

**A DESCRIPTIVE STUDY OF MULTICULTURAL AWARENESS  
TRAINING IN SELECTED OKLAHOMA  
HEALTHCARE ORGANIZATIONS**

**By**

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## **CHAPTER I**

### **INTRODUCTION**

Evidence of education or training regarding cultural sensitivity or multicultural awareness did not always appear to be a part of an individual's formal or informal educational experience. Surveys have shown that in American business corporations, the majority of managers indicated they had no contact before adulthood with members of different ethnic groups (Veniga, 1994).<sup>1</sup>

The potential impact of a lack of multicultural knowledge was reflected in estimates of workforce composition data which revealed that during the years 1988-2000, male and female workers representing non-Anglo groups would make up 63% of the U.S. workforce while Anglo males would constitute only 9% of those entering the workforce. These figures included both those immigrating to the U.S. as well as native born individuals. (Cumber & Braithwaite, 1995). In addition, The bureau of the Census Statistical Abstract of the United States advised that the workforce of the United States was projected to grow 1.2 percent annually from 1994 to 2005 (U.S. Department of Commerce. Statistical Abstract of the United States 1996, pg. 411).

Although many businesses might employ or service individuals of various cultural backgrounds, one such industry which must be thoroughly prepared to do so on a daily basis was the healthcare industry. Not only did this industry employ large numbers from their surrounding communities and beyond, but they also provided healthcare to all

individuals regardless of cultural identity. It was found that healthcare lacking cultural compatibility was not likely to be valued by recipients and the rejection of a patients beliefs or practices could result in alienation or dehumanization (Chien-Lin & Kavanagh, 1994).

Since healthcare facilities must deal with cultural differences not only among its employees, but among its clientele as well, this research effort was directed toward the healthcare industry . Specifically, the healthcare industry in Oklahoma.

### **Problem Statement**

The purpose of this study was to determine the current status of and future plans for multicultural awareness training practices followed by designated healthcare facilities in Oklahoma.

### **Objectives of the Study**

The objectives of this study were to:

1. Obtain definitive information regarding the existence of multicultural awareness training programs within selected healthcare institutions in the state of Oklahoma;
2. Determine the intended audiences for multicultural awareness training programs in the Oklahoma healthcare industry; and
3. Determine the content of existing multicultural awareness training programs in the Oklahoma healthcare industry.

### **Research Questions**

The objectives for this study were attained through the following research questions:

1. What is the status and perceived effectiveness of multicultural awareness training programs among selected healthcare facilities in Oklahoma?;
2. Who are multicultural awareness training programs provided to in selected Oklahoma healthcare organizations?;
3. If multicultural awareness training programs are offered, who provides the training?;
4. If multicultural awareness training programs are offered, is attendance voluntary or mandatory?;
5. What is the content of multicultural awareness training programs being offered?;
6. What cultures are highlighted in current multicultural awareness training program offerings?; and
7. If multicultural awareness training programs are not offered currently, are they being considered for future implementation?

### **Definition of Terms**

**Cross Cultural Competence** - Possessing the knowledge base, skills, and abilities to provide high-quality health care to diverse communities which results in improved patient outcomes (Walker, 1996). \*

**Cultural Relativism** - the belief there are other, equally valid ways of doing things even though these methods may be different than those practiced in one's own culture (Galanti, 1991).

**Culturally Competent Care** - Care that is sensitive to issues related to culture, race, gender, and sexual orientation (Campinha-Bacote, Yahle, & Langenkamp, 1996).

**Culture** - the shared, learned, and transmitted values, norms, beliefs, and lifestyles indicative of a certain group which directs their decisions, actions, and thinking in patterned ways (Reynolds & Leininger, 1993).

**Culture Care** - the beliefs, patterned lifeways, and values that are cognitively learned and transmitted, and which support, assist, facilitate or enable groups or individuals to keep their health or well being, to cope with illness, death, or handicaps, or to improve their way of life or human condition (Reynolds & Leininger, 1993).

**Ethnic** - of or relating to a people whose unity rests on racial, linguistic, religious or cultural ties. (The New Webster's Dictionary, 1993).

**Ethnocentrism** - the belief that the only right and natural manner of doing something is the manner practiced by one's own culture (Galanti, 1991)

**Multicultural** - Two or more cultures. Related terms: Multi-ethnic, multiracial, polyethnic, multicredal, and intercultural (Barrow & Milburn, 1986).

**Transcultural Healthcare** - a recognition of others' values and viewpoints, an

acknowledgement that the values and viewpoints of the patient are as valid as those of the caregiver and a respect for such differences (Galanti, 1991).

**Transcultural Nursing** - a formal area of study and practice in nursing focused upon comparative holistic cultural care, health, and illness patterns of individuals and groups with respect to differences and similarities in cultural values, beliefs, and practices with the goal to provide culturally congruent, sensitive, and competent nursing care to people of diverse cultures (Leininger, 1995).

### **Scope and Limitations**

Cost factors limited this study to the inclusion of those healthcare organizations with a minimum licensed bed size of 150 or greater. Organizations which met this criteria included those which served the larger metropolitan areas of Oklahoma as well as the largest of those healthcare facilities which served more rural areas of the state. Generalizations to other healthcare facilities not involved in this study were not intended. Findings were pertinent to those facilities involved in the study and may be applicable to similar facilities.

### **Assumptions**

1. Individuals responsible for human resource training in healthcare organizations surveyed were aware of the issue of multicultural sensitivity.
2. Respondents for healthcare organizations surveyed reported correct information regarding the status of multicultural training within their institutions.



### **Significance of the Study**

This study resulted in information which identified those healthcare facilities which were embracing the importance of multiculturalism. Additionally, it also revealed areas for improvement, as well as strengths and weaknesses for various institutions in the area of multicultural training. This study provided database information for the Oklahoma healthcare industry's use in planning and setting multicultural awareness training policies and practices.

## **CHAPTER II**

### **LITERATURE REVIEW**

#### **Chapter Overview**

Chapter II provides information regarding various areas of concern in the area of multiculturalism. Topics discussed include National Demographics, Oklahoma Demographics, Cultural Differences, Cultural Insensitivity, Cultural Mobility Considerations, Multicultural Training Programs, Cultural Concerns in Healthcare, and Healthcare Professions.

#### **National Demographics**

Cultural diversity was an apparent reality in the United States. The most current demographic information available from the United States Department of Commerce Bureau of the Census reflected the demographics obtained in the 1990 census of the U.S. population. Those demographics reflected an actual total population for 1990 of 248,709,873 individuals. This number represented the following percentages of divergent ethnic backgrounds.

White	-	75.8%
Black	-	11.8%
American Indian	-	.8%
Asian or Pacific Islander	-	2.8%
Hispanic Origin	-	8.8%

(U.S. Department of Commerce. Bureau of the Census, 1990 CP-2-1)

Further support of the idea of cultural diversity was provided by population projections by The Department of Commerce, Bureau of the Census. Such projections (based on 1990 census reports) for the years 1995, 2000, 2020, and 2050 were as follows:

1995 Total Projected Population - 262,820,000

Projected percent of ethnic diversion in the year 1995:

White	-	73.7%
Black	-	12.0%
American Indian	-	.7%
Asian	-	3.4%
Hispanic Origin	-	10.2%

2000 Total Projected Population - 274,634,000

Projected percent of ethnic diversion in the year 2000:

White	-	71.8%
Black	-	12.2%
American Indian	-	.7%
Asian	-	3.9%
Hispanic Origin	-	11.4%

2020 Total Projected Population - 322,742,000

Projected percent of ethnic diversion in the year 2020:

White	-	64.3%
Black	-	12.9%
American Indian	-	.8%
Asian	-	5.7%
Hispanic Origin	-	16.3%

2050 Total Projected Population - 393,931,000

Projected percent of ethnic diversion in the year 2050:

White	-	52.8%
Black	-	13.6%
American Indian	-	.9%
Asian	-	8.2%
Hispanic Origin	-	24.5%

(U.S. Department of Commerce. Bureau of the Census, P25-1130)

Such percentages reflected the prolific existent cultural variation possibilities among the population base. The Bureau of the Census report acknowledged that both racial and national origin or socio-cultural groups were included in the categories of race. These projections indicate an expected growth of the ethnic population of the United States.

In researching areas relating to cultural differences, an important consideration was that the term culture might not always have the same meaning for all people. In a paper which was presented to the Annual Meeting of the Western States Communication Association in 1995, respondents of an exploratory study on multiculturalism demonstrated the existence of different perceptions of multiculturalism. Respondents from the southwest portion of the United States perceived multicultural as domestic, United States ethnic groups, while respondents from the northern plains perceived it as people of other national origins (Cumber & Braithwaite, 1995).

### **Oklahoma Demographics**

The preceding information reflected cultural diversity across the United States.

However, since this study was concentrated on selected medical facilities within the State of Oklahoma, it was necessary to report demographic information for that specific state. While the area of concentration for the study was the larger metropolitan areas of Oklahoma, demographics for the entire state were important because the medical facilities in these areas might serve the needs of the entire state. Oklahoma was not immune to the existence of cultural diversity, and while its demographics did not reflect a mirror image of national demographics, they nevertheless did reflect diversity in its ethnic makeup. The United States Department of Commerce Bureau of the Census reported demographics for the state indicated 1990 population levels at 3,145,585 individuals with percentages of ethnic diversity as follows:

White	-	81.1%
Black	-	7.3%
American Indian	-	8.0%
Asian	-	1.0%
Hispanic Origin	-	2.7%

While the above population report and percentages provided actual figures for 1990 in the State of Oklahoma, projections based on this data by the Bureau of the Census for the years 1995, 2000, and 2020 were provided to ensure timely inclusion as well as consideration of future demographic trends.

Population projections and percentages of ethnic diversion for the years 1995, 2000, and 2020 in the State of Oklahoma were as follows.

1995 Total Projected Population - 3,271,000

Projected percent of ethnic diversion in the year 1995:

White	-	80.0%
Black	-	7.2%
American Indian	-	8.1%
Asian	-	1.5%
Hispanic Origin	-	3.2%

2000 Total Projected Population - 3,382,000

Projected percent of ethnic diversion in the year 2000:

White	-	79.0%
Black	-	7.1%
American Indian	-	8.2%
Asian	-	2.0%
Hispanic Origin	-	3.7%

2020 Total Projected Population - 4,020,000

Projected percent of ethnic diversion in the year 2020:

White	-	76.0%
Black	-	7.0%
American Indian	-	8.0%
Asian	-	4.0%
Hispanic Origin	-	5.0%

(U.S. Department of Commerce, 1994. Population Projections for States, by Age, Race, and Hispanic Origin: 1993-2020, P25-1111, Pages 18,19 & 23.)

Although the ethnic diversity represented by these figures reflected general cultural diversity, it did not of course provide an all encompassing summation because within each ethnic group multiple cultures might be represented. These figures still indicated a trend for a growing ethnic population in Oklahoma.

### **Cultural Differences**

The diverse ethnic composition demonstrated by US Bureau of Census reports pointed to increasing cultural diversity throughout the country. Individuals often identified what they perceived to be cultural differences by surface pointers. Such pointers included dress, language, and physical features. They were often used to identify at a glance or from a distance that a difference in culture existed between the person observed and the individual performing the observation (Nash, 1989). Identification of such differences might lead to withdrawal, exclusion, failure to communicate, or any of a number of social consequences if some knowledge or basic understanding about the culture observed was not known.

Culture was described as “the learned, shared, and transmitted values, beliefs, norms, and lifestyles of a particular group that guides their thinking, decisions, and actions, in patterned ways” (Reynolds & Leininger, 1993, pg. 19). A more definitive definition was provided for the term ‘culture care’. It was defined as “the cognitively learned and transmitted values, beliefs, and patterned lifeways that assist, support, facilitate, or enable another individual or group to maintain their well being or health, to improve their human condition and lifeway, or to deal with illness, handicaps, or death” ( pg. 19).

Factors showing evidence of cultural differences were social organizations (family, tribes), communication, spatial needs and relationships, orientation of time, and environmental control abilities or desires. The provision of culturally appropriate as well as competent care required the provider to remember the culturally unique status of individuals and that they were the product of cultural beliefs, past experiences, and

cultural norms (Giger & Davidhizar, 1995).

Concepts which were identified as key to overall cultural understanding were ethnocentrism and cultural relativism. Ethnocentrism was said to occur when people believed that the only right and natural manner of doing something was the way their culture did it. Cultural relativism, however, was the belief that other ways of doing things, although different from one's own methods, were equally valid. Actual cultural behavior was said to occur as a result of people adapting to both their physical as well as their social environments. In a review of the western healthcare system, researchers found it to be ethnocentric. This finding was based on the fact that practitioners of this system felt their approaches and methods toward healing were superior to other healing practices (Galanti, 1991).

Extensive cross-cultural interaction often resulted in problems for those involved. Often, due to socialization within their own culture, people viewed those who were different as less intelligent, ill mannered, and/or wrong because they felt their way was the correct and only way. Responses that were common in confrontations such as these were prejudice, stereotypes, discrimination and overall dislike of the culturally different party. In turn, individuals might experience heightened anxiety because what had been learned in the past in their culture as acceptable behavior was considered wrong or simply not acceptable in their new environment (Brislin, Cushner, Cherrie, Yong, 1986)

The emergence of ethnic awareness actually occurred at a very young age, between three and five years of age. In the United States, very young children were shown to be aware of cultural and physical differences. Research had shown the teaching professionals



responsible for these children could potentially make an impact on them by assisting them in becoming more understanding of cultural lifestyle differences and also the very basic similarities of all people. The display of a sensitive and accepting attitude regarding cultural diversity in the classroom could assist in making such an impact (Smardo & Schmidt, 1983). Culturally based patterns of communication were found in childrearing practices and were found to be imbedded early in one's life (Giger & Davidhizar, 1995).

### **Cultural Insensitivity**

Cultural diversity and problems resulting from such diversity appeared to be relatively frequent occurrences. Examples of insensitivity and/or lack of knowledge to various cultural traditions abounded in literature. Although some examples were more prominent than others, all reflected a need to correct the situation. One such example was that of a Northwest Airlines employee who made a remark which reflected cultural insensitivity to a Muslim passenger. The passenger subsequently sued Northwest Airlines and as a result of factual findings by the court, damages were ordered against Northwest Airlines. It was noted in the findings that sensitivity or cultural diversity training was not provided to the Northwest Airlines employees (*Bilal v. Northwest Airlines, Inc.*, 1995).

In yet another case, a couple sued after their daughter was wrongfully taken from them by the Department of Social and Health Services (DHS) in the State of Washington. In this case, day care workers, DHS workers, law enforcement personnel, and medical personnel mistakenly identified mongolian spots as bruises on the child. Mongolian spots were a very common condition which resembled bruising and occurred in Asian and African children. An important notation among the court findings was an indication that

the worker might have exhibited a lack of cultural sensitivity (Lesley v. Department of Social and Health Services, 1996).

Further, in 1994, insensitive cultural comments made by high ranking officials in the Texaco Corporation resulted in not only massive negative publicity for the corporation, but also in a class action lawsuit. Such behavior contributed to a situation costing the company not only in terms of real dollars, but also in time and public relations imaging (Solomon, 1996).

These examples pointed to the need for employers to assure cultural competence among their employees through training. In their book, Culture Shock, Furnham and Bochner (1986) stated a need existed for businesses to provide training and support for their employees who might encounter culture sensitive situations not only for the sake of the employee, but for the cultural traveler as well. Such an endeavor would not only smooth communication relationships, but possibly reduce financial and political cost associated with problems experienced by such individuals (Furnham & Bochner, 1986).

### **Cultural Mobility Considerations**

From an historical perspective, culturally diverse contact has ancient roots. Some of the better known examples included travels by Marco Polo and Christopher Columbus. Although culturally diverse contacts have occurred for centuries, a marked difference occurred between the jet and pre-jet age. Pre-jet travelers who traveled an extended period of time to reach their destination tended to be more rounded in their aims or interests, while jet age travel allowed travelers with more specific roles or purposes such as students, and business people, to interact with other cultures. Such changes have increased

the incidence of cross cultural contacts and the interest of social scientists (Furnham & Bochner, 1986).

Additional manifestations of culturally diverse contacts was reflected in statements made by Dr. Clemont E. Vontress, a pioneer in multicultural counseling, in a 1994 interview. Dr. Vontress advised that he felt frontiers were breaking down and individuals traveled more rapidly from various areas in the world to others. The existence of a global economy was a contributor to such movement as well as to the passage of refugees and immigrants between these frontiers. He further predicted a world population in the next century as being more of a mixture of peoples than ever before (Lee, 1994).

### **Multicultural Training Programs**

As reflected by the Bureau of Census data, the United States was comprised of people from many different cultural backgrounds. It was estimated that one-third of the population of the United States would be comprised of non-Anglo people by the year 2000. Such changes in demographics, along with the creation of laws to provide equal rights for all U.S. citizens, as well as tensions between groups of various ethnic identities were reported to result in increasing numbers of multicultural training programs. (Cumber & Braithwaite, 1995).

The manner in which multicultural awareness training programs had been delivered tremendously varied. The specific situation as well as the anticipated end result were considerations for the construct and conduct of such programs. Training techniques might include providing basic general information about various cultures which included

religious customs, food, clothing, or other items deemed important. This technique was relatively easy to deliver, but provided no experiential learning. Another technique was to base the program on sensitivity issues in which participants were given general information regarding other cultures and were then required to compare and contrast that information with their own cultural situation and observe the behaviors based on the perspective of the different societies. This program tried to instill self-awareness about attitudes and perspectives held by one's society and to assist participants in identifying their own attitudes and prejudices. Regardless of the type of training provided to enhance multicultural sensitivity, one major limitation found to exist in most cases was that intellectually accepting the differences of other cultures was quite different from actually encountering these differences and appearing to regard them as they were regarded by those of the 'other' culture (Furnham, & Bochner, 1986).

Reflective analysis was found to be essential in multicultural education training. In addition, to reach a desired level of learning and change, a level of disequilibrium or discomfort was found to be necessary. Although people were found to have the power to abandon prejudice and stop negative cognitive habits, they needed to make the decision to discontinue the former behavior, remember their decision to stop it, and repeatedly make the decision to lessen their rigid manner of thinking. Resistance was identified as a common reaction to multicultural training endeavors, and one that had to be addressed and mediated as a part of the entire training process (Greenman & Kimmel, 1995)

In an article on multicultural training, Fukuyama (1994) provided a critique of journal information by Ridley, Mandoza, and Kanitz and discussed the varying positions on

multicultural training which included the individual versus environmental, the universal versus culture-specific, and the inclusive versus exclusive emphases. She suggested as the cornerstones of multicultural training programs, two of the learning objectives outlined by Ridley, Mendoza, and Kanitz. Those objectives were: 1) the display of behaviors which were culturally responsive; and 2) ethical knowledge. She further identified as one major challenge for planners of multicultural training, the need for setting priorities which were realistic following a consideration of professional commitments and programmatic resources.

Further, considerations regarding the feelings of recipients of multicultural training were noted as important in the overall training program arrangement. The reactions exhibited by those who received training have experienced far less attention than other factors. Failure on the part of training developers to consider perspectives of the actual consumers of multicultural programs could lead to organizational difficulties. A further consideration cited was the need to focus on audience analysis. Such an analysis would reveal a need to ponder whether training needs were the same for all recipients and if some groups might require alternate methods for multicultural awareness implementation (Cumber & Braithwaite, 1995).

Indeed, in some cases, programs dedicated to the issue of cultural diversity actually assisted participants in an enhancement of their understanding of how communication was influenced by cultural factors. Knowledge of how individuals interacted based on culture was cited as a factor in better understanding of one another (Veninga, 1994).

In his article on the mediating potential of multiculturalism, Peter French summed up

the importance of multicultural awareness. He advised that “Multiculturalism no longer is an ornament to traditional education. It is fundamental for anyone who intends to celebrate the coming millenium and life in the years beyond” (French, 1992, pg.38).

### **Cultural Concerns in Healthcare**

In narrowing the scope of impact which culture might have to that of the health care industry, it was important to note that sociocultural forces had been found to influence the behaviors and expectations associated with health care (Leininger, 1991). The impact of culturally formed belief systems on health related experiences and outcomes, coupled with the expanding diversity of not only the U.S., but global societies as well, had shown an integral need for those receiving health care to perceive it as culturally appropriate (Chien-Lin & Kavanagh, 1994).

Further, an acknowledgement of the intertwined nature of healthcare and culture was evident in the arguments presented by Rachel Spector (1996) in her book on Cultural Diversity in Health & Illness. Those arguments were as follows:

- 1) *Each person enters the health professions with culture-bound definitions of health and illness.;*
- 2) *Health professions bring with them distinct practices for the prevention and treatment of illness.,*
- 3) *Professionals' ideas change as they are socialized into the 'health-care provider culture. ';*
- 4) *A schism develops between the provider of health services and the recipient.; and*
- 5) *If the provider becomes more sensitive to the issues surrounding health care and the traditional health beliefs of the consumer, more comprehensive health care can be provided. (Spector, 1996, pg. 6).*

Research revealed a requirement of transcultural healthcare was a culturally relativistic and holistic approach. Psychological and spiritual needs were considerations rather than a concentration on only physical needs. It was noted that essential elements of transcultural healthcare were: a) a recognition of others' values and viewpoints; b) an acknowledgement that the values and viewpoints of the patient were as valid as those of the caregiver; and c) the need to respect differences (Galanti, 1991).

Rachel Spector (1996) argued that if the healthcare provider became more sensitive to the multicultural issues surrounding healthcare and traditional health beliefs of the consumer, more comprehensive health care could be provided. However, utilization of the traditional western style of healthcare was not supportive of such sensitivity. The western model of medical care viewed a patient's illness as a completely separate entity from that of the patient's culture or world view. Such a view often resulted in the treatment of the patient with little concern to the possible effects of the patient's racial or cultural background within the treatment plan. A multicultural approach to care was recommended for all service provision systems which involved a relationship which was therapeutic between the provider and the patient (Barney, 1991).

An alarming outcome of lack of knowledge or insensitivity to cultural differences was the potential for misdiagnosis. Actual cases of misdiagnosis were attributed in part to misunderstandings in cultural differences (Galanti, 1991).

Healthcare reform had been a major focus in recent years. In consideration of this fact, Leininger (1995) advised that cultures and subcultures which demanded special attention would be major considerations because they drove not only the healthcare systems, but its

future practices. She further identified culture as an essential as well as integral part of being human and noted the culture care aspects must not be neglected or overlooked.

### **Healthcare Professions**

The composition of the workforce for a health care institution was found to be extremely varied, although the majority was comprised of nursing staff (Pope-Davis, Prieto, & Whitaker, 1994). The American Academy of Nursing Expert Panel on Culturally Competent Care in 1992 defined “culturally competent care” as care which was sensitive to issues related to culture, gender, race, and sexual orientation. They further stated culturally competent care was provided within the clients own cultural context (Campinha-Bacote, Yahle, Langenkamp, 1996, pg. 59).

Additionally, the nursing profession appeared to not only recognize the need for multicultural awareness and training, but to have incorporated it into their theories, concepts, research and practices. Madeleine Leininger, PhD, (1995), the founder of Transcultural Nursing, provided a definition of transcultural nursing as follows:

*Transcultural nursing is a formal area of study and practice in nursing focused upon comparative holistic cultural care, health, and illness patterns of individuals and groups with respect to differences and similarities in cultural values, beliefs, and practices with the goal to provide culturally congruent, sensitive, and competent nursing care to people of diverse cultures. (Leininger, 1995, pg. 4).*

Dr. Leininger advised that transcultural nursing was an important and legitimate need of society and identified transcultural nursing as a formal study area and practice of the nursing profession. Rather than trying to provide culturally diverse care through the use of



common sense or simply being nice to patients, she advocated the need to learn about how cultures affected the mainstreaming of healthcare, healing modes, and humanistic care to be essential to advancing the nursing profession. The essential necessity for nurses to participate in and complete programs focused on transcultural nursing was noted (Leininger, 1995).

Although the nursing profession appeared to have a preponderance of literature on multicultural awareness, other healthcare professions, as well as professions which operated both within healthcare environments and other business environments, indicated strides in the area of multicultural awareness. In the area of public relations, a recommendation was made for those professionals, as well as students of that profession, to acknowledge the pace at which the world was changing and to work toward a stance which was more proactive on international and multicultural training (Neff, 1993).

In a paper presented to the Annual Meeting of the Central States Communication Association, Neff (1995) advised that the American approach used in multicultural and international concerns was chiefly an awareness emphasis. She advocated changes which included: (1) shifting the paradigm away from public to interpersonal communication; (2) providing multicultural training as opposed to current trend toward an awareness approach; and (3) teaching professionals to appreciate different cultures and attempt to gain insights as well as understanding of one another's cultures. She argued that a paradigm shift to interpersonal communication while concurrently giving indepth multicultural training would result in not only a more sensitive exchange, but also increased the likelihood of support for an international community

Further, in the area of pharmacology, new emphasis on cultural awareness was reported. While the importance of interpersonal interactions with individuals of different cultural backgrounds was recognized, ethnic and racial responses to drugs were the object of some pharmacogenetic research. Significant differences were found in ethnic and racial populations concerning rates of metabolism, drug responses and possible side effects. Such outcomes spawned the relatively new field called ethnic pharmacology (Campinha-Bacote, Yahle, Langenkamp, 1996).

Another healthcare profession which was found to be acknowledging the importance of multicultural awareness was occupational therapy. Researchers, in an article on multicultural competencies in the occupational therapy profession, reported the need for occupational therapists to be attentive to the special needs of those patients who were ethnically or racially different. This was identified as paramount to the occupational therapy profession due to the growing diversity of the United States and the wish to provide quality, equitable care to their patients. In further studying the multicultural competencies of occupational therapists, the authors of this article performed a study researching this subject. The study revealed important implications for not only education, but also continued professional training in the area of multicultural issues for individuals in this profession. Continued professional training in multicultural issues was identified as a need in order to ensure the attainment of the goal of delivering culturally sensitive and holistic patient care. Through the enhancement of training and development programs for occupational therapists, this healthcare profession would be better prepared to meet the needs of the diverse patient population of the United States (Pope-Davis, Prieto,

Whitaker, Pope-Davis, 1993).

Regardless of the academic area studied, the issue of multiculturalism will be confronted no matter what profession college graduates pursue (Cumber & Braithwaite, 1995). Indeed, many healthcare and healthcare related professions were found to be cognizant of the need to be multiculturally competent to enhance patient care. However, as noted in the first chapter of this study, it was found that concern must be directed to the healthcare workers themselves as well. Religious or cultural beliefs might hinder medical practices. For example, a catholic nurse refused to assist in an abortion as this procedure conflicted with her basic religious beliefs. In her book regarding care for people of diverse cultures, Galanti recommended institutions should be aware of religious symbols, holy days and their restrictions, dietary taboos, and other cultural areas which could conceivably foster a conflict of interest for employees (Galanti, 1991).

Regarding intercultural relationships, Barnlund (1988) described what he called "Communication in a Global Village" on three separate levels. Those levels were to: (1) gain entrance to the world and its assumptions as seen by the other culture; (2) determine what the norms were that governed face-to-face relationships; and (3) equip individuals so they functioned in a social system which might be foreign, but not incomprehensible, to them. Barnlund further stated that "without this kind of insight people are condemned to remain outsiders no matter how long they live in another country." (Barnlund, 1988, Pg. 24)

To improve the patient outcomes of care, a consideration of medical ethics recommended that health care systems and health care providers improve cultural

competence so that effective health care could be given to culturally diverse communities. Cross-cultural competence in the arena of health care was defined as possessing the knowledge base, abilities, and skills from which to render high-quality care to those of diverse cultures which would result in improved patient outcomes (Walker, 1996).

In addition, it was suggested that training programs or the encouragement and support of staff members by employers to utilize workshops and seminars on the subject of multiculturalism would likely increase the delivery of effective services to all (Pope-Davis, D., Prieto, Whitaker, Pope-Davis, S., 1993).

A review of the 1996 Guidelines provided by the Joint Commission on Accreditation of Hospitals (JCAH), reflected information regarding the issue of multicultural sensitivity. In its' 1996 Guidelines, JCAH outlined standards in the area of patient and family education and responsibilities which encouraged consideration of cultural and religious practices in patient assessments. Medical facility staff were encouraged to contemplate the patient's and family's beliefs and values. By considering the impact of cultural influences on the patient's recovery and health maintenance, health care organizations could heighten the patient's as well as the family's compliance with and understanding of treatment. (Joint Commission on Accreditation for Hospitals, 1996)

### **Summary**

In summary, census data showed the U.S. to be a nation of increasing cultural diversity and the State of Oklahoma reflected a portion of this diversity. As the foregoing research has indicated, such diversity has resulted in problems when people of diverse cultures must

participate in communicative relationships. Such relationships have included employer, employee, and client situations. The results of miscommunication due to lack of multicultural awareness varied in their intensity. The possibility of misdiagnosis in the health care industry appeared to be an especially alarming situation due to the risks posed when errors of miscommunication were made. These risks might result in unacceptable patient outcomes associated with health and, in some instances, continued life.

As a result, the need for multicultural awareness in health care facilities appeared to be a widespread and acknowledged industry necessity. This study was conducted in an effort to determine whether selected health care institutions were considering or addressing the need for multicultural awareness education and the extent to which it was being considered and/or addressed in Oklahoma.

## **CHAPTER III**

### **METHODOLOGY**

#### **Chapter Overview**

Chapter III provided information regarding the procedures and methodology utilized for this study. The research instrumentation discussed included the construct and piloting of the research instruments as well as data collection recording, and analysis procedures.

#### **Research Methodology**

Research methodology for this study included a one time descriptive survey of selected healthcare institutions and indepth interviews. A total of 25 individuals responsible for the human resource function in their respective health organization volunteered to participate in the study. Twenty of those received a written questionnaire while five were asked to participate in a telephone interview. The five telephone interviews were conducted in an effort to determine if more indepth information could be gathered by an interview process rather than by a written instrument. Specific questions designed to provide answers to the research questions presented for this study were utilized in both the questionnaire and the telephone interview approaches. The written questionnaire required approximately 15 minutes of the respondents' time to complete while interviewees were asked to provide the researcher with 20 to 30 minutes of their time to complete the interview.

### **Selection of Surveyed Organizations**

The area of concentration for the study was the state of Oklahoma which has a population of 3,145,585 (U.S. Department of Commerce, 1990). This census population included individuals of various cultural backgrounds which was demonstrated by the specific census ethnic divergence percentages. According to the 1995 American Hospital Association Guide, 134 medical facilities existed within the state. It was important to note that while many of these were primary care facilities, some were rehabilitative centers and psychiatric facilities. Many of the 134 medical facilities were small facilities serving the more rural areas of the state. This study was primarily concerned with healthcare institutions and the issue of multicultural awareness training. Therefore, the target population for this study was healthcare institutions in the state. The group which was utilized and surveyed was composed of those healthcare institutions in the state identified as having an authorized licensure of 150 beds or more. Hospitals of this size not only served the medical needs of a larger percent of the 3,145,585 individuals residing in Oklahoma than did their smaller counterparts, but it is likely they also employed a larger percentage of Oklahoma's healthcare workforce than did the smaller medical facilities. As a result, the likelihood of dealing with individuals of various cultural backgrounds, whether on an employee or client relationship was greater.

The 1995 American Hospital Guide not only identified medical facilities but also provided descriptive information such as licensed bed size. Therefore, the facilities identified as being licensed for 150 beds or more were selected from this guide and constituted the group of organizations selected to be surveyed for this study. As a result,

the total number of facilities in the group equaled 25. This included facilities operating in some of the state's more densely populated areas such as Oklahoma City, Tulsa, Enid, Muskogee, and Lawton. The individuals responsible for Human Resources in twenty of these organizations were asked to complete the written survey. In an effort to determine if more indepth information could be obtained by an interview as opposed to a written questionnaire, five randomly chosen organizations were asked to participate in a telephone interview.

### **Research Design**

The research for this study was descriptive and utilized both qualitative as well as quantitative methods. The design involved a compilation of information from healthcare facilities in the state of Oklahoma regarding the issue of multicultural awareness training.

The form of validity utilized in the study was logical validity. This form of validity is determined primarily through judgment and includes content validity. Item validity was also considered which determines how well measurement is represented in the content area (Gay, 1996).

A Panel of Experts was selected to judge the face content, construct validity, and readability of the research instruments. The panel consisted of three members who met criteria which required one member to have a background in training & development, one to have a background in research, and one to possess a background in the health care field. Appendix B provides specific information on panel members.



### **Research Instruments**

Instrumentation for this study included a written descriptive questionnaire compiled for the purpose of determining specific pertinent information necessary to describe the implementation of cultural awareness programs as well as to obtain data regarding policy and administration of such programs. In addition to the distribution of the written questionnaire to 20 organizations, telephone interviews were conducted with five individuals responsible for the Human Resources function for their organization. The number of instruments administered totaled 25. The purpose of the telephone interviews was to compare responses to those provided by the written instrument and determine if more information could be obtained from the interview process.

The written survey instrument utilized a closed-ended format which required the respondents to select a forced choice item and was composed of multiple choice and dichotomous response types. The interview instrument also included the forced item questions and some open-ended questions that addressed the research objectives and questions in more depth.

### **Questionnaire Content**

The written questionnaire for this study consisted of ten questions designed to obtain information regarding the status of multicultural awareness training programs in Oklahoma healthcare facilities. Questions were included for both those facilities offering such programs as well as for those not currently providing such training to their employees. Questions were multiple choice or dichotomous and concerned whether

multicultural programs were offered, general policies regarding the programs, and program scope. Questions for those organizations not offering multicultural programs, included future plans for such offerings and barriers to the provision of multicultural training programs.

### **Interview Content**

The interview questions designed for this research endeavor were patterned after those in the written questionnaire. The interview purpose was to not only obtain answers to questions which were designed for the purpose of answering the identified research questions, but also to probe more deeply into the responses provided while allowing for comments and discussion. Since the interview questions were closely patterned after the written instrument, they also addressed whether multicultural programs were offered, general policies regarding the programs, and program scope. Questions were also developed to address those institutions which were not offering multicultural programs at the time of interview. Those questions included the prospects of future multicultural program implementation.

### **Pilot Study**

Piloting included both intimate and expanded approaches. Intimate piloting included opinions of the panel of experts and expanded piloting included actual distribution of survey document to selected individuals. An initial rough draft of the written survey instrument was forwarded to the panel of experts which was selected for this research

study for their review and critique. Revisions were made based on information gleaned from this endeavor, and the instrument was again forwarded for review. This process was followed until authorization for expanded method pilot testing was received. The survey was then reviewed by other individuals to determine its clarity and time to complete. Specifically, the survey was reviewed by two different healthcare professionals whose facilities were not included in the group being surveyed. Appendix C provides specific information on healthcare professionals reviewing survey. In addition to having the survey completed without the presence of the researcher, for the purpose of determining the clarity of directions provided in the instrument, the researcher viewed one of the surveys being completed. This provided an opportunity to ascertain nonverbal clues of the respondent as well as to answer any questions by the respondent or note comments as they occurred.

Revisions were made based upon findings in the pilot test, and the instrument was again forwarded to the research study Panel of Experts. Upon final approval by this panel and the research advisor the instrument was distributed

An initial draft of the interview questions to be used in the telephone interviews was also forwarded to the Panel of Experts for their review and critique. Based on comments and suggestions by this panel, revisions were made to the questions. Upon approval, the revised interview questions were used in conducting an actual pilot to determine their clarity, and to evaluate their delivery by the interviewer. Appendix D provides specific information on the healthcare professional participating in the pilot interview

As in the written instrument, the revisions made to the interview questions as a result

of the pilot were forwarded to the Panel of Experts. Upon final review and approval by this panel and the research adviser, the telephone interviews were conducted.

### **Data Collection Plan and Recording**

Preliminary telephone calls were made to the designated participants in an effort to gain voluntary agreement to participate in the study. Following a verbal agreement to participate, the written questionnaires were distributed via the United States Postal system. Each questionnaire was accompanied by a cover letter denoting the purpose and scope of the study, the timeline involved for the study, a deadline for return of the questionnaire, as well as a request for the assistance of that company in assuring its timely completion. This correspondence included a stamped, self-addressed envelope to help ensure return of the questionnaire.

The questionnaire included ten questions designed to answer the research questions identified for this study. Specific instructions for completing the questionnaire were provided and modeled from guidelines suggested in needs analysis (Rossett, 1987) and educational evaluation (Worthen & Sanders, 1987) literature.

When questionnaires were not returned by the stated deadline a follow-up telephone call requesting completion was made. If the survey was not returned within two weeks of the follow-up telephone call, a final call was made to the individual responsible for completion of the questionnaire to encourage the return of the instrument.

Those individuals which were interviewed rather than receiving the written instrument were contacted by telephone to schedule an interview time. The telephone conversation included identification of the researcher, a brief description of the nature of

the study and a request for the assistance of that individual. An estimated timeframe needed for the telephone interview was provided. A convenient time was scheduled for the interviewer to call again and conduct the interview. Upon receiving verbal agreement for interview participation, a written consent form as well as a stamped, self addressed envelope for its return, was mailed to the interviewee. The consent form acknowledged their agreement to participate and required their signature. The participants were advised to return the signed consent form prior to the scheduled telephone interview. A copy of the telephone survey instrument was also mailed to the five respondents prior to the actual interview to familiarize them with the interview questions.

Information received via written questionnaire responses was manually recorded as completed questionnaires were received. Information received from interviews was manually recorded during the interview. During this process, notes were taken and information was repeated back to the interviewee in order to verify accuracy of information obtained. A final transcription and review of interview information was made upon completion of each interview process. In order to ensure confidentiality, audiotapes were not utilized and definitive information such as place of employment, name of respondent, or any other information referring to the originating source was not recorded. Upon receipt of all information from questionnaires and interviews, totals were derived for analysis.

### **Analysis of Data**

Two types of statistics were used in the analysis of data. Descriptive statistics were

used to address with the quantitative information obtained from the written survey instrument. The descriptive statistics utilized included means, frequencies, percentages, and total sums. Qualitative comparative analysis was used in analyzing qualitative information obtained from the telephone interviewing process. Answers to interview questions were grouped by similarity, dissimilarity, and uniqueness to show consensus and trends.

## **CHAPTER IV**

### **FINDINGS**

#### **Chapter Overview**

Chapter IV provided information presented in two sections. The first section presented a description of the population utilized in obtaining the foregoing information as well as the response rate for both instruments. The second section presented the research questions for the study and the findings obtained. This included quantitative data, extraneous findings deemed relevant to the scope of the study, as well as qualitative findings such as long answer comments obtained by questionnaires or telephone interviews.

#### **Population Information**

The organizations surveyed for this study, as outlined in Chapter Three, included healthcare institutions in the State of Oklahoma with an authorized licensure for 150 beds or more. The number of facilities meeting this criteria equaled 25 and represented facilities in some of the states more densely populated areas, such as Oklahoma City, Tulsa, Enid, Muskogee, and Lawton. A specific listing of facilities identified is provided in Appendix A of this study. The individuals responsible for human resources in these 25 facilities were the intended respondents for the instruments administered. A telephone survey was randomly administered to five of these individuals while the remaining 20 were asked to participate in a written questionnaire. The telephone survey was administered in

an effort to determine if more in depth qualitative information could be obtained by interviewing rather than by use of a written questionnaire. The response rate for both instruments was 100% of the group surveyed or a total of 25 participants.

### **Research Findings**

Research findings reported below were obtained through the use of both a written questionnaire and a telephone interview designed specifically for the purpose of answering the research questions posed for this study. In some instances, data are presented in tables both in this chapter and in the appendix to enhance clarity of information presented. The tables provide responses to specific questions and include number of responses as well as percentages.

The findings reported reflect predominately quantitative data. Qualitative data expected from telephone interviews did not occur as expected and only two of the five organizations interviewed by telephone had multicultural awareness training programs.

#### **Status and Perceived Effectiveness of Multicultural Awareness Training**

The first research question was addressed through two separate questions in both the written questionnaire and the telephone interview. Forty percent of the sample reported multicultural awareness training programs were provided to employees of their organizations, while 60 percent reported such programs were not provided. Twenty percent of respondents who reported having a multicultural awareness training program in their organization rated their program as very effective, and 80 percent rated their program as moderately effective. There were no ratings of ineffectiveness reported.



The forty percent which reported the existence of current multicultural awareness training programs to their employees reflects the actual number of existing programs in the sample to be ten. Therefore, the following data presented concerning research questions two through six indicates numbers of responses and percentages based on a total of ten programs. Research questions two through six were answered only by those organizations offering multicultural awareness training programs and are addressed below in the order in which they were identified in Chapter One.

### **Employees Included in Multicultural Awareness Training Offerings**

The second research question was addressed in the written questionnaire with a question which provided possible specific responses as well as the category 'other'. The telephone interview simply made the inquiry and left the answer open ended. Data obtained indicated 90% of those organizations providing Multicultural Awareness Programs included all employees in their program offering. Responses and percentages of organizations with existing programs providing each response were as reported in Table 1.

**Table 1**

### **Employees Included in Multicultural Awareness Offerings**

	# of Responses	Percent of programs offered
All Employees	9	90%
Management Employees Only	1	10%
Management & Supervisory Employees Only	0	0
Nonmanagement/Nonsupervisory Employees Only	0	0
Other	0	0

### **Approach Used to Deliver Multicultural Awareness Programs**

The third research question was addressed in both the written questionnaire as well as the telephone interview by utilizing the same question and response options for each instrument. In addition, both instruments addressed the methodology utilized in the program presentation such as on campus or off campus and one day programs versus multiple day programs. While all responses are provided in Table 2, it is important to note that most programs (90%) were taught by inhouse personnel and further, that 70% of all programs being offered were taught on campus. Responses and percentages of organizations with existing programs providing each response were as reported in Table 2.

**Table 2**

### **Approach Used to Deliver Multicultural Awareness Programs**

	# of Responses	Percent of programs offered
Taught by inhouse personnel	9	90%
Taught on campus	7	70%
One day workshop/seminar	5	50%
Taught by outside consultants	4	40%
Multiple days workshop/seminar	2	20%
Taught off site	1	10%
Other	1	10%

Note: Respondents were allowed more than one response to this inquiry.

### **Methods of Instruction**

Additionally, respondents were asked what methods of instruction were used in their multicultural awareness training programs. Several response options, as well as the category "other", were provided on both survey instruments. All programs reported using lecture in their program presentation. While other methods may have also been utilized as Table 3 reflects, lecture was the only response given by 100% of the respondents. Responses and percentages of organizations with existing programs providing each response were as reported in Table 3.

**Table 3**

### **Methods of Instruction**

	# of Responses	Percent of programs offered
Lecture	10	100%
Video Tapes	5	50%
Group projects	4	40%
Small Group Activities	4	40%
Role Playing	3	30%
Guest Speaker	3	30%

Note: Respondents were allowed more than one response to this inquiry

### **Attendance Policy for Multicultural Awareness Training Programs**

The fourth research question was addressed in the written questionnaire with three possible response options, while the telephone interview instrument left the question

open ended. Responses to the telephone interview however, were not different from the written questionnaire options. Forty percent of the respondents indicated attendance as voluntary, 20 percent indicated attendance was mandatory, and 40 percent said attendance requirements varied.

### **Content of Multicultural Awareness Training Programs**

The fifth research question, was addressed utilizing the same question and response categories in both the written instrument and the telephone instrument. However, rather than a listing of 'other' as an additional response option as was done in the written instrument, the telephone sample was specifically asked if there were areas targeted in their programs other than the response options provided. "Communication" was clearly the most frequent response to program content with 80% of the programs reporting its inclusion in its offering. This response was closely followed by "cultural traditions" with 70% of the programs reporting its inclusion in program content. A complete summary of responses and percentages of organizations with existing programs providing each response was as reported in Table 4.

Table 4

**Focal Content of Multicultural Awareness Training Programs**

	# of Responses	Percent of programs offered
Communication	8	80%
Cultural Traditions	7	70%
Business Practices	5	50%
Holidays	4	40%
Attire	4	40%
Patient Expectations	4	40%
Medical Practices	4	40%
Religious Observances	3	30%
Other	3	30%

Note: Respondents were allowed more than one answer to this inquiry.

Additional findings were presented through additional comments given on the written instrument and in telephone interviews in response to the category 'other'. Additional issues of focal content reported were teamwork, emphasis on awareness and respect for individual differences, general diversity awareness, and understanding that individual differences creates the organization. New Hire Orientation was listed as the time when some multicultural awareness programs were offered

**Cultures Highlighted in Multicultural Awareness Training Programs**

The sixth research question was addressed using the same open ended question on both the written instrument as well as the telephone survey instrument. The response most often given was African American reported by 40% of those offering Multicultural Awareness Programs. Additional responses of American Indian, Asian, Hispanic, and

Vietnamese were each given by 20% of respondents. All other responses were single listings provided by various individual respondents. One organization addressed gay and lesbian issues as well as individuals who were physically challenged. Two respondents failed to answer the question. Appendix E provides a complete listing of all responses given as well as the number of respondents reporting each of them.

### **Plans for Future Implementation of Multicultural Awareness Programs**

The seventh and final research question was asked on both instruments with the same 'yes' or 'no' response choices given to respondents. This question was applicable only to those 15 organizations which did not have a multicultural awareness program. Results indicated that 67 percent of respondents not currently having a multicultural awareness training program indicated a 'yes' response, and 20 percent of such respondents indicated a 'no' response. One respondent answered 'unknown' to this inquiry and one respondent answered 'probably' to this inquiry. These additional responses represented 6.6% respectively of the total sample.

### **Barriers to Establishment of Multicultural Awareness Programs**

In addition to the above data received as direct answers to research questions, the study sample was also asked what barriers or problems would prevent establishment of a multicultural awareness program if one did not currently exist in their organization? This question was applicable only to the 60% of the population that reported a lack of a multicultural awareness program. The fact that a need had not been identified was the most frequent response given when responding to the question of problems or barriers to

establishment of multicultural awareness programs. Responses and percentages of organizations with existing programs providing each response were as reported in Table 5

**TABLE 5**

**Problems or barriers to establishment of Multicultural Awareness Programs**

	# of Responses	Percent of Total Responses
Need has not been identified	9	60%
Other	4	26%
Lack of interest by employees	2	13%
Cost/budgetary restraints	1	7%

Note: Respondents were allowed more than one response to this inquiry.

Those respondents which did not have a multicultural awareness program, reported that additional barriers to establishment (other than those listed in research instruments) included a lack of progressive human resources strategies being identified by the organization, recent changes in administration, time factors, and other priorities. These qualitative comments were provided by respondents to the category 'other'. One respondent answered unknown and one respondent failed to answer this question.

## CHAPTER V

### CONCLUSIONS AND RECOMMENDATIONS

#### Chapter Overview

This chapter includes five sections of information. The first section presents a brief summary of chapters one through four. The second section includes a discussion of research findings. Conclusions which were drawn from the findings of the completed research are included in section three, and recommendations for practice are in section four. In the final section, recommendations for further research as a result of the study are presented.

#### Summary

The purpose of this study was to determine the status of multicultural awareness training practices followed by selected healthcare facilities in Oklahoma. Information provided by The United States Department of Commerce, Bureau of the Census revealed the existence of ethnic diversity nationally as well as within the State of Oklahoma. In addition, population projections clearly indicated increased levels of ethnic diversity in years to come. In the literary review, examples of problems incurred as a result of cultural differences were provided for the general business sector and, since this study was primarily concerned with healthcare organizations, specific instances of problematic situations due to cultural differences in the healthcare arena were also given.

Cultural concerns in healthcare were presented and, although other healthcare



professions embracing the idea of multicultural awareness were recognized, the nursing profession was the most advanced in educational issues regarding this subject and was the profession representing the largest composition of a healthcare workforce. Information obtained from preliminary literature research which concentrated on multicultural training programs and considerations for their implementation, organization, and direction was provided in Chapters I and II.

This study was descriptive and utilized both qualitative and quantitative methods. The research methodology consisted of a one time descriptive survey of selected healthcare institutions and indepth interviews. The area of concentration was the State of Oklahoma, and the population utilized was composed of those healthcare institutions having an authorized bed licensure of 150 or more. Facilities meeting this criterion totaled 25

Only 40% of the sample provided multicultural awarenesss programs to their employees and that of this number, only 20% rated their programs as very effective while 80% rated them as moderately effective. In addition, 90% of the programs offered were provided to all employees in the organization and 10% were provided only to management employees. Various methods were reported in the presentation of these programs. However, the majority were taught by inhouse personnel on site. Regarding attendance requirements, 40% stated attendance was voluntary, 20% stated it was mandatory, and another 40% said attendance requirements varied. While several responses were given regarding program content, the majority of responses indicated communication and cultural traditions to be a part of their program. African American was the most frequent response given to the inquiry of what culture(s) were highlighted. For those

organizations not currently offering such a program, 67% indicated that multicultural programs were being considered for future implementation.

### **Discussion of Research Findings**

The lack of importance of multicultural awareness to healthcare organizations surveyed was apparent by the small number of existing programs and the lack of definitive implementation plans for future programs. With the present existence of numerous cultures and the projected cultural changes not only in Oklahoma, but the nation as a whole, the lack of specific programs targeted toward multicultural awareness appears to be an alarming deficiency in the overall operation of healthcare institutions.

Many of those healthcare organizations not providing multicultural awareness training to their employees indicated that a need had not been identified for such training. Such a response raises the question as to what would have to occur for an organization to determine there was such a need, and in addition, who would make such a determination. Does management alone make this decision, are employees involved, are patients needs considered, is the general public considered, or is it a dollar decision based on public relations or legal issues? The literature review in Chapter Two cited several examples of problem situations which occurred from a lack of multicultural knowledge. In some instances, multicultural awareness training was in place, however, in other cases, it was put into place after the event occurred.

Most of the multicultural awareness training programs reportedly offered by the surveyed group did not make attendance mandatory. If attendance were voluntary, it

would be questionable whether those employees who really needed the training were the ones who were receiving it. A concern would be that those who needed it most might not be the ones who volunteered to attend.

Most programs were rated as moderately effective. The choices given on the survey instruments were Very Effective, Moderately Effective, and Not Effective. The possibility that respondents may have inferred Moderately Effective as average was considered in the analysis of data. More definitive descriptors in the survey instruments would have provided more in depth information on program effectiveness.

Lecture was reportedly the method of instruction utilized by all multicultural awareness training programs. A program rating of moderately effective was not surprising when so many organizations chose the least effective pedagogy for changing attitudes as their method of training their employees about multicultural awareness.

Most multicultural awareness training programs were taught on site and 60% of the organizations utilized their own inhouse personnel in the delivery of the programs. The reason for this particular strategy was of concern since effectiveness ratings were only moderate. Instructor qualifications, economics, priority of multicultural awareness, consultants from outside the organization, and off site classes seemed to be valid issues for contemplation

The most frequently reported focal content issues of multicultural awareness training programs were communication and cultural traditions. This seemed to infer the programs offered were somewhat narrow in scope when compared with research data presented in the Chapter Two literature review regarding fundamentals and essential elements

African American was the response most often given regarding cultures highlighted in current multicultural awareness training programs. It was significant to note that even though this study was conducted in Oklahoma, only 20% of respondents mentioned American Indian in their responses.

### **Conclusions**

The following conclusions are based on data obtained through this study. They represent responses received from the selected survey group of medical facilities within the state of Oklahoma which were licensed for 150 beds. A total of 25 facilities met this criterion.

- Multicultural awareness was not a priority to the majority of healthcare institutions in Oklahoma. Less than half of the surveyed healthcare facilities offered multicultural awareness training and mandatory attendance by their employees was not required for most programs.
- Multicultural awareness was considered important since most healthcare organizations who do not offer such training, but plan to do so in the future.
- Cost and budgetary restraints did not appear to be a vital reason for the absence of multicultural awareness programs. The lack of an identification of need was the most common reason why programs had not been established.
- Those who do offer the training are using a holistic approach because the awareness program is included for all employees.
- The existing multicultural awareness training programs may have limited effectiveness due to a lack of mandatory attendance requirements, ratings of moderately effective, and use of lecture as the method of instruction

- Medical facilities that have multicultural awareness programs have a preference for conducting their own training primarily using inhouse personnel and the training programs are taught on site.
- The programs are not well developed because they are narrow in scope and do not reflect recommended dimensions as described in the review of literature. Communication and cultural traditions were the most frequently reported focal content of multicultural awareness training programs.

### **Recommendations for Practice**

The following recommendations were made based on information obtained from results of this research study

- Make multicultural awareness training programs a definitive priority to provide patients with healthcare which can be deemed effective regardless of the cultural background of the provider or the recipient.
- Provide multicultural awareness training programs to all employees.
- Establish a mandatory attendance policy for employees to attend multicultural awareness training.
- Seek strategies for improving existing program content so as to ensure a more effective product and end result for participants and the organization
- Determine specific criteria to be used in an evaluation of the effectiveness of current multicultural awareness training program offerings. Incorporate audience analysis and include issues of awareness important to employees and the organization. Criteria should include specific measurable factors, such as numbers of complaints linked to cultural problems, and employee feedback

- Revamp instruction methods to ensure that lecture is not only the only method utilized. Review current trends nationwide, consider essential elements and fundamentals for multicultural awareness training programs and consider data results of this study when considering various methods for instruction.
- Review credentials of inhouse personnel providing instruction for multicultural awareness training programs.
- Review and consider alternatives for off site programs and outside consultants.
- Provide a systematic evaluation of existing multicultural offerings which considers national trends in the field of multicultural awareness and reviews of other successful programs.
- For organizations considering implementation of multicultural awareness programs, an examination of other programs in healthcare facilities should be conducted in an effort to ease program implementation efforts and reduce avoidable errors in development.

### **Recommendations for Further Research**

This study was broad and introductory in scope. More in depth information regarding the topic of multicultural awareness training could be revealed by narrowing the scope of study. The following recommendations for further research were made based on information obtained from results of this research study.

- Conduct more indepth research into the specific plans various organizations have for future implementation of multicultural awareness training programs. Items to consider are target dates, program content, instructional methods, and general policy regarding the program.

- Research the organizations currently providing multicultural awareness training programs to determine what prompted them to start such programs. Compare results to determine if there is a singular cause and if programs were started because the company felt they were needed or if they were offered as a result of litigation.
- Provide additional indepth research which concentrates on organizations currently offering multicultural awareness training programs and the identification of specific examples or situations in which the company has thwarted potential problem areas and as a result incurred monetary savings. Specifically, the occurrence, frequency, or lack of grievances, complaints, lawsuits, and other disputes which are cultural in nature could be featured.
- Conduct further research into content of multicultural awareness training programs that are currently offered. A more indepth analysis of each category presented as focal content possibilities by the survey instruments utilized in this study would be beneficial.
- Research companies not currently offering a multicultural awareness program to determine what factors would result in their immediate attention to the issue of multicultural awareness and definitive program implementation plans
- Study the elements of participation in the current multicultural program offerings to determine which employees attend, and why they attend. Determine what example is set by management and whether those employees who really need the training are receiving it. Compare this data to program effectiveness ratings to determine if there is a correlation.
- Develop better probing questions for future interview research instruments in order to gather more qualitative data
- Research why companies are relying primarily on inhouse personnel to teach multicultural awareness programs.
- Research why Native American Indian does not appear to be a more focused upon group in current multicultural awareness training programs in Oklahoma.

**Concluding Comment**

Multicultural awareness is indeed an interesting subject and there are many avenues of research still open for study. The constant cultural changes around us seem to clearly indicate a need for more knowledge and insight among all who work and interact with other individuals.



## BIBLIOGRAPHY

- American Hospital Association Guide (1995). Pgs. A321-A328.
- Barrow, R. and Milburn, G. (1986). A Critical Dictionary of Educational Concepts. New York, NY. St. Martin's Press.
- Barney, K.F. (1991). From Ellis Island to assisted living: Meeting the needs of older adults from diverse cultures. American Journal of Occupational Therapy, 45, 586-593.
- Barnlund, D.C. (1988). Communication in a Global Village. In Samovar and Porter, (Eds.), Intercultural Communication: A Reader Vol. 6. Wadsworth. Pg. 24.
- Bilal v. Northwest Airlines, Inc. No. C4-94-416, slip op. (Minn. App. 1994 WL 593939).
- Brislin, R.; Cushner, K.; Cherrie, C.; Yong, M.. (1986). Intercultural Interactions, A practical Guide. Beverly Hills, California: Sage Publications.  
Chapter 1. pgs. 16 & 25 (Chap one is 13-56) volume 9
- Campinha-Bacote, J., Yahle, T., and Langenkamp, M. (1996). The Challenge of Cultural Diversity for Nurse Educators. The Journal of Continuing Education in Nursing, 27 (2), 59-64.
- Chien-Lin K., and Kavanagh, K. H. (1994), Chinese Perspectives on Culture and Mental Health. Issues In Mental Health Nursing, 15 (6), 551-567.
- Cumber, C.J., Braithwaite, D.O. (1995, February). An Exploratory Study of Student Perceptions and Understanding of Multiculturalism. Paper presented at the Annual Meeting of the Western States Communication Association, Portland, Oregon
- French, P.L. (1992), The Mediating Potential of Multiculturalism. Liberal Education, 78 (2), 36-40.
- Fukuyama, M. A. (1994). Multicultural Training: If Not Now, When? If not You, Who? The Counseling Psychologist, 22 (2), 296-299
- Furnham, A., & Bochner, S. (1986) Culture Shock. New York, NY: Methuen & Co.
- Galanti, G. A.. (1991) Caring for Patients from Different Cultures. Philadelphia, PA: University of Pennsylvania Press.

- Gay, L.R. (1996). Educational Research. Englewood Cliffs, NJ: Prentice-Hall, Inc.
- Giger, J. N. & Davidhizar, R. E. (1995). Transcultural Nursing: Assessment and Intervention. St. Louis, MO.: Mosby-Year Book Inc.
- Greenman, N. P. and Kimmel, E. B. (1995). The Road to Multicultural Education: Potholes of Resistance. Journal of Teacher Education, 46 (5), 360-367
- Joint Commission on Accreditation of Hospitals. (1996). The 1996 Comprehensive Accreditation Manual for Hospitals. Oakbrook Terrace, IL.: Joint Commission on Accreditation of Hospitals. 208-212.
- Lee, C. C. (1994). Pioneers of Multicultural Counseling: A Conversation With Clemmont E. Vontress. Journal of Multicultural Counseling and Development, 22, (2), 66-78.
- Leininger, Madeleine M. (1991). Culture Care Diversity & Universality: A Theory of Nursing. New York, NY: National League for Nursing Press.
- Leininger, M.M. (1995). Transcultural Nursing. New York, NY: McGraw-Hill, Inc.
- Lesley v. Department of Social and Health Services, State of Washington, 921 P.2d 1066 (Wash. App. Div. 1 1996).
- Nash, Manning. (1989). The Cauldron Of Ethnicity in the Modern Workplace. Chicago, Il: The University of Chicago Press.
- Neff, B. D. (1993, May). Emerging Public Relations in the Commonwealth of Independent States: An Academic Perspective. Paper presented at the Annual Meeting of the International Communication Association (43rd), Washington, D.C
- Neff, B. D. (1995, April). Teaching Public Relations from an American Perspective: An Assumption To Be Reconsidered. Paper presented at the Annual meeting of the Central States Communication Association, Indianapolis, Indiana.
- Pope-Davis, D. B., Prieto, L. R., Whitaker, C. M., & Pope-Davis, S. A. (1993) Exploring Multicultural Competencies of Occupational Therapists: Implications for Education and Training. The American Journal of Occupational Therapy 47, (9), 838-844.
- Reynolds, C. L. and Leininger, M. M. (1993) Madeleine Leininger Cultural Care Diversity and Universality Theory. Newbury Park, CA: Sage Publications, 19

Rossett, A. (1987). Training Needs Assessment. Englewood Cliffs, New Jersey: Educational Technology Publications, Inc.

Smardo, F. A. & Schmidt, V. (1983). Developing Multicultural Awareness. Children Today, 12 (3), 23-25.

Solomon, J. (1996, November 25). Texaco's Troubles. Newsweek, 128 (22), 48-50

Spector, R.E. (1996). Cultural Diversity in Health & Illness. Stamford, CT: Appleton & Lange

The New Webster's Dictionary (1993). Danbury, CT: Lexicon Publications, Inc.

U.S. Department of Commerce. (1994). Population Projections for States, by Age, Sex, Race, and Hispanic Origin: 1993 to 2020 (Economics and Statistics Administration, Bureau of the Census Publication P25-1111).

U.S. Department of Commerce. (1996). Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995 to 2050 (Economics and Statistics Administration, Bureau of the Census Publication No. P25-1130).

U.S. Department of Commerce. (1990). 1990 Census of Population, Social and Economic Characteristics. (Economics and Statistics Administration, Bureau of the Census Publication No. 1990 CP-2-1)

U.S. Department of Commerce. (1996) Statistical Abstract of the United States 1996, The National Data Book. (Economics and Statistics Administration, Bureau of the Census) 116th Edition, 411.

Veninga, R.L. (1994). Valuing Our Differences. Health Progress, 75 (10), 30-3, 54

Walker, P.F. (1996). Preventive Health Care in a Multicultural Society: Are We Culturally Competent? Mayo Clinic Proceedings, 71, 519-521.

Worthern, B.R., and Sanders, J.R. (1987). Educational Evaluation. White Plains, NY: Longman.

## APPENDICES

## **APPENDIX A**

### **Medical Facilities Licensed for 150 Beds or More**

## APPENDIX A

The 1995 American Hospital Guide identifies the following medical facilities as being licensed for 150 beds or more.

<b><u>Hospital</u></b>	<b><u>Licensed Bed Size</u></b>
Memorial Hospital of Southern Oklahoma	178
Jane Phillips Medical Center	233
Grady Memorial Hospital	156
St. Mary's Medical Center	177
Western State Psychiatric Center	178
Comanche County Memorial Hospital	289
McAlester Regional Health Center	198
Midwest City Regional Hospital	206
Muskogee Regional Medical Center	225
Griffin Memorial Hospital	215
Norman Regional Hospital	236
Baptist Medical Center of Oklahoma	529
Deaconess Hospital	206
Hillcrest Health Center	186
Mercy Health Center	385
Presbyterian Hospital	354
Southwest Medical Center of Oklahoma	298
St. Anthony Hospital	247
University Hospitals	420
Veterans Affairs Medical Center	297
Hillcrest Medical Center	446
Saint Francis Hospital	621
St. John Medical Center	597
Tulsa Regional Medical Center	345
Eastern State Hospital	324

## **APPENDIX B**

### **Panel Of Experts**

## **APPENDIX B**

### **PANEL OF EXPERTS**

**Research:**

**Dr. James Key**  
**Professor and Graduate Coordinator**  
**Oklahoma State University**  
**Stillwater, Oklahoma**  
**918-744-5129**

**Training & Development:**

**Jeff Clark**  
**Educational Project Director**  
**Oklahoma Community Health Care Alliance**  
**Tulsa, Oklahoma**  
**918-488-6057**

**Health Care:**

**Diane Sears, RN, MS, ONC**  
**Clinical Manager**  
**Saint Francis Hospital**  
**Tulsa, Oklahoma**



## **APPENDIX C**

### **Expanded Method Piloting Health Care Professionals Reviewing Instruments**

## **APPENDIX C**

### **Expanded Method Piloting Health Care Professionals Reviewing Instruments**

**Carol Taylor**  
**Director of Human Resources**  
**Okmulgee Memorial Hospital**  
**Okmulgee, Oklahoma**  
**918-756-4233**

**Lisa Kogan**  
**Business Development Representative**  
**Children's Medical Center**  
**Tulsa, Oklahoma**  
**918-628-6346**

## **APPENDIX D**

### **Health Care Professional Participating in Pilot Interview**

## **APPENDIX D**

### **Health Care Professional Participating in Pilot Interview**

**Carol Taylor  
Director of Human Resources  
Okmulgee Memorial Hospital  
Okmulgee, Oklahoma  
918-756-4233**

## **APPENDIX E**

### **Cultures Addressed in Existing Multicultural Awareness Training Programs**

## APPENDIX E

TABLE 6

Cultures Addressed in Existing Multicultural Awareness Training Programs

Reported Culture or Response	# of Respondents Giving This Response
Asian-Pacific	1
African American	4
American Indian	2
Arab American	1
Asian	2
Brazilian	1
Chinese American	1
Cambodian	1
Central American	1
Colombian	1
Cuban	1
East Indian	1
Eritrean	1
Ethiopian	1
Filipino	1
Gay	1
Guatemalan	1
Gypsie	1
Haitian	1
Hispanic	2
Hmong	1
Iranian	1
Japanese American	1
Korean	1
Lesbian	1
Mexican American	1
Native American	1

**Appendix E, con't.**

Nicaraguan	1
Nigerian	1
Pakistani	1
Physically Challenged	1
Russian	1
Salvadoran	1
Samoan	1
South Asian	1
Spanish	1
Vietnamese	2
West Indians	1
All Cultures & Nationalities	1
No Response	2
No Specific Culture Addressed	1
Various	1

The above information reflects combined responses of written and telephone instruments

**Note:** The above information was provided by respondents to an open ended question, therefore in some cases there were multiple responses provided by individual respondents.

**APPENDIX F****Cover Letter for Written Questionnaire Instrument**



Date

Name

Title

Organization

Address

City, State Zip Code

Dear :

Thank you for allowing me to briefly discuss via phone the enclosed Graduate Research Project Questionnaire. As we discussed, the project concerns the issue of multicultural awareness training in Oklahoma healthcare organizations. Your agreement to participate is appreciated.

Your timely input is requested through the completion of this questionnaire which addresses multicultural awareness. The survey consists of ten questions and should take only a few minutes of your time to complete.

All responses will be reported in aggregate, therefore, all sources contributing to the survey instrument will be confidential and are for scholastic purposes only.

Your response is needed to ensure a thorough research endeavor and will be greatly appreciated. Please return the completed questionnaire in the enclosed self-addressed, stamped envelope by Monday, November 17, 1997. Responses not received by this date will require follow-up contacts which could delay the timely completion of this research endeavor.

A summary of the research results will be made available to those survey participants desiring such information.

If you have questions regarding this research effort, I can be reached at 918-000-0000 (Tuesday - Saturday).

Thank you for your assistance.

Sincerely,

Sammie Dixon  
Graduate Student  
Oklahoma State University

Reynaldo Martinez, PhD  
Associate Professor  
Occupational Education Studies  
Oklahoma State University

## **APPENDIX G**

### **Cover Letter for Telephone Survey Instrument**

Date

Name

Title

Organization

Address

City, State Zip Code

Dear :

Thank you for agreeing to participate in a telephone interview regarding Multicultural Awareness Training. As discussed in our earlier telephone conversation, the purpose of this interview is obtain information for a graduate research project entitled 'A Descriptive Study of Multicultural Awareness Training in Selected Oklahoma Healthcare Organizations'.

I have enclosed a copy of the interview questions which will be asked of you as well as a consent form which is required by Oklahoma State University for all projects of this type. This form assures you that no specific reference will be made to you or your organization in the reporting of information received and additionally, that all data will be reported in aggregate. Upon completion of research and report approval, all records will be destroyed. Please read the consent form, sign it, and return it to me in the enclosed self addressed, stamped envelope. I am supposed to have the signed consent form back prior to our interview. I have enclosed an extra copy for your records. If you have any questions regarding the form, please contact me at 918-00-0000.

I look forward to our scheduled telephone interview on Tuesday, November 18, at 1:30 pm.

Thank you again for agreeing to participate in this scholastic project.

Sincerely,

Sammie Dixon  
Graduate Student  
Oklahoma State University

Reynaldo Martinez, PhD  
Associate Professor  
Occupational Education Studies  
Oklahoma State University

## **APPENDIX H**

### **Written Questionnaire Survey Instrument**

## QUESTIONNAIRE

Participation in answering this research questionnaire is completely voluntary. All responses will be held in strict confidence.

Please use a black or blue ballpoint pen to clearly indicate the appropriate response to each question.

1. Are multicultural awareness programs provided to employees of your organization?  
(Check applicable answer):

\_\_\_\_\_ Yes

\_\_\_\_\_ No

- If Multicultural Awareness Programs are not provided to employees of your organization, skip to question #9.

2. If such programs are provided, which employees are included in this offering?  
(Check applicable answer):

\_\_\_\_\_ Management employees only

\_\_\_\_\_ Management and supervisory employees only

\_\_\_\_\_ Non management and non supervisory employees only

\_\_\_\_\_ All employees

\_\_\_\_\_ Other: Please Specify: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. If Multicultural Awareness Programs are offered, is attendance voluntary or mandatory? (Check one):

\_\_\_\_\_ Voluntary

\_\_\_\_\_ Mandatory

\_\_\_\_\_ Varies (both)

4. Which of the following approaches is used to deliver your Multicultural Awareness Program? (Check all that are applicable).

\_\_\_\_\_ Taught by inhouse personnel

\_\_\_\_\_ Taught by outside consultants

\_\_\_\_\_ One day workshop/seminar

\_\_\_\_\_ Multiple days workshop/seminar

\_\_\_\_\_ Taught on campus

\_\_\_\_\_ Taught off site

\_\_\_\_\_ Other: Please Specify \_\_\_\_\_

Multicultural Awareness Questionnaire, Page 2.

**5. What is the focal content of your Multicultural Awareness Program?**

(Check all that are applicable):

\_\_\_\_ Religious Observances

Holidays

## Communication

### Patient Expectations

Other: Please comment

### Cultural Traditions

Attire

## Business Practices

## Medical Practices

**6. Which of the following methods of instruction are used in your Multicultural Awareness Training Program? (Check all that are applicable):**

**Active**

## Group Projects

## Role Playing

### Small Group Activities

Other: (Please list)

## Passive

### Video Tapes

Lecture

Guest speaker

**7. What cultures are addressed in your Multicultural Awareness Training Programs?**

Please specify:

**8. How would you rate the effectiveness of your Multicultural Awareness Program?**

(Check one):

\_\_\_\_ Very Effective

\_\_\_\_ Moderately Effective

       Not Effective

## Multicultural Awareness Questionnaire, Page 3.

- (Complete the following questions only if your organization does not offer Multicultural Awareness Training at this time).

**9. If programs are not offered currently, are they being considered for future implementation?**

(Check applicable response):

\_\_\_\_\_ Yes

\_\_\_\_\_ No

**10. What problems or barriers prevent establishment of such training programs?**

(Check applicable response):

\_\_\_\_\_ Need has not been identified

\_\_\_\_\_ Cost/Budgetary Restraints

\_\_\_\_\_ Lack of interest by employees

\_\_\_\_\_ Other (Please Comment)

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**APPENDIX I**  
**Telephone Survey Instrument**



# TELEPHONE SURVEY INSTRUMENT

1. Does your organization provide multicultural awareness programs to its employees?

(If response to question #1 is no, skip to question # 9)

2. Which employee groups are eligible to participate in such programs?

3. Are employees required to attend? (Is attendance mandatory?)

4. Which of the following approaches is used to deliver the program?

- |   |   |
|---|---|
| <input type="checkbox"/> Taught by inhouse personnel  | <input type="checkbox"/> Taught by outside consultants  |
| <input type="checkbox"/> One day workshop/seminar     | <input type="checkbox"/> Multiple days workshop/seminar |
| <input type="checkbox"/> Taught on campus             | <input type="checkbox"/> Taught off site                |
| <input type="checkbox"/> Other: Please specify: _____ |   |

5. What is the focal content of your Multicultural Awareness Program?

- |  |   |
|--|---|
| <input type="checkbox"/> Communication         | <input type="checkbox"/> Patient Expectations |
| <input type="checkbox"/> Religious Observances | <input type="checkbox"/> Cultural Traditions  |
| <input type="checkbox"/> Holidays              | <input type="checkbox"/> Attire               |
| <input type="checkbox"/> Medical Practices     | <input type="checkbox"/> Business Practices   |

Are there other areas targeted in your program which were not listed? Please comment: \_\_\_\_\_

Multicultural Awareness Telephone survey, Page 2.

**6. Which of the following methods of instruction are used in your Multicultural Awareness Training Program?**

<b>Active</b>	<b>Passive</b>
<input type="checkbox"/> <b>Group Projects</b>	<input type="checkbox"/> <b>Video Tapes</b>
<input type="checkbox"/> <b>Role Playing</b>	<input type="checkbox"/> <b>Lecture</b>
<input type="checkbox"/> <b>Small Group Activities</b>	<input type="checkbox"/> <b>Guest Speakers</b>

Are there other methods of instruction used in your program? If so, please comment: \_\_\_\_\_

**7. What cultures are addressed in your multicultural awareness training programs?**

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**8. How would you rate the effectiveness of your multicultural awareness training program?**

☐ **Very Effective**      ☐ **Moderately Effectively**      ☐ **Not Effective**

**ASK THE FOLLOWING QUESTIONS ONLY IF RESPONDENTS ORGANIZATION DOES NOT OFFER MULTICULTURAL AWARENESS PROGRAMS.**

**9. Are multicultural awareness programs being considered for future implementation?**

**10. What delays or prevents establishment of such programs?**

**APPENDIX J**

**Telephone Interview Consent Form**

**OSU INSTITUTIONAL REVIEW BOARD  
CONSENT FORM**

I, \_\_\_\_\_, hereby agree to participate in the telephone interview regarding multicultural awareness training in Oklahoma healthcare facilities. I understand the interview is part of a graduate research project. To maintain confidentiality, all information obtained in the interview process will be reported in aggregate and/or by code. No specific reference to my identity nor to that of the organization for whom I work will be made at any time. All records of this interview will be kept exclusively by the researcher under lock and key. After the research has been concluded and the report approved, all records will be destroyed.

This is done as part of an investigation entitled "A Descriptive Study of Multicultural Awareness Training in Selected Oklahoma Health Care Organizations."

The purpose of the procedure is to gather in-depth perceptions regarding the status, focus and issues surround multicultural awareness training in Oklahoma healthcare facilities. These perceptions will then be compared to other survey data to reach meaningful findings and conclusions.

I understand that participation is voluntary, that there is no penalty for refusal to participate, and that I am free to withdraw my consent and participation in this project at any time without penalty after notifying the project director. I may contact Mrs. Sammie Dixon at telephone number (918) \_\_\_\_\_. I may also contact Gay Clarkson, IRB Executive Secretary, 305 Whitehurst, Oklahoma State University, Stillwater, OK 74078; telephone (405) 744-5700.

I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ (a.m./p.m.)

Signed: \_\_\_\_\_  
(Signature of Subject)

I certify that I have personally explained all elements of this form to the subject or his/her representative before requesting the subject or his/her representative to sign it.

Signed: \_\_\_\_\_  
(project director or his/her authorized representative)

**APPENDIX K**

**Institutional Review Board Approval**

OKLAHOMA STATE UNIVERSITY  
INSTITUTIONAL REVIEW BOARD  
HUMAN SUBJECTS REVIEW

Date: 10-17-97

IRB#: ED-98-024

**Proposal Title: A DESCRIPTIVE STUDY OF MULTICULTURAL AWARENESS TRAINING IN  
SELECTED OKLAHOMA HEALTH CARE ORGANIZATIONS**

**Principal Investigator(s): Reynaldo Martinez, Sammie Dixon**

**Reviewed and Processed as:** Expedited

**Approval Status Recommended by Reviewer(s):** Approved

ALL APPROVALS MAY BE SUBJECT TO REVIEW BY FULL INSTITUTIONAL REVIEW BOARD AT  
NEXT MEETING, AS WELL AS ARE SUBJECT TO MONITORING AT ANY TIME DURING THE  
APPROVAL PERIOD.


APPROVAL STATUS PERIOD VALID FOR DATA COLLECTION FOR A ONE CALENDAR YEAR  
PERIOD AFTER WHICH A CONTINUATION OR RENEWAL REQUEST IS REQUIRED TO BE  
SUBMITTED FOR BOARD APPROVAL.

ANY MODIFICATIONS TO APPROVED PROJECT MUST ALSO BE SUBMITTED FOR APPROVAL.

---

**Comments, Modifications/Conditions for Approval or Disapproval are as follows:**

Signature



Chair of Institutional Review Board  
cc: Sammie Dixon

Date: October 29, 1997

2

**VITA**

**Sammie Scully Grant-Dixon**

**Candidate for the Degree of**

**Master of Science**

**Thesis: A DESCRIPTIVE STUDY OF MULTICULTURAL  
AWARENESS TRAINING IN SELECTED OKLAHOMA  
HEALTHCARE ORGANIZATIONS**

**Major Field: Occupational and Adult Education**

**Biographical:**

**Personal Data:** Born in Henryetta, Oklahoma, on February 24, 1957, the daughter of Sam and Juanita Scully.

**Education:** Graduated from Schulter High School, Schulter, Oklahoma in May, 1975; received Associate of Science degree in Administrative Management from Tulsa Community College, Tulsa, Oklahoma in May, 1981; received Bachelor of Science degree in Business from Northeastern State University, Tahlequah, Oklahoma in May, 1986. Completed the requirements for the Master of Science degree with a major in Occupational and Adult Education at Oklahoma State University in May, 1998.

**Experience:** Employed by Saint Francis Hospital, Tulsa, Oklahoma for 14 years. Last position held: Manager of Employment and Recruitment. Self employed for eight years in precious metals and numismatics.

**Professional Memberships:** American Numismatic Society