health care disparities in health care delivery.

Cultural awareness and sensitivity underpin the development of cultural competence. The environment within nursing education must be designed to broaden students’ awareness and appreciation of multiculturalism promoting sensitivity and commitment to multicultural concepts.

*Cultural skill.* Cultural skills involve the ability to collect relevant cultural data regarding the client’s presenting problem and accurately conduct a culturally based physical assessment (Campinha-Bacote 2003). Cultural skill represents the ability to systematically collect culturally relevant information about the client’s health and interpret the information for the purpose of culturally congruent interventions. The nurse’s approach must be done in a culturally sensitive manner, utilizing interpersonal skills, acceptance and respect for the client, and clinical and diagnostic skills informed by cultural knowledge

Campinha-Bacote (2003) presents an integrated model approach to conducting cultural assessments and purports that a wide selection of cultural assessment tools can be used across health care disciplines and integrated into existing health history or assessment forms. Using this approach, culture is not singled out but incorporated into
the client’s overall assessment. It allows the healthcare professional to review selected cultural assessment tools and incorporate selected questions that will augment the existing assessment to yield relevant cultural data.

Twelve domains are addressed in the model that are to be considered when assessing a client’s cultural background (Campinha-Bacote, 2003). These domains include: (a) inhabited localities and topography - heritage and residence, reasons for migration, and associated economic factors, education status and occupation; (b) communication - including language, dialect, communication patterns, temporal relationships and formats for names; (c) family roles and organization – family roles and priorities, issues surrounding gender and head of household, traditional families, and alternative lifestyles; (d) workforce issues – differences and conflicts that occur in the workplace setting and issues related to professional autonomy; (e) biocultural ecology – physiological and biological variations; (f) high risk health behaviors – specific behaviors common among the cultural group; (g) nutrition – the meaning of food, food rituals, dietary practices and common nutritional deficiencies; (h) pregnancy and childbearing practices - including birthing and postpartum care; (i) death rituals – including views on death and euthanasia, rituals to prepare for death, burial practices and bereavement; (j) spirituality – religious affiliation and practices, the use of prayer, the meaning of life, individual sources of strength, and spiritual beliefs and health care practices related to those beliefs; (k) health care practices – health seeking behaviors and beliefs, barriers to health care, and cultural responses to health and illness; and (l) health care practitioners – status, use and perceptions of traditional magico-religious practitioners and biomedical health care professionals.
Cultural knowledge. Cultural knowledge is the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups. It involves understanding world views of different cultures and ethnic groups, biological variations, treatment efficacy, disease prevention, health conditions, interaction styles within cultural groups, and other meaningful data necessary to understand the variations across cultural/ethnic groups. In obtaining cultural knowledge, the model stresses that it is critical to remember the concept of intra-cultural variation; that there is more variation within cultural groups than across cultural groups. Each individual is a unique blend of the diversity found within each culture, based on life experiences and acculturation into other cultures. As the nurse begins to understand the values, beliefs, practices and problem solving strategies of diverse groups, he/she is able to gain confidence during encounters with them.

Cultural encounters. Cultural encounters are the face to face cultural interactions with clients from culturally diverse backgrounds. Cultural encounters provide primary and experiential exposure to cross cultural interactions. This allows the nurse to refine or modify existing beliefs about a cultural group and prevent possible stereotyping. The nurse must be cognizant of the fact that when interacting with only a few members of a cultural group, these members may not be representative of the beliefs, values, and practices of their specific cultural group and that limited interaction does not make one an expert on the cultural group. Cultural exposure leads to further reflection and integration of learning about culturally congruent care and its delivery (Campinha-Bacote, 2003).
Analysis of the Model

Campinha-Bacote (2003) presents a comprehensive integrated model that addresses the constructs and concepts required for healthcare professionals to develop cultural competence. The first version of the model was developed by Campinha-Bacote in 1991 and included only four constructs; cultural awareness, cultural knowledge, cultural skills, and cultural encounters. The model was expanded in 1998 to include the construct of cultural desire and to redefine and expand the construct of cultural knowledge. From 1998 to 2002 Campinha-Bacote further developed and refined the model specifically in the area of cultural desire.

The Process of Cultural Competence in the Delivery of Healthcare Services Model follows a logical process that is consistent with its underlying goals. The concepts of cultural desire, awareness, knowledge, skills, and encounters are clearly defined. The model is comprehensive using an integrated and multidisciplinary approach to providing culturally competent care. Drawing from the works of M. Leininger in the area of transcultural nursing, P. Pedersen in the area of multicultural counseling, A. Klienman in the area of transcultural psychiatry, and E. Law in the area of theology, the concepts and goals of the model address both valuing diversity and managing diversity.

The potential of the theory to have a substantial impact and continuing influence on the development of new ideas, professional practice, and research is crucial (Brathwaite, 2003). The Process of Cultural Competence in the Delivery of Healthcare Services Model has been widely used to provide direction for research, education, and clinical practice. Application of the model has been demonstrated in various nursing
and healthcare specialties in the care of clients from various cultural backgrounds (Law & Muir, 2006; Sargeant, Sedlak, & Martsof, 2005; Marcinkiw, 2003; Warren, 2002; Brathwaite, 2003).

The Cultural Diversity Questionnaire for Nurse Educators

From Campinha-Bacote’s Process of Cultural Competence in the Delivery of Healthcare Services Model, Sealey (2003) developed the Cultural Diversity Questionnaire for Nurse Educators (CDQNE). Sealey (2003) developed and implemented the questionnaire during a research study on the cultural competence level of baccalaureate faculty in Louisiana in 2003. The results of the research study and the instrument were further discussed and analyzed by Sealey, Burnett, and Johnson (2006).

A preliminary version of the instrument consisting of 60 items was field tested using nursing faculty not currently teaching in baccalaureate nursing programs. Participants were nurse educators teaching in associate degree and diploma programs as well as nurse clinicians (Sealey, 2003). The field test was conducted to determine the clarity of the instructions for completing the questionnaire, the clarity of the items on the questionnaire, the existence of inconsistencies in interpreting the meaning of the individual items on the questionnaire, the comfort level of the respondents with the items, and the length of time it took to complete the questionnaire. The instrument was revised by Sealey based on the results of the field test as well as on the basis of the blueprint developed to ensure that the items on the questionnaire addressed the content areas necessary to measure each component of cultural competence.

The CDQNE was then reviewed by a panel of experts to ensure content validity. All items were deemed appropriate to the content they were intended to address.
according to the blueprint. Repetitive items were eliminated and other items were reworded and reordered to improve the clarity and overall flow of the questionnaire.

A factor analysis was conducted by Sealy, following the study on baccalaureate nursing faculty, on each of the subscales to determine how well each item fit on each subscale. As a result of this analysis, fourteen items that did not meet the criteria for retention (factor loading of ≤ .3) were deleted from the analysis of the study. The alpha coefficient for the CDQNE was calculated at .8287.

To date, the CDQNE has not been utilized in any other research studies (Sealey, 2007). It was chosen as the instrument for this study for several reasons. The basic organizing framework of the CDQNE is Campinha-Bacote’s model of cultural competence which serves as the organizing framework for this study. The CDQNE includes items to measure cultural awareness, cultural knowledge, cultural skills, cultural encounters, cultural desire, as other concepts in the literature related to acceptance and acknowledgement of cultural differences. Although several instruments designed to measure the cultural competence levels of nurses were found in the literature, the CDQNE is the only instrument found in the literature reviewed that includes items that measure transcultural teaching behaviors as well.

Summary

The cultural diversity challenge in nursing involves developing comprehensive curriculum designs that are inclusive of and sensitive to cultural diversity issues. The end result should create a change in health care behaviors from the perspective of the health care providers and recipients.
To meet this challenge, nursing faculty must not only maintain culturally competent perceptions, attitudes, behaviors, knowledge, and skills in themselves, but also serve as role models and possess the desire and ability to cultivate these attributes in the nursing students as well. The current level of these attributes and competencies among nursing faculty, particularly in associate degree nursing programs, is not well documented in the nursing literature. This study addresses the level of cultural competence of nursing faculty teaching in associate degree nursing programs in Ohio. By examining these competency levels, the need for faculty cultural diversity education and training in areas of valuing diversity and managing diversity can be assessed.
CHAPTER III
METHODOLOGY

This study addresses the level of cultural competence among nurse educators teaching in associate degree nursing programs in Ohio. This chapter presents the demographic and professional characteristics of the participants and the procedures used for conducting the study. The types of educational institutions in which associate degree nursing programs are located and the accessible population are described. The preliminary procedures, data collection procedures, procedures for human rights protection, data collection instrument, and data analysis procedures are described.

Two research questions are the focus of this study. The research questions are as follows.

1. What is the level of cultural competence of the nursing faculty teaching in associate degree nursing programs in Ohio as measured by the scales of the Cultural Diversity Questionnaire for Nurse Educators - Revised?

2. To what extent does nursing faculty teaching in associate degree nursing programs in Ohio include transcultural nursing concepts in the courses they teach as measured by the scales of the Cultural Diversity Questionnaire for Nurse Educators - Revised?
Procedures

The Cultural Diversity Questionnaire for Nurse Educators-Revised (CDQNE-R) was used to determine the level of cultural competence of nurse educators teaching in associate degree nursing programs in Ohio and the extent to which those nurse educators include transcultural nursing concepts in the courses they teach. The CDQNE-R was administered electronically via the Internet. Data collection took place during the 2008 spring semester.

Preliminary Procedures

Four general preliminary procedures took place before the CDQNE-R was administered. The preliminary procedures included: (a) development of the data bases; (b) input of the CDQNE-R into Checkbox ®; (c) evaluation of the online survey procedures; and (d) creation of cover letters.

The first preliminary procedure included the development of data bases for the associate degree nursing program deans/directors and for the faculty participants. A data base was created that contained the names of forty nursing deans/directors of associate degree nursing programs in Ohio along with their campus mailing addresses and telephone numbers. Information was obtained from nursing schools’ Internet sites, the Ohio Associate Degree Nursing Deans and Directors list serve, or personal contact with a representative from the school.

A second data base was created that contained the names of 538 full-time nursing faculty members teaching in an associate degree nursing program in Ohio, their campus
mailing addresses, and their electronic mailing addresses. The contact information was obtained from the individual nursing school’s Internet web site and some were confirmed through telephone contact with the program dean/director.

The second preliminary procedure was to input the CDQNE-R into Checkbox ® through the University of Akron’s internet web site. Checkbox® is the web based survey designer and feedback system that was used to administer the CDQNE-R online. Once the CDQNE-R was entered into Checkbox ®, the appropriate start and end dates were entered that provided a three week period to complete the survey. Access to the questionnaire was password protected to restrict access to the accessible population. Participants were provided a group access password in the electronic invitations that was required to proceed to the questionnaire once they entered the Checkbox® website.

The third preliminary procedure involved two evaluation procedures; a one-on-one evaluation of the online procedure and a face-to-face evaluation of the questionnaire completion process. A one-on-one evaluation was conducted online with three associate degree nursing faculty members regarding technical issues that may affect acquiring and completing the survey, and the amount of time it takes to complete the survey. The three faculty members completed the online questionnaire and submitted their responses to the Checkbox ® site. During individual follow up meetings, the preliminary participants were asked a series of questions pertaining to the online procedure regarding technical issues with acquiring, completing, or submitting the survey. Each participant reported no difficulties with the survey directions or procedures. The survey completion times ranged from seven to eleven minutes.
A face-to-face evaluation of the procedure was conducted with three additional associate degree faculty members during separate interviews. Questions were asked of each faculty participant regarding the clarity of the instructions, page design, and font size. No issues or concerns were noted during the evaluation sessions. Consequently, no modifications were made to the online procedures based on these two evaluations.

The last preliminary procedure was to create cover letters that were sent to the deans/directors of the associate degree nursing programs and to the full-time associate degree nursing faculty members. The letters to the deans/directors (see Appendix A) introduced the researcher, discussed the nature and purpose of the research study, and requested their cooperation in encouraging their full-time nursing faculty members to participate in the study. The letter also requested that the deans/directors distribute the cover letters that would be sent to them in a packet to the nursing faculty members. Each letter in the packet was individually addressed to a faculty member. The letters to the faculty members (see Appendix B) introduced the researcher, explained the nature and purpose of the research study and invited them to participate by completing the upcoming online survey. The letter also provided them information regarding the anonymity of the study participants, the benefits of participating in the study, the estimated questionnaire completion time, The University of Akron IRB approval and contact information, and researcher contact information.

*Data Collection Procedures*

The data collection procedures involved four steps: (a) contacting the deans/directors of the associate degree nursing programs in advance; (b) sending packets
of letters to the deans/directors to distribute to faculty members; (c) sending the
electronic or mail invitations to the accessible population to participate in the study; and
(d) sending follow up notices.

The first step of the data collection procedure was to contact the deans/directors
of associate degree nursing programs in Ohio in the form of a cover letter. The letters
were sent to 40 deans/directors at their campus mailing addresses. Follow-up telephone
calls were made to all 40 deans/directors seven to ten days after the mailing of the letters
to confirm receipt of the letter, their willingness to distribute letters to the individual
nursing faculty members, and the names of the full-time faculty members teaching in
their associate degree nursing program. Positive responses regarding the distribution of
the letters to the full-time nurse educators teaching in the associate degree programs were
received from 37 deans/directors. The dean of one nursing school requested that the
questionnaire be electronically mailed to the faculty members without the preliminary
faculty letter due to the closeness of the date that the faculty would be leaving the campus
for the summer. The dean of another nursing school requested that the packet of letters
not be sent to her until she received permission from her school’s Institutional Review
Board for the faculty to participate in the study. However, no follow-up response was
received from the school and neither the packet of letters nor the electronic
questionnaires were mailed to the school. A third director from a private career training
institution did not respond to the letter or telephone messages.

The second step involved sending the packet of letters to 37 nursing
dean/directors to distribute to their full-time associate degree nurse educators. Letters
were sent directly to individual faculty members teaching in one private career institution
where the nursing director did not respond. None of the deans/directors contacted, other than the dean with the IRB concern, refused to or were unable to distribute the letters.

The third step of the data collection procedure was to send an electronic invitation to complete the CDQNE-R to 538 members of the accessible population. Instructions for gaining access to the Checkbox® website and the questionnaire were included in the invitation. The link to access the CDQNE-R in Checkbox was provided in the electronic mail notification. Instructions included directions for cutting and pasting the Checkbox® address into the URL if the respondent was unable to open the link provided to access the CDQNE-R. Thirty-three invitations were returned as undeliverable decreasing the accessible population to 505.

A paper-and-pencil version of the invitation and the CDQNE-R was available to be sent to the campus mailing addresses of any potential participants that did not have electronic mail accounts or access to a computer. However, all known accessible participants had an electronic mailing address and none of the potential participants contacted the researcher electronically to request a pencil-and-paper version of the questionnaire.

The last steps of the data collection procedure were to send reminder/follow up notices to the electronic mail account of all members of the accessible population who had not responded to the initial invitation. Research supports a 20% increase in survey responses after the first follow-up notice and another 12% increase in respondents after the second follow-up notice (Gall, Gall, & Borg, 2003). Eighty-two respondents completed the questionnaire following the initial invitation to take the CDQNE-R constituting a 16% return rate. The first reminder/follow-up notice was sent to 423
nonrespondents one week following the initial invitation. Thirty-three participants responded to the first reminder/follow-up notice increasing the total response rate to 22.7%. The second reminder/follow-up notice was sent two weeks from the date of the initial invitation to the remaining 390 members of the accessible population. Twenty-two participants completed the CDQNE-R bringing the response rate to 27%. Due to the fact that the end of the spring semester or quarter was occurring in most of the educational institutions, no further reminders were sent.

Instrument

The psychometric review of the CDQNE presented in chapter two discusses the reliability and validity of the instrument. Permission was obtained from Dr. Sealey (see Appendix C) to use and modify the CDQNE for the study as needed. Based on the factor analysis of each of the subscales conducted by Sealey (2003), the fourteen items with low factor loading scores that did not meet the criteria set for retention at \( \leq 3 \) were deleted from the instrument for the current study. Additionally, Sealey (2003) found that most of the items that did not fit on the subscales were negatively stated items. Consequently, the negatively stated items were reworded to read as positive statements to decrease the risk of the items being confusing to the respondents. The electronic mail correspondence from Dr. Sealey granting permission to modify and use the CDQNE is included in Appendix C.

The CDQNE-R is comprised of two sections. The first section of the instrument includes forty-one items addressing concepts identified in the literature as being significant to cultural competence. The respondents were asked to indicate for each item if they strongly agree, agree, are undecided, disagree, or strongly disagree. A numerical
value was assigned to each response with strongly agree having a value of 5, agree having a value of 4, undecided having a value of 3, disagree having a value of 2, and strongly disagree having a value of 1.

The forty-one items in the first section of the CDQNE-R are organized into five subscales according to the component of cultural competence that is addressed. The cultural awareness subscale includes eight items; the cultural knowledge subscale includes eleven items; the cultural skills subscale includes eight items; the cultural encounters subscale includes six items; and the cultural desire subscale includes eight items.

Eleven items on the CDQNE-R form the transcultural teaching behaviors subscale. These items are specifically related to the respondents’ behaviors and practices with students in the classroom and skills laboratory as well as in the clinical practice areas. Items forming the transcultural teaching behaviors subscale are embedded within the other five subscales. Appendix D presents the individual questionnaire items in each subscale of the instrument. The blueprint for the instrument is included in Appendix E.

The second section of the instrument includes nine questions regarding demographic and professional characteristics of the respondents. A copy of the CDQNE-R is included in Appendix F.

Procedure for Human Rights Protection

Prior to implementation of the study, the proposal was submitted to The University of Akron Institutional Review Board (IRB) for approval. The study was approved and given exemption status due to the protocol of the study representing minimal risk to the subjects. The cover letter requesting participation in the study
included information regarding (a) the nature and purpose of the study; (b) the anonymity of the participants; (c) the benefits of participating in the study; (d) the estimated questionnaire completion time; (e) The University of Akron IRB approval and contact information; and (f) researcher contact information.

Participants

Associate degree nursing programs in Ohio are located in four types of educational institutions; community/technical colleges, N=21; private career training institutions, N=9; colleges and universities, N=8; and hospital affiliated schools N=2. A comparison of the accessible population of associate degree nurse educators in Ohio and the responding nurse educators by institution type is presented in Table 3.1.

Information regarding institution type and numbers of potential participants was obtained from the schools’ Internet web sites and through personal contact with school representatives. Currently, there are forty associate degree nursing programs in Ohio with full or conditional approval granted by the Ohio Board of Nursing (Ohio Board of Nursing, 2007). Among the forty programs, twenty-one are located in two year community/technical colleges, nine are located in private career training institutions, eight are located within colleges and universities, and two are hospital affiliated schools.

The accessible population includes 505 full-time nurse educators teaching in associate degree nursing programs in Ohio in community/technical colleges, private career training institutions, four year colleges and universities, and hospital affiliated schools. The nurse educators are teaching in classroom, laboratory, and/or clinical settings. One hundred percent of the sample was sought for the study.
Table 3.1 Accessible and Responding Ohio Associate Degree Nurse Educator Population by Institution Type

<table>
<thead>
<tr>
<th>Type of Institution</th>
<th>Accessible Ohio Associate Degree Nurse Educator Population By Institution Type</th>
<th>Responding Ohio Associate Degree Nurse Educator Population By Institution Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community/Technical Colleges</td>
<td>320</td>
<td>91</td>
</tr>
<tr>
<td>Private Career Training Institutions</td>
<td>35</td>
<td>3</td>
</tr>
<tr>
<td>Colleges and Universities</td>
<td>115</td>
<td>19</td>
</tr>
<tr>
<td>Hospital Affiliated Schools</td>
<td>35</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>505</td>
<td>137</td>
</tr>
</tbody>
</table>

Faculty Demographic and Professional Characteristics

The race/ethnicity, gender, and age characteristics of the nurse educators participating in this study are presented in Table 3.2. Most of the respondents were White American females between the ages of 45 and 64 years. After White Americans, (N=124, 90.51%), Black/African Americans (N=9, 6.57%) comprised the second largest racial group followed by Hispanic Americans (N=1, .73%).

Table 3.3 presents the professional characteristics of the participants regarding their highest academic degree, academic rank, and the number of years in nursing education. The majority of the participants (N=121, 88.32%) hold a master’s degree as their highest academic degree. A master’s degree is the requirement for nursing faculty teaching in an associate degree program in Ohio. The most frequent academic rank held is at the assistant professor level (N=53, 38.69%). This ranking is
Table 3.2  Demographic Characteristics: Race/Ethnicity and Age of Participating Ohio Associate Degree Nurse Educators. (N=137)

<table>
<thead>
<tr>
<th>Demographic Data</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White American (Non-Hispanic)</td>
<td>124</td>
<td>90.51</td>
</tr>
<tr>
<td>African American</td>
<td>9</td>
<td>6.57</td>
</tr>
<tr>
<td>Asian American</td>
<td>2</td>
<td>1.46</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1</td>
<td>0.73</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islander</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.73</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>133</td>
<td>97.08</td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>2.92</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 35 years</td>
<td>6</td>
<td>4.41</td>
</tr>
<tr>
<td>35-44 years</td>
<td>22</td>
<td>16.18</td>
</tr>
<tr>
<td>45-54 years</td>
<td>54</td>
<td>39.71</td>
</tr>
<tr>
<td>55-64 years</td>
<td>47</td>
<td>34.56</td>
</tr>
<tr>
<td>65-69 years</td>
<td>6</td>
<td>4.41</td>
</tr>
<tr>
<td>70+ years</td>
<td>1</td>
<td>0.74</td>
</tr>
</tbody>
</table>

commensurate with the large number of responses to years teaching in a nursing program in the less than nine years category. The largest response to years teaching in a nursing program is in the less than five years group (N=33, 24.09%) and the 5-9 year group (N=32, 23.36%). This is reflective of the large numbers of retiring faculty both nationally and statewide whose faculty positions are being filled by new faculty members.
Table 3.3 Professional Characteristics: Highest Academic Degree, Academic Rank, and Years Teaching in Nursing Education

<table>
<thead>
<tr>
<th>Professional Characteristics</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest Academic Degree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baccalaureate Degree</td>
<td>12</td>
<td>8.76</td>
</tr>
<tr>
<td>Masters Degree</td>
<td>121</td>
<td>88.32</td>
</tr>
<tr>
<td>Doctoral Degree</td>
<td>4</td>
<td>2.92</td>
</tr>
<tr>
<td>Academic Rank</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instructor</td>
<td>30</td>
<td>21.90</td>
</tr>
<tr>
<td>Assistant Professor</td>
<td>53</td>
<td>38.69</td>
</tr>
<tr>
<td>Associate Professor</td>
<td>25</td>
<td>18.25</td>
</tr>
<tr>
<td>Full Professor</td>
<td>29</td>
<td>21.17</td>
</tr>
<tr>
<td>Years Teaching in Nursing Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 5 years</td>
<td>33</td>
<td>24.09</td>
</tr>
<tr>
<td>5 – 9 years</td>
<td>32</td>
<td>23.36</td>
</tr>
<tr>
<td>10 – 14 years</td>
<td>10</td>
<td>7.30</td>
</tr>
<tr>
<td>15 – 19 years</td>
<td>21</td>
<td>15.33</td>
</tr>
<tr>
<td>20 – 24 years</td>
<td>16</td>
<td>11.68</td>
</tr>
<tr>
<td>25 or more years</td>
<td>25</td>
<td>18.25</td>
</tr>
</tbody>
</table>

Two-thirds of the participants (N=91, 66.42%) reported teaching in an associate degree nursing program that is located in a community or technical college. One-half of the associate degree nursing programs in Ohio (N=21, 52.5%) are located in community or technical colleges where the largest population of nurse educators is located. The fewest number of participants (N=3, 2.19%) reported teaching in private career training institutions where the faculty comprise only 8% of the accessible population. Just over one-half of the participants (N=58, 42.34%) reported teaching in the second year of the nursing program although one-third (N=46, 33.58%) reported teaching in both the
first and second years. Characteristics related to the type of educational institution in which the nursing program is located and the level of the nursing program in which the participants teach are presented in Table 3.4.

Table 3.4 Participants by Type of Institution in Which Program is Located and Program Level Taught

<table>
<thead>
<tr>
<th>Institution Type</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community/Technical College</td>
<td>91</td>
<td>66.42</td>
</tr>
<tr>
<td>Hospital Affiliated Institution</td>
<td>24</td>
<td>17.52</td>
</tr>
<tr>
<td>Four Year College/University</td>
<td>19</td>
<td>13.87</td>
</tr>
<tr>
<td>Private Career Training Institution</td>
<td>3</td>
<td>2.19</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program Level Taught</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Year</td>
<td>33</td>
<td>24.09</td>
</tr>
<tr>
<td>Second Year</td>
<td>58</td>
<td>42.34</td>
</tr>
<tr>
<td>Both First and Second Year</td>
<td>46</td>
<td>33.58</td>
</tr>
</tbody>
</table>

Population Validity and Generalizability

Although the response rate was only 27%, these demographics are typical of the professional nursing population in the United States and in Ohio. While all minorities combined comprise 30% of the nation’s population, they account for only 12% of the nation’s nurses (American Association of Colleges of Nursing, 2007). Ohio’s nursing workforce is 94.4% White American, 4.3% Black/African American, and 0.7% Hispanic American (Ohio Board of Nursing, 2007). Ohio’s nursing education workforce is 96.3% White American, 3% Black/African American, and 0.9% “Other”. The participants in
this study identified themselves as White American, N= 90.51%; Black/African American, N= 6.57%; Asian American N=1.46%; Hispanic American, N=.73%; and Other, N= .73%.

There were 133 (97.08%) female respondents and 4 (2.92%) male respondents. Nursing continues to be a predominantly female profession. In Ohio, 96% of professional nurses are female and 4% are male (Ohio Board of Nursing, 2007). Among nurse educators in Ohio, 98.3% are female and 1.7% are male. These demographics closely resemble the demographics of the participants in this study who were 97.08% female and 2.92% male.

The aging of the nursing workforce is also reflected in the study demographics. The largest number of respondents were in the 45-54 year (N=54, 39.71%) and the 55-64 year (N=47, 34.56) ranges. The median age for nursing faculty in the United States is 51.2 years (American Association of Colleges of Nursing, 2005) and the median age for nursing faculty prepared at the master’s level is 48.8 years. The majority of the nursing workforce in Ohio is over the age of 45 (Ohio Board of Nursing, 2007).

**Data Analysis**

The collected data were exported into an excel file. Using SAS, a program was written to read the data, create subscales, and calculate the alpha coefficient. The appropriate descriptive statistics were calculated. The following is a description of the procedures that were used to analyze the data collected regarding each research question:

**Question 1.** The first question addresses the level of cultural competence of nursing faculty teaching in associate degree nursing programs in Ohio as measured by their responses to the items on five of the subscales of the CDQNE-R: (1) the cultural
awareness subscale, (2) the cultural knowledge subscale, (3) the cultural skills subscale, (4) the cultural encounters subscale, and (5) the cultural desire subscale. Measures of central tendency and variability were computed for each of the cultural subscales as well as for the overall cultural competence scale.

**Question 2.** The second question addresses the extent to which faculty teaching in associate degree nursing programs in Ohio include transcultural nursing concepts in the courses they teach. This was measured by their responses to the eleven items included in the transcultural teaching behaviors subscale of the CDQNE-R that specifically describe teaching behaviors exhibited by the respondents that relate to transcultural issues. Measures of central tendency and variability were computed for each of the cultural subscales as well as for the overall cultural competence scale.

**Summary**

This chapter describes the methods and procedures used to conduct a study that describes the level of cultural competence of the nursing faculty teaching in associate degree nursing programs in Ohio and the extent to which nursing faculty teaching in associate degree nursing programs in Ohio include transcultural nursing concepts in the courses they teach. The demographics of the sample are described using data from each respondent’s survey. Additionally, this chapter provided details of the preliminary research procedures, data collection procedures, the instrument, procedure for human rights, and data analysis.

Findings from this study will contribute to the current body of nursing literature by providing information on the trends and differences in the levels of cultural competence among associate degree nursing faculty in Ohio. The findings will provide a
better understanding of the professional development needs of nursing faculty in the area of cultural diversity by identifying faculty areas of strengths and areas of needed growth.
CHAPTER IV

RESULTS

This chapter presents the results of the research study describing the cultural competence levels of Ohio associate degree nurse educators and the degree to which they include cultural content in the courses they teach as measured by the scales of the Cultural Diversity Questionnaire for Nurse Educators – Revised (CDQNE-R). The reliability statistics are presented followed by the scores obtained on the CDQNE-R and its six subscales.

Reliability Statistics

Cronbach’s alpha coefficient was used to determine the internal consistency of the subscales and the overall CDQNE-R. Table 4.1 presents the Cronbach’s alpha coefficient for the CDQNE-R and its subscales. All values indicate an acceptable level of reliability. Rewording of all negatively stated items on Sealey’s (2003) CDQNE may have contributed to the higher alpha coefficient of the overall Cultural Competence Scale as well as four of the six subscales.

Cultural Competence Levels

The first research question addressed the level of cultural competence of nursing faculty teaching in associate degree nursing programs in Ohio as measured by the scales of the CDQNE-R. Each subscale was designed to measure a component of cultural
Table 4.1 Cronbach’s Alpha Coefficient for the CDQNE-R and Subscales

<table>
<thead>
<tr>
<th>Scale</th>
<th>Cronbach’s Alpha Coefficient</th>
<th>Cronbach’s Alpha Coefficient Sealey (2003)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Awareness Subscale</td>
<td>.77</td>
<td>.63</td>
</tr>
<tr>
<td>Cultural Knowledge Subscale</td>
<td>.85</td>
<td>.82</td>
</tr>
<tr>
<td>Cultural Skills Subscale</td>
<td>.77</td>
<td>.69</td>
</tr>
<tr>
<td>Cultural Encounters Subscale</td>
<td>.66</td>
<td>.68</td>
</tr>
<tr>
<td>Cultural Desire Subscale</td>
<td>.74</td>
<td>.76</td>
</tr>
<tr>
<td>Cultural Teaching Behaviors Subscale</td>
<td>.84</td>
<td>.79</td>
</tr>
<tr>
<td>Overall Cultural Competence Scale</td>
<td>.93</td>
<td>.83</td>
</tr>
</tbody>
</table>

competence. The subscales were (a) The Cultural Awareness Scale; (b) The Cultural Knowledge Scale; (c) The Cultural Skills Scale; (d) The Cultural Encounters Scale; and (e) The Cultural Desire Scale. The respondents expressed their level of agreement with the items on each of the subscales. The responses were rated as 5 = Strongly Agree, 4 = Agree, 3 = Undecided, 2 = Disagree, and 1 = Strongly Disagree. A rating of “1” was considered the least favorable response and a rating of “5” was considered the most favorable response. The following categories, established by Sealey (2003), were used to interpret the responses: Strongly Agree = 4.6 – 5, Agree = 3.6 - 4.5, Undecided = 2.6 - 3.5, Disagree = 1.6 – 2.5, and Strongly Disagree = 1 - 1.5. An index was created for each subscale by computing the mean of the respondents’ scores on the combined items of each subscale.
Table 4.2 presents the scores of five of the subscales of the CDQNE-R: The Cultural Awareness Subscale, The Cultural Knowledge Subscale, The Cultural Skill Subscale, The Cultural Encounters Subscale, and The Cultural Desire Subscale.

### Table 4.2   CDQNE-R Subscale Scores of Ohio Associate Degree Nurse Educators

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Awareness Index</td>
<td>4.36</td>
<td>.45</td>
</tr>
<tr>
<td>Cultural Desire Index</td>
<td>4.10</td>
<td>.48</td>
</tr>
<tr>
<td>Cultural Skill Index</td>
<td>3.79</td>
<td>.54</td>
</tr>
<tr>
<td>Cultural Knowledge Index</td>
<td>3.75</td>
<td>.57</td>
</tr>
<tr>
<td>Cultural Encounters Index</td>
<td>3.34</td>
<td>.70</td>
</tr>
</tbody>
</table>

The highest indexes were on the Cultural Awareness Subscale (M=4.3, SD=.45) and the Cultural Desire Subscale (M=4.10, SD=.48). The Cultural Awareness Subscale addresses the recognition of one’s own biases, prejudices, and assumptions regarding individuals who are different from oneself. It also involves the awareness of documented racism and disparities in health care delivery. The Cultural Desire Subscale addresses the motivation and commitment to become culturally competent. The results indicate that the participants agree that they are culturally aware of and are motivated and committed to becoming culturally competent.

The Cultural Skill Subscale and The Cultural Knowledge Subscale indicate that participants agree that they are competent in the areas of cultural skill (M=3.79, SD=54) and cultural knowledge (M=3.75, SD=.57). Cultural skill involves the ability to collect and interpret culturally relevant information about the client’s health for the purpose of
providing culturally competent care. Cultural knowledge includes meaningful information about diverse cultural and ethnic groups that is necessary to provide culturally competent care. Participants scored lowest on The Cultural Encounters Subscale. This subscale is related to the face-to-face interactions with persons from different cultures in professional and social situations. Participants reported that they are undecided (M=3.34, SD=.70) regarding face to face interactions with culturally diverse persons.

The subscale indexes of this study are consistent with those of Sealey (2003) in a study of cultural competence levels of baccalaureate degree nurse educators in Louisiana. Sealy (2003) found cultural awareness as the highest subscale score, followed by cultural desire, cultural knowledge and skill, and cultural encounters scoring the lowest. No other studies using the CDQNE were found in the literature.

The second research question addressed the extent to which nursing faculty teaching in associate degree programs in Ohio include transcultural nursing concepts in the courses they teach as measured by The Transcultural Teaching Behaviors Subscale. This subscale addresses commitment to teaching cultural knowledge and cultural skills, promoting cultural awareness, providing culturally diverse clinical opportunities for students, and the screening of course media sources for appropriate culturally diversity material. The data show that the participants agree (M=4.06, SD=.51) that they include transcultural nursing concepts and use appropriate media resources in the courses they teach. Sealey (2003) also found that the transcultural teaching index was among the highest of the subscale scores.
An overall measure of cultural competence shows that faculty agree (M=3.88, SD=.45) that they possess cultural awareness, cultural knowledge, cultural skills, and culture desire; seek out cultural interactions; and include transcultural concepts in the courses they teach. This is comparable to Sealey’s (2003) Overall Cultural Competence Index of 3.73.

**Summary**

The literature suggests that to improve the overall health status of culturally diverse groups in this country, the provision of culturally competent health care is essential. Additionally, nurse educators must be adequately prepared to teach and role model cultural competence. As such, this study centered on the cultural competence levels of associate degree nurse educators in Ohio and the extent to which they include cultural content in the courses they teach. Findings from this study revealed that associate degree nurse educators in Ohio perceived themselves as being culturally competent in most categories and include cultural content in the courses they teach.

In the next chapter, the findings of this study will be discussed according to the subscales of the CDQNE-R; cultural awareness, cultural knowledge, cultural skills, cultural encounters, cultural desire; and cultural teaching behaviors.
CHAPTER V
DISCUSSION

The purpose of this study was to describe the level of cultural competence of associate degree nurse educators in Ohio and the degree to which they include transcultural nursing concepts in the courses they teach. The Cultural Diversity Questionnaire for Nurse Educators – Revised was the instrument used to provide descriptions of cultural competence levels. The questionnaire was sent to 505 associate degree nurse educators in Ohio teaching in community/technical colleges, private career training institutions, four year colleges and universities, and hospital affiliated schools.

This chapter contains four sections. The first section provides a discussion of the findings of the CDQNE and its subscales. The second section provides a discussion on the limitations of the study. The third section discusses implication for nursing education. The final section provides recommendations for future research.

This study sought to measure the cultural awareness, knowledge, skills, encounters, desire, and teaching behaviors of associate degree nurse educators that are needed to appropriately respond to issues of diversity in the health care system in the United States. The following research questions guided the study.

1. What is the level of cultural competence of the nursing faculty teaching in associate degree nursing programs in Ohio as measured by the scales of the Cultural Diversity Questionnaire for Nurse Educators - Revised?
2. To what extent does nursing faculty teaching in associate degree nursing programs in Ohio include transcultural nursing concepts in the courses they teach as measured by the scales of the Cultural Diversity Questionnaire for Nurse Educators - Revised?

Discussion of the Findings

The population of this study was defined as associate degree nurse educators teaching full-time in schools of nursing in Ohio. This population was chosen because associate degree nursing programs comprise the majority of the nursing programs in Ohio and most of the nursing graduates in Ohio are from associate degree nursing programs. This section will present the major findings regarding the cultural competence levels of the study participants as measured by their responses to items on the overall CDQNE-R and each of the six subscales. The responses were interpreted based on the following scale: Strongly Agree = 4.6 - 5, Agree = 3.6 - 4.5, Undecided = 2.6 - 3.5, Disagree = 1.6 – 2.5, and Strongly Disagree = 1 - 1.5.

Cultural Awareness

The first major finding involved the respondents’ level of agreement with statements regarding their cultural awareness. The Cultural Awareness Subscale addresses the recognition of personal biases, prejudices, and assumptions regarding individuals who are different. It also addresses the awareness of cultural bias and disparities in the health care delivery system. The process of gaining cultural awareness is essential to the development of cultural sensitivity and cultural competence (Caminha Bacote, 2003).
The cultural awareness index in this study was the highest of all of the subscale scores (M=4.36) and indicates that the respondents “agree” that they are aware of and appreciative of cultural diversity issues. This subscale includes statements regarding awareness of biological variations, cultural differences in perceptions of health and illness, and awareness of personal attitudes toward culturally diverse persons. This finding is notable taking into consideration that 90% of the participants were White American. A lack of awareness of the need to adapt to diversity was noted by Robins et al. (2006) as a chief barrier to cultural competence.

Cultural awareness is necessary to create an environment within nursing education that is designed to broaden awareness and appreciation of cultural diversity (Campinha-Bacote, 2003). Cultural awareness involves self examination and exploration of one’s own cultural background and cultural values, decreasing the risk of cultural imposition.

Cultural awareness scores are consistent with previous research on nursing faculty. Sealey, in the study on the cultural competence levels of baccalaureate degree nurse educators using the CDQNE, also found that the cultural awareness subscale had the highest mean score among the subscales. Sergeant, Sedlak, and Martsolf (2005), using Campinha Bacote’s Inventory for Assessing the Process of Cultural Competence (IAPCC), found that the highest mean score was in the “achieved cultural awareness” category. The participants in this study agree that they have achieved cultural awareness which is necessary for effective implementation of multicultural education.
Cultural Desire

Cultural desire is considered to be the key and pivotal construct of the Process of Cultural Competence in the Delivery of Healthcare Services Model (Campinha Bacote, 2003). Cultural desire and motivation provide the energy source and are the foundation for culturally competent care.

The cultural desire index (M = 4.10) was the second highest score among the subscales and indicates that the faculty “agree” that they possess cultural desire and a commitment to caring for and teaching about culturally diverse clients. Items on the cultural desire subscale address a commitment to teaching and providing culturally competent care and keeping abreast of cultural health concerns. The higher levels of cultural desire among the nurse educators in this study together with the relatively high index score on the cultural awareness subscale demonstrate movement toward becoming culturally competent.

Cultural desire is an important early step in becoming culturally competent. Cultural desire can facilitate faculty in cultivating a multicultural perspective among themselves and the students in the movement toward implementing a transformative approach to cultural education. Cultural desire is a necessary element in developing a commitment to cultural competence. The absence of cultural desire can lead to a lack of commitment from the faculty to attain a transcultural curriculum. A lack of cultural desire can affect faculty perceptions, attitudes, and behaviors toward persons from diverse backgrounds which in turn can affect perceptions and attitudes formed by students (Wells, 2000; Leonard, 2006). Cultural desire allows nurses to become more
sensitive to cultural diversity and modify biased attitudes and beliefs. Cultural desire implies a readiness among the participants to further engage in the process of becoming culturally competent.

Cultural Skill

The cultural skill subscale scores demonstrated that the faculty “agree” that they possess the skills needed to perform cultural assessments (M=3.79). Cultural skill includes the ability to collect relevant culturally data regarding the client’s health for the purpose of integrating culturally congruent interventions into the plan of care (Campinha Bacote, 2003). The cultural skills subscale includes items addressing comfort levels when using cultural assessment tools, communication styles when interacting with culturally diverse clients, and effectiveness in assessing culturally diverse clients.

Cultural skill is imperative in accurately assessing and implementing care for culturally diverse clients. Any degree of clinical uncertainty related to cultural or ethnic differences during the assessment can cause greater emphasis to be placed on prior expectations, promoting stereotypes and false assumptions (National Academy of Sciences, Institute of Medicine, 2002). The nursing profession requires transcultural skills for safe and effective practice.

Cultural Knowledge

Cultural knowledge involves understanding the values, beliefs, practices, and problem solving strategies of diverse cultural groups (Campinha-Bacote, 2003). Cultural knowledge encompasses an understanding of world views, biological variations, interaction styles, disease prevention practices, and other data related to the variations across cultural/ethnic groups.
The cultural knowledge index showed that participants “agree”, to a lesser degree than on the cultural awareness subscale, that they possess cultural knowledge (M=3.75). The cultural knowledge subscale includes items regarding knowledge of differences in drug metabolism, biological variations, disease prevalence, world views, beliefs and practices, socio-economic factors, United States population percentages, and terminology related to race and ethnicity. The cultural knowledge index is among the three highest subscale scores and indicates that the participants perceive that they have attained sufficient cultural knowledge.

The literature consistently suggests that cultural knowledge is germane to providing culturally competent care (Giger & Davidhizar, 2008; Campinha Bacote, 2003; Leininger, 2002; Purnell, 1998). Cultural knowledge is required to understand the biological differences and trends in the occurrences of diseases among certain racial and ethnic groups, in understanding the underlying disease risk factors and health seeking behaviors, and in understanding the underlying sociological and political factors that place minorities at higher risks for poorer health outcomes. Cultural knowledge is also necessary to engage in challenging dialogue with nursing students in the classroom regarding cultural diversity issues when transformative approaches cultural diversity education are employed. The findings of this study related to cultural knowledge are similar to those found by Sealey (2003) who also found cultural knowledge scores to be in the “agree” category but lower that most of the other subscales.

Cultural Encounters

The lowest index on the CDQNE-R was the cultural encounters index (M=3.34) indicating that participants in the study were undecided regarding their level of
engagement in face-to-face interactions with persons from racial and ethnic cultural
groups. Although the index score for cultural encounters was within the “agree”
category, it was at the lower end of the agree scale. The low scores may be attributed to a
lack of opportunity or desire to interact with persons from other cultural groups. Items
included on the cultural encounters subscale address the degree of social and professional
involvement with persons from different cultures as well as clinical exposure to persons
from different racial and ethnic backgrounds.

Face-to-face experiential encounters can validate, negate, or contradict book
knowledge that may have been learned about a cultural group. The experiential
knowledge can serve as a solid framework for developing culturally competent
interventions. The goal of cultural encounters is to generate a wide range of responses to
transcultural situations and is imperative to developing cultural competence (Cortis,
2003).

A lack of direct interactions with diverse cultural groups can foster erroneous
beliefs (Flowers, 2004) and faulty generalizations about those groups (Byrne, 2003). The
failure to interact directly with other cultural groups may result in stereotyping
individuals of that culture (Cortis, 2004).

Teaching Behaviors

Selected items from the Cultural Awareness Subscale, Cultural Knowledge
Subscale, Cultural Skill Subscale, Cultural Encounters Subscale, and Cultural Desire
Subscale were used to form The Teaching Behaviors Subscale. The Teaching Behaviors
Subscale includes items that address theory and clinical assignments related to cultural diversity, screening of course materials for appropriate cultural content, and personal and professional commitment to teaching culturally competent care.

An index of 4.6 on The Teaching Behaviors Subscale indicates that the nurse educators “agree” that they include cultural concepts in all aspects of the nursing curriculum. Meeting the goal of multicultural education requires cultural competence among the faculty as well as faculty efforts and commitment to well planned educational strategies and opportunities that incorporate culturally diverse concepts.

The overall cultural competence score (M=3.80) is a composite of the indexes of the five cultural components of cultural competence (cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire) and cultural teaching behaviors. This result indicates that overall, the associate degree nurse educators agree that they possess cultural competence.

Summary

This study sought to describe the cultural competence levels of Ohio associate degree nurse educators based on the components of Campinha-Bacote’s (2003) Process of Cultural Competence in the Delivery of Healthcare Services Model. The constructs of the model; cultural awareness, cultural knowledge, cultural skill, cultural awareness, and cultural encounters depict the essential attributes for engaging in the process of becoming culturally competent. The results of this study support that, to varying degrees, the associate degree nurse educators in the study agree that they possess cultural awareness, cultural knowledge, cultural skill, cultural desire, and engage in cultural encounters.
Disparities in the health status and health care received by many racial and ethnic minorities in this country continue to increase (United States Department of Health and Human Services, 2000). The causes of the disparities are believed to be related to genetic, environmental, behavioral, and sociological factors. However, significant contributing factors to the disparities were found to stem from negative clinical encounters with health care professionals involving actual or perceived bias, (The National Academy of Sciences, Institute of Medicine, 2002; Williams, Neighbors, & Jackson, 2003) health care provider stereotyping, and clinical uncertainty (The National Academy of Sciences, Institute of Medicine, 2002).

Culturally competent care has been shown to increase the effectiveness of all phases of health care provided to minority clients and decrease or alleviate actual and perceived negative clinical encounters (United States Department of Health and Human Services, 2000). The Health Resources and Services Administration, United States Department of Health and Human Services (2001) found that the provision of culturally competent care by health care providers ultimately increased the utilization of health care services by racial and ethnic minority groups, increased the benefits that they received from the healthcare services, and improved overall health outcomes of the groups. The increased benefits received from culturally competent care are a major step toward decreasing the disparities experienced by this nation’s racial and ethnic minority groups.

This study sought to describe the trends, strengths, and areas for growth in the cultural competence levels of Ohio associate degree nurse educators based on the constructs of Campinha-Bacote’s Process of Cultural Competence in the Delivery of Healthcare Services Model and teaching behaviors that have been found in the literature
to be essential in promoting cultural competence were assessed. An assumption of the Process of Cultural Competence in the Delivery of Healthcare Services Model is that there is a direct relationship between the healthcare professional’s level of cultural competence and the ability to provide culturally competent care (Campinha-Bacote, 2003). Additionally, cultural competence among nurse educators is essential in the preparation of culturally competent graduates (Sealey, Burnett, & Johnson, 2006).

A clear and established commitment to cultural competence by the nursing faculty is essential. The constructs of Campinha-Bacote’s Process of Cultural Competence in the Delivery of Healthcare Services Model; cultural awareness, cultural knowledge, cultural skill, cultural awareness, and cultural encounters, exemplify the commitment and attributes that are necessary for meeting the goals of multicultural education for nursing students. These attributes facilitate appropriate responses to issues of diversity in health care and the preparation of culturally competent nursing graduates. The components of cultural competence are essential to successfully implement a transformative approach to cultural diversity education that promotes active learning, critical reflection, self awareness and social change.

Study Limitations

A limitation of this study is that data is based solely on self report of the respondents. The sample is limited to associate degree nursing faculty teaching in Ohio and can only be generalized to that population. Further study is warranted to include nursing faculty teaching in associate, diploma, and baccalaureate programs in Ohio and in other areas of the country. Separate scores were not calculated for individual items on each of the subscales. Therefore individual subscale items cannot be analyzed.
Additionally, the 27% return rate for the CDQNE-R is a limitation of this study although the respondents were found to be similar to the nonrespondents regarding race/ethnicity, gender, and age. Implications of and recommendations from the study are derived based on the findings of the study taking the above listed limitations into consideration.

**Implications for Nursing Education**

The provision of culturally competent care is imperative in addressing the disparities in the health status and the health care of this country’s racial and ethnic minority population. Adequate preparation of nursing faculty in the area of cultural competence is a key component in the cultural education of nurses. Lower levels of cultural competence among nurse educators and nurse clinicians have been attributed to faulty approaches to teaching cultural competence (Byrne, 2003). The results of this study can provide guidance for the expansion of cultural diversity professional development activities for nurse educators. This researcher suggests professional development activities that foster the high levels of agreement on the cultural awareness and cultural desire subscales of the CDQNE-R. This entails developing professional development programs to increase cultural knowledge and skill levels that incorporate cultural encounters that provide professional and social interactions with culturally diverse groups. Learning can be facilitated between nurses and culturally diverse populations through professional development programs that employ the use of “learning loops” where nurses learn more about the diversity of the clients served and the diverse clients learn more about how the health care system works (United States Department of Health and Human Services Health Resource and Services Administration, 2003). With these types of programs, the community is involved in defining and addressing service
needs and, in some cases, actually provides the in-service training. Increasing interactions with culturally diverse groups can decrease or alleviate previously held erroneous beliefs and stereotypical views while increasing cultural knowledge and sharpening cultural skills (Baldwin, 1999).

There is a documented shortage of minority nursing faculty representing the racial and ethnic groups living in the United States (National League for Nursing, 2006). A diverse faculty contributes to a culturally sensitive teaching environment as well as an environment that can enrich cultural encounters (Drayton-Hargrove, 1997; Glanville, 2000). Educational administrators should be encouraged to seek out, hire, and retain qualified culturally diverse nursing faculty members to enrich the educational environment and facilitate cultural encounters.

A shortage in the number of racial and ethnically diverse nurses and nursing students has also been well documented (Sullivan Commission, 2004). A diverse student body can increase the effectiveness of classroom dialog as well as promote cultural encounters during educational processes (Sommer, 2001). Efforts should continue to recruit and retain nursing students that reflect the racial and ethnic diversity of our country.

**Recommendations for Future Research**

The results of this study can only be generalized to nurse educators teaching in associate degree nursing programs in Ohio. Future research is needed that examines the cultural competence levels of nurse educators teaching at the baccalaureate and graduate
levels. Given the diversity of this country and the health status and health care disparities occurring nation wide, national studies are needed to determine the cultural competence levels of nurse educators teaching in all types of nursing programs.

Observations of classroom interactions during conversations that are focused on the relationships between racial and ethnic diversity and health status and health care are recommended. Classroom observations could assess issues that arise when discussions and debates center on issues of diversity. A review of nursing curricular and course materials could evaluate course objectives, teaching/learning strategies, and student assignments, and evaluation methods related to cultural diversity. This type of document review could provide information on the quantity and the quality of cultural diversity competencies related to cultural diversity concepts.
REFERENCES


121


APPENDICES
APPENDIX A

COVER LETTER TO DEANS/DIRECTORS

[Date]

Dear [         ]

As the diversity of the population in this country continues to increase, the disparities in health and health status for many racially and ethnically diverse persons have also increased. Nurses comprise the largest percentage of health care professionals in this county making us key components in addressing and solving these disparity issues. Our accrediting bodies and the NCLEX-RN test plan encourage us as nursing educators to include cultural diversity in all areas of the nursing curriculum. However, we must first be educated to become culturally aware, possess cultural knowledge and skills, and seek cultural encounters.

As a fellow associate degree nurse educator and a doctoral student in the College of Education at the University of Akron and, I am appealing to you to encourage your full time nursing faculty members to participate in a research study by completing an on line Likert type questionnaire that inquires about their level of cultural awareness, knowledge, skills, and encounters. Their anonymity will be protected throughout the study. Completed questionnaires will be anonymously submitted without knowledge of names.

Their participation in the study will contribute to the current body of nursing literature regarding trends and differences in the levels of cultural competence among nursing faculty. The study will also contribute to the assessment of nursing faculty’s professional development needs in the area of cultural diversity through evaluating faculty strengths and identifying areas of needed growth.

This study has been approved by The University of Akron’s Institutional Review Board for the Protection of Human Subjects. Procedures approved for the study by this Board will be followed. As the investigator, I will be available to answer any questions or concerns regarding this research project. You may contact me at vmy1@uakron.edu. If at any time you feel that your questions have not been adequately answered, you may contact my faculty advisor, Dr. Susan Olson at (330) 972-8223 or The University of Akron Institutional Review Board at (330) 972-7666.

Sincerely,

Vivian Yates, MSN, RN, CNS
APPENDIX B

COVER LETTER TO FACULTY

[Date]

Dear [       ]

As the diversity of the population in this country continues to increase, the disparities in health and health status for many racially and ethnically diverse persons have also increased. Nurses comprise the largest percentage of health care professionals in this county making us key components in addressing and solving these disparity issues. Our accrediting bodies and the NCLEX-RN test plan encourage us as nursing educators to include cultural diversity in all areas of the nursing curriculum. However, we must first be educated to become culturally aware, possess cultural knowledge and skills, and seek cultural encounters.

As a fellow associate degree nurse educator and a doctoral student in the College of Education at the University of Akron and, I am appealing to you to complete a Likert type questionnaire that inquires about your level of cultural awareness, knowledge, skills, and encounters. Your anonymity will be protected throughout the study. Completed questionnaires will be anonymously submitted without knowledge of your names.

Your participation in the study will contribute to the current body of nursing literature regarding trends and differences in the levels of cultural competence among nursing faculty. The study will also contribute to the assessment of nursing faculty’s professional development needs in the area of cultural diversity through evaluating faculty strengths and identifying areas of needed growth.

This study has been approved by The University of Akron’s Institutional Review Board for the Protection of Human Subjects. Procedures approved for the study by this Board will be followed. As the investigator, I will be available to answer any questions or concerns regarding this research project. You may contact me at vmy1@uakron.edu. If at any time you feel that your questions have not been adequately answered, you may contact my faculty advisor, Dr. Susan Olson at (330) 972-8223 or The University of Akron Institutional Review Board at (330) 972-7666.

If you would like a summary of the results of this research study, please send your request to vmy1@uakron.edu. Thank you in advance for your participation.

Sincerely,

Vivian Yates, MSN, RN, CNS
APPENDIX C

PERMISSION LETTER - DR. SEALEY

From: lsealey@selu.edu [lsealey@selu.edu]          Sent: Sun 9/2/2007 9:52 AM
To: Vivian Yates
Cc: 
Subject: re: CULTURAL DIVERSITY QUESTIONNAIRE FOR NURSE EDUCATORS
Attachments:

Dear Vivian,

I am pleased that you are interested in the Cultural Diversity Questionnaire for Nurse Educators. You certainly have my permission to use it and you may modify it in any way you deem necessary to suit your study. You probably should cite my dissertation (available online at LSU.edu) as the reference for the instrument since it provides much more detail about its development than the article in the Journal of Cultural Diversity. I have not used the instrument in any other studies and while I have given permission for its use to several doctoral students, I have no information about their research outcomes.

For answers to your questions related to validity see pages 45–53 and Appendix C of my dissertation. In response to your question related to reliability, the discussion related to Factor analysis reports the reliability of each subscale. I have since computed the Cronbach Alpha of the instrument using the scores of each index as the items on the overall cultural competence scale and came up with a reliability coefficient of .8285.

If you should in fact decide to use my instrument, here are a few comments/suggestions: Starting on page 61 of my dissertation, there is the discussion of the factor analysis of each subscale, which was done to determine how well the items fit on each subscale (see tables 7, 9, 11, 13, and 15). The items that did not fit were eliminated and not used in the analysis. These are indicated at the bottom of each of those tables. I observed that most of the items that did not fit were stated negatively on the instrument and it is possible that this was confusing to the respondents. Anyway, they were not used in the analysis and were not part of the subscale indexes. If I were to repeat this study I would either revise the way those items are stated, or I would not use them at all.

Please keep me informed about the outcome of your study and I sincerely wish you the best in your research. Feel free to contact me at any time.

Lorinda
APPENDIX D

SUBSCALES OF THE CULTURAL COMPETENCE QUESTIONNAIRE FOR NURSE EDUCATORS - REVISED

Cultural Awareness Subscale

• (7) I am aware that biological variations exist in different cultural, racial, and ethnic groups.

• (10) 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.

• (28) 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. *

• (31) I encourage my students to examine their attitudes, preconceived notions and feelings toward members of other cultural/racial/ethnic groups. *

• (36) I teach my students that when working with clients who are culturally, racially, or ethnically different they should become familiar with indigenous beliefs and practices. *

• (37) 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.

• (38) What I believe about health, illness, and preventative care is influenced by my culture.

• (40) I accept that male-female roles may vary among significantly among different cultures and ethnic groups.

Cultural Knowledge Subscale

• (5) I am knowledgeable about variations in drug metabolism among specific cultural groups.
• (11) I am knowledgeable about the biological variations that exist among specific cultural, racial, and ethnic groups.

• (14) I am knowledgeable about diseases that have a high incidence among cultural/racial/ethnic groups in our service area.

• (16) 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. *

• (17) I have a clear understanding of the differences in meaning of the following terms; acculturation, assimilation, and socialization.

• (21) My students are expected to demonstrate knowledge of their client’s world views, beliefs, and practices by incorporating this knowledge in their plans of care. *

• (22) I am knowledgeable about diseases that are common in the countries of origin of recent immigrants in our service area.

• (29) 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.

• (32) I know the prevailing beliefs, customs, norms, and values of the cultural/racial/ethnic groups, other than my own, residing in our service area.

• (35) I am knowledgeable about the population percentages of the major ethnic groups living in my service area.

• (39) I have a clear understanding of the differences in meaning of the following terms; immigrant, alien resident, and citizen.

**Cultural Skills Subscale**

• (1) I feel confident in using a variety of cultural assessment tools in the health care setting.

• (8) I use the appropriate communication style and protocol to communicate with clients who are of different cultural/racial/ethnic backgrounds.

• (9) My students are required to seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally, racially, and ethnically diverse groups served by our program. *
• (12) 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.

• (18) 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.

• (33) I teach my students to recognize presenting signs and symptoms as they are manifested in individuals who are culturally, racially, and ethnically diverse. *

• (34) The cultural assessment tool that I use elicits information about clients’ dietary practices, health beliefs, and social organization.

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

Cultural Encounters Subscale

• (3) I am involved socially with cultural/racial/ethnic groups different from my own, outside of my teaching role and health care setting.

• (13) I seek out clinical opportunities for my students to care for clients who are culturally, racially, and ethnically diverse. *

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

• (20) I attend holiday celebrations within culturally, racially and ethnically diverse communities.

• (23) I have spent extended periods of time (i.e. at least seven consecutive days) living among people from cultural/racial/ethnic groups different from my own.

• (30) I patronize businesses on my service area that are owned by people who are culturally, racially, and ethnically diverse.

Cultural Desire Subscale

• (2) I make time to include cultural competence in my course content. *

• (4) Caring for clients who are culturally, racially, or ethnically diverse is a challenge that I welcome.
• (6) I avail myself of professional developmental and training opportunities to enhance my knowledge and skills in the provision of health care services to culturally, racially, and ethnically diverse groups.

• (19) 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.

• (24) I screen books, movies, and other media sources for negative cultural, racial, or ethnic stereotypes before using them in my course or sharing them with clients cared for by me or by my students.*

• (25) I am personally and professionally committed to providing nursing care that is culturally competent

• (26) I am personally and professionally committed to teaching how to provide nursing care that is culturally competent.*

• (27) I advocate for the review of my program’s mission statement, goals, policies and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

Transcultural Teaching Behavior Subscale

• (2) I make time to include cultural competence in my course content.*

• (9) My students are required to seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally, racially, and ethnically diverse groups served by our program.*

• (13) I seek out clinical opportunities for my students to care for clients who are culturally, racially, and ethnically diverse.*

• (16) 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.*

• (21) My students are expected to demonstrate knowledge of their client’s world views, beliefs, and practices by incorporating this knowledge in their plans of care

• (24) I screen books, movies, and other media sources for negative cultural, racial, or ethnic stereotypes before using them in my course or sharing them with clients cared for by me or by my students.*

• (26) I am personally and professionally committed to teaching how to provide nursing care that is culturally competent.*

133
• (28) 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.*

• (31) I encourage my students to examine their attitudes, preconceived notions and feelings toward members of other cultural/racial/ethnic groups. *

• (33) I teach my students to recognize presenting signs and symptoms as they are manifested in individuals who are culturally, racially, and ethnically diverse. *
APPENDIX E

THE CULTURALLY DIVERSE QUESTIONNAIRE FOR NURSE EDUCATORS – REVISED

1. I feel confident in using a variety of cultural assessment tools in the health care setting.
   
   Strongly agree   Agree   Undecided   Disagree   Strongly Disagree

2. I make time to include cultural competence in my course content.
   
   Strongly agree   Agree   Undecided   Disagree   Strongly Disagree

3. I am involved socially with cultural/racial/ethnic groups different from my own, outside of my teaching role and health care setting.
   
   Strongly agree   Agree   Undecided   Disagree   Strongly Disagree

4. Caring for clients who are culturally, racially, or ethnically diverse is a challenge that I welcome.
   
   Strongly agree   Agree   Undecided   Disagree   Strongly Disagree

5. I am knowledgeable about variations in drug metabolism among specific cultural groups.
   
   Strongly agree   Agree   Undecided   Disagree   Strongly Disagree

6. 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

7. I am aware that biological variations exist in different cultural, racial, and ethnic groups.
   
   Strongly agree   Agree   Undecided   Disagree   Strongly Disagree
8. I use the appropriate communication style and protocol to communicate with clients who are of different cultural/racial/ethnic backgrounds.

   Strongly agree  Agree  Undecided  Disagree  Strongly Disagree

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

   Strongly agree  Agree  Undecided  Disagree  Strongly Disagree

10. 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

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

    Strongly agree  Agree  Undecided  Disagree  Strongly Disagree

12. 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

13. 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

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

    Strongly agree  Agree  Undecided  Disagree  Strongly Disagree

15. 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

16. 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
17. I have a clear understanding of the differences in meaning of the following terms; acculturation, assimilation, and socialization.

   Strongly agree  Agree  Undecided  Disagree  Strongly Disagree

18. I am confident that I posses 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

19. 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

20. I attend holiday celebrations within culturally, racially and ethnically diverse communities.

   Strongly agree  Agree  Undecided  Disagree  Strongly Disagree

21. My students are expected to demonstrate knowledge of their client’s world views, beliefs, and practices by incorporating this knowledge in their plans of care.

   Strongly agree  Agree  Undecided  Disagree  Strongly Disagree

22. I am knowledgeable about diseases that are common in the countries of origin of recent immigrants in our service area.

   Strongly agree  Agree  Undecided  Disagree  Strongly Disagree

23. I have spent extended periods of time (i.e. at least seven consecutive days) living among people from cultural/racial/ethnic groups different from my own.

   Strongly agree  Agree  Undecided  Disagree  Strongly Disagree

24. I screen books, movies, and other media sources for negative cultural, racial, or ethnic stereotypes before using them in my course or sharing them with clients cared for by me or by my students.

   Strongly agree  Agree  Undecided  Disagree  Strongly Disagree

25. I am personally and professionally committed to providing nursing care that is culturally competent.

   Strongly agree  Agree  Undecided  Disagree  Strongly Disagree
26. I am personally and professionally committed to teaching how to provide nursing care that is culturally competent.

   Strongly agree  Agree  Undecided  Disagree  Strongly Disagree

27. I advocate for the review of my program’s mission statement, goals, policies and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

   Strongly agree  Agree  Undecided  Disagree  Strongly Disagree

28. 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

29. 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

30. I patronize businesses on my service area that are owned by people who are culturally, racially, and ethnically diverse.

   Strongly agree  Agree  Undecided  Disagree  Strongly Disagree

31. I encourage my students to examine their attitudes, preconceived notions and feelings toward members of other cultural/racial/ethnic groups.

   Strongly agree  Agree  Undecided  Disagree  Strongly Disagree

32. I know the prevailing beliefs, customs, norms, and values of the cultural/racial/ethnic groups, other than my own, residing in our service area.

   Strongly agree  Agree  Undecided  Disagree  Strongly Disagree

33. 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
34. The cultural assessment tool that I use elicits information about clients’ dietary practices, health beliefs, and social organization.

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

36. I teach my students that when working with clients who are culturally, racially, or ethnically different they should become familiar with indigenous beliefs and practices.

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

37. 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.

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

38. What I believe about health, illness, and preventative care is influenced by my culture.

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

39. I have a clear understanding of the differences in meaning of the following terms; immigrant, alien resident, and citizen.

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

**Please provide the following information about yourself.**

42. Gender:
   a. female
   b. male
43. Age range
   a. Under 25 years
   b. 26-35 years
   c. 36-45 years
   d. 46-55 years
   e. 56-65 years
   f. 65-75 years
   g. over 75 years

44. What is your racial/ethnic background?
   a. African American (Non-Hispanic)
   b. American Indian/Alaskan Native
   c. Asian American
   d. Hispanic
   e. Native Hawaiian/Other Pacific Islander
   f. White American (Non-Hispanic)
   g. Other

45. Which of the following best describes your employment status?
   a. full-time
   b. part-time

46. What is your academic rank?
   a. full professor
   b. associate professor
   c. assistant professor
   d. instructor

47. At what level of the nursing program do you teach? (check all that apply)
   a. first year associate degree
   b. second year associate degree

48. How long have you been teaching nursing?
   a. less than one year
   b. 1-5 years
   c. 6-10 years
   d. 10-15 years
   e. more than 15 years

49. What is your highest degree attained?
   a. Bachelor’s
   b. Masters
   c. Ph.D/Ed.D
50. In which of the following types of institutions is your nursing school located?
   a. community/technical college
   b. private career training institution
   c. four year college/university
   d. hospital affiliated institution

Comments:
Dear Associate Degree Nursing Faculty Member,

I am a doctoral student in the College of Education at the University of Akron and an associate degree nursing faculty member at Lorain County Community College. As a health care professional and a nurse educator, I am concerned about the increasing disparities in the health care and health status of many racially and ethnically diverse persons. Based on this concern, I am conducting a research study to investigate the level of cultural competence among associate degree nursing faculty in Ohio.

If you are a full time associate degree nurse educator, I hope that you will find time to complete Cultural Diversity Questionnaire for Nurse Educators - Revised. The survey will take about ten minutes to complete. Below is a link to the survey. A slightly more detailed explanation of the study is available at the link. Use the password "diversity" when prompted.

If clicking does not open this link, cut and paste the URL directly to your browser. Please contact me at vmy1@uakron.edu if you have any difficulties accessing the survey.

Thank you in advance for your participation.

Vivian Yates, MSN, RN, CNS

https://survey2.uakron.edu/Survey.aspx?s=c8098b48b35f40ccab367d982dc77dbd&invitationID=@@invitationID
Dear Associate Degree Nursing Faculty Member,

I hope that you will still find the time to complete the Cultural Diversity Questionnaire for Nurse Educators - Revised. Use the password "diversity" when prompted to enter a password. The survey will take about ten minutes to complete. Below is a link to the survey. A slightly more detailed explanation of the study is available at the link.

If clicking does not open this link, cut and paste the URL directly to your browser. Please contact me at vmy1@uakron.edu if you have any difficulties accessing the survey.

Thank you in advance for your participation.

Vivian Yates, MSN, RN, CNS

https://survey2.uakron.edu/Survey.aspx?s=c8098b48b35f40ccab367d982dc77dbd&invitationID=3143
Dear Associate Degree Nursing Faculty Member,

The end of the semester is quickly approaching. However, there is still time to become part of statewide survey by completing and submitting the Cultural Diversity Questionnaire for Nurse Educators – Revised. Use the password "diversity" when prompted to enter a password. The survey will take about ten minutes to complete. Below is a link to the survey. A slightly more detailed explanation of the study is available at the link.

If clicking does not open this link, cut and paste the URL directly to your browser. Please contact me at vmy1@uakron.edu if you have any difficulties accessing the survey.

Thank you in advance for your participation and have a great summer.

Vivian Yates, MSN, RN, CNS

https://survey2.uakron.edu/Survey.aspx?s=c8098b48b35f40ccab367d982dc77dbd&invitationID=3143
APPENDIX I

PERMISSION TO PRINT THE CDQNE-R – DR SEALEY

RE: CULTURAL DIVERSITY QUESTIONNAIRE FOR NURSE EDUCATORS

lsealey@selu.edu

Hi Vivian,
I am pleased to learn that the questionnaire worked well in addressing your research concerns. You may certainly publish it in your dissertation, as long as I am appropriately cited. I am curious about the psychometrics (e.g., factor analysis, reliability) and your findings in general. Congratulations on moving one step closer to achieving your goal!

Lorinda Sealey
APPENDIX J

IRB APPROVAL LETTER

The University of Akron

NOTICE OF APPROVAL

Date: April 1, 2008

To: Vivian M. Yates
  102 Monticello Circle
  Elyria, Ohio 44035-4517

From: Sharon McWhorter, IRB Administrator

Re: IRB Number 0080314
  "Cultural Competence Levels of Ohio Associate Degree Nursing Faculty"

Thank you for submitting your IRB Application for Review of Research Involving Human Subjects for the referenced project. Your application was approved on April 1, 2008. Your protocol represents minimal risk to subjects and matches the following federal category for exemption:

☐ Exemption 1 - Research conducted in established or commonly accepted educational settings, involving normal educational practices.

☐ Exemption 2 - Research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior.

☐ Exemption 3 - Research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior not exempt under category 2, but subjects are elected or appointed public officials or candidates for public office.

☐ Exemption 4 - Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens.

☐ Exemption 5 - Research and demonstration projects conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine public programs or benefits.

☐ Exemption 6 - Taste and food quality evaluation and consumer acceptance studies.

Annual continuation applications are not required for exempt projects. If you make changes to the study’s design or procedures that increase the risk to subjects or include activities that do not fall within the approved exemption category, please contact me to discuss whether or not a new application must be submitted. Any such changes or modifications must be reviewed and approved by the IRB prior to implementation.

Please retain this letter for your files. If the research is being conducted for a master’s thesis or doctoral dissertation, the student must file a copy of this letter with the thesis or dissertation.

Cc: Susan Olson, Advisor
    Rosalie Hall, IRB Chair

Office of Research Services and Sponsored Programs
Akron, OH 44325-0192
330-972-7668 * 330-972-6291 Fax

The University of Akron Jean Edeau Education and Employment Institute

☑ Approved consent form/s enclosed