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The Value of Transcultural Nursing Education: Perceptions of Nursing Graduates

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THE VALUE OF TRANSCULTURAL NURSING EDUCATION:

PERCEPTIONS OF NURSING GRADUATES

by

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This dissertation, submitted by Jane E. Bergland in partial fulfillment of the requirements for the degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby required.

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This dissertation meets the standards for appearance, conforms to the style and format requirements of the Graduate School of the University of North Dakota, and is hereby approved.

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Signature Jane E. Bergland

Date 12-11-02

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This paper is dedicated to the following people in my life:

To my husband, Bill, who provided me with never ending support. Bill, you are the greatest.

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ABSTRACT

The purpose of this qualitative study was to determine the value of transcultural nursing education as perceived by eight graduates from Minnesota State University Moorhead's baccalaureate nursing program. Perceptions of nurses' care provision and what influenced those care provision choices where obtained during first interviews when they reflected upon a culturally sensitive fictitious scenario. Second interviews were conducted with each interviewee in which they were given the opportunity to expand on their perceptions and verify conclusions being drawn. Reliability was established when half of the interview transcripts were analyzed by a nursing professor with experience in qualitative research. The study occurred during the spring, summer and fall semesters of 2002.

The study focused on nursing graduates' perceptions of care provisions that might be required considering the presenting condition of this baby and the culturally sensitive scenario. The participants' perceptions of what factors influenced care delivery were also explored.

After coding the interview data and establishing categories of responses, the following two themes emerged.

1. Participants perceived that caring for the physical needs of the baby were paramount; however, nursing care must have been provided within the context of the family. Care provision was holistic and culturally sensitive.

2. When providing care in a culturally sensitive situation, participants perceived that culturally competent nursing care was impacted directly by their Bachelor of Science in Nursing education (which included the transcultural nursing course), experience, personal characteristics of the nurse, and work settings.

One might symbolize the results of this study as parts of a four-legged table. The four categories of education, experience, personal characteristics of the nurse, and work settings were the legs that held up the holistic, culturally sensitive care provision of the baby and the family. If one of these legs were pulled out, the table would collapse and quality care would not be provided. The participants perceived that all of these factors impacted the plan of care. Recommendations for the field of nursing, the nursing program at Minnesota State University Moorhead and suggestions for further research were made as a result of this study's findings.

CHAPTER I

INTRODUCTION

Historical Background

The Civil Rights Movement in the 1950s and 1960s brought with it increasing pride in one's cultural background. The "melting pot" started to give way to the concept of a mosaic (Leonard, 2001). The dynamic changes occurring during the 1970s, 1980s and 1990s brought with it social change and increased refugee populations from war-torn countries. As immigration and migration to the United States increased, so did the variety of traditional, cultural, health and illness beliefs and practices (Spector, 1996). The concepts of health and illness are deeply embedded in culture. With this vast influx of differences, health care providers can no longer assume that there is a dominant set of values and beliefs about health care (Lindeman, 2000). As early as the mid 1950s, Madeline Leininger recognized these changes and realized the need for a new field in nursing known as "transcultural nursing". It was Leininger's belief that "if human beings are to survive and live in a healthy, peaceful and meaningful world, then nurses and other health care providers need to understand the cultural care beliefs, values and lifeways of people in order to provide culturally congruent and beneficial health care." (as cited in Leininger, 2002, p. 3).

The rationale for developing a required transcultural nursing course for the Minnesota

State University Moorhead (MSUM) Registered Nurse (RN) to Bachelors of Science in Nursing (BSN) program approximately seven years ago is obvious. Our world is dramatically and rapidly changing. The primary composition of culture, religion, ethnicity, and race in the United States is no longer a predominantly white, homogenous group of people. In response to these changing demographics, it is imperative that nursing education programs reflect the needs of the diverse patients being served.

Along with changing demographics and identified educational needs, the rationale for developing a required transcultural nursing course at MSUM includes the fact that nursing standards, along with national health goals, drive nursing care delivery. Each of these is described to provide the reader with a broader understanding of the history behind the development of a transcultural nursing course.

Nursing Standards

The American Nurses Association (ANA) is a full-service professional organization representing the nation's 2.6 million registered nurses through its 54 constituent state associations and 13 organizational affiliate members. ANA advances the nursing profession by fostering high standards of nursing practice. On the ANA WEB site, (http://www.nursingworld.org), there is a position statement as it relates to cultural diversity in nursing practice:

> Knowledge of cultural diversity is vital at all levels of nursing practice. Ethnocentric approaches to nursing practice are ineffective in meeting health and nursing needs of diverse cultural groups of clients. Knowledge about cultures and their impact on interactions with health care is essential for nurses, whether they are

practicing in a clinical setting, education, research or administration...culture is one of the organizing concepts upon which nursing is based and defined. (2002, p. 1) Standards of care in culturally diverse situations obviously require a knowledge level from which nurses can practice.

The Minnesota Chapter of the Transcultural Nursing Society concurs with the direction that the ANA statement provides. It is the society members' belief that in order for nurses to practice transcultural nursing competently, their caring practices must be grounded in the knowledge base and science of transcultural nursing. These standards shape nursing practice by providing a means of accountability and criteria that define the scope of nursing practice (Leuning, Swiggum, Wiegert, Zander, 2002). Education is a key ingredient to obtaining quality standards.

Changing Demographics

Although caution must be used when looking at the demographic changes of race and ethnicity in nurses and the patients they care for, the data is significant. Each comes into the health care setting with beliefs, values and practices that directly affect how care is provided and received. A survey of RNs showed that 86.60% identified themselves as white non-Hispanic (U.S. Department of Health and Human Services, 2000). The same survey indicated that only 2% of the registered nurse (RN) population was Hispanic, while Hispanics comprise 12.5% of the general population. The representation of minority nurses among the total nurse population increased from 7% in 1980 to 12% in 2000. Despite these increases, the diversity of the RN population remained far less than that of the general population where minority representation was more than 20% in 2000.

Minnesota State University Moorhead is located in the Red River Valley area of northwestern Minnesota, directly on the North Dakota border across from the city of Fargo. Data from Clay County, MN, (2000) where the city of Moorhead is located, indicated that in 1999 the total population was 51,816; the Hispanic population was 1,762. While the population of Hispanics may not seem large, it does not take into account the influx in the Hispanic population during the summer and fall months when migrant families move to the area for agricultural employment. No specific data was available that indicated the temporary population surge; however, my personal experience as a registered nurse for the Tri-Valley Migrant Head Start summer program would indicate a significant population surge.

In Fargo, ND, there has been evidence of a very active refugee program; the diversity of the refugee population is represented by the requests for interpreters. In the first quarter of 2001, Fargo Community Interpreter Services (Diversity News, 2001) had nine languages available for oral interpreters in medical, social and other settings. These included Arabic, Bosnian, Chinese, Farsi, Kurdish, Russian, Somali, Spanish, and Vietnamese. The four top languages in 2000 were Bosnian, Kurdish, Arabic, and Somali. The nurse-patient relationship has far reaching implications and the provision of culturally competent care is important in all health care settings and is essential to the acceptance of health services when care is provided (Bloom, 2000).

National Health Goals

As indicated in the previous section, the ethnic and racial demographics of our world have been changing. In 1998 the United States Department of Health and Human

Services (DHHS) acknowledged these changes and developed a set of national health targets that included eliminating racial and ethnic disparities in health. Public forums have been held seeking response to those targets. These health targets, or objectives, are found in the DHHS Healthy People 2010 (2000) document and focus on closing the ethnic and racial gaps found more specifically in the areas of diabetes, AIDS, heart disease, infant mortality, cancer screening and management, and immunizations.

Meeting these objectives requires collaboration of many professionals in the health care field, especially nurses, since they comprise the largest professional group to provide direct patient care. Those nurses with transcultural nursing knowledge of Western and non-western cultures are reported to be more effective in meeting the health needs of a multicultural world (Leininger, 1997).

Education

Dr. Barbara Leonard, an associate professor at the University of Minnesota School of Nursing, has an extensive background in alternative and complementary medicine. Having worked with a wide variety of cultures and known for celebrating diversity, she wrote:

> Nurses currently work within health care systems that reflect biomedical philosophy and practices. These systems serve an increasing number of diverse cultures that have their own health beliefs, values, and practices. These may conflict with those of Western medicine. The challenge for the nurse is to become knowledgeable about diverse cultures and to bring about greater cultural sensitivity and competence while working within the health care system. (2001, p. 1)

If we refute the fact that our world and health care needs are diverse, we remain ethnocentric in our view that Westernized medicine is the only acceptable form of intervention. This false sense of power within our Western world became all too apparent on September 11, 2001, when we learned the painful lesson that our ways were not admired and embraced by many people around the world (Edwardson, 2002).

If we are educated with a transcultural understanding, we can prevent major clashes or conflicts and lessen fears (Leininger, 1992). The content within a transcultural nursing course is not one that can be left as a last minute inclusion or exclusion. Nurse educators must prepare nurses for the emerging health care system and not the system of the past or one that they wish were in place (Lindeman, 2000). Purposeful, thoughtful effort was put into the design and planning of the course at MSUM. Students learn about respect and understanding of cultures other than their own. Thus, improved health outcomes have a higher likelihood of being realized when the health care provider and the patient acknowledge and respect each other's beliefs about illness (Patcher, 1994).

Culture and ethnicity are strong determinants in an individual's interpretation or perception of health and illness and with the increase in immigration rates and settling out patterns, perceptions of health and illness became more and more culturally diverse (Benginamin, Downey, and Heuer, 1999). Obviously, the health care system will suffer if nursing students do not have an opportunity to learn how to care for patients from diverse cultures. Nurse educators have the responsibility to meet this challenge and offer every nursing student a course based on transcultural nursing care. As a nurse educator, I hope

to provide an educational knowledge base that allows students the opportunity to provide competent nursing care to people from diverse backgrounds.

Need for the Study

Nurse educators have the obligation to present educational lessons that promote quality care and culturally sensitive nursing care to culturally diverse populations. Nurses, once they graduate, have the obligation to provide and promote care that is appropriate to and congruent with the cultural values, beliefs and practices of individuals, families and groups (Zoucha, 1998). Research is necessary to discover if nurses, who are educated in transcultural nursing theory and then graduate, actually perceive that culturally competent care can be provided. Discovering these caring perceptions is vital, as these are the nurses providing direct patient care.

It was hoped that a research study could address nurses' formulation of perceptions about how a transcultural nursing course did or did not impact their perceptions of culturally sensitive care and their attitudes about providing nursing care to patients with diverse backgrounds. It was valuable to learn what other influences, besides nursing education, contributed to the provision of culturally sensitive care.

Purpose and Design of the Study

The purpose of this study was to determine the value of transcultural nursing education as perceived by nursing graduates. This was obtained by discovering the perceptions of nursing graduates' care giving after reading a culturally sensitive fictitious scenario. The former nursing students all graduated from MSUM's BSN nursing program and had taken the required two credit transcultural nursing course. The study focused on

the graduates describing how they would plan their care for a Hispanic baby and his family. Qualitative methods were used for the study, including two interviews from each participant, participant feedback, and professional feedback for validity. The study was conducted during the spring, summer and fall months of 2002. Research procedures are discussed in detail in Chapter II.

Research Question

"Moving from appreciating cultural differences to tangible results is something that does not come easily and is certainly an idea whose time has come." (Edwardson, 2002, p. 1). The research question formulated for this qualitative study was: What is the value of transcultural nursing education as perceived by graduates from Minnesota State University Moorhead's Registered Nurse (RN) to Bachelors of Science in Nursing (BSN) degree program? Perceptions of nurses' care provision and what influenced those care provision choices where obtained when they reflected upon a culturally sensitive fictitious scenario.

Delimitations

1. Participants in the study were eight nursing graduates from MSUM.
2. The site was a relatively small university in Moorhead, Minnesota.
3. Participants were interviewed at various locations in Fargo, ND, and Moorhead, MN.
4. The interviews took place during the spring and summer of 2002.
5. The lengths of the interviews were between 20 and 45 minutes.

Definition of Terms

To assist the reader in obtaining a clearer understanding of Transcultural nursing theory, the following terms are defined:

Culture: "the learned and shared beliefs, values, and lifeways of a designated or particular group that are generally transmitted intergenerationally and influence one's thinking and actions modes" (Leininger, 1995, 2002, p. 9).

Transcultural nursing: "a formal area of study and practice focused on comparative human-caring (caring) differences and similarities of the beliefs, values, and patterned lifeways of cultures to provide culturally congruent, meaningful, and beneficial health care to people" (Leininger, 1995, 2002, p. 5).

Culturally congruent nursing care: "refers to the use of sensitive, creative, and meaningful care practices to fit with the general values, beliefs, and lifeways of clients for beneficial and satisfying health care, or to help them with difficult life situation, disabilities, or death" (Leininger, 1995, 2002, p. 12).

Emic: "inside cultural knowledge that nurses try to obtain from their clients" (Leininger, 2002, p. 48).

Etic: "outsider's knowledge, such as the nurse's professional ideas, may be very different from emic views and experiences" (Leininger, 2002, p. 48).

Ethnocentric: "belief in the superiority of one's own ethnic group" (Spector, 1996, p. 70).

Organization of the Dissertation

Chapter I contained the historical background and discussion of important factors that influenced the development of the transcultural nursing course at Minnesota State University Moorhead. Descriptions were also given with respect to the need for, purpose of, and delimitations of this study, along with a delineation of the research question and definitions for terminology that I used.

The methodologies used for the study are included in Chapter II. Initially, I have described qualitative research with regard to its fundamentals and the rationale for choosing this form of research. Next, I have shared procedures involved in the planning phase, the pilot study, the expanded study, and the data analysis.

The results of the study are described in Chapter III and are supported with examples of participant responses. Codes, categories, and patterns are discussed as well as the two major themes which emerged. These themes reflected the participants' perceptions of nursing care in a culturally sensitive fictitious scenario and factors that influenced those perceptions.

In Chapter IV, I have examined the two themes that emerged and discussed them with reference to current professional literature. In Chapter V, I have presented a conclusion of the study and shared recommendations for the field of nursing, for MSUM's nursing department and for further research.

CHAPTER II

METHODOLOGY

"Even though nursing science and theory are still evolving, it is evident that qualitative methodologies are integral to both. Nurses are discovering the richness of thick description and the emic perspective in developing culturally appropriate interventions and in gaining increased competence in the care of diverse and vulnerable populations." (DeSantis & Ugarriza, 2000, p. 351)

This chapter contains a discussion of qualitative research with reference to the fundamentals, the rationale for choosing this method, why qualitative research works well within the discipline of nursing, and my personal reasons for advocating for the use of qualitative methods. In addition, the research planning phase, the pilot study, the expanded study, and finally, the data analysis process are reviewed.

Qualitative Research

Fundamentals of Qualitative Research

The five primary qualitative research traditions are biography, phenomenology, grounded theory study, ethnography, and case study (Creswell, 1998). This study was unique in the fact that it did not fit specifically into one of the five traditional forms of qualitative inquiry. However, it did fit into what Congdon (2002), calls "qualitative descriptive" design, containing the following characteristics:

1. Informed by or guided by one of the major designs, but smaller in scale.
2. Scope of study limited by practical considerations such as smaller sample size, time, limitations, or inability to conduct a full study.
3. Novice researchers, students, limited funding, pilot studies.
4. More descriptive than interpretive.

The data for this qualitative, descriptive study was obtained from the reflective verbal responses of nursing graduates. Participants, when provided with a scenario, described how and why care was provided in one way or another. On a smaller scale, this study was guided by phenomenology. This perspective informs what was studied and how it was studied (Creswell, 1998). What was studied were graduates' perceptions. How it was studied was through the use of a culturally sensitive fictitious scenario and interviewing.

Rationale for Choice of Qualitative Design

It was the concept of inquiry and engaging in deep conversation that initially drew me to pursing research through qualitative means. Creswell (1998), provides a list of eight compelling reasons to undertake a qualitative study:

1. Select a qualitative study because of the nature of the research question.
2. Choose a qualitative study because the topic needs to be explored.
3. Use a qualitative study because of the need to present a detailed view of the topic.
4. Choose a qualitative approach in order to study individuals in their natural setting.
5. Select a qualitative approach because of interest in writing in a literary style.
6. Employ a qualitative study because of sufficient time and resources.

7. Select a qualitative approach because audiences are receptive to qualitative research.

8. Employ a qualitative approach to emphasize the researcher's role as an active learner who can tell the story from the participant's view rather than as an "expert" who passes judgement on participants.

Adhering to these reasons allowed me to maintain an inductive process where data was gathered from real life interaction, and I derived a general explanation of the participants' responses. When a qualitative study follows the inductive process, meanings given to responses guide nursing practice. The research question proposed in this study could not proceed with a deductive process where a hypotheses would be deduced from a theory and the hypothesis would require empirical testing in a real life situation (Nieswiadomy, 1998).

Within a holistic framework, qualitative research is a means of exploring the depth, richness, and complexity inherent in phenomena (Burns & Grove, 1999). Congdon (2002) provides the following list of common essential features that exist in qualitative research:

1. Is not approached from a cookbook orientation where each ingredient is controlled and each step is outlined.

2. Concerns itself with human beings and their environment in all the complexities (holistic).

3. Reports human experiences as they are lived.

4. Provides data that is values bound.

5. Reports multiple realities exist based on people's different understandings of lived experiences.

6. Seeks appropriate ways of studying phenomena (multiple ways of knowing).

7. Commits itself to interpreting participants' point of view (not measurable).

8. Involves the researcher as a co-participant instrument.

9. Considers participants as interactive and inseparable.

10. Utilizes narrative inductive analysis.

11. Utilizes an expressive and persuasive literary style of reporting with participant quotes, comments, stories, and photographs.

Each of these features reflects the purposes of a qualitative study in terms of discovering, understanding, describing, explaining, exploring, and developing potential theory.

Qualitative Methods and the Discipline of Nursing

Researchers Leininger, Munhall, Silva, and Rothbart define qualitative research as a "systematic, subjective approach used to describe life experiences and give them meaning" (as cited in Burns and Grove, 1999, p. 338). Qualitative research has been utilized by Glaser and Strauss and Kaplan since the 1960s, thus giving qualitative research a long history of successful implementation. The impetus for utilizing qualitative research comes from "the need to understand aspects of human values, culture, experiences, and relationships" (Congdon, 2002, p. 1). Comprehensive, holistic understanding cannot come from "yes" and "no" responses or rating scales from one to five. This study required the gathering up of words, an inductive analysis, a focus on the meaning of participants, and

finally, a description of the process that was expressive (Creswell, 1998). Qualitative researchers often rely on a few cases and many variables where quantitative researchers work with a few variables and many cases.

The most effective way to obtain a rich understanding of the graduate nurses' perceptions of care provision in a culturally sensitive fictitious scenario and determine the value of the transcultural nursing course was to proceed with a qualitative approach. Each individual's interpretation of the circumstances was of importance, rather than the interpretation I made as the researcher (Nieswiadomy, 1998). Schooled in the discipline of nursing over 20 years ago, discovering individual's perceptions on health related subjects came as second nature to me. How data is collected during the nursing process, which begins with assessment, can be very qualitative in nature. During this process nurses need to understand aspects of human values, culture, experiences, and relationships (Congdon, 2002). Nurses proceed with a very holistic approach when assessing and discovering meanings related to the human experience; a holistic approach is an essential feature of qualitative research (Congdon, 2002).

Qualitative Research as the Researcher

As I reviewed the research process, I was reminded of the reasons Creswell (1995) stated one should do qualitative inquiry. I wanted to know what was going on in order to obtain descriptions of quality care. From my years of experience as a nurse and now an educator, I knew this topic needed to be explored. Talking with experts in the field of multi-cultural education at the recent National Ethnic Studies Conference in Vancouver,

British Columbia, demonstrated that audiences were receptive to the educational needs of nurses and the provision of culturally competent care. I viewed myself as an active learner in qualitative analysis, and I desired to invest the time and resources necessary to conduct qualitative research.

The remainder of this chapter is devoted to the description of the methodology used in this qualitative study. I have described the planning phase, the pilot study, the extended study, and data analysis.

Research Planning Phase

The actual planning phase of this study began spring semester, 2002, at the University of North Dakota where I took the advanced qualitative research methods class. I completed the Human Subjects Education test, developed a concept map and proceeded with developing a fictitious scenario which gave direction to my research and research question.

Human Subject Education

All students must go through certain formalities for the research process to begin. For graduate students at the University of North Dakota (UND) this included completing the Human Subjects Review Forms and obtaining approval by the Institutional Review Board (IRB). During this process, I discovered that the words "transcultural nursing", words that were so comfortable to me, were not clear to those who read or heard about it. This reminded me that I needed to be aware of the audience of readers. In general, the on-line test on human subject education made researchers aware of their responsibilities that place an emphasis on maintaining confidentiality and preventing harm.

Concept Mapping

It was in UND's EFR 520 advanced qualitative research methods class that I produced a concept map that gave my research direction and organization. The concept map was completed through the use of cooperative learning. "Cooperative learning projects can involve the group construction of concept maps to better explicate students' understanding of concepts, their hierarchies, and interrelationships" (Bietz, 1998, p. 35). Support from peers was very encouraging, and at times, necessary for maintaining objectivity. The purpose of concept mapping was to provide structure and direction to the research topic. The process of concept mapping began with the researcher composing words that represented ideas related to the research question and then linking those words with other words in a hierarchical order. Meanings were then given to the framework of propositions (Bietz, 1998).

Fictitious Scenario

It is important to address how I planned to obtain qualitative data and why I chose the Hispanic culture to represent the culture in the scenario. The mode of systematic inquiry by participants was accomplished through the use of a culturally sensitive fictitious scenario followed by a "grand tour" question. I developed a culturally sensitive fictitious scenario while taking the advanced qualitative research course at UND and had both my colleagues and peers review it. After receiving comments from reviewers, I revised the fictitious scenario to reflect a much more objective situation. (See Appendix A.)

The rationale for choosing a Hispanic family in the scenario was based on the fact that I have worked with this culture for many years and am familiar with various health beliefs

and values. The Hispanic population was also a culture that the Caucasian nursing graduates were likely to encounter in the geographic area of this study. In the Red River Valley alone, 438 Hispanic children were enrolled in the summer Migrant Head Start program (Tri-Valley Opportunity Council, 2002). Many of these children and their family members received health care in the local clinics and hospitals; however, data collection methods to accurately track these numbers was unreliable.

Developing Research Questions

According to Rubin and Rubin (1995), interviews are built from three types of qualitative questions: main, probing, and follow-up. For the main question, the wording must be open enough to encourage interviewees to express their own opinions and experiences, but narrow enough to keep interviewees from wondering too far from the subject at hand. Nieswiadomy (1998) calls this an "unstructured interview question" where the interviewer starts the interview with a broad opening statement. This is similar to the term "grand tour question" which is the technique I used (Seidman, 1998). There was only one question that all the participants were asked to answer after they read the scenario: "What does Sue have in mind as she plans her care for this baby?"

Answering the grand tour question allowed the participant the freedom to express their perceptions without restriction. This main question was then followed up with probing questions. These were additional prompting questions that encouraged the respondent to elaborate on the topic that was being discussed (Nieswiadomy, 1998). Probes also signal participants that the researcher wants longer and more detailed answers, specific examples, or evidence (Rubin, et. al., 1995).

Historically, nurses ask probing questions when patients are being admitted to an institutional setting or are being seen by a nurse in the patient's home. Patients begin with a vague description of what they think their health problem is and it is the nurse's role, through the use of probing questions, to obtain a clearer picture of what is really happening to the patient based on their perceptions. The same technique was utilized for this study where probing questions were asked as the conversational interview occurred. Questions were not pre-planned. Examples are described further when reporting results in Chapter III.

One main follow-up question was also developed and asked at the end of the second interviews: "What would you think if we dropped the transcultural nursing course?" The purpose of instituting this question was to test my emerging themes (Rubin, et. al., 1995). I needed to know if I had interpreted the participants' perceptions of nursing education correctly. This is also discussed further in the results section.

Pilot Study

Purpose of the Pilot Study

Before embarking on this study, I decided to do a pilot study that would help me determine the feasibility of the study. I was able to test the fictitious scenario, gain experience with the methodology, and identify potential problems with data collection (Nieswiadomy, 1998). Successful completion of this process afforded me the confidence to proceed with an extended study. Once again, I had the support and feedback of peers from the advanced qualitative research class.

Participant Selection and Description

I began my inquiry into participant selection by meeting UND's IRB requirement that I obtain a cooperating letter from MSUM's Dean of Education and Human Service stating that I could access potential participant information from a graduate list filed in the nursing department at MSUM. With this approval, I selected potential participants using the following criteria: graduates of the MSUM nursing program, successful completers of the required transcultural nursing course within the past five years, residence within a 100 mile radius of MSUM, and, each representing a different area of clinical practice as described in their profiles below. I used what Nieswiadomy (1998) referred to as a "convenience sample". Creswell (1998) referred to this type of sampling as "criterion" which works well when all individuals studied represent people who have experienced a certain phenomena such as the same transcultural nursing course.

MSUM nursing graduates who fit the above stated criterion were chosen randomly from the alumni list in the nursing department and were called during the evening hours. Former students who answered their phones were given a description of my research, told the study involved being interviewed twice, were informed of confidentiality and the absence of incentives for participation. The graduates were then asked if they wanted to participate. Three of the four nurses from the pilot study who answered their phones agreed to participate. They chose the place and time in which to be interviewed individually. A description of each nurse follows:

1. Nurse #1 was a 37-year-old Caucasian female who worked in a Cardiac Intensive Care Unit at the time of this study. She took the transcultural nursing course in the spring

of 1999 and graduated from MSUM spring semester, 2000. Prior to that, she had 13 years experience as a RN with an Associate's Degree.

2. Nurse #2 was a 42 year-old Caucasian male who, at the time of this study, worked with patients who were still in the hospital but were transitioning to go live back in their homes. Many of these patients were male and had recently had surgery. Nurse #2 took the transcultural nursing course in the spring of 1998 and graduated that same semester. He had 7 years of experience as a RN before returning to obtain his BSN degree.

3. Nurse #3 was a 47 year-old Caucasian female who had worked as a public health nurse ever since graduating from MSUM spring semester 1999. She also took the transcultural nursing course the same semester. Prior to her graduation, she worked for 25 years as a RN in the hospital setting.

Interview Procedure

Formal data collection for the pilot study began in March, 2002, approximately mid-way through the advanced qualitative research course. Each participant was interviewed twice before the course ended in May, 2002. The time, day and place I interviewed each of the three participants varied according to their schedules and convenience. Nurses #1 and #2 had both of their interviews conducted in the afternoon in the small library of MSUM's nursing department. Nurse #3 had both of her interviews conducted in her home kitchen during the evening hours. First interviews took approximately 45 minutes and the second took an average of 30 minutes.

The tools utilized for the interviewing processes were simple: a pen, paper, and a cassette tape recorder. The first interview began with me describing the purpose of the research along with the fact that interviews were taped and later transcribed by me. The consent form was read by the participants as I highlighted main points including the purpose of the study, the lack of incentives for participating, the option to leave the study voluntarily without consequence, and the assurance of confidentiality. Consent forms were obtained from each participant.

I began the process of inquiry by asking the participants to read the fictitious scenario. When they finished, I asked: "What does Sue have in mind as she plans her care for this baby?" After this grand tour question, many probing questions followed. Questions were not formulated or pre-determined. They resulted from participants' responses. Probing questions were significant for the results, which are discussed in Chapter III.

With the first interviews complete, data was transcribed and analyzed. The data is described later in the data analysis section of this chapter. The purpose of conducting a second interview was first, to discover if the participants had anything more they wanted to say about the scenario and, second, to check for validity. At the beginning of the second interview, participants were provided with the same fictitious scenario and asked, "Is there anything more you would like to add to or say about this scenario?" Overall, this prompted little response. Member checking was utilized to establish credibility to my results (Creswell, 1998). I provided each participant with the transcribed copy of his/her interview for review. I then described the codes, categories, patterns, and themes I had

found to obtain their views. Each of the three participants found my interpretation to be accurate.

At the very end of the second interview, when the participants stated they had nothing further to add, I asked them one last question: "What would you think if we dropped the transcultural nursing course?" I continued to tape record during this time to obtain their verbal responses. I also noted their non-verbal responses and wrote those down. With the interviews now completed, I verbally thanked each participant for assisting with the study and one week later, mailed out a thank you letter.

Conclusions for the Expanded Study

Success of the pilot study was evident in all respects. I had willing participants with varied work experience who were interested in the study and the results. The fictitious scenario prompted the kind of thinking and responses I was hoping for, while the interviewing process itself was comfortable and conversational. Finally, I was able to discover meanings participants provided in response to their plan of care and began seeing patterns and themes emerge. With the participants confirming my conclusions, I was ready to begin an expanded study that was based on the pilot study.

Expanded Study

The process I went through for the expanded study can easily be understood when the reader realizes that the expanded study truly was that: an expansion of the pilot study. The process for participant selection was conducted in exactly the same way with five out of twenty agreeing to participate. I had a convenience sample of five more participants with the following descriptions:

1. Nurse #4 was a 39-year-old Caucasian female who worked as a clinic manager at the time of this study. She took the transcultural nursing course in the spring of 1999 and graduated in the spring of 2002. This nurse had 16 years of experience before graduating with her BSN degree.

2. Nurse #5 was a 24-year-old graduate who identified herself as Caucasian. Her work experience was not as extensive as the other participants and she had just started working at a college health center at the time of this study. She also had approximately one month's experience as a nurse for a summer migrant school. She took the transcultural nursing course in the spring of 2000 and graduated in the spring of 2001.

3. Nurse #6 was also 24 years old and a Caucasian female working part time as an oncology nurse providing direct patient care. After graduating with her Associate's Degree, she went directly into the BSN program at MSUM and did not work as a nurse during that time. She took the transcultural nursing course in the fall of 2000 and graduated in the spring of 2001.

4. Nurse #7 was a 43-year-old Caucasian female who coordinated the diabetic health care education in a clinic whose patients come from many diverse backgrounds. She took the transcultural nursing course in the spring of 1997 and graduated in the spring of 2000. This participant had over 15 years of nursing experience in a variety of different settings.

5. Nurse #8 was a 41 year old female and was practicing as a licensed school nurse at a high school with over 1,600 students. While she worked at the high school, she was actually employed by a county public health agency. She identified herself as Caucasian,

took the transcultural nursing course in the summer of 1998, and graduated in the spring of 2001. She had worked as a nurse for 10 years before graduating with a BSN.

Interview Procedure

Participants of the extended study were also asked where they wanted to be interviewed and at what time. For the first interviews, Nurses #4, #5 and #6 chose to come to the library in the nursing department at MSUM in the later afternoon. Nurses #7 and #8 asked to be interviewed in their offices at work during the morning. Discovering the participants' perceptions of care provision in a culturally sensitive situation and what impacted those care decisions remained the purpose of the first interviews. The procedures followed for the first interview of the pilot study continued through to the extended interviews with no changes. The interviews lasted approximately 45 minutes and were just as conversational in nature. Data was transcribed, read repeatedly, and analyzed as described later in Chapter III.

Those nurses who wanted the second interview conducted at their offices at work increased with the addition of Nurse #4. Nurses #5 and #6 returned to the nursing department and were interviewed in the small library. Each participant was given a copy of his/her interview transcript and a written copy of my findings to review as I explained each step. The purpose of the second interviews did not change nor did the time it took to conduct them, approximately 30 minutes. The participants had the opportunity to confirm, disconfirm, or add more comments to the conclusions I had reached. I then ended the interviews with the same follow-up question about dropping the transcultural course. The second interviews were conducted to discover if there were additional

comments about care provision as it related to the fictitious scenario and to check for validity of my interpretations. Additional comments were few and all participants agreed with the conclusions I had reached.

Data Analysis

In this section I have described the strategies used to analyze the data. I have also detailed the procedures taken in my study to address the standards of rigor related to reliability and validity.

Coding Procedures

The purpose of the first round of interviews was to discover MSUM graduates' perceptions of care giving in a culturally sensitive situation and the value of transcultural nursing education. Soon after each of the first interviews were completed, I transcribed the taped interviews. I listened to the tapes repeatedly to ensure accuracy in transcription. Doing the transcription myself deepened my understanding of the data. It was important for me to ask myself, "What did I hear? What was the meaning of what was being said?"

According to Rubin and Rubin (1995), I had begun the data analysis. The Rubins describe the steps required following transcription:

1. Read through the interviews paragraph by paragraph and word by word, marking off a particular idea or concept is mentioned.
2. Indicate this idea or concept as a code, the subject of each paragraph.
3. Group these responses describing the same idea/s into a category/ies.
4. Come up with an overall description that explains the category you are studying.
5. Develop a theme that explains what was understood. (p. 226-227)

This process is also very similar to the one taught in both the qualitative and advanced qualitative research courses at UND.

I spent more than 40 hours reading the transcripts and began picking out words that brought meaning to each paragraph of responses. Many of the words were the same or similar, and my codes took shape during this process. I began with over 80 codes; however, as I reviewed the transcriptions again and again, I reduced the number to 56. I also noted the similarities of the codes and realized that the codes represented ideas that were put into six categories.

I was then able to explain each category with a descriptive pattern statement that reflected on perceptions of care provision by the participants. Patterns are smaller units of recurrent behavior that contribute to themes. DeSantis and Ugarriz (2000) describe themes as abstract entities that bring meaning and identity to a recurrent experience and its variant manifestations. "As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole" (p. 363). I was then able to make links between categories in which two themes emerged. I was very confident in my data analysis, because the participants' responses were similar and were repeated often.

Although qualitative data analysis is a time consuming process, I was able to hand review my data again and again to make sure I was giving an accurate meaning to the codes, categories, patterns, and themes that emerged. The themes explained perceptions of MSUM nursing graduates' care provision in a culturally sensitive scenario and the value of transcultural nursing education.

Reliability and Validity

Research design suggests standards for good and convincing research. In this study, validity was achieved by conducting a second interview with the participants. Reliability was achieved when my results proved compatible with those of another nurse educator.

Validity

Once the data analysis was complete, participants were notified and a second interview was arranged. Participants had the opportunity to read through their transcripts and how I coded each paragraph. They were also given a visual and verbal explanation of the categories, patterns and themes I had discovered which explained their perceptions of care giving after reading the fictitious scenario. This procedure provided the participant with the opportunity to comment on anything they wanted to add. It was also a time when the participant reviewed the process of data collection and confirmed or disconfirmed my results. Congdon (2002) calls this "member checking". Six of the eight nurse graduates responded that they had thought of nothing more to add and were mainly interested in my analysis. Two of the participants made peripheral comments. All participants responded positively to the conclusions I had reached. Some of the comments were, "right on", "I agree with it", "I would think this would be pretty accurate", "I think it makes sense", and "I think this is good."

It was also during the second interview that the follow-up question was asked: "What do you think would happen if the transcultural nursing course was dropped from the curriculum?" The purpose of asking this question was to obtain a richer understanding of the importance the transcultural course had had in their nursing education.

Reliability

In order to discover if I had been consistent in the data analysis process and discovery of themes, I asked a nurse educator to read through 50% of the first interview transcripts. She had previously taught a transcultural nursing course, had years of experience in qualitative research and was proficient in the process. Two weeks later, she gave me her interpretation of the data. Her data analysis was so similar to mine that I knew my understanding of the participants' perceptions was reliable. Our categories were exactly the same and she agreed 100% with my themes. She had no further modifications or recommendations.

The data analysis process was completed and proved to be reliable and valid. I have continued discussion of this study with the results that are supported by participant responses in Chapter III.

CHAPTER III

RESULTS

Over the course of five months I interviewed eight MSUM nursing graduates twice. The initial interview was performed for the purpose of discovering the value of transcultural nursing education by obtaining their perceptions of nursing care after reading a culturally sensitive fictitious scenario. All participants had taken the required transcultural nursing course. A second interview was conducted with the participants to provide them an opportunity to agree or disagree with the assertions I had made and to check for validity. What naturally occurred during the interviewing and then the analysis process were two themes. The first theme reflected perceptions that were discovered after asking the grand tour question, "What does Sue have in mind as she plans her care for this baby?" The second theme represented responses that emerged from what became main probing questions, such as, "What do you think influenced the decision making process when she planned her care?", or, "What do you think has helped her with her decision making process?" These types of probing questions became a significant part of the interviews. In this chapter I have provided the reader with the codes, categories, patterns, and themes that emerged from this qualitative study. Each of these was supported by transcribed dialogue between the participants and myself.

Theme One

As stated above, the first theme of discovery represented responses to the grand tour question of how Sue was going to plan her care for this baby. Immediately the participants personalized the situation to themselves. Although many of the responses started out using Sue as the nurse, they actually became Sue and responded as if they were the nurse in that particular situation. There were seventeen codes and two categories that emerged for the first theme. Each category had a pattern and then the theme emerged which brought meaning to the perceptions. (see Table 1)

Table 1

Codes, Categories, and Patterns: Theme One

Codes	Categories
Baby's health/condition Dr.'s orders Data gathering Physical assessment Health history Red string Medical needs	Baby's Care
Pattern: Graduates immediately took responsibility to assess and care for the physical needs of the baby.	
Social needs (food, clothing, shelter) Communication/interpreter Teaching/Education Extended family involvement Support Holistic care Folk medicine Cultural values and beliefs Relaxed approach Health/illness perceptions	Family Care

Table 1 (continued).

Pattern: Graduates perceived that family needs were very important and must be included in the plan of care for this baby.

Taking the codes, categories and patterns into consideration, the first theme became: Participants' perceived that caring for the physical needs of the baby were paramount; however, nursing care must have been provided within the context of the family. Care provision was holistic and culturally sensitive.

Supporting dialogue to the grand tour question, which also supported the theme I discovered, was provided through excerpts of responses from each participant and myself as indicated by a "J". I have included responses from each participant to demonstrate how intertwined the categories of baby care and family care were. Two responses are noted here while the other six can be found in Appendix B. The responses also reflected that care provision was to be culturally sensitive and holistic in nature. The responses supported the shared meanings each participant had.

Participant One:

#1: "Well, I think first of all, she has the baby's interest in mind but in order to do that she needs good communication with the family and how she is going to get at that. She needs to look at the chart and see what the orders are in order to carry out her delivery of care. And then, next, find out is there somebody else that can do some, um, some mediation between the family and her and not just the high school girl."

J: "What else do you think she has to think about when she is providing care to that family? You mentioned the interpreter. What else?"

#1: "Well, there's something about the red string tied around the wrist. What is that? She just needs to find out how long that baby has been sick and carry through with the orders and provide social support for that family. I think the family support needs to be as instrumental as getting the baby well."

Participant Two:

#2: "Yeah, I think that she obviously, seen by the fontanels, is using the scientific approach of nursing that the baby is severely dehydrated and has impaired skin integrity...so those are the medical things. But, she also needs to see to the psychological things of involving the family and identifying how this disease affects the family and treatment."

J: "What do you think she is going to do about her care?"

#2: "She is going to try to accommodate that the best that she can. I would imagine that if census is down and there is a private room for this family that they could stay at least close to the baby. Depending on the setting. I would suspect that she is going to try to accommodate the whole family, having them there."

J: (towards the end of the interview I ask the following) "Actually, you have just given me a little bit of a summary. Can you expand on that?"

#2: "Sue, the nurse, is going to deliver, to the best of her ability, a holistic view of medical care. She sees the science aspect of knowing that she's got to correct the potential for electrolyte imbalance, she has to understand to re-hydrate this baby, definitely, you have to get rid of the diarrhea. But, you also have to be culturally sensitive which she is doing by doing...without making a judgement, cultural

judgement based on this client's health care practices and trying to accommodate this family the best she can. She incorporates the family in the health care."

Although this was just a sampling of responses, it was easy to see that the participants' perceived caring for the physical needs of the baby was paramount. Fallen fontanels, poor skin condition and turgor, as well as a red and cracked buttock were obvious signs of dehydration which can be life threatening in this situation. However, it was clear to them that the family must be involved, not with some token gestures or small talk, but with sincere inclusion of their needs and the care of that baby. The patient in this situation was the family, not just the baby.

I stated in the first theme that care provision was holistic and culturally sensitive. Nursing care that reflected a holistic approach was evident in participants' responses as they addressed the biological, psychological, social, and spiritual needs of the family. Culturally sensitive care was evident when the participants viewed care with an emic perspective versus an ethnocentric perspective. Evidence of holistic care provision utilizing a culturally sensitive approach was summed up by one graduate who stated:

#2: "As far as diversity, in nursing care...we don't all care for north European, white Anglo Saxons. I mean, you have to understand the clientele in order to provide quality care. Now, could you provide adequate care without it? Sure, it could be very scientific and go straight to the care of the baby, the listlessness, the dehydration...but, you also need to understand that you are taking care of the family, too."

This quote reflects the fact that nurses were no longer caring for a homogenous group, but diverse populations. It suggested that nurses need to understand the culture of clients in order that care provision reflected quality care. The baby's care could be addressed from a very technical aspect; however, the family needed to be cared for as a whole.

Theme Two

What became obvious during the interview process was the fact that these participants responded not only to the plan of care for the baby but also the factors that impacted those decisions. Thus, the main probing question became, "What influenced Sue's decision making process when planning care?". I discovered 38 codes that were reduced to 4 categories. Again, each category had a pattern that resulted in one theme. (See Table 2.)

Table 2

Codes, Categories and Patterns: Theme Two

Codes	Categories
Charge nurse Exposure to diversity/migrant families Life-long learning Skills Knowing resources Years of nursing practice Nursing school clinicals	Experience

Pattern: Graduates felt that actual clinical experience is vital to the provision of culturally competent care.

Table 2 (continued).

Values and beliefs (including religious) Self-confidence Respect Family influences Self value check Personal character Caring characteristics Motivation for learning Comfort zone Internal qualities Inherent qualities	Nurse's Personal Characteristics

Pattern: Graduates expressed that the RN as "self" influences cultural sensitivity.

Institutional philosophy Census Interpreter services (in person and phone) Adequate time Co-workers Hospital policies and procedures Hospital accreditation	Work Setting

Pattern: Graduates indicated that the institutional environment plays a role in the provision of culturally sensitive nursing care.

Red string Folk medicine Interpreter Spanish material Professional standards of practice Baby's medical needs Comprehensive care Recognize barriers Accommodate care Increases critical thinking Cultural sensitivity Verbal and non-verbal communication skills Family care/holistic care	Educational Impact

Table 2 (continued)

Pattern: Students who completed their BSN education at MSUM were able to recognize caring traits that are reflective of culturally competent care.

The theme that emerged from this section of data interpretation was: When providing care in a culturally sensitive situation, participants perceived that culturally competent nursing care was impacted directly by their BSN education (which included the transcultural nursing course), experience, personal characteristics of the nurse, and work settings. Responses that gave meaning to and supported each of the categories are explained in the next four subsections.

Experience

Each of the participants worked in a different area of nursing ranging from public health nursing to working in intensive care. Because these nursing graduates had all been RNs with an Associate Degree in Nursing before becoming BSNs, the number of years they had worked varied from less than a year to over 15 years. Even with this range of work experience and diversity of work settings, responses about how important experience was in the provision of quality, holistic, culturally sensitive care was evident and consistent. The following examples were comments made by two graduates; the first one had little nursing experience.

J: "How do you think she knows to take a holistic approach?"

6: "Experience, more so I think. It's like the other day there was a new provider situation and I thought, 'oh my gosh, I've learned so much from working here.' If you don't look at the whole picture, you are just going to miss the boat. It is so true, until

you really experience this, you don't really get it."

J: "So you can read and read all you want..."

#6: "Yeah, but you really don't get it."

The other graduate had many years of experience and not only discussed the importance of having experience but if those experiences were positive, negative, or neutral.

J: "And then you mentioned experience, her own experience. Can you elaborate on that a little bit?"

#3: "So, I think your experience definitely plays a part in your preparation or your ability to meet this kind of challenge. Also, she may have had good experiences where she feels that this type of family situation is ideal for a child. She may have had poor experiences where she feels that there are a lot of people around but they aren't very helpful. So, that is what I mean by experience. It may be positive, it may be negative, it may have been neutral, but definitely, the more she works in this, the more comfortable she is going to become."

Experience brought with it familiarity which then created a comfort level. Thus, providing care in a culturally sensitive situation was not what the participant considered a "challenge".

Other responses that gave credence to the pattern that clinical experience was vital to the provision of culturally competent care included statements that referred to the importance of experience along with an educational knowledge base. The responses were from two different participants, the first one had little experience.

J: "What are the things that impacted your answer right now?"

#5: "I learned that in transcultural and just getting a basis from my nursing courses and the books we read. Now I actually see it in practice and hear it. The nursing course gave me a basis for that because I really didn't know much about it coming from a small, white town in Minnesota. Now I come in and actually see it and practice it."

The second participant had many years of experience.

J: "So you think that what impacts how she proceeds with her care is the experience she has?"

#3: "Yeah, I think a lot of it goes with your experiences. Yes, your education will help you but it is never the same as when you learn it, when you have done that, when you have had that experience."

It was apparent that actual hands on experience was extremely important when providing culturally sensitive care. Even if the participants had a knowledge base with regard to working with various cultures, experience (whether positive, negative or neutral) was a main supporting factor.

Nurses' Personal Characteristics

In life, our mere presence has impacted the turn of events or outcomes to a situation. In the profession of nursing, this was no different. As indicated by the participants' responses, the nurse played a significant role in the provision of culturally sensitive care. What factors shaped the nurses' approach to his/her interventions and what he/she brought to the situation was largely influenced by her value and belief system. The term "value" was repeated often when asked what impacted Sue's decision making process. Included

were these statements: "Sue's value system is gonna come into play, what she considers important", and, "You also need to do a values check to make sure you don't provide biased care." What appeared to impact the value and belief system the most was upbringing and family. One participant spoke about "having parents that were open to cultures and not stereotypical"; she further stated that the nurse could carry stereotypes with her because her family upbringing was "ethnocentric" in nature and her parents were her role models. Another participant stated, "We are all biased by our own backgrounds, our religious experiences, our morals and ethical behaviors." Obviously, the nurse brings certain personal characteristics into the nurse/patient relationship.

What also affected care provision was if Sue was a caring nurse, a nurse who wanted to learn more about diversity and culture. One participant stated that when she did not understand something about a person's culture, she just asked them. One example was when a patient had a henna decoration on her hand. The participant asked the patient what it was for and what it meant. She also "used the Internet a lot" to find answers to many cultural questions. Caring nurses were ones who "really tried to get into the culture which helped with their understanding" of cultures. They were "pleasant and wanted to help." Most of the participants referred to a caring nurse as the one whom "tried to accommodate the family the best she could." Discovering the pattern that related to the nurse's personal characteristics provided support that the affective function a nurse possesses, her feelings, her emotions and her beliefs, influenced care provision in culturally sensitive situations.

Work Settings

Many of us can discuss a place where we have worked and describe the general philosophy of that institution. Work environments can be friendly or they can be frustrating; they can directly impact how we perform our jobs. The participants in this study definitely felt that the work environment played a role in how nursing care was provided. Specifically, in this culturally sensitive situation where there was a language barrier present, it was crucial that the institution provided an interpreter or a telephone service for adequate communication between the nurse and the family. "A Spanish interpreter that has no ties to a family, who can be objective", was viewed as necessary for the provision of quality nursing care. Another participant stated, "I would imagine that Sue would not want to use this family member as an interpreter. They need an interpreter when there is medical treatment involved."

Besides interpreters, the availability of other support services, the people power, within the work setting was important. One participant summed up her thoughts on this:

> #1: "She needs an interpreter, she needs that communication. But, in order to carry through with all of those things she is going to need help from other people. And she needs to look at who can help her. That might be another experienced nurse on the floor, she might have to call her manager at home, Social Services on-call, she needs to know who to call...nursing administrators, supervisors, whatever."

Services the institution offered and the support from those around her played a role in the provision of culturally competent care.

The fact that the census was down in this particular scenario was noted by the participants. They interpreted that low census meant "she would have more time to devote to this family." Having time also meant that Sue didn't have rush with her cares and assessment. She didn't have to "wisk the baby away from the mother", thus being able to develop a "sense of trust" with the family.

Finally, the participants considered the impact the institution had on the provision of culturally competent care in respect to the hospital being a business with a philosophy.

#2: "One of the unfortunate things about health care is it is becoming a marketing issue. It is about how you deliver care and how (that) keeps the hospital busy. It is the financial aspect that is 'out of nursing'."

J: "Consumerism?"

#2: "Correct."

If the philosophy of the hospital was bottom-line driven and "if the hospital looks as this family as a problem because it takes more time with an interpreter, plus the payment issues with medical assistance...if the hospital looks at them as difficult families, it is going to influence how Sue delivers her care, also."

Three other participants talked about the philosophy of the hospital as being the "culture of the hospital." "The culture of the place where you are is going to determine a lot of how you work as a nurse." The participants discussed the need for institutional "commitment", "support for diversity" and "director driven leadership." The participants' comments reflected how the multifaceted aspects of the health care institution impacted the provision of culturally competent care.

Educational Impact

Each of the participants in this research study graduated from the nursing program at Minnesota State University Moorhead. They received an Associate Degree in Nursing from other institutions and then entered the MSUM program and completed their Bachelor of Science Degree in Nursing. Once the participants reflected on the care provision in the fictitious scenario, they perceived that their course of action was impacted by the knowledge they had gained during their BSN education. Statements referring to a lack of knowledge about the diversity of cultures prior to obtaining their BSN degree were mentioned frequently: "The knowledge that there are other types of cultures out there...is something I didn't learn before I went through the BSN program", and "In the ADN program you learn the technical skills that you need to apply and in the BSN, you learn the theory to do holistic care", and, "There is definitely more emphasis in the RN to BSN program on this type of situation. The transcultural nursing and things like that, you didn't have a lot of that in your two year program." I felt confident that the responses I obtained truly represented the voices of the BSN educated alumni.

The first theme indicated that the graduates cared for the physical needs of the baby within the context of the family. Also, care provision was holistic and culturally sensitive. I discovered what impacted the theme of care provision was not solely the transcultural nursing course, but all of their BSN coursework. While all of the participants discussed the importance of their nursing courses and the transcultural course, one participant's comments summarized the educational impact best:

> I think all the nursing courses kind of bring in the BSN program, they kind of feed off one another. We would be doing one paper in one class and it would carry over into another class and what we would be talking about. Or the theory, or this and that. So, I think that every course added to the other course and added to the whole BSN experience. But, a lot of it is in the transcultural nursing.

Only one participant mentioned a liberal studies course that contained cultural content as having influenced her nursing care.

The most beneficial, culturally competent nursing care provided to this family was holistic nursing care. This was demonstrated when the participants perceived that the whole family would be taken care of, not just that baby. Holistic care provision was evident in this statement, "You really have to treat the whole family, especially in this scenario and what is going to make that baby better. You have to look at the whole and not just one person." Learning about holistic care came from all the nursing courses as indicated by the following comment: "I don't know if it was just that particular course (transcultural nursing) that impacted me in terms of me providing holistic care...it was the whole nursing education."

With the overwhelming evidence that all the BSN nursing courses impacted the care provision in this culturally sensitive situation, I wondered if I could discover more about the impact the transcultural nursing course had. It was toward the completion of the second interviews that I asked follow up questions such as, "If Sue had a transcultural nursing course in her bachelor's education, do you think that would have impacted her?", and, "What would you think if we dropped the transcultural nursing course?"

Overwhelmingly, participants perceived that the impact the transcultural nursing course would have had on Sue at the baccalaureate level was a "really good foundation for cultural care", and "I think it is a big plus and will help her immensely in giving culturally competent care. No matter what you learn in a course, you build on that...you get a good (knowledge) base to improve your skills and improve your understanding of giving that kind of care." Having the course would also provide Sue with a good "background into the special needs of this (Hispanic) family that would prevent her from making mistakes."

Besides providing a sound knowledge base, participants stated that the transcultural nursing course provided opportunities to "examine one's own biases and how that might influence decision making", and "become aware of differences and similarities." The course also helped the graduates to be more aware of the importance of symbolism, such as the red string around the baby's wrist where "you had to find out what that means." Participants stated that they learned what questions to ask and "discovered how other cultures perceived things." Having an understanding of concepts learned in this course allowed Sue the opportunity to "accommodate her care the best she can."

Asking the question that suggested dropping the course brought about non-verbal responses including a defensive stance where the participants pulled back and stared at me. Responses were, "I would think it would be a huge mistake to pull it out. I really both enjoyed the class and learned so much", and, "You would have to replace it with something else. You would not have a program that adequately addressed these things. So, it needs to be a required component and I think it will just grow." Participants

perceived that the course was not only a significant component of the BSN education but had the potential to expand.

CHAPTER IV

THEME DISCUSSION WITH REFERENCE TO LITERATURE

The purpose of this qualitative study was to determine the value of transcultural nursing education as perceived by nursing graduates after reading a culturally sensitive fictitious scenario. All eight participants graduated from Minnesota State University Moorhead's baccalaureate nursing program where they completed the required transcultural nursing course. Each participant was interviewed twice. Codes, categories, patterns, and themes emerged after the first interviews and second interviews were conducted to determine agreement or disagreement with the findings. All participants agreed with the themes, which were discussed in Chapter III. Reliability of the data analysis was further tested with the confirmation of themes by a nursing colleague familiar with transcultural nursing education.

Two themes were identified, one related to the plan of care for the baby in the fictitious scenario and one related to the variables that impacted that plan of care:

1. Participants' perceived that caring for the physical needs of the baby were paramount; however, nursing care must have been provided within the context of the family. Care provision was holistic and culturally sensitive.

2. When providing care in a culturally sensitive situation, participants' perceived that culturally competent nursing care was impacted directly by their BSN education (which

included the transcultural nursing course), experience, personal characteristics of the nurse, and work settings.

It was vital to note that during my extensive literature search there was no research found that focused on the perceptions of nursing alumni caregiving in culturally sensitive situations after they graduated from a nursing program that included a transcultural nursing course. There was research that either focused on or suggested evaluating students' perceptions of cultural caregiving during their BSN education; however, none focused on the perceptions of graduates (Hilgenberg & Schlickua, 2002; Leuning, Swiggum, Wiegert, & Zander, 2002; Reeves, 2001).

In this chapter, I have provided the reader with examples of current literature as it related to my findings by dividing the first theme into four components: caring for the physical needs of the baby, nursing care within the context of the family, the provision of holistic nursing care, and finally, the provision of culturally sensitive nursing care. Discussion of the second theme was also divided into four components: the importance of a BSN education (which included a transcultural nursing course), nurse's experience, the nurse's personal characteristics, and the work setting.

Theme One

One of the characteristics of this qualitative study was the discovery of a large quantity of rich data from the interviews. This was evident in that theme one had four parts to it. The participants read the fictitious scenario, which involved caring for a Hispanic baby, and were asked: "What does Sue have in mind as she plans her care for this baby?" The

theme that emerged was: Participants perceived that caring for the physical needs of the baby were paramount; however, nursing care must have been provided within the context of the family. I have discussed the literature as it related to the four parts of this first theme.

Caring for the Physical Needs of the Baby

Part of all nursing education is the study of anatomy, physiology and pathophysiology. This education provides a knowledge base in which nurses obtain an understanding of the human body and its functions. The baby in this study's fictitious scenario presented with poor skin turgor, a dry mouth, listlessness, a fallen fontanel, and reported diarrhea. The severity of the symptoms suggested a life-threatening situation especially because the patient was a baby (Bellack and Edlund, 1992). The participants knew this baby needed to be assessed for immediate intervention and further testing. If the diarrhea was serious enough to cause dehydration, the situation could have resulted in a fluid and electrolyte imbalance, which may have lead to depressed respirations, muscle weakness, or cardiac arrhythmias. Nursing care, which addressed the physical needs of this baby, were paramount.

Care Provision Within the Context of the Family

Caring for the needs of the baby within the context of the family was congruent with systems theory. This theory was useful in the assessment of the family's needs, because it emphasized the interdependence of the family's parts and asserted that the whole of the family was greater that the sum of its parts and that whatever affected the family as a

whole affected each of its parts (Hitchcock, Schubert, and Thomas, 2003) Obviously, the illness state of this baby affected the family's structure and function as evidenced by the presence of the extended family members in the hospital setting. The consequences of this baby's illness and care provision had an impact on the whole family.

The graduates who participated in this study received a great deal of content on systems theory in their BSN education. Systems theory was introduced in their first course on professional nursing , it was incorporated heavily in their family and community classes, and systems theory was presented in other nursing courses such as ethics, transcultural nursing, management and leadership, and preceptorship. Providing family-focused care required a partnership with the family to enhance the health management of the baby (Kaiser and Hays, 2002). The participants repeatedly stated that the inclusion of the family was very important when caring for the physical needs of the baby.

Holistic Care Provision

Participants were able to describe the relatedness of all the events that occurred in the fictitious scenario and how that influenced caregiving. Looking at the family as a whole and understanding that events were intertwined had a direct impact on nursing care provision. Ray (1999) saw this practice of holism as an integral part of transcultural nursing practice:

> What transcultural caring signifies in relation to the notion of truth is coherency between thinking and doing. It is characterized by having an attitude of love, acceptance, patience and a commitment to holism-body, mind, and spiritual sociocultural interconnectedness. (p. 180)

According to nursing theorist, Betty Neuman, nurses deal with clients as a whole. To Neuman, a client is a physiological, psychological, sociocultural, developmental, and spiritual being who can be attacked by internal, external, or created environmental stressors (Meleis, 1997). Neuman's concept of client is as human beings, yet she suggests assessing the stressors of that client by looking at the whole client system much like the participants in this study did. Cultural competence was about delivering care while attending to the total situation for the patient and family (Leonard, 2001).

Culturally Sensitive Care

Even in the short fictitious scenario of this study, participants were able to take into account the issues that addressed the provision of culturally sensitive care. Not only had they assessed the physical needs of the baby, they assessed the cultural needs of the family. This was evidenced by the following: they wanted to accommodate the large, extended Hispanic family, they were concerned about their social needs, they wondered what the caring customs of the family were as these would directly affect the health of the baby, they wondered what the family's belief system was, and they were curious as to what that red string around the baby's wrist meant. Obviously, these participants were interested in an emic perspective of this situation. Cultural sensitivity was apparent when the nurses showed regard for the client's beliefs, values and practices (Lister, 1999). They were caring, respectful, compassionate, and sincere (Leonard, 2001; McGee, 2001).

In addition, all of the participants in this study stated that there must be an interpreter in the hospital setting to provide for accurate translation. Providing an interpreter or

translation services with materials written in the appropriate languages was evidence of providing culturally sensitive nursing care (Warren and Munoz, 2001). There was a willingness and desire to communicate with this family that reflected a respectful attitude, not an ethnocentric one.

Theme Two

In this section, the four components of the second theme and discussion of related literature was approached in the same way as in the previous section. The second theme was: When providing care in a culturally sensitive situation, participants perceived that culturally competent nursing care was impacted directly by the BSN education (which included the transcultural nursing course), experience, personal characteristics of the nurse, and work settings. Each component supporting the overall theme is presented along with a summary that describes the relatedness of the categories to the provision of culturally competent care.

Impact of BSN Education That Included a Transcultural Nursing Course

It was clear in the responses of each participant that the knowledge gained in their BSN nursing courses directly impacted their plan of care perceptions in a culturally sensitive situation. The significance that the transcultural nursing course had on their knowledge base was also evident when they stated that if the course were dropped, the content must be covered somewhere in the nursing courses. Currently, only 38% of undergraduate nursing students in the United States have preparation in transcultural nursing, and yet all students are expected to give culturally congruent care (Leininger, 1999). This situation created a dilemma when the Commission on Collegiate Nursing

Education, National League for Nursing, most state boards of nursing, and other accrediting and certification bodies required or strongly encouraged the inclusion of cultural aspects of care in nursing curricula (Andrews & Boyle, 2002).

For nurses to practice transcultural nursing competently, their caring practices must be grounded in the knowledge base and science of transcultural nursing (Leuning, et. al., 2002). Furthermore, nurse education has been identified as an ideal vehicle for the promotion of transcultural competence in students (Green, 2001). Leininger's Standards of Transcultural Nursing and Josepha Campina-Bocate's culturally competent model of care as frameworks are considered to be the most helpful in establishing a foundation for a theoretical knowledge base for nursing students (as cited in Leuning, et. al, 2002). Both Leininger's and Campina-Bocate's theories were presented in the transcultural nursing course the MSUM nursing graduates in this study completed.

Although there were no research articles addressing the impact of transcultural nursing education and alumni, there were studies that evaluated the impact of transcultural nursing education and BSN students while still in college. In a study done at an upper midwestern university, researchers discovered that after nursing students took a transcultural health care course, they described an increased awareness of both personal and professional growth. Many of the participants in the study also indicated a desire for continued exposure and desired to seek opportunities to interact with people of varied cultures (Bengiamin et al., 1999) . Hilgenberg, et. al., (2002) found that transcultural nursing knowledge was built through an intercollegiate collaborative effort. Weaving transcultural nursing theory within a nursing curriculum was supported in another study where student

evaluations showed that most of the students were aware of the need to provide culturally congruent care (Reeves, 2001). With evidence that transcultural nursing theory impacted learners during their BSN education, it could be concluded that the theory course also impacted them as alumni.

Experience

Participants in this study acknowledged that nursing experience had an impact on the care he/she provided. They referred to experience as the "hands on", clinical situations that increased their knowledge and comfort level when working with diverse cultures. Writings by nurse scholars in the late 1970s and in the 1980s have supported the significance of clinicians' experiences as sources of knowledge (Meleis, 1999). In nursing, personal experiences have enabled the nurse to gain skills and expertise by providing direct care to patients and families; learning from personal experience enabled the nurse to cluster ideas into a meaningful whole (Burns, et. al, 1999). Benner (1984) contends that the amount of personal experience a nurse has affects the complexity of a nurse's knowledge base, ranging from novice to expert.

There are certain things that only face-to-face interaction would validate. These are referred to in Campinha-Bicote's (1998) cultural competency model as "cultural encounters" and are seen as necessary to validate the knowledge nurses have learned from books, web sites and lectures. Meanings emerge from transcultural encounters and form a basis for advocacy and collaborative planning (Ray, 1999).

It is apparent that the development of cultural competence occurs over time. In a study by St. Clair and Mckenry (1999), cross-cultural experiences in undergraduate

nursing education challenged and disrupted students' previous assumptions and forced nursing students to explore new perceptions, test new behaviors, assess feedback and reintegrate a new reality regarding beliefs and expectations. Unfortunately, the research articles that addressed the effect experience had in the development of cultural competence overwhelmingly addressed clinical immersion experiences or international travel, which did not represent the overall population of nursing students or nursing graduate students' experience.

Personal Characteristics of the Nurse

Research suggests that the starting point of any effort towards providing cultural competent care must begin with an exploration of the nurse as self, because the nurse's cultural values, beliefs, practices, stereotypes, prejudices all impact care provision. With this knowledge, nurses then have the ability to consider how these factors impact upon their interpretation of the values, beliefs and practices of people from ethnic backgrounds different from their own (Gerrish & Papadopoulos, 1999). According to Vinson (2000), personal knowledge of self with respect to another human being promotes wholeness and integrity.

Duffy (2001) wrote that "thoughtful action occurs when the individual nursing student brings knowledge, beliefs, and feelings to the surface in order to enhance understanding of oneself and other, particularly as the two intersect" (p. 489). Even before nursing education is implemented, a baseline evaluation of nursing students'/nurses' attitudes, strengths, limitations, existing biases, and fears needs to be performed (Jeffreys, 2000; Leininger & Mcfarland, 2002; McGee, 2001; Purnell & Paulanka, 1998; and Warren et al.,

2001). According to Campinha-Bicote (1998), the following statement describes the component of cultural awareness within her cultural competency model:

> You have to be aware of your own biases and prejudices toward a particular group and deal with them. An awareness of your own cultural or professional values helps you avoid imposing your beliefs and values on members of another culture. (p. 140)

Leonard (2001) also agrees that the first step in achieving knowledge, skills and respect is awareness.

Work Setting

Not surprisingly, the participants of this study perceived that the work environment impacted the provision of quality, culturally appropriate nursing care. The work environment was impacted by the institutional philosophy, the degree of support from other health professionals, and the services available to assist with the provision of culturally competent nursing care.

The values and principles of an organization set the parameters for decision-making and determine what is critical to the organization. Furthermore, the organizational culture of the hospital is influenced by the philosophical values held and espoused by those in critical positions in the organization. Organizations that acknowledge and value the diversity of their patients and promote the provision of culturally competent nursing care create a positive working environment (Tuck, Harris, & Baliko, 2000).

Some institutions demonstrate their commitment to the provision of culturally competent care by providing in-house or local educational opportunities to increase staff nurse's cultural knowledge (Amerson, 2001; Purnell, 2002). Josipovic (2000), and

McGee (2001) discovered that providing trained role models in the work setting assisted in tackling issues that related to patients and cultural diversity. Incorporation of an appropriate, streamlined cultural assessment/intake tool established systematic changes within a variety of health care settings (Bloom, 2000; Heinken & McCoy, 2000). Also, those participants whose work settings provided interpreter services also felt there was a commitment to communication and culturally competent nursing care.

A most impressive project that involved building cultural competence in the work setting was a collaborative model where nursing staff from Parkland Health and Hospital System in Texas were involved in an exchange program with the Insituto Mexicana Seguro Social Hospital in Cuernavaca, Mexico (Jones, Bond & Mancini, 1998). This program provided evidence that institutions could respond to the increase in diversity of patients by increasing the cultural knowledge and skills of their nurses.

The domain in which nursing care is provided is the work setting. Those institutions that support cultural diversity and the provision of culturally competent care create an environment in which nursing is valued (Tuck, et al., 2000).

Summary

It was important to substantiate each component of the two themes discovered in this study with research from the literature; however, the intent was not to compartmentalize each component of the themes. If the reader visualizes the findings of this study as a table with four legs, one sees that all four categories (legs) need to be present to support the provision of culturally competent care to the baby and the family in the fictitious scenario provided. (See Figure 1.)

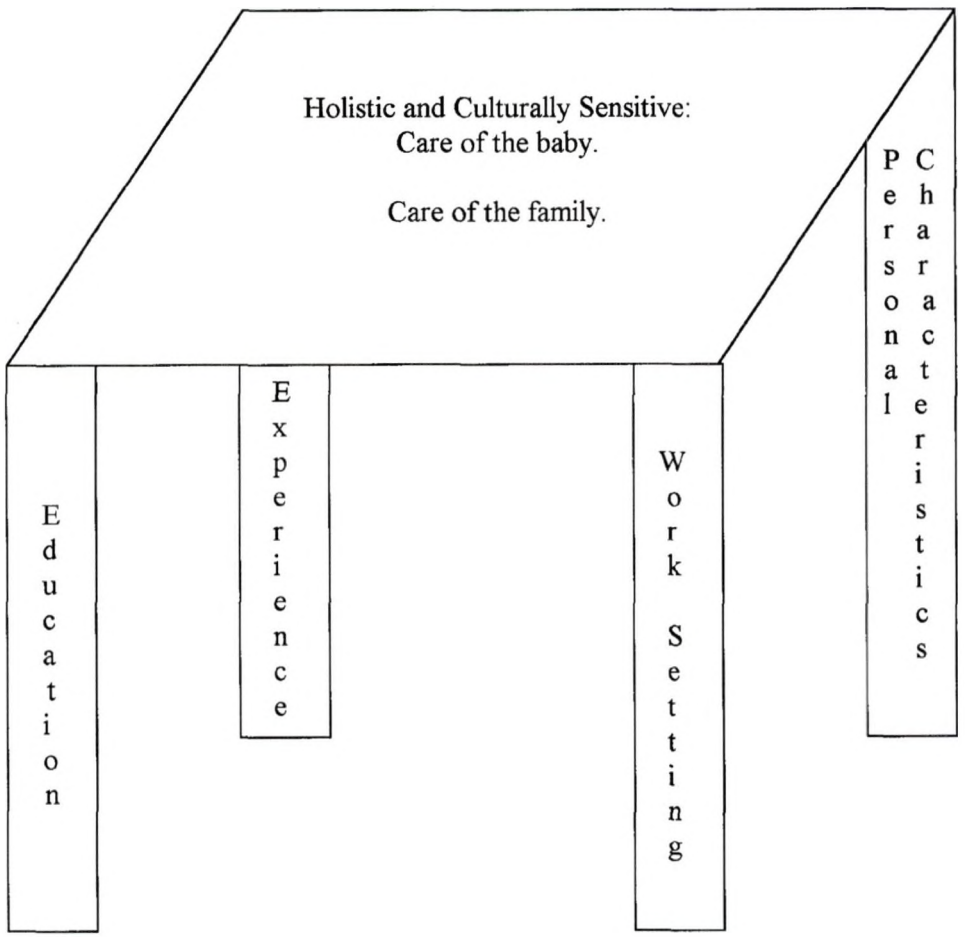

Figure 1. Cultural competence model.

Other researchers have described culturally competent nursing care as having multiple components. Campinha-Bocate's (1998) model for achieving cultural competence includes cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Purnell and Paulanka's (1998) approach to cultural competency involves

developing an awareness of self, knowledge and understanding, accepting and respecting cultural differences, and adapting care to be congruent with the client's culture. The American Academy of Nursing views cultural competence as a complex integration of cultural knowledge, cultural awareness or sensitivity, attitudes, cultural skills and cultural encounters (as cited in Goodwin, Clarke & Barton, 2001). A knowledge base, skills and abilities to provide health care to diverse groups is what nurses must possess in order that culturally competent care is achieved (Leonard, 2001).

The point of discussion in this summary was that the participants in this study identified the provision of culturally competent care as complex. However, it was a process that each graduate nurse participant perceived with enough similarity that codes, categories, patterns, and themes emerged. Theme one was supported by the literature on nursing care in an acute situation, systems theory, and what constituted the provision of holistic, culturally sensitive care. Theme two was reinforced by literature that addressed each of the supporting categories of nursing education, the nurse as self, experience, and work settings and the significant relationship these had in the provision of culturally competent care. The results of this study reinforce and support existing nursing theory that is currently in practice.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to determine the value of transcultural nursing education by discovering nursing graduates' perceptions of caregiving and what factors influenced those choices in care provision. The participants were recent graduates of Minnesota State University Moorhead's nursing program who had taken the required transcultural nursing course. A convenience sample of eight participants read the culturally sensitive, fictitious health care scenario and were interviewed twice. The first interview was completed to gain an understanding of the graduates' perceptions. The second interview was completed for the purpose of gaining additional information regarding their perceptions and establishing validity where participants agreed or disagreed with my results. Reliability of the study results was confirmed by a nurse colleague who examined the interview transcripts.

Two themes emerged from the data collected from the first interview. Theme one resulted when participants were asked the main probing question, "What does Sue have in mind as she plans her care for this baby?" The data analysis resulted in two categories including baby and family care. The categories were supported by the theme: Participants perceived that caring for the physical needs of the baby were paramount; however, nursing care must have been provided within the context of the family. Care provision needed to

be holistic and culturally sensitive.

The second theme emerged after asking questions that related to the factors that impacted Sue's decision making process when planning her care. This data resulted in four categories including experience, the nurse's personal characteristics, work settings, and educational impact. The second theme that emerged was: When providing care in a culturally sensitive situation, participants perceived that culturally competent nursing care was impacted directly by their BSN education (which included the transcultural nursing course), experience, the personal characteristics of the nurse, and work settings.

One might symbolize the results of this study as parts of a four-legged table. The four categories of education, the personal characteristics of the nurse, the work setting and experience are the legs which held up the holistic, culturally sensitive care provision of the baby and the family. If one of these legs were missing, the table might collapse and quality care would not be provided. The participants perceived that all of these factors impacted the plan of care. The whole was greater than the sum of its parts. (see Figure 1.)

Conclusions

Theme One

In the fictitious scenario it was apparent that the physical condition of the baby prompted participants' responses calling for the immediate care of the baby. Even though all of the participants worked in different areas of nursing, and none in a pediatric unit, it was perceived that the baby was in a potentially life threatening physical state. The baby needed to be assessed, orders had to be received and care had to be started.

After reading the scenario, it was also perceived that the extended family that

came into the hospital with the baby was not to be excluded. In fact, the participants felt that including the family in the baby's plan of care was a necessity. Participants wanted to set up a clear line of communication by getting an interpreter, they wanted to ask questions that would lead to the discovery of the family's health beliefs, and they wanted to include those beliefs in the plan of care. They felt there was some symbolism to the red string tied around the baby's wrist, and they wanted to find out what that meant. Understanding this would allow the participants to accommodate the physical needs of the baby with the beliefs and practices of the family.

Care provision was very holistic and culturally sensitive. When the participants discussed care giving in this situation, it reflected knowledge of systems theory where the whole is greater than the sum of its parts. The participants wanted a healthy outcome to this situation, and the best way they could achieve this was by providing holistic care to the baby and family. Transcultural nursing theory was evident when care provision was approached from an emic perspective, not an ethnocentric perspective.

Theme Two

A second theme emerged after discovering what participants felt impacted their care provision. Four categories became apparent: education, the personal characteristics of the nurse, work setting, and experience. These nurses already had their Associate Degree in Nursing and came to MSUM to obtain their Bachelors of Science Degree in Nursing. This additional education impacted their perceptions of care in this culturally sensitive caregiving situation. Their responses included obvious application of the nursing theory they had learned in many of their BSN nursing courses, including systems theory and

transcultural nursing theory. There was a knowledge base of holistic, culturally sensitive care evident in the fact that the participants could think critically and make care decisions based on their perceptions of Westernized and non-westernized medicine. The theory they gained in their transcultural nursing course contributed to their culturally competent plan of care for this baby.

Each participant clearly acknowledged that nurses, their personal characteristics, and their values, beliefs and practices, had a direct impact on the provision of quality nursing care. There was a relationship between nurses and their patients. How each perceived the other influenced the care in that situation. Becoming aware of one's own feelings about people from various cultures was vital to the discovery of stereotypes and prejudices that may exist and impact care provision. Respect, understanding and wanting to learning more about cultures and the patients they cared for were seen as necessary characteristics nurses needed for the provision of culturally competent care.

The amount of professional nursing experience each of the participants had varied from a few months to 25 years. Regardless of this vast difference, the participants felt that experience was essential for nurses to function in a situation involving culturally sensitive nursing care. Nursing is an applied science and learning occurs through actual experience. Participants felt that nurses could develop a sense of trust with their patients if they had experience working with diverse populations. They could also be more comfortable when providing their care without constantly having to be in new situations.

From provision of interpreters to the development of administrative philosophy, the work setting influences the provision of culturally sensitive nursing care. It was perceived

by this study's participants that if services were available to create good lines of communication between patients and nurses, health care provision would be much more successful. If the philosophy of the work setting was one that encouraged the provision of culturally competent care by offering educational opportunities, providing role models, and discussing culturally sensitive problems as they arose, nurses would more likely experience satisfaction and success. Because nurses work side-by-side with their peers, their support is also significant. Administrators and supervisors can create a work environment that encourages nurses to work together in the provision of culturally competent care or they can stifle it. Ultimately, it is the patient who gains or loses because of what is occurring in a particular health care setting.

The categories that emerged and the themes that were derived from these categories are interdependent. One nurse may perceive that education is more important than the work setting in his/her discussion of culturally competent care; however, all four of the categories must be present in order to achieve a balance.

Limitations

1. All of the participants identified themselves as Caucasian. I wondered what the perceptions would have been had the nurse identified him/herself as Hispanic.

2. All of the participants were from the same geographic location even though nurse graduates from MSUM practice in many areas of the United States.

3. This study was indicative rather that representative of nurse graduates and may not be true of all nurse graduates from MSUM or other BSN programs.

4. There is a high probability that the participants have provided care to the Hispanic population. Perceptions may have been different with a scenario of a less familiar culture.

Recommendations

As I reflected on the knowledge I have gained from doing this study and researching nursing literature, I provided the following recommendations. First, there are recommendations for the discipline of nursing; second, for the nursing program at Minnesota State University Moorhead; and, finally, recommendations for further research.

Discipline of Nursing

1. A separate transcultural nursing course adds to the provision of holistic, culturally sensitive care and should be part of all baccalaureate nursing programs in the United States, rather than 38% of these programs.

2. Associate degree nursing programs should offer content on transcultural nursing theory and practice.

3. Nursing organizations should continue to acknowledge the increase in patient diversity and offer continuing education opportunities for nurses.

Minnesota State University Moorhead Nursing Program

1. The program should maintain the broad, community based, holistic education focus currently in place as participants carry this with them even five years after they have graduated.

2. The program should continue with methodologies that focus on the nursing students' examination of "self" and the role they play in the nurse/patient relationship.

3. Students should have increased formalized nursing experiences with diverse clients.

4. Students should be encouraged to be "change agents" so that they might impact institutional policies and the work environment.

5. MSUM should explore what other nursing programs are doing in their transcultural nursing courses and the academic opportunities they provide.

6. MSUM should support the research and education efforts of faculty interested in transcultural nursing.

7. MSUM should collaborate with community organizations that employ nurses to meet their needs for transcultural nursing education.

8. MSUM should provide financial support to students participating in cultural immersion/international nursing care experiences.

Recommendations for Further Research

1. One might utilize the same scenario and interview nursing graduates of a nursing program where transcultural nursing content is interwoven into the curriculum and obtain their perceptions. The nursing program should be in the same geographic location as this study. What are the similarities or the differences?

2. It might be valuable to repeat the study with nurse graduates who have an Associate Degree in Nursing to assess for similarities and differences.

In closing, transcultural nursing theory is known for its broad, holistic yet culture-specific focus to discover meaningful care to diverse cultures (Leininger, 2002). The participants in this study were educated in this theory and able to recognize and value cultural differences. When they shared their perceptions of caregiving and what impacted

those decision, they were better equipped to describe how quality, culturally competent care was achieved.

This study has been a journey of discovery for me as a researcher. It has taught me that qualitative research is indeed an art and a skill. It has taught me that nursing graduates are a source of inspiration and they truly hold an interest in the nursing programs from which they graduate. The results of this study proved to me that the education provided in the nursing program at MSUM prepares nurses to provide holistic, culturally sensitive care, and that we should always strive for excellence in nursing education. There is value in this study in that it both informed and suggested improvements for practice. This study has been enlightening and rewarding and even though it is complete, it is the catalyst for my endeavors in life-long learning.

APPENDIX A

FICTICIOUS SCENARIO

Fictitious Scenario

As Sue walked down the hall towards the pediatric unity, she thought about the first time she was ever on the floor. She was a senior nursing student at the local college receiving her bachelor's degree in nursing. It seemed like only yesterday; however, three years had passed since then and now she was a charge nurse.

As usual, Sue put her supper in the fridge in the break room, then went into the report room for the change-of-shift report. Patient census was down so she anticipated a quiet evening. Ten minutes later, Sue received a telephone call from the pediatric clinic. The nurse from the clinic reported that they were sending up a sick baby who had diarrhea and was dehydrated.

Approximately 30 minutes later, a family arrived on the floor. There was an elderly man and woman, two teenage girls, a child around three years old, a man in his mid-twenties, and a young woman holding a baby. The family was talking rapidly to one another in Spanish. She showed them to room 202 and introduced herself. She then began asking assessment questions looking directly at the woman holding the baby. The woman gave no verbal response although she did nod her head. One of the teenage girls spoke up; "She only speaks a few words of English. But, I go to summer school here so I speak very good English."

At this point, Sue laid the baby boy in the crib and did a thorough physical assessment. She noted that the baby had a fallen fontanel, poor skin turgor, a dry mouth, his buttock was very red and cracked, and he seemed listless and sleepy. As Sue was taking the baby's vitals, she noted that he had a red string tied around his wrist. She finished her assessment, smiled and said, "I'll be right back."

Sue went to the baby's chart and obtained the following information:
-the family identified themselves as Hispanic migrant workers
-they were from a small town in Texas
-their primary language was Spanish
-their payment source was Medical Assistance

Question:

What does Sue have in mind as she plans her care for this baby?

APPENDIX B

INTERVIEW RESPONSES

Interview Responses

Participant Three:

#3: "She is assuming that the person holding the baby is the mom and it may not be so. I guess she should be looking at whether or not this teenage girl is someone who can interpret for her. Is she going to be able to do that well enough, using medical terms, or perhaps she should get a medical interpreter. She notices there is a red string tied around his wrist, that is pretty typical of the Hispanic culture, and that this family is one that we will be looking at folk medicines or something that is not in our medical delivery."

J: "How is she going to care for this baby?"

#3: "I think Sue's understanding of the hospital admission, having worked there for three years...she probably does a thorough physical assessment and knows how to physically assess the baby. She appears to be pleasant and wanting to help."

Participant Four:

#4: "I think Sue is going to want to identify, first of all, who is the spokesperson for this infant. In fact, the woman she is talking to may not be the mother. Perhaps she is, but in this culture it may be necessary to talk to the grandmother and make sure she is in agreement with all the cares. I would also imagine that Sue would not want to use this family member as an interpreter, especially when lying down the plan of care and trying to work with them in gaining information. It is best to have a medical interpreter. Certainly, she should be welcoming to this large group and make them all feel that they are part of the care."

J: "What else do you think is going on?"

#4: "Obviously this child needs to be rehydrated and obviously needs a physical assessment. Check airway, breathing and circulation, does the baby need oxygenation, etc. The physician would calculate fluid replacements and the child would probably get IV fluid replacement. I would teach good handwashing and infection control. Sue will not put this child in with another child."

J: (towards the end of the interview, I ask the following question) "If you could sum up this plan of care..."

#4: "The things that would influence Sue's plan of care are, number one, I would say the physical condition of the child, then, the importance of assessing culture, and the importance of recognizing the family as a significant group."

Participant Five:

#5: "I think what she would do is get an interpreter because to rely on a family member to interpret for her and their family would be kind of difficult because you want good medical information. So, I think caring for the baby and the family is number one importance. Finding out who cares for the baby and who cares for him the most. What are they thinking is going on and why they think the baby is in the hospital. Finding out when everything started happening, the symptoms. Maybe they think he is just fine. Just making sure that (Sue is) talking to the family, making eye contact, just letting them be in charge so they feel more comfortable."

J: "So, getting an interpreter, involving the family..."
#5: "Just explaining what the nursing staff will do at the hospital and seeing if they (the family) want to do this. Just...involving their health care methods."
J: "Like their folk care beliefs?"
#5: Yes, like their folk versus coming to western medication. Some people might stereotype, like...(long pause)"
J: " Think they (the family) are dumb?"
#5: "Yes, yes. Just blow them off and think, 'well, I will take care of the baby'. But hopefully she would help them and get really involved with them and do some teaching."

Participant #6:

#6: "First, you have to acknowledge that they are Hispanic and they don't speak a lot of English. They might need an interpreter or something. That their beliefs might be different than her own and maybe some of the ways they have taken care of the baby. Well, like that string around the baby's wrist might mean something. She is not sure what it might be but she could maybe ask them. And, obviously, there is the physical part that he is sick and has diarrhea. That is an important part, too."
J: "You said the physical needs of the baby..."
#6: "She did the assessment looking at the poor skin turgor, the dry mouth, he seemed really listless and sleepy. Obviously he needs some IV fluids. The Dr. needs to come in and see what the plan of care would be. (later on #6 continues) The physical part of care is the most important thing. That obviously needs to be taken care of. The family is probably scared though, too. It is important to keep them informed of what she is doing."

Participant Seven:

#7: "Well, she needs to identify who is who in the family. I'm a little concerned that she is making an assumption about who the mother is. She can tell from her assessment that she needs to get some vitals taken and she needs to call the attending and get some orders for some IV's and whatever else is indicated."
J: "OK."
#7: "If there is a translator there or an interpreter available, it would probably be a good idea to use their services, too. Then you want to find out what their belief system is, how they see the problem, what they think is causing the baby's problem What do they belief in?"

Participant Eight:

#8: "She will have to treat what she assessed. Treat the dehydration. Hopefully, when the Dr. calls, she'll get the orders. She will have to assess the person who is going to translate and hopefully get someone else in to translate."
J: "So, the physical assessment..."
#8: "You know, emotional, physiological, which is going to be hard because it is a baby, but...payment, and abuse issues, social services issues is what I would say, any cultural beliefs..."

J: ""How would you get that information?"
#8: "Through an interpreter...she needs to get the physical care started as long as the parents don't freak out or something. You have to start the IV. You may not know what they (the family) thinks, but do as much as you can."
J: "If you started to see them 'freak out', what would you do?"
#8: "I would just show them that you are going to wait for the interpreter. Or, if the teenager can interpret that much, I would have her interpret that much. But, I wouldn't have her do all the interpretation for the assessment and admission."

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