Nursing Faculty Care Expressions, Patterns, and Practices Related to Teaching Culture Care

Sandra J Mixer, University of Tennessee - Knoxville

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NURSING FACULTY CARE EXPRESSIONS, PATTERNS, AND PRACTICES RELATED TO TEACHING CULTURE CARE

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Sandra Jean Mixer

College of Natural and Health Sciences
School of Nursing
PhD in Nursing Education

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THIS DISSERTATION WAS SPONSORED

BY

Debra Woodard Leners, PhD, RN, PNP, CNE
Professor & Director, School of Nursing
Research Advisor

Sandra Jean Mixer

DISSERTATION COMMITTEE

Advisory Professor: ________________________________
Marilyn R. McFarland, PhD, RN, FNP-BC, CTN
Associate Professor, School of Health Professions and Studies
University of Michigan-Flint

Advisory Professor: ________________________________
Margaret M. Andrews, PhD, RN, CTN, FAAN
Director & Professor of Nursing, School of Health Professions and Studies, University of Michigan-Flint

Faculty Representative: ________________________________
Linda Lohr, EdD
Associate Professor, Education Technology

ASSISTANT VICE PRESIDENT FOR RESEARCH & EXTENDED STUDIES
DEAN OF THE GRADUATE SCHOOL

______________________________
Robbyn R. Wacker, Ph.D.

Examination Date of Dissertation: ________________________________
ABSTRACT

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The purpose of this ethnonursing research study was to discover the care expressions, patterns, and practices of nursing faculty related to teaching culture care within the environmental context of urban and rural baccalaureate nursing programs in the Southeastern United States. The goal of the study was to discover faculty caring that facilitated teaching nursing students to provide culturally congruent and competent care. Four major themes with universal and diverse patterns which supported the themes were discovered. The themes were faculty care as embedded in Christian religious values, beliefs, and practices; faculty teaching culture care without an organizing conceptual framework; faculty providing generic and professional care to nursing students; and care as essential for faculty health and well being to teach culture care. Discoveries regarding nursing actions and decisions for teaching culture care conceptualized with Leininger’s three modes and two newly discovered care constructs, care as mentoring and Christian care are presented. This study was a unique application of the culture care theory which further supported and substantiated Leininger’s work. Qualitative research findings contributed to the practice of nursing through understanding the complex nature of teaching culture care and to the discipline of nursing through building the body of transcultural nursing education knowledge.
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CHAPTER I

Introduction

Introduction and Background

As the world becomes increasingly multicultural transcultural nursing education, practice, research, and administration are imperative to respond to the global health needs of people, communities, and nations. Within the profession of nursing, there is a need and dictum to increase cultural sensitivity and competence in nursing students (AACN, 2004; McFarland & Leininger, 2002; Sullivan, 2004; US Department of Health and Human Services, 1996). Nursing educators worldwide are challenged to prepare a culturally competent nursing workforce (McFarland & Leininger).

The culture of the nursing profession embraces the shared value of preparing students to provide culturally competent nursing care for people in an increasingly multicultural world. The National Advisory Council on Nurse Education and Practice proposed that one of a set of Federal policy goals is:

…to enhance the ability of the registered nurse workforce to meet the challenges of cultural diversity in delivery of health care [and further recommends that] the Federal government should support educational activities to increase the cultural sensitivity and cultural competence in nursing students. (US Department of Health and Human Services, 1996).
In addition, the American Association of Colleges of Nursing (AACN) Strategic Plan for 2005-06 addresses the need to “Advocate for nursing curricula and research to address the health care needs of diverse populations” (AACN, 2004).

The editor of the official journal publication of Sigma Theta Tau, the International Honor Society of Nursing, asked several global nursing leaders what they saw as priorities for advancing nursing knowledge. Three out of five leaders addressed the need to teach students about global health needs and cultural sensitivity (Ryan, Guimeri, Buerhaus, Ketefian & Kim, 2002). Additionally, an entire issue was devoted to concerns related to race and ethnicity and health disparities. In her editorial, Hegyvary (2006) suggests that the increasing diversity in the population in the United States and in countries throughout the world compels nurses to examine cultural characteristics of persons and caring practices of nurses. According to estimates by the U.S. Census Bureau (2006), 33% of the American population in 2006 was made up of persons from ethnic, non-white backgrounds as represented by: 14.8% Hispanic/Latino, 12.8% African American, 4.4% Asian, 1% American Indian/Alaskan Native, and 0.2% Native Hawaiian/Pacific Islander. Finally, the honor society has published a Diversity Resource Paper which addresses the issues of diversity in the nursing profession and nurses’ responsibility to provide culturally competent care (Wilson, Sanner & McAllister, 2003).

As this researcher contemplated the process by which nursing students learning to provide culturally congruent care, curiosity about faculty culture care competence and knowledge, skills, and values necessary to effectively teach culture care emerged. Therefore, this study was developed to discover nursing faculty care expressions, patterns, and practices related to teaching culture care.
Domain of Inquiry

The domain of inquiry for this transcultural nursing study is nursing faculty care expressions, patterns, and practices related to teaching culture care within the environmental context of baccalaureate nursing programs. This study was conducted with nursing faculty in baccalaureate nursing programs in urban and rural contexts in universities in the Southeastern United States.

The domain of inquiry is a major interest in nursing because of the growing diversity of the population in the United States, concerns about the provision of global health care, and the call for nurses prepared in transcultural nursing. The researcher predicted that nursing faculty epistemology (cultural knowledge and teaching strategies) and ontology (faculty modeling culturally congruent care) is essential to teach students to provide culturally congruent care (See Appendix A).

Purpose and Goal of Study

The purpose of this study was to discover, describe, and systematically analyze the care expressions, patterns, and practices of nursing faculty related to teaching culture care in baccalaureate programs in urban and rural universities located in the southeastern United States. The goal of this study was to discover faculty care that facilitates teaching students learning how to provide culture care.

Significance of the Study

Despite 50 years of transcultural nursing knowledge development through theory, research, and practice, there remains a lack of formal, integrated culture education in nursing (Baldonado, 1998; Hughes & Hood, 2007). Nursing faculty have the responsibility to effectively disseminate transcultural nursing knowledge to ensure a
culturally competent workforce prepared to deliver satisfying, safe, and beneficial nursing care.

This research made a contribution to the practice of nursing by discovering similar and diverse nursing faculty care expressions, patterns, and practices related to teaching culture care. The influencing factors discovered among faculty and institutions is useful in understanding the complex nature of teaching culture care within the environmental context of a nursing program. Culturally diverse and similar students may be recruited and thrive in nursing programs where teaching culture care is embraced (McFarland, Mixer, Lewis & Easley, 2006; Pacquiao, 2007). Findings from this study have made a contribution to the discipline of nursing by contributing to the body of transcultural nursing education knowledge related to teaching culture care. This study is a unique application of the culture care theory in discovering nursing faculty care expressions, patterns, and practices which support and substantiate Leininger’s theory.

Research Questions

In studying the domain of faculty teaching culture care within the environmental context of undergraduate baccalaureate programs in nursing, several broad questions within the ethnonursing research method were used to guide the researcher. These research questions were:

1. In what ways do nursing faculty care expressions, patterns, and practices influence teaching culture care?

2. In what ways do worldview, culture and social structure, and environmental context influence nursing faculty teaching culture care?
3. Given the nature of the university or school of nursing culture, what influence does this have on nursing faculty teaching culture care?

4. In what ways does nursing faculty teaching culture care influence their health and well being within the environmental context of the school of nursing and university?

*Theoretical Framework*

This study was grounded in the discipline of transcultural nursing and the phenomenon of culture care (Leininger, 2006a). Transcultural nursing (TCN), established in the early 1970s, is an essential, formal, and legitimate area of study and practice with a comparative care focus (Leininger, 1989). Transcultural nursing “is a field of great relevance as nurses learn how to function in a multicultural world in which people want and expect their cultural values and lifeways to be respected and understood” (Leininger, 1989, p. 4). Transcultural nurses use theory and research to build discipline knowledge and inform nursing practice. Leininger’s (2006a) theory of Culture Care Diversity and Universality asserts that nurses can only provide culturally congruent care when the culture care expressions, patterns, and practices are known.

The study of the ways nursing faculty care expressions, patterns, and practices influence their teaching culture care was conceptualized using the culture care theory and ethnonursing research method within the qualitative paradigm. The methodology uses an open, largely inductive process of discovery to document, describe, understand, and interpret peoples’ care meanings and experiences (Leininger 2006b) and therefore is appropriate to understand the realities of faculty teaching culture care.
The culture care theory together with the sunrise enabler (which depicts an integrated holistic view of the influencing dimensions and major concepts of the theory) provided the framework for this research study (See Appendix B). This nursing theory was chosen because of the researcher’s interest in using the theory in the context of nursing education and its applicability to the domain of inquiry, nursing faculty care expressions, patterns, and practices related to teaching culture care. The culture care theory provides a holistic means to understand the range of factors that influence nursing faculty teaching culture care. McFarland and Leininger (2002) proposed that nursing education in the 21st century must become “transculturally grounded” (p. 528) by considering the phenomena of student, faculty, and client culture care values, beliefs, and practices. There have been no studies conducted to discover these phenomena related to teaching culture care and no ethnonursing research studies conducted using the culture care theory in this context.

Assumptive Premises of the Research

The following research assumptions are derived from Leininger’s (2006a) assumptive premises of the. These assumptions guided the researcher while conducting this transcultural nursing study and are:

1. Faculty care is the essence of nursing education and a distinct, dominant, central and unifying focus (derived from Leininger assumption number 1, p. 18).

2. Faculty care is essential for effectively teaching culture care in nursing programs (derived from Leininger, assumption number 2, p. 18).
3. Culture care expressions, patterns, and practices of faculty related to teaching culture care are influenced by and tend to be embedded in their worldviews, social structure, and environmental contexts (derived from Leininger, assumption number 6, p. 19).

4. Culture care is the broadest holistic means to know, explain, interpret, and predict faculty lifeways related to the education of students in the delivery of culturally congruent and competent nursing care. (derived from Leininger, assumptions number 7 and 8, p. 19).

5. Meeting the culture care needs of faculty and students promotes the health and well being of these persons within the environmental context of the school of nursing and university. (derived from Leininger, assumption number 2 and 11, p. 19).

*Orientational Definitions*

The culture care theory is useful for nurses in practice, research, and education. The theory can be used for planning care for individuals, families, groups, or institutions; conducting research studies; and/or developing educational programs (McFarland, Mixer, Lewis and Easley, 2006). The top of the sunrise enabler depicts the worldview, social structure dimensions, and care expressions, patterns, and practices which need to be considered when teaching culture care. *Worldview* refers to the way in which faculty look out at the world; the lens they use to see their world. *Cultural and social dimensions* of the theory consist of many factors to be considered when giving care; whether providing patient care, educating nursing students, or addressing the care needs of an institution. These social structure dimensions are technological, religious and
philosophical, kinship and social, political and legal, economic, and educational factors, and cultural values, beliefs, and lifeways (derived from Leininger, 2006a, p. 14-15; 1997).

This research study reflects a unique use of the culture care theory and the following orientational definitions were conceptualized within the theory and reflect the domain of inquiry for this study. The construct of culture care is central to transcultural nursing and providing culturally congruent care. It is conceptual and global, describing a holistic perspective of the emic (generic or family) and etic (professional) aspects of care. Culture care involves “cognitively learned and transmitted professional and indigenous folk values, beliefs, and patterned lifeways” (Leininger, 2002, p. 57). Care is an essential and distinct feature of nursing. “Nurses are expected to get close to people and to establish and maintain intimate caring relationships” (Leininger, 2006b, p. 45).

Culturally congruent care then “is defined as those assistive, supportive, facilitative or enabling acts or decisions that include culture care values, beliefs, and lifeways to provide meaningful, beneficial and satisfying care for the health and well-being of people or for those facing death or disabilities” (Leininger, 2002, p. 58). Culture care is the broader philosophical construct, while culturally congruent care refers to the actions and decisions (interventions) one provides that are culture specific for the person(s) being served.

The orientational definition of faculty care was defined at the beginning of the study as referring to abstract and concrete phenomena related to assisting, supporting, and/or enabling experiences or behaviors for students with evident or anticipated learning needs related to providing culturally congruent nursing care (derived from Leininger,
Examples of faculty care may include assisting a student after class, learning about individual students’ cultures, or presencing with a student in the clinical setting (McFarland, Mixer, Lewis & Easley, 2006). The faculty care orientational definition evolved as the study progressed to expand to caring not only for students, but faculty caring for one another. This is further discussed under findings in chapter four. 

*Faculty health* is demonstrated through embracing similarities and differences among one another, students, and those receiving nursing care; the accomplishment of graduates providing culturally competent nursing care; and scholarly activities related to teaching culture care (e.g. education, research, publication, and service). Faculty health and well being are culturally defined and involve being able to perform one’s daily roles related to teaching culture care (derived from Leininger, p. 10). Faculty health may be influenced by support from nursing and university leadership, mentoring and role modeling from colleagues, and creating a caring university environmental context. These factors are viewed as essential in creating a caring community to teach culture care.

Student, client, and faculty *generic (folk) care* (Leininger, 2006a) involves teaching and providing generic care as well as experiencing generic care. A faculty member would have experienced generic care in his/her family of origin and from friends and colleagues and therefore expresses generic care through specific expressions, patterns, and practices. For example, faculty members care for each other when there is a death or illness in a faculty member’s family by rallying around, teaching classes for each other, being present in the hospital, assisting with food preparation and child care, and using their areas of professional expertise to make referrals for specialty care.
Professional care-cure practices (Leininger, 2006a) involve the education one has received in preparation for teaching culture care whether through formal nursing degree programs or other educational opportunities. Nursing care practices related to teaching culture care involve ontology - faculty “being” (which includes generic and professional care expressions, patterns, and practices consistent with culturally congruent care) and epistemology – faculty “knowing” (e.g. generic and professional culture care knowledge and effective teaching strategies) (derived from Leininger). When teaching culture care, faculty address both epistemological and ontological perspectives. Faculty may know the empirical, ethical, aesthetic, and personal ways of knowing (epistemology) related to teaching culture care. The faculty member may ‘know’ cultural knowledge and possess effective teaching strategies to teach culture care. However, faculty members also teach culture care through their way of being (ontology). Faculty model their care expressions, patterns, and practices about culture and providing culturally congruent care. Faculty member’s epistemology and ontology come together to inform theory, research, and practice as they teach culture care in classroom and clinical settings.

Generic and professional care may be combined to help students reflect about explicitly discovering the roots of their generic and professional caring beliefs, patterns, and practices. This process is necessary for understanding the basis of providing culturally congruent and competent care for clients and community.

Environmental context involves the totality of the experience of teaching culture care within institutional (school of nursing and university) and clinical (hospital and community) contexts including physical, ecological, spiritual, sociopolitical, kinship and technological influences (derived from Leininger, 2006a, p. 10). Institutional Culture
refers to the learned, shared, and transmitted values, symbols, beliefs, norms, and lifeway practices within the academic setting (school of nursing and university) that guide the thinking, decision making, and actions of administrators, faculty, and staff (derived from Leininger, p. 13). Values and beliefs may be reflected in documents such as mission and vision statements, philosophy statements, course syllabi, or university and school of nursing websites.

The culture care theory includes application of research discoveries in nursing care using the three modes of culture care actions and decisions. These modes are derived from synthesis and analysis of qualitative study data and then confirmed with informants for accurate meanings. *Culture Care Preservation/Maintenance* refers to those assistive, supporting, facilitative, or enabling professional actions and decisions that help nursing faculty retain and preserve relevant care expressions, patterns, and practices to teach culture care and contribute to the health of faculty, students, and clients (derived from Leininger, 2006a, p. 8). *Culture Care Accommodation/Negotiation* refers to those assistive, supporting, facilitative, or enabling professional actions and decisions that help nursing faculty adapt to or negotiate with others relevant care expressions, patterns, and practices to teach culture care and contribute to the health of faculty, students, and clients (derived from Leininger, p. 8). *Culture Care Repatterning/Restructuring* refers to those assistive, supporting, facilitative, or enabling professional actions and decisions that help nursing faculty reorder, change, or greatly modify relevant care expressions, patterns, and practices to teach culture care and contribute to the health of faculty, students, and clients (derived from Leininger, p. 8). Finally, the theory focuses on diverse as well as universal culture care findings. Discovery of universal and diverse nursing faculty care
expressions, patterns, and practices related to teaching culture care are described and systematically analyzed using the culture care theory and ethnonursing research method (Leininger, 2006a, 2006b).
CHAPTER II
Review of Literature

Introduction

Culture care education in nursing focuses broadly on nurses, nursing students, and faculty developing transcultural expertise; the ability to provide culturally congruent care for people from similar and diverse cultures (Leininger, 2006a). Developing this expertise is multifaceted and is described in the literature as involving cultural awareness and sensitivity, cultural competence, cultural skills, cultural content, teaching strategies, culturally diverse clinical sites, cultural immersion experiences and institutional cultures. Focus has been placed on what is taught, how it is taught, and personal and professional reflection of the nursing professional. Following is a critical discussion of the literature including research studies that address culture care education in nursing.

Cultural Competence Development

Cultural competence development has been described as a process or journey rather than a destination. One does not become culturally competent; rather one works toward cultural competence throughout one’s professional nursing career (Campinha-Bacote, 2005).

Coffman, Shellman and Bernal (2004) conducted a study to review the use of the Cultural Self-Efficacy Scale (CSES) developed by Bernal and Froman. The items on the scale address a nurse’s knowledge about “cultural concepts, cultural patterns and skills in performing transcultural nursing functions” (p. 181). Study findings provided evidence
that the CSES tool used with nurses and nursing students is reliable and valid. Of importance to this discussion, “findings showed that ethnicity, previous coursework, and educational experiences can increase nurses’ self-efficacy in delivering culturally competent care” (Coffman, et. al., p. 185).

In another study, the cultural competence of senior nursing students was measured using the CSES for 32 students who received cultural diversity instruction and 31 students who did not. Findings indicated that introducing cultural concepts and care of diverse people into a course was insufficient in raising students’ perception of cultural competence. Researchers suggested comprehensive transcultural nursing education needs to be incorporated into curricula focused on teaching lifeways of various cultures, cultural assessment, and facilitating students in exploring their values and beliefs related to cultural differences and similarities (Alpers & Zoucha, 1996).

In a study by Kulwicki and Boloink (1996), the Cultural Self-Efficacy Scale (CSES) was modified to measure graduating nursing student’s confidence in meeting the transcultural nursing care needs of five minority groups in Michigan; African Americans, Latino-Hispanics, Middle Easterners/Arabics, Asian/Pacific Islanders, and Native Americans. Results revealed that students had little or no confidence in caring for people representing these minority groups. Researchers indicated their study results are similar to previous studies and suggested that nurse educators purposefully select clinical sites that allow students to care for diverse people. Additionally, the authors suggested the importance of clinical educators serving as role models for students in providing culturally congruent care.
In an effort to measure outcomes of a program to promote multicultural awareness among nursing faculty and students, Rew, Becker, Cookston, Khosropour and Martinez (2003) developed a cultural awareness scale (CAS). The scale was created based on a review of literature, critiqued by a panel of experts in nursing and culture, and then administered to 118 nursing students. The study provided evidence that the CAS is a reliable and valid instrument for measuring cultural awareness in nursing students. Researchers concluded that data “support the multidimensional nature of cultural awareness” and the importance of faculty modeling sensitivity to cultural diversity (Rew, et.al., p.225).

The authors also stressed the importance of defining the construct of cultural competence. They expressed concern that associated terms might be used interchangeably or dismissed as “buzzwords” and shared their belief that all four components of cultural competence should be incorporated in nursing education, practice, and research. After conducting an exhaustive review of literature, the authors proposed that:

Cultural competence can be conceptualized as consisting of four components:

- Cultural awareness (i.e., the affective dimension)
- Cultural sensitivity (i.e., the attitudinal dimension)
- Cultural knowledge (i.e., the cognitive dimension)
- Cultural skills (i.e., the behavior dimension) (Rew, et al., 2003, p. 250).

Jeffreys and Smodlaka (1999) proclaim the importance of transcultural nursing self-efficacy (confidence) in providing quality care for diverse people. Their study of 566 culturally diverse nursing students examined validity of the Transcultural Self-
Efficacy Tool (TEST), the growth of Transcultural Efficacy (TSE) over time, and whether student diversity influences TSE. Transcultural Efficacy was found to be higher for senior versus beginning nursing students. Both groups were most confident about their transcultural attitudinal self-evaluations and were least confident in their transcultural nursing knowledge. Researchers suggested one explanation for low levels of TCN knowledge may be that students in this sample were in associate degree programs where the two year time frame limits educators from including substantive TCN knowledge.

Students participating in the study represented diversity in terms of age, gender, ethnicity, income, previous health care experience, and language. Results substantiated that simply belonging to a minority group does make one culturally competent. The researchers concluded that formal, transcultural nursing education, including cultural immersion experiences, is required to prepare nurses to provide culturally congruent care (Jeffreys & Smolaka, 1999).

A study to examine undergraduate nursing students’ and nursing faculty self-reported cultural competence was conducted by Sargent, Sedlack and Martsolf (2005). Campinha-Bacote’s (2003) model of the process of cultural competence served as the foundation for the study. Cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire are described as constructs that make up cultural competence. These constructs are incorporated in Campinha-Bacote’s Inventory for Assessing the Process of Cultural Competence (IAPCC) instrument which was used to measure the level of self-reported cultural competence. First year students were compared to fourth year students to determine the effectiveness of the curriculum in
teaching students cultural competence. Both student groups were compared to faculty. Results demonstrated that “fourth year students are significantly more culturally competent than first year students” (Sargent, et.al., p. 218).

Researchers concluded that cultural competence can be effectively taught when purposefully integrated throughout the curriculum using active teaching strategies. Examples of these strategies are completing a cultural self-assessment, comparing and contrasting one’s culture to a person from a different culture through interview and review of literature, and caring for people from diverse backgrounds. The authors suggest that cultural desire [described by Campina-Bacote (2003) as motivation to become culturally competent] of students and faculty alike may be the most significant factor in developing cultural competence (Sargent, et. al., 2005).

Cooper Brathwaite (2005) found that a cultural competence course was effective in increasing the cultural competence of public health nurses. Quantitative and qualitative evaluation methods were used immediately after the course and at 3-months follow-up. Participants demonstrated an increase in self confidence and reported changes in their behaviors and practices. The importance of teaching culture care in undergraduate and graduate nursing programs was recognized (Cooper Brathwaite).

Teaching Strategies

A descriptive survey was conducted by Ryan, Carlton and Ali (2000) to ascertain trends in teaching transcultural nursing concepts and learning experiences in higher degree (baccalaureate and master’s) programs in the United States. Faculty from 217 National League for Nursing accredited programs responded, equating to a 36% response rate. Researchers found great diversity among schools about what was taught related to
culture and transcultural nursing and *how* these concepts were taught. Survey findings identified there was TCN content in most nursing curricula; however substantive content and integration throughout the curriculum were missing. Seventy four percent of undergraduate programs reported cultural clinical opportunities in their geographic area, while 9% offered national experiences, and only 4% offered international experiences. Although formal programs of transcultural nursing study at the masters’ and doctoral level are available at several universities, the survey found insufficient numbers of faculty with expertise in TCN available to teach and some schools reported no qualified faculty were available.

Researchers suggested that more substantive content related to transcultural nursing be integrated throughout curricula rather than simply offering modules or an elective course. Additionally, Ryan, et. al. (2000) recommended greater support for faculty development in transcultural nursing at the department and university levels to foster faculty expertise. Networking and electronic communication among schools of nursing to share resources and facilitate dialogue among faculty was proposed as a creative solution for potentially limited university resources.

Napholz (1999) conducted a study to determine the effectiveness of an innovative cultural sensitivity intervention with second semester junior nursing students. Students were divided into two groups. Both groups received traditional teaching related to cultural diversity provided by course faculty. In addition, the experimental group received an innovative cultural sensitivity intervention which consisted of a cultural diversity expert being available to students at the clinical site for three, two hour sessions during clinical and post-conference. The cultural expert was Black, reflecting
membership in an ethnic minority group, and had expertise in teaching and caring for people of diverse cultures. The researcher believed that the minority status of the expert added “face validity, depth and meaning” (Napholz, p. 82) to students’ understanding of cultural sensitivity.

Students in both groups took the Ethnic Competency Skill Assessment (ECSA) before and after teaching interventions. Using the ECSA, students self-reported their perceived cultural competency skills when caring for culturally diverse people. Post-test scores from both groups rose significantly; however, post-test scores from the experimental group increased more than those in the nonexperimental group, suggesting the treatment had an effect. These findings are useful for nurse educators seeking to facilitate cultural competency in students and provide a specific successful teaching strategy (Napholz, 1999).

Majumdar, Browne, Roberts and Carpio (2004) administered six instruments to health care providers and patients randomly divided into experimental and control groups over one and one half years to determine the effectiveness of cultural sensitivity training on health care providers’ knowledge and attitudes and how this training affected patient care satisfaction in home care and hospital settings. Providers in the experimental group received 36 hours of cultural sensitivity training at the beginning of the study with baseline instrument assessment and then had instruments administered to them and their patients at 3, 6, and 12 months. Health care providers in the control group received training just before the last data collection phase. The study began with 114 health care providers and 133 patient volunteers. At each phase of the study, patients dropped out due to illness or death and providers due to relocation resulting in approximately 75
providers and 47 patients completing all phases of the study. Despite the study being conducted in an urban setting where one quarter of the population was foreign born, demographics of the health care providers and patients were similar with participants being from predominately European descent and the Roman Catholic and Protestant faiths (Majumdar, et al.).

The findings showed that health care providers who had received the cultural sensitivity training earlier conducted more thorough cultural assessments and rated culture as more important than those in the control group. Once providers in the control group received training, they responded similarly. Qualitative and quantitative data revealed providers who had received training demonstrated improved communication with minority patients as well as more open-mindedness and insight toward caring for people different than themselves. The health care expenditures among long term community patients were reduced by $7,000 over 1.5 years of the study. Researchers concluded that cultural sensitivity training improves culture care (Majumdar, et al., 2004).

Baldonado, et al. (1998) surveyed 767 registered nurses (RN) and baccalaureate nursing (BSN) students from the east coast, west coast, and Midwest of the U.S.. The Transcultural and International Nursing Knowledge Inventory (TINKI) was developed by the researchers and completed by participants. The questionnaire included closed and open-ended questions related to participants’ experiences in providing culture care. Interestingly, both the RN and BSN students reported little confidence in caring for culturally diverse people.
Participants reported they learned about how to care for culturally diverse people most often from experience in caring for them. Additionally, participants’ own personal values and education influenced care provided. However, few had received any formal transcultural nursing education from their professional preparation, continuing education, or reading; and thus, did not describe care actions and decisions based on a conceptual framework. Researchers identified that participants serendipitously modified their care to preserve/maintain or accommodate/negotiate client’s cultural traditions which reflects two of Leininger’s (2006a) modes of care. Participants revealed that modifications in care related to culture most often occur in the areas of “language and communication, pain perception and relief, religious and spiritual dimensions, gender and family roles, and other values” (p. 21) such as privacy and modesty, lifestyle, access to health care, hot and cold theory, and Ying and Yang theory (Baldonado, et al., 1998).

Researchers assessed that these participants were at the first stage of transcultural nursing knowledge; cultural awareness (Leininger, 2006a). Themes identified in the research reflected that nurses and students overwhelmingly perceived a need for transcultural nursing and they modified care provided to meet their client’s culture care needs. The researchers recommended that transcultural nursing concepts and clinical experiences in caring for people from diverse cultures must be integrated in curricula at all levels of formal nursing education (e.g. associate degree, baccalaureate, master’s and doctoral work) and in continuing education programs for practicing nurses (Baldonado, et al., 1998).

Canales and Bower (2001) conducted a grounded theory research study of ten doctoral prepared, Latina nurse educators. It was discovered that these educators viewed
culture and culturally competent practice very broadly. They teach students how to care for anyone who is ‘different’ from them using strategies of connecting directly through communities and immersion in the lives of those they care for. Researchers suggested the need to expand how cultural competence is conceptualized in nursing research, education, and practice to caring for anyone who is different from oneself (Canales & Bower).

At St. Luke’s College in Kansas City, Missouri transcultural nursing principles were purposefully integrated throughout the nursing curriculum. Students were taught to examine their own cultural backgrounds, values, and beliefs. They were taught transcultural nursing theory, Leininger’s culture care theory, the ethnonursing research method, and cultural assessment using the Giger-Davidhizar Transcultural Assessment Model. Students learned about racial and ethnic groups in the local community and the U.S. and biological variations in laboratory and clinical settings. Groups conducted in-depth studies of cultural groups and used posters to present their learning to one another, at professional meetings, in the school of nursing, and in staff lounges in hospitals (Hughes & Hood, 2007).

The Cross-Cultural Evaluation Tool developed by Freeman (as cited in Hughes & Hood, 2007) is a 5-point Likert-type scale which was used to measure student ability to make culturally sensitive choices. The tool was used with students as a pretest-posttest instrument. Hughes and Hood found that nursing students became more culturally sensitive after engaging in these specific teaching strategies to teach transcultural nursing.

A variety of additional teaching strategies were identified in the literature as effective for teaching culture care. A sampling of the strategies discovered is shared
here. Brennan and Schulze (2004) assigned students to analyze one of seven randomly chosen ethnographies using teacher-set criteria that addressed cultural factors. Students then gathered in groups to discuss, share and seek clarification of meanings in the ethnographies. This teaching/learning activity resulted in students examining their ethnocentrism and broadened their understanding of cultural diversity. The need to engage students’ affective and cognitive domains of learning through experiential learning was identified by Carpio and Majumdar (1993) as necessary for effective culture care education. In addition, they purported that the teacher was responsible to create a learning environment where cultural diversity was viewed positively rather than negatively or as a threat. Finally, Evans and Severtsen (2001) taught novice nursing students to use story telling for cultural assessment. Through practice with peers and then clients in a long-term care clinical setting, students learned to “listen in a nonjudgmental, contextual way to the values and beliefs of the storyteller” (Evans & Severtsen, p. 180); which strengthened the nurse-client relationship.

*Cultural Immersion*

In a study using a triangulated research design, St. Clair and McKenry (1999) explored the relationship between short term international nursing clinical immersion experiences and cultural self-efficacy and cultural competence. Two hundred senior and graduate nursing students participated over a two year time frame. Eighty students chose international immersion experiences while the remaining 120 students cared for culturally diverse populations in the United States. Students who participated in 2-3 week international clinical experiences reported a statistically significant increase in cultural self-efficacy as demonstrated on the CSES. Analysis of qualitative data further revealed
that the international immersion experience facilitated students in recognizing their ethnocentrism and need to develop cultural sensitivity and awareness. Students were able to value international patients’ cultural beliefs and practices and incorporate them into their nursing practice. Researchers concluded that even short term cultural immersion experiences are valuable in developing nursing students’ cultural competence “in ways currently not possible with nonimmersion community cultural experiences” (St. Clair & McKenry, p. 228). Researchers found that caring for culturally diverse people in a community setting may contribute to increased cultural awareness, yet is not effective in addressing ethnocentrism (St. Clair & McKenry).

Integrating cultural content in an undergraduate nursing program was found to produce small to moderate gains in students’ perceived cultural competence. However, for students participating in a 5-week international cultural immersion experience, perceived cultural competence gains were very large. Authors discussed the importance of students’ values and attitudes in motivating their commitment to provide culturally competent care. Opportunities to care for persons very different from oneself were found to be critical in developing confidence and practice expertise (Caffery, Neander, Markle & Stewart, 2005).

Hern, Vaugh, Mason, and Wietkamp, (2005) discussed a strategy to develop cultural sensitivity, a global community perspective, and cultural competence through collaboration of U.S. hospital and university nurses in international nursing exchange programs with Scotland, Honduras, and Korea. Based on their review of literature that revealed cultural competence requires commitment and action over an extended period of
time, multiple and unique partnerships were developed. Exchanges were arranged among practicing nurses in the U.S. and Scotland and among faculty in the U.S. and in Korea.

Student nurses and faculty traveled to Honduras for a two week cultural immersion experience in the community (Hern et al., 2005). Similar to other research reported in this review of literature, the authors suggested that a cultural immersion experience be for a minimum of 2 weeks. They pointed out, “a week long exchange is not sufficient to gain sensitivity to the other culture” (Hern et al., p. 41). Faculty concluded at least two weeks or more was required to travel and assimilate to the new culture and nursing environment; and recommended that the longer the exposure to the diverse culture, the more students learned and therefore were considering a 4-week exchange in the future (Hern et al.).

The authors developed a workplace model for practice and education partnering which included: beginning with a shared vision; developing infrastructure; securing funding; identifying outcomes for practice, education, and research; marketing these programs; and focusing on future collaboration. The importance of institutional support was stressed. Poignant examples of learning outcomes achieved by nursing students, practicing nurses, and faculty from exchanges and immersion experiences were shared. Authors identified more similarities than differences existed among cultural groups involved (Hern et al., 2005).

A collaborative partnership between the University of Pittsburgh and Miami Children’s Hospital was created for senior nursing students to complete their final, practice-intensive semester. The purpose was to cultivate undergraduate nursing students’ cultural competence through exposure to people from different cultures.
Clinical nurse specialists in Miami coordinated the clinical experience of students with preceptors there and with faculty in Pittsburgh. Extensive communication among all participants facilitated the process. Technology such as video conference calls, e-mail, and a course web-page were used. Students received scholarships to fund the experience. Students had the opportunity to care for patients and families from Jamaican, Hispanic and Haitian backgrounds and “completed a three-credit independent study on culture in nursing” (Hoffman, Messmer, Hill-Rodriguez & Vazquez, 2005, p. 242). In addition, they attended culturally specific professional nursing organizations and multiple local and national professional nursing conferences. Examples of specific culture knowledge students learned was provided. Upon return to Pittsburgh, students shared learning with faculty and peers and at a regional conference (Hoffman et al.).

Ryan, Twibell, Brigham and Bennett (2000) conducted a qualitative study of nine practicing registered nurses who had participated in a cultural immersion experience while earning their baccalaureate degrees in nursing. Participants described phenomena experienced and their perceptions of how their cultural immersion experience has influenced their nursing practice. Graduates stressed that while classroom activities and content were important, their immersion experience was critical to facilitating “learning to care”. Participants provided vivid examples of how these immersion experiences influenced them to provide culturally competent care. Rather than offering an elective course, suggestions were made for transcultural care to be viewed as “essential” and integrated throughout the curriculum. The researchers proposed a dimensional matrix to guide nursing educators as they develop, implement, and evaluate cultural immersion experiences (Ryan, et. al.).
In 2002, Ryan and Twibell conducted a study to validate the concepts included in this model; a *Matrix for Personal and Professional Growth Through a Transcultural Immersion Experience*. The authors developed a Transcultural Nursing Immersion Experience Questionnaire (TNIEQ) consisting of four parts (Likert scale, open-ended questions, rank order statements, and demographic data) to measure dimensions of the model. The questionnaire was administered to 52 undergraduate and 2 graduate students from five Midwestern universities who had participated in a 2-3 week national or international cultural immersion experience.

Results of the study provided researchers with valuable feedback for further model development. Of importance to teaching culture care, the model provides nursing faculty with knowledge of multiple factors established through research which can be addressed to promote a more positive cultural immersion experience for students. In addition, respondents indicated personal growth, increased sensitivity to the needs of others, and a general expansion of their worldviews were outcomes of participating in a cultural immersion experience (Ryan & Twibell, 2002).

Based on this review of literature, clinical cultural immersion experiences are transformative resulting in nursing students’ growth in providing culturally competent nursing care and addressing the holistic perspective of ethnocentrism, and cultivating cultural sensitivity and awareness. Some researchers have challenged nurse educators to continue to explore students’ cultural competence development through cultural immersion experiences. They wondered whether national immersion experiences might be equally as effective as international experiences in challenging students’ ethnocentrism and growth in cultural competence (St. Clair & McKenry, 1999). In our
world of international instability and students with limited financial resources, national immersion experiences may be an appropriate option for students and warrants further study (St. Clair & McKenry).

Institutional Culture

Teaching culture care requires institutional support and a cultural climate where people and experiences which are different and similar are valued and embraced. Yearwood, Brown, and Karlik (2002) held one focus group with seven student volunteers representing diverse races, religions, nationalities, and genders to explore diversity. Topics included what it is, the role of the school of nursing and university, and ideas about incorporating diversity in courses and clinical experiences. Data gathered has application to nursing education and teaching culture care. Students defined diversity as “differences between people including biological, religious, sexual orientation, life and family style” and that diversity was “mostly about color” (Yearwood et al. p. 238). Students were confused by the university focus on embracing diversity while encouraging cultural events and ethnic organizations that focused on differences and that separated groups of students. Students offered the following suggestions for faculty interested in facilitating development of cultural sensitivity: small group activities to encourage the opportunity to work with people different from oneself; promoting discussion and tolerance; focus on experiential learning versus lecture; and a course on cultural diversity incorporated into the curriculum (Yearwood et al.).

From the educational literature, Marchesani and Adams (1992) tackled the increasing diversity in the student population in higher education in the U.S. and proposed a four-part model for teaching and learning in a multicultural context.
Dimensions were directly related to facilitating a teaching/learning environment which values diversity and fosters exploration and achievement of cultural competence. Components of the model speak to knowing oneself, knowing one’s students, developing coursework where diverse perspectives are presented, and teaching with a variety of strategies to promote student success in people from varied backgrounds.

Schmitz, Paul and Greenberg (1992) provided an in-depth description of implementing the “Classroom Climate Project” in their university which was undertaken to develop classrooms with an effective multicultural context for learning. The goal was for faculty to create a warm and inviting, inclusive environment where students were valued and respected. The framework used for faculty development was Palmer’s model for learning and behavioral change which involves four stages necessary to create lasting change in the classroom; discovering, formulating new behaviors, producing new behaviors, and generalization to the real world. Authors identified the critical ingredient for creating this environment is “a teacher who appropriately recognizes and values different cultural styles and perspectives and effectively engages students in the learning process” (Schmitz et.al., p. 75). In addition, the authors pointed out efforts for multicultural learning must involve system wide changes.

Similarly, Grossman, et al. (1998) illuminated incongruence between stated philosophical values related to multicultural learning and actual practice. Deans and Directors of nursing programs in Florida shared their mission and philosophy statements and conceptual frameworks which supported cultural diversity and reported that cultural content was either integrated throughout the curriculum or taught in a specific transcultural nursing course. Yet, lack of cultural knowledge, sensitivity, and awareness
was most frequently identified by participants as a critical issue related to cultural diversity in their nursing programs (Grossman, et al.).

Institutional commitment to cultural diversity and creating a climate for teaching culture care should be demonstrated in the institution’s mission statement, by financial resources for faculty, staff, and student development, and through faculty and students valuing diversity and multiculturalism (Schmitz, Paul & Greenberg, 1992). Creating multicultural learning environments in the university setting is dependent on a “large-scale, complex, sustained organizational and cultural transformation” (Marchesani & Adams, 1992, p. 10).

**Conclusion**

Teaching culture care in nursing education is critical to ensuring a culturally competent workforce (Andrews & Peters, 2005). The literature indicates faculty are not adequately prepared to teach culture care or mentor students in cultural sensitivity or cultural competence. The literature suggests culture care and cultural competence are complex phenomena requiring broad, holistic approaches and teaching strategies to promote student understanding and application in their nursing practice. There is ambiguity and lack of consensus in the literature about the meaning and use of the terms “cultural competence” and “culturally congruent care”. This researcher referred to these terms as they were used by authors in their articles. Overwhelmingly, researchers recommend that formal transcultural nursing be integrated throughout the curriculum (Alpers & Zoucha, 1996; Baldonado et al.,1998; Cooper Brathwaite, 2005; Hughes & Hood, 2007; Ryan, Carlton & Ali, 2000;; Ryan, Twibell et al., 2000; Sargent et al, 2005) and that cultural immersion experiences are essential for learning to provide culturally
congruent care (Bosworth, et al., 2006; Caffery et al., 2005; Ryan, Twibell et al. 2000; Ryan & Twibell, 2002; St. Clair & McKenry, 1999).

While nursing programs and institutions of higher learning may have mission and philosophy statements supporting diversity and cultural content incorporated in curricula, the literature reflects there is incongruence between what is stated and the practices of faculty and students in classroom and clinical settings (Canales & Bowers, 2001; Cook & Cullen, 2000; Evans, 2004; Gardner, 2005; Grossman, et al, 1998). Learning to embrace the diverse and similar needs of nursing students and the individuals, families, and communities cared for requires a deep level of personal, faculty, college, and university commitment (Andrews & Peters, 2005; Campinha-Bacote, 2005; Cook & Cullen, 2000; Edwards, 2003; Newman & Williams, 2003). Cultural diversity must be valued and respected by institutional culture and integrated throughout nursing curricula to move beyond cultural awareness and cultural sensitivity to cultural competence.

There are gaps in the quantitative and qualitative research literature about the preparation faculty have had in transcultural nursing and in teaching about culture care, cultural diversity, and culturally congruent and competent care. Few studies were found which used nursing theory as a framework for nursing research and practice related to teaching culture care. Many studies have been conducted using a variety of quantitative measurement tools to measure student learning about culture and related concepts. In conclusion, there have been no studies conducted to discover nursing faculty care expressions, patterns, and practices related to teaching culture care nor have there been any ethnonursing research studies conducted using the culture care theory in this context.
CHAPTER III
Methodology

Ethnonursing Research Method

The ethnonursing research method within the qualitative paradigm (Leininger, 2006a) was used to discover nursing faculty care expressions, patterns, and practices related to teaching culture care. Leininger developed the ethnonursing research method to study transcultural human care phenomena using her theory of culture care diversity and universality (Leininger). Ethnonursing research methodology is “a qualitative research method using naturalistic, open discovery, and largely inductively derived emic modes and processes with diverse strategies, techniques, and enabling tools to document, describe, understand, and interpret the people’s meanings, experiences, symbols, and other related aspects bearing on actual or potential nursing phenomena” (Leininger, 2006b, p. 47-48). Qualitative research in general and the ethnonursing research method specifically requires the researcher to suspend any a priori judgments (Leininger; Lincoln & Guba, 1985). The researcher functions as co-participant with informants working together to discover how people experience and practice care in their daily lives. The method uses systematic and reflective processes while focusing on the cultural context to explicate lifeways and understand their meaning for informants (Leininger).

The ethnonursing method embraces the importance of discovery from the people’s ways of knowing and gives credence to the professional nurse’s way of knowing. The philosophic and epistemological sources of knowledge using the
ethnonursing research method are “…the people as the knowers about human care and other nursing knowledge” (Leininger, 2006b, p. 52). In this research study, faculty as knowers were interviewed using an open inquiry guide to discover their generic and professional care expressions, patterns, and practices related to teaching culture care.

Data Collection

Selection of Informants

Research informants, nursing faculty teaching in generic baccalaureate programs, were purposefully selected based on the domain of inquiry. Faculty from schools of nursing in public universities in the Southeastern United States from urban and rural environmental contexts were invited to participate.

Key informants are described by Leininger (2006b) as those people holding the most knowledge about the domain of inquiry. Key informants for this study were tenured nursing faculty who were willing to participate. These faculty were knowledgeable about the nursing curriculum, teaching culture care, and the environmental context of the university and school of nursing. General informants may not be as knowledgeable as key informants about the domain of inquiry; however, they provide reflective data about teaching culture care, stimulating the researcher to focus on care similarities and differences among informants (Leininger). Other nursing faculty including tenure-track, adjunct, clinical, and new nursing faculty served as general informants for this study.

Data collection was extensive and used multiple modes and contexts. Participant observation was documented in field notes and included touring the university and school of nursing; touring the town/city to discover the environmental context; and observing students at the state student nurses association meeting. Informants participated in
unstructured, open-ended interviews in multiple contexts including face-to-face, phone, and e-mail, contexts.

Field journal documentation and field information such as public documents related to teaching culture care and the university context were used as a source of data for the study as well. The researcher viewed university and school of nursing public documents such as philosophy and mission statements, faculty and student recruitment policies and procedures, nursing school admission and retention policies and procedures, faculty and student learning opportunities related to culture and diversity, and curricula information such as syllabi, course descriptions, clinical evaluation tools, and some PowerPoint presentations related to culture. Many of these documents were available on the university web site and some faculty shared course documents.

Research Enablers

Access to the faculty was gained through the directors of the schools of nursing. An initial e-mail was sent introducing me and the study with a request to contact faculty. The directors of nursing were extremely supportive and gave suggestions about how best to gain participation of their faculty in the study. Informants were asked to participate in the study by either phone or e-mail at a time and date of their convenience. The researcher had learned through conducting a pilot study that many faculty preferred meeting away from the university in a location they chose. As a way of expressing appreciation to informants for participation, the researcher offered to purchase a cup of coffee or soda and a snack or lunch. One faculty chose a public library, one chose her home, several chose the university setting, and most a chose a coffee shop or restaurant.
Word of mouth or formal introduction was the most effective way to gain access to faculty. A few faculty responded readily to the researcher’s initial e-mail.

The researcher communicated with informants via phone and/or e-mail to set up interview dates and times. Leininger’s Stranger to Trusted Friend Enabler (see Appendix C) was used to establish trusting relationships with informants. Leininger explains such trusting and friendly relationships are necessary “during the ethnonursing research process to obtain accurate, sensitive, meaningful, and credible data” (Leininger, 2006b, p. 59). Since the researcher was also a nursing faculty, she was careful to suspend any apriori judgments and to maintain an open, neutral approach. Being a nursing faculty member was useful in understanding nursing and faculty contexts, in particular the clinical setting. Therapeutic use of self, presencing, and active listening was used to make a connection with faculty. The ‘trusted friend’ relationship was readily established with informants after several e-mails, phone calls, and quickly during the interview process.

Several informants requested the audio recorder be turned off during the interview to share confidential information. Most (23) Informants were interviewed (face-to-face) using an audio recording device. Four informants preferred telephone interviews. Interviews ranged from one to two hours. Informants were asked to spend an hour and then as they participated, most chose to continue longer.

To guide in-depth, open-ended interviews, an open inquiry guide enabler (see Appendix D) was developed based on the components and major constructs of the culture care theory and sunrise enabler and considering the research questions and domain of inquiry (Leininger, 2006b). The inquiry guide was further refined based on the evaluation of four doctorally prepared transcultural nursing experts. This document was
used as a guide and the interview flow was based on participant responses. Follow up phone calls and e-mails were made to clarify interpretations, meanings, and findings.

**Human Subjects Considerations**

Approval from The University of Northern Colorado Institutional Review Board was received (see Appendix E). Participants were made aware of their right to volunteer and withdraw, the nature of the interview questions, and steps taken to protect their confidentiality through the informed consent process. Participants were asked if their voices could be used in sharing the data anonymously. There were no foreseeable risks to participants in this study. Participation required the use of informants’ time which was estimated to be a maximum of two to three hours. There were no direct benefits for participation. Informants may have found participation useful in their teaching related to cultural diversity, cultural care, and cultural competence. The knowledge discovered may benefit the practice and profession of nursing and the ever-evolving body of transcultural nursing knowledge.

Interviews were audio recorded and later transcribed by the investigator and/or a transcriptionist. Numeric identifiers were used for data collected to keep participant names private. Only the researcher and her research advisor/committee had access to the data. Names of participants and institutions were not used in any part of the published research document or professional presentations. Audio recordings, transcribed interview data, documents, field notes, and e-mail communications were stored in a locked file cabinet in the researcher’s home. Signed consent forms are stored in the school of nursing for three years after the completion of this project. In addition, data has been reported in aggregate so the participants will not be able to be identified.
Data Analysis

Audio recordings, transcribed interview data, e-mail communication, documents, and field notes were analyzed using Leininger’s (2006b) four phases of ethnonursing analysis for qualitative data (see Appendix F). Phase one of data analysis began on the initial day of research and continued throughout the study. Informants’ interviews were transcribed in Microsoft word and excel. The researcher was fully immersed in the data and personally transcribed most of the audio recordings. Several interviews were transcribed by a professional transcriptionist carefully reviewed by the researcher. Listening to informant voices and expressions brought forth important contextual data, tone, and emphasis of data.

In the second phase of ethnonursing qualitative analysis, data was studied for similarities and differences, and meanings were sought from recurrent components in the data. In the third phase, patterns and ideas related to teaching culture care were identified. The fourth phase involved synthesis and interpretation of data, abstracting themes from the findings. Finally, themes confirmed were used to identify nursing decisions and actions in teaching culture care. As data was analyzed, informants were contacted for additional data and clarification. Informants confirmed findings related to themes and patterns and provided valuable feedback about the accuracy of discoveries made. In all phases of analysis, findings were traced back to the raw data which was essential for an audit trail and to meet the five qualitative criteria for ethnonursing studies; credibility, confirmability, meaning-in-context, recurrent patterning, and saturation (Leininger, 2006a).
The ethnonursing research criteria of credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability were used in this study to ensure rigor. *Credibility* refers to the accuracy or believability of the research findings (Leininger, 2006b). Informants’ emic perspective was sought particularly through their stories and examples about the domain of inquiry. The researcher obtained data from participant observations, artifacts, and the environmental context. As suggested by Leininger, the researcher collected data over six months to ensure prolonged engagement within the environmental context and with the informants to understand the reality of teaching culture care in baccalaureate nursing programs (Leininger).

*Confirmability* refers to direct evidence of informants’ experiences and meanings. The researcher reaffirmed over time what was seen and heard. Data was maintained and systematically documented to ensure findings can clearly be traced to actual data collected. The findings reflected universality and diversity among informants as anticipated using the culture care theory (Leininger, 2006b; Dr. M. Leininger, personal communication, May 24, 2000). As data was analyzed, informants were contacted for additional data and clarification of meanings. Informants confirmed findings related to themes and patterns and provided valuable feedback about the accuracy of discoveries made. One informant shared, “The co-mentoring seen as reciprocal caring especially stuck out to me as well as your findings promoting healthy lifeways. I did see myself throughout your comments.” Another stated, “Your findings are congruent with my experience as a faculty in dealing with culture and caring with students. I didn’t find any areas that were not applicable (or didn’t fit) with my experiences”. Still another communicated, “I have read your findings and find them consistent with my interview
and with my 31 years of experience in nursing education.” Since informants were master’s and doctoral prepared faculty, acquainted with research processes, a document with the patterns, themes, and modes in outline format was sent for their review and confirmation. This type of confirmability with informants was a unique opportunity afforded this ethnonursing research study.

*Meaning-in-context* refers to “data that are understandable and relevant within certain situations, settings, life experiences, or within specific or total frames of reference” (Leininger, 2006b). The researcher’s holding knowledge was that teaching culture care in nursing occurs within the context of the university and school of nursing. Extensive field information and artifacts such as philosophy and mission statements, web pages, policies and procedures, curriculum documents, tours of the schools of nursing and universities, and reflections provided additional sources of data for relevant data analysis.

*Recurrent patterning* refers to evidence that patterns reflecting lifeways, meanings or experiences occur over time. Some consistency in patterns can be identified (Leininger, 2006b). The researcher found that being immersed in the natural setting of schools of nursing, the university, and its city/town over a six month period allowed the opportunity to observe similarities and differences of culture care expressions patterns and practices (generic and professional) among nursing faculty.

*Saturation* refers to the notion that data is collected until redundancy occurs; informants share similar information (Leininger, 2006b). The researcher transcribed interview data and field notes continuously throughout the study. Preliminary interpretations were made based on the domain of inquiry and specific research
questions, while being open and attentive to new insights. As the data collection proceeded, the researcher noted when redundancy of data occurred. Several more interviews were conducted and redundancy was confirmed by a research mentor.

Transferability refers to when findings from one qualitative study can be used in another similar context (Leininger, 2006b). The researcher anticipates nursing faculty teaching in other baccalaureate nursing programs and in other geographic regions of the U.S. may use the findings from this study. Nursing faculty in other similar contexts may use findings to integrate transcultural nursing into nursing courses and to develop new transcultural nursing courses. Findings may contribute to a future meta-analysis conducted to discover data about teaching culture care in nursing programs.

The use of a research mentor was critical to the entire research process. The research mentor holds a PhD in nursing with a focus in transcultural nursing; co-authored numerous works with Dr. Madeline Leininger; has extensive research expertise particularly with the ethnonursing method; and is certified in transcultural nursing. Leininger (2006b) has articulated the importance of using a research mentor to reduce biases; reflect on the data and ensure findings are well grounded; and to facilitate meaningful linkages with similar and diverse data and with discoveries from other ethnonursing research studies.

Pilot Study

A pilot study was conducted prior to the full study. Approval was received from the University of Northern Colorado Institutional Review Board and 3 key and 3 general informants participated. The pilot study provided valuable knowledge about refining the open inquiry guide, qualitative interviewing in the contexts proposed for this study, type
of and use of recording equipment; data analysis procedures; use of the culture care
theory and ethnonursing research method; and the overall study plan.
CHAPTER IV
Results and Findings

Introduction

This chapter presents in-depth findings from the study. Ethnohistory and ethnodemographics reveal embedded data which was valuable in understanding informants within the environmental context of these urban and rural schools of nursing/universities. Four universal themes with universal and diverse patterns which supported the themes are presented. Descriptors are shared extensively to illustrate informants’ worldviews and religious and cultural values, beliefs, and practices and lifeways that contributed to the patterns and themes abstracted. Implications for nursing practice using the culture care theory three predicted modes of nursing actions and decisions; culture care preservation or maintenance, accommodation or negotiation, and repatterning or restructuring are presented (Leininger, 2006a).

Ethnohistory and Ethnodemographics

This study was conducted with nursing faculty teaching in baccalaureate programs in the Southeastern United States. The universities were part of a public state system. One university was located in an urban setting in a city of approximately 1.3 million people with many universities and medical centers. Diversity was reported as 62.48% White, 28.16% Black, 6.22% Hispanic, 2.97% Asian, 0.33% Native American, and 5.67% claim 'Other' (Sperling’s Best Places, 2007). Informants report availability of diverse clients to care for listing African American, Hispanic, Middle Eastern, Iranian,
African, Haitian, Kurdish, Asian, people of color from the Caribbean, middle class, poor, affluent clients and a variety of religious groups referring to Muslims most often.

Students represented diverse groups comparable to those described above; however informants mentioned there were few Hispanic nursing students, especially when compared to the large Hispanic population in the area. An informant stated students’ parents were “professors, share croppers, and factory workers” noting differences in affluence among students. Faculty diversity was described by an informant as all female and 60% African American, 40% Caucasian, and one Hispanic faculty member.

The other university was located in a rural setting in a city of less than 30,000 people with a mid-sized university and a regional medical center serving a 15 county region. There were no other major universities or hospitals and consequently the school of nursing enjoys significant support from the community and area health care agencies. Diversity was reported as 89.03% White, 3.28% Black, 5.49% Hispanic, 2.50% Asian, 0.18% Native American, and 4.63% claim 'Other' (Sperling’s Best Places, 2007). Informants report availability of diverse clients to care for listing Euro-Americans, Guatemalan, Asian, Appalachian, African American, Jehovah’s Witness, Mennonite, Catholic, Moon, and Jewish clients. Additionally, several informants noted the influx of retirees with money and health care benefits moving to the area.

The student population is predominantly white. There is student diversity in terms of gender and several black students as well. One informant stated that diverse students are “well received” by faculty and students stating “they [students] didn’t seem to give that a second thought”. Many students are first generation in college. Faculty
were all Caucasian females describing Euro-American heritage including Scottish, Irish, French, English, Polish, and Native American and one of Egyptian background.

Both regions continue to experience population and economic growth with low unemployment rates (cite best places website). Faculty at each site arranged diverse learning opportunities and stimulated a broadened worldview for students beyond their own region. Faculty in the rural setting provided a learning experience for students in an urban setting and faculty in the urban setting assigned students to care for clients in a rural setting. Both facilitated students to develop a commitment to care for underserved populations. Most faculty were raised participating in organized Christian churches. Faculty expressed a strong work ethic and “doing what it takes” for the nursing program and students to succeed.

Twenty seven nursing faculty participated in this study. Ten tenured faculty were key informants; 5 from an urban setting and 5 from a rural setting. Seventeen faculty were in a tenure track or adjunct/clinical faculty role of which 8 were urban and 9 were rural. As is congruent with the ethnonursing methodology, faculty were interviewed until saturation occurred.

The overall age range of informants was 25-71 with an average informant age of 45. Key informants (average age 52) were older than general informants (average age 41). Urban key informants were significantly older (average age 60) than rural key informants (average age 46) (see Table 1). All participants were female. In terms of race, Caucasian informants referred to themselves as such while some informants of color referred to themselves as African American and most as Black. There were 7 Black and 5
Caucasian urban participants while all rural participants were Caucasian. Overall, 26% of informants were Black and 74% were Caucasian.

Table 1

Age and Ethnicity of Informants (N = 27)

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<td>Range</td>
<td>Average</td>
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<tr>
<td>Urban</td>
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<td>Key</td>
<td>33-71</td>
</tr>
<tr>
<td>General</td>
<td>25-62</td>
</tr>
<tr>
<td>Overall</td>
<td>25-71</td>
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</tbody>
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When asked about cultural background, it is significant to note that most informants did not relate to a specific bloodline, rather described themselves in terms of their family, siblings, community, socioeconomic class, work ethic, or education. Those that had American Indian ancestry knew their heritage well and usually could name the nation they descended from. There was marked diversity among faculty heritage and each described a mix. For example one faculty who labeled herself as African American shared her family ancestry was African American, French, Creole, German, and American Indian. A Caucasian faculty member described her family ancestry as Scottish, Irish, French, and American Indian and further described her heritage by naming the region of the state she was raised in and that she grew up in a closely knit African American community. One faculty member described her cultural background as “raised in a large extended family in an African American ‘community village’ by friends and church members”. Another described her family “has always lived in the country” and came from “low socioeconomic status”. In terms of their religion, all key informants
were Christians from varying denominations. Thirteen general informants were Christians from varying denominations and four described a universal spirituality.

All key informants were tenured. Eight general informants were in tenure-track positions, three were in full-time non-tenure track positions, one was part-time, and five were adjunct faculty. Six key informants achieved the rank of full professor and four were assistant professors. One general informant was an associate professor and ten were assistant professors. Key informants had significantly more teaching and nursing experience than general informants (see Table 2).

Table 2

<table>
<thead>
<tr>
<th></th>
<th>Years Teaching Exp</th>
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<th>Years Nursing Exp</th>
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<tbody>
<tr>
<td></td>
<td>Range</td>
<td>Average</td>
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<tr>
<td>Key</td>
<td>6-40</td>
<td>21</td>
<td>10-48</td>
<td>30</td>
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<tr>
<td>General</td>
<td>0.25-11</td>
<td>4</td>
<td>2-37</td>
<td>16</td>
</tr>
<tr>
<td>Overall</td>
<td>0.25-40</td>
<td>10</td>
<td>2-48</td>
<td>21</td>
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</table>

Seven of the ten key informants held doctoral degrees. Two doctoral degrees held were in nursing, two were in counseling, and three were in education. The highest degree held for three key informants was a Master’s of Science Degree in Nursing (MSN). All urban key informants held doctoral degrees while two out of five rural key informants did. Similar educational patterns were seen in general informants. In the urban setting three informants held doctoral degrees, two were in nursing. One urban informant was in doctoral education, two were making plans, and two had no plans to further their education at this time. In the rural setting, one general informant held a doctoral degree
which was in education. One rural informant was working on her doctoral degree in
nursing, one was making plans, and six had no plans to continue their education at this
time.

All informants had earned an MSN except one rural adjunct/clinical faculty held a
Bachelor of Science degree in Nursing. Every key informant earned a MSN with a
clinical focus and seven were nurse practitioners (NP). Thirteen general informants held
advance practice certification with a focus in nursing education, health management, and
case management and three did not.

For many informants, formal education was a life-long process. Five began their
nursing careers as licensed practical nurses and four began as diploma or associate degree
nurses. Two informants came into nursing through a ‘bridge’ program; earning their
MSN from a degree in another field. An interesting observation was made in terms of
faculty who chose to teach in the same program from which they earned a degree. One
half of urban general informants and three fifths of rural key informants earned their
bachelor or master’s degree from the same institution they now taught at. In contrast,
only one of five key urban informants and two of nine rural general informants now teach
where they were taught.

Nursing practice was identified by informants as an important component of the
faculty role. Twenty one of the 27 informants have continued their nursing practice
while teaching. One half of key informants and 15 of 17 general informants were
actively practicing. Practice settings reflect the diversity of practice expertise. Six
provide care in psychiatric out-patient settings, seven work in clinics (urban and rural)
caring for disadvantaged, and the remaining practice in a variety of acute and community settings.

Approximately one half of urban informants and one seventh of rural informants stated they had some transcultural nursing education incorporated into their graduate education. Two fifths of urban key informants and no rural key informants had received formal transcultural nursing education or participated in faculty development in transcultural nursing. Seventeen informants spoke only English. Seven described speaking some language other than English with Spanish most commonly known, and German and French mentioned. One informant was fluent in Creole and one informant was fluent in Spanish and French and knew some Italian. Interestingly, four informants have lived outside the United States and seven have participated in nursing work in other countries. No informants have taken or taught a formal cultural immersion nursing course.

Urban and rural faculty described major steps taken by their universities to foster diversity on campus. An urban faculty member shared that the first class session always included the mission at the university of “creating education for a diverse world”. Many faculty shared that they addressed health disparities of underserved populations. A rural faculty member discussed steps the university took to broaden students’ worldview beyond the region. Strategies such as international travel opportunities, including funding and cultural diversity days on campus were described. Interestingly, faculty discussed struggles on both campuses related to diversity. On the urban campus, there were struggles related to equity and resource distribution among students. On the rural
campus, there were struggles to get students to expand their worldview beyond their homes and local region.

In this study, technological factors were more advanced in the rural setting than in the urban setting. Rural faculty had laptop computers and described outstanding support from the university technology department, reflecting one of the mission statements of that university. One informant stated that technology was “way more advanced here than in New York City.” She believed that the challenges related to travel and distance in the rural setting account for this difference.

Nursing faculty struggle with issues related to their buildings. This concern is being resolved in the rural setting as a new nursing building was under construction through the support of a variety of funding sources including the university and community. A five year increasing enrollment plan with corresponding increase in faculty lines was underway. Faculty in the urban setting were challenged with an aging building and limited secretarial support and office equipment. Neither faculty groups were satisfied with funding for faculty travel.

**Major Research Findings**

Based on extensive data analysis over time, the researcher extrapolated four universal themes and universal and diverse patterns related to nursing faculty care expressions, patterns, and practices for teaching culture care. Descriptors illustrate informants’ worldview and religious and cultural values, beliefs, and practices and lifeways that contributed to the patterns and themes abstracted.
Theme I: Faculty care is embedded in Christian religious values, beliefs, and practices within the context of the southern United States.

This universal theme was derived from faculty expressions of their Christian faith permeating every aspect of one’s being. One informant shared “absolutely influences every aspect of my life…God the Father, Jesus the Son, and Holy Spirit the comforter…to do what I do every day.” Another stated “I have a personal relationship with the Lord Jesus Christ…integral part of who I am. So I don’t see that I could ever leave that out. The south is known as the Bible belt and this is the buckle of the Bible belt. There are more bible believing people who rely on faith.” A faculty member shared that she had cancer as a young child and she sees nursing as a way of giving back. She describes how her faith permeates her being as a nurse; “If your hands and heart aren’t one together, you can’t be a great nurse.”

The care patterns that supported this theme were: (a) Faculty care as spiritual connectedness; (b) Religious/spiritual care for people who were diverse and similar; and (c) Care as prayer. There was some diversity in the patterns in that four of the twenty-seven informants had a more universal spiritual approach.

The faculty care as spiritual connectedness pattern was expressed as an ecumenical focus. Faculty strong beliefs enhanced their ability to care for students and patients and families from similar and diverse religious backgrounds. Faculty were intentional about avoiding cultural imposition themselves and teaching students to do so. One informant provided an example of helping a student work through her religious beliefs when caring for a patient. “The student said ‘I don’t know if I can do this [care
for a gay patient with AIDS]…it is against my value system’. I said you don’t have to change anything you believe to take care of patients. What does your faith tell you about caring for others? The student said ‘I love them’. So I asked can you do this. And the student said ‘Yes’.”

Another informant described the influence of her faith on teaching; “I recognize we all have weaknesses and we all have forgiveness that we must ask for. The whole Christian belief. And through that I see acceptance more because as you know in nursing we see a lot, hear a lot and you see people sometimes during their best and sometimes during their worst parts of their life. And there are times you see a lot of weaknesses in human kind as well as strengths and just recognition of all that. And that’s why I try to take each person as an individual and where they’re at now and try not to judge.” This informant further described how she shared this sense of grace with her students as she assisted them to examine their values and beliefs toward the patients and families they cared for.

One faculty described that she comes into her teaching un-biased, “even though God is the center of my world, all students may not have similar beliefs.” She gives them the chance to explore their spirituality “whatever that might be; from whence their energy comes.” Another shared learning from Sunday school, “judge not lest ye be judged” stating her faith has “provided a way of getting along with colleagues. It really has…has been good for me.”

Faculty were mindful of teaching in a state system while attending to students’ spiritual needs. A faculty member stated “Students asked, ‘can we close the door. I’m having a problem, can you pray for me?’ I had to do that under the table because I work
at a state institution.” This informant went on to say that such activity needs to be “student led”. Several other informants shared, “at a state school, you have to be careful…” how religion is discussed and integrated. One participant expressed, she would have liked to teach at a Christian university. Then she reflected, “A positive note in a public university is the equity of all different spiritual beliefs and values. One part of me wants to share my values and the other side might not. Being in a public institution made me be cautious…that might be a good thing.”

The second pattern contributing to this theme was religious/spiritual care for diverse people as taught to students. Faculty focused on teaching students to be respectful in attending to religious/spiritual care. Several faculty taught students to care for others as they would themselves or their own families. All faculty focused on teaching students to be nonjudgmental in caring for patients and families. One informant shared “Students are very spiritual when they come to us…Religiosity is big in their lives and it takes a while for students to understand that they don’t have to embrace the culture or religion of the patient, yet certainly must talk to them on their journey.”

Another faculty communicated she teaches students to “treat every patient the same, no matter how they got to be in our care and whether we agree with their lifestyle or habits.” She further articulated, “You can’t let personal feelings get into your nursing. You just can’t.” The faculty noticed a student struggling as she cared for a patient who was an IV drug abuser. The faculty discovered that the student was working hard to raise her brothers and sisters because her mom was an IV drug abuser; it “hit really close to home.” The faculty assisted the student in dealing with her feelings and shared “She did very well [caring for this patient]. It’s another way that the Lord works with us because
He got into my head to see her struggle and help her through it. Things happen for a reason.”

*Care as prayer* was the last care pattern which supported this theme that faculty care is embedded in Christian religious values, beliefs, and practices. Care was expressed as praying with and for faculty, students, and patients and families. Faculty shared that students frequently requested prayer before tests. Praying was described by one informant as “it’s an integral part of who I am so I don’t see that I could ever leave that out.” Another shared “to me, prayer is always in order.” A clinical faculty stated, “Mornings I go to teach include students in prayer and me to teach them in a way that they will get it.” These three care patterns and descriptors led to the discovery of this universal theme that faculty care is embedded in their Christian values, beliefs, and practices.

**Theme II:**

*Faculty taught students culture care without an organizing conceptual framework and with differences among classroom, on-line, and clinical contexts.*

Although this theme tended toward universality, some diversity among the patterns as faculty taught culture care was present and will be discussed within presentation of the patterns. The care patterns that supported this theme were: (a) Faculty taught culture care without an organizing conceptual framework in classroom and on-line contexts; (b) Faculty explicitly taught culture care in clinical contexts; (c) Some faculty taught culture care in classroom and on-line contexts.

The care pattern *faculty taught culture care without an organizing conceptual framework in classroom and on-line contexts* demonstrated some universality and
diversity. All faculty valued teaching culture care and most taught without the use of an organizing conceptual framework, theory, or model. These faculty focused heavily on rich experiences and less so on scholarly work in transcultural nursing. This finding relates to the demographic data described above that most faculty had little or no transcultural nursing education. There was diversity in this pattern in that several informants discussed using a theoretical base to teach culture care, specifically Leininger’s culture care theory. Additional discoveries related to this pattern are that few informants used a theoretical base to teach nursing in general and even fewer to teach culture care. Those informants who used a theoretical base to teach asserted that they rarely made the theory overt to students. Faculty that held doctoral degrees in nursing tended to teach based on nursing theories.

The second care pattern contributing to this theme was universal and is that faculty explicitly taught culture care in clinical contexts. Faculty in urban and rural settings valued the importance of teaching students culture care and did so through caring for diverse patients and families. While the type of diversity represented in urban and rural populations differed, faculty in both settings spoke about the diversity of client population in terms of racial, ethnic, religious, economic, educational, and kinship factors. Informants described being intentional in making clinical assignments to provide students the opportunity to care for diverse clients.

Informants clearly identified that culture care was taught in clinical settings through modeling. One informant expressed “I’m hoping it is my example more than me telling them what to do.” One participant communicated she teaches her students to treat all people with respect and to address individual needs. An example was her student
cared for a patient who was being discharged from the hospital and couldn’t read or write. The available resources were not useful. The faculty informant discussed how she assisted the student through this challenge by modeling respect for and using creativity to teach the person.

Faculty articulated they learned and taught caring through modeling and mentoring. An informant shared she learned to care “watching the other nurses I respected” and therefore feels strongly she must model for students. Another participant spoke about a faculty mentor from her undergraduate nursing program that inspired her to care about culture. “We’d be working in pediatrics and she would say ‘this family has four other kids. They [mom, dad, and one child] are in the hospital for two weeks, how are they taking care of the other kids? Why is this nurse being so judgmental about the mom not being here for hours in the morning? She has to work or she’ll be fired.’ She just really brought that culture and psychosocial piece home…That stayed with me and still stays with me to this day.” This faculty informant further explained how she similarly inspires her students to address patient and family culture care needs today.

Another universal pattern that supports this theme is some faculty taught culture care in classroom and on-line contexts. While all informants taught culture care in the clinical setting, some informants addressed culture explicitly in the classroom. There were no formal transcultural nursing courses nor was there a culture care thread in the curricula within the environmental context of the schools of nursing where informants taught. Culture care was most often addressed within a course through a class session devoted to culture. Faculty used a variety of strategies to teach culture care in classroom
and on-line contexts; textbook reading assignments, lectures, care plans, journals, seminar-style discussion and case study analyses.

One informant asked students to write a journal reflecting on a cultural encounter and analyzing what they might do differently. Several faculty described cultural sensitivity exercises involving role play. An informant shared, “Students don’t really get culture until they role play.” Another informant asked students to address patient and family culture needs in their nursing care plan. One informant taught her students about a clinical encounter she had related to caring for a diverse patient and family. As she described this situation, she reflected that there needs to be “infrastructure for what needs to be in place, because I don’t have it, and I think it is essential…I want to teach them what they need to know so that when they get out there, they are culturally competent. That’s the big word, culturally competent; culturally competent. What detects? what measures cultural competence and preparedness?”

A faculty member with many years of teaching experience shared this wisdom “Let students know you’re on their side.” She shared it is important to create an environment where “no matter how you feel, we’re not going to put you down or say you’re a bad person. It’s OK. [There is] confidentiality and trust. What is discussed here, stays here.” This informant further explained she tells students “…and it doesn’t mean if you have stereotypic beliefs of blacks or whites that you are a bad person or Hispanics or whatever. You have to go beyond it.” The informant felt strongly that faculty have a responsibility to create a safe environment for students to explore their values and beliefs related to people who are similar and different from them. This faculty participant used resources such as professional and popular books and movies;
documents (such as Healthy People 2010), statistics, and health disparity data; and integrated discussion of culture related to the issues of nutrition, breast cancer, glaucoma, health prevention and safety. She described having students analyze their own family was “quite therapeutic”. For a midterm exam, this informant gave students a movie list such as “the American Family” or “Soulfood” to choose from and requested students write up and analyze the movie, then share and discuss with one another. The universality and diversity expressed within this theme and these three patterns reflects how faculty taught culture care in these urban and rural schools of nursing.

Theme III:

Faculty provided generic and professional care to nursing students to maintain and promote healthy and beneficial lifeways.

This universal theme was derived from faculty expressions of the generic and professional care provided to nursing students as they taught culture care. The care patterns that supported this theme were: (a) Faculty identified roots of generic care came from their family or mentors and (b) Faculty care as professional mentoring and role modeling for students is essential to teach culture care. Most faculty identified their roots of caring came from their generic family and some identified they learned to care from mentors. One informant explained “Granny always wanted to be a nurse. She taught me how to love; if you know how to love, you know how to care.” Another stated that learning to care came from “family. Goes back to childhood; probably my mother…And I passed on to my daughter and granddaughter.” A faculty informant shared she learned to care from “my mom, from my professors, from my church family.” Another stated “I learned how to care by people caring for me; my instructors, my
friends, mentors that have been in my life, and then I learned how to care from hands-on experience working in a hospital setting.” Generic care patterns, expressions, and practices were learned and then passed on to students.

*Faculty care as professional mentoring and role modeling for students is essential to teach culture care* was a universal pattern that supported this theme. Faculty provided professional care to nursing students which contributed to their healthy and beneficial lifeways. Faculty care through mentoring and role modeling was essential to teach culture care. Faculty were mentored and in turn passed it on. One informant described her job was to “help students grow”. She shared she had been mentored and in turn mentored others. Faculty expressed the need to teach students to be healthy and learn to practice self-care. Several articulated one must “care for self before you can care for others.”

Informants fostered a caring community in their schools of nursing. Faculty gave numerous examples of how they demonstrated respect for students and practiced student empowerment. Respect was demonstrated by faculty honoring student responsibilities outside of nursing school. Faculty demonstrated flexibility with students meeting course requirements as students dealt with caregiving issues in their families, including illnesses and deaths. Informants taught students to respect themselves, one another, and patients. Respect was modeled even in the written word, in the form of honest and constructive feedback so students could learn. Expectations for students to be successful were clearly articulated throughout the student experience at the university, in the school of nursing, and individual courses. One faculty described how she empowered students in her course. After a test was returned, she encouraged students to make an argument for
incorrect test answers and rewarded them with points for daring to speak up and articulate their developing nursing judgment.

The professional caring behaviors of “listening”, “checking in”, being “approachable” and socializing/visiting with students contributed to creating a caring community in the schools of nursing. Informants communicated the importance of listening to one’s students. One seasoned faculty provided an example of “listening” in the on-line environment; [I] “read between the lines of student discussion and ‘heard’ their concerns.” She was able to address these concerns and in turn received students’ gratitude. “Checking in” occurred with students in class, and via e-mail, and telephone calls providing open avenues of communication with students. Such interaction might be used to clarify assignments, answer questions or negotiate flexible assignment dates to facilitate students meeting their responsibilities outside the school of nursing. Another described an activity her students were participating in which she did not have to attend, “…but I wanted to check in with them, see if they had questions.”

Being “approachable” and socializing/visiting with students was used by informants to establish caring relationships. One informant described “…just really stopping and talking to the students, you know, not just about class work, but about some other things that, you know, might be on my heart to talk to them about that involve caring about someone beyond just class work things.” Another faculty described a program the university had instituted to facilitate freshmen student satisfaction and retention. Freshman students took a survey course within their major to establish relationships with faculty and learn more about their career choice. This faculty
informant cultivated caring relationships with students; [I] “try to be personable with them.” She recognized freshman students have fears and encouraged them to call her.

Faculty further fostered caring in the school of nursing by providing services for student success; tutoring, feedback, coaching, assistance for ESL students, and instilling hope. One informant stated she works to make the best clinical assignment for each student and then was available by phone as students prepare paperwork for the clinical day. She encourages students to stop preparing and go to bed to get some rest. Some faculty spend extra time with student athletes who have had to miss class for sporting events to facilitate their success. A clinical faculty informant shared how impressed she was with the full-time faculty who called a meeting with the teaching team to brainstorm how to assist a struggling student. Another informant described coaching given to students to teach professional behaviors; “calling students” on their behavior when it is inappropriate. Students were held accountable for their verbal and nonverbal professional communication. Finally, faculty described a balance between caring for students and maintaining a professional relationship to facilitate their success. This “balance” occurs on a continuum based on individual faculty informant boundaries.

In the spirit of investing in students’ success, an experienced faculty shared “Education isn’t so much about what you learn, but about who you become.”

Theme IV: *Care is essential for faculty health and well-being to teach culture care within the environmental context of the school of nursing/university.*

This universal theme was derived from the informants’ worldview and religious and cultural values, beliefs, and practices. The universal care pattern that supported this
theme was caring as leadership to create a healthy faculty community. The diverse pattern that supported this theme was noncare was expressed as cultural conflict.

The universal pattern of caring as leadership to create a healthy faculty community was expressed by informants as referring to both formal administrative leadership and personal leadership of each faculty member. Administrative leadership as caring was described by one informant as “[She’s] been a mentor to many…knows how to work the politics of the university to be effective for the faculty…knows how to get things done. She’s probably one of the most effective people I’ve ever known.” Faculty informants also described that caring leadership provided support staff and resources that facilitated faculty scholarship, students, and created a positive environment. Another informant shared that some faculty took ‘leadership’ to be responsible for the school of nursing and further stated “I think everybody has to take their responsibility for the school; it’s not just on one person, but it’s a collective effort.” Caring behaviors were described among three caring constructs; collective caring, reciprocal caring, and self-care.

Respect was expressed by faculty as the most important caring construct to create a healthy faculty community to teach culture care. Informants described that “appreciating” similarities and differences among one another and being “amenable to” and “embracing different cultures and traditions” was necessary to express respect. One stated “all [faculty] have a unique contribution and all respect each other”. Another shared faculty are “honored for who they are. Differences are worked out among faculty simply by talking to one another” and usually resolved through the shared value of “being there for the students”. Informants addressed the need to be open about and work out
conflict. One stated “being willing to sometimes have the conflict in order to resolve issues” and described how the school of nursing culture expects faculty to speak directly to one another to resolve conflict and as a faculty group, lively discussions occur in meetings and then faculty walk out the door and go to lunch together. An informant shared “…not having that backbiting…you know you have a situation with another faculty member, you go to them and just kind of work it out, you know you don’t go to other people and harm their reputation.” Another said, “When you can sit in a faculty meeting and get things out on the table and leave without hurt feelings…Acknowledge and embrace we are women and OK, let’s move on. In the afternoons, we were short-tempered. We used humor a lot.” Another informant shared that among faculty she expected an “overall promise that we can agree to disagree and it’s OK and we can still get the work done.” An informant who had taught for forty years and been a nurse for forty eight years was asked by the researcher what her words of wisdom would be for faculty teaching culture care. She articulated the need for love and forgiveness among faculty within the environmental context of a school of nursing and further asserted that “forgiveness is the essence of health and caring”.

Informants conveyed that a healthy faculty community values family and supports one another to meet familial responsibilities. Faculty health and well being were discussed at length in relationship to balancing the tripartite faculty role of teaching, scholarship (publication, research, grants, and practice), and service (school of nursing, university, professional, and community). When discussing the tripartite role, most tenured and tenured-track faculty laughed out loud. One stated “how many pounds have I gained because I slide down the working out because of all the other duties? Stress
levels are much higher. [The faculty role] is the hardest job I’ve ever done because I don’t clock out…I triage down the healthy things I need to do.” Another faculty described scholarly activities as “a hassle”. Her face fell and she looked down and further shared she has guilt about leaving her daughter so much when she was growing up to meet these faculty role requirements. An adjunct faculty informant, who had previously been in a tenure-track position, shared that she just “didn’t have the passion for what was necessary for tenure”. She shared there were no hard feelings; she and the faculty continue to have a positive relationship.

Faculty informants expressed that a healthy faculty and school of nursing environmental context is one which continually seeks to improve and move forward. Responsibility for this cultural value was placed with the formal leadership (e.g. director of the school of nursing) and self-leadership of each faculty member. One informant expressed frustration with the approach by some faculty of “we’ve always done it that way.” Another expressed “times change. New faculty come in and assist in change…The leadership says a lot. As long as new faculty are allowed to come in and influence…” the goal is success for all. One faculty informant described the leadership of the director. She shared ideas and journal articles with faculty to facilitate the process of moving forward. Another shared that caring among faculty was “hard right now” as the faculty was growing and there was much to be re-evaluated in terms of workload and processes. All faculty informants revealed a strong work ethic to contribute to the success of the students, school of nursing, and university.

The caring construct of reciprocal caring was discovered as essential for faculty health and well being and to create a healthy faculty community to teach culture within
the environmental context of a school of nursing/university. Reciprocal caring was expressed as faculty mentoring and co-mentoring. Faculty verbalized that mentoring had a significant impact on their lives. Mentoring was described as occurring throughout their careers and many had long term mentoring relationships. One informant shared “over the years, I’ve had mentors and mothers that have been very gracious to me…One is still a great friend today.”

Some faculty had formalized faculty mentors that were assigned by the school of nursing. One informant described her faculty mentor “takes very good care of me. She is very patient, walks me through…never leaves me…checks back with me”. Another informant was “touched” when as a new faculty, her mentor called during the summer before she began and invited her to a faculty gathering for lunch and exercise. She felt supported in the school of nursing as she learned the role of faculty. Faculty “reached out and welcomed me.” They were “kind” and “only assigned 5-6 students to advise” so she could watch another faculty and learn. Another new faculty informant shared that a mentor provided course materials, powerpoint slides, and compact discs and encouraged her to call her home number with any questions or concerns. An informant described she valued “stolen wisdom” referring to learning from an older, experienced faculty mentor with great experience and wisdom she shared with the new faculty. For example, the wise mentor shared history at the school of nursing, her perspective, and advice for scholarly work.

Informants described co-mentoring relationships where faculty contributed to the personal and professional growth of one another. The relationship was reciprocal and exhibited mutuality. Working together, faculty achieved a high level of scholarship and
synergy. One faculty described her teaching partner and co-mentor “I adore her. We compliment each other. You help each other get better.” Another faculty shared that collaborative relationships with faculty peers was the “glue that holds us together. We are nurtured and are nurturing to each other.” She spoke about sharing expertise among one another, being dependable, trustworthy, and credible. Faculty co-mentor one another in meeting the faculty tripartite role. One informant discussed a research project that she and a colleague were working on. The similar and diverse expertise and experience each faculty contributed enhanced the quality of the project and contributed to the growth of the individual person. Based on the synergy of this project, these faculty were making changes in the courses they taught together, had submitted an abstract for presentation, and were planning to publish an article together.

Reciprocal care was also demonstrated by faculty doing for one another and supporting each other in balancing the tripartite faculty role. One informant spoke about filling in for each other “Where ever anybody’s life is taking them, there is consideration with the other faculty typically. We’re small enough that we pick up and do for each other duties like that [grading]”. Another faculty informant shared that her peers provided a sounding board “If you’re having a crummy day, you get a note in your mailbox…a phone call with encouragement.” A faculty member shared we “pull together. We are there for each other…What can I do to help her?” Faculty provided examples of supporting those in doctoral work. The director of one school of nursing adopted a “grow your own” philosophy in the school of nursing. She secured an endowment to fund tuition, books, and travel for faculty earning a doctoral degree in nursing. Faculty are released from committee work and other scholarly activity while
earning their doctoral degrees. One informant shared that when she earned her doctoral
degree some years earlier, the university provided similar funds and her teaching load had
been reduced to one half. Several informants served on dissertation committees of fellow
faculty to share expertise and support them in the process. Conversely, an informant
from another school of nursing shared she is very angry about the requirement to get a
PhD. She doesn’t want to get her PhD in nursing and is concerned about giving up her
life. She doesn’t want to do an on-line program and doesn’t want to move.

Maintaining an active faculty practice was perceived by informants as supporting
faculty health and well being. One informant stated “Nursing practice needs to be part of
faculty workload. No practice borders on unethical. What is our mission?” Several
faculty pointed out that practice is required to maintain advanced practice certification.
One informant reflected that she needs the mix of practice and teaching to “fuel” her
teaching. Another stated that the scholarship of practice has been respected university
wide and is important to be a good teacher.

Self-care was discovered to be essential for faculty health and well being. Faculty
expressed the need to care for oneself to be enabled to care about others. Self-care was
described by faculty as including adequate sleep, nutrition and exercise and avoiding
overeating and smoking. Faculty articulated their belief that as nurses and nurse
educators, they had a responsibility to role model of health for students and patients and
families. A faculty discussed the challenge of teaching students self-care through
modeling. It was fall break and the faculty reminded students to take time to relax and do
something special for themselves. “Then it clicked for me; telling them that and you sure
don’t have anything planned.” This informant re-arranged her weekend to follow her
own advice and take some time away. Self-care was also addressed in the context of balancing the tripartite faculty role. An informant articulated that faculty “need to be careful during the academic year as one can get overloaded. I’m having to pull back and relax. I’ve got to take the reins and control.” She shared this was an issue among peers as well.

The institutional culture of the school of nursing and university were discussed as a factor in contributing to faculty health. One informant shared “no place is perfect; it’s what you make it, so [her name] gets up and [her name] takes care of self and is the best she can be. So what happens there happens. She is not going to take anything home. It is good for faculty morale to have happy people. Unfortunately, we don’t have a say about people’s home lives or their health.” She went on to describe that longevity can be a good thing and a bad thing, stating the key is good leadership.

Finally, most faculty addressed their love of nursing and teaching as an integral part of their health and well being. One informant shared that teaching contributes to her health and well being; it sparks her creativity. Several clinical faculty shared their love of teaching: “[Teaching] keeps me on my toes; it keeps me honest”; “pushes me out of my comfort zone...makes you be ahead of your game...keeps me moving forward”. Another shared she loves nursing, “nursing has been good. I feel good about what I’ve done.” A faculty spoke about the difference she has made in the lives of patients by teaching her students “How many lives are they [students] going to touch? I may not be out there working with patients, but I sure have a lot to do with their care.” Nursing and teaching nursing has contributed to faculty satisfaction, enjoyment, and making a difference in the world.
The diverse pattern *noncare was expressed as cultural conflict* was derived from diversity in faculty informant descriptors. Informants described diverse values, beliefs, and practices among and between fellow faculty and/or school of nursing/university institutional culture which resulted in conflict and was viewed as having a negative effect on health. Several faculty expressed lack of leadership support whether in the school of nursing formal leadership, university formal leadership or among faculty self-leadership. A few informants spoke about the negative health impact of meeting the faculty tripartite role. The tenure process was described as not healthy; it’s “not always nice”. Another informant laughed and said, “Turn this tape off [kidding]. If I met the person who invented tenure, I’d punch their nose.” She did not like all the “hoops involved” and feels energy toward tenure takes away from teaching.

There was diversity in assisting new faculty. New faculty described earlier in these findings had a very positive experience. In contrast, several new faculty informants described difficult situations. One informant shared “Gosh, I don’t know who to trust. That’s how I was feeling and I was feeling like, you know, the ones that should be sharing with me are not and so what I decide to do is not fell like I have to be tied into those relationships. I always want to surround myself with positive influences so what I decided, I’ve joined an organization.” This faculty member joined a local professional nursing organization and received the mentoring and encouragement she was seeking. Another informant verbalized “I had people who appeared like they wanted to give the impression like they were helping me, but they weren’t.”

Several faculty described negative mentoring or collegial experiences. One informant stated she was assigned a mentor and didn’t receive any mentoring. She
doesn’t blame the assigned mentor as the person was “going through heart ache and pain”; rather she blamed the person who assigned the mentor. An informant who was a newer faculty member stated:

We talk about what we can do to maintain, attract, and keep people, because it’s not the money! It’s not the money, so you got to be creative, you gotta care because people will leave…If you have options, you’re going to be gone. And I think this is like a test. I really want to do this and I know this is a transition for me, so difficulties don’t turn me away, I think they kind of fire me up to just really, to move forward. But really having a formal way of really putting your arms around the new people and pairing them up with someone, not just saying it, but actually doing it, making sure that whoever is doing it is wanting to do it, like you know, like when you’re a nurse, you’re part of a buddy and mentoring system, making sure that happens so that the [new] faculty don’t feel like they are just running around, feeling lost.

An experienced faculty informant shared that collegial conflict was a “huge issue”. She looked the researcher square in the eye with a very troubled look on her face and stated she had multiple health problems as a consequence. This informant stated she “kept a low profile. I don’t talk about anyone to anyone…it will come back.” She further described “hostility” among faculty, “pseudo camaraderie”, and a cultural climate of “no forgiveness…women, regardless of race”.

Several informants described incidences of overt and covert racism among faculty. Racism was expressed by both black and white faculty and was described as occurring among one another white-black/black-white; black-black; and white-white.
One informant shared that the racial environment is charged “from both sides”. Further descriptors are withheld here at the request of study participants.

This theme and the universal and diverse patterns and descriptors provide rich data and insight into meeting the culture care needs of faculty to promote their health and well being to enable them to teach culture care within the school of nursing and university environmental context. Since culture care is primarily taught through modeling, establishing an environment that is culturally sensitive, caring, and competent is essential to teach culture care.

*Discoveries for Teaching Culture Care*

The culture care theory includes application of research discoveries using the three predicted modes of nursing actions and decisions; culture care preservation or maintenance, accommodation or negotiation, and repatterning or restructuring (Leininger, 2006a) These modes were abstracted from the patterns and themes derived from nursing faculty care expressions, patterns, and practices related to teach culture care. The following care modes support nursing faculty teaching culture care within the environmental context of schools of nursing and universities.

*Culture Care Preservation/Maintenance*

Nursing faculty are engaging in many professional actions and decisions that support care expressions, patterns, and practices to teach culture care and contribute to the health of faculty, students, and clients. The following actions and decisions preserve or maintain current culturally congruent care practices:

1. *Maintain efforts to assist students to care for culturally diverse clients in the clinical setting.*  Nursing faculty in urban and rural settings valued the importance
of students caring for diverse clients and families. Faculty invested significant energy in making clinical assignments to ensure students had these opportunities. Faculty in the urban setting ensured students provided care in rural settings and faculty in the rural setting ensured students cared for clients and families in the urban setting. Nursing faculty are encouraged to continue these efforts to teach students culture care in clinical settings to promote culturally congruent care.

2. *Maintain faculty combining own generic care with professional care (mentoring and modeling) to promote student health and well being.* The importance of learning to care from one’s generic family was a powerful influence on faculty professional care. When faculty combined their generic and professional care of mentoring and modeling, students benefited and were able to be successful in the nursing program and apply these caring behaviors to their patient and family culture care. The combination of these actions and decisions fostered a caring community within the environmental context of the school of nursing.

3. *Preserve faculty collective/reciprocal care.* Faculty collective and reciprocal care involved respect, love and forgiveness, honoring family responsibilities, balancing the tripartite faculty role, change/moving forward, and mentoring/co-mentoring. These caring behaviors were expressions of valuing similarities and differences among faculty, thus meeting the culture care needs of faculty and contributing to their health and well being. Faculty are encouraged to preserve collective and reciprocal care to model these culturally congruent behaviors for students.
4. **Preserve faculty care based on Christian religious values, beliefs, and practices.**

Faculty Christian religious values, beliefs, and practices formed the basis of faculty character and integrity and facilitated the ability to care for students and clients and families from similar and diverse backgrounds. Their ecumenical perspective contributed to faculty avoiding cultural imposition and facilitated teaching students how to provide culturally congruent care. Preserving faculty care based on Christian religious values, beliefs, and practices enhances teaching culture care.

**Culture Care Accommodation/Negotiation**

Nursing faculty are encouraged to accommodate or negotiate these care expressions, patterns, and practices to teach culture care and contribute to the health of faculty, students, and clients:

1. **Negotiate integrating culture care content into established nursing courses throughout the curriculum and introduce required and elective courses on culture care.** As faculty participated in this study, it became clear to them that teaching culture care was given minimal attention and was not integrated throughout their curricula. No required or elective courses were offered in the schools of nursing in this study. This finding was incongruent with the faculty value that students learn to care for diverse and similar clients. Nursing faculty are encouraged to negotiate to incorporate culture care education in curricula to prepare students to provide culturally congruent and competent care.

2. **Negotiate for culturally congruent strategies to promote healthy faculty lifeways.**

Healthy faculty lifeways contribute to care that is essential for faculty to teach
culture care within the environmental context of the school of nursing/university. Study findings revealed strategies that are culturally congruent for healthy faculty. Examples are: faculty schedules consistent with family activities, cultural traditions and holidays; Assistance and support for balancing the faculty tripartite role; and culturally congruent practices to resolve faculty conflict.

_Culture Care Culture Care Repatterning/Restructuring_

Nursing faculty are asked to make the following change; to repattern their practices related to teaching culture care. This modification is suggested to facilitate a culturally congruent approach to teaching culture care and thereby contribute to meeting the culture care needs of and promote the health of faculty, students, and clients.

1. _Use an organizing framework for teaching culture care in the classroom, on-line, and clinical contexts – culture care theory._ Findings revealed that the majority of faculty teach culture care without an organizing framework. While faculty rich experiences contribute to student learning, the use of an organizing framework, specifically the culture care theory ensures that students learn to provide culturally congruent care based on evidence from years of transcultural nursing research. Additionally, using the sunrise enabler (a cognitive map of the theory) is useful for students in comprehending a broad and holistic view of providing culturally congruent care and the application of nursing theory to practice.

These ethnonursing research findings were confirmed by informants. Descriptors illustrated informants’ worldviews and religious and cultural values, beliefs, and practices and lifeways which led to the identification of patterns. Themes were abstracted from interpretation and synthesis of patterns and facilitated the three modes of nursing actions
and decisions presented which are useful to guide faculty as they teach culture care to nursing students in urban and rural schools of nursing. These modes assist faculty to teach in a way that is culturally congruent and therefore contributes to the health of faculty, students, and clients.
CHAPTER V
Discussion of Findings

Introduction

This chapter presents a discussion of the findings. The assumptive premises of this study and six of the assumptive premises of the culture care theory were supported. Six care constructs from the transcultural nursing research were further substantiated by this study and two new care constructs were discovered. Discoveries from this study are compared and contrasted with findings from other ethnonursing research studies. Reflections from this ethnonursing research study and recommendations for future studies are presented. Findings from this study compared and contrasted with other transcultural nursing studies and the culture care theory contributed to building the body of knowledge of transcultural nursing and expanded the use of the theory to the context of nursing education through the study of faculty care.

Significance of the Study

Contribution to Nursing Theory

Assumptive Premises

The faculty care theme that was embedded in Christian values, beliefs, and practices was a universal finding for all key informants and reflected some diversity in that 4 general informants out of 17 professed a more universal belief system beyond an organized Christian framework. This finding supports the first assumptive premise in the culture care theory which states “care is the essence and central….unifying focus of
nursing” (Leininger, 2006a, p. 18) and the first assumptive premise of this study which states that faculty care is the essence of nursing education ….and unifying focus. If care is the essence of nursing education and care in this study revealed faculty care was grounded in Christian values, we will need to have care grounded in culture-specific spiritual care to provide culturally congruent and competent care. Increasingly important for faculty who teach and care for diverse students, peers, patients and families is to understand how to combine generic spiritual care with professional nursing care and nursing education to know these spiritual care needs and attend to the spiritual nature of care. Regardless of whether one teaches at a state/secular or religious-based school, caring for /attending to these spiritual values, beliefs and practices was discovered as essential for providing culturally congruent and acceptable care.

The theme which reflected that faculty provided generic and professional care to maintain healthy lifeways for students supported the second assumptive premise of the culture care theory related to care is essential for health and well being (Leininger, 2006a). This also supported the second assumptive premise for this study that faculty care is essential for effectively teaching culture care. Teaching culture care is essential for the health of nursing students and patients and families they care for and for the health of the nursing program and the profession of nursing as a whole. A healthy nursing program and profession is one that assures that students are prepared to satisfy the culture care needs of those in their care.

All four themes discovered in this study supported the third assumptive premise of the study and specifically assumption six of the culture care theory which states culture care is embedded in the worldviews, social structure factors and environmental context
(Leininger, 2006a). For example the first theme discovered faculty care was rooted in the religious and philosophical dimensions of the social structure and the second and fourth themes were rooted in the environmental context of the classroom, on-line, clinical, school of nursing, and university contexts.

The assumptive premise of this study which states culture care is the broadest means to know and predict faculty lifeways related to teaching students to provide culturally congruent care supported Leininger’s assumptive premises seven and eight. Assumptive premise seven states that every culture has generic and professional care. Assumptive premise eight states that culturally congruent care occurs when culture care beliefs are known and used appropriately with people (Leininger, 2006a). For example it was discovered in this study in theme three that faculty identified the roots of their caring came from their generic family and professional mentoring and in turn they passed these caring values, beliefs, and practices on to their students. Discoveries in theme two were that faculty explicitly taught culture care in clinical contexts through modeling these caring values, beliefs, and practices thus providing an environmental context that was culturally sensitive and caring.

Theme three and four address student and faculty health and well being and that generic and professional care are essential to achieve heath and well being. These findings support the fifth assumptive premise of the study which reflects that meeting the culture care needs promotes the health and well being of both faculty and students. These findings further support Leininger’s second theoretical assumption which states that care is essential for human growth, health, and well being and her eleventh assumptive premise that transcultural nursing practices lead to attaining and maintaining the goal of
culturally congruent care for health and well being (Leininger, 2006a). For example faculty care expressions and practices fostered a caring community within the school of nursing through respect for students, listening to students, being approachable, and socializing and visiting with students. Examples of faculty care that promoted health and well being in the school of nursing was expressed as respecting similarities and differences among one another, willingness to demonstrate love and forgiveness to work out conflict among faculty, and mentoring and co-mentoring of one another.

The discoveries of this study supported the assumptive premises of this study and six of the assumptive premises of the culture care theory. These discoveries have contributed to the body of knowledge of transcultural nursing and expanded the use of the theory to the context of nursing education through the study of faculty care.

*Care Constructs*

Over five decades of transcultural nursing research using the ethnonursing research method has led to the discovery of 175 care constructs from 58 cultures (Leininger, 2006c). These care constructs contribute to nurses understanding the meaning of care to people. Further study of care constructs facilitates knowing the epistemic roots of caring and health phenomena (Leininger). Care constructs discovered by Leininger, others, and further substantiated in this study are respect, praying with, listening, collective care, reciprocal care, and surveillance care.

The most important care construct for adult informants as discovered by Leininger (2006c; personal communication, May 15, 2000) was respect. Respect was also held to be the most important care construct among nursing faculty participating in this study. Examples were respect for self, students, clients, colleagues/other faculty.
Nursing faculty spent a great deal of time and energy on teaching and modeling respect specifically for clients and families cared for. Nursing faculty noncare occurred most significantly and frequently when individuals felt disrespected by peers. Creating a school of nursing culture where all are respected sets the tone for faculty and student health and portrays cultural congruence for students learning to respect others.

Faculty demonstrated care for students by listening to them in class and in the online environment as part of providing surveillance care. One faculty described that she read between the lines of student postings on the discussion board and ‘heard’ their concerns. She addressed their concerns and students valued this caring action. Surveillance care was further described by informants as ‘checking in’ with students and ‘being approachable’. McFarland (1995) described the care construct of surveillance in her study of elders in a long term care facility. Elders practiced surveillance care by surveying the dining room to make sure cognitively impaired residents came down for meals. Additionally, professional staff practiced surveillance care by monitoring resident participation in daily recreational activities and clinic appointments.

In this study, collective care was expressed by faculty as caring actions and decisions that benefited all faculty. For example, faculty spoke about the school of nursing expectations to cover teaching responsibilities for other faculty members in times of need. Faculty worked together to meet faculty role expectations of teaching, scholarship, and service. Collective care was found by McFarland (1995) and McFarland and Zehnder (2006) in two studies on elder care in nursing home contexts. They gave examples of care that benefited the entire nursing home such as participating in bazaars to
raise funds for audiovisual equipment for residents’ use and taking care of the flower boxes that were enjoyed by all.

Reciprocal care was provided by faculty to one another. Examples are a faculty member would invite another to lunch or offer to guest lecture in another’s class and these efforts would be reciprocated. Reciprocal care was also discovered in studies using the culture care theory (Gates, 1988; McFarland, 1995; McFarland & Zehnder, 2006). Gates found that hospice patients often cared for the nurses in many small ways that cared for them such as inquiring about their families and health. McFarland and McFarland and Zehnder found that residents in a long term care setting often assisted one another in getting down to the dining room, reminding one another of appointments, and shopping for small items for one another.

*Mentoring/co-mentoring* was discovered as a new care construct in this study. Mentoring/co-mentoring is a form of reciprocal care yet stands as a distinct care construct in that the caring is over a sustained period of time and involved faculty members making a significant impact on one another’s professional careers. Often a mentoring relationship began between a faculty and student or new faculty and an experienced faculty member. Over time these relationships moved into co-mentoring relationships. Some relationships began as co-mentoring relationships as faculty worked together on professional projects and co-taught together. In one school of nursing, a mentor was assigned for all new faculty members with the goal of assisting the new faculty member in learning/teaching within the context of the school of nursing and university.

*Christian care* is the second newly discovered care construct. Within the context of Christian values and beliefs, faculty expressed loving one another as demonstrated as
accepting where a person is, working with a person at that point and facilitating movement forward. Another informant shared an example of Christian care is through Christian teaching at her church she has learned not to judge another faculty member. Another stated what we need is to forgive one another, without knowing or understanding another’s circumstances. Although related to spiritual care, Christian care is a distinct care construct because informants have described it as being specifically related to and evolving from their basic Christian values and beliefs which have been taught and practiced since childhood. A related care construct discovered in this study was *praying with*. One faculty informant described that students often requested her to pray with them. Another stated that she prays before each teaching encounter both in the classroom and clinical setting. Another informant stated that “to me, prayer is always in order.”

**Contributions to Nursing Education**

The researcher purposefully selected informants who taught at public universities in rural and urban contexts as part of the comparative analysis used in the ethnonursing research method as described in previous culture care studies by Morgan (1996) and Wenger (1992). Rural and Urban faculty value teaching culture care and do so primarily through modeling in clinical settings. Faculty intentionally provided clinical experiences in diverse settings recognizing and appreciating the diversity in the rural setting even though the population was 89% white (U.S. Census Bureau, 2006; Wenger). Congruent with the findings of this study, Kulwicki and Boloink (1996) research concluded that nurse educators purposefully select clinical sites that allow students to care for diverse people. Interestingly, the themes and patterns discovered did not reflect differences in rural and urban faculty teaching culture care.
In this study eight out of 27 faculty had preparation in transcultural nursing and most of those described an assignment in graduate education rather than a formal, integrated curricular approach. Discoveries from this study are congruent with the literature; faculty are not formally prepared to teach culture care (Ryan, Twibell et al., 2000). Preparing students to meet the culture care needs of patients and families may be a challenge if faculty have limited preparation in transcultural nursing. However, nursing faculty in this study valued students caring for patients and families from similar and diverse cultures. They made great efforts and used creative strategies to ensure students had these opportunities in clinical assignments. Faculty taught culture care based on their generic care background and rich clinical experiences, rarely using a conceptual framework. The researcher has recommended culture care repatterning with faculty to teach culture care using a conceptual framework, specifically the culture care theory.

This study extends the use of the culture care theory beyond caring for diverse and similar cultures composed of individuals, families, and communities to the context of nursing education and faculty teaching culture care to nursing students. This research impacts the practice of nursing by making a contribution to understanding the complex nature of teaching culture care to diverse and similar nursing students who will be the future providers of culturally competent and congruent care. Embracing cultural similarities and differences in the school of nursing and university context contributes to student and faculty health and well being and allows all students to thrive where teaching culture care is embraced and leads to promoting a more culturally diverse nursing workforce.
This study is a unique application of the culture care theory which further supports and substantiates Leininger’s work. Nursing actions and decisions for teaching culture care and two newly discovered care constructs, care as mentoring and Christian care were discovered. The discovery of new knowledge related to teaching culture care contributes to the body of transcultural nursing education and the discipline of nursing.

Reflections on the Study

The researcher is a nursing faculty member and situated in the environmental context of a school of nursing within a state university system. Therefore, the researcher brought some insider knowledge and understanding of the domain of inquiry which facilitated the ability to discover and tease out complex data and meanings. Being ‘one of them’ (a nurse educator) enabled the researcher to move quickly from stranger to trusted friend (Leininger, 2006a). The level of trust extended by informants was humbling. Informants shared ‘off the record’ which was strictly honored, yet this rich data provided further understanding of the context and meaning of teaching culture care.

Informants were asked to spend an hour in the first interview and frequently chose to continue longer. The researcher believes there may be therapeutic benefit for faculty in telling their stories. The researcher noted that when interviewing very experienced faculty, there was little need for the researcher to guide the interview. Faculty signed the consent form and their experience and wisdom simply flowed. Nursing faculty who chose to participate in the study were extremely gracious. Many faculty described they were happy to participate in my study because others had participated in theirs or they hoped that others would participate in their future studies. This reflects a form of professional reciprocal caring among nursing educators.
The researcher’s mentor was invaluable in focusing on the domain of inquiry, reflecting on the findings, and using the culture care theory, sunrise enabler, and ethnonursing research method. The discovery of faculty care as the core construct of nursing education and rooted in their generic Christian values, beliefs, and practices was a powerful learning experience in gaining in-depth understanding of how nursing faculty teach culture care.

Recommendations for Future Research

This research has provided the background and basis for future ethnonursing research studies at schools of nursing in both public and private schools and in other geographic locations in the United States and worldwide. Similar faculty care studies focused on faculty generic and professional care in other health care disciplines would contribute to the understanding of faculty care in these contexts.

Conclusion

The culture care theory with the sunrise enabler and ethnonursing research method provided a useful framework and method for this study. This research has further substantiated the culture care theory; thus contributing to building knowledge for the discipline of nursing. Findings from this study have made a contribution to the practice of nursing in the areas of nursing education related to teaching students to provide culturally congruent and competent care.
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Appendix A

Conceptual Map to Generate Nursing Knowledge to Teach Culture Care
Appendix A

Conceptual Map to Generate Nursing Knowledge to Teach Culture Care

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Appendix B

Leininger’s Sunrise Enabler to Discover Culture Care
Appendix B

Leininger’s Sunrise Enabler to Discover Culture Care

**Leininger’s Sunrise Enabler to Discover Culture Care**

**CULTURE CARE**

Focus: Individuals, Families, Groups, Communities or Institutions in Diverse Health Contexts of

- Generic (Folk) Care
- Nursing Care Practices
- Professional Care–Cure Practices

Transcultural Care Decisions & Actions

- Culture Care Preservation/Maintenance
- Culture Care Accommodation/Negotiation
- Culture Care Repatteming/Restructuring

Culturally Congruent Care for Health, Well-being or Dying

Appendix C

Leininger’s Stranger to Trusted Friend Enabler
Appendix C

Leininger’s Stranger to Trusted Friend Enabler

The purpose of this enabler is to facilitate the researcher (or it can be used by a clinician) to move from mainly distrusted stranger to a trusted friend in order to obtain authentic, credible, and dependable data (or establish favorable relationships as a clinician); The user assesses him or herself by reflecting on the indicators as he/she moves from stranger to friend.

<table>
<thead>
<tr>
<th>Indicators of Stranger (Largely etic or outsider’s views)</th>
<th>Date Noted Informant(s) or people are:</th>
<th>Indicators as a Trusted Friend (Largely emic or insider’s views) Date Noted Informant(s) or people are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Active to protect self and others. They are “gate keepers” and guard against outside intrusions. Suspicious and questioning.</td>
<td>1. Less active to protect self. More trusting of researchers (their ‘gate keeping is down or less’). Less suspicious and less questioning of researcher.</td>
<td></td>
</tr>
<tr>
<td>2. Actively watch and are attentive to what researcher does and says. Limited signs of trusting the researcher or stranger.</td>
<td>2. Less watching the researcher’s words and actions. More signs of trusting and accepting a new friend.</td>
<td></td>
</tr>
<tr>
<td>3. Skeptical about the researcher’s motives and work. May question how findings will be used by the researcher or stranger.</td>
<td>3. Less questioning of the researcher’s motives, work, and behavior. Signs of working with and helping the researcher as a friend.</td>
<td></td>
</tr>
<tr>
<td>4. Reluctant to share cultural secrets and views as private knowledge. Protective of local lifeways, values and beliefs. Dislikes probing by the researcher or stranger.</td>
<td>4. Willing to share cultural secrets and private world information and experiences. Offers most local views, values, and interpretations spontaneously or without probes.</td>
<td></td>
</tr>
<tr>
<td>5. Uncomfortable to become a friend or to confide in stranger. May come late, be absent, and withdraw at times from researcher.</td>
<td>5. Signs of being comfortable and enjoying friends and a sharing relationship. Gives presence, on time, and gives evidence of being a ‘genuine friend.’</td>
<td></td>
</tr>
<tr>
<td>6. Tends to offer inaccurate data. Modifies ‘truths’ to protect self, family, community, and cultural lifeways. Emic values, beliefs, and practices are not shared spontaneously.</td>
<td>6. Wants research ‘truths’ to be accurate regarding beliefs, people, values, and lifeways. Explains and interprets emic ideas so researcher has accurate data.</td>
<td></td>
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</tbody>
</table>

Appendix D

Open Inquiry Guide Enabler
Appendix D

Open Inquiry Guide Enabler

Faculty Care Expressions, Patterns, and Practices
Related to Teaching Culture Care

KEY Informant (Tenured Faculty) Open Inquiry Guide

**Ethnodemographics**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date(s) of Interview(s):</th>
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<tr>
<td>Informant #:</td>
<td>Languages Spoken:</td>
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<tr>
<td>Gender:</td>
<td>Undergraduate Degree &amp; Institution</td>
</tr>
<tr>
<td>Age:</td>
<td>Graduate Degree(s) &amp; Institution(s):</td>
</tr>
<tr>
<td>Place of Residence:</td>
<td>Cultural Background/Ethnic Orientation:</td>
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<td>Previous places of residence:</td>
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<tr>
<td>Geographic location of universities:</td>
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</tr>
<tr>
<td>Number of Years Teaching Nursing:</td>
<td>Spiritual/Philosophical Background:</td>
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<tr>
<td>At Current University:</td>
<td></td>
</tr>
<tr>
<td>Formal course/workshop in Transcultural Nursing:</td>
<td></td>
</tr>
</tbody>
</table>

**Ethnohistory**
Tell me about your nursing career /Teaching career / how you came to teach nursing

**Worldview**
Tell me how you feel about the place of nursing/nursing education in the world today
U.S. / TN / Middle TN

**Care**
1. Tell me about how you view the construct of care in nursing
2. Describe your source/roots of caring?
3. As nurses, we all gave direct client care at one time (body, mind, and spirit), how do you bring these concepts of care into the classroom?
4. What part does care play as you go about your typical teaching encounter?
   a. Putting together your course(s)
   b. Describe how students care for each other; for you

5. Tell me about the care you have given to your students in the classroom and/or clinical settings.

6. Describe how you teach students to care? (what design, content, teaching strategies do you use?)

7. What strategies do you use to pass on this caring component to students in the clinical setting?

**Generic/Family/Folk Care**

1. Describe what you learned about caring from your family.

2. Do you ask students to examine their own generic care background?

3. How do you teach students to care for one another? How might this be expressed in the clinical setting in caring for people?

**Professional Care**

1. Tell me about how you were taught in your initial nursing education.
   a. your educational experiences since.

2. Describe how you may have brought together your family care background and your professional educational background to teach nursing students; specifically about how to care and about culture.

**Cultural Values, Beliefs, and Lifeways**

1. In providing nursing care and teaching nursing, your cultural values, beliefs, and lifeways are important for colleagues and students to understand.
   a. What values and beliefs do you feel are most important for providing/teaching nursing care?
   b. Give me some examples of how you share these values and beliefs with others.

2. Describe a time when you felt students provided good care and the patient’s culture was considered.
3. What cultural groups are represented here among the students, faculty, staff, peers?
   a. What effect does this have on your teaching?
4. Describe the cultural backgrounds of people the nursing students care for.
5. Tell me about how you view teaching students about culture.
   a. How do you become knowledgeable about caring for diverse people?
   b. Tell me about teaching strategies you have used to teach about culture.
   c. Tell me about the content you teach.
   d. Describe the types of clinical experiences nursing students have.
   e. What strategies do you use to teach cultural assessment to your students?
   f. How does your cultural background effect what and how you teach?

**Health (Well being)**

1. Have you ever thought about the idea of health/well being as it is applied to a faculty or an institution?
   a. How would you describe a healthy institution?
      i. a health school of nursing?
      ii. a healthy nursing faculty.
   b. How would you evaluate your health and well being in your role as a faculty member.
2. Tell me about care that nursing faculty, staff, or peers may have given you. Tell me how this care affected your health and your ability to teach and conduct scholarly activities.
3. Describe how your ability to teach nursing students is influenced by your health/well being.
   a. Give an example of a time when you felt energized by teaching and/or scholarly activities.
Environmental Context

**A. Educational Factors**

1. Describe the culture knowledge you feel is essential for nursing students to have.
   
   i. Describe how you teach this.

   ii. Give examples of experiences you have planned for students to learn about Transcultural nursing.

2. Tell me about how you learned about culture and its importance to giving care.

3. Are there any particular theories (nursing, education, or your own) you use to guide your teaching in terms of philosophy?

4. Regarding teaching about culture / care:
   
   i. What are you doing well? What should be maintained?

   ii. What needs further improvement/refinement?

   iii. Do others need to be involved in this process? (e.g. administration, colleagues, etc)

   iv. What needs a total overhaul?

   v. What road blocks do you come up against in teaching about culture?

   vi. What facilitates teaching about culture?

**B. Technological Factors**

1. How does technology facilitate you teaching about culture / care? What helps or hinders you?

2. What technology seems to be most essential in terms of teaching culture / care in nursing?

3. Are you teaching in an on-line environment? How is care taught/ incorporated in this environment?
C. Political Factors

1. Tell me how politics affects your teaching of culture and care.

2. What is the importance of considering culture at this institution?
   i. (Gather artifacts related to institutional culture-university and school of nursing: mission statements / philosophy statements, syllabi, curriculum documents, view pictures, pamphlets, web site) Describe how culture is integrated into these artifacts.
   
   ii. Give an example of what you view the university is doing well in relation to cultural diversity

   iii. And what you believe is an area for growth

3. Tell me about how teaching students about culture is viewed among faculty.

4. Do other organizations influence your teaching about culture?

5. What are the requirements of your accrediting organizations?

D. Economic Factors

1. Describe how financial resources affect your ability to teach.

2. Cultural immersion experiences have been described in the literature as an effective means to teach students about culture;
   
   i. What funding might there be available for students or faculty
      1. to be immersed in another culture
      2. to attend a conference about culture needs of patients or students

E. Kinship/Social Factors

1. Tell me how you teach students about the importance of family as client.

2. Describe your professional/collegial relationships and how these relationships help or hinder you to teach nursing / nursing care.

3. Give an example of how faculty might care for one another.
F. Religious Factors

1. Describe any relationship your religious/spiritual beliefs have with your success as a teacher/faculty member. Tell me about this relationship. Who or what is your source of spiritual strength?

2. What do you teach your students about the spiritual/religious dimensions of care?

3. Do you assist students in examining their own spiritual/religious backgrounds and how this affects their care?

4. How does your spiritual/religious background influence how you teach care?

Summary Questions

1. Is there anything else you want to tell me about your experience of teaching? …Or about teaching culture / care / Transcultural nursing?

2. Is there anything else you want to share with me before we close?

3. I would like you to call / e-mail me if you think of anything you would like to add

4. After I have had a chance to review this information, I would like to call you back / e-mail to clarify


Revised 4/16/07
Appendix E

Institutional Review Board Application
Appendix E

Institutional Review Board Application

**UNC INSTITUTIONAL REVIEW BOARD**
Application Cover Page for IRB Review or Exemption

Select One:  **X** Expedited Review  __ Full Board Review  __ Exempt from Review

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**Project Title:** Nursing Faculty Care Expressions, Patterns and Practices related to Teaching

**Culture Care (Dissertation study)**

**Lead Investigator**
Name: Sandra J. Mixer
Department: Doctoral Student, School of Nursing
Telephone: __________________________
Email: __________________________

**Research Advisor**
Name: Dr. Debra Leners
Department: Professor, Interim Director, School of Nursing
Telephone: __________________________
Email: __________________________

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Complete the following checklist, indicating that information required for IRB review is included with this application.

<table>
<thead>
<tr>
<th>Included</th>
<th>Not Applicable</th>
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<tbody>
<tr>
<td><strong>X</strong></td>
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<tr>
<td></td>
<td>Copies of questionnaires, surveys, interview scripts, recruitment flyers, debriefing forms.</td>
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<tr>
<td><strong>X</strong></td>
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<tr>
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<td>Copies of informed consent and minor assent documents or <em>cover letter</em>.</td>
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<td>Letters of permission from cooperating institutions, signed by proper authorities.</td>
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**CERTIFICATION OF LEAD INVESTIGATOR**
I certify that this application accurately reflects the proposed research and that I and all others who will have contact with the participants or access to the data have reviewed this application and the Procedures and Guidelines of the UNC IRB and will comply with the letter and spirit of these policies. I understand that any changes in procedure which affect participants must be submitted to SPARC (using the Request for Change in Protocol Form) for written approval prior to their implementation. I further understand that any adverse events must be immediately reported in writing to SPARC.
I. Statement of Problem / Research Question

As the world becomes increasingly multicultural, transcultural nursing education, practice, research, and administration is imperative to respond to the global health needs of people, communities, and nations. Within the profession of nursing, there is a need and dictum to increase cultural sensitivity and competence in nursing students (AACN, 2004; McFarland & Leininger, 2002; Sullivan, 2004; US Department of Health and Human Services, 1996). Nursing educators worldwide are challenged to prepare a culturally competent nursing workforce (Andrews, 1995; McFarland & Leininger, 2002).

Transcultural nursing, established in the early 1970’s, is an essential, formal, and legitimate area of study and practice with a comparative care focus (Leininger, 1989). Transcultural nursing “is a field of great relevance as nurses learn how to function in a multicultural world in which people want and expect their cultural values and lifeways to be respected and understood” (Leininger, 1989, p. 4). Transcultural nurses use theory and research to build discipline knowledge and inform nursing practice. Leininger’s (2006a) Theory of Culture Care Diversity & Universality asserts that nurses can only provide culturally congruent care when the culture care expressions, patterns, and practices are known.

The construct of culture care is central to transcultural nursing and providing culturally congruent care. It is conceptual and global, describing a holistic perspective of the emic (generic or family) and etic (professional) aspects of care. Culture care involves “cognitively learned and transmitted professional and indigenous folk values, beliefs, and patterned lifeways” (Leininger, 2002, p. 57). Culturally congruent care then “is defined as those assistive, supportive, facilitative or enabling acts or decisions that include culture care values, beliefs, and lifeways to provide meaningful, beneficial and satisfying care for the health and well-being of people or for those facing death or disabilities” (Leininger, 2002, p. 58). Culture care is the broader philosophical construct, while culturally congruent care refers to the actions and decisions (interventions) one uses that are appropriate for the culture of the person(s) being served.

Review of Literature Summary

Teaching culture care in nursing education is critical to ensuring a culturally competent workforce (Andrews, 1995). The literature indicates that faculty are not adequately prepared to teach culture care or mentor students in cultural sensitivity or
cultural competence. The literature suggests culture care and cultural competence are complex phenomena requiring broad, holistic approaches and teaching strategies to promote student understanding and application in their nursing practice. There is ambiguity and lack of consensus in the literature about the meaning and use of the terms “cultural competence” and “culturally congruent care”. Overwhelmingly, researchers recommend that formal transcultural nursing be integrated throughout the curriculum (Alpers & Zoucha, 1996; Baldonado, 1998; Cooper Brathwaite, 2005; Hughes & Hood, 2007; Ryan, Carlton & Ali, 2000; Ryan, Twibell, Brigham & Bennett, 2000; Sargent, Sedlack & Martsoff, 2005) and that cultural immersion experiences are essential for learning to provide culturally congruent care (Bosworth, et al., 2006; Caffery et al., 2005; Ryan, Twibell, Brigham & Bennett, 2000; Ryan & Twibell, 2002; St. Clair & McKenry, 1999).

While nursing programs and institutions of higher learning may have mission and philosophy statements supporting diversity and cultural content incorporated in curricula, the literature reflects there is incongruence between what is stated and the practices of faculty and students in classroom and clinical settings (Canales & Bowers, 2001; Cook & Cullen, 2000; Evans, 2004; Gardner, 2005; Grossman, et al, 1998). Learning to embrace the diverse and similar needs of nursing students and the individuals, families, and communities they care for requires a deep level of personal, faculty, college, and university commitment (Andrews, 1995; Campinha-Bacote, 2005; Cook & Cullen, 2000; Edwards, 2003; Newman & Williams, 2003). Cultural diversity must be valued and respected by the institutional culture and integrated throughout the nursing curriculum to move beyond cultural awareness and cultural sensitivity to cultural competence.

There are gaps in the quantitative and qualitative research literature about the preparation faculty have had in transcultural nursing and in teaching about culture care, cultural diversity, and culturally congruent and competent care. Few studies were found which used nursing theory as a framework for nursing research and practice related to teaching culture care. Many studies have been conducted using a variety of quantitative measurement tools to measure student learning about culture and related concepts. In conclusion, there have been no studies conducted to discover nursing faculty care expressions, patterns, and practices related to teaching culture care nor have there been any ethnonursing research studies conducted using the Culture Care Theory in this context.

Domain of Inquiry

The domain of inquiry for this transcultural nursing study is nursing faculty care expressions, patterns, and practices related to teaching culture care within the environmental context of baccalaureate nursing programs. This study will be conducted with nursing faculty in baccalaureate nursing programs in urban and rural contexts in universities in the Southeastern United States.

This domain of inquiry is a major interest in nursing because of the growing diversity of the population in the United States, concerns about the provision of global health care, and the call for nurses prepared in transcultural nursing. The researcher predicts that nursing faculty epistemology (knowing how to teach culture care) and
ontology (faculty modeling culturally congruent care) is essential to teach students to provide culturally congruent care.

Purpose and Goal of Study

The purpose of this study is to discover, describe, and systematically analyze the care expressions, patterns, and practices of nursing faculty related to teaching culture care in baccalaureate programs in urban and rural universities located in the southeastern United States. The goal of this study is to discover faculty care that facilitates teaching students learning how to provide culture care.

Significance of the Study

Despite 50 years of transcultural nursing knowledge development through theory, research, and practice, there remains a lack of formal, integrated culture education in nursing (Baldonado, 1998; Hughes & Hood, 2007). Nursing faculty have the responsibility to effectively disseminate transcultural nursing knowledge to ensure a culturally competent workforce prepared to deliver satisfying, safe, and beneficial nursing care.

This research will make a contribution to the practice of nursing by discovering similar and diverse nursing faculty care expressions, patterns, and practices related to teaching culture care. The influencing factors discovered among faculty and institutions will be useful in understanding the complex nature of teaching culture care within the environmental context of a nursing program. Culturally diverse and similar students may be recruited and thrive in nursing programs where teaching culture care is embraced (McFarland, Mixer, Lewis & Easley, 2006; Pacquiao, 2007). Findings from this study will also make a contribution to the discipline of nursing by contributing to the body of transcultural nursing education knowledge related to teaching culture care. This study is a unique application of the Culture Care Theory in discovering nursing faculty care expressions, patterns, and practices which are predicted to support and substantiate Leininger’s theory.

Research Questions

In studying the domain of faculty teaching culture care within the environmental context of undergraduate baccalaureate programs in nursing, several broad questions will be used within the ethnonursing research method to guide the researcher. These research questions are:

5. In what ways do nursing faculty care expressions, patterns, and practices influence their teaching culture care?
6. In what ways do worldview, culture and social structure, and environmental context influence nursing faculty teaching culture care?
7. If a university or school of nursing culture exists, what influence does this have on nursing faculty teaching culture care?
8. In what ways does nursing faculty teaching culture care influence their health and well being within the environmental context of the school of nursing and university?
II. Method

The ethnonursing research method within the qualitative paradigm (Leininger, 2006) will be used to discover nursing faculty care, patterns, and practices related to teaching culture care. Leininger (2006) developed the ethnonursing research method for use in studying her theory of Culture Care Diversity and Universality. The ethnonursing research methodology uses an open, largely inductive process of discovery to document, describe, understand, and interpret people’s meanings and experiences. The ethnonursing method embraces the importance of discovery from the people’s ways of knowing and gives credence to the professional nurse’s way of knowing. The philosophic and epistemological sources of knowledge using the ethnonursing research method are “…the people as the knowers about human care and other nursing knowledge” (Leininger, 2006b, p. 52). In this research study, faculty as knowers will be interviewed using an open inquiry guide to discover their generic and professional care expressions, patterns, and practices related to teaching culture care.

Participants and Procedure

Research informants, nursing faculty teaching in generic baccalaureate programs, will be purposefully selected. Faculty from schools of nursing in public universities in the Southeastern United States from rural and urban environmental contexts will be invited to participate. Key informants are described by Leininger (2006b) as those people holding the most knowledge about the domain of inquiry. Key informants for this study will be tenured nursing faculty who are willing to participate. These faculty are knowledgeable about the nursing curriculum, teaching culture care, and the environmental context of the university and school of nursing. General informants may not be as knowledgeable as key informants about the domain of inquiry; however, they may provide reflective data about teaching culture care, stimulating the researcher to focus on care similarities and differences among informants (Leininger, 2006b). Other nursing faculty (including tenure-track, adjunct, clinical, or new nursing faculty) will serve as general informants for this study. Nursing or university administrators may provide valuable information about the domain of inquiry as well. Leininger (2006a) recommends 12 to 15 key informants and 24 to 30 general informants for a large scale “maxi” ethnonursing research study. The researcher plans to interview the number of informants within these ranges until the ethnonursing qualitative criterion of saturation occurs.

Initially, informants will be asked to participate in this study through a letter or e-mail explaining the nature of the research and requesting voluntary involvement. Participants will be made aware of their right to volunteer and withdraw, the nature of the interview questions, and steps taken to protect their confidentiality through the informed consent (attached) process. The researcher may communicate with participants via phone or e-mail to set up interview dates and times and possibly, later to clarify meanings from the interview.
Participants will be interviewed (face-to-face) using an audio recording device, in a location they choose, at their convenience. Interviews can range from approximately thirty minutes to an hour. Participants will be asked open-ended questions related to how they teach nursing students about caring and culture. An interview guide (attached) has been developed for this study. Within the qualitative, ethnonursing research method, this document is only a guide. The interview flow is based on participant responses. Data is anticipated to be collected in one to two interviews for 30 to 60 minutes each and a follow up phone call or e-mail to clarify meanings. The maximum commitment anticipated from a participant is two interviews on two different occasions with a combined maximum of two hours of participation.

Field journal documentation and field information such as public documents related to teaching culture care and the university context will be used as a source of data for the study as well. The researcher is interested in viewing university and school of nursing public documents such as philosophy and mission statements, faculty and student recruitment policies and procedures, nursing school admission and retention policies and procedures, faculty and student learning opportunities related to culture and diversity, and curricula information such as syllabi and course descriptions. Many of these documents are available on the university web site. If these documents cannot be found there, the researcher will ask participants if they are willing to share copies.

Interviews will be audio recorded and later transcribed by the researcher and a professional transcriptionist. Numeric identifiers will be used for data collected to keep participant names private. Only the researcher and her research advisor/committee will have access to the data. Participants’ names and institution will not be used in any part of published research documents or professional presentations. Use of anonymous direct quotes and anonymous audio clips may be used for publication and presentation. Audio recordings, transcribed interview data, documents, field notes, and e-mail communications will be stored in a locked file cabinet in the researcher’s home. Signed consent forms will be stored in the school of nursing for three years after the completion of this project. In addition, findings will be reported in aggregate so the participants will not be singled out or identified.

**Proposed Data Analysis**

Audio recordings, transcribed interview data, e-mail communication, documents, and field notes will be analyzed using Leininger’s four phases of ethnonursing analysis for qualitative data (Leininger, 2006). The researcher will use QSR NVivo 7 © 1999-2006 qualitative software to assist in managing the data and data analysis. Data will be studied for similarities and differences; meanings will be sought from recurrent components in the data. In the third phase, patterns and ideas related to teaching culture care will be identified. The fourth phase involves synthesis and interpretation of data, abstracting themes from the findings. Finally, themes confirmed may be used to identify nursing decisions and actions in teaching culture care. In all phases of analysis, findings will be traced back to the raw data which is essential for an audit trail and to meet the five
qualitative criteria for ethnonursing studies; credibility, confirmability, meaning-in-context, recurrent patterning, and saturation (Leininger, 2006).

III. Risks/Benefits and Costs/Compensation to Participants

There are no foreseeable risks to participate in this study beyond those typically encountered in an interview setting. Participation will require the use of informants’ time; estimated to be a maximum of two hours. There are no anticipated direct benefits for participation. Informants may find participation interesting and knowledge discovered will benefit the practice and profession of nursing and the ever-evolving body of transcultural nursing knowledge. During the pilot study, most informants preferred to meet in public places such as a coffee shop or restaurant; therefore, the researcher may purchase informants a cup of coffee or soda and a snack or lunch during the interview facilitating a place to meet and offering a way to express appreciation to participants.

IV. Grant Information

Three credit hour release time was awarded to conduct this study and prepare findings for dissemination through publication and presentation from the Middle Tennessee State University, College of Graduate Studies, University Faculty Research and Creative Project Committee.

V. Documentation

Attached are copies of the informed consent document and study interview guide. Within the qualitative, ethnonursing research method, this document is only a guide. The interview flow is based on participant responses.
As the world becomes increasingly multicultural, teaching about culture and care in nursing education has become important. I am interested in learning from you how you teach nursing students about caring and culture. I would like to interview you once or twice at your convenience in a location you choose (possibly your faculty office, conference room, or coffee shop). Interviews can range from approximately thirty minutes to an hour. I will ask you to tell me about what you teach students related to care and culture including content, teaching strategies, and clinical experiences students have. I am also interested in looking at public documents at the university such as philosophy statements, faculty and student recruitment policies and procedures, and nursing school admission and retention policies and procedures. You and I may communicate via phone or e-mail to set up our interview dates and times and possibly to clarify meanings from the interview.

Interviews will be audio recorded and later transcribed by the researcher and a professional transcriptionist. Your identity will be coded with a number and kept private. Only the researcher and her research advisor/committee will have access to the data. Participants’ names and institution will not be used in any part of the published research document or professional presentations. Use of anonymous direct quotes and anonymous audio clips may be used for publication and presentation. Audio recordings, transcribed interview data, documents, and e-mail communications will be stored in a locked file cabinet in the researcher’s home. In addition, data will be reported in aggregate so participants will not be singled out or identified.

There are no foreseeable risks to participate in this study. Participation will take your time; estimated to be a maximum of two hours. There are no anticipated direct benefits...
for participation. You may find participation interesting and the knowledge discovered may benefit the practice and profession of nursing.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact the Sponsored Programs and Academic Research Center, Kepner Hall, University of Northern Colorado, Greeley, CO 80639; (970) 351-1907.

Thank you for your participation.

Sandy Mixer, MSN, RN  
Doctoral Student, University of Northern Colorado

___________________________________   ____________________
Participant’s Signature     Date

___________________________________   ____________________
Researcher’s Signature     Date
Appendix F

Leininger’s Phases of Ethnonursing Data Analysis Guide Enabler
Appendix F

Leininger’s Phases of Ethnonursing Data Analysis Guide Enabler

Fourth Phase (Last Phase)
Major Themes, Research Findings, Theoretical Formulations, and Recommendations

This is the highest phase of data analysis, syntheses, and interpretations. It requires synthesis of thinking, configuration analysis, interpreting findings, and creative formulation from data of the previous phases. The researcher’s task is to abstract and confirm major themes, research findings, recommendations, and sometimes make new theoretical formulations.

Third Phase
Pattern and Contextual Analysis

Data are scrutinized to discover saturation of ideas and recurrent patterns of similar or different meanings, expressions, structural forms, interpretations, or explanations of data related to the domain of inquiry. Data are also examined to show patterning with respect to meanings-in-context and along with further credibility and confirmation of findings.

Second Phase
Identification and Categorization of Descriptors and Components

Data are coded and classified as related to the domain or inquiry and sometimes the questions under study. *Emic* or *etic* descriptors are studied within context and for similarities and differences. Recurrent components are studied for their meanings.

First Phase
Collecting, Describing, and Documenting Raw Data (Use of Field Journal and Computer)

The researcher collects, describes, records, and begins to analyze data related to the purposes, domain of inquiry, or questions under study. This phase includes: recording interview data from *key* and *general* informants; making observations, and having participatory experiences; identifying contextual meanings; making preliminary interpretations; identifying symbols; and recording data related to the DOI or phenomenon under study mainly from an *emic* focus. Attention to *etic* ideas is also recorded. Field data from the condensed and full field journal can be processed directly into the computer and coded, ready for analysis.