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Care, Culture, and Education Nursing Students' Perceptions of Care and Culture: Implications for Practice

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*Care, Culture, and Education
Nursing Students' Perceptions
of Care and Culture:
Implications for Practice*

A DISSERTATION

Submitted by

Pauline Rita Wright

**In partial fulfillment of the requirements
For the degree of
Doctor of Philosophy**

**Lesley University
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Abstract

Today's nurses work and live in a multicultural society where they encounter patients whose backgrounds are different from theirs, and who need care from nurses who are both proficient in their work and knowledgeable about the role that culture plays in patient treatment. In this study, 45 student nurses enrolled in a baccalaureate program at a northeastern urban college completed a survey about their perceptions of care and culture including their relevance and application to the practice of nursing. Findings based on qualitative analyses indicated that parents and family were instrumental in students' learning about care and a combination of family and educators influenced their learning about culture. Responses revealed that while the importance of obtaining specific cultural information from patients through effective communication was noted, the use of a medical interpreter was considered important by only one student. This finding is problematic since students were unaware of the importance of utilizing interpreter services when caring for a patient who has limited knowledge of the English language. The findings of this survey suggest the need for further transcultural education on the baccalaureate nursing level specifically as it pertains to communication with patients of diverse cultures in the provision of care.

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“As a way of motivating people, cultivating fear is easier than investing the time and effort necessary to engender respect. Respect requires greater knowledge, and in my experience the more you know, the less you fear.”

Michael J. Fox

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Chapter I: Introduction

Nurses live and work in a multicultural world and need to be knowledgeable about culture and how it affects the quality of care given to patients. Knowing how to communicate effectively with patients includes an understanding of language. In a diverse city such as Boston, many patients who access the healthcare system are not proficient in the dominant English language and as such, would need the assistance of an interpreter when discussing health issues. Tufts Medical Center which is situated in downtown Boston has “an average of 3800 ‘interpreter encounters’ each month” (2010). This information is astounding and supports the notion that schools of nursing include the topics of care and culture in their general curriculum.

However, since there is no uniformity in what students learn about these subjects, their application to practice, or their importance to the nursing profession in general, I undertook this study as an attempt to identify how student nurses view culture and care in relation to nursing practice. The intent here is twofold: to use the information gained in this study of student nurses’ perceptions about care and culture to inform curriculum development so nursing faculty can teach students to address patients’ culture as they learn clinical skills and prepare to deliver care in various health care settings; and to indicate extensions of this topic for future study and exploration.

This topic is one of great importance as hospital patient populations grow increasingly diverse. As mentioned above, “Tufts Medical Center and Floating Hospital for Children have one of largest interpreter services departments in the region, making translation services available in over thirty-seven languages, as well as video sign language interpreting” (2009, p. 1). Because of the need for accuracy in medical

treatment, it is critical for nurses to learn the skills necessary to communicate effectively with their patients in order to assure a positive outcome in patient care. Therefore accessing interpreter services is a necessary component for providing culture sensitive patient care.

Personal background and context

My interest in culture and my belief in the importance of caring began when I was a child growing up in New Bedford, Massachusetts, a seaport city with a diverse population. The citizens of my native city who were of English, Portuguese, Norwegian, Polish, Greek, Syrian, Cape Verdean, Chinese, French, Italian, Irish, and Lebanese descent brought their culture and religious beliefs with them and demonstrated it in the way they lived and conducted business. For instance, in my neighborhood my family shopped for food at the Polish meat market for ham, pickles, and pumpernickel bread, the Portuguese bakery for sweetbread and rolls, the French bakery for pastries and cookies, the Jewish bakery for bagels and cakes, and the Greek candy store for ice cream, chocolates, and Easter bunnies. Families enjoyed trying specialties of other cultures and sharing their own.

I remember family friends who were from cultures different from ours, yet our immediate neighborhoods were pretty much divided by ethnic background. Each nationality had its own church or synagogue and many had schools where classes were given in English as well as in the language of the ancestral homeland. Growing up in a multicultural environment gave me a taste of other cultures and led to my appreciation of the richness of diversity. In fact I thought that every city was this way. What I learned later in early adulthood dispelled this notion, as I realized that most others I met did not

share a similar experience or feel the same way about diversity.

As I reflected on my belief in the value of cultures other than my own, I came to understand the importance of the role of family and how families perceived the world. My mother and grandmothers were the prime caregivers for my family. These women taught me by their example, how to care for myself, my brother, the people I interacted with on a daily basis, my community, as well as my treasured dolls on whom I practiced and modeled what I learned. The influence of these important women in my family led me to consider nursing as a career path for carrying out the values they instilled for the importance of caring for others.

My mother valued education so highly that she found a way to pay for 12 years of parochial schooling in a French Catholic neighborhood school. After graduating from St. Anthony High School, one of the many French Canadian institutions in the city, I entered Catherine Labouré School of Nursing in Boston, Massachusetts. Leaving New Bedford to pursue higher education in “the big city” was perceived as a major move. The geographical change into life in a metropolitan location was not the one that affected me the most, however. For the first time in my life, I came across people of Asian and African American descent and, moreover, was led to understand that these people were to be feared. At first I was apprehensive of these people who looked so different from me and those from my New Bedford upbringing. I wondered why I was warned to be wary of them; however, when I became more acquainted with the students who were different from me, I realized that in contrast to nursing educators’ cautions, we had many common values and very similar goals. I have carried this realization, one which affirmed the way I was raised, with me ever since. It has affected profoundly the way I live and work,

including my choice of a dissertation topic.

After graduating from nursing school, I entered the United States Air Force Nurse Corps where I was further exposed to different cultures, values, and traditions. This latter experience was instrumental in allowing me to witness how people who were not of the dominant culture were treated. I found the study of nursing to be not only strenuous but exceedingly grueling. As I sat in nursing classrooms and listened to the lectures taught from a seemingly irrefutable, one size fits all, medical model, I often asked myself why I was drawn to this profession. My answer came when as a young United States Air Force officer I was sent to nurse the injured troops involved in the Vietnam War. My 30 bed Intensive Care Unit at Clark Air Base in the Philippines allowed me to see caring at its best. In this setting I saw death through the eyes of my patients who were my age. I also saw the fright and courage they exhibited and held their hands and comforted them as they drew their last breath. Following the teachings of my nursing instructors not to cry or show emotion in front of the patient was extremely difficult. My peers and I would later gather after work in an intimate group to discuss our daily ordeals and to commiserate, cry, and comfort each other. The tragedies we experienced made us grow up rapidly and forever changed our outlook on life, war, and the political system that allowed us to witness these horrors.

After leaving the military I continued working in hospitals as an Intensive Care Nurse and further observed cultural differences. I also realized the need to communicate in the individual's language and the importance of understanding the cultural context for treatment. Later, as a faculty member and then as an administrator of a nursing program, I had the opportunity to work with people from other countries who wanted to be nurses.

Learning about the health care systems and wellness practices of the nursing students I taught, gave me insight on how to care more effectively for patients whose health beliefs were different from mine. This revelation made me realize the importance of studying both care and culture because of their complex inextricable relationship.

As a seasoned nurse, working in the educational arena, I was made privy to a caring attitude that was somewhat different from the one I had lived through in my clinical settings. I worked with nurses who cared immensely for their multicultural students both in the clinical and classroom surroundings. These kindhearted nurses acted as role models for the future nurses they were educating. A few nursing instructors went so far as to lend their students a textbook so that they could study. Others provided emotional encouragement when the student felt like he/she was never going to succeed in nursing while some cried with sadness or joy with their students. These selfless acts of caring were extremely important to both the recipient and the giver.

During my nursing career, my work assignments have taken me to large urban areas as well as to small towns and suburbs. Further, as a military nurse I had the opportunity to be stationed not only in various sections of the United States, but also in Asia, Europe, and Central America. Collectively, I have had the opportunity to work with patients, nurses, healthcare workers, faculty and students of different ages, ethnicities, cultural, and educational backgrounds.

The cultural awareness I developed and the caring interactions I encountered broadened my outlook on my life as a nurse and the possibilities for improving the practices of the profession. While faculty and administrator of a nursing program, I became acutely aware that nurses who had not had exposure to or experiences with

other cultures required more instruction in these areas. This revelation increased my interest regarding how nursing instructors could better teach culture and care to nursing students from various backgrounds, with the goal of serving patients more effectively.

Teaching the nurses of the future is a challenge as well as a reward. In light of the nursing shortage, it is imperative that nursing instructors acknowledge and address increasing cultural diversity of patient populations and understand how, where, when, and why they teach their students to be caring and culturally competent.

The scholarly basis for this work is presented in Chapter II: The Literature Review. The Methodology section follows and includes the research study and findings. The Discussion and Implications sections address the relationship of this study with previous research and current curriculum and pedagogical practices in nursing education.

Chapter II: Literature Review

The scholarly work that serves as a foundation for this study draws from three areas: the role of care in nursing; the relationship between culture and nursing; and, the impact of education on adult learners in nursing.

The Role of Care in Nursing

Introduction

Caring is an attribute that has been embraced by the nursing profession since early times as it refers to providing for another's wellbeing. Caring is a concept that is linked with strong emotions like love, when a person willingly gives to another, and with situational use, such as when showing kindness and concern in attending to those in need.

The act of caring is the foundation upon which nursing is built. Throughout time, nurses have been told by their profession that they must care for their patients unconditionally even though this may be difficult in certain situations. Caring is also a quality nurses believe they exhibit in their daily work life. In fact nurses believe that they are the only ones who care for the well-being of their patients and that no other profession can emulate them. Nurses consider caring, a characteristic that has traditionally been assigned to women, to be the core of their profession.

In order to understand the influence of care on nursing, it is necessary to review the historical perspectives of the profession. The study of history assists nurses in understanding how the notion of care emerged in nursing, how care impacts the patient-nurse relationship, and how nurses will continue to practice care. The positive and negative aspects of nursing care are addressed as well as how care can be taught in schools of nursing and healthcare settings alike. Finally an example is presented in an

effort to make the reader appreciate how a truly caring nurse overcame adversity to follow the teachings of her heart.

The history behind care and the profession of nursing is examined because in order to understand care in today's nursing environment it is necessary to review how care developed as a core value in the nursing profession. The terms care and empathy are defined and their differences and similarities are identified. These characteristics are drawn from the review of works by Noddings (1986), Roach (1987), and Watson (1990a) among others.

In this section, the attributes of caring are related to nursing care. The concept of the "caring" nurse is examined from a universal perspective as is the notion of how a caring nurse is developed and nurtured. Finally, a brief description of Boston's forgotten Nightingale, Frances Slinger, is presented as the ultimate example of a caring interaction between a nurse and her patient.

Historical perspective

Historically nursing has been seen as a caring profession. Throughout the years, those who have entered the profession "have been socialized by nursing schools, hospitals, and professional organizations to feel personally responsible for the care and comfort of patients" (Weinberg, 2003, p.153). Nurses as the healthcare givers within the medical community who spend the most time with patients, take the time to actively listen, get to know the families, and are in a special position to act as liaisons between their colleagues in the healthcare field and patients. Therefore, because of these personal interactions, nurses understand that without care and communication the patient's environment is greatly compromised.

Caring is also a characteristic that has traditionally been assigned to women, mothers, and nurses. Since the majority of nurses are women Noddings' (1986) comment that "...women often define themselves as both persons and moral agents in terms of their capacity to care" (p.40), seems particularly relevant here. Nursing has attracted young women to the profession over the years because of the values of opportunities for nurturing, and caring.

The notion of submissiveness was not widely tested and nurses became subservient to the male dominated medical profession (Luttrell, 1992, p. 50). Nurses were therefore "trained" to take orders from doctors and to carry out their directives without question. Creative thinking was not encouraged because nurses involved in the conduction of these actions were expected to do so out of blind obedience. This top-down authoritarianism lead to the development of nurses who were self-effacing and self-critical and thus remained "silent about their practices and talk(ed) only about their caring and compassion" (Nelson and Gordon, 2006, p.177).

While subordination of nurses by doctors can still be seen today, in the last fifty years the field of nursing has attempted to redefine itself so that it is more respected as on par with others who treat patients. Being a caring and warm person is not enough in today's professional milieu. As Roach (1987, p. 3) noted "caring has been used as a popular catch-all in commercials, advertising, posters, and billboards" as a way of presenting a caring image to the public about the scope of nursing. This view of caring which is rampant in nursing today is more detrimental than helpful to the profession as the term care loses its significance.

Nursing is an old profession, and examples of caring and empathy are found in

the *Bible*. Martha and Mary who were friends of Jesus, cared for and nursed their ailing brother Lazarus until he died. The grief stricken sisters solicited the help of Jesus during their time of need; and, Jesus, sensing how Mary and Martha felt about the loss of their beloved brother, resurrected Lazarus from the dead. In this example, caring for the sick and infirm was exhibited through the behavior of close attention and loving concern modeled by Jesus. (John, ch. 11, v. 32-44)

In early India pious men were selected to care for the sick and to assist them with their spiritual needs. This work was considered an honor for these men. During the Middle Ages nursing was carried out by religious sisters and brothers who turned their monasteries into hospitals for the care of the sick and destitute. These religious had a profound effect on nursing that is prevalent even today. With the advent of the Crusades, nursing entered the realm of the battlefields of Europe, Northern Africa, and the Middle East. Today nursing still plays an integral part in the modern military.

Not everyone entered the military for pious reasons. For example, some like Walt Whitman, the American poet, became a military nurse for personal reasons. Upon hearing that his brother had been wounded during the Civil War, Whitman not only cared for his brother, but also he went on to nurse the wounds of other soldiers. As “an early practitioner of holistic nursing, he incorporated encouragement, active and nondirective listening, and intentional use of touch into his nursing care” (Ahrens, 2002, p. 2).

Whitman believed that care in the context of hope and love saved lives.

Modern nursing evolved in England during the late 1800s when Florence Nightingale, a friend of Queen Victoria, opened a school for the training of nurses. Nightingale’s schools were founded on a principle of absolute authority implying

that nurses did what they were told. Nurses were not encouraged to think for themselves or to talk to their patients about their concerns and fears.

The provision of care in a relational sense, an important aspect in nursing today, was not widely encouraged. Patients were not allowed to express themselves or to voice what ailed them. Furthermore, patients were isolated from family and friends and so they had no one to speak to about their physical, spiritual, and emotional needs. To quote Leininger, “contrary to what many nurses attribute to Florence Nightingale, she did not focus specifically on the phenomenon of care. Her major focus was patients, the environment, and the conditions to support care. Nightingale did not define or explain the concept of care” although it was apparent to those around her that she cared deeply for the soldiers she nursed during the Crimean War (1988, p12).

Although relational care was of little concern to the nurse “trained” in the formal Nightingale model, care was exhibited when conditions were set to meet the physical needs of the patients. This way of thinking and the treatment accorded to the patients continued in the hospital based schools of nursing for over fifty years and eventually carried over to the academic setting when schools of nursing began granting degrees. Nightingale’s philosophy is still paramount today in nursing programs in the United States and Western Europe and in many instances student nurses continue to be treated with little empathy or care by their instructors. This behavior by the nursing instructors produces an undesirable model of empathy and care for students who must in turn attempt to empathize and care for their patients. Fortunately today, an attempt is being made to rectify this lack of concern for the other. Happily, as some schools of nursing are attempting to introduce courses on caring interactions in the curriculum, Gordon and

Nelson reiterate Leininger when they emphasize that

nurses must examine the history of their profession as ‘virtuous workers’ and understand the power that what we call the ‘virtual script’ has over the nursing profession. The virtual script bases the presentation of nursing on characteristics such as kindness, caring, compassion, honesty, and trust worthiness’ attribute associated with ‘good women’. This script sentimentalizes and trivializes the complex skills, including caring skills, nurses must acquire through education and experience – not simply individual inclination. (2005, p.63)

Unfortunately the nursing profession is at times not open to learning from other disciplines. This may be the consequence of an elitist attitude that deems nursing as the only caring profession in healthcare, and some nurses readily accept as true the belief that they are the only profession capable of delivering “high-quality care” (Weinberg, 2003, p.156).

While nurses care deeply for their patients, busy work schedules and insufficient staffing may make it appear that nurses lack concern for the wellbeing of their patients. In today’s world of managed care, cost constraints, and a paucity of qualified personnel, time for quality of care may be set aside in the push to accomplish technical procedures and routine tasks. Barlett and Steele refer to the fact that “Patient care could be industrialized” (2006, p.114). This dilemma can be seen in the manner in which nurses interact with their peers, other healthcare workers, patients, and the patient’s family members. Yet nurses report that they want to find time to listen attentively to their patients.

Traditionally nurses have been taught in school to beware of becoming too

involved with the patient for fear that this interaction could affect the way they care for patients. However, since “nursing is a caring profession; part of caring is maintaining communication and ensuring that trust continues throughout the interactions between the nurse and the patient” (Guido, 2004, p. 363).

Nurses at times lack care for each other by not listening to their peers and dismissing their concerns regarding patient care and working conditions. An example when any of my nurse colleagues and I call out sick the supervisor will coax us into coming to work sick and even make us feel guilty by telling us that we are leaving the clinical unit short staffed. This lack of consideration given to ill nurses makes them feel culpable and in desperation they will come to work ill and consequently undermine their health as well as that of their patients and colleagues. This lack of care toward nurses’ and patients’ wellbeing in deference to the need to meet legal coverage is a problem in the American healthcare system.

Nurses are at the patient’s bedside around the clock. Therefore, “a good nurse is able to see what is not going well” (Boisvert, 1994, p. 3) and thus is in a position to listen to the patients’ concerns and feelings. Consequently, nurses can then assist the patients in exploring these feelings and aiding in making decisions about what is beneficial for their wellbeing and health. The act of caring can be accomplished while the nurse is changing a dressing or administering medications. Care can also be carried over to interactions with a patient’s family. When student nurses witness care, they are able to incorporate this behavior into their own practice of nursing.

Nurses are in a unique position because they can care for patients, students, and other staff members in the clinical setting. As Roach so aptly notes,

care has become a popular expression in the language of nursing but their claims must be substantiated. Care is also a major component of the metaparadigm of nursing for many nurses. Nurses can no longer assume that care and health values are alike or even similar terms culturally. The myth that whatever is good for one client will be good for others regardless of cultural values and background must be dispelled because it is limiting nurses' therapeutic effectiveness and client satisfaction. (1988, pp. 13-15)

Definitions of care that embrace empathy

Many definitions of care and caring exist in the literature and this section includes also the relationship of empathy to care as it relates to nursing and nursing education. While functional care, or attending to patient's medical needs, is understandable, the relational aspects of care are more difficult to grasp. One of the key aspects of the relational characteristics of care is empathy.

The concept of care often embraces empathy. "The word empathy entered the English vocabulary as a translation of the Greek *ematheia*" (Singer, 2001, p.2) and refers affection and passion. To be empathic, implies that one listens attentively in order to experience what the other is feeling. This is done with the understanding that the listener is aware that he/she and the other are two separate feeling beings. For being empathic lets the other know that the listener is there and available to help the other explore and understand his feelings.

Empathy allows patients to feel better about their situation even though it may not change their circumstances. As Reynolds, Scott, and Austin state "if clients are able to

perceive the amount of empathy existing in a helping relationship, they are in a position to advise professionals on how to offer empathy. However, the client's perception of empathy has generally been ignored in the construction of measures of empathy" (2000, p.5). Rather than be ignored by nurses and other healthcare workers, it is necessary that nurses learn to pay more attention to what their patients are saying about how they feel and what they need. What patients say has a profound effect on how they will be cared for and how they will cope with illness and prescribed treatments

Care involves "a feeling with" the other and this relationship is termed "empathy" (Noddings, 1986, p. 30). This connection between care and empathy allows nurses to be concerned with the well being of their patients. Roach identifies qualities that nurses should possess when caring for patients. These include compassion, competence, confidence, conscience, and commitment. Compassion is "a response of participation in the experience of another; a sensitivity to the pain and brokenness of the other; a quality of presence which allows one to share with and make room for the other" (Roach, 1987, p. 58). Roach thus equates compassion with empathy which suggests that nurses should be empathic when caring for patients.

Roach affirms that "caring is the means, the medium, the mode through which the human being is a being-in-the-world." She further states that "Caring is essential, not only to the development of the human being, but to the development of the *caring* of the human being. And that human development is dependent not only on being cared for, but also on being able to care" (1987, p. 2). For Roach care is the essential ingredient that keeps humans alive. Care is carried out when children are nurtured by their caregivers and they, in turn, learn to care for others. This caring cycle continues with each

subsequent generation.

Erikson states that “caring is an objective, impersonal concept in the sense that health personnel do not sufficiently have regard for the unique individual human being. The caring caritive, love, is based on the fact that nurses try to serve by seeing and confirming *the other*” (as cited in Gaut and Boykin, 1994, p. 6). Erikson further asserts that nursing, which is a humanistic discipline, is a caring science that has its roots in all aspects of human life. Nurses care for patients from newborns through the elderly, in ways that they may not fully understand because caring is a complex phenomenon.

From another perspective, “caring is the means or tool used to put nursing concepts into practice through a process founded on reverence for life, love of self and others, and concern for improving world conditions” (Forsyth, Delaney, Maloney, Kubesh and Story, 1989, p. 165). This reverence for life challenges nursing instructors to teach caring concepts to students as a way of improving the quality of life for all individuals. Higgins believes states that “...human care requires a deep respect for life” (1996, p. 136). For without respect for life there can be no caring.

To Kapborg and Bertero “caring is central to human experience and nursing, and involves a commitment to human beings” (2003, p. 185). The authors further attest that the profession of nursing has emphasized the concept of care but has failed to clearly define what care is to nursing. To them caring involves the interaction of knowledge and skills as well as taking care of the entire human being. It is necessary for nursing to identify where and when care is needed and how care impacts nursing and can lead to positive implications for patients, student nurses, and healthcare workers alike.

Leininger is emphatic when she states that “human care is one of the most

essential and powerful forces to help people recover from illness, maintain health, and survive” (1998, p.11). For without care, a person is not going to thrive or live. For this reason nurses need to be truly caring individuals without prejudice or discrimination.

“Caring is an essential feature and expression of being human” (Boykin and Schoenhofer, 2001, p. 1). Caring is a humanistic process, as Erikson reminds us that sustains life and ensures the perpetuation of future human beings.

Caring is the act of showing kindness or being present for the other in his or her time of need. This action can last for a fleeting moment or a lifetime depending on the circumstances surrounding the caring. Included in the relational aspects of caring is the experience of empathy which is the act of being in the world of another as if it were your own. As Shea states “empathy is one person feeling what the other person feels as if one were the other person” (2003, p. 62). To be empathic means knowing and feeling as the other knows and feels in a particular situation. This is a difficult achievement for the nurse who has not been in a situation where empathy is practiced.

“Empathy is a developmental reality: it develops as an adult self develops. This development is along the lives of a shift from seeing the person as physical to seeing the person as psychological, a shift from seeing the person as exterior to seeing the person as interior” (Shea, 2003, p. 72). Empathy involves a letting go of one’s self in order to better understand the other. For this reason, empathy is closely allied to care and ultimately leads to love. Empathy, consequently, encompasses the caring interactions that are believed to be the foundation of nursing. Empathy allows the nurse to enter into and understand the world of another person and to communicate this understanding to the patient. Thus the practice of empathy leads to more meaningful caring interactions

between nurses, students, and patients. “Empathy is a way of being” (Egan, 1986, p. 95). Hence when practicing empathy the nurses listen to the patient by putting themselves in the other’s place, understanding how the other feels, and subsequently caring deeply for this other person.

As Jordan noted “without empathy there is no intimacy, no real attainment of an appreciation of the paradox of separateness within connections” (1991, p. 69). Empathy is what allows nurses to understand what the patient is experiencing without actually experiencing the pain. For nurses to truly empathize they “must have a well-differentiated sense of self in addition to an appreciation of and sensitivity to the differences as well as the sameness of the other. Empathy always involves surrender to feelings and active cognitive structuring; in order for empathy to occur, self boundaries must be flexible” (p.69). Being empathic necessitates that nurses put themselves forward in such a way as to focus entirely on the patient; however, it does not warrant that nurses forget who they are and what their obligations are not only to themselves but to their family, friends, and other patients. Separating one’s self while still being connected takes practice to accomplish this skill successfully.

Using myself as an example, as a nurse I developed my own style of caring which involved treating everyone as an equal. While serving in the United States Air Force, I nursed patients who were from allied as well as enemy factions without regard to their political position. This was no easy task since I was not to judge the actions of these patients; I was to take care of their health needs and assist them to return to their optimal wellbeing. This was daunting at times because of the situations I found myself in; yet as a nurse I felt ethically bound through the Florence Nightingale Pledge that I took at

graduation from nursing school to equitably care for anyone in need.

“As human beings we want to care and be cared for” (Noddings, 1986, p. 7). Functional care may involve performing acts that one dislikes in order to ease a patient’s pain or distress, just as relational care might require being present with a patient’s family member who has lost a loved one or with a patient who faces a difficult diagnosis and surgical procedure. In dramatic contrast, functional care may involve helping a patient through a painful labor and delivery, while relational care may be rejoicing with a mother who has just delivered a healthy baby. As Roach states “caring is the human mode of being. It is the most common, authentic criterion of humanness and is expressed through love or compassion, sorrow or joy, sadness or despair” (Roach, 1987, p.2).

Learning to care

The basics of care originate in the home where children learn caring from their Parents and family members. Everyone has the capacity to care; however, the mode and degree of caring varies from person to person. Children learn functional caring from their parents, who provide them with food, clothing, and shelter. They also learn the relational care that involves empathy and love. As babies grow they are cared for by family members who in turn teach them how to care for their siblings, pets, toys, and later those outside the immediate family. When they are old enough to attend school a new set of caregivers, namely teachers, begin to influence how children care for others. Later as children enter adulthood they begin to emulate their parents in the act of caring for their significant other and children. Thus caring is continuous through the generations.

As Noddings remarked “apprehending the other’s reality, feeling what he feels as nearly as possible, is the essential part of caring from the view of the one-caring. The

one-caring, in caring, is present in her acts of caring for caring is largely reactive and responsive” (1986, p. 16). That is to say, that nurses react by responding to patient needs with care. The attitude of the nurse is influential in how the patient feels cared for. Further the motivation elicited in caring is directed toward the welfare, protection, or enhancement of the one being cared-for. The manner in which care is manifested is evident in how parents care for their children and nurses care for their patients and how they present themselves as role models of care.

In nursing, “caring involves stepping out of one’s own personal frame of reference and into the other’s. For when nurses care, they consider the other’s point of view, his objective needs, and what he expects” (Noddings, 1986, p. 19). Individual ways of caring may not be alike yet they are ways of caring. Care may be manifested differently for each individual because one’s perception of how one was cared for is very personal and profound and cannot be dismissed.

Roach maintains that “individuals care because they are human beings, and they select particular professions because they care. The capacity to care is rooted in their very nature and this capacity to care can be enhanced, called forth, or inhibited by the educational experience of the student, and most importantly by the presence or absence of caring models” (Roach, 1987, p. 8). This is an altruistic way of looking at care since nurses have varying reasons for entering the profession.

Contrasting functional and relational care in nursing

Nursing relies on care for its very existence. Nurses utilize care in different ways when tending to the sick. A functional form of care refers to following the physician’s orders in meeting patients’ physical needs. In this respect, nurses are called on to manage

the patients' daily requirements for nutrition and bodily needs in addition to the provision of performing procedures and administering medications. Care can also be manifested relationally. This type of care can be communicated non-verbally by a look or touch or verbally through a kind word, or by attentive listening and conversation. Although most care is given to make the other feel better, not all acts of caring are dispensed in a positive way.

For instance during World War II, the nurses of Nazi Germany participated in active euthanasia of the infirmed and elderly believing they were doing what was right for the good of their patients and their nation. As one nurse accused in the Munchner Schwesternprozess (nurses' trial at Munich) stated, "When giving the dissolved (poisoned) medicine, I proceeded with a lot of compassion...I took them lovingly and stroked them when I gave the medicine" (Benedict and Kuhla, 1999, pp.246, 254). These nurses equated their heinous measures to acts of caring.

Shields (2005, p. 2) states that "education for registration in nursing is universally centered on principles of caring and caring is seen as the essence of nursing." However, she noted that there is a sinister side to care as was demonstrated by these Nazi nurses who believed that killing was part of doing what was right for their patients. This unusual aspect of "care" resulted from the notion that nurses were inculcated with ideas of obedience and subjugation to the medical profession and that by virtue of their "nurse's training" they had an obligation to follow their superiors' orders without question as to whether they were doing right or wrong.

On the other hand, Noddings (1986, p.55) notes that "conflict may arise between the perceived need of one person and the desire of another; between what the cared-for

wants and what we see as his best interest; between the wants of the cared-for and the welfare of the persons yet unknown.” This statement would assist the nurses not involved in the Nazi atrocities to understand how the German nurses were able to carry out their orders without questioning them. These nurses firmly believed that they were working for the “common good” of the nation and not of mankind.

A contrast to the Nazi nurses is Italian chemist Primo Levi who spent most of World War II at the concentration camp in Auschwitz. Levi spent his time in the camp caring for his fellow prisoners by keeping their spirits up and encouraging them to think beyond their present situation. Levi (1996, p. 180) states “I and my two French companions were consciously and happily willing to work at last for a just and human goal, to save the lives of our sick comrades.” Levi’s unselfish act is an example of profound caring for another person.

The handmaiden theory where female nurses deferred to the male doctor’s authority is not considered to be a natural female response to human needs. In fact Jolley and Brykczynska (1993, pp. 45-46) state that this mentality is the “outcome of a system which openly supports separations between cure and care, while covertly relying upon nurses to fill the gap between.” In addition one should not consider nursing to be a natural female response to caring. In addition, anti-intellectualism in nursing is not the cause but the effect of its deferential status in healthcare organizations.

Gordon and Nelson (2005, p. 64) found that before the advent of Florence Nightingale, “nursing was considered the domain of religious women and servants. Religious women were portrayed as angels and non religious nurses were not considered to be respectable.” This idea led to the suggestion that nurses were “Angels of Mercy”

who were there to care for patients from birth to death. It also allowed for nurse reformers like Nightingale to make it possible for women to find purposeful work. This idea was also introduced in Russia in 1815 when the Empress Maria Fedorovna established the order of Compassionate Widows. According to Bessonov (2009, p.8) these war widows who were literate, were “trained” to care for the sick in hospitals and private homes alike. Nursing thus became the first social activity for women outside the home to gain acceptance among respectable classes. “Nursing in particular, was born of care, organized for care, and professionalized through care” (Roach, 1987, p. 12).

As noted by Leininger, “some of the major factors influencing care differences are closely related to differences in the clients’ social structure, cultural context, and values. Nurses must learn to use care concepts with precision and skill comparable to some medical caring modes” (1988, p.16, 18). Nurses need to be aware of cultural differences surrounding care and learn to respect their patients if they are to provide effective nursing care. When they become informed about culture and care, nurses can use this knowledge in ways that are congruent with a patient’s values.

Leininger says that

because culture is so much an integral part of daily actions and thinking, nurses seldom pause to reflect on how the culture of nursing care influences care practices and attitudes. The pre-1965 cultural values of deference to authority figures; of being other-directed, active doers, and less intellectual sharers; of imitation of the physician’s role; and of handling practical and sundry tasks in the environment have been some of the many traditional

cultural values influencing care in the United States (1988, p. 21).

These nurses tend to uphold and endorse traditional values by resisting changes they view as belonging to the medical profession; however, nurses educated from 1965 on have less difficulty dressing more casually and have a more collegial relationship with physicians. These contrasts in attitudes do not make nurses from an older era better or worse than nurses from a more modern time they just make them different.

Personal attributes of caring related to nursing

The American Association of Colleges of Nursing, an accrediting agency for baccalaureate and masters entry-level nursing programs, has identified seven values deemed to be the basis for nursing care. These ideals are: altruism, esthetics, human dignity, justice, freedom, equality, and truth. These principles were specifically recognized because “caring and respect are essential values guiding nursing in a practice that honors compassion and competence” (Gaut and Boykin, 1994, p. 50). Compassion is needed in order to provide the patient an atmosphere where caring is carried out by an empathic nurse who exhibits a competent manner that will enhance health and well being of the one being cared for.

As stated earlier, the attributes of caring originate from one’s family and upbringing and are dependent on how one was cared for as a child. Watson (1990b, pp. 63-64) affirms that “women in spite of all their gains, remain largely invisible in the human consciousness” and that “if caring is to be sustained, those who care must be strong, courageous and capable of inner love, peace, and joy – both in relation to themselves and others.” This statement implies that nurses must be advocates for their patients who are in a vulnerable position vis-à-vis the healthcare team who may be

making decisions the patient does not want or understand.

“To humanistically ‘care’ requires the presence and use of the nurse ‘self’ and the sharing of the ‘self’ with another” (Chipman, 1991, p. 175), that is to say, that nurses give of themselves by sharing themselves with the patients they are caring for. For without this sharing, the care received by the patient will not allow for growth and healing. This a “caring moment involves an action and a choice by both the nurse and the other” (Watson, 2000, p. 9) who allows the nurse to deliver the needed care.

Morse, Bottorff, Anderson, O’Brien, and Solberg note that “The Theory of Human Care” developed by Watson, states “the kind of relationships and transactions that are necessary between the caregiver and the care receiver to promote and to protect the patient’s humanity influence the patient’s healing potential” (2006, pp.7-8). This theory emphasizes the psychological, emotional, and spiritual dimensions of care which are necessary components for patient well-being. The authors also found that the Sunrise Model used by Leininger in her “Theory of Transcultural Care Diversity and Universality alerted nurses to the need to consider cultural values and practices that influence patterns and meanings of care” (pp.7-8). Nurses therefore must be culturally sensitive to how patients view, receive, and understand the care they are receiving.

According to Boykin and Schoenhofer “developing the fullest potential for expressing caring is an ideal and the belief that all persons are caring entails a commitment to know self and other as caring persons” (2001, pp. 2-3). They further state that the one who cares must be willing to know not only one’s self but also others. A common belief with these authors is that all persons are caring and that caring grounds the focus of nursing as a discipline and a profession because “the nurse enters into the

world of the other person with the intention of knowing the other as a caring person” (p. 3). Nurses care willingly for the sick in an effort to provide a sense of being valued as a worthwhile human being.

The universal concept of a caring nurse

The concept of caring is universal; however it is not defined universally. People care for themselves and others by emulating how they were cared for. Student nurses enter the profession in order to care for the sick. They are taught by instructors who may have ways of caring that differ from those of the students and the parents who raised them. As student nurses mature into the profession, they develop their own unique ways of caring for patients. Three examples come to mind. Two are positive instances of care while the other may be viewed as a truly negative example of care.

The first example of care involves health care attorney Kenneth Schwartz. When Schwartz died of lung cancer in the mid 1990s, he left a legacy for those who cared for him while he was a patient at Massachusetts General Hospital in Boston. This legacy called The Schwartz Center Rounds was created as “a safe place for hospital staffers to express the frustrations, fears, and sadness that can reverberate during the drive home” (Huff, 2006, p. 98). The Schwartz Center Rounds which are scheduled monthly in over 100 hospitals throughout the United States allow healthcare workers to speak about their concerns of dealing with issues of patient care. The participants share their experiences and elicit support from their colleagues. This act of caring by Schwartz for those who cared for him when he was ill is helping to spread the notion that care is beneficial to all who participate in this altruistic behavior.

The second example is that of the Nazi nurses in Germany during World War II.

These nurses who were “trained” along Nightingale’s doctrine of unquestionable compliance to one’s superiors, believed that they were acting in a caring manner when they blindly followed orders resulting in the deaths of the elderly, the infirmed, and the mentally challenged. Although these nurses viewed their behaviors as expressions of care, others viewed their acts as monstrous. These nurses carried their “training” in obedience to the ultimate end by killing their patients in the name of care.

The final model of care involves former United States President, Jimmy Carter, who grew up in Plains, Georgia as the son of a farmer and a nurse. His parents showed him caring examples in their daily lives when his father gave food and land to his sharecroppers and his mother cared for the sick, not only in the local hospital, but in their homes as well (Carter, 2001, p. 59). After he left office, Carter became involved with Habitat International. As a member of this organization, Carter has devoted much of his time and energy in aiding homeless people build homes for themselves and their families. This significant act of caring is aiding to eradicate homelessness. (Slavitt and Loveman, 1994, p. 4)

These cases illustrate how care can be beneficial and detrimental when viewed from different perspectives. One can also argue that the “care” delivered by the Nazi nurses was not care because it caused harm to a great number of innocent people who were considered “undesirable” by the government.

Implications for the profession

In order to develop as a profession, nurses need to devote themselves to self development, including coming to learn in ways Belenky et al. (1986) termed procedural and connected. Learning intentionally how to respect others and self while learning about

the context of others' needs and experiences eventually leads nurses to “channel their increasing sense of self into their growing capacity to care for others” (p. 46). Nurses value their patients and go to great lengths to provide them with physical, emotional and at times spiritual care. The spiritual care may be seen as hand-holding, listening, and praying. Nurses are with their patients in times of happiness and sadness from birth to death. Although nurses may see these activities as part of their daily routine, these caring interactions are in fact evidence of empathy. As Siegel aptly states “the *only* real reason to stay in (medicine) was to offer people a friendship they can feel, just when they need it most” (1986, p. 18). Offering friendship in the manner described reveals how important care and empathy are for the caring professions.

The Kaiser Permanente Medical Group has developed “The 4 Es Model” (Engage, Empathize, Educate, and Enlist) to assist physicians in becoming empathic. This model is being used in medical schools and hospitals in the Western United States to make physicians more aware of opportunities where they can use empathy when interviewing patients (Hardee, 2003, p. 4). In addition this model also lends itself to the teaching of empathy in schools of nursing. In order to implement care in the curriculum, the instructors must possess and practice both empathy and care in their own professions. By modeling empathy and care nursing instructors emulate a positive behavior for student nurses who will then conduct themselves in a way that conveys care to their patients. These actions in turn provide patients with a sense that nurses are sincere in their endeavors to provide the understanding and support necessary for healing and acceptance of the human condition.

As a nurse my colleagues and I have often been referred to as “Angels of

Mercy”. This designation is a misnomer since angels are heavenly bodies who do not inhabit the earth. Nurses do not look upon their work as being out of the ordinary and they would not give themselves such an exalted title. This is not to say that nurses have not been God’s messenger because there have been many times when they have been called upon to sit with a dying patient, to hold his hand, and to even give him permission to let go and die. Being in these situations is very humbling; yet as much as this angelic designation is flattering, it does not make a nurse an “angel”.

Leininger has identified several factors that make up the culture of nursing in the United States. These include the fact that: 1. the culture of nursing relies heavily on material goods and technologies in education and client care, 2. there is an increasing focus on the nurse’s self-interests and a decrease in the value of culturism which is the outward orientation of a person toward others with the desire to help others rather than oneself, 3. there exists a concept of rights or egalitarianism for all nurses, 4. nurses may or may not perceive themselves as caregivers, and 5. whether care is considered worthy of investments in the form of money for research, education, and practice. Because these issues are so important in nursing today, Leininger (1998, pp. 22, 26) firmly believes that “nurses must help the public to understand nursing as a caring profession and demonstrate the powers and effectiveness of care to help people recover from illnesses and disabilities and maintain wellness.” In other words, nurses must be pro-active in what they do and how they perform their skills.

Boston’s forgotten Nightingale

Frances Slinger demonstrates the truly caring nurse. As a young Polish immigrant to the United States, she survived many forms of discrimination including nationality, religion, education, gender, and socio-economic status. Her strong Jewish faith gave her

the foundation necessary to pursue her goals to be a nurse and minister to her patients with care, empathy, and love.

Frances was the daughter of a fruit peddler from the South End of Boston, Massachusetts. Her poverty may have hindered her education but it did not deter her determination to surmount this obstacle and become a nurse. Her dream of being a nurse motivated her to study in order to obtain her high school diploma. The achievement of this milestone led her to enter Boston City Hospital School of Nursing from which she graduated in 1937. After obtaining her license as a Registered Nurse, Frances worked at Boston City Hospital honing the skills that would assist her in her biggest challenge. When not at work at the hospital, Frances found the time to assist her family and neighbors in meeting their health needs.

The onset of World War II was looming as Frances was deciding where she was most needed as a nurse. The invasion of Poland, and the massacre of many of her relatives stirred in her the desire to do more. Thus in 1943 she applied to enter the United States Army Nurse Corps in order to care for the wounded soldiers who were protecting the freedom she loved. In June of 1944, Frances was one of the first nurses to land in Normandy, France where she worked in a field hospital and lived in a tent while her hospital moved through France and Belgium.

Frances, who was a quiet and thoughtful nurse, was beloved by her co-workers. She pulled her weight without complaint and worked long hours tending to the sick and wounded. “Frances’ caregiver bent had worn such a deep groove in her life that even the thought of straying from it triggered guilt. Caregivers hate to cause others pain. They live to ease others’ pain” (Welch, 2004, p. 113). This attitude led to her most noteworthy act

of care and empathy when she nursed a wounded German Prisoner of War. In fact while she was out on the battlefield she may have asked herself the following question that comes from the heart, “Must I ignore the reality of the other’s hatefulness toward me (if such exists)?” (Boykin and Schoenhofer, 2001, p. 24). It was at this time that “Frances looked into the eyes of the young German soldier. She then knelt next to him, raised her arm toward him, and dabbed his forehead with a cool rag” (Welch, 2004, p. 169). In a moment of profound love, she set aside her nationality, religion, and contempt for the Germans to minister to the enemy who was her patient.

In October, 1944 2nd Lt. Frances Y. Slinger made the ultimate sacrifice and act of caring when her hospital was shelled by the Germans. Memories of her loving care bolstered the servicemen stationed in Europe because her life and death exemplified the deepest caring action one can give to another human being.

Culture and Nursing

Introduction

The study of culture¹ has a profound impact on today's nurse. Since "cultural inheritances undeniably cut across social classes, it is in these cultural inheritances that much of our identity is constituted" (Freire, 2003, p. 71). Although aware of their own ethnic background, nurses have not always been sufficiently attentive to the importance of culture in their daily lives let alone in healthcare surroundings.

It is in the healthcare setting; however, that nurses meet patients of different traditions and experiences which have a deep influence on how patient care is perceived and received. Here again, it is important to reflect on Leininger's statement about the importance of "how care is experienced and known to people of different cultures, and how care is linked with religion, language, politics, economics, and culture values" (1998, p. 11). Culture not only affects the nurse's understandings and behaviors but also those of their patients. Nurses need to be sensitive to how care is experienced and understood by people of different cultures.

The history of nursing as it refers to culture will be discussed including the influence of immigration on nursing, and definitions of culture and communication will be addressed. Further, three nursing models relating to culture are addressed. The models include *The Leininger Sunrise Model to Depict the Theory of Cultural Care Diversity and Universality*, *The Purnell Model for Cultural Competence*, and *The Giger and Davidhizar Transcultural Assessment Model*. These models can be used to teach culture to nursing students but also to nurses in the practice setting.

All nurses grow up with their own cultural identities, yet on a daily basis they

¹ For the purpose of this dissertation culture refers primarily to cultural diversity.

encounter patients and colleagues who have a culture different from their own. Many nurses have difficulty understanding the elements of culture, and some may fear people of diverse cultures. These misunderstandings and apprehensions eventually may lead to distrust and, in the worst instances, possibly to a lack of quality nursing care. By studying another culture and coming to appreciate the values and practices of that culture, nurses can learn to identify similarities and dissimilarities between their culture and that of the patients they care for. They can also learn about aspects of different cultures that influence patient care and healing in important ways.

This chapter is intended to explain why nurses need to be aware that, “each cultural world operates according to its own internal dynamic, its own principles, and its own laws – written and unwritten” (Hall, 1990, p. 3). Consequently, by studying culture, nurses can begin to break down stereotypical barriers and promote understanding between themselves, their patients, and student nurses who will follow in their footsteps.

Nursing history

In order to understand why nurses should study culture, it is important to examine the history of nursing. As Hjorth states, “the history of a profession is the basis for a deeper understanding of the identity of a profession and thus its possibilities” (2006b, p. 1). Though now a predominately female profession, nursing has roots reaching back in time to the religious societies who took care of the poor, the orphans, and the infirmed of all ages, as well as the military who cared for those wounded in combat. Early religious societies of brothers and nuns, and the volunteers who cared for those injured in the military were the forerunners of today’s nursing profession. Although not formally trained or educated as nurses, these devoted people helped the underprivileged in their

time of need.

In the late 19th century a well-to-do English woman named Florence Nightingale approached Queen Victoria and asked her help in the establishment of a school for training women to become nurses. Nightingale who studied briefly with the Protestant deaconesses at Kaiserswerth, Germany (Bostridge, 2008, p.97) and later worked as a nurse in Turkey during the Crimean War understood the importance of public health and nursing care under austere conditions. The combined efforts of Queen Victoria and Nightingale laid the foundation for modern-day nursing. Nightingale's theories on "sanitation, health, nursing, and nursing education" (Ellis & Hartley, 1998, p. 135) spread throughout Europe, Canada and the United States. Interestingly, "the development of nursing in Russia after the Crimean War followed an entirely different path" (Bessonov, 2009b, pp. 1-2). The nurses who returned home from the Crimea were either retired or worked in military hospitals. This action by the Russian government thus left the future of nursing in the hands of the doctors.

In understanding the role of culture in nursing, it is important to note that the first schools of nursing in the United States were established in the 1890s in large metropolitan hospitals as a form of generating cheap labor. Unlike the women of an earlier age who were either nuns, prostitutes or prisoners, the future nurses of Florence Nightingale's time came from families of "good character," which is to say, that the families of the nurses were respected by the community. Some women who became nurses were first generation Americans from Western Europe. To them nursing was appealing because it offered an opportunity to obtain an education, secure employment and provide money for their families (McGoldrick, 1996, p. 553).

Cultural heritage and personal factors of these student nurses receded into the background as they were expected to become a homogenized group of learners. Typically, the women lived in a nurses' residence attached to the hospital where they attended classes taught by physicians and nursing supervisors. These early nurses were trained in an austere environment where obedience was of paramount importance. The women had little personal time available for individual pursuits. In exchange for their education, the women worked 12 to 16 hour shifts in the hospital six, sometimes seven days a week. On Sunday they were obliged to attend church, and in the afternoon they were allowed to visit their family, if nearby, for a couple of hours. Upon graduation, these nurses were expected to work at the hospital where they had trained and continued to live in the nurses' residence. (Canadian Museum of Civilization Corporation, 2002, p. 3) This practice thereby ensured the hospital of a readily available nursing staff. After several years of nursing practice, some of these nurses who had worked closely with the male physicians became not only the supervisors but also the instructors for the new student nurses that conformed to and protected the hospital's culture, by keeping the nurses busy and, as a result, pushing their personal interests and connections aside as they were placed in a seven day insular pattern that was focused on the hospital rather than themselves.

After several years of practice, some of these nurses who had worked closely with the male physicians became not only the supervisors but also the instructors for the new student nurses, thus perpetuating the culture of the hospital by exclusion of outsiders as teaching faculty. The women were the chosen few who had come to identify and conform fully to doctors' and hospital expectations, buying into the system as it were. The

physicians continued to teach anatomy and physiology while the nursing instructors taught bathing, medication administration, and comfort measures to the students. For many of these women, nursing became their life for unlike the male doctors they served, they were expected to be selfless, to give themselves over to the hospital's culture and practice. The result of this gender disparity was that countless nurses abandoned their dreams of marriage and raising a family in order to care for the sick. (Ellis and Hartley, 1998, p.143)

Early 20th century hospital- run schools of nursing followed the same guidelines of having classes taught by physicians and nurse supervisors. Nuns dedicated to caring for the poor and the infirmed ran many of these hospital-based schools. They, and their military counterparts, came from a cultural background that demanded obedience and subservience. Therefore, these nuns and early nurses assumed the stern, authoritarian, and dominating traits of their 19th century instructors. Again students had very little freedom and had to account for all of their time. They had study hours, quiet time and curfews where they were required to sign in and out of the residence. Any breach in the rules resulted in the nurse being punished. Twelve hour shifts were common and the duties of the nurse included not only patient care but cooking, laundry, and housekeeping chores as well. These rules and regulations also applied to the graduate nurses who lived in the nurse's residence. Many of these regulations supporting a workplace culture of subservience and depersonalization continued until the demise of the hospital schools of nursing in the late 20th century. These nurses were expected to be the "handmaiden to the doctor" in other words, obedient and never questioning the doctor's orders. (Ellis and Hartley, 1998, p.143)

These early schools had strict requirements which barred men and African Americans who were required to have their own schools of nursing. This practice perpetuated segregation of the races and the sexes and continued until nursing education moved into the academic realm (Clay, 2008, p. 4; Aetna, 2003, p. 1).

The self-regulatory basis for the field of nursing shifted in the 20th century when three important events occurred that impacted nursing and nursing education. “In 1903, the passage of the first nursing laws set standards for nursing education and practice” (Kelly, 1991, p. 51). Nursing education became more externally regulated and New York became the first state to require licensing exams as a minimum requirement, with the goal to protect the public. Licensing examinations became the norm after graduation and nurses who wanted to work in other states had to request approval from the Board of Nursing before they could become employed.

In 1920, as the profession of nursing developed, private foundations took interest. For example, the Committee for the Study of Nursing Education was funded by the Rockefeller Foundation. Nursing pioneers Annie W. Goodrich, M. Adelaide Nutting, and Lillian Wald published the Goldmark Report in 1923. This report stated that “the quality of existing programs was inadequate” and that “education took precedence over service to a hospital, with training based on an educational plan rather than on service needs” (Winslow et al, 1922, p.1). This decision implied uniformity for the nursing programs because it set specific guidelines on what was to be taught and practiced in these schools. As an outcome of this report in recognition of the need for additional training, Yale University in New Haven, Connecticut opened its school of nursing in order to prepare nurses on the baccalaureate level.

In the 1920s and 1930s diploma schools of nursing began to offer similar educational programs and licensing of nurses was instituted on a state-by-state basis in order to provide continuity of care to the sick. During World War II the demand for nurses increased in order to support the war effort. As a result, the 1940s saw the advent of the practical nurse program that graduated nurses in two years rather than three or four years and the Cadet Nurse Corps which prepared nurses for future military service. Not surprisingly, these programs conformed to military cultural expectations of conformity.

In 1948 Esther Lucille Brown, a social anthropologist with the Russell Sage Foundation, recommended that nursing education move out of the hospital and into an academic setting. Predictably the report was perceived as threatening, and “the report received mixed reviews...since some hospital administrators considered it a subversive document, fearing that it had economic security implications for nurses. These administrators did not appreciate the fact that the authoritarianism of hospitals was pinpointed” (Kelly, 1991, pp. 68-69). The homogeneity and conformity of nursing education shifted when as a result of this report, some schools began to affiliate themselves with local communities and four year colleges while others closed entirely. A key point to note here is the moving nursing into the college setting did away with the notion of training nurses and introduced concept of educating nurses.

Thus after the Korean War nursing education moved from the hospital into a more academic setting where degrees were offered. The field of nursing opened up, and it was at this time that African American women who had attended segregated hospital schools of nursing and men were allowed to study in the community college nursing programs (Buerhaus, Staiger, et al., 2009, p.165).

At the beginning of the 21st century, only a handful of nursing programs remained under the auspices of the hospitals. Nursing was now fully ensconced in colleges offering associate, bachelor, and masters entry-level degrees. However, the change in the educational environment had yet to dispel the demands for a culture of obedience. Although less restrictive than their hospital counterparts, collegiate nursing programs continued to have instructors who command and demand respect and obedience to the norms and practices of the academic institution. This behavior by instructors towards students of nursing is what Freire would term oppression. He states that “One of the basic elements of the relationship between oppressor and oppressed is *prescription*. Every prescription represents the imposition of one’s individual choice upon another, transforming the consciousness of the person prescribed into one that conforms to the prescriber’s consciousness. Thus, the behavior of the oppressed is a prescribed behavior, following as it does the guidelines of the oppressor” (Freire, 2003, pp. 46-47). In other words, the harsh treatment by the nursing instructors, many of whom were nuns or former military nurses who learned obedience from the church’s and military’s doctrines, was meant to perpetuate itself by making the oppressed student a harsh nurse who would carry on the behavior exhibited by the former instructors.

Military nursing

Nurses have been an integral part of the military in all wars involving the United States. Although nurses have cared for the wounded since before the Civil War, it was not until 1901 that the Army Nurse Corps came about. In 1908 the Navy Nurse Corps was established. These two branches of the service allowed American military nurses to serve in World War I and later in World War II. In 1949 the Air Force Nurse Corps was

formed when it split from the Army. During the Korean War the Air Force Nurse Corps joined its military sisters in tending the sick and wounded. At the time of these wars, men who were registered nurses were excluded from practicing their profession in the military because nursing was considered a profession practiced by females and not males. In fact the nurses who were men were relegated to working as corpsmen or nursing assistants. It was not until 1955 when President Eisenhower signed the Bolton Act that these men were finally allowed to join their sisters as military nurses. Today they are accorded full military benefits as “they serve parallel to their female counterparts...” (U. S. Army, nd, p. 3). Today both men and women have equal rank and privileges as military nurses. Many have furthered their education through the military and now hold senior nurse management positions in the Army, Navy, and Air Force.

Men as nurses

It is important to look further at gender here and its relationship with culture. Men have been nurses since the beginning of time. In fact the world’s first school of nursing was founded in India in 250 B.C. and only accepted men who were pure enough to become nurses. In 300 A.D. a group of men known as the Parabolani opened a hospital and provided care to the victims of Europe’s Black Plague. Later St. Benedict founder of the Benedictines and St. Alexis founder of the Alexian Brothers opened and operated schools of nursing devoted to the education of men. The Alexian Brothers continue to operate hospitals throughout the United States and Europe. (Kozier, Erb, et al. 2004, pp.2-4; Wilson, 1997a, p.6)

Early men in nursing represented other than the dominant White culture. The first identified American man in nursing was Friar Juan de Mena, a man with Hispanic

origins, who was shipwrecked off the coast of Texas during the Spanish invasion in 1554. In 1783 James Derham a slave from New Orleans, Louisiana began working as a self-taught nurse in order to purchase his freedom. After the Civil War, Derham went on to study medicine in Philadelphia where he became the first African American physician in the United States. 1888 saw the opening of The Mills School for Nursing and St. Vincent's Hospital School for Men in New York City (Wilson, 1997b, pp. 7-8). These first schools trained men to nurse sick males and did not allow them to study pediatrics or maternity because these areas involved the care of children and women.

At the beginning of the 20th century women nurses began to organize, and in 1917 the American Nurses Association was founded. This forerunner in nursing societies for the betterment of nursing education and patient care excluded men until 1930. This association was also instrumental in excluding men from military nursing believing that women were more capable of men in rendering nursing care (Kozier et al., 2004, pp. 20-21). "In the latter half of the 20th century men were finally admitted to once all-female schools of nursing. It was at this time that men finally returned to their historical role as caring and nurturing nurses" (Wilson, 1997b, p. 10). Finally, men were allowed to practice their profession in every area of nursing.

The plight of men can be summed up in the following statement:

As a man in nursing, Luther Christman, an icon in nursing, encountered more barriers than most nurses. In fact, if he wrote a tell-all book, many nurses would be embarrassed by the blatant sexism he experienced. He goes on to say that women in nursing blocked his path to becoming a nurse and later tried to prevent his

moving ahead with progressive ideas such as graduate education and faculty practice. In spite of his experiences, Christman went on to become one of the most honored nurses in the history of nursing around the world. (Sullivan, 2002, p. 12)

Many women feared that men would take over nursing as they had medicine and felt threatened. At the start of the 21st century Christman, who married a nurse with whom he attended school, was finally recognized as an influential nurse leader.

The impact of immigration on nursing

Immigration to the United States came in waves from the earliest of colonial times to the present. Immigrants came for various reasons, including the escape from religious and political oppression, the flight from famine, to seek employment, and the desire to provide a better life for their children and themselves. Some later immigrants came to this country in order to join family members who were already living in the United States.

The first influx of immigrants arrived during the colonial era between 1600 and 1760. “Chief among these newcomers were 250,000 Scots-Irish, 125,000 Germans who were the second most significant European minority...and 2,000 Huguenots from France. Of note is the fact “that in Colonial America religions and their identities were often intertwined” (Dinnerstein and Reimers, 1999, pp. 1, 10) thus making religious vocations superior to secular careers. Immigrants coming to America were not openly welcomed by the British colonists who not only seemed to forget their own immigration status but also considered themselves to be the elitist gatekeepers.

Further, the British colonists distrusted anyone whose native language was not

English and whose religion was Jewish or Catholic. In addition, they viewed the immigrants as inferior second-class citizens who were not entitled to the rights and privileges enjoyed by the British colonists. The colonists feared that the new immigrants would take over the land and impose their language, customs and religious beliefs on them.

The English colonists and later Americans of the majority group appreciated the cheap labor that the newcomers could provide, but expected them to absorb existing customs while shedding their own as quickly as possible. Minority group members were despised for their ignorance of English, their attachment to cultures and faiths prevalent in the Old World and their lack of knowledge of the American way. (Dinnerstein and Reimers, 1999, p. 15)

The new immigrants worked as indentured servants for the wealthy where they performed farm labor, household chores, and childrearing skills in order to eke out a living.

The next large group of immigrants who came between 1789 and 1890 were mostly from Western Europe and Canada. Again these immigrants came to the United States because “of poor economic conditions in their native lands and prospects for a better life” (Dinnerstein and Reimers, 1999, p. 18). They came to work in factories and later those with skilled crafts opened shops in the cities. These new Americans had children who were better educated and led the way in industry, education, and medicine.

The mid 19th century saw an influx of Chinese immigrants who were selected to work on the transcontinental railroad while the 20th century saw the arrival of immigrants

who were displaced during and after World War I and World War II. Many of these immigrants were well educated professionals who were often able to secure positions of importance in this country. In the latter half of the century immigrants from the war torn areas of Asia came to the United States to better their lives. According to the 2000 U.S. Census, today's immigrants are from Africa, Asia and Central and South America. Like their earlier counterparts, these new arrivals come to the United States for the same reasons listed above.

One group of Americans who came to the United States for very different reasons is known collectively as African American. The new immigrants came from Africa on European-owned slave ships in order to provide cheap labor for wealthy white Americans. These slaves were torn not only from their countries but their families, customs, and religion. Once in the United States, the plight of the slaves continued for they were denied their freedom, a relationship with their families, an education, healthcare, and the basic dignities of human life. (More Hines and Boyd-Franklin, 1996, p. 68)

The United States as a nation of immigrants has contributed greatly to healthcare especially in medicine and nursing. Immigrant pioneers were instrumental in opening hospitals to care for their own in an environment that respected and honored the language and practices of the particular cultures. Some of the early Boston hospitals include Carney, Beth Israel, and New England Deaconess. Carney first opened in South Boston in 1863 and cared for the Irish; Beth Israel which opened in 1916 cared for Jews; and, New England Deaconess, founded in 1896, cared for people of the Anglican faith. At that time it was not unusual for different religious denominations to operate hospitals for their

faithful. According to Linenthal “hospitals were created as symbols of a community’s pride, as tangible evidence of people caring for one another.” He further states “many people felt that hospitals should provide for the souls as well as for the bodies of those housed within” (1991, p.71).

The immigrants of both the 20th and 21st centuries continue to come for religious and political reasons and for the opportunity to make a better life. Like those who came before them and from whom most of us are descended their ideals, family values, and cultures continue to blend to form the American society we know today. It is important to note that because the children of these early immigrants intermarried over the years, most Americans now share two or more cultures. Although they are descended from more than one ethnic background, many Americans tend to associate more with one culture than another. This may be due to the fact that the family favored one ethnic background over another or that the dominant parent’s culture prevailed. In an attempt to become more Americanized, some first generation Americans had a tendency to deny their ethnic background and refused to speak the language of their parents. In order to succeed, some of these early Americans changed their names and even denied their cultural heritage. What is amazing is that their children and grandchildren are interested in their family origins and attempt to learn as much as they can about their cultural roots. These younger Americans do this by learning the language of their ancestors, doing genealogical research and returning to the ancestral homeland for visits. There are many personal reasons for this including finding a way to feel more connected to their past. (Dinnerstein and Reimers, 1999, p. 18; McGoldrick, Giordano and Pearce, 1996, p. 25)

Unlike the immigrants of yesteryear, the most recent émigrés are opting to keep

their culture and language by blending it with their new American culture. To them being bilingual or trilingual is not a sign of inferiority as it was in times of old but rather an indication that they can be part of two very distinct cultures and still be American. These new Americans want to embrace both cultures and identities in their adopted country. This blending of cultures brings new life and vitality to the United States as it allows those living here to experience new ideas and outlooks that were once unknown or unwelcome. This country continues to be a melting pot which struggles to encompass and restrain the new and the old simultaneously. This dichotomy, albeit uncomfortable for some Americans, is what makes the country diversified and challenges healthcare (Leininger and McFarland, 2002, p. 264).

Cultural traditions for nursing

Culture and nursing traditions provide structure and continuity in the delivery of nursing care. Madeleine Leininger, a nurse anthropologist who has devoted her life to care and culture, developed the notion of transcultural nursing. She states that

Transcultural² Nursing refers to a formal area of humanistic and scientific knowledge and practices focused on holistic culture care (caring) phenomena and competencies to assist individuals or groups to maintain or regain their health (or well-being) and to deal with disabilities, dying, or other human conditions in culturally congruent and beneficial ways.

(Leininger and McFarland, 2002, p. 84)

Further, transcultural nursing is concerned with the provision of nursing care in a manner that is sensitive to the needs of individuals, families, and groups who represent diverse

² For the purpose of this dissertation transcultural and multicultural are used as synonyms.

cultural populations within the society. The major aim of transcultural nursing is to understand and to assist varied cultural groups with their nursing and health care needs.

In order to understand this concept more fully, the nurse needs to be familiar with the common terms that are present in regards to culture and nursing. For Leininger and McFarland, culture “refers to patterned lifeways, values, beliefs, norms, symbols, and practices of individuals, groups, or institutions that are learned, shared, and usually transmitted intergenerationally over time” (2002, p.83). In other words, nurses are aware of how culture affects health care practices. This knowledge is of utmost importance in assessing, planning and delivering health care to any individual. This knowledge allows nurses to formulate plans of care that are specific for the individual because the plan takes into account not only the patient’s disease but also how the patient perceives the illness and how coping with the health status will be managed.

In one’s practice setting, nurses meet persons who are of a different culture than the one that dominates the care setting. This diversity of culture involves meanings of health and wellness, values and practices that may be unfamiliar to the nurse, and respecting the customs the patient brings to the healthcare setting. (Leininger and McFarland, 2002, p. 83; Campinha-Bacote, 2003, p. 1) Purnell (2003, p.2) suggests that at times nurses may feel sensitive about another’s culture and may fear saying something offensive. This sensitivity can easily lead to serious miscommunication and misunderstandings between the nurse and the patient.

Once nurses become culturally aware of the diversity of the patients, self-information and in-depth explorations of one’s cultural and professional background may occur. This process should involve the recognition of one’s biases, prejudices, and

assumptions about individuals as well as becoming aware of the external signs of diversity such as clothing and food choices. (Campinha-Bacote, 2002, p. 182; Purnell, 2003, p.2) As this awareness takes hold, nurses can decide to be culturally knowledgeable by seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups. This course of action involves understanding others as they are and not as nurses would like them to be. This knowledge helps nurses to be more culturally competent in assessing patient needs. Being culturally competent requires a conscious effort by nurses since it involves being aware of attitudes and behaviors that can enhance or deter the outcomes of care. (Tripp-Reimer, Brink, and Saunders, 1984 p. 79; Purnell, 2000, p. 43; Purnell, 2003, p 2; Leininger and McFarland, 2002, p. 84)

By being comfortable in caring for patients of diverse cultures, nurses become empowered to look beyond the obvious and begin to understand that culture transcends nursing care. This transcendence leads nurses to making culturally sensitive decisions through careful communication with the patient and the patient's family. This in turn allows the patients to be knowledgeable about their personal welfare and the achievement of their personal health goals.

The influence of communication on nursing

“Perception is at the core of interpretation and is affected by many contextual dimensions consisting of past experiences, sociocultural context, emotions, motivation, cognition, ability, developmental capacity, and gender” (Pacquiao, 2000, p. 5). Many nurses' first impressions are lasting impressions. However, nurses need to go beyond this first encounter which clouds the perception of what one thinks about the other and

look further at what is seen in order to understand and know the other. Nurses need to be aware that “Ninety percent of culture is invisible. It’s the bottom part of the iceberg - people’s values, beliefs, history and geography – all those things that really make people act the way they act” (Gelbtuch, 2009, p. 6). This process takes time and practice because nurses must set aside personal feelings and biases in order to see the patient more clearly.

Nurses must also understand that communication is a social act that reflects how people live, relate, and get along with others. Since language differences are probably the single most important obstacle to providing culturally relevant health care, ignorance of cultural differences can lead to gross misunderstandings of nonverbal behavior. For that reason it is important for nurses to know that in order for communication to be successful, the message being sent must be clear, delivered properly, and comprehended (Tate, 2003, p. 214). A clear message is one that is sent so that the receiver understands what is being said while proper delivery indicates that the language used to convey the message is recognized by the receiver. Comprehension indicates that the receiver knows what the message states and that it can be acted upon appropriately.

In order to communicate effectively with a patient from another culture, nurses need to be cognizant of the factors that can facilitate the interaction. Facework, plays a major role in this communication interaction. “The concept of “face” is about identity respect and other-identity consideration issues within and beyond the actual encounter episode” (Ting and Toomey, 2004, p. 73). Associated with facework is the notion of politeness which is extremely important when communicating with anyone; however, when speaking with people from another culture, politeness or respect is of utmost

necessity in order to preserve and maintain mutual-face.

Language attitudes are also important when communicating since violations in the principle of language attitudes, or how persons speak to each other may cause serious communication misunderstandings. Speakers have “the impression that as long as we are aware of cultural differences, we will be able to “understand” people from other cultures and engage successfully in intercultural encounters” (Ladegaard, 1998, p. 182). The way people speak and interact with each other has an effect on how the message is delivered by the speaker and how it is interpreted by the receiver. Agar states that “the speaker’s intentions are the most important raw material for frame building and that what Anglo-Americans think of as ‘lies’ aren’t really lies at all. They’re just normal, proper social discourse, discourse that considers group members more than American discourse does” (Agar, 2002, pp. 159-160). This point is important for nurses to keep in mind when dealing with patients from other cultures. What nurses may think of as untruths or evasive behavior may be normal dictates or behaviors of the culture.

The creation of a culturally competent nurse

Culture influences how people determine if they are ill and how they care for themselves. For example, the use of traditional folk practices to prevent illness has been a tradition of care for many cultures over time. Some of these preventive measures may involve magic and religion as well. (Purnell, 1999, p. 334) Therefore, when caring for patients who use alternative medical treatments, nurses need to ask these patients where and how they get their health care. When planning care, nurses should try as much as possible to incorporate the patient’s traditional measures with modern medicine; in so doing, nurses are accepting the fact that the patients may be more inclined to use

practices that are beneficial to their well-being.

Cultural groups vary in the nature of support they receive from and offer their members. For example in some societies the elderly are cared for at home instead of in a nursing home where care is provided by nurses instead of the family. Nurses need to gain an understanding of the cultural groups for which they are providing care in order to be familiar with what the patient and family are seeking. Nursing interventions that are culturally relevant and sensitive to the needs of the patient decrease the likelihood of stress and conflict arising from cultural misunderstandings. (Campinha-Bacote, 2002, p.1) In order to be efficient, nurses need to be sensitive to their own cultural biases and behaviors as well as to those of their patients.

Many tools exist to assist faculty to teach culture to nursing students; however, before faculty members can be effective in this area, they must “demonstrate knowledge of the cultural differences and similarities” that enhance their “ability to manage the impression” others have about them. (Pacquiao, 2000, p. 6) Similar to faculty in other professions, nursing faculty come from different backgrounds and cultures and also have preconceived ideas of how other people live. Therefore, nurses must evaluate and come to terms with their understandings and biases of others before they can teach culture to student nurses. Because the “goal of nursing education is to educate a diverse population of nurses and to teach all nurses culturally competent practices” (Rew, Becker, Cookston, Khosropour, and Martinez, 2003, p. 256) instructors must be committed to following through with the notion of being culturally competent. In order to facilitate this process, three models for the study of culture are discussed in the next segment.

The Leininger Sunrise Model to Depict the Theory of Cultural Care Diversity and

Universality “is a guide to discover new knowledge or to confirm knowledge of cultural informants.” This theory developed by Madeleine Leininger, a nurse anthropologist, states that culture care universality “refers to commonalities or similar culturally based care meanings (truths), patterns, values, symbols, and lifeways reflecting care as a universal humanity” (Leininger and McFarland, 2002, pp. 80-83). This model looks at what people have in common. Further, it also looks at cultural differences and how nurses can take this knowledge and develop plans of care for individual patients.

The Purnell Model for Cultural Competence is a tool that can be used by all healthcare givers to assess, plan, deliver, and evaluate the care being dispensed to all patients. This model by Larry Purnell, a nurse from Appalachia, “was originally developed to provide an organizing framework for nurses to use as a cultural assessment of the patient. The model is an ethnographic approach to promote cultural understanding about the human situation during times of illness, wellness, and health promotion” (Purnell, 2000, p. 40). By using this tool nurses and other healthcare workers can individualize their patient’s plan of care by incorporating the patient and the family in the development of this arrangement. When care is personalized, the patient feels empowered and develops a trusting relationship with the nurse.

The Giger and Davidhizar Transcultural Assessment Model “postulates that each individual is culturally unique and should be assessed according to six cultural phenomena: 1. communication, 2. space, 3. social organization, 4. time, 5. environmental control, and 6. biological variations.” The nursing model is based on the idea that culture:

- is a patterned behavioral response that develops over time,
- is the result of acquired mechanisms that may have innate influences,

- is shaped by values, beliefs, norms, and practices that are shared by members of the same cultural group,
- guides our thinking, doing, and being and becomes patterned expressions of who we are,
- implies a dynamic, ever-changing, active, or passive process and,
- guides actions and decision-making while facilitating self-worth and self-esteem.

(Giger and Davidhizar, 2002, pp. 185-187)

Use of this model assists nurses in looking more closely at the dominant culture as well as the represented cultures in the society in an attempt to better understand the patient being cared for.

By using these nursing models, “the nurse continuously strives to achieve the ability and availability to effectively work within the cultural context of a client, individual, family or community and requires nurses to see themselves as becoming culturally competent, rather than being culturally competent” (Campinha-Bacote, 2003, p. 3). Being competent implies that one is all-knowing about a given culture while becoming competent implies that nurses are continuously striving to learn more about culture and how it impacts patient care. Care must be adapted in a way that is consistent with the patient’s culture. (Andrews and Boyle, 2002, pp. 178, 180; Campinha-Bacote, 2002, p. 184; Leininger, 2002, p. 190; Purnell, 2002, p. 2) In order for this to happen, nurses must make use of the above models to enhance cultural awareness in becoming more competent when caring for patients of diverse backgrounds.

In today’s multicultural world it is important for nurses to understand cultural differences and similarities because the use of knowledge regarding cultural diversities

has considerable relevance to the practice of nursing, medicine, and other healthcare specialties. A person's reaction to illness, health maintenance, daily activities, body discomforts, change in lifestyle, food preferences, and various caring and curing treatment practices are all linked to cultural beliefs, values, and experiences.

There are many reasons for nurses to study how culture influences health care. Three explanations are: (1.) Nurses tend to be ethnocentric in their approach to health care delivery and they tend to believe that their own professional health practices are superior to the health norms and practices of other cultural groups. This attitude leads nurses to want to impose their "superior" cultural practices on the patient's "deviant" culture. (2.) By studying different cultures, nurses are better able to understand their own culture and why they react negatively or positively towards others. (3.) The relevance of cultural diversity to the nursing profession becomes clear if one assumes that cultural patterns are an integral part of providing safe, effective and evidence based nursing care.

A cultural approach to understanding others recognizes that these persons may be trying to satisfy needs that are fairly common across cultural backgrounds but that attitudes and behavior of individuals are to a large extent culturally determined. Culture serves as a guide to persons on the ways in which they fulfill their needs; it determines what actions and kinds of behavior are considered acceptable (Leininger and McFarland, 2002, p. 9).

Implications for nursing

The nursing profession has come a long way in the last century, however; there is still room for improvement. Today nurses come from diverse ethnic backgrounds which they cannot completely deny. Culture is inextricably linked to and often forms the

foundation from which they come. Along with their knowledge and experience, nurses bring to the profession their behaviors, biases and prejudices which influence how they interact with patients, staff and student nurses. What is important, however, is that nurses be mindful of this phenomenon and differentiate their own cultural background so that patients from other cultures can be understood and treated with respect.

As the twentieth century has grown into the twenty-first, the demand for more culturally aware nurses have grown. Surprisingly, while seminars and workshops are being presented to introduce seasoned nurses to cultural awareness, schools of nursing lag behind even though they have a distinct advantage in that the teaching of culture could be integrated throughout the curriculum. The next section addresses nursing education, particularly as it relates to teaching nurses about care and culture.

Nursing Education: Adult Learning's Impact on Care and Culture in Nursing

Introduction

As a nurse educator and administrator I observed that the nursing students of the 21st century are, for the most part, adult learners who bring with them a wealth of educational knowledge as well as work experience. They are a culturally diverse population who vary in age from 17 to 65 or older and many of them are choosing nursing as a second career. Because of their knowledge and background, these new students are to be treated as adult learners.

Nursing instructors who have traditionally worked with recent high school graduates often times find it difficult to work with students who may be older and more learned than they are. Nursing instructors need to be aware of the needs of the current student nurse population so that they can facilitate how these students learn what is needed to become competent registered nurses.

Historical perspectives

Historically education was for the sons of the wealthy and not for their daughters who were raised to be wives, homemakers, and care for their family. Women were trained to manage the home while men were taught trades and professional skills. The poor, on the other hand, were left to develop skills that would be useful in their work for the rich.

The early nurses, who were recruited by nuns, came from the ranks of prostitutes and prisoners. These women were taught the nursing skills necessary to care for the sick and poor of the community. This practice continued until the end of the 19th century when Florence Nightingale of England began reforming the image and culture of nursing.

Nightingale who was a friend of Queen Victoria proposed educating virtuous women of means to assist physicians in the hospital care of patients. These early nurses were dressed to resemble maids and wore caps on their heads and aprons over their long dresses. They lived in the housing provided by the hospital and attended classes that were taught by physicians and the matrons or nursing supervisors of the hospital. (Mowbray, 2006, p. 21)

At the dawn of the 20th century, schools of nursing remained situated in the hospital setting. After World War I a number of colleges and universities opened nursing departments in order to educate women who were interested in caring for the sick. The advent of World War II saw the introduction of the practical nurse program; an accelerated nursing program that produced nurses in 12 to 18 months. Although licensed, these nurses function in less critical areas of care than do registered nurses. In the 1950s the junior or community colleges began offering two year nursing programs which granted an Associate Degree and allowed the graduate to sit the licensing examination for Registered Nurse. The last half of the 20th century saw the closure of most of the diploma hospital-based nursing programs and the inception of new entry level Bachelor of Science and Masters in Science nursing programs. These programs were primarily designed for applicants who had degrees in areas other than nursing and were established in the hope of easing the shortage that is plaguing nursing today. However, these nursing preparatory programs only fuel the debate over entry into practice. While many countries have mandates university level education for their nurses, the United States continues to lag behind. Presently, North Dakota is the only state requiring a baccalaureate degree in nursing “as a minimum educational credential” (Gordon, 2005, p.418).

As the focus on the importance of adult learning has increased, it is interesting that a one time society thought that education was only for children. Since the world has become smaller and more complex this notion has vastly changed. Educators now know that learning occurs at any age as older adults return to school to obtain a high school diploma or a college degree. Sometimes in spite of adverse reactions from family and friends, these adults are fulfilling lifelong learning goals. Now with the introduction of on-line classes, more adults are able to take advantage of learning without leaving their homes, with fewer disruption to family life. Educators must be aware that even with on-line classes the target of the teaching is the student (Caffarella, 2001, p.11).

Nursing is also being affected by these new trends in education. Traditionally nursing was taught in a classroom or simulation laboratory and students practiced their skills for lengthy periods of time before going into the clinical setting of the hospital to care for patients. Also students had very little say about their course of study and relied heavily on what was dictated by the curriculum and what they learned from their instructors. The early educators and reformers in nursing also had to assuage physicians by downplaying nurses' knowledge and skills in order to emphasize their virtue and ethics. This practice was demeaning because nurses were taught to do as they were told and not to think for or about themselves, but to follow through on doctors' orders as they "served" their patients. Accordingly, "today's nurses are under increasing pressure to concretely connect nursing practice and patient outcomes" (Gordon and Nelson, 2005, pp. 65, 67) by learning critical thinking skills to apply when caring for multicultural patients. In order to understand this expectation and to understand better how to instruct future nurses, it is beneficial important for nurse educators to be familiar with the

principles of adult development and education and development.

Adult development

As mentioned above, adults return to school for various reasons. The current student nurse population is older and has more experience than their predecessors and as such this unique adult grouping may find themselves temporarily reverting to Erikson's developmental stage of identity versus role confusion. These career-changing students returning to school, face opposition to their decisions from family, friends, and co-workers. Thus achieving their goals may be more difficult because of the barriers that have been created for them both at home, at work, and at school.

The gap in age between learner and teacher may also factor in, as instructors could also find themselves in Erikson's stage of generativity versus stagnation when they are in the process of educating the next generation of nurses. Proficient instructors can make this stage of development work to their advantage by using their creativity and wide knowledge base to enrich student learning. (Erikson, 1963, pp. 266-267) Instructors of all ages, though, benefit by knowing the developmental stages they help students attempt to make meaning and extend their learning with and serve effectively the patients in their care.

Sometimes the students themselves are the same age or older than instructors. Hiemstra who has done extensive research on how older adults, especially women, process information, remember, and learn, states that "individual differences among older learners exist" and include the fact that persons who are "55 and older can learn new skills, become increasingly more self-directed, and be taught to use their past experiences in learning new material" (1993, pp.6-8). This observation is important for

teachers and learners alike. Instructors need to be aware of the various teaching and learning styles that are most effective in the classroom, laboratory, and clinical setting, while students should be familiar with their individual styles of learning.

Teaching

Teaching nursing students can be a challenge for today's instructors. The mainstream student who was a recent high school graduate is rapidly being replaced by the adult student who has work and life experience and maybe even a degree or two. These new nursing students require instructors who are attuned to their ways of learning. Also these students are asking that their instructors teach them what is necessary to achieve success in their new chosen profession.

Based on the above, instructors need to know that "student motivation and learning are enhanced when the teacher is closely and purposefully involved with them" (de Tornyay and Thompson, 1987, pp. 167-168). Students need to feel that their instructors are knowledgeable and that they are willing to work diligently with them so that they can thrive both in the classroom and most importantly in the clinical setting. Furthermore, instructors should be aware that the successful transfer of knowledge and skills to the clinical area takes time and effort in order to be realized fully. By remembering how they were as student nurses, instructors can empathize with their students and help them find ways of coping with the clinical experience.

Teaching takes practice, and since many of today's instructors teach the way they were taught, students may not readily grasp what is valued and how the nursing hierarchy has evolved. Teachers of nursing may inadvertently make it difficult for students to recognize any of nursing's hidden messages. (Dickleman, 1993, p. 97; Jolley and

Brykczynska, 1993, p. 83) Therefore, nursing instructors must be cognizant of how and what they teach and try not to overwhelm the student. Also instructors of nursing need to admit that, “If students are to have a relevant and positive learning experience it must reflect and prepare them for reality” (Hewison and Wildman, 1996, p.759). This reality should include that fact that nurses care for culturally diverse patients.

Teaching styles

Up until the late 1990s nurses could obtain a masters degree in nursing with a focus on education. This concentration of study consisted of 2 or 3 nursing education courses and a classroom practicum. Although this was a minimum requirement, few nursing instructors studied basic educational theory. This lack of a sound educational background disposed many nurses to be biased to their own literature. In other words, if the article, book, or course made no mention of nursing or if a course was taught by an instructor from another discipline, a lack of appreciation by nursing faculty existed. Nursing traditionally views its pedagogy as having little or no bearing on adult education theories and principles.

To compound the situation, many institutions of higher learning closed their nursing education departments in the 1990s in favor of the Nurse Practitioner (NP) programs. These latter programs were more lucrative than the nursing education programs because government funding was better. Some ten years later with an ever increasing shortage of nursing faculty and a lack of nurse practitioner positions especially in large metropolitan areas, the universities are re-thinking this issue. Some colleges and universities with nursing departments are now establishing a two-semester certificate program in nursing education for nurses with a Masters degree in nursing in an effort to

prepare qualified instructors (Gordon, 2005, pp. 331-333).

As an educator and nursing program administrator, I observed worked with many nurse practitioners who were hired as nurse educators even though they had no background in teaching. They in fact were learning on the job and were becoming frustrated because they had difficulty identifying the level of students' learning needs. They were cognizant of the nurse education preparation programs yet few were willing to invest the time and money necessary to become instructors. This was an exasperating ordeal for those of us who were trying to teach the next generation of nurses.

Schaefer and Zygmunt state that “although faculty members may use a variety of methods in an attempt to meet individual student learning styles and to promote learning, these learning activities may take place in settings which the academic environment makes it impossible to achieve a student-centered approach” (2003, p.244). Nursing faculty need the time and the resources necessary to develop their teaching skills so that the student can benefit from the learning process. These authors along with Oermann further recommend that: 1. faculty members discuss both formally and informally ways to improve the climate of learning, 2. junior faculty be mentored by a senior faculty member, and 3. faculty members work together with administrators to find ways to eliminate the barriers to achieving a student-centered learning environment. (Schaefer and Zygmunt, 2003, p. 244; Reilly and Oermann, 1992, p. 196)

Instructors know that teaching can be a daunting experience since “the task for the teacher is to build on the capacity for theory to enhance experience and for experience to enhance theory” (Tenant and Pogson, 1995, p. 156). Since most teachers use the traditional lecture as their primary strategy, the transmission of facts from teacher to

student relies less on experience and more on presentation that requires only recall of facts as the activities most frequently utilized in the classroom. Further, many of the questions asked by these instructors require only a recall to answers without the comprehension of important larger concepts or the ability to think critically. Belenky et al. (1986) describe this way of learning as one of received knowing, in which learners do not integrate knowledge with experience or engage in dialogue to form connections with the ideas of others, but rather accept memorize points as standard. This style of teaching points to the necessity for the use a variety of methods including opportunities for early clinical experiences in order to capture the essence of learning and thus enable the students to feel more secure and safe in school.

In some nursing school settings where Learning Activity Packages (LAPs) are used, students bear the responsibility for teaching themselves by using these LAPs as an outline of what they need to know for class. Given that student nurses are expected to teach their patients about health and wellness issues, they require the presence of a role model to facilitate their education. Some suggestions that teachers can make use of include: assuring that all students are engaged in the class activities, selecting teaching styles that work best and fine-tune them to meet the institutional goals, allowing students to work in their strongest learning styles in order to build self-confidence, giving students the opportunity to work in all learning modes, and observing students so that their learning styles can be identified. (Morse, Oberer, Dobbins and Mitchell, 1998, p. 42; Silver, Strong and Perini, 2000, pp. 32, 34-35) Variety in learning allows the student to explore new styles which may enhance the way they view a topic. Also if the classroom is deemed a safe haven for student exploration and the teacher fosters new learning

styles, and presents opportunities for the student to integrate their learning, the students will find the educational experience not only more enjoyable but more meaningful and ultimately useful. Belenky et al. (1986) appreciate the process and benefit of connected knowing, in which the learner and the object or person of the learning experience are both considered important, and whereby, the learner through respectful observation and dialogue comes to understand the perspective of the other. This process is key to recognition of patient cultural contexts toward achieving accurate diagnoses and providing appropriate successful treatment protocols.

Learning

Learning begins with an infant's parents as teachers. The parents or caregivers teach the child to distinguish right from wrong and how to survive in this complex world. As the child grows, formal learning through the elementary school system becomes of paramount importance. It is at this time that the child realizes how to integrate various ways of learning. Some ways of learning may seem simple while others are more complex. As the child continues to develop and learn a sense of what is needed educationally and later professionally in life emerges. If children are taught how to learn in a positive manner they will like learning and find ways to enhance or embellish this learning; however, if children's learning is inadequate; they may feel frustrated and later fail in their efforts to achieve in school. Erikson addresses this in his stage of industry versus inferiority. Through exposure to diverse ways of learning, the child's preferences start to become known. If the teacher aids in developing the preferred styles than the child will enjoy the learning process. For the child with poor learning habits, the teacher must work diligently with the student in order to promote the development of the good

habits needed for success. These ways of learning can then be carried through to higher education in the adult years (Erikson, 1963, p.268).

Adults who come to higher education with positive learning experiences may be more open to trying new learning styles in a way to enhance education. Learning can be a difficult process if early experiences were not positive or if guidance for the student is lacking. Because adults carry with them their learning skills from childhood, it is therefore necessary to identify and enhance the positive learning styles and find ways to suppress negative habits that developed during the earlier school experience. In following Erikson's theory some adults who are having difficulties with acquired poor learning habits may need the assistance of the instructor to find ways to turn the negative patterns into positive ones (1963, p. 268).

Faculty members deal with adult learners from different generations and these learners may have developed styles that are different from those of the instructor. This dilemma may pose a challenge for both the instructor and the student especially when a traditional 18 year old high school graduate entering nursing school has been joined by the second-career, middle-aged parent who is returning to school after a long hiatus. Nursing faculty thus need required to be aware that some of their students may be older and more experienced in life than they are and adjust their curriculum and pedagogy to accommodate the range in age and background of their students.

In my work as an administrator in an associate degree granting nursing program, I observed that many older students come to nursing with college degrees and the skills to advocate for themselves. They also have goals they wish to attain within a certain timeframe. These savvy students pose a challenge to traditional nursing faculty because

they tend to question authority and expect responses to their queries and they want a return on their educational investment.

These adults continue their educational pursuits for various reasons. For instance, professionals like physicians and nurses are mandated by their licensing boards to have a certain amount of continuing education in their field of expertise as a requirement to renew their license. Other adults may attend informal job training classes related to their work or enroll in formal college courses in order to advance in their present jobs or to procure another position. There are adults who are also returning to school because they are changing careers and want to acquire the language and professional skills that will make them more marketable. Some immigrants come to this country with a wealth of education and experience only to find that they cannot work in their professions either because their credentials are not considered adequate by United States standards or because they need to have a working knowledge of English in order to write the multiple choice licensing exam.

Tenant and Pogson "...hold the view that the relationship between teachers and adult learners should be participative and democratic and characterized by openness, mutual respect, and equality" (1995, pp. 3, 171). Additionally, adult students want to be treated as peers and respected for their knowledge and experience in the workforce. They do not want to be coddled, demeaned or taken for granted. So even though they are new to the nursing profession, adult nursing students expect their instructors to treat them as adults and not talk down to them.

Nursing school is a difficult undertaking for any student. This fact is attested by Benner (1994) who incorporated the Dreyfus Model of Skill Acquisition and

Development to identify the five phases a student nurse passes through from: novice, advanced beginner, competent, proficient, and expert in nursing. As a novice, a nurse has no experience and is taught the basics of weight, pulse, and blood pressure measurement. This is a skills oriented phase where learning takes place in a nursing laboratory setting. Advance beginners start to concentrate on remembering what they have been taught in class and in the laboratory function under supervision in a clinical setting. The competent nurse is the one who has been in a single position for 2-3 years and is beginning to set long range goals. The proficient nurse sees the entire situation and is guided by past experience, whereas the expert nurse who has an extensive background to draw on, is able to consider a larger range of solutions to a problem by thinking critically. (Benner, 1984, pp. 31-32) Benner believes that the Dreyfus Model has implications for both the nursing curriculum and continuing professional education since expertise takes a while to develop. She also believes that most nurses can eventually function at the advanced level but that very few will become experts.

Learning styles

Each nursing student comes to the classroom with a different way of learning. Although many of these students are unaware of how they learn, a competent and resourceful instructor can aid them in identifying these behaviors. One method that can be used is a learning style inventory such as the one used by Conner (2004, p. 34). The learning style inventory is a form of self-assessment that assists students in identifying the best way they learn.

Self “assessment is an enlightening experience, and is the beginning of the transformation to developing personal insight and strategic thinking” (Wolf, Bradle &

Nelson, 2005, p. 57). An individual can come to learn about his or her learning style through the process of self-assessment and gain insights that help the learning process. “Learning styles classify different ways people learn and how they approach information. The use of a learning styles assessment provides the learner the opportunity to learn how one is likely to respond under different circumstances and how to approach information in a way that best addresses particular needs” (Conner, 2004, p. 34). Adults who take a learning styles inventory might be relieved to discover their particular way of learning. For years they may have had an inclination of how they learn and might be delighted when they actually verify their particular style. Having this knowledge can empower the student by assisting one to focus on a particular style and therefore develop ways of learning that create success. Consequently the use of self-assessment is beneficial not only for the learner but also for the teacher. With this knowledge, both the teacher and the student can work as peers to develop a plan of activities that will enhance learning. One limiting factor to the learning styles inventory is that it can label a student and consequently limit growth in the learning process.

According to Morse et al (1998, p. 42), “learning styles involve perceptual strengths and processing styles.” They identify these strengths as visual, auditory, tactual, and kinesthetic and further state that most people “are either global learners or analysis learners.” Global learners are the ones who need to know what they need to know and why they need to learn it, while analytic learners understand best when information is introduced sequentially and factually. As a result, this information enables students to learn new material by using their primary strength while reinforcing their secondary strength. Knowledge of learning styles therefore, can enhance the experience of being a

student.

Since most students favor one or two styles of learning over the others, these techniques can be strengthened through practice in the classroom and application in the clinical setting. It is necessary for teachers to look at how they are presenting information and to use various ways of conveying knowledge to their students. This transferal of data can be accomplished with the employment of handouts, the viewing of videos, and question and answer periods in class. In the laboratory, learning can take place through demonstrations, simulation, and the practice of skills. Ultimately it is the teacher's responsibility to find a balance that is appropriate for all involved. Students, for the most part, like creative approaches which help them develop better critical thinking skills which are consistent with student-centered learning. (Silver et al., 2000, p. 31; Schaefer and Zygmunt, 2003, p. 239)

Adult learning theory

“Learning typically occurs through active participation in the experience and subsequent analysis of the experience” (Tenant and Pogson, 1995, p. 171). This is very evident in nursing since students learn the didactic content in class, practice their nursing skills in the laboratory, and then are supervised giving nursing care to patients in a clinical setting. David Kolb known as an experiential learning theorist developed an inventory that assists learners to identify their own learning preferences. He describes four styles that a person goes through when involved in a new learning situation. These include: 1. Concrete Experience (CE) or abstract conceptualization-how learners take in information such as learning from personal involvement and relying on feelings; 2. Reflective Observation (RO) or active experimentation-how learners internalize

information which includes learning by observing and listening before making a judgment; 3. Abstract Conceptualization (AC) or learning by thinking and analyzing ideas rather than using feelings to solve problems; and, 4. Active Experimentation (AE) which is learning by doing or taking action. Kolb further differentiates his model by identifying learners as: 1. activists, those who feel concrete experience, 2. reflectors, the ones who watch and think, 3. theorists, learners who form abstract concepts and generalizations, and 4. pragmatists, students who involve themselves in active experimentation. (as cited in Motter-Hodgson, 1996, p. 2)

By observing students, teachers can begin to decipher the learning styles that are prominent in their class. David Kolb in association with Roger Fry developed four basic learning style categories which are converger, diverger, assimilator, and accommodator. They further realized that there are strengths and weaknesses associated with each learning style and that being locked into one style can put a learner at a disadvantage. (as cited in Smith, 2001, p. 3) Learners have a primary and a secondary learning style and to a lesser extent utilize other styles to complement their own learning. Tenant (as cited in Smith, 2001) points out that “the model provides an excellent framework for planning teaching and learning activities and is useful as a guide for understanding learning difficulties, vocational counseling, and academic advising” (p.11).

Gardner asserts that the theory of Multiple Intelligences (MI) can be used to describe individual learning styles. In 1966 while at Harvard University, Gardner became a part of Project Zero, which provided an environment for him to explore his interest in human cognition. A product of this project was the development of the theory of Multiple Intelligences. Gardner defines “intelligence as the ability to: 1. solve problems

that one encounters in real life (such as critical thinking in nursing); 2. generate new problems to solve (this occurs when the nurse assesses the patient's condition); 3. and, make something or offer service that is valued within one's culture, (nursing care is offered to all regardless of circumstances). (Silver et al, 2000, p. 7)

Gardner's Multiple Intelligences are listed here with implications for nursing in parenthesis: 1. Verbal-Linguistic (V) or the ability to manipulate words (nurses need good communication skills); 2. Logical-Mathematical (L) used for establishing cause and effect relationships (medication administration and intravenous therapy); 3. Spatial (S) or thinking in images (seeing the entire patient from head to toe with each assessment in order to determine condition changes); 4. Musical (M) which is the ability to produce music (using soothing music to calm an anxious patient); 5. Bodily-Kinesthetic (B) which relates to the manipulation of one's body (using proper body mechanics when rendering care); 6. Interpersonal (P) where one works with others (multiple layers of interactions in nursing); 7. Intrapersonal (I) for those who prefer to work alone (e.g., continuing one's education); and, 8. Naturalist (N) identifies those who are highly attuned to the natural world of plants and animals (working with the body; anatomy and physiology and knowing when it is ill). (Gardner, 2004, p. 5; Silver et al, 2000, p. 7) Gardner's theory assists researchers to think about how students learn in their own creative ways. This theory can also be used by nursing instructors to energize student learning and to assist the nurse to be more aware of how patients learn. This knowledge is then used to develop teaching aides for clinical use.

Mezirow is the author of transformational learning that "pertains to epistemic cognition...where learning is understood as the process of using a prior

interpretation to construe a new or revised interpretation of the meaning of one's experience as a guide to future action" (2002, p. 5). Transformational learning is a way to solve problems by defining or reframing them. This involves becoming more reflective and critical, being more open to the perspectives of others, and being less defensive and more accepting of new ideas. Mezirow's work supports Belenky et. al.'s (1986) recognition of the importance of connected knowing.

With the idea of the importance and benefit of connections in mind, the nursing profession could benefit from being more open to exploring how other disciplines apply teaching and learning theories in their respective educational settings. Mezirow (2002) states that "transformative learning can be an intensely threatening emotional experience in which the learner becomes aware of the assumptions underestimating ideas and those supporting emotional responses to the need for change" (p. 7). Students must be open to change in order to take advantage of transformation in their learning experiences. Students who refuse to change miss out on important learning opportunities that enrich their learning and their practice of nursing.

According to Mezirow "in fostering transformative learning efforts what counts is what the individual learner wants to know" (2002, p.31). In a classroom setting, the teacher and the student need to communicate what is important to each of them in the teaching and learning processes. The teacher of adults recognizes that learners are responsible for acquiring and enhancing their own understanding and skills. Therefore the role of the educator is one of; 1. helping learners focus on and examine the assumptions that underlie their beliefs, feelings, and actions; 2. assessing the consequences of the assumptions; 3. identifying and exploring alternative sets of assumptions; and, 4. treating

the validity of assumptions through effective use of reflective dialogue. This can be accomplished by having a verbal dialogue in the class where expectations are examined, assessed, determined to be valid, and finally acted upon. Students need to know firsthand what is needed for them to be successful in the learning process and individual adjustments require the consensus of both the instructor and the student (Mezirow, 2002, p. 31).

Teachers need to be aware of what is transpiring in their class. For instance, student behaviors in the classroom can indicate that they are having difficulty with the presentation of the content. For example, a visual learner might have difficulty in a class where the teacher lectures and does not make use of visual aids. In contrast, an auditory learner may have difficulty with commotion. Morse states that “women need more quiet during learning while men tend to be more visual, tactual, and kinesthetic” (1998, p. 44). In addition to setting up adequate pedagogical considerations, “instructors should be clinically competent, use effective evaluation strategies, be well prepared for teaching, explain concepts clearly, be approachable, and communicate clear explanations.” (Gignac-Caille, 2001, p. 352) Students need to have well-prepared role models if they are expected to be caring and culturally competent in the delivery of care.

Classroom environment

Song and Hill point out “that the context where learning takes place influences the level of learner autonomy that is allowed in the specific context” ((2007, p. 38). Therefore the learning environment can be either beneficial or detrimental to the teacher and the student, and may need adjustment for different classes. For example, for both men and women, aspects of learning styles may change according to age where the older student

may require brighter lighting or a different time schedule for class. Besides learning and teaching styles, teachers need to be aware of the preferred learning condition in the classroom. The placement of furniture, lighting, climate control, and sound are part of the physical environment that motivates student learning as well as their emotional state. Teachers also need to ascertain if students like to work alone or with others as part of the social setting. The physical needs of the students are also important for learning since sight, hearing, and mobility require necessary considerations in the learning environment. Since students and faculty spend extensive amounts of time in the nursing classroom the environment must be safe, uncluttered, clean, and conducive to learning.

Given that “the learning climate established by the teacher has a major impact on how well students are able to achieve (their) goal” (de Tornyay and Thompson, 1987, p. 166), it behooves the instructor to do all that is possible to maintain an atmosphere that fosters student growth. If students are happy in their educational setting they will be excited about the learning process. Furthermore, “...the classroom should be an exciting place, not boring.” (hooks, 1994, p. 7) Consequently teachers need to be aware of how they present course content and be vigilant as to what is transpiring in their class so that they can correct any negativity before it becomes rampant.

In addition, “the clinical instructor plays a key role in the development of professional nurses by providing an environment conducive to (safe) practice. The National League for Nursing has developed core competencies for nurse educators. The eight competencies are to:

- Facilitate Learning
- Facilitate Learner Development and Socialization

- Use Assessment and Evaluation Strategies
 - Participate in Curriculum Design and Evaluation of Program Outcomes
 - Function as a Change Agent and Leader
 - Pursue Continuous Quality Improvement in the Nurse Educator Role
 - Engage in Scholarship
 - Function within the Educational Environment
- (NLN, 2007)

To be a safe and effective teacher of nurses, faculty should encompass the above-mentioned competencies in their practice. “Therefore the instructor’s strategies for teaching are critical to developing this environment and fostering learning in the clinical area.” (Gignac-Caille, 2001, p. 347) Because students are culturally diverse and they encounter patients from different cultures, the instructor needs to make sure that no one is slighted and that cultural considerations of both students and patients are addressed. Students need to be familiar with the clinical setting they are studying in so that they can enrich their learning and render the best of care to their patients.

The impact of teaching care and culture has a profound effect on the students and the faculty. Because of this “the administrator of a caring-based nursing program directs all actions toward creating, maintaining, and supporting a caring environment in which knowledge of the discipline can be discovered” (Boykin, 1994, p. 7). If the administrator is not encouraging a caring-based environment and fostering the study of culture, the instructors will not be able to demonstrate care to the students who represent a multitude

of cultures. This negative attitude toward care and culture has a ripple effect which makes itself known in how the student cares for her peers and his patients.

Curriculum

The majority of nursing students today are adults who come with years of work experience and educational degrees. These students who are culturally diverse bring their learning habits and values into the new educational setting. Since these can pose a challenge for both the student and the instructor, it is necessary for a teacher of nursing to be familiar with how students learn and “to respond to the needs of culturally diverse” (Wilby, 2009, p.57). This knowledge should be incorporated in the instructor’s teaching plan which is intended to be used to assist the student in identifying learning styles. Oftentimes, the adult learner is unaware of how learning takes place and therefore, may be unable to change learning styles or to modify old ways of learning. An instructor who is knowledgeable in learning theory can thus identify and assist the student in these areas. This information will enable the student to perform more efficiently in the classroom and more confidently in the clinical setting.

“The theory and practice of nursing are vitally connected. Classroom and clinical learning experiences are about the knowledge and practice of nursing which are inseparable in the study and doing of nursing” (Boykin and Schoenhofer, 2001, p. 35). Theory and practice need to be integrated over the program and reflected in the curriculum which is the blueprint employed to teach nursing students. A carefully crafted blueprint allows the curriculum to flow in a way that benefits the student and ultimately the patient.

Effective curriculum content needs to address learning styles. For example in

developing effective curriculum, the following information is important to keep in mind: visual learners are linguistic and spatial and learn best through written language. They also tend to write down directions. To increase the learning of these students the teacher can employ graphs, charts, and handouts. Kinesthetic learners enjoy moving and touching while they are in class. They can best be assisted with their learning when teachers incorporate action-oriented activities such as movement, or manipulation. The laboratory setting allows students to move around as they are learning to perform nursing tasks and perfecting their clinical skills.

Curriculum developers working with Kolb's model would include strategies using the four learner types. The first is Concrete/Reflective, where the instructor motivates students who like explanations by asking "why" questions. Building in assignments that involve "why" questions is helpful for these learners. The second is Abstract/Reflective, where the curriculum material is presented in an organized, logical way that leads to mastery of These learners respond best to "what" questions. The third learning type is Abstract/Active, and addresses curriculum that incorporates getting to "how" questions. The instructor might set up the curriculum with carefully defined tasks, whereby students learn content and are challenged to work in small groups to learn together and in which basic clinical skills learning including giving and receiving feedback is involved. The fourth is the Concrete/Active learner who benefits from curriculum that includes "what if" questions and applies course material in new situations to solve problems (Conner, 2004b, p. 1). For this learner, the instructor can maximize opportunities that enable students to discover their unique characteristics and strengths in approaching and solving problems and expand their knowledge of cultural differences through exploring ways that

different cultures view situations and solve problems.

When incorporating Gardner's theory of Multiple Intelligences into curriculum design, teachers can incorporate student learning styles into content presentation, class activities, and out of class assignments by using a variety of different approaches that appeal to and engage students' multiple intelligences, e.g., use of creative writing and formal speaking for verbal linguistic learners, audiotapes for auditory learners, laboratory exercises, sculpture, and mind mapping exercises for students who prefer spatial intelligence and role playing for bodily kinesthetic learners. When dealing with the interpersonal intelligence planning group projects makes sense; on the other hand, building in thinking strategies and opportunities for personal reflection work better with intrapersonal intelligence. For the naturalist intelligence, laboratory experiments and field trips to observe application of theory in different patient settings are possibilities to build into curriculum planning.

Another component of the curriculum that instructors present is hidden from students. At times "the student is exposed to both an implicit curriculum of education and a hidden curriculum" (Jolley and Brykczynska, 1993, pp. 27-28, 61). This type of curriculum includes acquiring the accepted behaviors of the profession such as learning the skills of interpersonal interaction and becoming confident in handling new situations in a local hospital setting. Learning about the hidden agenda in the nursing curriculum can be a daunting feat for a student nurse who is trying to understand what it means to be a caregiver.

One example of an implicit curriculum can be seen in the caregiver model that evolved from the training school founded by Florence Nightingale where character and

obedience were emphasized throughout the curriculum, and care was viewed as a hands-on (rather than empathic) process in the delivery of physician's orders. This model reinforced the physician's demand that the nurse be obedient and selflessly devoted to both the doctors and the patient. As a result of this implicit curriculum, nurses were removed from decision making and placed in a subservient role. Put politely, "nursing became the discipline of caring and the physician was the professional responsible for curing which was seen as a much more valuable commodity" (Chipman, 1991, p. 171). To a limited extent, this differentiation is still seen in many of today's nursing educational and practice settings.

Nursing education and the processes used in teaching care and culture

The term "nurses' training", popular until the latter part of the twentieth century, has been replaced by the more professional idiom "nursing education". As previously stated this changeover occurred when the schools of nursing moved out of the hospital realm and into the college setting. Today, it is more common to teach nurses to think critically and to incorporate evidence based principles in their practice so that they can care for patients and inform the physician of any changes in the patient's condition. Nurses are also encouraged to be pro-active and to act as patient advocates. Nowadays, nurses work more cooperatively with the physicians and in some instances are being treated more like peers than handmaidens. These strides taken by nurses may seem to be enormous, yet the nurse continues to be less regarded than the physician (Gordon, 2005, p. 93-93).

In 1990 the National League for Nursing (NLN), the accrediting body for nursing programs in the United States, introduced a resolution that called for caring to be the core

value in schools of nursing curricula. The NLN also called for enhancing caring practices between faculty and students. However, this practice is only possible when the climate of the school is supportive of caring practices. Beck believes that “creating a caring environment in schools of nursing is critical not only for teaching nursing students how to care but also for developing cohesiveness among faculty and students” (2001, pp. 101, 108). Therefore, in order for student nurses to care for themselves as well as their patients, it is necessary that they experience caring from their instructors while they are in school.

Along with the act of caring, nursing students need to become of their own culture as well as those of their peers and the patients they care for. “One culture may not use care constructs (like touch) in the same way as another culture; (yet) as nurses become knowledgeable about these differences, they can use them in ways that are congruent with a client’s cultural values and life ways for more effective caregiving” (Leininger, 1988, p. 18). Also in 1993 the NLN called for curricula innovations that paid “special attention to the multicultural, multiracial and growing diversity of both individual and family lifestyles” (p. 12). Therefore, care and culture go hand in hand in nursing and must be taught and practiced in order to be beneficial for all concerned.

There are many innovative ways of teaching culture and care to student nurses, and much depends on how knowledgeable and sensitive the instructor is to culture, care and the pattern of interaction with students. The instructor needs to understand care and culture on a personal level before attempting to teach students how to care for patients of the non-dominant culture. By understanding one’s culture, one can then identify similarities and differences in other cultures. The same is true of how one cares for

others. It is imperative that one understands how to care before identifying how others care. Examining one's own biases and prejudices is necessary before understanding what care and culture mean to others. Consequently, one must look at where these biases are originating from and what impact they have had and have on one's life. Also it is necessary for one to identify if these behaviors can or should be changed and, if so, how to make positive adjustments that will lead to change that results in better patient care. Clearly adult learners need to be able to put aside their insecurities and prejudices in order to learn about culture and ways of caring.

“The goal of any health profession program...is to professionalize the human capacity to care through the acquisition of knowledge and the skills needed to fulfill prescribed professional roles” (Roach, 1987, p. 8). The study of culture enhances ones ability to care. For as Chipman eloquently stated, “caring in nursing is not just an emotion, concern, or benevolent desire; it is the moral ideal whereby the end is protection, enhancement, and preservation of human dignity” (1991, pp. 171-172). Preservation of human dignity is a tenet of care and is essential for the well being of the patient as well as that of the nurse. Isaacs indicates that “it is not so much about learning a different culture; it is more about how nurses come to keep an open-mind” (2010, 0. 19). This is not to say that nurses should not concern themselves with the study of culture; rather as Isaacs' point has to do with the importance of nurses' keeping open minds and being mindful of the patients as individuals, with all their uniqueness. Even the most educated and experienced nurse must remember to be present and remain unbiased when delivering care to patients so that all necessary information and communications take place toward accuracy in diagnosis and success in treatment In the

end, a successful nurse respects and addresses others' cultures without prejudice in caring for each patient, in teaching each student, and in working thoughtfully among colleagues.

Chapter III Methods

Statement of the problem and context for research

A qualitative study was undertaken to identify how baccalaureate student nurses who have not yet begun the clinical portion of their program perceive care and culture in American society. The information gathered from these nursing students was used to identify areas of care and culture requiring additional study in the education of nurses.

My interest in care and culture has evolved over many years as a result of my rich nursing experience which includes military nursing in critical care areas on three continents, clinical practice in an internationally recognized specialty hospital, and nursing education and administration in various nursing programs. The knowledge gathered from the various experiences across education and practice in the nursing profession led me to identify the fact that too often nurses are not adequately prepared to care for patients from different cultures.

In my quest to find answers to this contemporary problem I began a personal study of care and culture. This pursuit of knowledge brought me to the Transcultural Nursing Society and to the International Association of Human Caring which, in turn, gave me access to literature, seminars and classes in cutting-edge presentations on both culture and care. In studying culture, I was privileged fortunate enough to attend a transcultural nursing seminar in New York City where Madeleine Leininger a nurse anthropologist and the founder of transcultural nursing gave the keynote address on how important it is for nurses to deliver skilled care to culturally diverse patients. Later I attended a course on transcultural nursing at Kean University in New Jersey given by Larry Purnell, a renowned transcultural nurse researcher and educator, who affirmed the

same goal.

My study of care dates back to my entry-level nursing program at Catherine Labouré School of Nursing in Boston where one of my instructors was Sr. Simone Roach, a foremost authority on care. Later while I was pursuing a Master of Science in Nursing degree at the University of Massachusetts, Boston, my research partner and I replicated a study concerning caring interactions between students and faculty. Further studies in care involved courses at Boston College with Fr. John Shea and a recent seminar in Boston featuring Jean Watson, a prominent expert in care and nursing. Encountering these theorists on care and culture who speak to the importance of teaching nursing and medical professionals more specifically about care inspired me to explore the study of culture and care more deep. Consequently I developed the following investigation to learn student nurses' perceptions of care and culture toward learning about how care and culture can be taught more effectively in nursing programs. Information from the literature reviewed here and a response to Leininger's, Purnell's, and Watson's call for action on behalf of the profession and the patients it serves contextualized the problem addressed in this research.

Instrument development

In order to gather the information needed for this research, my doctoral committee and I decided that a qualitative questionnaire based on an extensive literature review of care, culture, and nursing education would be the best tool to utilize for a survey of nursing students. The committee members assisted me in narrowing the focus of the study and helped to refine the wording of the questions. Since the survey participants had not yet attended their first clinical nursing site and because of the possibility that some

subjects would possibly identify a language other than English as their primary language, the committee and I decided to use common everyday English terminology in phrasing the research questions.

The original number of 15 questions was reduced to 10 open-ended questions so that students would be able to give short answers and respond in their own voices. Since demographic information was also a necessary component for this study, a check off and direct style of questioning was used for this portion of the survey. The length of the survey was also considered because the researcher wanted to attract as many participants as possible to the instrumentation area without infringing on the students' free time. For that reason, a decision was made to make use of a two-sided sheet of paper that could be completed in 15 minutes or less.

In the demographics section of the survey, students were asked to identify the following: gender, age range, country of origin, date of arrival in the United States, ethnic background, nationality, primary language and other languages spoken, where they were educated, highest level of study, and whether they had prior nursing experience, what type of experience, and where this experience took place. Ten short answer questions followed. The first three asked the participants to define care, where and how they learned about care, who taught them care and how this person influenced them. The next three questions asked the surveyed to define culture, how they learned about culture, who taught them culture and how that individual influenced them. Questions seven through ten requested that the student nurses think about how they would respond in culturally sensitive situations involving patient care. Question seven asked them to describe what they thought nurses needed to know about care and culture in order to

perform their job. In question eight, the surveyed were requested to list some considerations that a nurse would make when determining the care of a patient from a different background than the caregiver. The next question asked the students where culture specific information could be obtained for a patient. The final query asked the participants to determine how a cultural conflict with a patient could be resolved.

Participants and data collection

The qualitative study was undertaken with a group of first year declared nursing students enrolled in a baccalaureate degree program at Curry College in Milton, Massachusetts. Internal Review Board (IRB) approval was obtained from both Lesley University and Curry College (See Appendices A and B). The survey was conducted in the spring of 2009 on a day when approximately 90 students would be on campus for their nursing uniform fittings. On the date in question, this researcher arrived at the nursing department and was instructed to proceed to the college's Nursing Resource Center (NRC) where the uniform fittings were taking place. The researcher was assigned a classroom suite next to the NRC. Leaflets inviting the above-mentioned students to participate in the survey were hung by the elevators and outside the uniform fitting area.

After their uniform fittings, students who wanted to participate in the survey were directed to report to the researcher's location. As students entered, they were introduced to the researcher who sat at a desk in the ante room. The purpose of the survey was explained and those who wished to participate were given a letter of introduction, an informed consent form to sign and the two-sided survey (See Appendices C, D and E). The students were advised that the researcher would be available to answer any of their questions. The participating nursing students next entered the adjoining classroom where

they were able to complete the survey in private. Upon completion the participants were directed to place their consent forms and surveys face down in a designated collection box. The researcher thanked the surveyed students and gave each of them a letter containing the researcher's contact information. Forty eight students approached the researcher and inquired about the survey. All 48 students took copies of the survey; however, only 45 completed it. The three other students who took a copy of the survey said that they would return it at a later time but they never did. Thus the participants who completed the survey represent approximately 50% of the nursing class.

Chapter IV Findings

A mixed method study incorporating quantitative and qualitative research was attempted. The demographic section of the project was quantifiable; however, the data were too skewed for statistical analysis. Consequently, the responses to the questions were analyzed qualitatively.

Demographics

The sample consisted of 45 declared nursing students who completed a two-sided form with demographic data and 10 short answer questions relating to care and culture. The majority of the students were female (41) while 4 were males. The age range was as follows: 38 females and 3 males were under 25 years of age, 2 females and 1 male were between 26 and 35 years of age, and 1 female was between 36 and 45 years old.

The country of origin for the majority of students was the United States (39). Other countries included 1 student each from Ireland, Romania and Haiti. Three students did not specify a country of origin. Fifteen ethnic backgrounds were identified, however, some students listed between 2 and 4 ethnicities. Seven subjects did not list an ethnic background while Caucasian was listed as a primary or secondary ethnicity by 12 of the participants. (See Figure1)

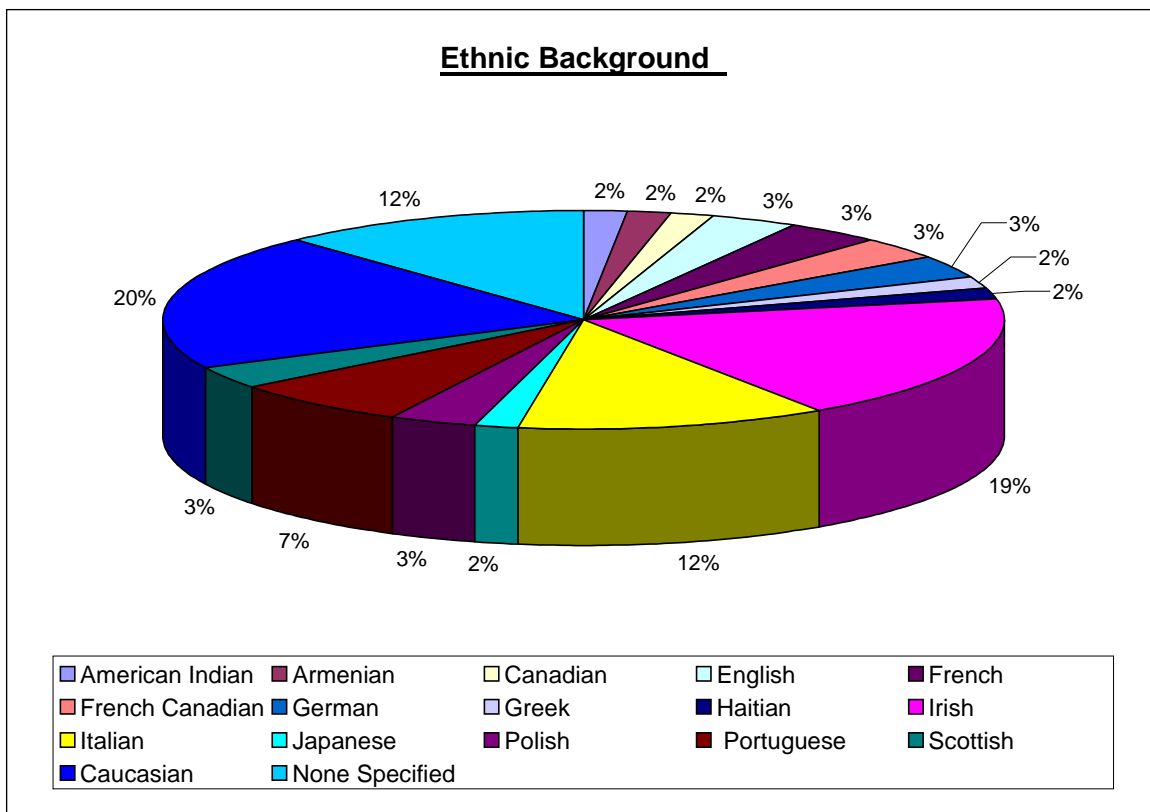


Figure 1. Ethnic backgrounds of participants

Fourteen different nationalities were identified with American (9) and Irish (9) comprising the majority. Three students listed 2 or 3 nationalities while 1 participant listed Black and 2 listed White. Of those surveyed, 17 did not answer the question.

The entire group spoke English and 1 respondent listed French and Haitian Creole as primary languages. Other languages spoken included Greek (1), Japanese (1), Portuguese (1), and Spanish (3). (See Table 1)

Table 1. Languages spoken besides English

Greek (1)
Haitian Creole (1)
Japanese (1)
Portuguese (1)
Spanish (3)

Only 1 student self-identified as being educated in Ireland while 4 stated they held a Bachelor's degree outside of nursing. Eleven of the surveyed specified having some nursing experience. The experiences comprised Certified Nursing Assistant (CNA) (6), and 1 each for ski patroller, student internship, and job shadow. The 6 CNAs worked in hospital and nursing home settings.

The 10 qualitative questions were examined and analyzed for recurring themes. The questions were then separated and categorized according to care, culture, what nurses need to know in their job, considerations to be mindful of when caring for patients of a different culture, obtaining culture specific information for a patient, and how to resolve a conflict with a patient of a different culture. The findings for each question follow.

Questions

Question 1. What is your definition of care?

Defining care took on various formats from helping, comforting and respecting others to empathy, love and compassion. Taking care of the patient both physically (12) and emotionally (16) was deemed important for the surveyed students. The physical element of care was referred to by such answers as helping someone achieve wellness, making the person feel better, doing whatever it takes to make a patient comfortable, and making sure they were well treated. Respect, being considerate, and courteous were specified as important elements in caring. On a more profound level, compassion, love, being there for someone, nurturing, and empathy were brought forth thus revealing a deeper understanding of what is considered to be care. As one respondent stated, "care is being there for someone else". (See Table 2) for the responses, followed by number of participants who wrote the response.

Table 2. Participants' responses to definition of care

Helping someone get better (18)
Emotional support (1)
Love and respect for another person (5)
Attending to someone (4)
Providing empathy (1)
Emotionally and physically improve someone's state (1)
Directing your abilities to another individual (1)
Taking care of someone (4)
Make a person feel comfortable (12)
Having the heart to help someone (1)
Do what is best for the well-being of the patient (1)
Showing affection (1)
Providing someone with what they need (2)
Assist anyone in need in a comforting manner (1)
Being considerate of others (1)
Being courteous (1)
Better an individual's quality of life (1)
An emotional attachment to someone (1)
Treating people well (1)
Giving someone the time and effort to make them feel better (1)
Helping people in healthy ways (1)
Compassion (1)
Understanding (1)
Ensuring the patient is free of pain and safe (10)
Taking care of people to the best of your ability (1)
Concern (1)
Having sympathy for someone (1)
Being there for someone else (1)

Care was further identified as being an emotion (12) or function (18). Function comprised the physical tasks done by nurses when giving care to patients. These tasks included helping, comfort, attention and concern. Emotion was the act of love, empathy, compassion, and emotional attachment. Affection, consideration, courtesy, respect, and being there overlapped both categories. (See Figure 2 and Table 3)

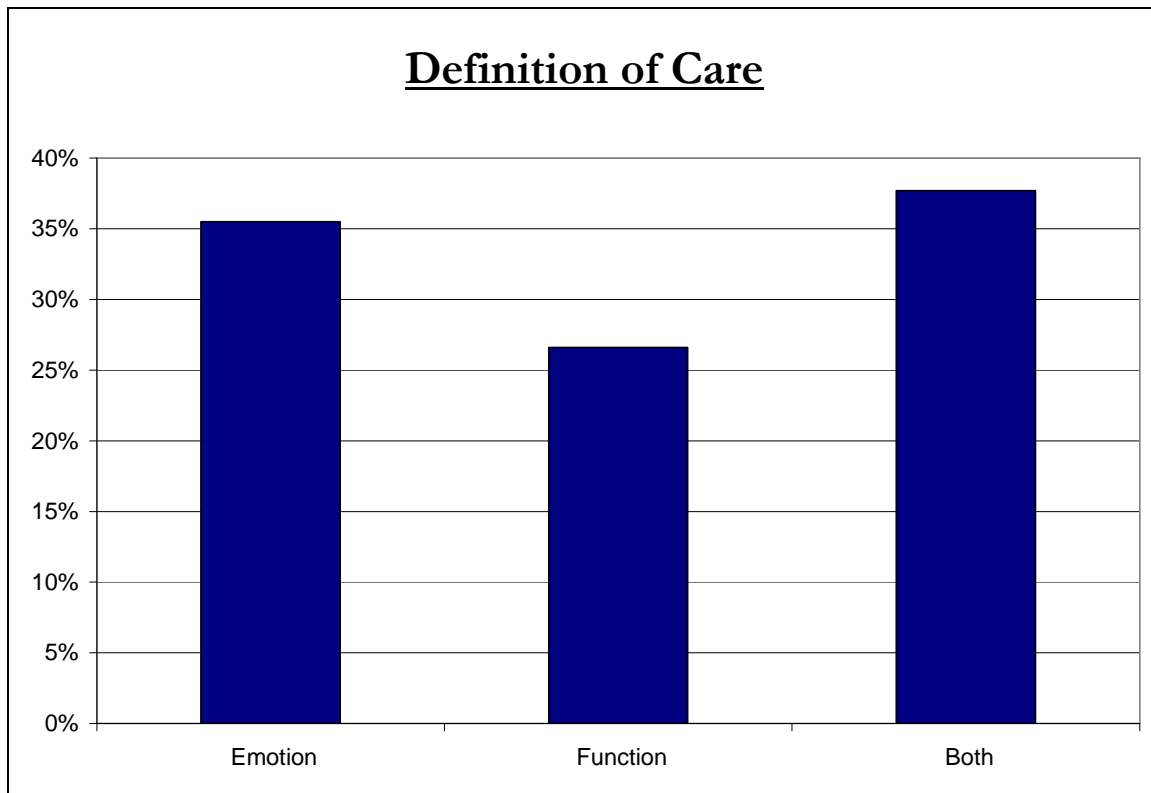


Figure 2. Participants' definition of care

Table 3. Participants' definitions of care by category

Physical Care	<ul style="list-style-type: none"> ❖ Helping ❖ Comfort ❖ Attention ❖ Concern
Emotional Care	<ul style="list-style-type: none"> ❖ Love ❖ Empathy ❖ Emotional Attachment ❖ Compassion
Both Emotional and Physical Care	<ul style="list-style-type: none"> ❖ Affection ❖ Consideration ❖ Courtesy ❖ Respect ❖ Being There

Question 2. Where and how did you learn about care?

The surveyed students stated that they learned care at home, in school, and

through life experiences. Twenty eight of the surveyed identified parents and other family members such as grandparents, aunts and uncles as the people most instrumental in assisting them to learn about care. Teachers, friends and nurses (1 each) provided influence in learning about care. One's life experiences (7) were also included as a way for learning about care.

Question 3. Who taught you about care and how did that individual influence you?

The students' definitions for care included beliefs, background, traditions, identity, values, heritage, shared thoughts and actions, and views on the world. As in the previous response, the students indicated that they were taught care at home by their parents (38) especially their mothers. Yet again, teachers (1) and other people (3) were identified as the outside influence in how care was taught.

Question 4. What is your definition of culture?

The definition of culture involved heritage, beliefs, traditions, values, morals, code of ethics, language, and food. When answering the question reference was made to not only the heritage, beliefs and traditions of other cultures but also to those of the students responding to the survey. Food and family stories were indicated as a means of continuing family heritage and traditions. Combination (30) responses included morals, values and the code of ethics of a society were applied to groups of people sharing the same thoughts, ideas, actions, behaviors, and culture. These shared beliefs and ideas were also were part of the group's way of life and views on the world. One student mentioned that culture was "the piece of identity that defines who you are".

Table 4 includes responses followed by the number of participants who chose that response. Table 5 shows responses by category.

Table 4. Participants' definition of culture

Beliefs (8)
Background (12)
Traditions (11)
Ways people live by (1)
Practices of society (5)
Identity (1)
Code of ethics (1)
Way of living based on morals (1)
Views of the world (1)
Customs (1)
One's place of origin (1)
Norms (3)
Behaviors (1)
Shared ideas and practices of a group (1)
Thoughts and actions (2)
Heritage (3)
Language (3)
Religion (1)

Table 5. Participants' responses to definition of culture

Heritage	<ul style="list-style-type: none"> ❖ Background ❖ Traditions ❖ Place of Origin ❖ Values
Beliefs	<ul style="list-style-type: none"> ❖ Views of the world ❖ Behaviors ❖ Norms ❖ Ways people live by
Both Heritage and Belief	<ul style="list-style-type: none"> ❖ Identity ❖ Practices of Society ❖ Shared Ideas ❖ Ideas and beliefs by a group ❖ Peoples' thoughts and actions

Question 5. Where and how did you learn about culture?

The students stated that culture was learned at home (11), by teachers in school (19), and through life experiences (5). Traveling (1), television (2), and family traditions (1) were also identified as a way of learning about culture. (See Figure 3)

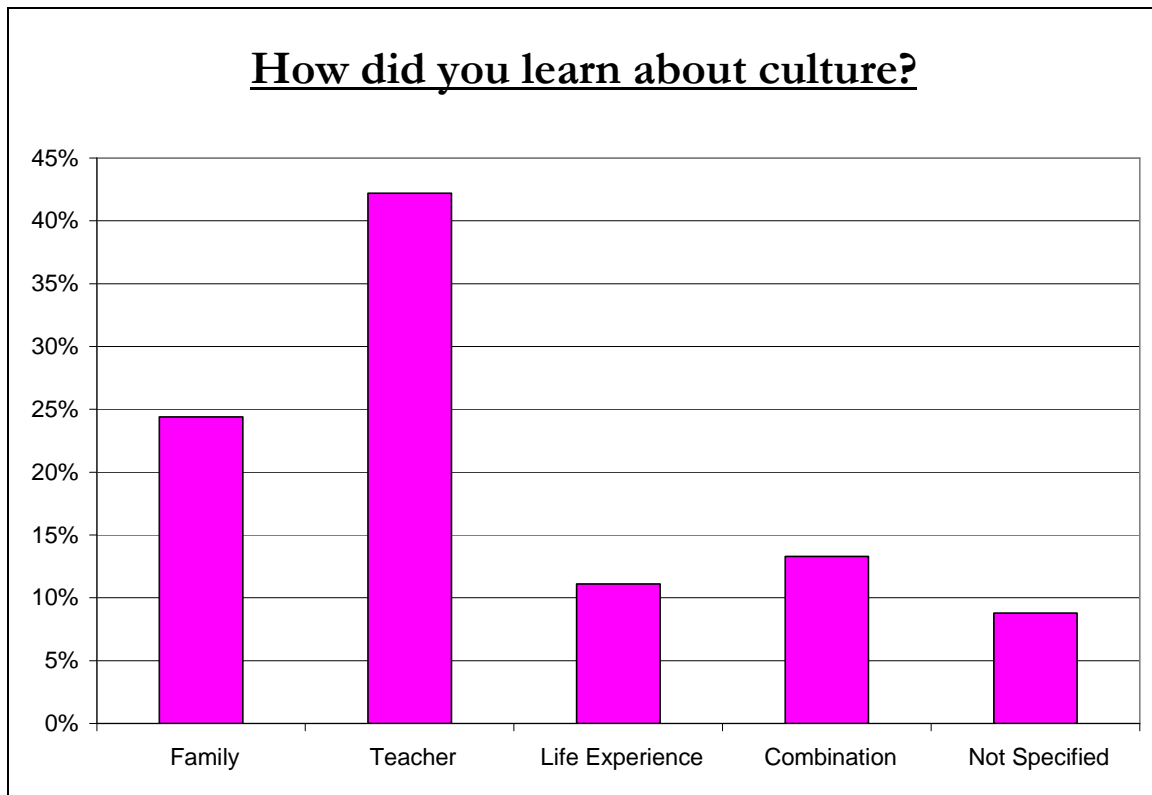


Figure 3. How participants learned about culture

Question 6. Who taught you about culture and how did that individual influence you?

Again as with care, students indicated that they were taught about culture by their parents (9) and teachers (11). Life experiences, friends of other ethnic cultures and travel were also cited by 1 student each.

Question 7. What do nurses need to know about care and culture in order to perform their job?

Many tasks were listed for nurses to know in order to perform their jobs effectively. The responsibilities mentioned were basically procedures and treatments that nurses do routinely when caring for patients. Included tasks were safety, caring, comfort, gentleness, and giving treatments that are appropriate. Students also addressed the issue of being non-judgmental, accepting and being sensitive to other cultures when caring for patients. Being aware of the patient's culture, race and religion were indicated

as being helpful to the nurse in providing culture sensitive care. What's more, the surveyed mentioned that people care differently, each person is unique, and everyone needs to be cared for and treated individually (1 each). In addition nurses needed to respect the patient's culture by having knowledge of that culture. When planning care the following elements such as beliefs and wishes were included. Table 6 lists the responses, followed by the number of participants who wrote that response.

Table 6. Participants' perceptions of what nurses need to know in order to do their job

People care differently (2)
Understand and relate to patients (4)
Accept each individual in order to provide care (1)
How people like to be treated (1)
Make people feel safe and comfortable (2)
Nurses need to know that their job is to care and not judge (4)
Unbiased opinion (2)
Understand a patient's culture (1)
Each person is unique and has a different background (1)
Relate to the patient's culture (1)
Sensitivity (3)
Sympathy (1)
Care is equal for every patient (1)
Be open-minded (2)
People have strong beliefs (1)
Consideration (1)
Respect differences (1)
Everyone needs to be cared for (1)
Be gentle and heart warming (2)
Do everything necessary to help others (1)
Do not violate cultural beliefs and wishes (1)

Question 8. What are some considerations you as a nurse would make when determining the care of someone whose ethnic background is different from yours?

Participants wrote a range of responses. The following were included: respect is of importance when considering the care of a patient from another culture, the nurse must consider that the patient's values, beliefs, and language may differ from those of the dominant culture, the patient's religion, likes and dislikes, limitations, use of medicine

and personal needs should be regarded when planning how care will be delivered. Being considerate, open-minded, and treating everyone as an individual were again noted in the responses. Also cited was the fact that the patient is relying on the nurse for care and wants to be treated in the same manner as someone from the dominant culture. The responses are listed in Table 7, followed by the number of participants who wrote that response.

Table 7. Participants' considerations for nursing

Do what they want (4)
Ask the patient about cultural traditions (1)
Get to know the patient's likes (1)
Understanding (1)
Respect (6)
Values may be different (1)
Ask questions (1)
Try to relate to the patient's culture (1)
Consideration (2)
Open-minded (1)
Know the patient's limitations (1)
Language (2)
Be unbiased (1)
Religion (2)
Treat everyone equally (4)
Provide proficient care (1)
Beliefs (5)
Study and research (2)
Make the patient comfortable (5)
Treat them as individuals (2)
Be mindful that everyone needs care (1)
Make sure that the patient understands (1)

Nursing considerations in patient care were also categorized as being patient centered, nurse centered and both. (See Table 8)

Table 8. Nursing considerations in patient care

Patient Centered	<ul style="list-style-type: none"> ❖ Do what the patient wants ❖ Get to know the patient's likes ❖ Know the patient's limitations ❖ Make them feel comfortable ❖ Treat them as individuals
Nurse Centered	<ul style="list-style-type: none"> ❖ Be understanding ❖ Patient's values may be different ❖ Ask questions ❖ Be open minded ❖ Study and research ❖ Try to relate to the patient's culture
Both Patient and Nurse Centered	<ul style="list-style-type: none"> ❖ Ask the patient about their cultural traditions ❖ Be considerate ❖ Provide proficient care ❖ Language ❖ Religion ❖ Respect ❖ Treat everyone equally

Question 9. How would you obtain culture specific information for your patient?

Obtaining culture specific information incorporated numerous suggestions such as asking the patient and the family, consulting with staff members who have cared for the patient, reading the medical records, listening to the patient, doing research, and forming a relationship with the patient. Other responses included learning about the culture, doing research, and utilizing the internet. The responses are listed in Table 9, followed by the number of participants who wrote the response while Table 10 shows the ways the respondents anticipate gaining information.

Table 9. Participants' suggestions for obtaining cultural specific information

Ask the patient (32)
Ask the family (9)
Internet (10)
Research (7)
Ask others (4)
Inquire about cultural preferences (2)
Check the patient's chart (8)
Speak with people who have cared for the patient (2)
Speak with people of the same culture (1)
Listen to the patient (2)
Read (1)
Learn the culture (1)
Become personal with the patient (1)
Form a relationship with the patient(1)
Write down information (2)

Table 10. Categorical results for participants' suggested ways of obtaining cultural specific information

Task Oriented	<ul style="list-style-type: none"> ❖ Check the patient's chart ❖ Listen to the patient ❖ Read ❖ Write down information
Conversation Oriented	<ul style="list-style-type: none"> ❖ Ask the patient ❖ Ask the Family ❖ Ask others ❖ Inquire about cultural preferences ❖ Speak with others who have cared for the patient ❖ Speak with someone of the same culture
Both Task Oriented and Conversation Oriented	<ul style="list-style-type: none"> ❖ Internet ❖ Research ❖ Learn the culture

Question 10 How would you resolve a cultural conflict when caring for your patient?

Participants stated that they would resolve a cultural conflict, by communicating with the patient and the patient's family, employing respect doing what patient wants, and utilizing compromise. Knowing the culture and why there may be a conflict was

thought to be helpful. One respondent out of 45 wanted the physician to speak to the patient while another would employ the services of an interpreter to help with the resolution of a conflict. The responses are listed in Table 11, followed by the number of participants who wrote the response.

Table 11. Participants' suggestions for resolving conflict with a patient

Do what the patient wants (2)
Make the patient happy (1)
Serve them (1)
Respect their thoughts, beliefs, and needs (2)
Put the patient first (1)
Speak to the patient (4)
Accommodate their differences (1)
Know the patient's culture (1)
Ask the patient why there is a conflict (1)
Explain possible resolutions (1)
Listen to the patient (1)
Find an alternative plan (1)
Respect the patient's wishes (2)
Find the problem and correct it (1)
Apologize (1)
Do what is culturally appropriate (1)
Do what is best for the patient (1)
Try to understand the patient's point of view (1)
Make the patient feel comfortable (5)
Respect their culture (1)
Compromise (1)
Have an interpreter (1)
Be open-minded (1)
Remember that the patient is important (1)
Learn about their culture (1)
Incorporate the patient's cultural beliefs in the care plan (1)
Put cultural differences aside (1)
Communication (1)
Try to agree (1)
Explain to the patient that the treatment will help get better (1)
Have the doctor speak with the patient (1)

Themes

Various themes emerged from the responses provided by the sample group. For the question defining care, the themes of emotion and function were identified. Emotion (16) was recognized as love, support, and compassion while function (12) was indicated as comfort, helping others, ensuring patient safety, and taking care of people. As far as where the sample group learned about care, the themes that appeared were life experience (7) education (1) or another person (28). Eight students stated that they learned care from two sources while one student did not answer the question. The question on who taught them care the surveyed recognized family members (38), teachers (1) and other people (3) as instrumental in this area. Three students indicated that a combination of people were involved in teaching them about care. (See Figure 4)

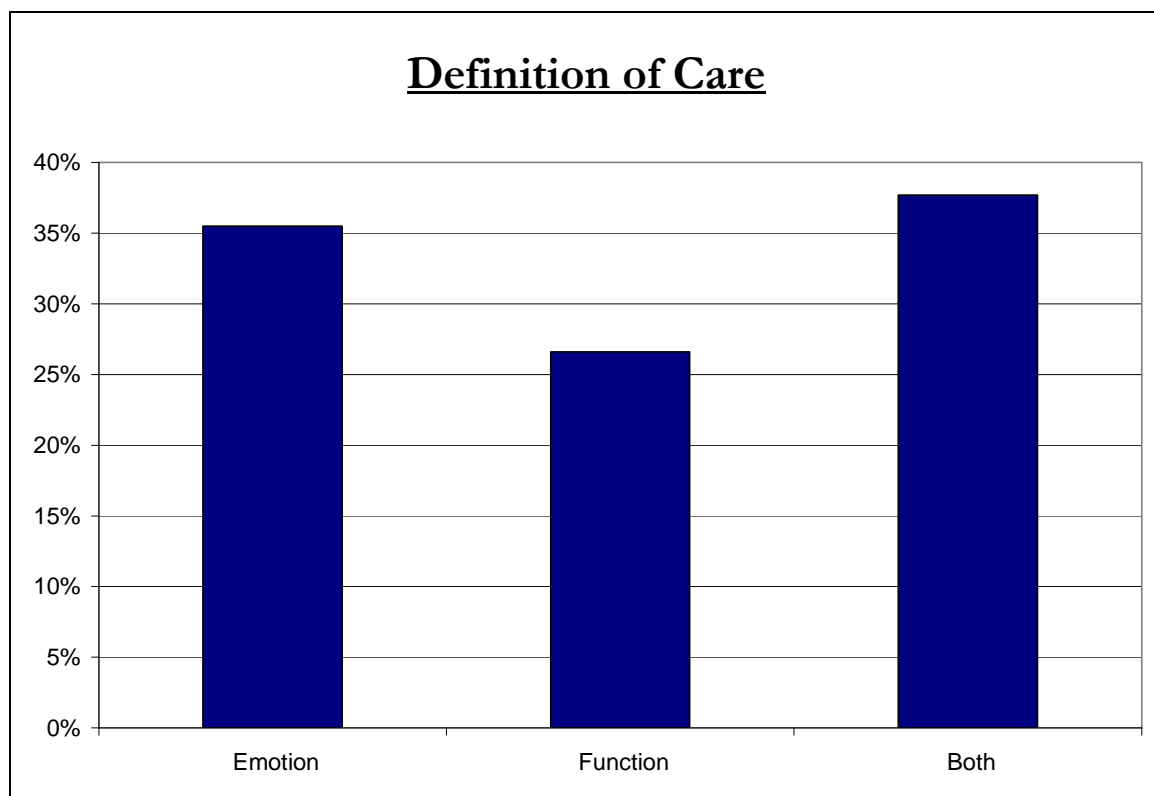


Figure 4. Definition of care

Beliefs, traditions, and background were the themes identified for the definition of culture. Thirty of respondents gave a combination of beliefs, traditions, and background for their definition of culture. Four students did not answer the question. The question regarding where the surveyed students learned about culture indicated family, teachers and life experience as influential in this area. A combination of these responses was identified by numerous students. Four students did not answer this question. Parents and teachers were among those who taught culture to the sampled students. A combination of parents, teachers and other people were also listed. Six respondents did not answer the question.

According to those surveyed, nurses need to be respectful and patient centered and recognize the patient's cultural traditions when caring for patients. Patient considerations were identified as patient focused (12) or other (33) focused. When it came to obtaining culture specific information for patients, the respondents listed asking the patient, talking with the family, referring to other sources such as books or other people, and using the internet. For the resolution of a cultural conflict the respondents were patient focused, nurse focused, and other focused. Seven of the surveyed did not answer the question.

In addition to the above responses, 36 students employed the word care in their answers and 40 indicated the term culture in their responses. The use of the term family relevance was included by 11 of the surveyed students. Overall, the survey responses were found to be patient focused (26), nurse focused (9) while no one mentioned family focus in their answers. (See Table 12)

Table 12. Themes of definition of care

Physical Care	<ul style="list-style-type: none"> ❖ Helping ❖ Comfort ❖ Attention ❖ Concern
Emotional Care	<ul style="list-style-type: none"> ❖ Love ❖ Empathy ❖ Emotional Attachment ❖ Compassion
Both Emotional and Physical Care	<ul style="list-style-type: none"> ❖ Affection ❖ Consideration ❖ Courtesy ❖ Respect ❖ Being There

Chapter V Discussion

This chapter presents an overview and analysis of the findings of the research study. The presentation is based on the results as reported in Chapter IV, Findings, and draws comparisons between the results and the literature presented in Chapter II. This chapter also includes limitations of the study and implications for future research, nursing education and curriculum development, and nursing practice.

Discussion, analysis and interpretation of findings

The general finding of this study points to the need for improving the education of student nurses prior to placing them in clinical settings so that they enter the “direct-care arena” with a greater understanding about the essential relationship of care and culture and the importance of recognizing patients’ language and cultural considerations in all aspects of nursing practice.

Demographics

The sample was made up of 41 female and 4 male respondents who are nursing students in a small, private New England college. The disproportionate sample of females who responded to the survey corresponds with the fact that nursing continues to be a female dominated profession. The inclusion of four male respondents was considered important in collection of data for this study for it assisted the researcher in comparing the variables between both sexes. Males as well as females were concerned about care and culture and gave similar definitions for these terms. The family influence especially from the mother was evident in how the surveyed learned and were taught about care and culture. What nurses needed to know and what considerations they needed to employ when caring for patients was also comparable between females and males. Similarly,

obtaining information and resolving a conflict showed little differences in response.

Thus, the findings of this study indicate that both males and females who enter nursing appear to share common background characteristics and perceptions.

Care and caring

Students frequently confused the phenomenon of care with the action of caring. Care is a profound experience involved in improving someone's life and involves putting another person before oneself. This unselfish act does not require anything in return. On the other hand, "caring involves the activities directed towards assisting a person" (Leininger and McFarland, 2003, p.47). Included in caring were the show of affection, love, and being considerate of another. These activities were identified as a way of caring for a patient by providing comfort. One student replied that care came from unconditional love; while another respondent stated that caring is one of the stronger gifts a person can have and involves being there for someone else. These definitions of care are profound and involve love and caring, the basis for empathy. The physical context of providing care was an important element for some of these students as they defined the term functionally, including provision of safety, nutrition, and assistance with ambulation.

Respect

Many of the respondents identified respect as a right of every person. Approximately one third also indicated that nurses should recognize and respect a patient's beliefs, values, religion, language, and customs with an open mind. A few referred to treating others as one would want to be treated and pointed this out as a basis for respect. Other students were concerned with being sensitive and not offending the

patient and the patient's culture and that being non-judgmental was a way of showing respect for others. Only a minority indicated realization that treating patients with respect, regardless of their cultural heritage or practices, is intertwined with care.

Comfort

Providing comfort was seen as an important element when administering patient care. The activities of bathing, bed making, nutrition, and ambulation were identified as important elements in providing the basic elements of comfort and safety. However, what makes these activities important in caring is the manner in which the duties are carried out by the nurse. The nurse's demeanor sets the tone for how comfort and therefore care are to be delivered to the patient. The demands on nurses to attend to the needs of multiple patients make it more challenging to attend to their personal needs; especially when rushed and feeling under pressure, student nurses may forget that the patient needs attention to language and communication in order for nursing to be effective.

Doing what the patient wants

Doing what the patient wants may not be in the patient's best interest. For instance, the patient might be requesting to smoke inside the hospital or to have an intravenous which is necessary for fluid intake or medication administration removed. In this scenario, the nurse would need to explain that smoking is not allowed in hospitals because of safety concerns for patients, visitors and staff. The continuation of the intravenous solution might be considered a nuisance by the patient; however, with the proper explanation from the nurse, the patient may understand more fully both the purpose and the importance of administering the intravenous solution and thus come to realize that the inconvenience is necessary. Nurses need to be cognizant of the fact that

what the patient requests might be a detriment in the healing process.

Culture

Asking the patient or family about culturally specific preferences is necessary in order for the nurse to plan appropriate care for the patient. Although asking is an important beginning, it is not enough particularly if there is a conflict in the belief systems. This simple act shows that the nurse respects and is sensitive to the patient's needs and culture and is willing to incorporate the patient's cultural preferences in the plan of care whenever possible. However, unless the nurse is culturally competent he/she may not include or understand the patient's preferences. Culture is an essential part of one's identity so it is important for student nurses to be open-minded and non-judgmental. While some students identified an understanding of culture, e.g., as the ideas and values collectively believed by a group of individuals and spoke of accepting people for who they are even if different from one's self, the fact is that many of the respondents did not do so and, furthermore, did not relate culture to the provision of care.

Ethnicity, race and nationality

The terms race, ethnicity and nationality were used interchangeably by the surveyed students. According to Purnell and Paulanka (1998, p.3) and Leininger and McFarland (2002, p. 49), ethnicity refers to a group of people who share a common background based on national origin while race and nationality are the primary characteristics of how people view their culture. Although race refers to color of skin, nationality refers to national origin. Hall speaks to the issue of cultural variables (1990, p. 3). These variables are related to culture differences but they are not how culture is defined. When caring for a patient it is important that the nurse not pre-judge the

customs, characteristics, and values of the patient. For in so doing the nurse is imposing the biases and prejudices of the dominant culture on the patient. Only a handful of student nurses indicated this understanding and drew a connection that the actions by the nurse that are unfamiliar or unacceptable to a patient's culture can lead to distrust and, consequently impede nursing care

Language

Knowing what languages a patient speaks is essential to the nurse. It is extremely important that the patient understand what the nurse and medical staff are saying, what the treatment plan incorporates, and how the patient will manage the treatment protocol and promote wellness at home. Narayan states that "difficulties stemming from words' nuances are magnified when the patient's primary language is different from the nurse's" (2010, p. 41). This emphasizes the fact that when a patient does not speak English, a licensed interpreter is needed. An interpreter is someone who has a degree of dual language proficiency in both the languages spoken by the patient and the nurse. A competent interpreter can assist the staff in conveying this important information to the patient and family. Using family members as interpreters is helpful in certain minor situations such as what foods the patient likes to eat and inquiring about the use of the bathroom; but any discussion of the patient's medical history and treatment procedures should be done with the use of a qualified medical interpreter.

According to the Civil Rights Act of 1964, persons with Limited English Proficiency (LEP) are entitled to receive the services of a qualified medical interpreter (Partridge and Proano, 2010, p.77) The medical interpreter is a person who has received training in medical terminology and is thus able to convey specific information about the

patient's condition and treatment with accuracy and sufficient detail that the patient and family can listen and ask questions to gain understanding about what is involved in the patient's situation.

Additionally, it is important to honor the patient's rights. It is imperative for nursing students to learn upfront that if they ask a family member to perform the task of interpretation, the nurse is violating the patient's privacy. Under no circumstances should any duty of interpretation be performed by a child, not only because of developmental considerations but also since this activity can be ultra sensitive or embarrassing for both the child and the adult and impose a burden on both parties.

Information

Many ways of obtaining information were identified by the respondents; asking the patient and the family were foremost. However, it was a shock to realize that the complexity of communicating with a patient who does not speak English was not addressed by the respondents. Only one student responded that it was important to seek an interpreter!

Responses to how student nurses would learn about cultural factors varies, showing that a filtering process for information accuracy is needed. Responses showed logic, e.g., speaking to someone of the same culture as the patient, asking assistance from another staff member who has cared for the patient, and reading books and journals as valued sources for the obtaining of information pertaining to the patient care. Other responses raise concern, as the use of the internet was selected by ten of the respondents. While general information about a particular culture or cultural practices may be available on the internet, the practice of drawing conclusions based on downloading

information can be both helpful and harmful. Caution must be taken when using the internet since inappropriate/inaccurate information can be accessed. The use of an embassy web site for a specific country can be helpful since the site will provide an historical perspective and cultural background of the particular country. However, information on health care practices might be lacking. One student mentioned cultural immersion as a way of learning about a culture. This notion is admirable but is not advantageous when the required information is needed immediately. Few mentioned the need to learn about cultures most represented in the area in which the nurse works.

Patient Needs and Considerations

Some of the traits identified by the surveyed students as necessary for nurses to know include acceptance, showing respect, being sensitive to the patient's culture, and being open-minded. Respect is a resounding attribute for these respondents because if a nurse can respect a patient, the patient may feel more comfortable with the care being tended. Accepting the patient's culture is also a show of respect for the patient, while being sensitive to the patient's needs is a way of providing comfort and safety to the patient. Again, it is important to note that approximately half of the students did not indicate a relationship between culture and nursing practice, and only one acknowledged the importance of seeking an interpreter for patient communication.

Conflict resolution

Reaching a compromise with a patient was mentioned as a way to help resolve a conflict. The amount or the type of compromise was not mentioned and neither was how compromising is beneficial to the patient. Speaking nicely was one method identified as a way to help resolve a conflict because the tone of the nurse's voice can help diffuse the

patient's anger. Asking for help was deemed appropriate to lessen a serious conflict for it provided for the safety of both the patient and the nurse. The goal is to provide a culturally responsive resolution to the conflict.

Intercultural communication appeared to be important when dealing with a conflict and the use of a person of the same culture was mentioned as a means of assisting in the resolution of a conflict. The use of an interpreter was recognized by one student as an asset in conflict resolution. The interpreter could assist by asking the patient what caused the conflict and what is needed to help resolve the incident because the patient may not know how to resolve the conflict. Since it is possible that a conflict has arisen because of misunderstanding the role of the interpreter may be critical in the process of resolution toward attending to the patient's needs. To quote Flores, "the provision of adequate language services results in optimal communication, patient satisfaction, outcomes, resource use, and patient safety" (2006, p. 2).

The use of feedback was noted by one student as a solution in conflict resolution. As important as feedback is, nonessential points should be presented in debriefing after the incident is over. While debriefing, comments about what happened and how the situation could have been managed differently are important feedback, the priority for student nurses, and all nurses, is accuracy of information to promote patient understanding.

Naiveté was shown by two students who suggested that conflict resolution would not be necessary since there would be no conflict to resolve. Another student insisted on having the physician speak to the patient about a conflict. In this act, the nurse defers to the physician by removing him/herself from the obligation of assisting the patient through

a difficult situation. This type of performance does little to promote nursing autonomy in patient care (Stokowski, 2010, p.2). Still another student suggested telling the patient that the treatment being suggested would be beneficial. Nursing students need to learn that this statement could be misunderstood during a conflict to mean that the dominant culture decides the treatment modality and that the patient has to go along with the decision. In essence, this takes away the patient's right to decide how care and treatment are to be rendered, accepted and carried out after hospital discharge.

Furthermore, it is not enough to say that learning a patient's culture is helpful in patient care; in fact it is essential for nurses and other healthcare professionals to be knowledgeable about culturally specific differences that may negatively impact care.

Patient-centered focus in contrast to nurse-centered focus

Most student responses indicated that the patient is the primary focal point in nursing practice, and that focusing on the patient is the essence of care. In fact for nurses, the patient is the most important entity in the hospital and nurses must do what is proper, appropriate, and culturally sensitive when caring for the patient.

Some of the surveyed appeared more nurse-focused than patient-focused when answering the researcher's questions. Although the nurse is important, what the nurse does or does not do for the patient has a deep impact on how the patient perceives the care being received. While the profession of nursing requires informed, aware, and grounded practitioners, student nurses need to understand that their preparedness, self-understanding, and emotional maturity are expected in order that they can concentrate on the needs of the patient.

Limitations

The limitations of the study included: the use of a young group of students for the survey, a limited number of male respondents, and a small cultural diverse population. Unlike the community college setting where the average student is older and has prior work experience, the baccalaureate college student is for the most part a recent high school graduate with little to no work experience. Also, the diversity in the community or state college nursing programs is higher since these programs are perceived to be more affordable and to have higher admission rates than non public institutions.

Another drawback was with the instrument itself. The use of a two-sided sheet of paper may have contributed to the fact that four of the forty five students did not answer the questions on the reverse side. The use of clearer instructions could possibly have prevented this situation.

The researcher was able to capture 45 out of 90 possible candidates for the survey. Also a larger number of students may have completed the form if they had learned about the project prior to the day of the uniform fittings.

Implications

Gathering information from the surveyed respondents indicated to the researcher that student nurses have a narrow field from which to gather information on care and culture and as an extension, how to implement culture-sensitive care to patients in the healthcare setting. As stated earlier, most students learned about and were taught care and culture at home or in school. Home provides the foundation for life and this narrow lens lends itself to imposing biases and prejudices, marginalizing those who are not like the dominant culture, and excluding those who do not “fit” into the dominant world view.

Educators and schools/educational institutions were listed as contributors for the teaching and learning of care and culture. However, one needs to examine the type of school attended by the surveyed student to ascertain what influence this may have had on the student. It's good to keep in mind that a large inner city school is more diversified than a small town or private school. What is perhaps more relevant is that many people grow up attending school only with people of their own ethnic background, nationality and religion. This type of environment also limits exposure to other cultures and may lead students to bring in biases unwittingly that need to be addressed.

Learning about care and cultural differences from books, videos, travel, and television, can be very subjective, because the author or the books and the media representatives of the videos and television programs more than likely incorporate their own biases into their works. Travel, on the other hand, exposes one to different cultures and traditions. Yet again one must be cognizant of the fact that tourists might not be introduced to the citizens of the area being visited and that often tours are staged for tourists. Additionally, travel costs money and takes time, and individuals and families may not have discretionary income to support it as a priority to take off from work or family responsibilities.

The surveyed students made a noteworthy attempt at identifying what nurses need to know in order to perform their job and what considerations they need to be mindful of when giving care to persons of a different culture. Some of the caring aspects the students mentioned were basic tasks performed by nurses routinely. Getting to a deeper level of what care really is may not be possible for a student or beginning nurse since care is a profound phenomenon that might only be understood through experience.

Understanding culture in-depth might not be achieved on the undergraduate level; therefore, further study is required. Being sensitized to another culture by immersion is the ideal method of learning about persons of diversity. While it is not possible to learn about each culture that one encounters, it is feasible to learn about the major cultures of the community in which the nurse lives and practices. One way for nursing students to gain knowledge of care and culture is through special courses dealing with these subject matters. This learning process can begin at the baccalaureate level and continue through graduate school and through professional development on the hospital sites, by attending classes and seminars given by qualified instructors, preferably with first person knowledge of the language and culture. However, it would be more advantageous for colleges of nursing to include a transcultural component in the first and second year of the liberal arts portion of the curriculum. This course should be taught prior to the student entering the clinical nursing courses.

Internet usage was noted as a good way for obtaining culture specific information. Because a wealth of data can be found on the internet, one needs to be mindful that not everything one reads on the internet is accurate. In addition to the suggestions of using an embassy site's services, it is important for nursing education programs to look at the curriculum. Precise information pertaining to the care of a culturally diverse population would be found in articles and books that specialize in transcultural nursing. Students will benefit from learning the transcultural models designed by Leininger, Purnell, and Giger and Davidhizar.

After reviewing the findings and realizing the lack of knowledge about culture, the researcher looked at the cultural content of eight basic popular nursing textbooks

dating from 1999 to 2009. The books varied in size from 591 to 2368 pages. Despite the size of the text each of the eight books contained only one chapter on culture. It is interesting to note that these chapters were located at the beginning of the books where the content introducing students to the profession and practice of nursing are found. While such placement would seem advantageous, it is important to note further that each chapter was disproportionately slim in contrast to total book length and contained a low number, ranging from 10 to 25 pages of material on culture. Further of note is the fact that only three chapters were written by nurses who are experts in transcultural nursing. This situation indicates that student nurses are not being properly prepared to care proficiently for patients of diverse cultures. (See Appendix F for curriculum comparison chart)

Though student nurses at all entry levels to the profession are introduced to culture; it is only at the graduate level of education that some nurses immerse themselves more fully in the study of culture. This lack of cultural study is a disadvantage to both the nurse and the patient since neither is benefiting fully from the healthcare experience.

As mentioned previously, conflict may arise out of cultural misunderstanding, and resolution of the conflict may require assistance from persons familiar with the patient's culture, those who have cared for the patient previously, family members, and a qualified interpreter. The use of the interpreter, referred to by one of the 45 students who responded to the survey, indicates that students are not aware of the importance of interpreters. An important implication for this study is to teach nursing students about the need for interpreters in patient communication in the first year of study, before they enter a clinical setting. Student nurses must know that interpreters play a vital role in the

healthcare setting for they are the preferred liaison between the patient and the nurse. Interpreters can assist both patients and nurses by dispelling myths and allaying concerns regarding hospital and home care. Using the interpreter assures the patient that the correct information will be conveyed and that patient confidentiality will be maintained. Student nurses need to understand that the use of interpreters is not a personal preference but rather a professional mandate.

The Joint Commission, the accrediting body for hospitals in the United States, has required that “language access service options include bilingual staff, interpreters, and contact interpreter services” (2010, Standard RI.01.01.03). These language services are available for patient use free of charge at any time. Further having family members involved in interpreting does not insure that the patient or the nurse will receive the proper information necessary for the care of the patient. For instance, a family member might deliberately or inadvertently omit pertinent information, the patient might be uncomfortable in providing information that the family member may not aware of, and the family member might not understand the medical terminology that is being used. In studies by Chen (2009, p. 1) and Flores (2006, pp. 1-2) many physicians have opted not to use interpreters because of time constraints or because they feel that they are not needed unless serious matters are being discussed. The cost of using interpreters was also cited by Jacobs et al. (2004, p. 867) and Partridge and Proano (2010, p.77) who noted that the practice of not providing interpreters hinders the delivery of optimal healthcare and leads to serious medical errors. This practice is alarming since the patient is not receiving proper care.

Patients entering the healthcare system need to be guaranteed of their right to

privacy and to know that their cultural beliefs will be respected. Moreover, they need to have care that is given by culturally competent nurses. Therefore patients should be informed that The Joint Commission respects patient rights by accommodating “cultural and personal values, beliefs, and preferences” (2010, Standard RI.01.01.01). These values are to be honored unless they infringe on the rights or safety of others or the patient’s practices are deemed to be therapeutically or medically contraindicated. Here again, a nurse who is knowledgeable of the patient’s culture can plan care that will abide by this standard and render no harm.

The importance of rendering culturally sensitive care cannot be understated. For as Leininger (1995, p. 20) stated that there “is the urgent need to prepare nurses in transcultural nursing in order to meet critical and worldwide needs to care for clients of diverse and similar cultures. The goal is to prepare culturally competent and responsible nurses.” Fifteen years later the attainment of this goal continues to be important in the education of today’s nurses.

Chapter VI Conclusions

This chapter summarizes the major conclusions and recommendations of this study. The results of this study indicate that family, school and friends have a profound effect on how culture and care are perceived by student nurses who have yet to be exposed to patient care. Students' familial influence can be both advantageous and detrimental depending on how one learns and was taught about care and culture because students bring their prejudices and biases to higher education and then to the clinical environment. Working with diverse patients can be very difficult at times for nurses who have not had training in transcultural nursing because a feeling of mistrust or a lack of understanding about the patient's culture can cloud patient care. This can be further exemplified in the clinical area of the hospital where a nurse cannot pick and chose a patient assignment and where a lack of appreciation can lead the nurse to label the patient as difficult. This occurrence could thus be based on how the patient is approached or whether the nurse is more sensitive to the patient's cultural needs. While other nurses who are more familiar with diverse patients may encounter less difficulty when dealing with patients of the non-dominant culture, student nurses may be experiencing other cultures for the first time.

In order to perform in a multicultural environment, it is clear that nurses need to become competent in transcultural nursing. As presented in the literature, both Leininger (2002) and Purnell (2002) have developed in-depth theories in transcultural nursing which should be incorporated into baccalaureate nursing programs. Each has written a chapter in one of the textbooks listed on the chart in the appendices; however, their authorship only appears in two textbooks of all those listed.

Faculty also needs to be adequately prepared in transcultural nursing in order to be able to assist their students to be caring and empathic toward people of different cultures. This endeavor involves curriculum changes and an alteration of attitude for faculty who may prefer the comfort of their familiar ways of teaching.

Nursing is changing rapidly in the 21st century. As indicated in the introduction, air travel, tourism, and immigration have changed the face of the patient seen at local as well as at metropolitan hospitals. Not only have the patients changed in appearance but so have the nurses and the medical staff who care for them. Nurses and doctors in the United States are no longer all native born or educated in the U.S. The new wave of immigrants also has brought medical and nursing personnel from every continent of the world. The complexity of factors makes it of utmost importance that nursing students study culture and care in their basic nursing programs. Students cannot be experts in every culture; however, they should know about basic care and culture, where to access information about a patient of a different culture, how to interact with the patient and the family, and how to let go of their biases and prejudices towards others.

As Isaacs so aptly stated:

We as nurses and others engaged in health care systems need to consider our own acculturation processes as we adapt to the changes happening in our society. Systemic approaches to cultural competency in health care need to be considered that enable nurses and other health care providers to be adaptive and resilient in a transnational nation.

(2010, p.15)

The best way to begin the transformation from a one-culture dominated way of caring for patients of diverse backgrounds is to educate the future nurses on the benefits of transcultural nursing. This alteration in nursing curricula should begin with first and second year while students are in the liberal arts portion of their education and before they enter their first clinical setting. This undertaking will require much time and effort on the part of faculty in order to accomplish the goal of caring for multicultural patients in hospitals and other healthcare settings. Nurses who are culturally competent will acknowledge the patients' beliefs, values, religion, cultural preferences, treatment modalities, receipt of information, proficiency of the English language, and how family involvement supports health. This is an enormous but necessary responsibility if nurses are to be accurate practitioners within a culturally sensitive and caring profession in this century.

As previously stated, much has been written but little research has been done. In light of this, my study predominately supports the literature on care, culture, and nursing education and points to the need for more research.

In ending I would liked to quote Elie Wiesel who spoke recently at my *alma mater*, Saint Louis University. In describing empathy he said, "Whatever you do in life, always think higher. Feel deeper. Be sensitive to each other—to each other's pain, to each other's joys and each other's fears" (2009). My vision holds the nursing profession to these standards, and this study is intended to help inform nurse educators of the importance of addressing care and culture in educating nurses of the future.

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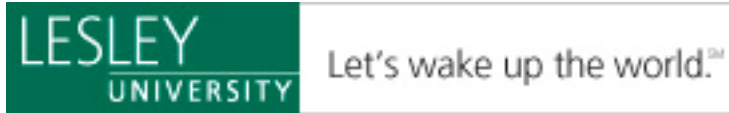
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Appendices

Appendix A



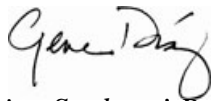
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Institutional Review Board

Office of the Provost

May 1, 2010

To: **Pauline R. Wright**

From: Gene Diaz, Co-chair Lesley IRB 

RE: Application for IRB Review: *Nursing Students' Perceptions of Care and Culture: Implications for Practice*

IRB Number: 3608

This memo is written on behalf of the Lesley University IRB to inform you that your application for approval has been granted following a review by the full board. Your project poses no more than minimal risk to participants.

If at any point you decide to amend your project, e.g., modification in design or in the selection of subjects, you will need to file an amendment with the IRB and suspend further data collection until approval is renewed.

If you experience any unexpected "adverse events" during your project you must inform the IRB as soon as possible, and suspend the project until the matter is resolved.

Date of IRB Approval: **02.11.09**

Appendix B

FW: Pauline Wright

Page 1 of 1

From: Anderson, Donald <danderso0703@post03.curry.edu>
To: pitoune17@aol.com
Subject: FW: Pauline Wright
Date: Wed, 25 Mar 2009 11:10 am

Hi Pauline,

Below is the official confirmation of the approval for your research.

This is the only approval you will get in writing from the IRB at Curry College.

Email me what your schedule looks like. We have this month to collect the data.

Don Anderson, CMSRN, EdD
Professor
Division of Nursing
617.333.2336

From: Steinberg, Bruce
Sent: Fri 2/27/2009 12:21 PM
To: Anderson, Donald
Subject: RE: Pauline Wright

Dear Don,

The Curry College IRB has reviewed Pauline Wright's research plan and has approved her proposal for research with Curry College students.

Sincerely yours,

Bruce Steinberg, Ph. D.
Chairperson,
Curry College IRB

From: Anderson, Donald
Sent: Wednesday, February 25, 2009 1:12 PM
To: Steinberg, Bruce
Subject: Pauline Wright

Hi Bruce,

Could you email me official Curry IRB approval for the study to be done by Pauline Wright, the doctoral student I am working with from Lesley University?

Thanks,

Don

Don Anderson, CMSRN, EdD
Professor
Division of Nursing
617.333.2336

<http://webmail.aol.com/42169/aol/en-us/mail/PrintMessage.aspx>

3/26/2009

Appendix C

Pauline R. Wright RN, MS, MEd

Pitoune17@aol.com

617-742-8664

April 2, 2009

Dear Potential Study Participant,

I would like to invite you to participate in my Lesley University doctoral research project. This is a study in how care and culture relate to nursing practice in a multicultural healthcare environment. Your participation will allow me the opportunity to gain the information I need to help improve nursing education.

I will gladly answer any questions you may have. My contact information is above. Please read and sign the Informed Consent form below.

Sincerely,

Pauline R. Wright RN, MS, MEd

Doctoral Student

Lesley University

Cambridge, MA

Appendix D

Informed Consent

Title: Nursing Students' Perceptions of Care and Culture:
Implications for Practice

Investigator: Pauline Wright RN,MS,MEd,(Doctoral Student)

Sponsor: There is no sponsor for this research.

Description and Purpose: A qualitative study will be undertaken whereby open-ended questions on care and culture will be posed to undergraduate declared nursing students. These questions are intended to explore the students' thoughts and beliefs about care and culture and how knowledge of care and culture can enhance their nursing practice in a multi-cultural society.

Procedure: Demographics regarding age, gender, race, ethnic background, nationality, country of birth, languages spoken, and educational background will be collected. The students will be asked questions regarding their thoughts and beliefs about care and culture, where and how they learned about care and culture, how this knowledge will enhance their nursing practice, and what resources they can use to enhance their knowledge of care and culture.

Risks: There are no risks involved in this research.

Confidentiality: You have the right to remain anonymous. Your records will be kept private and confidential to the extent allowed by law. Numeric identifiers will be used on study records rather than your initials. Your initials and other facts that may identify you will not appear when this study is presented or the results are published.

Right to Withdraw: Your participation in this study is entirely voluntary, and you may withdraw from the study at anytime even after signing this consent.

Compensation: There is no compensation provided in this study.

Signatures and Names

Investigator's Signature:

Date

Investigator's Signature

Print Name

I am 18 years of age or older. The nature and purpose of this research have been satisfactorily explained to me and I agree to become a participant in the study as described above. I understand that I am free to discontinue participation at any time if I choose, and that the investigator will gladly answer any questions that arise during the course of the research.

Subject's Signature:

Date

Subject's Signature

Print Name

**Nursing Students' Perceptions of Care and Culture:
Implications for Practice**

Appendix E

Instructions for Completing Survey

This is a questionnaire to learn about your perceptions of care and culture as they relate to nursing. There are no right or wrong answers, so please respond to each question as thoroughly as possible according to your own knowledge and opinions. Please know that your responses will be kept confidential, so you may answer as much or as little as you like.

Feel free to use either a pen or a pencil when responding.
When you have completed the survey, please put your responses in the designated envelope.

Gender F--- M---

Age range Below 25--- 26-35--- 36- 45--- over 45---

Country of Origin

Date of arrival in US

Ethnic Background

Nationality

Primary Language

Languages Spoken

US Educated Yes--- No---

If no, where were you educated?

Highest level of education and area of study:

Prior nursing experience Yes--- No---

If yes, what type and where

What is your definition of care? (Describe what you mean by care)

Where and how did you learn about care?

Who taught you about care, and how did that individual influence you?

What is your definition of culture? (Describe what you mean by culture)

Where and how did you learn about culture?

Who taught you about culture, and how did that individual influence you?

What do nurses need to know about care and culture in order to perform their job?

What are some considerations you as a nurse would make when determining the care of someone whose ethnic background is different from yours?

How would you obtain culture specific information for your patient?

How would you resolve a cultural conflict when caring for your patient?

Thank you so much for taking the time to fill out this survey.

Best wishes in your nursing program!

Pauline

Appendix F

Year	Title	Authors	Chapter Title	Publisher
1999	Medical – Surgical Nursing Across the Health Care Continuum	Donna D. Ignatavicius, M. Linda Workman, Mary Michler	Complimentary Therapies	W. B. Saunders Company
1999	Medical/Surgical Nursing: Concepts and Clinical Practice	Wilma J. Phipps, Judith K. Sands, Jane F. Macek	Cultural Care Nursing*	Mosby Inc.
2003	Textbook of Basic Nursing	Caroline Bunker Rosdahl, Mary T. Kowalski	Transcultural Care	Lippincott Williams and Wilkins
2004	Nursing and Contemporary Society: Issues, Trends, and Transition to Practice	Linda Haynes, Teresa Boese, Howard Butcher	Cultural Diversity in Health Care*	Pearson Prentice Hall
2005	Fundamentals of Nursing	Patricia A. Potter, Anne Griffin Perry	Culture and Ethnicity*	Mosby Inc.
2006	Foundations in Nursing	Barbara Lauritsen, Christensen, Elaine Oden Kockrow	Culture and Ethnic Considerations	Mosby Inc.
2006	Fundamentals in Nursing	Carol Taylor, Carol Lillis, Priscilla LeMone, Pamela Lynch	Cultural Diversity	Lippincott Williams and Wilkins
2009	Brunner and Suddarth's Textbook of Medical Surgical Nursing	Suzanne C. Smeltzer, Brenda G. Bare, Janice Hikle, Kerry H. Cheever	Perspectives in Transcultural Nursing	Lippincott Williams and Wilkins

Appendix G

Student quotes on care

Care is the ability to emotionally and physically improve someone's state
Care is having the heart and wanting to help someone
Care is taking your abilities, love, and instinct and directing them at another individual
Care is a learned thing
Care is helping someone in need
(I was taught) Care by my mother who influenced me by setting prime examples in my life
Care is having an emotional attachment to someone and providing (them) with a comforting or nurturing environment
(My parents) Influenced me to treat other people kindly and respectfully
(Care is to) Give someone the time and effort of making them feel better to the best of your ability
My mother and aunts showed me that care comes from unconditional love
(My parents taught me) To treat people the way you want to be treated and have empathy for them
My mother taught me to care for others as I want to be cared for, kindly and respectfully
Care is taking care of people to the best of (your) ability
(Care is) Being there for someone else, to protect someone, to give them a helping hand, and thinking of someone else's best needs before your own
Care is being there for someone else and putting forth your best efforts to help them. My parents raised me to be kind and loving towards others. They taught me that being caring is one of the stronger gifts a person can have
My mother taught me to care about others and always help others. This inspired me to be a kind and caring person

Student quotes on culture

(Culture is a) Group of people with generally the same beliefs and background
(Culture) Is what we live by and are influenced by
(Culture consists of) Shared ideas, beliefs, and practices of a common group
Culture is the ideas or values collectively behind a group of individuals
Culture is a set of beliefs (and) moral ways of a particular people
My teachers taught me about other people and how they may be different but to accept them nonetheless

What nurses need to know in order to do their job

Nurses need to know that everyone is different and that sometimes people of different cultures need different care
Care is equal for every patient
Nurses need to be able to) Treat people appropriately and (realizing that) knowing culture can help them do that

Patient considerations

Finding the best way to put the patient first in everything
(Nurses) Need to make sure (that they) treat them correctly and take into consideration cultural differences
Shoot for the highest and most proficient level of care no matter race or ethnicity

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