

## DEVELOPING CULTURAL COMPETENCE IN RURAL NURSING

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### ABSTRACT

Preconceptions of rural lifestyle and culture can color the perspective of future health care providers. To encourage Advanced Practice Nurse (ANP) students to think beyond the mythology about a rural place different than where they practice, two nurse educators and universities teamed up to develop a unique curriculum in which students immersed themselves in a new rural experience. In this innovative curriculum design, students visited a rural Appalachian coal-mining community in an immersion experience to conduct a community assessment and worked with local health care providers in community health education projects in collaboration with a nurse educator and ANP who provides health care to the community through a primary care clinic. The students discovered for themselves the distinctions of rural life in rural West Virginia. This project led to experiential learning and heightened attainment of cultural competence on the part of the students and demonstrated how a collegial effort between nurse educators in two universities and long distance collaboration can benefit students who may someday deliver care in rural communities.

### INTRODUCTION: DEVELOPING CULTURAL COMPETENCE IN RURAL NURSING

Health care providers may have preconceived and even erroneous perceptions of people living in rural areas regarding their lifestyles, health habits, and culture. Although there are some concepts considered to be central to rural people as a whole, the culture of rural areas may vary widely from region to region. Since rural culture can be manifested in many ways and often differs by setting, nursing educators need to consider broadening the perspective of students to a variety of cultural settings in an effort to increase rural cultural competency. The purpose of this article is to describe the collaborative relationship and the unique curricular design of a practicum in which students visited a rural community quite different from their own. They conducted a community assessment, assisted on a community health teaching project, and immersed themselves in a rural community in a coal mining area of West Virginia in order to build cultural competence. This project allowed students to discover for themselves the distinctions of rural life in a unique locale.

### CULTURAL IMMERSION

Providing high quality health care and assisting people to change behaviors and understand the benefits of health living is fundamental to nursing practice. Cultural

misunderstandings and miscommunications may form obstacles that thwart the level of nursing services provided (National Alliance for Hispanic Health, 2001). Rural America is diverse with varying populations, geographies, economies, and ethnicities. Appalachia is a predominantly rural and diverse region within the United States. As a population of health interest, many Appalachian people exceed other Americans in years per life lost on many national health indicators (Health Risks, 1995). Culturally, Appalachian people have been portrayed throughout the twentieth century as a static, homogenous, white mountain culture (Reel, 2002; Newell-Withrow, 1997). However, Appalachia traverses a broad stretch of land from New York to northern Mississippi with diverse geographies, economies, and people (Appalachian Regional Commission, 2002).

This paper presents a cultural immersion strategy for exploring diversity of rural Appalachia between New York and West Virginia. Cultural immersion, as a strategy to educate culturally competent nurses and has been successfully utilized elsewhere to develop cultural competence and cultural self-efficacy among nursing students (Ryan, Twibell, Brigham & Bennett, 2000; St. Clair & McKenry, 1999; Jones, Bond, & Mancini, 1998). Cultural immersion in this project relied on a short-term program that permitted graduate nursing students from Binghamton University to have lived experiences in rural West Virginia, and promoted opportunities for transforming static perspectives about rural Appalachian people and places. This approach is consistent with that of the American Academy of Nurse Experts on culturally competent care, which supports that cultural sensitivity is prerequisite to cultural competence (Leininger, Meleis, Davis, Ferketich, Flaherty, Isenberg, Koerner, Lacey, Stern & Valente, 1992).

While rurality is diverse, one of the challenges to understanding any culture, including rural ones, is recognition that human societies tend to develop ethnocentrism—the viewing of one’s own cultural standards as the true universal and the judging of other cultures by one’s own standards (National Alliance for Hispanic Health, 2001). Culturally immersed clinical experiences promoted opportunities for transforming static perspectives about rural Appalachia in West Virginia and rural New York. For example, the target county for cultural immersion experiences is located in the Southern West Virginia coalfields. Rural life in this county is dominated by the coal industry and changes affiliated with this industry, and differs considerably from the predominantly farming rural areas with which nursing students at Binghamton University are familiar. The educational exchange between Binghamton University and Marshall University relied on immersion as a strategy to expand student’s realities of rural diversity as well as to dispel negative connotations historically associated with Appalachian people.

### **HOW IT ALL BEGAN: BRAINSTORMING LEADS TO COLLABORATION**

The connection began in 1998 at the First International Congress of Rural Nursing in Saskatoon, Saskatchewan, Canada. The authors met and discussed methods to teach diversity in rural nursing courses. The brainstorming and sharing of ideas lead to collaboration between two nurse educators at the two universities. The common bond for these educators was searching for ways to increase cultural competency in nurses who would be advanced nursing practitioners working with rural people.

The Decker School of Nursing (DSO), of Binghamton University is part of the State University of New York system. Binghamton University began as Triple Cities

College in 1946 and has grown into one of the four premier university centers in the State University of New York educational system. The DSON was established in 1969 and today offers Baccalaureate, Master of Science, and Doctor of Philosophy programs in the field of nursing. Fifty-one percent of Decker School Master of Science (MS) Degree Nurse Practitioner graduates practice in rural under-served areas after graduation. The DSON is the first in the country to offer a Ph.D. in nursing focusing on rural health care. In 1998 the O'Connor Office of Rural Health was created at the Decker School of Nursing. The purpose of this office is to serve as a resource regarding the health care needs of rural residents.

Myths about rural lifestyles are common among Americans. The picture of a pastoral life, healthy eating, and fresh air is promoted from early childhood books to the current media of film, television, and advertising. Further, specific regions of rural America have a second layer of mythology, especially seen in common views regarding Appalachia and coal mining areas. The Decker School of Nursing has integrated rural concepts and experiences into every part of the curriculum and offers an eight-credit concentration in rural nursing to MS students. However, the focus had been on the rural experience in upstate New York. Many of these students have lived and worked in rural upstate New York, where dairy and fruit farming are prevalent. The goal was to encourage students to think beyond the mythology about another rural place.

The Marshall University College of Nursing and Health Professions is one of nine schools and colleges in Marshall University, a public university founded in 1837. Consistent with the mission of Marshall University, the College of Nursing is committed to offering quality undergraduate and graduate nursing education. The focus of the School of Nursing is upon being interactive with the community in assessing the health care needs of the people, including rural and under-served areas, and in responding to contemporary and future needs of society and the nursing profession. All health science students in West Virginia public institutions of higher education must receive training in rural areas. Marshall University nursing students all experience a clinical rotation with rural or under-served population prior to graduation.

In 1998, the U.S. Department of Health and Human Resources, Health Resources and Services Administration, Division of Nursing, funded a nursing special project grant to the Marshall University College of Nursing and Health Professions. This grant created the Marshall University Appalachian Rural Outreach Primary Care Nursing Center (ARONPCNC), which is located in an elementary school in the target county. Advanced nursing practice is the cornerstone of the nursing center.

The immersion practicum for Decker School of Nursing students was designed to incorporate the objectives of the rural nursing concentration within the context of a rural nursing center practice located in an Appalachian coal-mining community. This project not only gave students an opportunity to meet individual and course objectives but also built connections for future collaboration in education and research between the two universities.

## **CURRICULUM DESIGN OF THE RURAL NURSING IMMERSION EXPERIENCE**

### *Assumptions and Definitions*

This course was based on the assumption that rural life is a culture. For the purposes of this course, rural communities may be considered rural by nature of their low population, sparseness of population, isolation, dependence on the land, or lack of urban influence. Students were expected to define and provide rationale for a community to be considered rural. Purnell and Paulanka define culture as “the totality of socially transmitted behavioral patterns, arts, beliefs, values, customs, lifeways, and all other products of human work and thought characteristics of a population of people that guide their worldview and decision making” (1998, p. 2).

Cultural competence (Purnell and Paulanka, 1998) is achieved through four actions: (1) developing an awareness of one’s own existence, sensations, thoughts, and environment without letting it have an undue influence on those from other backgrounds, (2) demonstrating knowledge and understanding of the client’s culture, (3) accepting and respecting cultural differences, (4) adapting care to be congruent with the client’s culture. Cultural competence is a conscious process and not necessarily linear (p. 2).

### *Setting: Appalachia*

Appalachia is an ancient region that has periodically claimed national attention. Considerable debate lingers regarding whether a distinct Appalachian culture exists as the lines of Appalachian culture are heterogeneous and often overlap both rural and urban norms. Both literary writers and scholars have portrayed Appalachian people as ignorant, uneducated, backward, and primitive. After John F. Kennedy was elected president, Appalachia was the common arena for new public assistance policies and programs designed to alleviate the suffering of those residing there. Yet, despite a concentration of national attention, the health status of Appalachian people remains one of risk.

About 23 million people live in the 410 counties of the Appalachian Region, which is predominantly rural (Appalachian Regional Commission, 2002). Much of central Appalachia (which encompasses the southern coal belt) has a poverty rate of 27 percent, rural per capita income only two-thirds of the national average, and unemployment much higher than the national average. Demographically, West Virginia is the second most rural state in the United States with 63.9% of the total state population living in counties designated as rural (U. S. Census Bureau, 1995). Historically, the state is poverty-plagued with impoverished children the most significant concern. One quarter of the population under age 18 is impoverished and in four counties, 100 percent of female-headed households with children under age 5 are impoverished (WV Primary Care Access Plan, 1996).

This immersion experience was conducted in a rural county located in the heart of the southern West Virginia coalfields. The majority of towns in the target county are quite small. No local bus systems operate within or between them, and the mountainous terrain and winding secondary roads lead to transportation barriers being repeatedly identified as an issue that affects health care access. The county has a total population

base of 25,870 residents. Coal, although no longer “king” throughout Appalachia, is the central economic resource of the county. Job layoffs are common among the mines, and there are no other major employers to accommodate displaced miners.

New York state itself is quite diverse, encompassing pockets of both great wealth and deep poverty; as well as remote mountains, rolling farmlands, and vast metropolitan New York City. Statistics fail to capture the rural aspects of the state because the data are usually merged with those of metro areas.

Binghamton University is situated in a county that is part of the Appalachian region. It has a metro area surrounded by farmlands. Terrain is rarely a barrier to services, but poverty and distance can be. The public transportation in the rural areas is inadequate to assist with obtaining services. When farmers leave farming, there are sometimes alternative occupations available, often in manufacturing, the service industry, or tourism. Table 1 displays census data comparing the two counties, two states, and the United States.

Table 1

*Comparison of the Two Counties, Two states, and United States; as of the 2000 U. S. Census*

	Broome Co., New York	New York State	Boone Co., West Virginia	State of West Virginia	United States
Population	200,536	18,976,457	25,535	1,808,344	281,421,906
Population density	283.7 persons per sq. mile	401.9 persons per sq. mile	50.8 persons per sq. mile	75.1 persons per sq. mile	79.6 persons per sq. mile
Percent rural	--	15.7%	--	63.9%	24.8%
Persons below poverty	13.8%	15.6%	19.7%	16.8%	13.3%

(U. S. Census Bureau, 2000)

### ***Objectives and Learning Strategies***

The learner will:

1. Develop personal cultural competence by:
  - a. Developing an awareness of one’s own existence, thoughts, and environment without letting it have an undue influence on those from other backgrounds;
  - b. Demonstrating knowledge and understanding of the client’s culture;

- c. Accepting and respecting cultural differences;
- d. Adapting care to be congruent with the client's culture.
2. Analyze the health status of a rural community using a framework.
3. Develop skills to enhance practice in rural communities.
4. Synthesize rural cultural competence and advanced nursing practice.

Teaching/learning strategies included a personal journaling, readings, discussion, immersion in the new community, e-mail consultation with colleagues, community assessment, community education project, and a poster presentation.

### ***Implementation***

Implementation begins with planning. Collaborating faculty and institutions worked together to assure an effective learning experience for the students. Many details had to be discussed and worked out prior to the students embarking on the practicum. These details included logistics such as professional licensure, legal contracts, getting the students to the site, living arrangements, exposure to the culture and the people of the area as well as designing the actual learning experience. Ramifications of small details can have a potentially large effect on the outcomes of the project. For instance, there was discussion of what messages students might inadvertently bring to the community by driving a car with New York State license plates in rural West Virginia. Another big consideration was living arrangements. There were benefits and problems with each potential living situation and these had to be weighed and balanced. For instance, if the students lived in a setting together it would allow ample discussion time among them as well as promote work on the assessment project while the students were on site. The alternative considered was placing the students with families. The benefit would be access to key informants to clarify and amplify information collected during the day. Living with the people would provide a true immersion. However, this option would place undue burden on both students and the host families and would be more difficult to arrange for the entire group.

Costs of the course were not considered prohibitive by the students. The students paid for their professional licensure in West Virginia. While they were not providing "hands-on" care, this precaution was made to legitimize the community assessment process and because they were developing a community education project. Since this was a clinical course, malpractice insurance is provided through the school of nursing and is part of tuition expenses. Travel expenses (gasoline and hotel en-route for two nights) were borne by the students and were variable according to choices. Some meals were provided by community residents and some were purchased by the students.

### **THE EDUCATIONAL EXPERIENCE—AN IMMERSION PRACTICUM**

Each student was expected to meet the course objectives of developing personal cultural competence, analyzing the health status of a rural community using a theoretical model, develop skills to enhance practice in rural communities and to synthesize rural cultural competence in advanced nursing practice. These objectives were to be met through a mix of group and individual learning activities.

Students had already successfully completed a three-credit didactic and theoretical course in rural health and rural health care systems. This summer semester five-credit course was the clinical portion of a concentration in rural health. The experiential part of this concentration was designed to bring the theory to life and allow the students, with the guidance of the local nurse educator, to focus on developing cultural competence. The actions of developing cultural competence (Purnell & Paulanka, 1998) were used to design the learning strategies for students to participate in this rural nursing practicum where they immersed themselves in a rural coal-mining community in West Virginia.

Students prepared themselves for this immersion experience by reviewing the literature about coal mining communities in addition to the reading popular literature, viewing pertinent videos, and participating in class discussion. There were 2 pairs of students that visited the site for 1 or 2 weeks over a period of one summer. A third pair was scheduled to go, but experienced unforeseen personal barriers (health and family responsibilities). The students went by car to West Virginia. One overnight was necessary so that they would arrive in daylight to the clinical site. The ARONPCNC Project Director / preceptor in West Virginia arranged for a windshield survey of the area with a driver who had grown up in the community. This took the better part of a day, and this person served as a key informant and access point for them to speak with other residents. After this introduction, each team created their own paths to obtain the information desired for their portions of the community assessment. They were expected to involve themselves in as many community activities as possible in addition to their assessment activities. Choices made included church services, dances, family dinners, and hiking. Each evening they participated in e-mail consultation with their classmates in New York State. The preceptor arranged an excellent housing opportunity for the students on the second floor of a collaborating health care facility (in renovated former hospital rooms). This supplied them with privacy, bedrooms, showers, computer access, telephones, TV/VCR, and library.

Each team on site reported daily via e-mail to classmates who recorded information in a Community-Oriented Health Record (Stanhope & Lancaster, 2000) and responded with questions for the on-site team to follow up. The students used Anderson and McFarlane's (2000) Community-as-Partner model to guide the community assessment. Each student selected one "piece of the pie" to focus on. Areas of assessment data were recreation, physical environment, education, safety and transportation, politics and government, health and social services, communication, and economics. Since students might gather information for any section, the "owner" of each section was responsible for organizing and following up on missing data. The students maintained personal journals to confront personal biases and preconceived notions about the community visited. This journal was shared with the instructor who offered suggestions and feedback about progress. The students were expected to assist local health providers in health education projects as well as share the community assessment document with the ARONPCNC Project Director / preceptor. The project completed was a brochure to advertise a cancer prevention program. Finally, the students prepared a poster on their experience and the community assessment for presentation at a rural nursing conference.

## OUTCOMES

### *Objective 1*

The students demonstrated development of personal cultural competence in their journals and the extent to which they successfully immersed themselves in the new culture.

### *Objective 2*

The students found that the “Community as Partner” Model (Anderson & McFarlane, 2000) was very useful for information gathering. They went on to describe this success in their poster presentations.

### *Objective 3*

Skills for practice in rural communities were developed, although the extent of this development is becoming more evident as they pursue their practices post graduation.

### *Objective 4*

The synthesis of rural cultural competence and advanced nursing practice is evidenced to some degree; however, this remains a lifelong goal.

The students met the objectives of the course, and in some cases exceeded expectations. Students viewed themselves as having increased their cultural competence to work with individuals in a rural community that was new and different than those they had previously experienced. One student shared candidly in her journal her preconceived notions about Appalachia and coal mining, as well as her evolution considering where she will begin her nurse practitioner work upon graduation. It appeared to the instructor that the course was extremely helpful and well timed for her personal and professional development. The student has since obtained employment in a third world country and continues electronic journaling and seeking input via e-mail from faculty and colleagues. Two have sought employment as rural Nurse Practitioners – one in a southern state and one in New York. Others are pursuing more education and continue to demonstrate their interest in rural health.

The students chose to share their experiences and findings with the professional community by developing and presenting a peer-reviewed poster at a rural nursing conference. As a team they were very excited to see the work come together on the poster. The poster is entitled “Appreciating the importance of using a community assessment wheel model to identify the needs of a rural community.” The student team presented similar posters at the local Sigma Theta Tau chapter research conference and at the American Public Health Association Convention in November 2000.

The community assessment was a team effort and the model assisted in dividing the tasks among the students. It was an ambitious project that took longer than expected. One lesson learned is that it is difficult to maintain momentum for completion in a long

distance project with students completing the immersion portion of the course at various times. Life events and scheduling difficulties of adult students planning an immersion experience can cause scheduling problems for the faculty, preceptors, and community contacts and lead to the need for creative strategies. Even families left at home had the opportunity to consider some of the realities of rural life while adjusting to their family member's preparations and absence. These issues of distance, time, and limited resources for education are areas for further exploration with future groups.

## CONCLUSION

The practicum course with its immersion experience provided opportunities for students to develop cultural competence as well as for the two universities and the schools of nursing to develop a beginning working relationship with rural communities quite different from the surrounding areas of each school. With some modifications, the course design will be used again, and it is hoped that relationships among schools and communities will evolve to provide more opportunities for students. Rural clinical sites with adequate supervision are sparse and must be used efficiently so that as many students as possible can develop cultural competence. This unique curriculum with the immersion model supplied excellent access for students to begin their progress toward such competence.

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