learning. We have also been able to provide documentation to other agencies regarding the positive environment they provide for teaching/learning, thus strengthening these relationships.

Changes in objectives have resulted subsequent to discovering some objectives were not attainable at the level they were placed. For example, one objective in the second semester of junior year state: “The student is able to give evidence of an ethical framework that guides own practice.” It became evident through evaluation that students at this level did not have enough theoretical background or sufficient practice to meet this objective. As a result, the objective was changed to: “The student is able to apply ethical principles to selected nursing situations.” Our present data indicate this is a realistic objective at this point in the program.

In other instances we found content was not appropriate in helping the student to meet certain objectives that were realistically placed. Currently, we are attempting to develop better synchronization between objectives and content.

Summary

The comprehensive scope of this evaluation plan, with both summative and formative components, will provide the data necessary to guide our decision making. Some aspects, such as sampling students’ work, the use of simulation, and the testing of actual learning, strengthens this process.

However, satisfaction with our initial attempts at evaluation has not clouded an attitude of scrutiny. Undoubtedly, revision of the evaluation methods will be necessary in the future as inadequacies are pointed out to us through experience.

The faculty have become acutely aware that curriculum evaluation is a time-consuming, tedious process. However, the faculty, committed to bearing responsibility for student performance, have found their involvement educational as well as satisfying. A well-constructed curriculum evaluation system can give the teacher a sense of security; a belief that what works will be preserved while ineffective components will be deleted. As Dressel points out, “Unless continuing constructive evaluation is evident in some form, both teaching and learning degenerate to rote patterns that hardly justify the designation of education” (Dressel, 1980, p. 197).

References


Multiculturalism in Nursing: Implications for Faculty Development

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The view that America is a homogeneous melting pot is gradually being replaced by one which recognizes and promotes not only characteristics of basic commonality, but also those of cultural diversity. Within the past two decades there has been a shift in society's attitude toward cultural pluralism. Ideally, comprehensive nursing care is holistic, serving clients with unique problems and needs. As technology becomes more complex, there is a greater need for a sensitive and caring human response. This phenomenon has been described by Naissiitt (1984) as “high tech/high touch.” Today, as comprehensive nursing care becomes very high tech, the nursing profession is becoming aware of the danger of a concomitant depersonalizing effect on the client (Kelly, 1984). A multicultural emphasis is needed as a part of any high touch dimension. As this is sought in nursing education, well-planned faculty development programs will become necessary to ensure the desired emphasis in baccalaureate curricula.

Historically, the relationship between multiculturalism and nursing theory or practice has received minimal emphasis in baccalaureate nursing curricula. Adams, Bell, Chow, and Martinez (1976) have reported that most nursing school curricula have either failed to include content concerning cultural and racial diversity, or have presented it as a minor digression from the dominant white, middle-class American culture. This digression has been based on the melting pot theory of assimilation, which has implied that various ethnic groups relinquish the unique aspects of their culture as they become absorbed by the dominant culture. Since persons of diverse cultures perceive their health problems in culture-specific ways, with particular expectations for health care (Leininger, 1967), such a premise is untenable.

The Western Interstate Commission for Higher Education (WICHE, 1978) has reported that the failure of some nursing schools to include multicultural concepts within their curricula in an organized and systematic manner has resulted in incidents not only of inappropriate nursing assessment and intervention, but also of actual malpractice. Although some progress has been made since the 1960s when few nursing programs included cultural content, nursing education programs have begun only recently to reflect aspects of culturally relevant nursing care. As of 1983, approximately 18% of all NLN baccalaureate accredited nursing schools included cultural content within their curricula (Leininger, 1984).
Curricula must enable students to appreciate and understand cultural diversity and its function in a society composed of a plurality of cultures, each diverse, yet interdependent (Baptiste, 1979). National accrediting organizations such as the National League for Nursing (Criteria for the Evaluation of Baccalaureate and Higher Degree Programs in Nursing, 1983), as well as regional and state accrediting bodies, now include criteria and standards which address cultural diversity (Beach & Martin, 1983). Distinct and identifiable multicultural content is required in baccalaureate nursing curricula, not only for the purposes of accreditation, but also for the development of behaviors that will enable nursing graduates to render sensitive, holistic, and quality nursing care.

In a recent study conducted by Glynn (1984), nursing program administrators and faculty in NLN-accredited nursing programs in three southeastern states agreed that nursing school curricula and health care must reflect four pertinent categories of multiculturalism: (a) family structure, (b) intercultural communication, (c) values/attitudes, and (d) beliefs and practices. Inherent in the study of family structure are the sociological phenomena of kinship organization and role relationships. Cultural aspects of communication exist which, whether discursive or analogic, appear to be both unique and varied. Certain configurations of values and attitudes toward such variables as health, illness, pain, age, and sex have been identified as culture specific and capable of influencing client behavior. Significant client beliefs and practices, such as those which are spiritual, folk, or ritualistic, have implications for the delivery of health care. All of the above factors affect client behavior in times of developmental and situational crisis.

Although faculty respondents supported the relevance and inclusion of these four categories of multiculturalism and indicated that these concepts received some attention in their respective curricula, they reported that multiculturalism was not a substantive part of their faculty development programs. It is illogical to assume that faculty educated during a period when multicultural concepts did not appear in nursing school curricula would be implementing them in institutions which provided little assistance for implementation through faculty development activity. In light of current and anticipated health care trends and population mobility, faculty development activities should reflect the continually changing cultural diversity inherent within a pluralistic society, and ensure planned rather than incidental integration of cultural concepts in baccalaureate curricula.

A faculty development program for the inclusion of multiculturalism should have four goals: (a) to promote sensitivity and commitment to multicultural concepts; (b) to increase knowledge of cultural difference; (c) to develop an organized plan for the integration of identifiable multicultural content within nursing school curricula; and (d) to plan appropriate experiential opportunities enabling students to enhance the development of caring behaviors which would allow them to render culturally sensitive, comprehensive care.

The first of these goals may be inadequately atttained if it is assumed that faculty are innately sensitive to the concept of cultural uniqueness. Health care givers recognize the importance of comprehensive nursing care and strive toward that ideal; however, the knowledge base needed to provide such care to individuals of differing beliefs and value systems must be learned. Once faculty sensitivity has been developed and the new knowledge base has been acquired, the last two goals can be addressed — desired modifications in curricula and student experiential opportunities. Effective change requires attention at three levels — institutional, programmatic, and individual/professional.

Institutional support will need to be evident not only in commitment to the concept of multiculturalism but also in its support through such provisions as necessary faculty time and library and data resources. At this level, a policy statement and related goals will need to be generated.

Programmatic decisions must be made concerning the inclusion of multicultural concepts in the curriculum through the provision of separate content courses and special seminars, as well as their integration within existing courses and clinical practice. Acquiring knowledge about cultural attitudes, beliefs, and practices does not guarantee sensitivity to them, ability to detect them, or skill to consider implications for health care. Innovative teaching strategies and instructional materials will need to be devised and chosen to promote and enhance intercultural understanding. Performance indicators and examinations used to evaluate students will have to reflect the new multicultural emphasis. All of these programmatic modifications are essential if multiculturalism is to be a continuing part of the curriculum.

The individual/professional level is the most critical. Faculty must be provided with the supportive and collaborative atmosphere necessary to promote professional and personal growth. Such growth can enhance the development of sensitive and caring behaviors that are ultimately transmitted to students by example during the teaching-learning process. Within such a positive environment, the concept of intercultural understanding can become an achievable curricular goal. Since the multicultural dimension is relatively new to nursing curricula, and faculty have had minimal formal exposure to cultural concepts and content, planned faculty development is necessary.

Today, institutions of higher education are planning faculty development programs which promote professional growth as well as instructional enrichment. Chait and Guetha (1981) have identified the following six characteristics of successful programs:

1. The roles and activities through which faculty participate are those which are normally associated with prestige status.
2. The rationale and approach are constructive and developmental rather than remedial.
3. The central administration and senior management support are identifiable and positive.
4. The program is faculty directed, not administratively controlled, and is sensitive to faculty concerns.
5. The effort is structured on a college-wide basis rather than on a departmental one.
6. The reward system includes a wide range of options.

The inclusion of multicultural concepts in baccalaureate nursing curricula can facilitate a broader, more enlightened approach to health care. Only as such concepts are cognitively and affectively understood and integrated clinically by everyone involved will the multicultural dimension of nursing care become a viable reality and not just an academic exercise.

References

Use of Nonparametric Correlation Analysis in Graduate Students Research Projects

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Parametric or nonparametric statistical tests: when is which test appropriate? Siegel (1956) purports that there are four considerations that are involved in choosing an appropriate statistical test: (1) the power of the test; (2) the way the sample of scores is drawn; (3) the nature of the population the sample is drawn from, and (4) the type of measurement of the variables. In order for a parametrical statistical test to be used, certain assumptions or conditions must be met. The observations must be independent and must be drawn from normally distributed populations. In addition, the variables must be measured on either the interval or ratio scale. If these conditions cannot be met, a nonparametric test should be used. A nonparametric statistical test does not require an assumption concerning the parameters of the population from which the sample is drawn. Nonparametric statistics require data to be measured only on an ordinal or nominal scale.

A continuing controversy among statisticians exists, however, over whether or not it is valid to use parametric statistics with data measured on an ordinal scale. One side of the argument asserts that if parametric statistics are used with ordinal data, the research findings will be distorted (Siegel, 1956). Proponents belonging to the other side of the argument believe that the use of parametric statistics with ordinal data is appropriate since the type of statistical test, nonparametric or parametric, and the scale of measurement used are two separate considerations (Armstrong, 1981). Even if one does believe in the latter argument, the researcher must still make certain his or her ordinal data meet all the assumptions for a particular parametric test before using it.

The crux of why this controversy holds significance for researchers is that nonparametric statistics are less powerful than parametric statistics. The probability of failing to reject the null hypothesis when it is indeed false is higher if a researcher uses nonparametric statistics. In this case, the investigator obtains significant results but the nonparametric statistic is not strong enough to detect the significance, so the findings appear to be nonsignificant. The power of a nonparametric test may, however, be increased by increasing the sample size.

No matter which side of this statistical argument nursing faculty are on, they will still be confronted with the frequent use of nonparametrical tests in advising graduate students' research projects/theses. For example, even though a student's primary variable can be measured on an ordinal or interval scale and the assumption regarding the normality of the population drawn from can be met, if the relationship to be investigated is between this primary variable and a dichotomous variable, a nonparametric test must still be used. Both variables are not measured on either an ordinal or interval scale.

The analysis of such a relationship between an interval or ordinal variable and a dichotomous variable was common in the graduate students' research projects during my first year teaching research in a master's program in primary health care nursing. Due to the time constraint of this one-year program, research projects instead of theses had been required. Because of these smaller scale research studies, the majority of the samples of scores were drawn non-randomly. After reviewing the literature and consulting with a faculty member,* two nonparametric statistics rarely addressed in statistics books, were found which were appropriate for the analysis of the correlations in the graduate students' data. Rank biserial correlation and point biserial correlation were these two nonparametric statistics. Five out of a total of eight research projects in my class used point biserial correlations. Two research projects utilized rank biserial correlations, and only one project did not use either of these two nonparametric statistics.

The purpose of this article is to share with nursing faculty who are involved in advising of graduate students theses or research projects these two lesser known nonparametric statistics which can be used to determine whether or not a relationship exists between two variables. Examples from the graduate students' research projects have been included to illustrate these nonparametrics statistics.

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