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Exploring Organizational Culture and Intercultural Communication Practices in a Teaching Hospital

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EXPLORING ORGANIZATIONAL CULTURE AND INTERCULTURAL COMMUNICATION PRACTICES IN A TEACHING HOSPITAL

by

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DISSERTATION

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DEDICATION

To my mentors and friends, the strong women who

have always inspired me to find my voice and use it.

To Maria, Ann, Janet, and most of all, Mom.

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ABSTRACT

As the population in the United States becomes more diverse, communities are increasingly experiencing disparities in health care quality that follow racial and ethnic lines. It has been documented that improving health care providers' intercultural communication is one way to help reduce these health disparities.

This study investigated the intercultural communication practices of employees at a large teaching hospital in the Southwest that is actively working to reduce health disparities in its community. Recognizing the influence of organizational culture on communication in a workplace, this study looked not only at communication practices, but also at organizational culture and at diversity training as an artifact of organizational culture. This study used the intercultural praxis framework as a theoretical foundation and investigated the utility of the framework in this organizational setting.

Both qualitative and quantitative data collection methods were used to explore employees' intercultural communication practices. Hospital texts including website text, newsletters, and diversity training materials were analyzed to determine whether the hospital's organizational culture supported intercultural communication practices. A

survey instrument designed to measure the use of intercultural praxis modes was developed and distributed to a random sample of hospital employees to determine what communication practices employees use and whether there is a difference between the practices of employees who have and have not completed diversity training. This study sought not only to understand what communication practices are used, but also how they are used. Employees' narratives were analyzed using a critical incident survey to investigate how intercultural communication practices are used in this organization and how organizational members define culture.

Results indicate that the organizational culture at this hospital is supportive of several intercultural communication practices, and employees are using some practices more than others in their intercultural interactions, including the additional practice of avoidance. Employees understand culture as including a person's language, ancestry, tangible attributes like gender and practices, and intangible attributes like beliefs and values. Their communication practices were found to contain four underlying factors—engagement, positioning, inquiry, and introspection—and a fifth factor, language, also emerged in both textual and narrative data as being important to employees' intercultural communication.

Findings in this study were used to build theory, including a suggested revision of the intercultural praxis framework, to contribute methodologically to communication research, and to suggest practical next steps for the hospital in their continued fight against health disparities.

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CHAPTER 1: INTRODUCTION

The United States has historically been a nation of changing demographic diversity, and in the last few decades, the population has continued to shift. This shift has produced health disparities that can potentially be reduced by improving intercultural communication in health care settings (Saha, Korthius, Cohn, Sharp, Moore, & Beach, 2011). In this dissertation, I examine the intercultural communication practices of health care employees at a large, public teaching hospital in New Mexico that serves a diverse and economically disadvantaged patient population to inform hospital personnel's future actions to reduce health disparities in their community. To do this, I propose a theory-based instrument that combines intercultural and organizational communication literature to identify communication practices that can improve health outcomes.

In the following chapter, I provide evidence of changing patient demographics and health disparities. Then, I explore the health care workforce's relatively stagnant demographics and health care organizations' attempts to improve intercultural communication through diversity training. Next, I examine the specific health disparities that are evident in the state of New Mexico and the problems I seek to address in this dissertation. I conclude the chapter with my purpose, research questions, assumptions, and definitions of key terms I use throughout the study.

Demographics and Health Disparities

Nationally, the patient population in the United States continues to grow and change. As evidence of this change, the U.S. Census Bureau (Mackun & Wilson, 2011) reports that the population of the United States has grown around 9-13% every decade for

the past 50 years. In each census period, the growth of specific racial, ethnic, gender and age populations has fluctuated, changing the overall makeup of the population. Between 2000 and 2010, over half of the increase in total U.S. population is due to an increase in people of Hispanic ethnicity, a group that now comprises 16% of the total population (Humes, Jones & Ramirez, 2011). All major race groups increased in population between 2000 and 2010, with the Asian population growing at the fastest rate and what the Census Bureau calls the "White alone" population experiencing the slowest growth. The White alone population was the only race group to decrease its proportion of the total population in that time (Humes, Jones & Ramirez, 2011). Changing racial patterns mean changing patient populations, which impact health care providers.

Other population shifts also contribute to changing patient demographics. For example, the 2010 census revealed that the U.S. population is aging. The population over 65 years old rose 15.1% while the total population rose only 9.7%. The 65-and-older population's proportion of the total U.S. population has also increased from 4.1% in 1900 to 12.4% in 2000 and to 13.0% in 2010 (Werner, 2011). Nationally, the percentage of the population living in poverty rose from 12.2% in 2000 to 15.9% in 2012 (Bishaw, 2013). Adults who are living with severe disabilities are more likely to experience persistent poverty than adults with nonsevere disabilities or no disabilities. In 2010, 18.7% of the population had a disability, and 12.6% of the population had a severe disability (Brault, 2012). Age, ability to pay for medical services and disability rates are additional concerns for health care providers serving our changing population.

As the U.S. population becomes more diverse, health care providers place more attention on differences in health outcomes. For example, the Centers for Disease Control

and Prevention (CDC) identified health disparities linked to race, ethnicity and socioeconomic factors in the U.S. (2011). Health disparities are "differences in health outcomes between groups that reflect social inequalities" (CDC, 2011, p. 1). The CDC (Brennan Ramirez, Baker & Metzler, 2008) reported that "most health disparities affect groups marginalized because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location, or some combination of these" (p. 6). African Americans were nearly nine times more likely to die of AIDS as Whites in the U.S., members of all other major racial and ethnic groups were more likely than Whites to be diagnosed with diabetes, and the cancer death rate is higher among African Americans than Whites (Brennan Ramirez, Baker & Metzler, 2008). Clearly, some health disparities follow racial lines.

Health disparities go beyond death and diagnosis rates and also include disparities in quality of care. Not only are some racial and ethnic minority groups in the U.S. statistically more likely than Whites to suffer or die from various illnesses, but they are also more likely to report experiencing poor quality provider-patient interactions when they seek health care (Department of Health and Human Services [HHS], 2011). Individuals living with disabilities are more likely to experience health problems but less likely to receive preventative care than their non-disabled counterparts. Individuals who identify as lesbian, gay, bisexual, or transgendered are more likely to experience psychological distress and use mental health services than are their heterosexual counterparts (Association of American Medical Colleges [AAMC], 2010). As patient populations become more diverse and disparities increase, efforts must be made to improve health care workers' abilities to understand and address these disparities. Thus,

as the HHS reports that "the ability of the healthcare workforce to address disparities will depend on its future cultural competence and diversity" (2011, p. 3). While many health care organizations in the U.S. attempt to increase the diversity of their workforce through hiring and promotion, they do not always train workers effectively to deal with diversity. I argue that intercultural communication training is one way to improve care and reduce health disparities, but more research needs to be done to measure communication results from such training.

Health Care Workforce

While the patient population in the United States has become more diverse, the health care workforce has not changed at the same rate. There are notable differences in the racial, ethnic, age and gender composition of the health care workforce in the U.S. as compared to the general population. In 2008, the U.S. Census Bureau estimated that males made up approximately 51% of the population ("Vintage 2008: National Tables"); and the AAMC (2010) reported that in the same year, males made up 63% of the physicians in the U.S. In 2012, in health care management in the U.S., White males achieved promotion to upper management positions at higher rates than their female or ethnic or racial minority counterparts. Females achieved CEO positions in health care organizations at 50% of the rate of males with comparable experience in 2012 (American College of Healthcare Executives [ACHE], 2012). In 2008, more White males achieved CEO positions than males of other racial and ethnic groups (ACHE, 2008). Women and members of racial and ethnic minority groups earned 20-34% less than their White male counterparts in U.S. health care management positions (ACHE, 2008, 2012). Because the demographics of the health care workforce do not align with the demographics of the

patient population in the U.S., more opportunities for intercultural interaction in health care may exist.

Hiring and managing a diverse workforce is important in the health care field for several reasons. First, there is evidence that sound diversity management in organizations in any industry can create competitive advantages in the areas of cost, resource acquisition, marketing, creativity, problem-solving, and organizational flexibility (Cox & Blake, 1991). These advantages can be achieved when a variety of perspectives and backgrounds contribute to key decisions and when the culture of the organization supports a harmonious and respectful work environment.

Second, health care organizations can provide more efficient and effective care when their workforce mirrors the population it serves (Gordon, 2005). Notably, 15% percent of African Americans, 13% of Hispanics, and 11% of Asian Americans believe they would receive better health care if they were of a different race or ethnicity. These three groups also reported being treated with disrespect in a health care setting at a higher rate than reported by Whites (Commonwealth Fund, 2001). Ideally, a diverse workforce contributes to more culturally appropriate care.

Third, across industries, a corporate culture that values diversity is a strong predictor of organizational adoption of diversity programs and trainings (Dobbin, Kim, & Kalev, 2011). Dobbin et al. (2011) found that although regulatory necessity and industry norms have very little effect on diversity program adoption, managerial diversity and corporate culture promote program adoption. For example, in the health care industry, certain diversity initiatives are required for organizations to maintain accreditation. But, as Dobbin et al. (2011) found, even in a highly regulated environment, the level at which

organizations adopt diversity programs is still driven primarily by ethnically diverse management teams and an organizational culture that values diversity.

Diversity Training

Adopting diversity training programs is one of the key ways organizations attempt to manage diversity effectively (Cox & Blake, 1991). In the health care field, diversity training is particularly relevant because, as the HHS (2011) reported above, cultural competence is necessary for addressing health disparities and providing competent care. On the macro level, Curtis, Dreachslin, and Sinioris (2007) argue that training is an important contributor to human resources practices that manage diversity effectively in a social context where unequal access to health care and institutional biases exist.

On the micro level, health care providers who perceive themselves as effective intercultural communicators and believe they are culturally sensitive report less anxiety in intercultural patient encounters, which improves the quality of care (Ulrey & Amason, 2001). Training may help increase self-efficacy beliefs because employees are given the tools they need to improve their communication. Diversity training is typically designed to raise awareness of cultural differences, to help employees acknowledge their biases and change their attitudes, and to build skills that are directly applicable to the workplace (Curtis et al., 2007). The successful transfer of these skills to a health care provider's job is necessary for providing culturally competent care (Curtis et al., 2007). Thus, it is not only important that diversity training is implemented in health care settings, but that it is directed toward on-the-job practices.

Health Care in New Mexico

Intercultural communication is particularly important in hospitals and clinics in the southwestern United States. In the Southwest, many of the groups that experience health disparities are more widely represented than they are in the rest of the country. For example, in New Mexico, 20% of the population lives in poverty compared with 15.9% in the rest of the country (American Community Survey, 2013). Forty-seven percent of the population identifies as Hispanic compared with 16.9% in the U.S., and 10% of the population is American Indian compared with 1% of the total U.S. population (U.S. Census Bureau, 2012). These demographics create a unique patient population for New Mexican health care providers to serve.

Health issues in New Mexico are numerous. The teen birth rate in New Mexico is nearly 70% higher than the national average; more than half of New Mexicans with diabetes do not receive the recommended services; suicide rates for adults and teens in New Mexico are significantly higher than national averages; and adult and youth obesity, particularly among the American Indian population, are above national averages in New Mexico (New Mexico Department of Health, 2012). Approximately 20% of New Mexicans have no health insurance (New Mexico Department of Health, 2011). A disproportionate number of New Mexicans who live in poverty and/or identify with racial and ethnic minority groups receive health care at a large public hospital, Southwest Teaching Hospital (STH), because of the locations of its clinics and the financial assistance it offers as a public hospital. At this institution, lowering health disparities is a priority, and management sees interculturally competent care as one way to address the problem.

Diversity and inclusion are emphasized at STH in a number of ways. The vision statement of STH states, "STH will be the leader in improving our state's health outcomes through both our academic specialty programs and our community responsive, culturally competent, patient care, education, and clinical research programs," and one of the organization's five core values is "diversity in people and thinking" ("Our Mission, Vision, and Core Values," n.d.). In October 2010, STH created the Office of Diversity, Equity & Inclusion (DEI), which "leads the effort to make sure that every STH patient receives the safest, most effective, most sensitive medical care possible, regardless of the patient's race, ethnicity, or any other group identity" ("Diversity, Equity & Inclusion at STH," n.d.). In a culturally diverse community with an abundance of health disparities, this office is charged with identifying and addressing disparities among the patient population.

One of the ways DEI attempts to fight health disparities is through training. DEI offers four training courses for employees: Diversity & Intercultural Competence I and II, which focus on general communication practices that can help providers interact more effectively with a variety of patients; Caring for the LGBT Community, which focuses on the specific health and care needs of lesbian, gay, bisexual and transgender patients; and Creating Reader-Friendly Print and Web Materials Frontline Training, which focuses on training employees to ask questions on hospital intake forms in a way that promotes a "judgment-free zone." DEI also helps coordinate a short online diversity training module and a health literacy course. The online module is among dozens of required annual training modules for all employees, but all of the face-to-face courses are voluntary. Neither DEI nor STH collects data about the effectiveness or on-the-job implications of

any of their diversity-related training programs. Thus, decisions they make about training and other programs and initiatives designed to address health disparities are not made based on data.

Problem Statement

The problems I seek to address in this study are threefold: there is inadequate information available to inform health care providers' decisions about how to address health disparities; there are several gaps in the existing communication literature; and there is currently no instrument designed specifically to identify intercultural communication practices in intercultural communicative interactions.

First, diversity training programs are one of the key ways many organizations attempt to improve intercultural communication among employees, but these programs often have limited success. Without structural forces in place that contribute to accountability and expertise in managing diversity, diversity training targeting biases has virtually no effect (Kalev, Kelly, & Dobbin, 2006). When organizations have affirmative action plans, diversity managers and departments, and diversity committees/taskforces directed toward structural change, the organizational environment may provide the necessary support for employee diversity training to be effective. This study sheds light on the interrelationships among organizational culture, training, and employee communication to provide a more holistic approach to improving intercultural communication. Specifically, this study seeks to inform the decisions of health care organizations as they address health disparities in the United States.

Second, there are key gaps in the literature that I seek to fill with this study. When researchers approach diversity training, they frequently focus only on particular training

outcomes rather than considering employees' actual performance in intercultural interactions or the organizational culture that influences those performances. For example, De Meuse, Hostager, and O'Neill (2007) studied participants' perceptions and attitudes following training, and King, Dawson, Kravitz, and Gulik (2012) studied levels of ethnic discrimination before and after training. More research is needed to focus specifically on practice in the workplace to determine what other factors may contribute to effective diversity training. Bezrukova, Jehn, and Spell (2012) reviewed and examined 178 studies of diversity training in the U.S., and they found that a critical gap in the literature is a deep understanding of the behaviors and cognitions that stay with trainees. The authors argued, "these outcomes are likely to have the strongest ties to the ultimate purpose of diversity training" (p. 222). This dissertation looks specifically at practices being currently used in the workplace at STH. Additionally, Bell, Connerley, and Cocchiara (2009) call for studies that compare the work-related behaviors of employees who did and did not participate in diversity training, which this study does. In addition to these notable gaps in current diversity training literature, there are few studies that investigate diversity initiatives through the lens of communication. Because communication is at the heart of provider-patient interactions, it is important to consider diversity training in terms of its communication objectives.

Finally, I propose a theory-based approach to identifying intercultural communication practices. As I argue here, employee practices and actions in intercultural interactions need to be the focus of a study of the intercultural communication practices in an organization. But, there is no current instrument available for identifying intercultural communication practices in a particular community without making some

kind of judgment of "competence" or "effectiveness." In this study, I propose an instrument based on Sorrells and Nakagawa's (2008) framework of intercultural praxis to identify and understand the intercultural communication practices health care employees use.

Purpose of the Study

This study investigates how health care organizations, specifically STH, can create an organizational culture that supports diversity and inclusion. Specifically, I focus on the practices, or praxis, of intercultural communication evident in employee interactions, and compare the practices used by employees who have and have not participated in basic diversity training at STH. The site of this research is STH, a large public teaching hospital located in a diversely populated city in New Mexico. This is an appropriate site for studying intercultural communication practices and the effectiveness of diversity training because of the demographic diversity of the patient population, the organizational efforts to promote diversity, and the hospital's mission to be a leader among public hospitals.

Inequality persists in patients' access to health care and to the quality of treatment they receive in the United States and in New Mexico. Hospitals like STH try to close the gaps in health care by making diversity a stated organizational focus and by creating training to help employees communicate with diverse populations more effectively. Through a thorough examination of the key texts about diversity at STH, the communication practices of employees, and the stories employees tell about their intercultural work experiences, I offer insight into the complex relationships shared by organizational culture, intercultural praxis, and diversity training.

Research Questions

The following research questions guide my study:

RQ1: To what extent do textual artifacts at STH create an organizational culture that supports intercultural praxis in the workplace?

RQ2: How can employees' use of intercultural praxis modes be measured in a hospital environment?

RQ3: How do narratives express employees' understanding of culture?

RQ4: How do narratives express the way employees use modes of intercultural praxis in workplace interactions?

RQ5: To what extent does the use of intercultural praxis modes differ between employees who have and have not participated in diversity training?

Assumptions

I approach this research with several key assumptions. First, my work is informed by a social constructionist approach to organizational culture. I assume that reality within an organization is co-constructed by its employees, its management, and its cultural artifacts through symbolic interaction. Organizational practices and textual artifacts provide employees with a context for sensemaking and cues for interpreting and evaluating the defining characteristics of the organization (Ravasi & Schultz, 2006). Second, I assume that the way organizational members make sense of the cues and textual artifacts in their organizational environments is through the stories they hear and tell. I believe that "organizations need a coherent narrative, just as humans do" (Czarniawska, 1997, p. 24), and organizational narratives can be uncovered and understood through the stories told by their members. Finally, I assume that learning is an

ongoing process, and learning from training is not taking place unless employees continually transfer their learned attitudes, knowledge, skills, and abilities to their jobs (Baldwin & Ford, 1987).

Definitions

Before examining the literature that serves as a foundation to this study, I offer definitions for key terms that are relevant to the concepts under investigation. Because I seek to understand the organizational culture at STH to determine the ways in which it may foster a culture of diversity, I adopt the following definitions that are used in the Diversity & Intercultural Competence I (DIC I) training course at STH.

Diversity

Diversity is defined as "human attributes that are different from your own and from those groups to which you belong. Valuing diversity means valuing the differences in experiences, attitude, knowledge, and skills between any and all groups." In addition to valuing the diversity of others, the training attempts to foster in participants an awareness and appreciation of their own diversity.

Culture

STH's diversity training adopts a definition of culture that is attributed in presentation materials to Stella Ting-Toomey: "A complex frame of reference that consists of patterns of traditions, beliefs, values, norms, symbols and meanings that are shared to varying degrees by interacting members of a community." Culture is represented visually in presentation materials as an iceberg, with some parts being visible and recognizable, but most being below the surface and not readily apparent. My perspective of culture is that cultures are group identities with shared patterns of

communication and interpretation; they are always multiple and constantly changing; and they are shaped by context and social structures. I believe this is true for all cultures, including organizational cultures, national cultures, ethnic cultures, and family cultures.

Intercultural Competence

Intercultural competence as a communication construct is not addressed in this study. I do not make a judgment of whether employees at STH are "competent;" rather, I examine their intercultural communication practices. But, intercultural competence is a term used in both the course title and the training content, so it warrants definition. STH defines intercultural competence as "keeping your biases from interfering with how you perceive and treat people [and] treating people the way they want to be treated." The terminology choice is made explicit in the presenter's notes: "I prefer 'intercultural competence' instead of 'cultural competence' because we are trying to build competence in being flexible in our interactions and responses, NOT expertise in other cultures" (capitalization in original). The presentation notes further explain that the goal of the training is "expanding our toolboxes" rather than narrowing communication options, as a person might if he or she attempted to study only the specific generalizable attributes of a particular group.

In addition to definitions used at STH, I offer definitions from communication literature for three more key terms: organizational culture, cultural artifacts, and intercultural praxis.

Organizational Culture

Organizational culture is the assumptions and norms that are collectively shared by organizational members (Louis, 1980) and are co-created by organizational members

through communicative interaction (Keyton, 2005). Organizational culture can be studied through its artifacts, values and assumptions (Schein, 1985). Specifically, this study examines textual cultural artifacts, such as training materials, Web pages, newsletters, and policies that are in place at STH.

Artifacts

Artifacts are elements of a cultural group that reveal members' symbols, meanings, and norms (Keyton, 2005). Artifacts may be material objects, such as documents, or intangible concepts such as traditions. Along with members' values and assumptions, artifacts comprise organizational culture (Schein, 1985). This study focuses on documents as artifacts of the organizational culture at STH. Documents are defined as "symbolic texts that can be retrieved for analysis" (Lindlof & Taylor, 2011, p. 229). Documents analyzed in this study include training materials (handouts, slides, and presenter script), website copy, and newsletters.

Intercultural Praxis

Intercultural praxis is a process of "socially responsible intercultural engagement" (Sorrells & Nakagawa, 2008, p. 19). It is a framework that captures the practices individuals may use to navigate everyday intercultural interactions. There are six component parts of the intercultural praxis framework: inquiry, framing, positioning, dialogue, reflection, and action. All six of these ports of entry into intercultural praxis are discussed in detail in Chapter 2.

In the following chapter, I review the scholarly literature that informs key constructs in my research questions, including organizational culture, learning in training contexts, learning transfer to the workplace, and intercultural communication praxis.

Then in Chapter 3, I provide a methodological overview of my study and discuss in detail my mixed method approach to answering my research questions. Chapter 4 is an analysis of my data and findings, and Chapter 5 discusses my conclusions as well as the implications, applications and limitations of this study.

CHAPTER 2: REVIEW OF LITERATURE

As our nation's population increasingly diversifies and disparities in health outcomes persist, many health care organizations are trying to adapt to changing patient needs through diversity training for health care workers. But, I argue that training is only one piece of a larger puzzle that influences the way health care workers interact with people in the workplace whom they see as culturally different from themselves. Understanding these interactions and identifying the communication practices, symbols and contextual factors involved in health care workers' intercultural communication can help provide health care organizations with data to inform their decisions as they work to fight health disparities in their communities.

This study investigates how organizational culture can support diversity and inclusion, how health care employees practice intercultural communication and express their understanding of it through narrative, and the impact of diversity training on employees' stories and praxis. In this chapter, I review the literature in four key areas that provide the theoretical grounding for this study. First, I briefly explain symbolic interactionism as a theoretical framework guiding my research. Next, I examine organizational culture, how it is constructed in organizational environments, and how it can be understood through narrative. Then, I look at learning in organizational contexts and the transfer of that learning to the job. Finally, I discuss intercultural praxis and six modes of entry: inquiry, framing, positioning, dialogue, reflection and action.

Symbolic Interaction

Symbolic interactionism is important to this study because it explains the ongoing production of the symbols used by organizational members, which drives their organizational culture, their learning, and their communicative practice. Symbolic interactionism explains meaning not as inherent in a thing or action, but as arising from interaction among people (Blumer, 1969). For example, the way employees at STH understand "culture" may differ from the way their friends or family members define it because they have had different interactions that have created the meaning of "culture" within their particular community. The socially produced meaning of "culture" at STH may be entirely different from the meaning produced at another organization. Blumer (1969) explains, "human beings act toward things on the basis of the meanings that the things have for them" (p. 2). Thus, to understand the way people act toward culturally different people, it is necessary to understand what meaning the actors assign to culture and difference. That is why this study seeks to unearth the specific symbols and practices used around culture at STH to better understand employees' intercultural communication. But, understanding employee communication is difficult to do without also identifying what practices they use, and the intercultural praxis framework provides a useful theoretical lens for this purpose.

Symbolic interaction theory frames this study because it is a point of convergence for all of the topics I discuss in this chapter. Organizational culture is constructed through sensemaking interactions, that sensemaking is expressed and understood by members through narrative, and the symbols used become the basis for learning and training in the organization. Studying the symbols used by organizational members and their self-

reported interactional behavior is essential to understanding and explaining their intercultural communication practices. Symbols and their meaning are at the root of organizational culture and intercultural communication. This study is grounded in symbolic interactionism as a way of understanding intercultural interactions in health care to better inform organizational decisions and practices aimed at reducing health disparities. Symbolic interactionism helps explain how organizational cultures arise.

Organizational Culture

When studying employee communication, the culture of the organization can provide essential context to the investigation because it influences employees' communication and actions. Louis (1980) defines organizational culture as the assumptions and norms that are collectively shared by organizational members. Expanding upon this definition, Schein (1985) describes organizational culture as "feelable" and "visible" because even though assumptions and norms are intangible, "the phenomenon of culture is real and has an impact" (p. 24). Culture is so pervasive that Schein (1985) argues that individual and organizational actions cannot be understood without accounting for the cultural elements that provide context to that action. Thus, investigating the cultural aspects surrounding diversity at STH is critical to understanding the intercultural praxis of employees.

While analyzing organizational culture, it is important to remember that the collective understandings and interpretations of shared culture are not all universal within the organization. Organizational culture is co-constructed by organizational members through their communicative interactions with members and with written texts such as websites and newsletters. Thus, organizational culture is constantly shifting and adapting.

Keyton (2005) explains that members create the culture of an organization through their "strategic and spontaneous, intentional and unintentional, formal and informal, and verbal and nonverbal interactions" (p. 44). Culture is created and reproduced through interaction, and thus, interactions are a primary focus of this study.

Organizational culture can be further understood by examining its component parts. The elements that comprise organizational culture are artifacts, values and assumptions. This particular segmentation of organizational culture appears in the literature routinely over the past few decades (e.g., Armenakis, Brown, & Mehta, 2011; Chen & Corritore, 2008; Keyton, 2005; Schein, 1985). Artifacts can be tangible, such as documents or training materials, or intangible, such as norms and traditions. Artifacts, particularly norms, can provide unstated expectations about behavior because organizational members may act a particular way simply because everyone else is acting that way and not because there is an explicit policy in place (Keyton, 2005). Artifacts alone are not sufficient for understanding a culture because they do not necessarily reveal the meanings that organizational members attach to the textual artifacts (Schein, 1985).

Values and assumptions are important for researchers to consider when investigating culture. Keyton (2005) defines values in the organizational context as the "strategies, goals, principles, or qualities that are considered ideal, worthwhile, or desirable, and as a result, create guidelines for organizational behavior" (p. 24). Assumptions are deeply held beliefs that are taken-for-granted among organizational members and are rarely acknowledged or discussed. They are "subtle, abstract and implicit" (Keyton, 2005, p. 26). Assumptions guide behavior because they direct how organizational members think, feel, perceive and act, and behavior based on any premise

other than the assumptions of the organization would be inconceivable (Keyton, 2005; Schein, 1985). All three components of culture—tangible and intangible artifacts, values, and assumptions—work together to shape and guide practices within an organization. They also reveal the priority issues for organizational leadership (Schein, 1985). Employees' workplace interactions cannot be fully understood without examining the necessary context of organizational culture. As health care organizations work to reduce health disparities, understanding the cultural influences on employee communication may be a key way to improve patient care. Part of what makes organizational culture so influential to communication is its co-constructed nature.

Co-construction of Culture

As stated above, organizational culture is constructed through communicative interaction with others and with messages and texts. As Keyton (2005) observed in case studies, "organizational members are simultaneously responding to and creating the social and symbolic reality of the organizations' cultures. From the social and symbolic realities of all organizational members, an organizational culture emerges. Thus, organizational culture is communicatively constructed" (p. 43-44). In this way, organizational culture is fluid and dynamic. Culture can change as members move into, out of, and within the organization, which creates opportunities for new patterns of behavior and shared meanings (Keyton, 2005).

Critics of organizational culture as a lens for research argue that there is no way to nail down a single collective perspective in organizations because organizational members all belong to a number of collectivities outside the organization (Lewis, 1998). But, understanding organizational culture as dynamically constructed allows for

differences among individual members. Although individuals will inherently be different from one another, within the collective of the organization, the meanings they have will be shaped by those people and messages that comprise their shared organizational culture (Keyton, 2005). This is why organizations, such as hospitals, provide a rich site for study. Gioia (1986) explains:

> People who are organizing can only do so on the basis of some sense of collective understanding. The understanding arrived at is dependent on the interpretations given to the shared experience; and because those interpretations can be markedly different within varying contexts and with different organizational members, the reality constructed is relative to the actors and their immediate context. (p. 51)

Thus, the differences between individual organizational members contribute to, not detract from or obscure, the culture of the organization. This perspective helps illuminate the variety of shared meanings and patterns that comprise an organizational culture. One way to access the symbols, meanings and behaviors of an organizational culture is to study the sensemaking of organizational members.

Sensemaking

The collective understandings in an organizational culture are the ways that organizational members make sense of their environments and what occurs within them. This is known as sensemaking. Gioia (1986) argues, "sensemaking *is* meaning construction" (p. 61, italics in original). He defines sensemaking as the process in which people engage to create meaningful explanations for situations and experiences. When a nurse considers her supervisor's request to allow family members in the exam room, for

example, he might draw on past experiences at the hospital, compare this request to previous requests, and reflect on how coworkers responded to the request in order to make sense of it. Gioia approaches sensemaking in this definition as an individual endeavor, but Weick (1995) argues that in organizational contexts, the individual and the organization are inseparable. He notes, "sensemaking is never solitary because what a person does internally is contingent on others" (p. 40). Continuing with the example above, when the nurse makes sense of the request and decides how to react, he will consciously or unconsciously be considering how his actions will impact others. This is what Weick (1995) calls the "implied, imagined presence of others" (p. 40). In this way, sensemaking, like organizational culture itself, is social in nature and is co-constructed by organizational members. The symbolic interactions of employees create and reproduce culture, and they also help members make sense of that culture. Thus, this study approaches workplace interactions and organizational culture as inseparable.

Sensemaking links organizational culture and member behavior because it explains the process by which organizational members use cultural cues to make decisions about how to act. The ways organizational members use sensemaking to guide action is driven by the artifacts, values and assumptions of the organizational culture. Textual artifacts contribute to sensemaking through the vocabulary employed by the organization. Gioia (1985) argues, "the language used by an organization 'defines' its reality and thus influences its culture" (p. 67). The role of management, in his view, is to manage the words and symbols that provide employees with the labels, categories and explanations they need to make sense of and give meaning to their work environment. For example, if a hospital that traditionally referred to the medical staff as "employees"

changed all of its documents to refer to staff as "team members," that change in label may lead to a shift in employees' understandings of their roles and, in turn, the practices they use to enact those roles. This study examines textual artifacts and the language they contain to gain insight into the organizational culture at STH.

Organizational culture is also critical to this study because it directly influences employee action. Weick (1995) argues that organizations exert influence over values and assumptions through "premise control," whereby the values and taken-for-granted implicit assumptions limit members' options in decision-making. Premises come into play at the beginning of the sensemaking process. Because of what organizational members consider important or irrelevant (values) and what they consider to be their roles and organizational goals (assumptions), the range of possible interpretations and resulting actions are constrained (Weick, 1995). Sensemaking processes may happen in a variety of ways, but each one generates action (Maitlis, 2005). This provides further support for the argument that employee actions cannot be understood without accounting for organizational culture. As Choo (1996) explains, organizational sensemaking produces an enacted reality that influences both decision-making and knowledge-building within the organization. Sensemaking explains how culture influences action, which is why it is important to consider sensemaking in a study of the communication practices organizational members use in intercultural interactions. Members express their sensemaking and the meanings they ascribe to different symbols through narrative.

Narrative

Organizational members reveal their sensemaking in the context of their organizational experiences through the stories they tell (Keyton, 2005). This makes

narrative a useful point of entry for a researcher to understand organizational culture, sensemaking and action. Sensemaking is, by nature, retrospective (Gioia, 1986; Weick, 1995), and storytelling is a means for sensemaking (Boje, 2008); both involve piecing together information into a logical explanation. As Eggly (2002) explains of narrative, "When we see something we do not understand, we try to understand it. We do this by creating an explanation for extraordinary events, stringing them together into a logical plot" (p. 341). Similarly, when making sense of their organizational experiences, members often use a storyline or plot to organize their conceptualization of the situation. Thus, organizational members' narratives can provide insight into their sensemaking and symbolic meanings.

Weick (1995) notes several advantages to using narrative to express sensemaking. Among these advantages are that stories help people reconstruct complex events; they guide action; they help people build a database of experiences on which to draw in the future; and they convey shared values and meanings. All of these characteristics of narrative underscore the importance of narrative to this study. By asking organizational members to reconstruct a complex communication event, such as an intercultural interaction, I can gain insight into their choices of action and the shared values and meanings that indicate characteristics of their organizational culture. And, because organizational members keep drawing on their interactional experiences to guide future action, I can better understand their patterns of practice.

In a study of communication in an organization, narrative is important because it is a key way in which members express sensemaking. As Czarniawska (1997) argues, "The main fount of organizational knowledge is the narrative" (p. 21). To understand

organizational culture and individual sensemaking within that culture, narrative provides a unique and necessary access point. I think it is important to note that while some scholars differentiate between story and narrative (Boje, 2008), I follow Reissman's (2008) lead in using the terms interchangeably in this study. Here, I argue that organizational culture is co-constructed by members through communicative interaction, and members make sense of and express their sensemaking of these interactions through their stories. But, organizational culture is one of many influences on an individual's communicative action, and learning is another important factor to consider. Particularly as health care organizations implement diversity training programs as a way to improve provider-patient communication and reduce health disparities, the combination of learning and culture becomes important for understanding employee communication practices.

Learning

Organizational members learn in many ways in their workplaces. These learning experiences contribute to employees' understanding of diversity and culture in their particular work environment. Here I define learning for the purposes of this study and discuss the different types of learning that happen in organizations.

Learning is a change in human knowledge, attitude or behavior that is retained over time and is attributable to some factor other than growth (Gagné, 1977). This definition includes several component parts. Learning can be cognitive, meaning the acquisition of knowledge; affective, meaning changing attitudes, beliefs or values; or psychomotor or behavioral, meaning changes in behavior or skill (Bloom, 1956). Cognitive learning includes "the recall or recognition of knowledge and the development

of intellectual abilities and skills" (Bloom, 1956, p. 7). Examples of cognitive learning include remembering the definition of diversity, learning inclusive words or phrases and applying them in appropriate conversational settings, and taking several perspectives on "culture" and distilling them into an understanding of the concept.

Affective learning is the emotional dimension of learning. "Meaningful learning is fundamentally grounded in and derived from the adult's emotional, imaginative connection with the self and with the broader social world" (Dirkx, 2001, p. 64). Affective learning is about feeling, not fact. It is about changing the way people see the world in relation to themselves, and vice versa. Examples of affective learning include uprooting a strongly held stereotype about a particular group of people, learning to approach cultural difference with an open mind, and learning not to judge people's worth by the color of their skin. Behavioral learning is rooted in action.

Behavioral learning can be found in changes in action or skill, not thought or emotion (Merriam, Caffarella, & Baumgartner, 2007). Examples of behavioral learning may include asking open-ended questions to learn more about a patient's culture, including family members in health care conversations, and calling for interpretive services when a patient's first language is not English. Diversity training engages all three types of learning simultaneously (Roberson, Kulik, & Pepper, 2009). The DIC I program at STH is no exception. The stated course objectives, found on p. 4 of the booklet given to participants, are:

1. Define diversity, culture and intercultural competence
2. Gain knowledge of how culture affects perception and how one is perceived

3. Develop awareness of group membership, personal biases, and how these affect interaction with others
4. Build skills to minimize the effects bias and communicate more effectively

Objectives 1 and 2 are cognitive, objective 3 is affective, and objective 4 is behavioral. In diversity training, simply acquiring knowledge without the affective or behavioral elements is not enough (Curtis, Dreachslin & Sinoris, 2007).

To be considered learning, changes must be sustained over time and not fleeting, as memorization can be, for example. The key to sustained learning is meaningful learning (Ausubel, 1967). Ausubel studied cognitive learning and found that learning is meaningful only when it can be related to existing concepts in a learner's cognitive structure. Without links to existing content, Ausubel calls the learning "rote" and easily forgotten. In organizations, existing content may take the form of artifacts in the workplace such as signs, newsletters, or training materials. For example, Kulik, Pepper, Roberson and Parker (2007) found that employees who have greater awareness of equal opportunity laws and higher cultural competence were more likely to attend and engage in diversity training. For these employees, their existing knowledge of the legal environment prompted better diversity training attendance and engagement. This study illustrates why organizational culture is so important as a context for diversity training and how training itself is an artifact of organizational culture. Training materials are important artifacts because they reflect what the organization considers important and reveal the symbols organizational members use to convey particular meanings. When an organizational culture supports diversity and provides employees with exposure to key

ideas in the workplace, the learning that happens in diversity training may be more meaningful.

Learning does not happen exclusively in structured learning situations. The workplace itself produces many learning situations every day. Adult learning happens in a variety of contexts. Marsick and Watkins (2001) differentiate among adult learning experiences that are formal, informal and incidental. Formal learning happens in traditional learning settings, like classrooms. Informal learning is typically less structured, and the control of the experience lies solely in the hands of the learner. Incidental learning is also informal, but it is unintentional and is often the byproduct of another activity. For example, diversity training is a type of formal learning. An employee who goes online and researches patient diversity on her own is learning informally. An employee who works in a hospital where signs, newsletters, and other employees carry messages of cultural competence will likely learn incidentally. Marsick and Watkins underscore the idea that informal and incidental learning are "the most pervasive forms of adult learning" (p. 31). Employees spend much more time doing their jobs or looking up information they need for their jobs than they do in formal training settings. Barr (2007) argues that informal learning drives the agenda for institutional, or formal, learning. The information employees seek out to do their jobs and the information deemed important in the organizational culture will determine the topics on which formal training is offered. Understanding the cultural context around formal training is necessary for understanding training decisions because the two are interrelated.

Diversity Training

Diversity training in the United States was developed from regulatory requirements. Following John F. Kennedy's 1961 Executive Order 10925 requiring federal contractors to take "affirmative action" to hire and treat employees without regard to race, companies began to adopt non-discrimination policies that were a precursor to today's diversity training (Dobbin & Kalev, 2013). Health care organizations must comply not only with federal and state non-discrimination standards, but also with the standards of The Joint Commission, an accrediting body. The Joint Commission website describes the organization as "An independent, not-for-profit organization [that] accredits and certifies more than 20,000 health care organizations and programs in the United States" ("About the Joint Commission," 2013). Maintaining accreditation is important to STH, and it is one of the motivating factors behind the organization's current diversity training program.

The regulatory climate of the health care industry is important to this study because it impacts some of the decisions made by STH and creates a macro-level context in which individual employees are interacting. The Joint Commission provides a comprehensive set of standards for hospital accreditation. Among these standards is the requirement that "Staff participate in education and training that is specific to the needs of the patient population served by the hospital" ("Roadmap for Hospitals," HR.01.05.03 EP5, 2010). Diversity training falls under this standard, among others. Additionally, a recent focus of The Joint Commission has been patient-centered communication, and new standards went into effect on July 1, 2012 ("Advancing Effective Communication, Cultural Competence, and Patient-and Family-Centered Care," 2012). New standards

include communication in a way that is culturally and linguistically appropriate for the patient. At STH, these specific communication topics are covered in the DIC I training, but separate training for patient-centered communication is also available.

In organizations of all types in the United States, a business case can be made for the benefit of cultural competence and diversity training (Cox & Blake, 1991). For health care organizations, cultural competence is not only a good business move, but it is also necessary for accreditation and compliance. Accreditation standards require employee training to meet patient needs, but the culture of the health care organization will have a greater impact on the programs offered (Dobbin, Kim & Kalev, 2011). Dobbin, et al. (2011) found that organizations do not respond to industry adoption norms as much as their own organizational culture when adopting diversity training programs. As I argued earlier, that is why understanding the culture of diversity at STH provides a crucial context for this study. Organizational culture and its associated textual artifacts, including training, are key ways in which organizational members may learn the practices they should use in intercultural communication interactions. The effects of all artifacts should be considered by health care organizations as they work to fight health disparities, and those effects can be understood by examining the concept of learning transfer.

Learning Transfer

When the knowledge, skills and attitudes taught in training programs or learned incidentally in the workplace are subsequently used by employees in their jobs, the training has transferred to their jobs. Learning transfer is "universally accepted as the ultimate aim of teaching" (McKeogh, Lupart, & Marini, 1995, p. 1) and is "the aim of all education" (Haskell, 2001, p. 3). These accolades for learning transfer underscore its

importance in on-the-job training. Baldwin and Ford (1987), who proposed a widely accepted model of learning transfer, define the concept as "the degree to which trainees effectively apply the knowledge, skills, and attitudes gained in a training context to the job" (p. 63). The authors clarify that the learning must be generalized to employees' specific job and sustained over time in order for transfer to have occurred. Young (2013) views transfer as ongoing and processual: "If we agree that learning is an ongoing, situated process that does not end when the learner leaves the classroom, workshop or other educational setting, then it is easy to see the need to view transfer as a fluid rather than a static concept" (p. 72). I adopt Baldwin and Ford's definition in this study because its inclusion of attitudes, knowledge and skills aligns well with the training objectives of this particular course at STH, which are discussed above. I also accept Young's assertion that learning transfer is an ongoing process because it broadens the more traditional conceptualization of transfer to include informal and incidental learning.

One key distinction in transfer theory is near transfer versus far transfer. Foley and Kaiser (2013) explain that near transfer occurs when the new situation or opportunity for transfer closely resembles the training situation, while far transfer requires a greater degree of generalization by trainees because the new situation is dissimilar to the training situation. For example, one of the scenarios discussed in DIC I is a situation where a Muslim patient has a miscommunication with his physician in regard to the way his religion impacts his treatment options. A near transfer opportunity could include a trainee's interaction with a Muslim patient in regard to a religious issue, whereas a far transfer opportunity might involve an interaction with an American Indian patient regarding alternate healing methods. Near transfer is most commonly observed in

manufacturing or technology training, where a specific process or tool is taught, and the exact same process or tool needs to be implemented on the job. In a health care setting where the goal is for employees to communicate effectively with culturally different patients, the diversity of the patient population makes it nearly impossible for near transfer opportunities to be provided by a trainer.

While scholars agree on the importance of learning transfer, they also acknowledge that it rarely occurs (Haskell, 2001). Leimbach (2010) found that only 15-20 percent of the money organizations invest in learning actually results in workplace changes. This finding is consistent with Faerman and Ban's (1939) conclusion that although "millions of dollars are spent on training in the public sector … there is little empirical evidence linking training to improved job behavior or employee attitude" (p. 299). This could be because organizations and researchers may be looking for transfer in the wrong places. Roberson, Kulik and Pepper (2009) found that in diversity training programs, only skill-based or behavioral learning showed a significant positive correlation to transfer; affective and cognitive learning did not.

Thus, this study focuses primarily on workplace practices, not cognitive or affective factors. Baldwin and Ford (1987) argue that the factors influencing transfer are the work environment, trainee characteristics, and the design of the training program. This study examines the organizational culture at STH to understand the organizational environment, surveys a cross-section of the employee population to gather data about individual characteristics, and identifies communication practices employees use in intercultural interactions to focus on the practical elements of the training design. To accomplish this, I structure this study around the intercultural praxis framework, which

focuses more on communicative practices than on affective or cognitive workplace learning.

Intercultural Praxis

To study the intercultural communication practices that STH employees use in workplace interactions, I propose using the intercultural praxis framework. Intercultural praxis was introduced by Sorrells and Nakagawa (2008) as a process for "socially responsible intercultural engagement" (p. 19). The authors created the framework as an alternative to intercultural competence models, which Sorrells (2013) says lack the depth of knowing, complexity, and emphasis on process that is needed to understand intercultural interactions (K. Sorrells, personal communication, November 13, 2013). The authors define intercultural praxis as "a process of critical, reflective, engaged thinking and acting that enables us to navigate the complex, contradictory, and challenging intercultural spaces we inhabit interpersonally, communally and globally" (p. 26). In other words, humans take part in intercultural interactions every day, and the intercultural praxis framework captures the practices that they may employ to get through the interactions. Sorrells and Nakagawa (2008) write that humans potentially have opportunities to use intercultural praxis "at all moments in our day" (p. 26). In health care settings in diverse communities like the one served by STH, intercultural interactions are occurring constantly. The intercultural praxis framework may provide scholars a way to categorize and more deeply understand the practices employees use in these interactions.

The intercultural praxis framework also has roots in social justice, or socially responsible communication. As Sorrells (2013) explains, "the model, then, attempts to address cultural differences (which may manifest on individual/interpersonal, group and

global/international levels) as well as how these differences are constructed, viewed and experienced in relationships of power and systems of power" (K. Sorrells, personal communication, November 13, 2013). In the United States today, health disparities are, by definition, evidence of social inequality (CDC, 2011). This social inequality creates an interactional power difference between patients and providers. Because providers are trained professionals, Ulrey and Amason (2001) argue that the burden of ensuring effective communication is on health care providers. Thus, it is the responsibility of health professionals to communicate in a way that accounts for cultural difference and acknowledges the power dynamics of the patient-provider interaction. If a health care provider is engaging in intercultural praxis, he or she will communicate in a socially responsible way (Sorrells & Nakagawa, 2008). It is reasonable to assume that intercultural communication in health care settings that is rooted in social justice may help reduce health disparities in the community.

Intercultural praxis is a practical tool for analyzing health care employees' communication practices. Sorrells and Nakagawa (2008) divide intercultural praxis into six component parts: inquiry, framing, positioning, dialogue, reflection, and action. The authors call these components "ports of entry" because at any time, each one may be the most salient way a person enters a particular intercultural interaction. Sorrells (2013) specifies that all six ports or modes of praxis are not used equally in a single interaction. "All portals [sic] are necessary, and yet I think it's useful to think about them as foreground and background. In other words, we may be focusing particularly on inquiry at one moment, but as we inquire, we're also aware of framing and positioning" (K. Sorrells, personal communication, November 13, 2013). The six ports of entry are

important because they illustrate specific mindsets and behaviors that will allow me to identify whether and how employees at STH are engaging in intercultural praxis during intercultural interactions. Sorrells (2013a) argues that intercultural praxis provides "a blueprint for developing intercultural competencies" (p. 231). Intercultural competence is an explicit goal of (not to mention the title of) the basic diversity training course at STH. Thus, this framework can be used to measure the extent to which STH's training practices are used in intercultural interactions. In the next six sub-sections, I explain each of the modes of entry into intercultural praxis in the context of health care.

Inquiry

In intercultural praxis, the first port of entry is inquiry, which "means a desire and willingness to know, to ask, to find out and to learn" (Sorrells & Nakagawa, 2008, p. 27). The authors explain that inquiry is a mindset as much as an action. A person engaging in inquiry will not only ask questions, but will also genuinely want to know the answers. Sorrells and Nakagawa (2008) cite the work of Rosaldo (1989) as illustrative of the interrogative dimension of praxis. Rosaldo's approach to culture centers on context: "The translation of cultures requires one to try to understand other forms of life in their own terms" (Rosaldo, 1989, p. 26). He explains that what may seem outrageous to one person is commonplace to another, and the only way to understand cultural practices is to allow individuals to define the context of their own culture. To do that, a person has to ask, which is the nature of inquiry in intercultural praxis. Inquiring about the culture of another person allows the other to define his or her practices in his or her own terms.

In a health care setting, inquiry means providers do not only ask the prescribed questions of a patient, but also ask questions that will lend insight into the patient's

cultural practices. For example, a nurse asks a patient if he would consider a blood transfusion if necessary. The patient says he would not. If the nurse is using inquiry as a port of entry into the conversation, he would not just check a box on a form and consider the question answered, but rather, would ask "why" with a genuine desire to understand the patient's perspective. In a study on health education for immigrants, Zou and Parry (2012) found that asking questions was key to nurses' abilities to provide effective education and overcome barriers such as culture and socioeconomic disadvantage. They concluded, "improving cultural competence in nursing practice, careful inquiry and comprehensive knowledge of immigrants' social circumstances are essential to every health education programme" (p. 487). Whether it is used in an education program that reaches many or in a conversation between two people, inquiry is a strategy for creating socially responsible intercultural communication.

Inquiry emerges in an interaction in several ways. Sorrells (2013b) defines the characteristics of inquiry as: "Curiosity about self and others who are different from ourselves; interest in learning, growing and understanding others; willingness to take risks and suspend judgment; flexibility to challenge worldview and be changed" (lecture slide 4). These characteristics include the necessary mindset that I mentioned above. They also include another important point that Sorrells and Nakagawa (2008) highlight: that inquiry involves risk. The risk the authors reference is the risk of having one's taken-for-granted assumptions challenged and one's perceptions changed. For true inquiry to occur in a health care setting, the provider must not only be interested in learning about a patient's culture, but must also be open to changing the way he or she sees medicine and healing.

Framing

The second mode of praxis is framing. Sorrells and Nakagawa (2008) see framing in intercultural praxis as the ability to access a variety of perspective-taking options. The authors explain, "our perspectives, our views on ourselves, others, and the world around us are always and inevitably both constrained and enabled by frames" (p. 28). Frames are the lenses or cognitive schema that human beings use to organize and make sense of the world.

The roots of framing theory trace back to Bateson (1972) and Goffman (1974). Over the past four decades, framing theory has been most often applied in media and agenda-setting contexts. Goffman proposed frames as "primary frameworks" that "allows its user to locate, perceive, identify, and label a seemingly infinite number of concrete occurrences defined in its terms" (p. 21). I conceptualize these frames as internal frames, an internalization of experiences and information that helps an individual make sense of new information. Individuals use frames to categorize new information and to make choices about what is relevant and what is not. For example, a nurse who sees a sign posted in the hospital reminding employees to wash their hands frequently may interpret this through a personal frame of good hygiene, a professional frame of communicable diseases, and an organizational frame of medical malpractice. All three operate on different levels that combine to influence his perception of the message.

In the media effects sense of framing, frames are **externally** imposed by mediated communication. When a communicator chooses what to include or exclude from a mediated message, she imposes a frame on the content that influences the audience's perception of it. For example, if the handwashing signs specifically mention hygiene but

ignore disease spread and malpractice lawsuits, the hospital administration has selected the frames through which they want their audience to interpret the signs. Sorrells and Nakagawa (2008) draw directly from Goffman's (1974) original work and focus on internal frames, not external ones.

Sorrells and Nakagawa (2008) specify that framing in intercultural praxis has two parts: recognizing one's own frames on the micro, meso, and macro levels; and the ability to consciously shift among these frames. Micro-level frames include recognizing one's own communication styles, identities, and preconceived notions. In the example above, the nurse's personal hygiene frame is micro-level because it reflects his own personal knowledge, priorities and values. Meso-level frames involve the norms of the cultural groups to which one belongs. The nurse's communicable diseases frame is meso-level because it reflects his role as a health care professional and his group membership in the organizational culture of the hospital. Macro-level frames include larger structural forces and contexts. The nurse's medical malpractice frame is macro-level because it reflects the regulatory and legal structures within which the hospital operates. If this nurse were explaining handwashing to a patient in a way that engages intercultural praxis, he would be aware of the various frames he employs to understand the issue and would be able to consciously shift among his perspectives.

Positioning

The third port of entry is positioning. Part of what shapes the frames people use on the micro and meso levels is social positioning. Sorrells and Nakagawa (2008) argue that individuals' positioning in socially constructed hierarchical categories, such as race, class, gender, and physical ability, have real consequences in interactions. The authors

explain, “Like the lines of longitude and latitude that divide, map, and position us geographically on the earth, these hierarchical categories position us socially, politically, and materially in relation to each other and in relation to structures and configurations of power” (p. 29). Because positioning is relational, it depends on context. For example, a well-respected engineer may be in a position of considerable power at work, but then when she leaves work to go to a doctor’s appointment, she occupies a less powerful position because her physician has a greater understanding of her health conditions. Being aware of patient and provider positioning in various socially constructed categories is the first step in using positioning to engage in intercultural praxis.

The second element of positioning in intercultural praxis is attention to the consequences of our and others’ positioning. When first introducing the concept of positioning, Davies and Harré (1990) focused on its consequences: “The main relevance of the concept of positioning for social psychology is that it serves to direct our attention to a process by which certain trains of consequences, intended or unintended, are set in motion” (p. 51). Those trains of consequences, in intercultural communication interactions, are manifested in whose voice is heard. Continuing with the previous example, the physician gained his position of power by being more knowledgeable in the specific context of an office visit. If both the physician and the engineer accept this positioning, the doctor’s voice will be heard, but the engineer’s may not.

Davies and Harré (1990) explain that when one speaker adopts a story line where he is in a position of power, the other speaker has several options. Among these are to conform to the story line, to reject the story line out of a lack of understanding of the first speaker’s intentions, pursue her own story line as an attempt to resist, or to conform

because she doesn't think she has a choice. In a health care setting, the patient's perception of her own power and her understanding of her own positioning will determine her reaction to a provider's assertion of power through knowledge. That is why it is so important for providers to be aware of their own positioning and what story lines they initiate in patient conversation. As Sorrells and Nakagawa (2008) explain, "attention to positioning demands that we question whose knowledge is privileged, authorized, and agreed upon as 'true' and whose knowledge is deemed unworthy, 'primitive,' unnecessary, and 'false'" (p. 29). In health care, the scientific approach to healing is often valued over naturalistic approaches, which privileges the voices of doctors over the voices of shamans or spiritual healers. Health care providers who use positioning to enter intercultural praxis will be aware of their own and others' positioning and what effects that positioning may have on the interaction.

Dialogue

The fourth mode of intercultural praxis is dialogue. One of the potential consequences of positioning is whether or not the interactional participants will be able to engage in dialogue. Dialogue has many academic definitions, but in the intercultural praxis framework, it refers to communication that stretches across difference and engages actively with other points of view (Sorrells & Nakagawa, 2008). The authors conceive of dialogue as a process that

> invites us to stretch ourselves—to reach across and to exceed our grasp—to imagine, experience, and engage creatively with points of view, ways of thinking, being and doing, and beliefs different from our own while

> accepting that we may not fully understand or may not come to a common agreement or position. (p. 30)

Two key ideas emerge from this definition. First is the idea of creative engagement. As Bohm (1996) explains, creative engagement means that through communication, new understanding is created. That new understanding "may not have been the starting point at all. It's something creative. And this shared meaning is the 'glue' or 'cement' that holds societies together" (p. 6). In the context of health care, this element of dialogue may occur when a provider and patient work together to create a plan for how to engage the patient's spirituality in the healing process. Both may have entered the interaction with ideas about what should be done, but the result of the dialogue is something new that neither could have created alone. Dialogue is distinct from inquiry because it involves not only asking genuine questions of the other person, but also actively engaging in an interaction that co-creates meaning. In dialogue, each person actively listens to the other, takes into account what the other says, and modifies positions or ideas based on what others say or do in interactions (Arnett, 2001).

In an ideal world, perhaps patients and providers would always agree completely, but that is not realistic, and that is where the second element of dialogue emerges. For dialogue to occur, participants do not necessarily have to come to agreement, nor should agreement necessarily be the goal of the interaction (Sorrells, 2013a). As Sorrells and Nakagawa (2008) explain, the "stretching across differences" is the most valuable outcome of a dialogic interaction. Agreement is often difficult to achieve in dialogue because of the inherent tension in the interaction. Arnett (2001) defines dialogue as "the communicative exchange of embedded agents standing their own ground or standpoint

while being open to the Other's view or standpoint" (p. 323). All participants in dialogue have their own frames and positioning, but if they are truly engaging in dialogue, they are open to others' perspectives as well. Sorrells (2013b) calls this tension both oppositional and transformative. This concept is particularly important in intercultural interactions because "given the differences in power and positionality in intercultural interactions, dialogue is necessarily a relationship of tension" (Sorrells & Nakagawa, 2008, p. 30). The tension will always be there, which is why dialogue requires participants to stretch themselves and creatively engage with others. In the provider-patient example above, the two may not agree on the utility of the patient's spiritual practices, but when the provider engages in dialogue as a mode of entry into intercultural praxis, the new understandings that emerge and the connection, empathy, and respect present in the interaction will satisfy participants even if they do not achieve agreement.

Reflection

The fifth port of entry is reflection. Reflection is necessary to enter and sustain dialogue; it is critical to understanding one's own positioning and frames; and it is essential to engaging in curious inquiry (Sorrells & Nakagawa, 2008). That is why reflection is so important to intercultural praxis. Reflection is "the capacity to learn from introspection, to observe oneself in relation to others and to alter one's perspectives and actions based on reflection" (Sorrells & Nakagawa, 2008, p. 31). Observation, learning, and change are key parts of this definition. Reflection involves thinking about one's own positions, observing oneself, learning from observations of self and others, and making changes because of that learning.

In a diverse health care setting, reflection is particularly valuable. Plack and Greenberg (2005) concluded that reflection not only allows providers to evaluate and change their own practices, but also to recognize how their attitudes, beliefs and values may differ from those of their patients. The authors argue that reflecting on this type of information can help providers understand how closely patients and their families may adhere to the provider's recommendations. In a similar vein, Stephens, Reamy, Anderson, Olsen, Hemmer, Durning and Auster (2012) compared the performance of medical students who did and did not engage in reflective practices and found that reflection enhanced provider-patient communication. The authors concluded, "Each individual physician carries a system of biases, fears, and attitudes that can either help or hinder their ability to provide patient care. By reflecting on these emotions and experiences consciously, communication with patients can be improved" (p. 28-29). That improvement is possible with reflection in a way that would not be possible without it.

Freire (1998), an author whose work Sorrells and Nakagawa (2008) draw upon, notes reflection is necessary for improvement. He writes, "Thinking critically about practice, of today or yesterday, makes possible the improvement of tomorrow's practice" (p. 44). Without reflection, changes in practice are "ingenuous" and do not lead to the same methodological rigor that characterizes change based on reflection (Freire, 1998, p. 43). This level of rigor is important in health care. As Plack and Greenberg (2005) found in a study of pediatricians and reflection, reflection goes beyond "just stopping to think and act based on what we already know" and instead engages critical thinking (p. 1550). "Skillful reflectors are critical thinkers, and critical thinking is the basis for effective clinical decision-making, which is at the heart of quality pediatric practice" (Plack &

Greenberg, 2005, p. 1550). Reflection may help enhance clinical decision-making because it has the potential to disrupt the status quo. Sorrells and Nakagawa (2008) argue, "reflection can intervene in uninformed actions that may otherwise be normalized as 'the way things are' and 'the way things must be'" (p. 31). Rather than operating on autopilot and making decisions based on established norms, health care providers engaging in reflection as a mode of entry to intercultural praxis see themselves as agents of change and can alter their actions based on their reflection.

Action

The final port of entry is action. In the intercultural praxis framework, the five ports of entry I have already discussed help not only to increase understanding and awareness, but also to stimulate action that is informed by that awareness. Sorrells and Nakagawa (2008) see intercultural praxis as a continual process of thought, reflection, and action. The action that is characteristic of intercultural praxis is that which links "intercultural understanding with responsible action to make a difference" (Sorrells, 2013b, lecture slide 4). Intercultural understanding comes from genuine inquiry, awareness of frames and positioning, and creative engagement in dialogue. Responsible action is determined by the communicator through reflection. Actions make a difference and are socially just when they challenge stereotypes and prejudice, generate alternative solutions, and are compassionate (Sorrells, 2013b, lecture slide 4). Lack of socially responsible communication contributes to health disparities in the United States, and health care professionals engage in compassionate action based in intercultural praxis diminish those disparities for their patients.

In an organizational context like STH, it is important to remember that individuals cannot act in a vacuum. As discussed earlier, organizational culture and the ways individuals make sense of their reality within that culture influences their actions (Weick, 1995). Giddens (1984) argues that action and structures, in this case, organizational structures, simultaneously influence each other. This is called the duality of structures, which means, "the rules and resources drawn upon in the production and reproduction of social action are at the same time the means of system reproduction" (Giddens, 1984, p. 19). The actions of organizational members produce and reproduce the organizational structures at the same time that the structures enable and constrain members' actions. Thus, organizational culture provides necessary contextual information in any study of intercultural praxis. Intercultural praxis culminates in socially just action, but socially just action is not possible in an organization whose culture would constrain such action.

Chapter Summary

This chapter reviewed relevant literature in the areas of symbolic interactionism, organizational culture, learning and learning transfer in the context of diversity training, and intercultural praxis in health care. All of these areas inform this study in important ways. As I argued in Chapter 1, the patient population in the United States is changing, health disparities are prevalent, and health care providers need to adapt their intercultural communication to meet the new demands of their field. Health care organizations like STH are responding with diversity initiatives and training, but they need a way to identify the communication practices employees are using in their workplace interactions. I propose intercultural praxis as a framework to identify those practices. But, identifying practices is only the first step toward understanding these workplace interactions.

Because of the complexities of organizational culture, sensemaking, learning, and symbol use in a health care organization, it is essential to also understand the contextual influences on these interactions. I will do this by examining textual artifacts and by gathering narratives to better understand employees' symbol use and actions as they interact interculturally. Thus, each of the areas of literature explored here is needed to inform my research questions:

RQ1: To what extent do textual artifacts at STH create an organizational culture that supports intercultural praxis in the workplace?

RQ2: How can employees' use of intercultural praxis modes be measured in a hospital environment?

RQ3: How do narratives express employees' understanding of culture?

RQ4: How do narratives express the way employees use modes of intercultural praxis in workplace interactions?

RQ5: To what extent does the use of intercultural praxis modes differ between employees who have and have not participated in diversity training?

In the next chapter, I will explain my data collection and analysis methodologies for answering the questions posed.

CHAPTER 3: METHODS

The review of literature in Chapter 2 on symbolic interactionism, organizational culture, learning, and intercultural praxis provides a theoretical framework for this study and highlights the three key problems addressed: health care providers like STH need data to inform their decisions as they fight health disparities; the communication literature lacks studies of the influence of diversity training programs; and there is currently no instrument available for identifying the communication practices used in intercultural praxis. My study investigates the intercultural communication practices of employees at STH through a holistic approach that accounts for the influences of both organizational culture and training on employee communication. To do this, a mixed methods approach is used that includes a thematic analysis of textual artifacts that will provide insight into the organizational culture at STH, a quantitative survey instrument to identify intercultural communication practices, and a critical incident survey asking employees to tell the story of a memorable intercultural interaction.

In this chapter, the methodological rationale of the mixed methods approach is presented. Next, the research design and data collection methods are discussed. Then, the research subjects and the specific data gathering procedures are explained. Validity and reliability are discussed, and finally, the data analysis techniques used in this study are presented.

RQ1: To what extent do textual artifacts at STH create an organizational culture that supports intercultural praxis in the workplace?

RQ2: How can employees' use of intercultural praxis modes be measured in a hospital environment?

RQ3: How do narratives express employees' understanding of culture?

RQ4: How do narratives express the way employees use modes of intercultural praxis in workplace interactions?

RQ5: To what extent does the use of intercultural praxis modes differ between employees who have and have not participated in diversity training?

Methodological Rationale

Mixed methods are used because this approach provides the best way to answer the research questions of the study. The following is a description of both quantitative and qualitative research to justify the use of both instruments in this study.

Quantitative Research and Post-positivism

On a very basic level, quantitative research is different from qualitative research because it seeks to study communication phenomena using an empirical design with results that can be presented numerically (Baxter & Babbie, 2003). This difference is driven by certain underlying philosophical perspectives. Quantitative research is often grounded in a positivist or post-positivist research paradigm. The post-positivist paradigm allows for a certain level of generalizability. Post-positivism assumes that humans interact in patterned ways, and "those patterns 'reify' social beliefs about phenomena and infuse them with predictability, significance, and consequence" (Lindlof & Taylor, 2011, p. 7). That is to say, even if one assumes, as I do, that reality is socially constructed and meaning is constantly changing through symbolic interactions, those human interactions form patterns that provide a stable enough reality to study. The word

"predictability" in this definition is one characteristic of post-positivism that is often difficult to reconcile with other paradigms. As the next section will discuss, researchers using the interpretive paradigm assume realities are unique and local, and they are not concerned with prediction (Lindlof & Taylor, 2011). I believe in a certain level of predictability when quantitative measures are used with an appropriate sample that is representative of the population being studied, is randomly selected, and ensures everyone in the population has an equal chance of being selected (Wrench, Thomas-Maddox, Richmond & McCroskey, 2008).

Another important aspect of some quantitative research is generalizability. The results of a survey, which is the type of quantitative instrument used in this study, can be generalized to the entire population when the results of the sample mirror the results of the entire population or when a large enough sample is randomly selected (Wrench, et al., 2008). Understanding the communication practices of the entire employee population at STH is more useful than understanding only localized practices and experiences because, as I argued earlier, organizational members' actions are interdependent with those of the organization as a whole. Thus, when researchers only examine individual practices, they tend to ignore the highly influential organizational culture surrounding and informing those actions. Baxter and Babbie (2003) point out that quantitative research aims to generalize over an entire class of events (which, in this study, is the intercultural workplace interactions at STH), but the level of explanation is often superficial. That is why adding a qualitative component will allow a deeper level of interpretation of the communication practices in this organization.

Qualitative Research and Interpretivism

Qualitative communication research seeks localized and rich descriptions of communication phenomena rather than quantifiable results (Lindlof & Taylor, 2011). As with quantitative research, the methods used stem from a particular worldview. Qualitative communication research in this study is grounded in the interpretivist paradigm. Interpretive researchers view human actions as purposeful and centered on meaning, not on causality and prediction (Baxter & Babbie, 2003). Thus, Baxter and Babbie (2003) explain that interpretivist research emphasizes how people make meaning rather than explaining causation among variables, as quantitative research often does. This paradigm aligns well with the symbolic interactionism perspective. Because people in organizations "are embedded in different systems of meaning, the researcher must attempt to understand the particular systems of meaning of those whose actions are being understood" (Baxter & Babbie, 2003, p. 59). Human beings co-create meaning for the symbols they use through symbolic interactions, and the interpretivist researcher seeks to understand the meaning systems and the actions they produce. This perspective is particularly important because my study investigates communicative practices, and the interpretive paradigm provides a way to understand the symbols and meanings that influence and constrain those practices.

Interpretivist researchers seek a deep understanding of human actions (Lindlof & Taylor, 2011). To achieve this goal, interpretivist research must "illuminate how humans use cultural symbol systems to create shared meanings for their existence and activity" (Lindlof & Taylor, 2011, p. 9). This study uses two qualitative methods, a textual analysis and a critical incident survey, to investigate how organizational culture

influences communication and how intercultural communication practices are used at STH. As the following sections describe, doing an analysis of textual artifacts of organizational culture contributes data for understanding the context and symbols that likely influence organizational members' actions in that context. Furthermore, I combine the critical incident method with narrative analysis to explain communicative practices and symbol use as presented through participants' own voices and stories.

Mixed Methods Research and Pragmatism

Quantitative research can measure practice; and qualitative research can provide details about practice as presented through individual voices (Creswell & Plano Clark, 2011). In this study, both must be used to effectively answer the research questions. Combining qualitative and quantitative research is commonly referred to as a mixed methods approach. Creswell and Plano Clark (2011) explain mixed methods research: "Its central premise is that the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone" (p. 5). This study adopts that research philosophy, and both approaches are necessary given the research questions this study seeks to answer.

Focusing on the research questions follows the research paradigm proposed by Creswell and Plano Clark (2011) called pragmatism. The authors argue that multiple paradigms can and should be used in mixed methods research, and pragmatism allows researchers to reconcile different paradigmatic assumptions by privileging the research questions above all else. I adopt the pragmatist paradigm in this study to integrate post-positivism and interpretivism. My first priorities as a researcher are to answer the

research questions in the most effective way possible and to gather meaningful data. Thus, this study uses a mixed methods approach.

Combining three different methods provides a comprehensive picture of the communication practices at STH. Analyzing textual artifacts to study organizational culture provides a macro-level look at the organization; surveying employees to determine which practices are used in the STH employee population contributes a meso-level look at organizational members' communication; studying employees' stories of intercultural interactions allows for micro-level insight into how these particular practices are enacted in this particular organization. All three methods combine to answer the research questions in this study. This section isolates each research question and discusses the rationale for the methodological choices made for each question.

RQ1: To what extent do textual artifacts at STH create an organizational culture that supports intercultural praxis in the workplace?

The first research question focuses on textual artifacts. As discussed in Chapter 2, organizational culture can be studied and identified through its artifacts, values and assumptions (Schein, 1985). This study examines several texts as cultural artifacts. When dealing with documents, researchers can choose to approach them in a variety of ways, some quantitative and some qualitative (Baxter & Babbie, 2003; Lindlof & Taylor, 2011). The qualitative approach is appropriate because the focus of this study is on the cultural symbol system at STH that embeds themes and meanings in written texts, such as training materials and website copy.

RQ2: How can employees' use of intercultural praxis modes be measured in a hospital environment?

The second research question asks for the measurement of communicative practices. I use a quantitative survey instrument (see Appendix I) to generalize the results to the entire employee population at STH. There is currently no instrument that focuses specifically on identifying practices in the intercultural praxis framework, and the instrument created for this study, which will be discussed in a later section, contributes to communication literature by providing a new way to measure intercultural communication in organizational settings. The next two research questions will be answered with qualitative methods designed to respect individual voices and realities, but I also show how research participants' voices connect with each other at an organizational level through quantitative survey data (Creswell & Plano Clark, 2011).

RQ3: How do narratives express employees' understanding of culture?

The third research question focuses on individual experiences and the symbols used in this particular organization. To answer this question, I turn to narrative communication, which is an important data collection method in interpretivist research (Lindlof & Taylor, 2011). Investigating the stories of individuals within this organization provides insight into the meanings employees assign to "culture" and the symbols they use to discuss this quality of organizational life at STH. The critical incident technique (CIT) is the means I use to collect stories, and narrative analysis provides the analytical framework needed to understand the symbols and meanings in employees' stories. These methods embrace the methodological assumptions of the interpretivist paradigm and provide insight into the symbolic interactions that occur at STH. I interpret these stories using thematic narrative analysis, which groups emergent themes into a typology of practice (Reissman, 2008).

RQ4: How do narratives express the way employees use modes of intercultural praxis in workplace interactions?

This research question also focuses on employees' stories and the symbols they choose to use in their own words. In the CIT instrument (see Appendix III), participants will be asked to tell the story of what they said and did in a particular intercultural communication interaction. Employees' practices will be extracted from their narratives and categorized according to the six parts of the intercultural praxis framework: inquiry, framing, positioning, dialogue, reflection, and action.

RQ5: To what extent does the use of intercultural praxis modes differ between employees who have and have not participated in diversity training?

The final research question draws upon the data collected through the intercultural praxis survey instrument and the CIT instrument. This combines both quantitative and qualitative analysis. Participants in each part of the study are asked whether they have completed STH's basic diversity training, which allows for comparison of the practices of those who have and have not completed training. As I have argued here, both qualitative and quantitative measures are needed to effectively answer the research questions posed in this study.

Research Design

The design of a study begins with identifying the type(s) of research that will be conducted (Babbie, 1992). In this section, I explain the three primary types of research conducted in this study—descriptive, explanatory, and exploratory—and then discuss the research design that best integrates these types of research, the convergent parallel design.

Description

Descriptive studies attempt to characterize and report on situations and events (Babbie, 1992). Babbie (1992) uses the U.S. Census as an example of a descriptive study. The U.S. Census Bureau seeks to precisely and accurately describe characteristics of the country's population. My study is more narrowly focused than a census, but the basic purpose is the same. I will precisely and accurately describe the communicative actions of the STH employee population in intercultural interactions. To do this, I created a quantitative survey instrument to identify the communication practices STH employees in their interactions with others in the workplace.

Explanation

Describing and identifying communication practices is useful, but communication research is more comprehensive when the "why" is also considered. Understanding why people do what they do is the foundation of studies that seek to explain (Babbie, 1992). In this study, I describe the communication practices of employees, but also explain them, since explanation derives from my qualitative measures. To discern the voices of employees and analyze the symbols and meanings embedded in the textual artifacts that surround them promotes understanding of why certain intercultural practices are or are not present in employees' intercultural interactions. Then, employees' stories of their own practices help explain how particular aspects of intercultural praxis are enacted by employees' at STH.

Exploration

There is currently no instrument designed to study the communication practices people use in intercultural interactions, and this is a gap in the communication literature

that this study seeks to fill. This study is exploratory in nature because it is designed to determine whether the instrument I created effectively identifies intercultural communication practices, and on a larger scale, whether the intercultural praxis framework is a useful model for organizing and studying communication practices. Through the multifaceted approach to analyzing communication practices that I propose, I also can theorize about the interrelated nature of organizational culture, training, and employee communication practices.

Convergent Parallel Design

With these research types in mind, I structure this study using the convergent parallel design. The convergent parallel design involves collecting and analyzing qualitative and quantitative data simultaneously and merging the two sets of results to form an overall interpretation (Creswell & Plano Clark, 2011). The purpose of the convergent parallel design is to collect "different but complementary" data on the same topic to "bring together the differing strengths and nonoverlapping weaknesses of quantitative methods … with those of qualitative methods" (Creswell & Plano Clark, 2011, p. 77). The authors explain that the convergent parallel design can be used for a variety of reasons, and among these are to collect qualitative and quantitative data on similar topics and to synthesize findings to develop a more complete understanding of particular phenomena. In this study, I use the results of the intercultural praxis survey (quantitative) and the critical incident survey (qualitative) to see whether and how trained and untrained employees use different practices in intercultural communication interactions. I also use the qualitative and quantitative data in concert to better understand

the larger phenomenon of intercultural communication practices at STH. Thus, the convergent parallel design is an appropriate choice for this study.

Data Collection Methods

As I have explained throughout this chapter, I use three methods of data collection in this study to answer my research questions and understand the intercultural communication practices of employees at STH. Those methods are a textual analysis of artifacts related to diversity and culture at STH using an open and closed coding process, a quantitative survey of the ways employees may enact intercultural practices, and a critical incident survey providing employee narratives about their intercultural communicative interactions. Next, I describe my data collection procedures for all three.

Textual Analysis of Documents

Textual artifacts are a component part of organizational culture that provide insight into culture and why organizational members act the way they do (Keyton, 2005). These texts are messages disseminated by organizations to inform members and/or outsiders of the policies and practices of the organization. In this case, I concentrate on texts related to cultural diversity. Artifacts were not studied by communication scholars for many decades because they were considered static and less expressive than verbal and behavioral symbols (Lindlof & Taylor, 2011). Currently, however, scholars are starting to view objects "not 'as' communication, but as elements 'in' communication" (Lindlof & Taylor, 2011, p. 220). In this way, interpretive scholars view textual artifacts as a valuable source of field data about organizational culture.

A variety of textual artifacts from this organization's culture were collected to gain insight into the symbols, meanings and culture that employees at STH create through

their interaction. These artifacts are both electronic and physical. Electronic textual artifacts from the STH website include the organization's mission, vision, and value statements; text from the About Us page; and text from the pages associated with the Office of Diversity, Equity and Inclusion. I also look at issues of the hospital's two e-newsletters from the past calendar year. Physical artifacts include the training materials for STH's Diversity and Intercultural Competence I course (handouts, slides and presenter script). Lindlof and Taylor (2011) explain that cultural artifacts are only of analytic interest if they matter to members of the cultural group. That principle guided my selection of the artifacts included here. I cultivated relationships with a few key informants at STH, and the artifacts I collected are documents that one or more informants have directed me to, mentioned in conversations about culture and diversity at STH, or provided as examples of the organization's approach to culture.

Intercultural Praxis Survey

The quantitative survey instrument identifies whether or not employees at STH use the practices included in the intercultural praxis framework (see Appendices I and II for the complete instrument and a grouping of survey measures by mode of praxis). Wrench, et al. (2008) define a survey as "a social scientific method for gathering quantifiable information about a specific group of people by asking group members questions about their individual attitudes, values, beliefs, behaviors, knowledge and perceptions" (p. 214). My survey instrument asks participants to respond to both behavioral and attitudinal measures. The survey is a means for quantifying intercultural communication practices by breaking down each port of entry (inquiry, framing, positioning, dialogue, reflection, and action) into the practices associated with it to

determine the frequency with which employees use these practices in intercultural interactions. Intercultural communication practices include physical behaviors (such as asking a question) and internal processes (such as genuinely wanting to know the answer to that question). Thus, this instrument includes both behavioral and attitudinal measures. Surveys such as mine that seek to determine how common a phenomenon is among the target population are called descriptive surveys (Wrench, et al., 2008), which further supports the use of this method of descriptive research.

The intercultural praxis survey contains 41 measures of intercultural communication practices, with between four and nine measures for each port of intercultural praxis. Each measure is a statement, such as "I want to learn more about the other person's differences," and participants are asked to rate how often this statement is true when they are interacting with someone at work whom they consider culturally different from themselves. Participants rate each statement on a seven-point interval scale ranging from 1 (Never) to 7 (Always). Each statement addresses only one port of entry into intercultural praxis. The instrument does not define "culture" for participants because this particular organization has it own interactionally constructed meanings for culture and culturally related terms like diversity. I code what those meanings are in the qualitative portion of my study.

To construct the instrument, I used a theory-based approach. The measures are designed to capture the behaviors and attitudes that characterize each port of entry into intercultural praxis, and each behavior and attitude was pulled from the literature on each part of the framework. The design and format of the instrument were informed by existing instruments measuring intercultural communication competence (Koester &

Olebe, 1988; Hammer, Gudykunst & Wiseman, 1978; Ahmed & Bates, 2012). I referenced intercultural competence instruments because competence measures appear to be most closely related to intercultural communication practice measures. The statements on the intercultural praxis survey were written in a way that had face validity for me, and they were refined through the input of three committee members, one of whom has experience designing quantitative instruments. I first administered the survey to a small group of volunteers at STH to get feedback and then refined the instrument before distributing it to research subjects.

The instrument also includes a few demographic questions that allow for comparison between the overall employee population at STH and the respondents to this survey. The six demographic questions are designed to determine respondents' employee characteristics (e.g., patient interaction level) and cultural identifications. Most are nominal measures, and some have choices provided, while others do not. I included choices on questions where I wanted to be able to group respondents into specific categories, and I left open-ended the questions where I did not want to impose particular group classifications on respondents. For example, "Have you taken the Diversity & Intercultural Competence I course offered by UNMH?" is a closed-ended question that offers participants only "Yes" and "No" as possible answers. Likewise, I wanted to limit responses to the follow-up to this question, "If you have taken Diversity & Intercultural Competence I, how long ago did you take it?" to a few general categories for ease of analysis. Rather than juggling potentially vague responses, such as "a few months ago," I force respondents to choose among groups like "Within the last year" or "Within the last 2-4 years." In other questions, such as gender, I allowed for write-in responses to allow

participants to define themselves in the terms with which they identify, not the terms I might use to describe them. Since meaning is subjective and co-constructed, I allowed study participants to define what terms mean.

Critical Incident Survey

The third and final method in my study is the critical incident technique (CIT) (see Appendix III for the complete instrument), which is "the identification of specific behaviours in an efficient a manner as possible through concentrated questioning or observation of participants" (Irvine, Roberts, Tranter, Williams & Jones, 2007). The methodological focus on practices makes CIT an ideal choice for this study. CIT, first introduced by Flanagan (1954), is a five-step process: determine the aims of the study, plan data collection, collect the data, analyze the data, and interpret and report on the results. This process is not significantly different from the processes used in most other methods, so I rely on Flanagan and contemporary scholars using CIT as guides primarily for the data collection and analysis phases of CIT.

CIT instruments should elicit as much rich description and specific detail as possible to get optimal data (Schluter, Seaton & Chaboyer, 2011). Flanagan (1954) explains that researchers can achieve desirable responses from participants if the questions asked accomplish three things. The instrument must refer briefly to the general aim of the activity, specify what exactly is desired of participants, and "tie down" the requirements in some way to make sure participants provide the desired information. In the CIT instrument I created, I begin with a general statement directing participants to think about their interactions with people at work who are culturally different than they are, then I specify that they should choose one particular interaction to answer the

subsequent questions, and I include specific, targeted questions designed to extract particular information about the interaction. Although many CIT studies use interviewing to collect participant data, written accounts are equally well-accepted as sources of CIT data (Irvine, et al., 2007).

CIT is a particularly appropriate method for this study because it lends itself to the incorporation of the narratives of organizational members. Organizational members reveal their sensemaking of their organizational culture and experiences through narrative (Keyton, 2005). Thus, in an organizational context, asking members to tell the story of a particular communication event (a "critical incident," in CIT terms) is a good way to gain insight into their sensemaking and symbol using. In this study, I ask organizational members to tell the story of what they said and did in an interaction with someone at work who they consider culturally different from them, which reveals their sensemaking, respects their voices, and focuses on their communicative practices, all of which are key to this study.

Subjects

Selecting the participants in a study is one of the most important considerations in any research project (Wrench, et al., 2008). This process involves first identifying the population being studied and then selecting a sampling method. The population I studied consists of current employees at STH. In this study, the samples for the intercultural praxis survey and the CIT survey were selected in different ways.

When selecting participants for the intercultural praxis survey, my two key considerations were being able to test the variable of diversity training and being able to generalize my results. First, with the diversity training variable, I want to survey people

who have and have not been trained. According to data collected and provided by STH, 240 employees have taken the DIC I course since the current version was implemented Jan. 1, 2010. The total employee population includes 6,139 employees. I surveyed the entire trained population (240 people) and a random sample of 2,190 people who are untrained. I needed at least 200 respondents to conduct the factor analysis discussed later in this chapter, so I sent the survey to a total of 2,430, which assumed about an 8% response rate. This estimate was based on informants' experience with response rates to previous surveys sent via email to this population. The actual number of respondents was 248, a 10% response rate.

This sample is appropriate in this study because of my second consideration: generalizability. To ensure generalizability, my sample also needs to be randomly selected (Wrench, et al., 2008). Random sampling means every member of the population has an equal chance of being included in the sample. To randomly select the 2,190 untrained employees in my sample, I used an Excel spreadsheet of all current employees listed in alphabetical order. I began with the third person listed and selected every subsequent third person on the list. I alphabetized the list to ensure my sample population covered a cross-section of the alphabet. Names were eliminated if the individual had completed DIC I, was no longer employed by STH, or was one of the handful of volunteers who previously provided feedback on the instrument. If a name was eliminated, I used the next name on the list.

Because quantitative and qualitative studies have different requirements for sample groups and sizes, I selected the sample for my CIT survey differently. Qualitative results are not intended for generalization to the entire population, and thus, scholars are

more concerned with depth rather than with a particular number of respondents (Lindlof & Taylor, 2011). I sent this survey to all employees who have completed DIC I and randomly selected 650 people who have not completed the training for a total of 890 people. Lindlof & Taylor (2011) explain that there is no specific number or percentage that constitutes "sufficient" data in qualitative work, and it is up to the researcher to determine what is appropriate for the study. My goal was to get at least 20 responses, and knowing that the CIT instrument requires more time and effort from participants than the praxis survey, I prepared for a low response rate. To select the sample, I used the same alphabetized spreadsheet procedure as I did with the intercultural praxis survey. On a spreadsheet listing the 5,899 employees who have not been trained, I began with the seventh person and select every subsequent seventh person on the list. Again, I eliminated people from the sample if they had completed the training, had volunteered to provide early feedback on the instrument, or were no longer employed by STH, and I instead selected the next name on the list.

Participant Protection

This study protects participants in several ways. First, no personally identifiable information is collected from any participant, so participant identities are protected, even from the researcher. Second, participation was completely voluntary. Employees were given the option to participate or decline without repercussions at work and without the knowledge of their supervisor or employer. Recruitment emails (see Appendix IV) advised employees of the optional nature of the surveys, and participants could change their mind about participation and leave the surveys at any time without penalty. Third, participants were asked to affirm their consent to participate before beginning the

surveys. For these reasons, the Institutional Review Board at the University of New Mexico found no issues with the human research subject protection measures in place in this study.

Specific Procedures

The table below (Table 1) shows the timeline for the specific procedures in this study. In a convergent parallel design, both the qualitative and quantitative data is collected simultaneously. In this study, the intercultural praxis survey and the CIT survey were not actually administered at the same time. I made this departure from typical procedures because many individual will be part of the sample groups for both surveys, and I did not want to potentially disrupt their work (or lower my own response rate) by asking for two things at the same time. However, the spirit of the simultaneous data collection remains intact. In other types of mixed methods designs, one type of data is collected before another so that the first set of data can inform the second. In convergent parallel studies, however, neither data set informs the other instrument, which is true of this study.

Table 1. Study Procedures

Method	Preparation	Data Collection	Results	Analysis
Textual Analysis	Select documents for analysis	Gather textual artifacts	Closed and open coding	Identify themes, make connections
Intercultural Praxis Survey	Get employee feedback on instrument Pull sample group	Send recruitment email via SurveyMonkey Send two reminder emails Download results to SPSS	Analysis using SPSS and Stata	Descriptive statistics, factor analyses and t-tests
Narrative CIT Survey	Get employee feedback on instrument Pull sample group	Send recruitment email via SurveyMonkey Send two reminder emails Download results to Excel	Closed and open narrative coding	Identify themes, make connections

Finalizing the Instruments

The input of members of my target population was important for assuring instrument validity. I assembled a small focus group of five volunteers from STH and asked them to take both surveys and provide feedback. The group took the praxis survey on a computer using SurveyMonkey, the same online survey mechanism that was used in the actual administration of the survey, and then they talked to me about the experience and the suggestions they had for improvement. The process was repeated with the CIT instrument. The purpose of pilot testing is to make sure instructions are understandable

and questions make sense to members of the target population (Wrench, et al., 2008). While this was not a formal pilot test, the intent was the same. I noted the time it took employees to complete each survey so I could provide actual participants with a reasonable estimate of the time commitment. Then, the group discussed their experiences, and I took detailed notes. Later, I used the group's feedback and their survey responses to make minor adjustments to the instruments. This exercise contributed to the reliability and validity of my study, which I discuss in the next section.

Textual Analysis of Documents

For the textual analysis, I gathered hospital documents related to culture and diversity by scouring the public website and by asking my informant to send me internal documents. I already had training documents (trainee handout, presentation slides, and presenter's notes) from a training session I attended on September 20, 2013. With the corpus of data selected, I printed each electronic document so I could code each text by hand. Coding and analysis procedures are discussed later in the chapter.

Intercultural Praxis Survey

After finalizing the instrument and randomly selecting the sample group, I built the survey electronically in an online tool called SurveyMonkey. I chose to distribute the survey electronically because all STH employees have a STH email address at which they are accustomed to receiving work-related email. I composed the text for a recruitment email and a reminder email (see Appendix IV), and the Director of Professional Development at STH, who is one of my informants for this study, sent the emails to the sample group from her STH email account. The survey was sent on Monday, April 7, 2014. A reminder email was sent on Tuesday, April 15. There was

another reminder email scheduled for Thursday, April 10, but there was an emergency situation at the hospital that prevented my informant from sending the email. Two email reminders were planned because research shows that three touch points (initial email and two reminders) nearly doubles the response rate on email surveys (Schaefer & Dillman, 1998). Participants were given a deadline of Wednesday, April 16, to complete the survey. Raw results were downloaded into SPSS, and responses with significant data missing were removed from the data set.

Critical Incident Survey

The critical incident survey procedure was very similar to the procedure for the praxis survey. The instrument was loaded into SurveyMonkey for electronic data collection. The Director of Professional Development sent my pre-written recruitment email, including a link to the survey, to the sample group on Monday, April 21, 2014. Reminder emails were sent on Thursday, April 24, and Tuesday, April 29, and the survey deadline was Wednesday, April 30. Results were downloaded into Microsoft Excel, and incomplete responses were eliminated.

Reliability and Validity

Reliability and validity are important factors in ensuring that study results are dependable (Lindlof & Taylor, 2011). Reliability is the consistency and accuracy of the measurement tools; validity is the degree to which the instrument measures what it is intended to measure (Wrench, et al., 2008). Ensuring reliability and validity can be done in different ways for quantitative and qualitative work, so I address my strategies for each method separately.

Textual Analysis of Documents

Lindlof and Taylor (2011) explain that reliability is not as important in qualitative studies as it is in quantitative work because of the assumption of multiple, changing realities. The authors acknowledge, however, that documents have an inherent truth value because they have been constructed and vetted by users and/or internal or external authorities. Additionally, unless users are actively challenging the truth of a document, they are routinely regarding it as trustworthy, and researchers can as well. This adds a level of reliability to the artifacts I studied as indicators of organizational culture because they can all be considered documents and are thus inherently consistent and trustworthy.

The validity measure I used for the textual analysis of documents in this study is member validation. Lindlof and Taylor (2011) explain that in qualitative research, members of the population being studied are considered to have some level of awareness of the cultures of which they are a part and can be relied upon to recognize findings as true or accurate. Thus, taking findings back to the population to see if they ring true with members is a common type of validity check. After I completed a preliminary analysis of the artifacts, I sent a brief synopsis of my findings to an informant at STH as a way of using the member validation technique.

Intercultural Praxis Survey

In survey research, reliability means that if a researcher gives the same survey to the same subjects multiple times, the results would be the same every time (Wrench, et al., 2008). One way to assess reliability is to measure the reliability of the scale itself, which is called scalar reliability. To measure scalar reliability, researchers mix oppositely worded questions in with standardly worded questions (Wrench, et al., 2008). For

example, to identify the presence of inquiry as a mode of intercultural praxis at STH, most of the statements posed to participants are examples of using inquiry, such as "I ask questions about the other person's differences" and "I want to know what the other person considers 'normal.'" If a person marks "Always" for these statements, she is reporting that she always uses these particular intercultural communication practices. But, some of the statements in this section are oppositely worded, which means that marking "Always" would indicate the person does not use communicative practices of intercultural praxis. An example of this is "I ask people about their differences mostly to be polite" because it indicates that the respondent does not have a genuine desire to understand the other person's culture, as she would if she were using the intercultural praxis port of inquiry. After respondents completed the instrument containing oppositely worded statements, I will use the Cronbach Alpha Reliability Test, which is the most commonly used reliability test in communication research (Wrench, et al., 2008). Cronbach's alpha test allows researchers to determine whether participants answered questions consistently or inconsistently, such as marking the same answer for every question on the instrument. I will re-code the instrument so that all questions are formatted the same way (i.e., "Always" indicates intercultural praxis on all questions) and use SPSS software to determine the alpha reliability of each scale in the instrument.

A valid survey instrument measures what it is intended to measure. There are many ways to determine validity, and this study uses both face validity and construct validity. Face validity means that "on face," the statements appear to measure what I want them to measure (Wrench, et al., 2008). The focus group portion of the informal pilot test helped measure face validity. I asked questions of hospital employee volunteers

to make sure the survey questions meant the same things to the participants that they mean to me. I also asked my committee members to look carefully at my intercultural praxis instrument to evaluate whether the statements I wrote appear to measure communication practices that comprise the ports of intercultural praxis as I have described them in my literature review. Additionally, I talked on the phone to Kathryn Sorrells, one of the creators of the intercultural praxis framework, and I verified with her my understanding and interpretation of the framework as an additional measure of face validity.

Construct validity means that a survey instrument "taps only the attribute in which [the researchers] are interested" (Stamm, 2003, p. 138). If a survey instrument includes multiple scales designed to measure different variables, each scale should measure one, and only one, underlying variable. Factor analysis can be used to test construct validity by identifying the underlying variables, or *factors*, in a data set. As DeVellis (2012) has explained, "Factor analysis is an essential tool in scale development. It allows the data analyst to determine the number of factors underlying a set of items so that procedures such as computing Cronbach's alpha can be performed correctly" (p. 158). Thus, after the survey data was collected, I used factor analysis to assess the construct validity of the survey instrument.

Critical Incident Survey

Since the critical incident survey is a second qualitative measure, the roles of reliability and validity are similar to the textual analysis of documents. Reliability has a limited role in qualitative research because "the replication of results via independent

assessments is neither practical nor possible" (Lindlof & Taylor, 2011, p. 272). Thus, I am not concerned with reliability in this portion of the study.

Validity of the instrument, however, is certainly of concern. I asked hospital employees for feedback on the survey instrument along with the intercultural praxis survey to assess face validity in the same way I did for the quantitative measure. Following the survey administration, I asked participants to talk to me about items that were confusing or difficult to understand, and I reviewed their responses to see if I received the type of data I needed to answer my research questions. As a result of this conversation, several minor wording changes were made to the instrument. Even though face validity is not typically applied to qualitative studies, it makes sense in this case because it helps to ensure that the questions I asked elicit the information needed.

Data Analysis

In this study, I analyzed data in several ways to answer the research questions posed. Each analysis method is explained here.

Textual Analysis of Documents

To analyze the textual artifacts I collected and to answer RQ1, I performed a thematic analysis using Lindlof and Taylor's (2011) categorization and coding method. I used both closed coding and open coding to answer my first research question. RQ1 asks to what extent textual artifacts found at STH create an organizational culture that supports intercultural praxis in the workplace. My primary intent in this question was to investigate the organizational culture at STH, and my secondary purpose was to understand if and how that culture may support intercultural communication practices among employees. Thus, I used a theoretical categorization method to sort content based

on the mode(s) of intercultural praxis it best fit, if any. Lindlof and Taylor (2011) explain that this type of categorization applies theory to the data in a deductive way. Then, as Lindlof and Taylor (2011) suggest, I decided on a coding system that would allow me to identify which words and phrases in the data belong to each category. Codes link the data to the categories of data (Lindlof & Taylor, 2011). Next, I used closed coding to code the data according to the theoretical categories in the intercultural praxis framework: inquiry, framing, positioning, dialogue, reflection, and action.

Since organizational members co-create their symbols and meanings, there were themes and meanings in the textual artifacts that did not fit any of the theoretical categories. Thus, I used open coding to identify the other categories that emerged. Lindlof and Taylor (2011) explain that this type of category forms after the researcher has read through the data several times and has begun to form "chunks" of data. To do this, I looked for words, phrases, or sentences that related to each other in ways that suggested they should be grouped together. Then, I defined the boundaries of each category by giving it a name (Lindlof & Taylor, 2011) and coded the remaining data using the same procedure as with the theoretical categories.

I see the categorization process as dynamic, and as I revisited the data to code, I remained open to the possibility of modifying my categories and adding to my coding choices. In this way, my analysis was reflexive. In the end, the categories I created cluster into themes that emerged from the data. I use these themes to better understand the organizational culture at STH and to compare the themes to the practices of intercultural communication to evaluate their compatibility.

Intercultural Praxis Survey

The intercultural praxis survey collected quantitative data that I use to answer RQ2 and to inform my observations related to RQ5. I loaded the data into the statistical analysis program SPSS as a tool for analysis. To answer RQ2, which asks how to measure employees' enactment of intercultural praxis practices in a health care environment, I calculated descriptive statistics (mean, median and mode) for each of the six ports of entry into intercultural praxis using the responses to the survey questions designed to measure each mode of entry. I then conducted a confirmatory factor analysis (CFA) to determine whether the data revealed the same six underlying groups as the intercultural praxis framework suggests they should. As I discuss in the next chapter, the CFA revealed that the intercultural praxis is not a good fit for the survey results, so I also conducted an exploratory factor analysis to determine what the underlying factors in this study might be.

To answer RQ5 from a quantitative perspective, I completed a series of statistical tests. This research question asks to what extent there is or is not a difference in intercultural communication practices used by employees who have and have not completed diversity training. I ran a t-test to compare the overall results of the group that has been trained with the results of the group that has not. A t-test examines one nominal variable with two groups (trained and untrained) and their scores on one dependent interval variable (mean survey score) (Wrench, et al., 2008). Then, to compare employees' use of each of the modes of praxis within each group, I used a series of t-tests, isolating each mode of praxis as it relates to the each of the sample groups.

Critical Incident Survey

Narrative analysis was used for data collected in the critical incident survey that asked participants to tell their stories. The CIT survey is designed to answer RQ3 and RQ4. These questions deal with the way employees tell the story of their experience:

RQ3: How do narratives express employees' understanding of culture?

RQ4: How do narratives express the way employees use modes of intercultural praxis in workplace interactions?

To analyze participants' narratives, I used one of Reissman's (2008) thematic analysis approaches, which focuses on content rather than the form or structure of the narratives to see what themes emerge from individual stories. Reissman (2008) presents several exemplars of studies that approach thematic analysis in different ways, and the method that is most appropriate for my study is adapted from a 2003 study by Ewick and Silbey in which they set specific criteria for the stories they collected from their data, and then they grouped the stories to construct a typology that would answer their research questions. I followed this practice.

I used theoretical categories to set the specific criteria for analysis so that when I later compared the stories of trained and untrained employees, there were consistent categories that facilitated an apples-to-apples comparison. The natural division of criteria in this study follows the intercultural praxis framework and the six ports of entry it contains because these categories are key to answering the research questions. Thus, I began with six theoretical categories into which aspects of the stories could be sorted and then used closed coding to determine what story elements represented one or more modes of praxis. Then, I grouped the story elements as Reissman (2008) suggests to create a

typology of each port of praxis (RQ4) and a typology of the characteristics of "culture" and any related symbols that employees might use (RQ3). I used this procedure for two separate data sets: responses from employees who have completed basic diversity training and responses from employees who have not. For each of the modes of praxis and symbols used by employees, the data produced two typologies. Then, to answer RQ5, I compared the typologies to determine whether and to what extent there is a difference between the two groups. Using the data analysis methods discussed here, I was able to sufficiently answer all of the research questions posed.

Chapter Summary

In this chapter, I discussed my methodological choices in this study; provided my methodological rationale for selecting a mixed methods approach; detailed the purposes my study fulfills and why a convergent parallel design is an appropriate choice; and explained the data collection methods. Then, I gave detailed descriptions of my study subjects, specific procedures and timeline, and the validity and reliability measures I have in place. Finally, I revisited my research questions to explain how I answer each one using the data collection and analysis methods I have chosen.

This study seeks to provide valuable data to STH that will help the organization improve its employees' intercultural communication in a way that will further its mission to fight health disparities. It fills notable gaps in the existing communication literature. I propose a new instrument for measuring intercultural communication practices through a more holistic approach to organizational culture. As the demographics of patients in the health care system in New Mexico change and health disparities widen, health care organizations need tools to prepare their front-line providers to provide high-quality care

to a diverse patient population. This study will provide the data STH needs to make educated decisions about how best to fight health disparities through improved intercultural communication practices.

CHAPTER 4: RESULTS AND ANALYSIS

Through a mixed methods approach, this study attempted to determine the intercultural communication practices of hospital employees and explain how those practices may or may not be supported by the organizational culture of the hospital. The three data collection methods included a textual analysis of key hospital documents related to diversity; a quantitative survey designed to capture which, if any, modes of intercultural praxis are used by employees in multicultural interactions; and a critical incident survey using participants' narratives to determine how those practices are enacted in workplace interactions. This chapter describes the data and findings for each of the data collection methods utilized in the study as they relate to the research questions. First, I present the textual data and findings; then I describe the survey data and findings; and finally, I explain the critical incident data and findings.

Textual Analysis Data

Texts produced by STH were analyzed in this study to examine the ways STH discusses diversity and culture in written materials. Texts are one type of artifact that allows a researcher a glimpse into organizational culture, and they are useful in this study for examining the extent to which the organizational culture at STH supports intercultural praxis. The results of this analysis will answer RQ1: To what extent do textual artifacts at STH create an organizational culture that supports intercultural praxis in the workplace? Textual materials analyzed in this study include website text, hospital employee newsletters, and training materials for the basic diversity training course. I describe each of those document categories in more detail here.

Website Text

The public website at STH appears to have a dual audience of employees and outsiders, many of whom may be patients, potential patients, or accrediting institutions. Some pages contain information explicitly directed toward patients, including the main page, which includes links called My Chart, Find a Doctor, and Patient Appointments. The About Us page, which is included in this study, contains a basic, high-level overview of the organizational structure that also appears to be directed toward people outside the organization. Some pages, however, are more directed toward employees. For example, in the Office of Diversity, Equity and Inclusion's section of the website, there is a page called For [STH] Employees that is explicitly directed toward members of this organizational culture.

A total of nine pages of the STH hospital website were selected for analysis. The pages were chosen because they contained information about the hospital overall or the Office of Diversity, Equity and Inclusion specifically. All website pages were accessed on March 19, 2014, and the URLs and page content were copied and pasted into a Microsoft Word document that was saved and printed for analysis. Because websites are often dynamic and may be modified at any time, I chose to copy all relevant pages and texts as of the same date to keep the corpus of data static for analysis. The titles of the pages selected for analysis are (note that all titles below use the formatting and punctuation used by STH on their website):

- *About Us* provides a high-level overview of the organization and the academic and clinical entities that comprise it.

- *Our Mission, Vision, and Core Values* contains public statements of the mission, vision and core values of the organization.
- *Diversity, Equity & Inclusion (DEI) at [STH] Hospitals* explains the history, goals, role, and guiding committees of DEI.
- *Office of Diversity, Equity, and Inclusion (ODEI) Mission and Vision* repeats information from the previous page, which contains mission and vision statements.
- *Health Literacy* defines health literacy in individual and organizational contexts and states the mission of the Health Literacy Task Force.
- *LGBT Collaborative [Lesbian, Gay, Bisexual, Transgender]* describes the history and purpose of the LGBT Collaborative and provides information about the LGBT 101 course provided by DEI.
- *For [STH] Employees* provides resources and contact information for employees to use for diversity-related situations.
- *Language Services* describes the function and mission of the Interpreter Language Services Program at STH.
- *Native American Health Services* explains STH's commitment to native populations and provides contact information for the Native American Health Service Office.

The first two pages listed here contain content about STH as a hospital, and the next seven are located navigationally on the site under Diversity, Equity, and Inclusion. All potentially have internal or external audiences, but all are reflective of internal decisions about what information to make public and how to phrase it. In this way, website text is a

key artifact of organizational culture. Artifacts, along with values and assumptions, comprise organizational culture (Keyton, 2005). Organizational and individual action cannot be understood without accounting for the cultural elements, including artifacts, that contextualize them (Schein, 1985). Because this study focuses on individual practices, the texts that contextualize those actions provide necessary insight.

Newsletters

Newsletters are a rich source of cultural information in this organization because they are created internally for internal consumption, unlike website text, which has a dual audience. The Human Resources Department at STH generates the newsletters, and they reflect strategic content choices. Newsletters are a good source of insight into the organizational culture at STH because they reflect what the organization deems important and newsworthy for employees.

Two hospital newsletters were used for analysis, *Starting Gate* and *The Monitor*. *Starting Gate* is a weekly publication that is emailed in PDF form to all employees on Friday afternoons. It is typically five pages long, one page for each day of the week, but there are also occasional special issues that vary in length. *The Monitor* is a monthly publication that is emailed in PDF form to all employees around the first of the month and is typically 40-50 pages long. Back issues of both are available on the STH intranet, and both are generated by the Human Resources Department.

To gather an appropriate newsletter sample, I asked my informant in the Office of Diversity, Equity, and Inclusion to provide me with every newsletter that contained diversity-related content during calendar year 2013. She chose three issues of *Starting Gate*, two of which were standard five-page issues and one of which was a one-page

special issue. All eleven pages of content were diversity-related. My informant also chose eight issues of *The Monitor* containing a total of 16 diversity-related articles ranging in size from a full page to about a quarter of a page. I requested newsletters from my informant rather than selecting them myself because I wanted to ensure my data set conformed to the organization's definition of diversity rather than to my own. I printed the relevant pages for analysis.

Further Context

Both website and newsletter texts were rich sources of organizational cultural data that provided useful contextual information to help understand employee practices. Close reading of hospital documents for the textual analysis revealed some additional findings that do not directly address any of the research questions in this study, but do provide deeper insight into the culture of the hospital. I address these findings here because they expand upon definitions of the key concepts of "diversity" and "communication," which provide helpful context to the findings that are within the scope of this study.

First, how the organization defines diversity is expressed in more detail in hospital webpages and newsletters, which enhances the definition found in training materials cited in Chapter 1. The definition of diversity used in Diversity and Intercultural Competence I (DIC I) training materials is, "human attributes that are different from your own and from those groups to which you belong. Valuing diversity means valuing the differences in experiences, attitude, knowledge, and skills between any and all groups." The STH website further refers to "diversity in people and thinking" (Mission, Vision, and Core Values), and diversity as "the patient's race, ethnicity, or any other group identity" (Diversity, Equity, and Inclusion). The hospital's newsletter

coverage of its *DiversityInc* Top 10 Hospital Systems award includes gender as an element of diversity, specifically mentioning gender, race, and ethnicity of hospital leadership as part of the rationale for external recognition of diversity (*The Monitor*, September 2013, p. 5). The same newsletter article also lists "cross-cultural relationships" in its mentoring program as indicative of the organization's diversity. Diversity is emphasized frequently throughout the STH website and its employee newsletters, both in terms of patient diversity and employee/leadership diversity, which points to the necessity of successful multicultural communication interactions in this particular organization.

Second, the way the organization defines effective communication is a useful contextual factor for my study. In several newsletter articles, STH addressed not only what effective communication looks like, but also the results it produces. Specifically, the articles focused on communication with patients, not internal communication. Effective communication means using "more common terms, less jargon, and a caring tone of voice" (*Starting Gate*, September 24, 2013, p. 2) and using printed documents that match the reading skills of average U.S. adults and are "understandable" (*Starting Gate*, September 24, 2013, p. 1). It may also include careful explanations, analogies, anatomical models, and simple drawings (*Starting Gate*, February 25, 2013, p. 2). Effective communication results in better recall and understanding of procedures, more careful adherence to treatment plans, more satisfaction with patient care, better health outcomes, coming into appointments and tests more prepared, decreased repeat visits, improved trust in and loyalty to the organization, cost savings, and greater efficiency

(*Starting Gate*, September 24, 2013, p. 3; *The Monitor*, July 2013, p. 32; *The Monitor*, November 2013, p. 38). These projected positive results that the hospital attributes to communication underscore the hospital's commitment to reducing health disparities through communication and the importance of studying the communication practices of hospital employees.

Training Materials

While website and newsletter texts describe diversity initiatives and the organization's approach to culture, diversity training materials are an interesting artifact because they show how the organization attempts to train employees to think and act about diversity in a particular way. At STH, training materials are not made available publicly, or even to all employees. Only those who take the optional basic diversity course receive and use STH's diversity training texts. The same department that delivers the training also submits article ideas to the newsletters, so while the training materials themselves are not widely distributed, many of the ideas appear in other texts that are available to all employees. Because this study seeks to understand whether trained and untrained employees employ different practices in intercultural communication situations at work, training materials provide critical insight into potential differences in employees' experiences of organizational culture.

The training materials that I used for analysis were from the Diversity and Intercultural Competence I (DIC I) course, which is the basic half-day diversity training course offered by STH. Documents included the booklet given to training participants, printouts of the PowerPoint slides shown in the training session, and printouts of the presenter's notes that accompany the presentation slides. All of these texts were provided

by the trainer who conducts the DIC I course at STH. To limit possible changes and modifications to these materials, I analyzed only the handout, slides, and presenter's notes that were used by the trainer in a training session on September 20, 2013, which I observed. A sample slide and accompanying presenter's notes are located in Appendix V.

With a description of the data in the document analysis portion of this study and a deeper understanding of a few key definitions, I now address how this data answers RQ1.

Analysis of Textual Artifacts

In this section, I analyze the previously described textual artifacts as they relate to my first research question. I begin by briefly discussing my method of analysis, explaining how the intercultural praxis framework relates to organizational culture, and then discussing my findings for each mode of intercultural praxis and additional findings that surfaced in the analysis.

RQ1: To what extent do textual artifacts at STH create an organizational culture that supports intercultural praxis in the workplace?

To answer this question, a textual analysis of the documents listed above was conducted to determine what themes emerged from the data. Coding involved a two-part process, where I first used closed coding to uncover any evidence of the six modes of intercultural praxis as presented by Sorrells and Nakagawa (2008); and second, I used open coding to see what other themes were present in the texts. Here, I discuss how the intercultural praxis framework applies to organizational communication, present my findings of which modes of praxis are present in hospital documents, explore the possibility of a seventh mode of praxis, and discuss the value themes that direct employee behavior and communication in the workplace.

Intercultural praxis and organizational communication. The intercultural praxis framework (see Table 2) details communicative practices that may be used by individuals on an interpersonal, interactional level. When these individuals are part of an organization, their interactional choices are influenced by organizational culture and, as discussed in Chapter 2, the "implied, imagined presence of others" that constrains action (Weick, 1995, p. 40). Individual communicative action and organizational culture are inseparable because individuals act as agents of the organization, co-constructing culture while at the same time reproducing it (Giddens, 1984; Weick, 1995). Tsoukas (2010) calls the influence of the organization the "disembedding" of individual interactions. "Through the process of disembedding, social systems extend their reach beyond the here and now of interaction in conditions of co-presence" (Tsoukas, 2010, p. xi). The social systems, in the organizational sense, are defined by organizational culture.

Organizational culture reaches into individual actions, and as discussed in Chapter 2, organizational culture is made up of artifacts, values and assumptions (Keyton, 2005). Thus, when organizational artifacts (in this case, texts), contain elements of individual communicative practices and the values and assumptions that guide those practices, organizational practice can be interpreted as influencing individual practice. Although the intercultural praxis framework refers specifically to individual practices, in an organizational context, it is appropriate to analyze organizational communication using the same framework.

Table 2. Intercultural Praxis Framework

Mode of Entry into Intercultural Praxis	Basic Definition
Inquiry	A desire and willingness to know, to ask, to find out and to learn
Framing	The ability to access a variety of perspective-taking options
Positioning	An individual's location in socially constructed hierarchical categories such as race, class, gender, and physical ability
Dialogue	Communication that stretches across difference and engages actively with other points of view
Reflection	The capacity to learn from introspection, to observe oneself in relation to others and to alter one's perspectives and actions
Action	Linking intercultural understanding with responsible action to make a difference

Source: Sorrells & Nakagawa, 2008

In the next six sections, the results of the textual analysis reveal how the six modes of entry in intercultural praxis—inquiry, framing, positioning, dialogue, reflection, and action—appear in the textual artifacts of STH. Rather than organizing the modes of praxis in the order presented by Sorrells and Nakagawa (2008), I organize the modes according to their relevance to STH as evidenced by the hospital's written communication. Relevance was determined by the relative frequency with which each mode of praxis appears in hospital texts.

Reflection. As an organization, STH exhibits reflection in many ways, both personal and organizational. Personal reflection can be found primarily in the training materials for DIC I, in which one quarter of the course is spent on a section called Awareness in which participants reflect on their own identities, cultures, biases, skills, and assumptions. In the next section, I discuss how this portion of the course also

contributes to participants' awareness of their own and others' positioning. Examples of questions for reflection in the training workbook include:

- "How do I self-identify?"
- "How does that affect the way others see me?"
- "What biases and assumptions have I learned? How does that affect the way I see others?"
- "What can I do to get around my biases?"
- "How can I communicate more effectively?"

These questions prompt participants to engage in introspection and modify their actions and perspectives accordingly, which is the essence of reflection in the intercultural praxis framework (Sorrells & Nakagawa, 2008). Employees at STH enact reflection at work, as evidenced by employee comments following a course on health literacy (*The Monitor*, March 2013, p. 20):

- "I didn't realize I needed this information until I attended the class. I was shocked at how much I had to learn! I have used this information and your materials over and over again."
- "Your class was a huge wake-up call for me. I am pretty sure most of the information we provide our patients is way too complicated for their health literacy level."

These quotations suggest that employees do reflect on their communication with patients, and in the case of the first quotation, how they change their behavior based on their new learning from the training. By publicizing these comments, STH seemed to encourage

similar reactions from other employees, which may serve to educate employees about desired communication practices even if they have not completed diversity training.

In addition to promoting individual reflective practice, STH exhibits reflection at the organizational level. On the STH website, frequent mention is made of "data collection and analysis" informing decisions. For example, the DEI home page states the office's goal of making sure "every [STH] patient receives the safest, most effective, most sensitive medical care possible, regardless of the patient's race, ethnicity, or any other group identity. We do this through data collection and analysis … and process improvement." This dissertation, in fact, could be considered one way DEI can promote research and use the results to improve their communication. This type of reflection is more scientific in nature than it is thoughtful, but the guiding principle is the same as individual reflection because the organization is observing itself and looking back on past actions to inform future action.

After data are collected and analyzed by management, they are shared with employees to direct employee practice. For example, the hospital did a study to see if providers were checking for patient understanding of take-home instructions. A subsequent newsletter article stated their interpretations of the study data: "This was our second-lowest scoring item out of eight in this category! We're not really doing as well as we could" (*Starting Gate*, September 23, 2013, p. 1). The next four pages of the newsletter contained information and training about how employees could improve in this area. Another article states that the hospital is in the beginning stages of collecting data about how patients respond to new, easier-to-read documents. One separate

newsletter article posed questions for reflection to help employees think about the impacts of their own forms:

> Are patients better able to understand what we are trying to tell them? Are they showing up for their tests better prepared? Are they having fewer problems with their care? Can we see cost savings related to our efforts as people are better able to understand what they need to know? (*The Monitor*, November 2013, p. 38)

These examples illustrate the prevalence of reflection and reflective practice in STH documents. Through some of its organizational communication channels, the hospital appears to promote and encourage reflection in various forms, creating a supportive organizational culture for this mode of intercultural praxis. As mentioned earlier, this reflection often overlaps with another mode of praxis, positioning.

Positioning. Positioning refers to individuals' recognition of and attention to the consequences of their own and others' places in socially constructed hierarchical categories (Sorrells & Nakagawa, 2008). Once again, positioning appears in STH documents at both an individual and an organizational level. Many of the questions in the DIC I workbook serve not only the purpose of reflection, but also encourage participants to think critically about their positioning and its consequences in their interactions. Additionally, in an activity in the workbook, participants list several of their identities and check a box to note whether these identities conform to dominant or non-dominant groups. For example, if I were to fill out the worksheet, I might write "White" and check "Dominant" next to it, and then I might write "Female" and check "Non-dominant." Even though it is not called "positioning" specifically in the workbook or presenter's notes,

positioning as defined above is the specific focus of this activity. Participants identify their own positioning, and then through group discussion, they identify the consequences of that positioning in their interactions. Once the activity is completed, participants engage in a discussion of biases, which should lead participants to think about others' positioning.

On an organizational level, positioning is subtly acknowledged in some texts and more overtly expressed in others. For example, in the quotation from the DEI webpage included above, where the office strives to ensure patients receive safe, effective, sensitive medical care "regardless of the patient's race, ethnicity, or other group identity," the implication is that group identity might be a cause for a patient NOT to receive safe, effective, and sensitive care. Statements like this acknowledge that group membership and its resulting social positioning can have consequences, which demonstrates an organizational awareness of positioning. Likewise, in a newsletter article asking providers to check for patient understanding, providers are asked to do so in a "non-shaming way" (*Starting Gate*, September 23, 2013, p. 2). This statement acknowledges that providers are in a position of power, and it urges them not to abuse that power when asking questions to patients that could be seen as condescending.

STH also focuses on positioning more explicitly in its textual artifacts by acknowledging historical social and healthcare inequalities experienced by some groups. In the program description for the hospital's LGBT 101 training course (lesbian, gay, bisexual, transgender) on the STH website, the history of this group in the United States and the stories from group members are included among the topics covered in the course to "assist participants in developing their skills and knowledge about the LGBTQ

community." The inclusion of the historical perspective and the voices of people who are members of a historically disadvantaged group both demonstrate the hospital's awareness of group positioning and suggest an attempt on the part of STH to change the dynamic of whose voice is privileged. In another example, on the Native American Health Services page of the STH website, the text makes clear that Native American patients have "priority access to admission and outpatient clinic appointments" because "[STH] honors our historic relationship with Native Americans." This appears to be an attempt to raise the positioning of another historically disadvantaged group and, possibly, to claim that valuing this particular group is not new to STH.

STH documents reveal a clear awareness of positioning and show some attempts to disrupt socially constructed power structures, which creates a very supportive environment for this particular mode of intercultural praxis. As such, the hospital also encourages employees to act to promote equality and social justice.

Action. In the intercultural praxis framework, action refers to "responsible action to make a difference" (Sorrells, 2013b, lecture slide 4). At the heart of the praxis framework is social justice, which in the healthcare field means equal access to care and reduction of health disparities. The document analysis of STH texts revealed two types of action at STH: action that directly advances a social justice mission, and action that indirectly contributes to lowering health disparities by improving overall care.

It is clear from STH documents that the hospital explicitly focuses on minimizing health disparities. The hospital's vision statement says, "[STH] will be the leader in improving New Mexico's health outcomes." The website also repeats several key phrases, including:

- “health status improvement”
- “equity in the delivery of healthcare”
- “identifying and addressing any health disparities”
- “reduce any identified disparities”
- “diversity, equity, and inclusion in U.S. healthcare”
- “become a more health literate organization”
- “decreasing barriers to health care”
- “access to healthcare”

These phrases share the theme of conscious action toward the goal of minimizing health disparities. In addition, the hospital promotes social-justice-oriented action in the community by encouraging employees to join the hospital in its participation in the local Pride event, which focuses on educating the public and supporting the New Mexico LGBTQ community (abqpride.com/about). The newsletter article invites employees to volunteer for the event, specifying that participation will “help support diversity as an organization” (*The Monitor*, June 2013, p. 20). Specific mention of efforts to minimize health disparities and maximize participation in community events aimed at equality both are ways in which STH demonstrates overt focus on socially just action.

Other actions promoted by STH focus on overall patient care. Some of the ways the hospital describes itself and its goals as an organization are:

- “accessible, high quality, safety focused, comprehensive care provider”
- “community oriented public teaching hospital”
- “compassion and respect in our interactions”
- “focus on the health and well-being of the diverse communities we serve”

- "educate the [STH] community"
- "work with … patients, staff, and families in a compassionate and culturally competent manner"
- "facilitate communication between providers and patients, family and visitors"
- "connect and care for a diverse population"

These phrases are separated from the section above because while these actions contribute to socially just patient care that lowers health disparities, they do so in a less direct way because they potentially improve the experience of all patients, rather than just leveling the playing field.

Both types of action discussed here demonstrate the hospital's focus on action and active communication of the type of action that is valued in STH's organizational culture. The actions discussed here fit well with the intercultural praxis framework by describing an environment that is supportive of this mode of praxis.

The three remaining modes of entry into intercultural praxis—framing, inquiry, and dialogue—are present to some degree in STH communications, but they do not appear to be key foci of the hospital culture.

Framing. Framing in intercultural praxis is the ability to access a variety of perspective-taking options (Sorrells & Nakagawa, 2008). Framing is unique in this study because it is the only mode of praxis that has a strong presence in training materials and is virtually nonexistent in other hospital documents. The DIC I training materials present four definitions of culture, and two of the four definitions directly link culture and framing: "Culture designates what we pay attention to and what we ignore." (Edward T. Hall); and "A complex frame of reference that consists of patterns of traditions, beliefs,

values, norms, symbols and meanings that are shared to varying degrees by interacting members of a community" (Stella Ting-Toomey). The wording and attribution of these definitions is found in the training participant handout, but neither is attributed to a source. Both of these definitions highlight multiple ways of looking at the world and state that people who are culturally different have different perspectives.

Trainers encourage employees to think about others' perspectives and their own through some of the questions displayed in the reflection section above. These same questions also ask trainees to reflect on themselves and others, recognize each person's positioning, and think about how that positioning influences one's perspective. Additionally, training materials offer specific suggestions for framing intercultural communication, asking employees to frame their communication in a way that respects traditional practices, takes patients and their communication seriously, and considers hearts and souls to be as important as bodies (p. 21). Not only does the training course explain what framing is and how it relates to culture, but it also guides participants through reflection and discussion in order to help them open their minds to different perspectives, and it provides suggestions for framing techniques to use in intercultural interactions. Thus, the DIC I training course shows a highly supportive environment for this mode of intercultural praxis. However, unless employees have taken the course and had this exposure, they may not see their organizational culture as supportive of this practice. Since few employees take the training course and it is not required, the effect of STH's basic diversity training course may be limited. Inquiry and dialogue, the two remaining modes of intercultural praxis, are even more loosely attached to the organizational culture at STH than framing is.

Inquiry. Inquiry is the practice of asking questions and genuinely wanting to learn about another's differences from the answers (Sorrells & Nakagawa, 2008). In a few places, inquiry appears in STH documents, but not in many. The best example of inquiry is in the DIC I training workbook, where employees are encouraged to "Listen to understand. Take risks. Ask questions" (p. 18). These examples clearly support the use of inquiry in interactions, but it is not something that is emphasized in the training. It appears on a page titled "Some Suggestions" that is briefly noted in the training. A looser example from the training documents is the Platinum Rule, a heavily emphasized concept that means to treat others the way they want to be treated. While training materials do not specify that the way to find out how someone wants to be treated is to ask, the trainer in the session I observed on September 20, 2013, verbally encouraged trainees to ask questions.

In other textual data that resembles inquiry, STH materials do not focus on getting to know others or on listening carefully to answers. Several newsletter articles on the topic of checking for patient understanding recommend asking questions, but they focus only on asking questions to gauge comprehension, not questions that help them learn about the person as an individual. Another newsletter article about health literacy states, "Even if the patient does not ask for an interpreter, offer one" (*Starting Gate*, February 25, 2013, p. 3). This directive could potentially lead to a situation in which genuine inquiry about a patient's preferences and cultural norms would take place, but not necessarily. Other potential opportunities for inquiry include references to community collaboration, where it might be assumed that hospital employees can use inquiry practices to better understand community members and groups, but this is never stated.

The data reflect an organizational culture that is not unsupportive of inquiry, but it is not overtly supportive, either.

Dialogue. Dialogue involves creative engagement and stretching oneself across difference in an interaction (Sorrells & Nakagawa, 2008). Much like inquiry, dialogue is a mode of intercultural praxis that may be inferred but rarely is directly expressed in hospital communications. The one exception to this statement is in the DIC I training materials, where participants are encouraged to "give and receive feedback," "include others and ask to be included," and "encourage respect by treating people the way they want to be treated and letting others know what respect looks like to me" (p. 22). These statements imply two-way communication in which ideas are shared and, particularly where ground rules are negotiated for respectful interaction, creative engagement occurs.

Other potential examples of dialogue are implied. The hospital website uses the phrases "community outreach," "community collaboration," "community engagement," "community partnership," and "patient involvement." Much like one might assume that community collaboration surely must involve inquiry, one might also assume that these five phrases refer to dialogue. However, none of these phrases is explained or defined, so while dialogue is implied, it is not necessarily a part of STH's actions in the community. Much like with inquiry, STH textual materials indicate that its organizational culture is not unsupportive of dialogue. Moreover, members have not created enough cultural cues around dialogue to create a completely supportive environment, either.

Another answer to RQ1 (To what extent do textual artifacts at STH create an organizational culture that supports intercultural praxis in the workplace?) is that the organizational culture at STH is supportive of some, but not all, modes of entry into

intercultural praxis. Reflection, positioning, and action are important parts of the culture at STH. Framing is supported in training, but not in other hospital artifacts. Inquiry and dialogue are not discouraged, nor are they encouraged in this environment. In addition to showing the ways in which intercultural praxis is and is not supported in the organizational culture at STH, the open coding portion of this analysis revealed another communicative practice that is not included in the praxis framework but is included in organizational texts. *Language* emerged as an additional, clearly relevant, mode of praxis in this workplace.

Language. Language is a potential seventh port of entry into intercultural praxis. In this context, language means both using the world language spoken by the other individual and also using vocabulary within that language that is understandable and accessible. Language merges well with the other modes of praxis because inquiry and dialogue are important ways of determining the world language and word choices that will best facilitate communication, and framing and positioning can be helpful to a person to ensure language choices are made in a sensitive and empowering way for the other person. Much like the other modes of praxis, language choices may be more salient in some interactions than in others, but it has the potential to be a relevant mode of entry into any interaction.

In this particular context at STH, choosing an effective world language for communication means potentially enlisting an interpreter or providing written materials in the other person's most comfortable language. For example, a recent immigrant to the area might feel most comfortable communicating orally in Spanish or Farsi, and a member of the Navajo Nation might have better reading comprehension with a brochure

written in Diné Bizaad. An entire division at STH is called the Interpreter Language Services (ILS) program. The ILS webpage states: "Our mission is to provide quality service by decreasing barriers to health care for limited-English-proficient and hearing-impaired patients who receive their care at [STH]." References to interpretation and translation services are present throughout the website, newsletters, and training materials. The hospital strives for "easy access to health information" as a part of its health literacy initiative, and *Starting Gate* defines "easy access" as "being sure all information is delivered in the language patients are most comfortable using" (February 25, 2013, p. 3). Additionally, at the end of the DIC I training course, participants are encouraged to take the Beginning and Intermediate Spanish courses as a possible next step toward enhancing their skills as intercultural communicators.

Within a person's most familiar language, STH emphasizes using words and phrases that will be most easily understood. This takes the form of STH's health literacy initiatives. Throughout the newsletters in particular, using "everyday 'living room' language without acronyms, jargon, and medical terms" is encouraged (*Starting Gate*, February 25, 2013, p. 5). The hospital rewards and encourages "patient-friendly communication" and has created a set of document templates that departments can use to make their forms easier to understand (*The Monitor*, November 2013, p. 38). These language and word-choice initiatives are directed primarily toward patients, but in an organizational culture that values linguistically appropriate communication, choosing appropriate languages and vocabulary to speak to co-workers and others in the organization would be supported as well.

Value themes. In addition to supporting various modes of intercultural praxis, the textual materials from STH reveal additional organizational values that do not directly impact praxis, but are nonetheless part of the organizational culture and have the potential to influence action. As a component of organizational culture, values are important because they "create guidelines for organizational behavior" (Keyton, 2005). In addition to organizational support for intercultural praxis that may enable or constrain behavior in particular interactions, an organization's values provide overarching guidelines for employee practices and decision-making that may also influence these communicative interactions. Table 3 displays the values identified in this study and corresponding examples from STH textual artifacts.

Table 3. Value Themes

Value	Examples
Efficiency	"**caring** and **efficient** services" (*The Monitor*, Sept. 2013, p. 5)
	"teach back can increase **efficiency**" (*Starting Gate*, Sept. 23, 2013, p. 3)
	STH created style sheets and templates to facilitate more efficient transition of documents to patient-friendly language (*The Monitor*, Oct. 2013, p. 4)
Safety	"evidence-based patient **safety** practices" (*Starting Gate*, Sept. 23, 2013, p. 1)
	"research-based health literacy strategy that can improve patient-provider communication, patient **safety**, **quality** of care, adherence, and health outcomes" (*Starting Gate*, Sept. 23, 2013, p. 2)
	"one of the essential '**safe** practices' to improve health care" (*Starting Gate*, Sept. 23, 2013, p. 3)
Quality	"we strive to meet this obligation with high **quality** healthcare services" (Native American Health Services)
	"… high-**quality**, **safety** focused, comprehensive care" (Mission Statement)
	"guide and serve the Native American community by promoting **quality** customer service" (Native American Health Services)
Compliance	"**compliance** with national standards" (DEI home page)
	STH has a Compliance task force
	"link between culturally competent patient care and the Affordable Care Act" (*The Monitor*, June 2013, p. 1)
Care & Compassion	"… promoting **quality** customer service through **compassion** and dedication" (Native American Health Services)
	"**compassionate** and culturally competent manner" (*The Monitor*, Nov. 2013, p. 33)
	"use more common language, less jargon, and a **caring** tone of voice" (*Starting Gate*, Sept. 23, 2013, p. 2)

To answer RQ1, (To what extent do textual artifacts at STH create an organizational culture that supports intercultural praxis in the workplace?), the textual artifacts produced by STH create an organizational culture that supports some modes of intercultural praxis and does not support nor discourage others, emphasizes language as an additional component of effective intercultural communication, and works within a series of values that do not directly influence communicative practice but do

provide a frame of reference for decision-making. In the next section, the use of a quantitative instrument for measuring employees' interactional use of the modes of intercultural praxis is discussed.

Intercultural Praxis Survey

With an understanding of the organizational culture at STH and the ways in which some of the modes of intercultural praxis are supported, I next examine whether and how employees use these modes of praxis in their workplace interactions. The first method was a quantitative instrument (see Appendix I) I developed using the intercultural praxis framework. In this section, I describe the survey participants and then analyze survey data as it relates to RQ2 (How can employees' use of intercultural praxis modes be measured in a hospital environment?) and RQ5 (To what extent does the use of intercultural praxis modes differ between employees who have and have not participated in diversity training?). Quantitative data only provides a partial response to RQ5, and this question will also be further addressed in the critical incident survey analysis that follows.

Praxis Survey Participants

A total of 248 people responded to the intercultural praxis survey, and of those, 209 completed the survey without substantial missing data. Surveys with substantial missing data were discarded and were excluded from the study. The age and race/ethnicity makeup of survey respondents closely matched the makeup of the entire employee population at STH (see Table 4). White participants were slightly overrepresented, and Hispanic/Latino participants were slightly underrepresented. Respondents who identified as "Other" on the race/ethnicity question listed American,

European American, "grew up in Europe," Italian, Jewish, and Spanish (n = 1 each). Participants ranged in age from 26 years to 71 years, with the highest percentage being in their 40s and 50s (59%, n = 123).

Table 4. Praxis Survey Participants

	All STH Employees		Survey Respondents	
	n	%	*n*	%
Gender				
Female	4706	77%	164	78%
Male	1433	23%	40	19%
Decline	0	0%	5	3%
Total	6139	100%	209	100%
Race/Ethnicity				
Aboriginal	1	0.2%	0	0%
American Indian/Alaskan Native	246	4%	9	4%
Asian	117	2%	6	3%
Black/African American	207	3%	4	2%
Hispanic/Latino	2,793	45%	70	33%
Native Hawaiian	63	1%	0	0%
White	2,558	42%	121	58%
Decline	55	0.8%	6	3%
Other	99	2%	6	3%

Note: Participants could select multiple race/ethnicity categories.

Most participants interact with patients multiple times a day (66%, n = 137), while only a few never interact with patients in their jobs (8%, n = 17). Some respondents interact with patients once a month (8%, n = 17), once a week (6%, n = 12), or once a day (11%, n = 23). Patient interaction is not directly related to this study, but understanding respondents' level of interaction with patients helps contextualize how frequently their intercultural workplace interactions are with people who are and are not members of the same *organizational* culture.

A majority of respondents had taken the DIC I course (57%, *n* =121), while three declined to respond. Of those, 42% reported taking the course within the past year (*n* = 51), 39% reported taking the course in the last two to four years (*n* = 47), and 19% reported taking the course more than four years ago (*n* = 23).

Analysis of Praxis Survey Data

The results of the intercultural praxis survey served two functions in this study: to provide a means of measuring employees' use of the modes of intercultural praxis, and to identify whether practices differ between trained and untrained employees. I address each of these sets of results here.

RQ2: How can employees' use of intercultural praxis modes be measured in a hospital environment?

This study measured hospital employees' use of the six modes of intercultural praxis using a 41-question quantitative instrument designed using Sorrells and Nakagawa's (2008) original framework. After filtering out surveys with substantial incomplete data, all remaining surveys had less than 5% missing data. Mean scores are reported for each survey item in Table 5. Data were analyzed using SPSS 22. Item 16 was removed from calculations because it exhibited extreme negative skewness and extreme positive kurtosis, possibly as a result of having a strong socially desirable response.

Respondents indicated slightly higher-than-midpoint frequency of nearly every item on the instrument with the exception of three: "When the other person and I have different personal characteristics (e.g., race, gender, physical abilities, job title, income, social status, etc.), I feel like those differences affect which one of us has more power in the conversation" (*M* = 2.84, *SD* = 2.554); **"**My primary goal in a conversation is to reach

agreement with the other person" (reverse coded) (M = 3.83, SD = 1.351); **"**The other person's differences do not influence the way I interact with him or her" (reverse coded) (M = 3.88, SD = 1704). The most frequently used practices were "I work collaboratively with the other person to solve problems" (M = 6.13, SD = 0.908) and "I look for ways to show respect for others' differences when I interact with them" (M = 5.88, SD = 1.066).

Table 5. Means and Standard Deviations for Praxis Survey Items

No.	Item Text	*M**	*SD*
1	When I perceive that someone is different from me, I want to learn more about those differences.	5.29	1.321
2	I think the other person and I may see the world in different ways.	5.21	1.229
3	As I talk to the other person, I am aware of that person's personal characteristics (e.g., race, gender, income and education levels, cultural practices, physical abilities).	4.66	1.446
4	I work collaboratively with the other person to solve problems.	6.13	0.908
5	I reflect on a conversation after it has happened.	5.54	1.191
6	I notice things about the other person that don't fit the stereotypes of people with his/her differences.	4.92	1.292
7	When I don't understand something the other person says, I ask a follow-up question.	5.85	1.081
8	I find it easy to consider multiple points of view when I'm having a conversation.	5.60	1.097
9	When talking to other people, I am aware of my personal characteristics (e.g., race, gender, income and education levels, cultural practices, physical abilities).	5.02	1.570
10	My primary goal in the conversation is to express my agreement or disagreement with the other person.**	4.98	1.455
11	I learn new things about myself by thinking back to past conversations.	5.30	1.117
12	I find that my views of the other person's differences are true.**	4.15	0.973
13	I ask questions about the other person's differences.	4.14	1.351
14	I think about how my differences might influence my point of view.	4.88	1.282
15	When the other person and I have different personal characteristics (e.g., race, gender, physical abilities, job title, income, social status, etc.), I feel like those differences affect which one of us has more power in the conversation.	2.84	1.554

Table 5 (continued)

No.	Item Text	*M**	*SD*
16	I am open to learning new things.	6.40	0.904
17	I forget the details of conversations almost immediately after they happen.**	4.91	1.340
18	Conversations with others lead me to consider alternatives I hadn't thought of before.	5.29	1.032
19	I want to know what the other person considers "normal."	4.52	1.441
20	I maintain one point of view throughout the entire conversation.**	4.92	1.162
21	I notice that how much people listen to me at work is affected—either positively *or* negatively—by my personal characteristics (e.g., race, gender, physical abilities, job title, education, or work experience).	4.31	1.491
22	I think the conversation produces new ideas.	5.17	1.054
23	I think back about what worked and what didn't work in a particular conversation.	5.24	1.086
24	Talking to other people changes the way I think about people who are different from me.	4.99	1.248
25	I am curious about other people's differences.	5.47	1.116
26	I think about what points of view the other person might have.	5.39	1.077
27	I feel creative during the conversation.	4.69	1.076
28	I adjust my current behavior after thinking back on conversations.	4.83	1.081
29	I challenge other people on their stereotypes and prejudices.	4.16	1.607
30	I avoid asking people questions about their differences.**	4.39	1.338
31	I approach the conversation using several different points of view.	4.68	1.127
32	My primary goal in a conversation is to reach agreement with the other person.**	3.83	1.351
33	Following a conversation, I think about how my beliefs may have been different from the other person's beliefs.	4.87	1.159
34	I feel compassion for people who are different from me.	5.04	1.45
35	When I ask people about their differences, I do so primarily to be polite.**	4.38	1.801
36	I look for ways to show respect for others' differences when I interact with them.	5.88	1.066
37	When a conversation does not produce agreement I feel like that conversation was a waste of time.**	5.61	1.197
38	Reflecting on conversations with other people helps me be more aware of what is considered "normal" at work.	4.61	1.329

Table 5 (continued)

No.	Item Text	*M**	*SD*
39	The other person's differences do not influence the way I interact with him or her.**	3.88	1.704
40	I leave a conversation feeling like I can relate to the other person.	4.86	0.947
41	If someone disagrees with me, I examine my position to see if I should change.	4.70	1.195

* 1 = Never; 7 = Always
** Item is worded in reverse. Responses were standardized prior to calculating means.

The survey instrument assumed that the six modes of intercultural praxis in Sorrells and Nakagawa's (2008) framework are six distinct sets of practices. To verify the validity of this assumption, a confirmatory factor analysis (CFA) was performed using Stata 13. Jackson, Voth and Frey (2013) recommend a sample of at least 200 for CFA to achieve a high likelihood of a proper solution, and this sample contained 209. The resulting chi-square fit test was significant ($X^2 = 1604.01$, $p < .001$), indicating a significant difference between the proposed model and the observed data. Other fit statistics also indicated the model was a poor fit (RMSEA = 0.076, CFI = 0.617, TLI = 0.588). These findings indicate that either there are not six distinct sets of practices in the intercultural praxis model, or that the items on this instrument do not adequately measure six distinct sets of practices.

To determine what common underlying dimensions may exist in this data set, an exploratory factor analysis was performed. A principal components analysis with direct oblimin rotation and Kaiser normalization was used. The principal components analysis was selected because it is the most common type of analysis (Field, 2013) and is preferred for exploratory studies (Mertler & Vannatta, 2005). Oblique rotation is

appropriate in this study because it assumes the factors may be correlated (Field, 2013). Sorrells (2013) acknowledges that the six modes of intercultural praxis often act in concert in a single interaction, so it is reasonable to assume the practices are likely to be correlated. Because respondents were permitted to skip questions, a few data points are missing (less than 5%), and those were replaced with the mean for that item for the exploratory factor analysis. Item correlations are reported in Table 6.

Table 6. Correlation Matrix

Item No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1																					
2	.280+																				
3	.172*	.177*																			
4	.290+	.058	.210+																		
5	.302+	.212+	.231+	.200+																	
6	.318+	.293+	.398+	.129	.354+																
7	.220+	.042	.048	.324+	.095	.126															
8	.239+	.204+	.011	.337+	.179+	.195+	.325+														
9	.135	.178*	.406+	.083	.117	.353+	.039	.089													
10	.051	-.033	-.052	.028	-.012	-.099	.056	-.008	-.218+												
11	.333+	.232+	.296+	.317+	.475+	.439+	.340+	.278+	.253+	-.050											
12	.022	-.043	-.309+	-.028	.042	-.130	.004	.166*	-.248+	.300+	-.117										
13	.317+	.090	.239+	.103	.240+	.284+	.251+	.141*	.289+	-.175*	.320+	-.281+									
14	.338+	.196+	.279+	.212+	.398+	.358+	.271+	.270+	.272+	.012	.495+	-.236+	.469+								
15	-.148*	.148*	.170*	-.118	.095	.167*	-.147*	-.095	.181*	-.226+	.047	-.238+	.018	.038							
16	.218+	.151*	.057	.236+	.020	.048	.092	.171*	.063	-.042	.092	-.091	.015	.174*	-.173*						
17	.058	.029	.109	.267+	.174*	.092	.167*	.090	.017	.046	.243+	.051	.039	.111	-.160*	.232+					
18	.282+	.260+	.159*	.255+	.281+	.193+	.229+	.282+	.071	-.012	.297+	.039	.147*	.277+	.010	.007	.196+				
19	.241+	.144*	.164*	.069	.235+	.229+	.195+	.047	.272+	-.137*	.232+	-.221+	.379+	.355+	-.007	.090	.065	.185+			
20	.065	-.083	-.083	.138*	.076	.024	.093	.144*	-.032	.162*	.041	.170*	.045	.130	-.239+	.095	.208+	.130	-.054		
21	-.008	.057	.271+	-.005	.090	.154*	-.052	-.066	.367+	-.267+	.092	-.349+	.100	.259+	.275+	.060	.109	.023	.224+	-.080	
22	.297+	.214+	.141*	.279+	.221+	.149*	.225+	.250+	.101	-.108	.354+	-.095	.233+	.314+	-.159*	.086	.195+	.314+	.202+	.016	.068
23	.244+	.139*	.221+	.149*	.283+	.181+	.262+	.174*	.143*	-.085	.419+	-.137*	.151*	.360+	.009	-.010	.234+	.344+	.165*	.077	.179*
24	.204+	.159*	.202+	.188+	.118	.215+	.150*	.094	.047	.019	.247+	-.051	.124	.257+	.042	-.058	.144*	.458+	.172*	-.034	.123
25	.518+	.381+	.158*	.175*	.246+	.300+	.259+	.214+	.209+	-.055	.279+	-.002	.386+	.304+	-.029	.102	.132	.399+	.316+	.071	.045
26	.388+	.340+	.164*	.121	.246+	.206+	.249+	.231+	.138*	-.022	.327+	-.029	.321+	.318+	-.019	.073	.103	.376+	.430+	.008	.053
27	.286+	.234+	.062	.223+	.342+	.138*	.265+	.272+	-.039	-.010	.309+	-.087	.207+	.276+	.056	.009	.127	.297+	.204+	.057	.063
28	.279+	.342+	.258+	.230+	.462+	.370+	.229+	.214+	.067	.063	.501+	.002	.153*	.379+	-.003	.041	.241+	.316+	.289+	.075	.134
29	.122	.147*	.106	.027	.195+	.250+	.093	.144*	.109	.068	.203+	.133	.099	.261+	.074	.136	.008	.160*	.224+	.030	.005
30	.115	.111	.073	.027	.059	.131	.049	-.005	.117	-.080	.177*	-.073	.360+	.145*	-.015	.093	.103	.005	.172*	-.133	-.006
31	.177*	.074	.108	.162*	.276+	.226+	.236+	.344+	.115	.000	.250+	-.048	.169*	.311+	-.144*	.152*	.115	.241+	.094	.249+	.141*
32	-.018	.056	-.146*	-.193+	.023	-.040	-.146*	-.047	-.132	.281+	-.186+	.210+	-.017	-.098	-.087	-.129	-.067	-.023	-.114	.013	-.111
33	.293+	.216+	.235+	.145*	.270+	.320+	.226+	.078	.214+	-.119	.407+	-.178*	.204+	.504+	.116	.147*	.188+	.286+	.187+	.009	.219+
34	.208+	.060	.075	.160*	.178*	.198+	.121	.032	-.024	-.087	.284+	-.110	.203+	.228+	.016	.071	.074	.070	.060	.027	.062
35	-.082	.062	-.019	-.161*	.008	-.028	.081	.100	-.061	.251+	-.031	.226+	-.030	-.012	-.048	-.095	.013	.045	-.107	.073	-.186+
36	.288+	.174*	.064	.301+	.121	.096	.157*	.212+	.128	.030	.179+	-.085	.160*	.161*	-.166*	.113	.223+	.239+	.131	.115	.007
37	.216+	.098	-.090	.091	.069	-.076	.061	.126	-.070	.284+	-.039	.255+	-.019	.018	-.339+	.066	.164*	.184+	.070	.195+	-.133
38	.177*	.058	.141*	.158*	.174*	.153*	.193*	.030	.106	-.096	.286+	-.236+	.112	.240+	.090	-.010	.126	.226+	.290+	.041	.116
39	.069	.047	.113	-.168*	.117	-.026	.036	-.126	.084	-.026	-.003	-.092	.173*	.095	.016	-.037	.003	.032	.279+	.010	.136
40	.272+	.020	.064	.195+	.170*	.154*	.134	.074	-.093	.075	.223+	-.018	.039	.140*	-.085	.073	.088	.160*	.007	-.011	-.053
41	.265+	.097	.175*	.186+	.214+	.221+	.255+	.114	.062	.143*	.133+	-.043	.140*	.278+	-.074	.006	.052	.111	.199+	.072	-.022

Table 6 (continued)

Item No.	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41
1																				
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22																				
23	.517+																			
24	.420+	.326+																		
25	.345+	.260+	.502+																	
26	.382+	.343+	.476+	.713+																
27	.381+	.295+	.208+	.303+	.337+															
28	.338+	.414+	.377+	.253+	.338	.400+														
29	.062	.060	.045	.185+	.168*	.083	.198+													
30	.090	.055	.046	.180+	.156*	-.039	.015	.174*												
31	.243+	.299+	.104	.162*	.197+	.288+	.289+	.238+	-.019											
32	-.175*	-.229+	-.009	.070	.047	-.034	-.050	-.024	-.058	.045										
33	.409+	.507+	.385+	.328+	.294+	.233+	.392+	.186+	.090	.189+	-.212+									
34	.206+	.146*	.345+	.314+	.219+	.201+	.156*	.110	.118+	.125	-.198+	.339+								
35	-.217+	-.016	-.136	.038	.037	-.162*	-.032	.157*	.065	-.003	.295+	-.220+	-.251+							
36	.362+	.334+	.227+	.368+	.321+	.183+	.245+	-.039	.076	.081	-.163*	.290+	.286+	-.211+						
37	.183+	.134	.186+	.284+	.170*	.066	.185+	.053	-.087	.044	.197+	.011	.048	.179*	.227+					
38	.342+	.306+	.221+	.152*	.173*	.284+	.256+	-.004	-.052	.202+	-.335+	.423+	.246+	-.334+	.319+	-.057				
39	.057	.150*	.153*	.153*	.183+	.097	.116	-.089	.089	.099	.018	.044	.031	-.099	-.006	.199+	.140*			
40	.286+	.288+	.188+	.125	.080	.153+	.298+	.059	.026	.173*	-.227+	.238+	.269+	-.152*	.267+	.082	.265+	-.081		
41	.265+	.398+	.135	.111	.195+	.265+	.398+	.233+	.068	.156+	-.204+	.281+	.188+	-.092	.288+	.114	.268+	.014	.463+	

** = Correlation is significant at the 0.01 level. + = Correlation is significant at the 0.05 level.*

The exploratory factor analysis began with the process of extraction, which narrows the number of factors to those that have the largest substantive importance (Field, 2013). Importance is measured by eigenvalues, so a scree plot of factor eigenvalues was generated, and factors above the point of inflexion were retained (Field, 2013). Four factors were retained. Within those four factors, items that showed evidence of substantial cross-loading were excluded, and items that loaded above .4 were retained (Floyd & Widaman, 1995). Factor loadings are shown in Table 7. This factor solution accounted for 52.08% of the total variance. A factor solution should explain over 50% of the variance of the measured variables (Streiner, 1994), although some scholars call for a stricter standard (Floyd & Widaman, 1995). Eigenvalues and variance explained are reported in Table 8.

Table 7. Factor Loadings for Praxis Survey Items

No.	Item	Factor 1	Factor 2	Factor 3	Factor 4
23	I think back about what worked and what didn't work in a particular conversation.	**.667**$_a$	.086	-.026	-.153
38	Reflecting on conversations with other people helps me be more aware of what is considered "normal" at work.	**.642**$_a$	.171	.029	.032
33	Following a conversation, I think about how my beliefs may have been different from the other person's beliefs.	**.619**$_a$	.256	-.042	-.150
22	I think the conversation produces new ideas.	**.604**$_a$	-.061	-.265	-.047
40	I leave a conversation feeling like I can relate to the other person.	**.555**$_a$	-.286	.176	-.252
24	Talking to other people changes the way I think about people who are different from me.	**.495**$_a$	.049	**-.419**	.146
36	I look for ways to show respect for others' differences when I interact with them.	**.474**$_a$	-.141	-.348	.080
21	I notice that how much people listen to me at work is affected—either positively *or* negatively—by my personal characteristics (e.g., race, gender, physical abilities, job title, education, or work experience).	.174	**.739**$_b$	.064	.115
9	When talking to other people, I am aware of my personal characteristics (e.g., race, gender, income and education levels, cultural practices, physical abilities).	-.111	**.672**$_b$	-.171	-.130
3	As I talk to the other person, I am aware of that person's personal characteristics (e.g., race, gender, income and education levels, cultural practices, physical abilities).	.071	**.543**$_b$	.038	-.300
25	I am curious about other people's differences.	.097	-.040	**-.843**$_c$	-.010
26	I think about what points of view the other person might have.	.152	-.024	**-.799**$_c$	.001
13	I ask questions about the other person's differences.	-.197	.230	**-.493**$_c$	-.303
19	I want to know what the other person considers "normal."	.001	.361	**-.473**$_c$	-.047
1	When I perceive that someone is different from me, I want to learn more about those differences.	.060	-.157	**-.459**$_c$	-.379
5	I reflect on a conversation after it has happened.	.068	.012	.043	**-.715**$_d$
11	I learn new things about myself by thinking back to past conversations.	.228	.090	-.001	**-.679**$_d$
6	I notice things about the other person that don't fit the stereotypes of people with his/her differences.	-.032	.267	-.030	**-.620**$_d$
28	I adjust my current behavior after thinking back on conversations.	**.417**	.010	.025	**-.507**$_d$
8	I find it easy to consider multiple points of view when I'm having a conversation.	-.080	-.315	-.230	**-.480**$_d$
14	I think about how my differences might influence my point of view.	.143	.282	-.204	**-.478**$_d$

Note: Extraction method: Principal component analysis. Rotation method: Direct oblimin with Kaiser normalization. Shared subscripts indicate common factor loading.

Table 8. Factor Eigenvalues and Variance

Factor	*M*	*SD*	Initial Eigenvalue	% of Variance	Cumulative %
Engagement	5.09	.740	6.149	29.280	29.280
Positioning	4.66	1.139	1.888	8.988	38.628
Inquiry	4.96	.902	1.542	7.344	45.613
Introspection	5.18	.804	1.358	6.467	52.080

Factor 1 (Engagement) had an eigenvalue of 6.149. It accounted for 29.3% of the overall variance, and Cronbach's alpha was .768. An alpha of .7 or higher is acceptable, and in exploratory research, some scholars will even accept alphas as low as .5 (Field, 2013). This factor was labeled Engagement because all seven items related to reflecting and acting in a way that is reflexive and translates directly into current and future active engagement with others. Three items related to Sorrells and Nakagawa's (2008) conception of reflection, two related to dialogue, and three related to action loaded onto this factor. The combined mean for the seven items in this factor was 5.09 (*SD* = .740), suggesting that respondents use Engagement more often than "Sometimes" in their intercultural workplace interactions.

Factor 2 (Positioning) accounted for 8.9% of the variance and had an eigenvalue of 1.888. Cronbach's alpha was .613. This factor had the lowest alpha even though factor loadings were high for all three items. This finding indicates a strong connection among the items but a lower reliability. All three items that loaded onto this factor related to the intercultural praxis mode of positioning, but because the positioning survey item related to power did not load cleanly onto this factor, it does not truly represent Sorrells and Nakagawa's (2008) conception of positioning. However, the label Positioning is retained,

as this mode of praxis indicates that people are aware of their own and others' personal characteristics, and they understand that those characteristics potentially have consequences. The combined mean for these three items was 4.66 (*SD* = 1.139), suggesting that respondents use Positioning less frequently in their interactions than the other three factors, but more frequently than "Sometimes."

Factor 3 (Inquiry) had an eigenvalue of 1.542 and accounted for 7.3% of the total variance. Cronbach's alpha was .759. All but one of the items that loaded onto this factor were designed to measure the intercultural praxis mode of inquiry, and the remaining item is associated with framing. Although multiple modes of praxis were represented, other commonalities in the items resulted in the retention of Sorrells and Nakagawa's (2008) label of Inquiry. The combined mean for these five items was 4.96 (*SD* = .902), suggesting that respondents engage their Inquiry slightly more than "Sometimes" in their intercultural interactions at work.

Factor 4 (Introspection) accounted for 6.5% of the total variance, had an eigenvalue of 1.358, and Cronbach's alpha was .773. Three of the items that loaded onto this factor represented the reflection mode of praxis, two represented framing, and one represented action. This particular combination of survey items all contained some element of thought or reflection, but unlike the reflection represented in Factor 1, there is no action component. The action represented in the one item categorized on the survey as corresponding to "action" as Sorrells and Nakagawa (2008) theorized is the act of noticing, which is an inward action rather than an outward action or interaction. Thus, this factor was labeled Introspection, which is thought and reflection focused on the self. This is distinct from the Engagement mode of praxis because Introspection, in this case,

the thought and reflection is not necessarily intended for use in interaction with the other. The combined mean of these six items was 5.18 (*SD* = .804), indicating respondents use Introspection in their workplace interactions more than any other factor revealed in this study.

As these results demonstrate, employees' use of the modes of intercultural praxis in a hospital environment can be measured through a quantitative survey asking about the frequency of certain practices in intercultural workplace interactions. However, as I will discuss more in Chapter 5, the failure of the confirmatory factor analysis to confirm the presence of six categories of praxis as suggested in the theory and the discovery of four underlying dimensions in the exploratory factor analysis indicate either that this particular instrument is not appropriate for measuring intercultural praxis, or that the intercultural praxis framework is not inclusive of the real practices employees at STH are using in their interactions. Next, I use survey data to examine whether differences exist between trained and untrained employees.

RQ5: To what extent does the use of intercultural praxis modes differ between employees who have and have not participated in diversity training?

Two methods were used to answer this question. First, the quantitative intercultural praxis survey was used to identify whether there was a significant difference in reported practices between those who had and had not completed training. Second, qualitative responses to the critical incident survey were analyzed to determine whether trained and untrained employees enacted the practices in the intercultural praxis framework in different ways. Here, I provide results from the first method, and in the next section, I return to this question using the critical incident survey data.

Because the exploratory factor analysis revealed four underlying factors in the intercultural praxis instrument, not six as Sorrells and Nakagawa's (2008) framework suggests, the four factors discussed above were used for this analysis. For each factor, an independent samples t-test was performed to compare mean scores of respondents who reported completing DIC I and respondents who said they had not taken the course. Results revealed that on all four factors, there was no significant difference between those who completed the training and those who did not (see Table 9). Because training materials and other textual artifacts such as newsletter and website texts are all linked to the Office of Diversity, Equity and Inclusion at STH, it is possible that trained and untrained employees are getting relatively the same information from the textual artifacts that surround them.

Table 9. Trained vs. Untrained Employees

	Completed Training					
	Yes	**No**				
	***M* (*SD*)**	***M* (*SD*)**	***N***	***df***	***t***	***p***
Engagement	5.05 (.75)	5.13 (.73)	206	204	-.74	.46
Positioning	4.66 (1.17)	4.66 (1.11)	206	204	-.02	.98
Inquiry	4.50 (.84)	4.97 (.98)	206	204	-.28	.88
Introspection	5.20 (.79)	5.16 (.81)	206	204	.28	.78

Critical Incident Survey

The final method used in this study was a critical incident survey (see Appendix III) designed to collect employee narratives of their intercultural encounters. Narrative is an important element of this study because it provides depth whereas the intercultural

praxis survey can only provide breadth. While the textual analysis revealed employees' organizational culture and the quantitative survey revealed the practices employees use, their stories reveal how they make sense of their culture and how they use these practices. Organizational members disclose their sensemaking of their organizational culture through their stories (Keyton, 2005), which is why employee narratives are useful for understanding the way the organizational culture at STH is enacted in daily interactions. As Reissman (2008) explains, for researchers, "stories function to alter the ways we view mundane everyday events" (p.63). The stories of employees' everyday conversations at work, when analyzed, reveal the interplay between organizational culture and employee communication practices. In this section, I first describe the participants and then analyze their stories as they relate to RQ3 (How do narratives express employees' understanding of culture?), RQ4 (How do narratives express the way employees use modes of intercultural praxis in workplace interactions?) and RQ5 (To what extent does the use of intercultural praxis modes differ between employees who have and have not participated in diversity training?).

Critical Incident Survey Participants

A total of 22 STH employees completed the critical incident survey they received via email. No information was collected about respondents other than their stories and whether or not they have taken the DIC I course. Of those who responded, 15 had taken DIC I, and seven had not. Respondents were asked to describe an intercultural interaction they had at work, who the participants were, what happened or what was said, and what was the outcome of the interaction. Half of the stories told by participants resulted in what the storyteller considered to be a positive outcome, seven of the stories (32%) had a

negative outcome, and four of the stories (18%) had neutral outcomes where the storyteller indicated uncertainty or used words like "fair" or "okay" to describe the outcome. See Appendix VI for a sample employee narrative.

Analysis of Critical Incident Survey Data

The stories participants provided about their intercultural communication experiences illustrated how they define "difference" and what practices they use in interactions with people they consider different from themselves. Because each person also indicated whether or not they had completed the basic diversity training course, their stories can also be used to examine whether trained and untrained employees report using different practices. I analyze participants' stories in the context of the research questions I posed for my dissertation study.

RQ3: How do narratives express employees' understanding of culture?

To answer this question, I asked participants in the critical incident survey to think of a conversation they had with someone culturally different from themselves and then describe how they knew the other person/people in their story were different from them. The question reads, "What made this person culturally different from you? How did you (or do you now) know there were cultural differences?" This question was designed to elicit descriptions of what constitutes "culture" to these individuals. Responses to this question can be found in Table 10. To analyze these responses, I assigned each response as many initial, categorical codes as I saw in the data, and then I further grouped those categories into a larger typology found in Table 11 (Reissman, 2008). In the tables that follow, each participant is designated by a letter of the alphabet, which appears to the left of their response. All responses are copied directly from

participants' written responses, and all spelling, punctuation, and grammatical choices were the participants'.

Table 10. Responses and Coding for CIT Item 2

Response		Category(ies)
A	She had only been in USA for ~ 2-3 years and knew very little english. I have travled extensively when younger as dependent of military family.	Language Place of origin
B	I was made aware of our cultural differences because this male patient advised me that he is from Saudia Arabia.	Gender Nationality
C	Native American	Race/ethnicity
D	they are Arab	Race/ethnicity
E	Hispanic female	Race/ethnicity Gender
F	her acent.	Accent
G	She is a representative from the latino community (I am not) and I knew this because she stated her ethnic, racial and language background when we met.	Race/ethnicity Language
H	The other nurse believed in a religious practice know as Santeria (spelling?). I have issues with any animals being harmed or sacrificed.	Practices Religion
I	This person was born and raised in India and worked 10 years in Sadia Arabia as a nurse.I knew there were cultural differences. She was muslim and did not respond when I would say Bless you for one of her sneezes. She has a very thick accent.	Nationality Religion Practices Accent
J	She spoke a different Spanish dialogue from a different area.	Dialect Place of origin
K	They did not speak English.	Language
L	This patient had a need to communicate through sign language. I knew of these differences once he came to my desk and started writing on a piece of paper. The patient told me he was deaf and would need assistance with therapy.	Language Ability
M	The parent of the patient had strong religious beliefs. They were reflected in her accessories as well as her statements about prayer and healing.	Religion Beliefs Appearance
N	He wouldn't acknowledge a question had been asked or when given patient information he ignores it.	Practices

Table 10 (continued)

	Response	Category(ies)
P	My pt and his family were culturally different due to having a Native American background. (San Felipe Pueblo)	Race/ethnicity
Q	It was clear to me that there were cultural differences as the patient spoke only Navajo.	Language
R	Their clothing and manner of speaking made me think they were culturaly different.	Appearance Language
S	These people were from low income Hispanic families and did not value education	Race/ethnicity Income level Values
T	I don't see any difference.	Colorblind
U	Eastern culture--previous encounters with Eastern people and their beliefs and ethics	Place of origin Beliefs Ethics
V	My patient was originally from China, Mandarin Chinese was her primary language even though she did speak fluent English. Her mother was with her and only spoke Mandarin.	Nationality Language

All responses are direct quotes from the respondents. No edits have been made.

Table 11. Attributes of Cultural Difference

Typology of Attributes	Associated Categories
Origin/Ancestry	Place of origin Race/ethnicity Nationality
Language	Language Accent Dialect
Tangible Attributes	Gender Ability Appearance Practices Income level
Intangible Attributes	Religion Beliefs Ethics Values

When performing an initial open coding, 16 different categories were identified. From those categories, four different groups emerged: origin/ancestry, language, tangible attributes, and intangible attributes. These groups combine to form a typology of attributes that these STH employees have identified as indicating someone is culturally different from themselves.

First, respondents indicated that people who have different genetic or geographical origins than they do are culturally different from them. This includes identifying people by their national, racial and ethnic, and place-based heritage. Second, respondents identified linguistic differences as markers of cultural difference between themselves and others. People were considered "culturally different" because they spoke a different world language than the respondent or spoke the same language, but spoke a variation of it that included an unfamiliar accent or dialect. This reinforces the textual analysis finding that language is an important part of intercultural communication at STH. Third, respondents considered others culturally different because of tangible traits such as appearance, gender, ability level, income, or behaviors. And finally, when respondents had knowledge of another person's intangible traits such as religion, beliefs, values, and ethics, they sometimes identified those traits as markers that a person was culturally different.

In the data set, there was one outlier. One respondent, when asked how he/she knew the other person was culturally different, wrote, "I don't see any difference." I interpreted this to be a "colorblind" statement where the person was attempting to convey that he or she treats everyone equally and does not notice or regard cultural differences. However, I did not include this response in the typology for two reasons. First, this

person completed the survey in the same way as other respondents, and the survey is based on the premise that the respondent is describing a conversation with a person who is culturally different from him or herself. If this particular respondent truly saw no differences between him or herself and those with whom he or she interacts, it would have been impossible to complete the survey, as this individual did. Second, in a later response in the survey, when discussing the outcome of the interaction, this individual wrote: "The outcome is when the person from another country don't understand or speak English very well." This indicates that the respondent was identifying both nationality and language as markers of cultural difference but chose not to include those when responding to the earlier question. This response was a true outlier and did not belong in the typology.

The typology of attributes that these STH employees are using to define culture include origin, language, tangible attributes, and intangible attributes. Understanding how individuals are defining culture is helpful in this study because it provides context to both the praxis survey and the critical incident survey, both of which asked participants to respond based on their conversations with people they consider culturally different from themselves. Although the CIT results are qualitative and are not intended to be generalizable, they reflect individual sensemaking, which provides insight into organizational culture (Keyton, 2005). Thus, the way employees define culture and identify those who are "culturally different" from themselves is useful in the broader context of this study and not just in relation to the narratives of these individuals. With this context in mind, I analyze the stories themselves to understand the communication practices employees use in their intercultural interactions.

RQ4: How do narratives express the way employees use modes of intercultural praxis in workplace interactions?

Much like in the textual analysis of hospital documents, I first used closed coding to identify occurrences of practices that are part of the intercultural praxis framework, and I next used open coding to see what other themes and practices emerged from the narratives. I explore each mode of the intercultural praxis framework here, beginning with the most-used practices, and next I identify the additional practices that respondents used.

Inquiry. Sorrells and Nakagawa's (2008) mode of inquiry appeared frequently in participants' stories. Inquiry was the most-used practice mentioned in employee narratives, and in addition to their own use of inquiry, employees mentioned times they *didn't* use inquiry or times that their patients did. Examples are included in Table 12. Participants express interest in learning about other cultures, provide concrete examples of times they asked questions to learn more, and describe how they tried to keep an open mind in the interaction they describe. Balanced with these examples of using inquiry in their practice, however, are several examples of when the storyteller indicates a desire to know more but did not ask questions. These instances often resulted in frustration and misunderstanding. Additionally, in interactions where the other person was a patient, employees describe their patients' use of inquiry to better understand the employee and what was happening with their medical care.

Table 12. Examples of Inquiry

Respondent	Examples of Inquiry
A	I have typically been very culturally aware and interested in different cultures.
B	I think I am open to learning about other people and our cultural differences.
J	I was a confused and asked for her to give me a little more detail as to what she needed
L	I have learned to keep a very open mind with others that I communicate with.
G	It reminds me to be nondefensive and to listen carefully,understand, make inquiry when I feel there isn't enough information
Respondent	**Examples of Lack of Inquiry**
I	I guess in one of our conversations she must have understood something way wrong.
K	Two co workers speaking Spanish and you feel left out and not sure why they are speaking Spanish when they can speak English.
O	I wasn't sure the patient or the family understood everything.
C	I wasn't sure whether I was doing anything inappropriate for their culture.
Respondent	**Examples of Patient Use of Inquiry**
A	She asked good questions
B	patient asked me, "Why do you work?"
T	People came and asked questions.

Although hospital documents showed that inquiry is not well supported by organizational culture, employees appear to be using inquiry frequently in their interactions. However, their stories also reveal a need for improvement. In many narratives, employees had a desire to know more or to act in a way that was culturally appropriate at the time, but did not take the step of asking questions of the other person. Most examples of inquiry include primarily the internal components of inquiry (desire to learn, know, and find out) but not the action component of being willing to ask.

Employees also acted favorably when others asked questions of them about their culture. In one narrative, the female employee described a male Saudi Arabian patient

who was interested in why she and other U.S. American women work. She explained to him why she works, and he "stated that women should not have to work because it is a man's place to work and support the family" (Respondent B). The employee stated that she looks back positively on this conversation because "this male patient treated me with the utmost respect even though he did not believe I should be working" (Respondent B). In this story, the employee described how inquiry and dialogue can be used to enhance mutual cultural understanding and communicate in a respectful way.

Reflection. Reflective practice is found frequently throughout employees' narratives. This may be a result of the highly supportive organizational environment, but it also may be a result of the nature of this survey, which asked participants to think back to a conversation and tell the story. While, as many respondents found, the survey did not inherently require reflection, it encouraged reflection as part of the narrative re-telling. The last question on the instrument reads: "Since this interaction, what, if anything, have you reflected on, learned, or changed about the way you interact with people who are culturally different from you?" Not all participants engaged in reflection, but about half did. Examples of reflective statements are in Table 13.

Table 13. Examples of Reflection

Respondent	Examples of Reflection
G	I wince inside when I think of the person I was, sitting at the table with this group of advocates for the first time.
H	I now realize that his beliefs are very important to his way of life, even though they conflict with my own.
L	I have also reflected on how much it means to others who communicate differently when someone else understands them
V	now I know that it isn't as hard as I had prevously thought.
C	next time I will insist and make the supervisor aware of my role as an interpreter.
U	be more patient with people involved with these services
P	made me more aware of their potential reactions to their diagnosis or how pts and family members react, can be directly related to their culturally background

Respondent G tells a story of serving on a committee to try to improve relations between the hospital and the Latino community. At a meeting with community advocates, this person recalls feeling defensive and guarded. Trying to follow the example of a more experienced colleague, the respondent decided to focus on listening. Respondent G reflects, "The initial interaction was difficult but over time (this occurred over a period of two years) my opinions, openness to really see the issues and my desire to make a difference for this community changed markedly." The respondent also states that this initial interaction is one he or she reflects on frequently to continually make behavior and attitude changes. "It reminds me to be nondefensive and to listen carefully, understand, make inquiry when I feel there isn't enough information, and to try to put myself in another's shoes before rendering a decision or course of action" (Respondent G). Upon reflection, Respondent G appears to have adopted both inquiry and framing practices.

Respondents use reflection in many ways in their intercultural interactions. Employees reflected on what they felt at the time, what surprised them, what they learned, what they will try to do differently in the future, and what they have realized since the interaction. Some indicated previous reflection; others may have been reflecting solely for the purposes of the survey; and some did not reflect at all. In an organizational culture that is highly supportive of reflection, some employees appear to be using this mode of praxis to improve their future interactions.

Action. Culturally, STH encourages action that promotes social justice and equality in health care as discussed earlier. Employee narratives reflect their use of this type of action in the intercultural interactions. Action is not present in employee narratives to the same degree as inquiry or reflection, but it does have a fairly strong presence. Examples of employee action are found in Table 14.

Table 14. Examples of Action

Respondent	Examples of Action
B	I treat people the way I desire to be treated which is with dignity and respect.
D	able to take to room to see doctor [despite a language barrier and the absence of an interpreter]
R	then did not press the issue and did not perform that portion of the evaluation
V	I told the mom I was sorry I uncovered the baby for so long and thanked her for covering her grandson with a blanket since my hands were busy.

Respondent V, for example, told a story of caring for a mother of Chinese nationality who had just given birth to a son. The respondent became aware that the family's cultural norms prohibited the mother from caring for herself or the baby after

birth and that mother and baby needed to be kept warm for a certain amount of time. Having undressed the baby while holding him to his mother to nurse and receiving negative non-verbal feedback from the grandmother, the employee realized the mistake and worked to make amends. For the remainder of the patient's stay at the hospital, Respondent V adhered to the norms and values of the family and gave them the care they needed. The respondent wrote: "I was glad that I had learned a little about their cultural expectations before I took care of this family. It felt good to be able to give this family the care they needed in a way that was appropriate for them." This is a good example of an employee who changed his or her actions based on new learning about others and acted in a way that promoted culturally sensitive care. The result was positive. "When she went home that day, she and her mother thanked me for my care. They filled out the patient survey and had wonderful things to say about our unit and our hospital" (Respondent V). This analysis revealed that, like Respondent V, some STH employees engage in responsive action in their intercultural interactions.

Fewer examples were found of the remaining three modes of intercultural praxis—dialogue, framing, and positioning—than in the previously discussed modes of praxis. I examine these next.

Dialogue. Dialogue appears infrequently in STH employee narratives. This may be, as one respondent points out, because of a lack of time. Three respondents (B, I and J) discussed situations in which involved parties had interactions that included creative engagement that stretched across difference, as Sorrells and Nakagawa (2008) suggest dialogue should. Respondent A emphasized the importance of empathy in the interaction,

which is an element of dialogue, but alone is not indicative of a true dialogue. These excerpts are included in Table 15.

Table 15. Examples of Dialogue

Respondent	Examples of Dialogue
A	I try to be empathtic to their situation.
I	The 3 of us sat down to talk
J	I explained that to me what she had asked for was a check stub not a copy of her W-9, then she asked how she could as for this information so that we would understand what she meant.
O	don't really feel there is time to engage in a lengthy enough conversation to discover everything necessary to insure they receive everything they need

As these examples demonstrate, very little real dialogue appears to be happening between STH employees and the people with whom they interact at work. The best example of creative engagement is the story described above between Respondent B and her Saudi Arabian patient who was curious about the culture of working women in the United States. As Respondent O indicates, the reason for the lack of dialogue may be time. This respondent expresses an interest in learning more about patients and their needs, but does not appear to believe that the necessary dialogues are a possibility in the current work environment. Dialogue is a practice that was found to be largely unsupported in the document analysis portion of this study, which aligns with this respondent's viewpoint.

Framing. Framing was a unique mode of praxis in the document analysis because it had a significant presence in training materials but was largely absent from other

hospital documents. Likewise, framing is largely absent from employee narratives, even among those who have completed the DIC I training course (see Table 16).

Table 16. Examples of Framing

Respondent	Examples of Framing
G	and to try to put myself in another's shoes before rendering a decision or course of action
N	I just continue to try and understand where they come from
P	How pts and family members react, can be directly related to their culturally background and has medical providers we have to be respectful of this

While some employees appear to be trying to "put myself in another's shoes" (Respondent G) and acknowledge a variety of perspective-taking options, few express this practice in their narratives. Framing does not appear to be an important part of the intercultural communication practice of STH employees.

Positioning. Likewise, positioning is rarely acknowledged in the practice of intercultural communication among respondents. The one clear acknowledgement of positioning was in Respondent C's narrative, where others in the interaction were described as "power playing." This remark indicated Respondent C's understanding that there were power differences in the interaction and that he or she was not in a position of relative power. Other acknowledgements of positioning in socially constructed hierarchical categories appeared in one of the themes I will discuss in the next section, which is a deference to authority. This theme reflects employees' understanding of their own hierarchical position in the organization, but does not include positioning in Sorrells

and Nakagawa's (2008) sense, which involves positioning among participants in an interaction.

To answer the research question (How do narratives express the way employees use modes of intercultural praxis in workplace interactions?), the analysis revealed that employees primarily use inquiry, reflection, and action, and they rarely use dialogue, framing or positioning. Inquiry is used in a multitude of ways, including both desiring to learn and acting upon that desire by asking questions, and employees appear to respond positively to inquiry when others outside the organizational culture use it in their workplace. Reflection is used to better understand interactions, reflect on feelings, and create plans for future action. Action, then, is used by employees to provide inclusive and culturally sensitive care. The results of this analysis closely match the findings of the intercultural praxis survey, where reflective and inquiring practices were dominant in employees' intercultural communication interactions. In addition to these findings, three other important themes emerged from employees' narratives: language practices, avoidance, and deference to authority.

Language. Much like language emerged as a potential seventh mode of intercultural praxis in the document analysis portion of this study, language again became an important emergent theme in the CIT data. Practices related to language use were more common among employees than four of the six modes of intercultural praxis. Language examples are included in Table 17.

Table 17. Examples of Language

Respondent	Examples of Language
C	I informed the staff that I am an interpreter
J	Words can change the meaning when using different language dialogues.
L	ensure that there would be an interpreter with him as well during future appointments
O	I explained the situation as best I could in terms that I felt were understandable
T	Sometimes times it is hard to explain or to the people understand because of speaking.
Q	We utilized an interpreter as the patient understood very little English.
U	had to use interpretors for communication purposes

As I discovered in the textual analysis, using both the same world language as the other person and the same dialect or vocabulary was important to employees. For example, Respondent J encountered a person who was speaking the same language, but using a different dialect. While this person wanted a tax form, she was asking for a check stub, and a misunderstanding resulted. Respondent J was able to calmly engage the woman in a dialogue not only to understand what she wanted, but also to help both of them understand the other's language choices so they and others could communicate more effectively in the future. Like Respondent J, several of the other respondents identified language barriers as the reason the particular interaction in their story was so difficult and memorable. Many mention interpreter services, but as Respondent J illustrates, two individuals do not need to be speaking a different language to have difficulty communicating across cultures.

Avoidance. In addition to using their language resources to communicate in the workplace, employees also demonstrated that they use the practice of avoidance in intercultural situations. In several stories, employees describe how one uncomfortable

interaction resulted in general avoidance of the topic or person in the future. Examples of avoidance are in Table 18.

Table 18. Examples of Avoidance

Respondent	Examples of Avoidance
E	Stay away from that subject
R	I need to steer clear of those conversations before they get so intense.
H	I was upset and said I didn't want to hear about it because I love animals and don't believe that they should be sacrificed for any religious purposes.
I	now I am friendly with Julie but I never talk to her anymore
K	I said, did nothing. Still happens.
U	keeping the interactions (I felt) toa minimum as the use of interpretor services was taking more time than the actual activity needed to be done

These examples illustrate employees' inclination to avoid intercultural interactions rather than engage in them. This practice is contrary to both Sorrells and Nakagawa's (2008) framework and to the teachings of STH's basic diversity course. However, it is more prevalent in employee narratives than three of the modes of intercultural praxis are. This finding is significant for STH. With an understanding of employees' tendency to avoid intercultural interactions, STH can develop training that will better address what appears to be a culture of avoidance.

Deference to Authority. The third theme that emerged outside the intercultural praxis framework was deference to authority. As I mentioned earlier, this is closely aligned with positioning because respondents recognized their place in the constructed categories of the organizational hierarchy. Employees who expressed this theme indicated that there was a level of frustration in their intercultural interaction, but they place the impetus for minimizing this frustration on the organization rather than on

themselves (see Table 19). Employees looked for policies and procedures to guide their behavior or make their communication easier (such as Respondent J, who was looking for better explanations in patient forms), and in the absence of guidelines, they turn to individuals who occupy higher places than themselves in the hospital hierarchy.

Table 19. Examples of Deference to Authority

Respondent	Examples of Deference to Authority
C	I wish it can be explained better why the hospital asking the questions
J	am concerned that it is not clear when intervention would be needed to give the child the care she needs.
L	I talked to his supervisor
O	I feel our institution can improve pt [patient] care and outcomes, with the improvement of cultural awareness among medical providers.

In these examples, employees indicate recognition of their relatively low positioning in the organization and their belief in the ability of those higher than they are in the organizational hierarchy to initiate positive change. Ranging from Respondent L, who reported culturally insensitive behavior to a supervisor, to Respondent O, who would like to see better cultural awareness across the organization, these employees believe it is the job of people higher in the hierarchy than themselves to fix any problems with cultural interactions in the workplace. This is potentially good news for the Office of DEI. Although training did not have any impact on employees' use of intercultural communication practices, as the intercultural praxis survey results showed, employees look to hospital administration for resources and solutions to difficult intercultural interaction issues and likely would be receptive to training in these areas.

Employee narratives indicate that in addition to their varied usage of the six modes of intercultural praxis, employees are also using language accommodation practices, avoidance practices, and display deference to authority in regard to fixing issues and frustrations in intercultural interactions. Next, I return to RQ5 to examine whether employee narratives reveal any difference between those who have and have not completed basic diversity training.

RQ5: To what extent does the use of intercultural praxis modes differ between employees who have and have not participated in diversity training?

The answer to this question combines both the results of the intercultural praxis survey and the critical incident survey. As discussed earlier, the intercultural praxis survey results indicated no significant difference between trained and untrained employees in regard to the practices they use in intercultural interactions.

Results of the critical incident survey reveal some differences in the stories told by trained and untrained employees. First, trained employees tended to select stories with more positive outcomes. Nine out of 11 stories with positive outcomes (82%) were told by people who had completed basic diversity training. Trained employees were also less likely to tell neutral stories (one out of four neutral stories was told by trained employees) that indicated ambiguity or uncertainty with the outcome. These findings imply that people who have completed diversity training have a more positive outlook on their intercultural interactions and are more likely to have a definitive understanding of what occurred in a given interaction.

In regard to usage of the six modes of intercultural praxis, people who have and have not completed training expressed their enactment of all modes of praxis in roughly

the same proportion and in roughly the same ways as the overall responses to the survey. As in the praxis survey, the critical incident survey revealed no substantial difference in the intercultural communication practices of employees who have and have not completed basic diversity training.

Chapter Summary

In this chapter, the results of three data gathering methods were presented and the data analyzed in relation to the research questions. First, results of the textual analysis were presented and analyzed. Next, the intercultural praxis survey results were examined, and finally, results of the critical incident survey were discussed. Here, I present a brief recap of each research question.

RQ1: To what extent do textual artifacts at STH create an organizational culture that supports intercultural praxis in the workplace?

Documents produced by STH indicate that reflection, positioning, and action are supported by the organizational environment at STH. Framing, inquiry, and dialogue are neither supported nor unsupported. A seventh mode of praxis that is emphasized by the hospital is language, which means communicating in the world language and at the vocabulary level of the other person is important to organizational members.

RQ2: How can employees' use of intercultural praxis modes be measured in a hospital environment?

Employees' use of the modes of intercultural praxis can be measured using a quantitative survey instrument developed in this study. However, a confirmatory factor analysis revealed that the six modes of praxis proposed by Sorrells and Nakagawa (2008) do not appear to be six distinct sets of behaviors. Rather, four underlying factors have

been identified using employee data: Engagement, Positioning, Inquiry, and Introspection.

RQ3: How do narratives express employees' understanding of culture?

Employee narratives reveal that respondents define culture as a person's origins and ancestry, language, tangible attributes like gender and practices, and intangible attributes like beliefs and values.

RQ4: How do narratives express the way employees use modes of intercultural praxis in workplace interactions?

Employees use inquiry, reflection, and action in their intercultural interactions in a variety of ways. Narratives demonstrate rare usage of dialogue, framing, and positioning. Employees also tell stories of their language usage and avoidance practices, and their belief in the need for authority or those higher in the organization to solve some of the intercultural communication problems they experience.

RQ5: To what extent does the use of intercultural praxis modes differ between employees who have and have not participated in diversity training?

Both the intercultural praxis survey and the critical incident survey revealed no difference in whether and how employees use intercultural communication practices in their interactions. Employee narratives, however, demonstrated higher levels of positivity and assurance in relation to their intercultural interactions among those who had been trained than among those who had not completed diversity training.

CHAPTER 5: DISCUSSION

This study set out to investigate the interrelationships among organizational culture, diversity training, and employee intercultural communication practices at a large public teaching hospital for the purpose of informing hospital decisions regarding reducing health disparities in the community. Chapter 1 presented an overview of the problem and situational factors surrounding this study. Chapter 2 provided a review of relevant literature that grounds this study theoretically. Chapter 3 described the three methods of data collection used in this study: textual analysis of documents, a quantitative survey instrument, and a qualitative critical incident survey and the rationale for using these methods. Chapter 4 displayed and summarized the results of these three data collection methods.

In this chapter, I return to the original problem statement for this study and discuss how the results not only answer the research questions posed, but also contribute to communication literature on a larger scale. The chapter begins with a review of the research questions and problem statement, and then describes the theoretical, methodological, and practical implications of this study. I discuss limitations to the study and suggest directions for future research.

Problem Statement and Research Questions

At the beginning of this study, three key problem areas were presented: key gaps in the communication literature related to workplace intercultural communication and diversity training; the lack of a theory-based approach for measuring intercultural

communication practices; and the need for more information to inform hospital decisions about how to best address health disparities in the community.

First, Bezrukova, Jehn, and Spell (2012) called for studies that seek a deep understanding of the practices that stay with employees after diversity training, a challenge that this study addressed by measuring quantitatively and interpreting qualitatively the intercultural communication practices used by employees who completed basic diversity training in the past four years at a large teaching hospital, STH. In addition, Bell, Connerley, and Cocchiara (2009) argue that more data are needed about the differences between employees who have and have not completed diversity training, which I addressed in this dissertation by collecting data about both groups and comparing their performance in intercultural interactions. In this way, my study filled two important gaps in the communication and training literature with regard to diversity. A subsequent section in this chapter discusses the theoretical implications of this study's findings.

Next, prior to this study, there was no instrument available to identify intercultural communication practices without judging the respondent's level of "competence." Measuring competence was not a goal of this study because an understanding of how employees are communicating interculturally is more relevant to the hospital's efforts to reduce health disparities than is a judgment of employees' competence levels. For that reason, this study uses the theoretical framework of intercultural praxis proposed by Sorrells and Nakagawa (2008) to develop an instrument designed specifically to identify the practices respondents actually use in intercultural communication interactions. In this chapter, I discuss the methodological implications of this study.

Finally, STH and other hospitals nationwide need more information as they work to reduce health disparities in their communities. This study provides practical data and analysis that STH administrators can use to inform future decision-making. While the conclusions in this study are not meant to be generalized beyond STH, they provide a framework and an approach that can be used by other hospitals and health care providers to investigate their own organizational culture and intercultural communication practices. Practical implications of this study are also addressed below.

The three problem areas mentioned above led to the goals and methods used in this study. The research questions this study answered are:

RQ1: To what extent do textual artifacts at STH create an organizational culture that supports intercultural praxis in the workplace?

RQ2: How can employees' use of intercultural praxis modes be measured in a hospital environment?

RQ3: How do narratives express employees' understanding of culture?

RQ4: How do narratives express the way employees use modes of intercultural praxis in workplace interactions?

RQ5: To what extent does the use of intercultural praxis modes differ between employees who have and have not participated in diversity training?

With these problem areas and resulting research questions in mind, I next discuss the theoretical, methodological, and practical implications of this study.

Theoretical Implications

This study was designed not only to better understand the intercultural communication practices at STH, but also to advance communication scholars'

understanding of intercultural communication in organizational settings and the utility of the intercultural praxis framework for understanding intercultural communication practices. This section describes the contributions of this study to the way scholars study intercultural communication in organizations. I also address contributions that are made to the intercultural praxis framework.

Organizational Culture and Intercultural Communication

This study filled necessary gaps in the communication literature by studying employees' typical practices and by comparing the practices of trained and untrained employees in intercultural communication situations. Additionally, this study placed employee intercultural communication in an organizational context, accounting for organizational culture as a primary influence on employee praxis, which combines intercultural communication and organizational communication literature in a unique way.

By using a triangulated data collection method to investigate employee communication and by combining these two bodies of communication literature, this study argues that organizational culture and employee communication practices are inextricably linked and must be considered in tandem. In addition to filling gaps in the communication literature, this study indicates that organizational culture is critically important to studies of intercultural communication in organizations. However, this connection is not typically found in the literature.

Intercultural Praxis Framework

This study also makes a significant contribution to the intercultural praxis framework to advance its use as a theory of intercultural communication. To date, little

has been written about the intercultural praxis framework since it was introduced by Sorrells and Nakagawa in 2008. This study is the first to use the framework to investigate the intercultural communication practices of a group of people.

Expanding the framework. The first way in which this study contributes to the intercultural praxis framework is by expanding the theoretical components of each of the six modes of praxis. Not only have other scholars not used the framework, but the authors also have not used it to conduct further research. Subsequently, little information and theoretical support for the framework was available prior to this study. In order to effectively create an instrument to measure the six modes of praxis, this study needed a more thorough explanation of and theoretical grounding for each mode of praxis. Drawing on the limited publications about this and other foundational works in the communication literature on each topic, this study expanded on Sorrells and Nakagawa's (2008) original work to further define and explain the six modes of praxis, which represents a significant contribution to the advancement of the framework.

Testing the framework. In addition to using the intercultural praxis framework as a basis for understanding employee communication practices at STH, this study also determines whether the framework is a useful tool for this type of analysis. I selected the intercultural praxis framework for this study because it approaches intercultural communication in a practical way, focusing on individuals' actions and mindsets rather than on whether those actions and mindsets qualify the person as "interculturally competent." In an organizational environment like STH where leaders attempt to use training to get employees to communicate in a particular way, learning about employees' actual practices is more valuable than deciding where their behaviors fall on a

competence scale. Practices are identifiable and teachable. After using the intercultural praxis framework in this study, I believe it is a useful tool for studying intercultural communication. However, while the six-pronged framework Sorrells and Nakagawa (2008) propose makes sense from a theoretical standpoint, this study found that in practice, the framework needs further development. By exploring what underlying factors may better describe intercultural praxis and investigating how people practice intercultural communication in their everyday work life, this study made important contributions to this effort.

As the confirmatory factor analysis (CFA) in this study revealed, a significant difference exists between the proposed theoretical model and the observed data. In short, the data did not support the theory. CFA seeks to determine whether observed results match the theoretical model, but it does not shed light on why a mismatch occurs, as it did in this study. As I mentioned in Chapter 4, this result might indicate that there are not six distinct practices that make up the concept of intercultural praxis, or that six practices do exist, but the instrument did not adequately measure them. Because this study was a pilot test of a newly developed instrument, I acknowledge that there could be problems with some of the survey items, despite my best efforts to ensure their validity. This is an implication that invites further development of the survey items. However, the survey items likely were not the sole cause of the mismatch between theory and results.

During the theoretical investigation of the intercultural praxis framework that was used to build the praxis instrument and in Sorrells and Nakagawa's (2008) own work, I found that the six modes of praxis overlap in several places. Specifically, dialogue and inquiry were closely related on a theoretical level, as were reflection and framing. For

example, the action and mindset that best characterize inquiry, asking questions and genuinely wanting to know the answers, are also present in true dialogues. In a similar way, to understand one's own perspectives and the perspectives of others (the framing idea of "putting oneself in another's shoes"), a person is likely also engaging in reflection. Action overlapped with all other modes of praxis because in order to be effectively using any of the modes of praxis, a person would inherently be acting in a socially responsible way. Sorrells and Nakagawa (2008) acknowledge these theoretical overlaps, describing the six ports of praxis as "inter-related points of entry into the process" of intercultural communication (p. 26). However, the findings of this study indicate that the modes of praxis inter-relate to such a degree in actual communication practice that there are four, not six, distinct practices in the intercultural praxis framework. Because the theoretical and empirical findings both point to fewer communication practices than the framework currently contains, and these findings also indicate an additional one that is not originally included, I suggest revising the framework to reflect these findings.

Revising the framework. I propose the intercultural praxis framework be collapsed into a five-pronged framework. This revision includes the four factors that emerged from an exploratory factor analysis of the praxis survey data and a fifth set of practices that emerged in both the textual analysis and narrative analysis findings: Engagement, Positioning, Inquiry, Introspection, and Language (see Table 20). This proposed revision acknowledges Sorrells and Nakagawa's work by retaining their language and concepts wherever possible, but collapses their categories of practice into

groupings that more accurately reflect real-world intercultural communication practice as evidenced in this study.

Table 20. Proposed Intercultural Praxis Framework

Mode of Practice	Description
Engagement	Reflecting and acting in a way that is reflexive and translates directly into current and future active engagement with others
Positioning	Awareness of one's own and others' locations in socially constructed hierarchical categories and understanding that those characteristics potentially have consequences
Inquiry	A desire and willingness to know, to ask, to find out and to learn
Introspection	The capacity to observe oneself and to learn from self-reflection
Language	The desire and ability to use words and phrases with meanings that are shared between oneself and another

This proposed new framework captures both the theory behind intercultural praxis and the empirically determined practices that individuals are using in their interactions with others. As in Sorrells and Nakagawa's (2008) conception of intercultural praxis, I see these five modes of praxis working best in combination with one another. While one or more modes may be most salient in a given interaction, all have the potential to be useful to a communicator and may be used concurrently. At STH, these modes could be incorporated into training and textual materials, as I note in my discussion of practical implications. As I suggest later in the chapter, use of the revised framework in future studies is needed to confirm or to continue to refine the theory.

Methodological Implications

This study makes methodological contributions in three areas: the intercultural praxis survey, the critical incident survey, and narrative analysis.

First, the intercultural praxis survey is the first attempt to operationalize the intercultural praxis framework into an instrument that measures individuals' intercultural communication practices. While this was a pilot test, and findings suggested the theoretical framework be revised (which would in turn require revision of the instrument), the tool itself is a first step toward helping organizations better understand their culturally diverse interactions as part of an organization. More than labeling a person intercultrally competent or not, this instrument looks at the practices, or what people are actually *doing* in their day-to-day interactions. As it did in this study, this tool can help organizations identify their current practices and then identify their training needs to better achieve their desired communication objectives.

Second, this study expanded the use of the critical incident method. While previous studies have proven the utility of written responses in addition to interview responses (Irvine et al., 2007), this study provides additional support for CIT as a survey tool to collect written data in addition to being an interviewing tool. Respondents in this study provided rich data and narratives, which made the data set useful and complete. Not every respondent provided a full narrative, but those were the exception rather than the rule. In general, written CIT results provided the desired level of detail. Additionally, a written survey removed any potential interviewer bias. I was looking for practices that reflected six very specific theoretical categories. An interview situation would potentially have resulted in skewed data because it would have been difficult not to probe further

into actions that appeared to be aligned with one or more of the modes of praxis. Written, anonymous CIT responses removed some potential bias and provided a rich data set that worked well for the purposes of this study.

Third, while CIT has been in use since the 1950s, it is not frequently found in the communication literature. This study not only utilized this under-used method, but it also grounded it in communication theory by employing narrative analysis. In my research, I did not encounter any other examples of CIT studies that approached responses from a narrative perspective. By considering the responses to be stories and looking at their meaning, I was able to focus on participants' communication, not just the situational content of their responses. I think combining CIT with narrative analysis is a natural way to bring CIT into the communication discipline, particularly in organizational contexts where storytelling is critical to sensemaking.

Practical Implications

On a practical level, STH is a large public hospital serving a highly diverse patient population, many of whom experience health disparities. STH, and hospital leaders in general, needs more information as they continue to address these disparities. One way STH is attempting to address health disparities is by offering optional diversity training to help employees improve their intercultural communication. However, as this study found, there is no difference in intercultural communication practices between employees who have and have not completed this training. Thus, the current training program may not be the only answer. Hospital employees appear to be receiving the same information both through training and through textual artifacts, which both influence and seem to enhance their intercultural communication practices. Even more than employees

use some of the practices in the intercultural praxis framework, they avoid intercultural interactions in general. This is contrary to the practices the hospital encourages in basic diversity training, which include listening, asking questions, and acknowledging difference (DIC I training handout, p. 18). Employees' practice of avoidance in intercultural interactions is an important finding for STH because avoidance seriously inhibits the hospital's goal of reducing health disparities by improving communication.

Although employees are currently avoiding intercultural interactions with some frequency, this study also found that they look to hospital leadership for policies, procedures, and guidance to make their interactions more positive. This finding suggests that while the current training program has no effect on employee communication practices, a different and/or more widespread training program might have the desired effect. Likewise, hospital documents need to expressly address the issue of avoidance and provide guidance for how to engage rather than avoid those who are culturally different.

Findings suggest that organizational culture has a greater impact on employee practice than training materials do. Specifically, framing practices are a good example of this finding. Framing is discussed in detail in diversity training materials but is not an element of organizational culture that is found elsewhere in textual artifacts. Both trained and untrained employees rarely use framing in their intercultural interactions. This indicates that employee practice is more aligned with organizational culture than with communication practices taught in training. Thus, to improve intercultural communication overall and reduce avoidance practices, STH needs to make a cultural shift.

This finding appears to support the elimination of the training program altogether rather than its expansion, but because employees are looking to administration for guidance, I recommend the revision and expansion of the training program and the inclusion of a dialogue about avoidance in texts disseminated to employees by the hospital, such as newsletters. Organizational culture is co-created through interaction among members and is constantly changing (Keyton, 2005). In this particular organizational culture, members look to leaders for cues. For STH leadership to attempt to steer employees toward intercultural communication practices that will help reduce health disparities, they need to infuse employees' interactions with such practices. This can be done through training and other forms of written communication such as the newsletter and website.

Current diversity training at STH is optional and has a very limited reach, and concepts are covered in a generalized way. I suggest implementing a skills-based training that focuses less on general knowledge and awareness and more on exactly what employees can *do* in intercultural communication interactions. Using role plays, simulations, and other hands-on strategies, this training could employ the revised intercultural praxis framework as a way to organize and teach communication practices. I also suggest implementing a program whereby a majority of employees are trained rather than a small minority (4%), which is the status quo. Additionally, hospital leadership needs to emphasize desired communication practices and explicitly address avoidance in hospital texts that reach all employees, such as the newsletters. In this way, employees' need for guidance from leadership would be met, and the process of shifting the organizational culture to one that communicates rather than avoids would begin. Making

this cultural shift is a necessary step toward achieving the hospital's goal of reducing health disparities in the community it serves.

Limitations

There are inherent limitations in any study, including this one. First, questionnaires were used in this study to determine communication practices used by participants in an intercultural interaction. The results are limited by the willingness of participants to respond to questions and to respond to open-ended questions with sufficient detail when using narrative. Second, though one goal of this study was to identify communication practices that impact health care outcomes, not all STH employees' communicative interactions have the potential to impact quality of care. For example, maintenance personnel and some food service providers do not necessarily have patient interactions. Thus, their contributions may be more reflective of the overall culture of the organization rather than directly related to improving health outcomes.

Additionally, physicians' interactions with patients and employees are not considered in this study. The hospital system is structured so that STH employs nurses, skilled staff such as technicians, administrators, and support personnel, but the hospital does not employ the physicians who work there. Because physicians are not employed by STH, they are not subject to the same rules, and they are not offered the same training programs. Thus, it is not practical to include physicians in the population of this study. However, because they are a significant contributors to the overall culture of the organization, their absence limits the quality of the data I collected about the culture and intercultural communication practices at this hospital. Overall, the views of the

participants may not reflect the views of those who did not have an opportunity to participate in the study.

Though a significant amount of data was collected, more data might have enriched this study. Despite the time constraints faced by employees in their jobs and problems encountered when sending one of the reminder emails for the intercultural praxis survey, a sufficient but not overwhelming amount of data was collected. It might have been better to spread the surveys out over a longer time period rather than administering them back-to-back. This might have helped boost responses because many people, including the employees who have completed diversity training, were included in both sample groups. However, it was not possible to spread out the surveys in this study because of the researcher's own time constraints. Future studies might consider a timeline that is more conducive to gathering larger numbers of responses.

Directions for Future Research

Because this was a pilot study, directions for future research are numerous. I see a great deal of potential in the intercultural praxis framework, and I think it merits further investigation. While this study took the important first steps toward operationalizing, testing, and revising the framework, much more research into the framework and its use is needed. Specifically, future work should test the revised framework this study proposes in an empirical way, and scholars should continue to revise and refine the intercultural praxis survey instrument. The instrument is one of the greatest contributions this study makes for communication practitioners and trainers in organizational environments, and more testing is needed before the instrument can be put to wider use.

Additionally, I think more studies that incorporate organizational culture and the artifacts that represent it along with evaluating intercultural communication training practices would enhance understanding of the interrelationships among these factors and the ways they influence communication. Until communication scholars recognize that employee communication cannot be fully understood or changed without accounting for contextual and organizational cultural factors, organizational and intercultural communication research will continue to be limited. However, it should not take a dissertation-length study for a communication practitioner to investigate an organization's culture and the intercultural communication practices of its employees. Much like the intercultural praxis questionnaire attempts to provide an easy-to-use tool for practitioners to measure intercultural communication practices, future research should focus on a way to streamline investigations into organizational culture in a similar way.

Conclusions

Health disparities are a problem that STH and other healthcare organizations across the United States continue to face in their diverse communities. However, like STH, many hospitals are actively trying to address these disparities by improving communication practices used by their employees especially as they relate to interculturally diverse interactions.

This study found that the intercultural communication praxis framework proposed by Sorrells and Nakagawa (2008) is a good first step toward understanding intercultural communication practices. The framework should be taken as a work in progress, and through this study and others that should follow, the framework can be refined into a practical and accurate way of measuring how people communicate with those who are

different from them. Combining this knowledge with an understanding of the organizational culture of the hospital or other organization and they ways in which this culture is co-constructed can help leaders develop training and other ways of influencing organizational culture to cultivate the types of communication practices that will help them achieve their goals.

This study successfully answered its research questions and provided theoretical, methodological, and practical contributions to the field of communication and to the leadership of STH. It is my hope that I and others can continue this body of research to work toward improving intercultural communication in a way that also improves our communities and our understanding of difference.

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Appendix I

Intercultural Praxis Instrument

Think about your conversations with patients and coworkers at UNMH who you consider culturally different from you. Mark the box that most closely matches how frequently the following statements are true. (1 = never; 7 = always)

	1 Never	2	3	4 Sometimes	5	6	7 Always
1. When I perceive that someone is different from me, I want to learn more about those differences.							
2. I think the other person and I may see the world in different ways.							
3. As I talk to the other person, I am aware of that person's personal characteristics (e.g., race, gender, income and education levels, cultural practices, physical abilities).							
4. I work collaboratively with the other person to solve problems.							
5. I reflect on a conversation after it has happened.							
6. I notice things about the other person that don't fit the stereotypes of people with his/her differences.							
7. When I don't understand something the other person says, I ask a follow-up question.							
8. I find it easy to consider multiple points of view when I'm having a conversation.							
9. When talking to other people, I am aware of my personal characteristics (e.g., race, gender, income and education levels, cultural practices, physical abilities).							
10. My primary goal in the conversation is to express my agreement or disagreement with the other person.							
11. I learn new things about myself by thinking back to past conversations.							
12. I find that my views of the other person's differences are true.							

Intercultural Praxis Instrument continued.

	1 Never	2	3	4 Sometimes	5	6	7 Always
13. I ask questions about the other person's differences.							
14. I think about how my differences might influence my point of view.							
15. When the other person and I have different personal characteristics (e.g., race, gender, physical abilities, job title, income, social status, etc.), I feel like those differences affect which one of us has more power in the conversation.							
16. I am open to learning new things.							
17. I forget the details of conversations almost immediately after they happen.							
18. Conversations with others lead me to consider alternatives I hadn't thought of before.							
19. I want to know what the other person considers "normal."							
20. I maintain one point of view throughout the entire conversation.							
21. I notice that how much people listen to me at work is affected—either positively *or* negatively—by my personal characteristics (e.g., race, gender, physical abilities, job title, education, or work experience).							
22. I think the conversation produces new ideas.							
23. I think back about what worked and what didn't work in a particular conversation.							
24. Talking to other people changes the way I think about other people who are different from me.							
25. I am curious about other people's differences.							
26. I think about what points of view the other person might have.							
27. I feel creative during the conversation.							
28. I adjust my current behavior after thinking back on conversations.							

Intercultural Praxis Instrument continued.

	1 Never	2	3	4 Sometimes	5	6	7 Always
29. I challenge other people on their stereotypes and prejudices.							
30. I avoid asking people questions about their differences.							
31. I approach the conversation using several different points of view.							
32. My primary goal in a conversation is to reach agreement with the other person.							
33. Following a conversation, I think about how my beliefs may have been different from the other person's beliefs.							
34. I feel compassion for people who are different from me.							
35. When I ask people about their differences, I do so primarily to be polite.							
36. I look for ways to show respect for others' differences when I interact with them.							
37. When a conversation does not produce agreement I feel like that conversation was a waste of time.							
38. Reflecting on conversations with other people helps me be more aware of what is considered "normal" at work.							
39. The other person's differences do not influence the way I interact with him or her.							
40. I leave a conversation feeling like I can relate to the other person.							
41. If someone disagrees with me, I examine my position to see if I should change.							

Intercultural Praxis Instrument continued.

Now, please answer a few questions about yourself to help researchers understand your role at UNMH and how you identify yourself culturally.

1. What is your race/ethnicity?
   - Aboriginal
   - American Indian/Alaska Native
   - Asian
   - Black/African American
   - Hispanic/Latino
   - Native Hawaiian/Other
   - White
   - Decline to state ethnicity

2. What is your gender?
   - Male
   - Female
   - Other
   - Decline to state gender

3. How old are you (in years)? _____

4. On average, how often do you interact with patients at work?
   - Never
   - Once a month
   - Once a week
   - Once a day
   - Multiple times a day

5. Have you taken the Diversity & Intercultural Competence I course offered by UNMH? (Yes/No)

6. If you have taken Diversity & Intercultural Competence I, how long ago did you take it?
   - Within the last year
   - Within the last 2-4 years
   - More than 4 years ago
   - I have not taken the course

Thank you for your participation!

Appendix II

Intercultural Praxis Measures
Organized by Port of Entry into Intercultural Praxis

INQUIRY

1. I want to learn more about the other person's differences from me.
2. When I don't understand something the other person says, I ask a follow-up question.
3. I ask questions about the other person's differences.
4. I want to know what the other person considers "normal."
5. I am curious about other people's differences.
6. I don't ask people questions about their differences.*
7. I ask people about their culture mostly to be polite.*

FRAMING

1. I think the other person and I may see the world in different ways.
2. I find it easy to consider multiple points of view when I'm having a conversation.
3. I think about how my differences might influence my point of view.
4. I maintain one point of view throughout the entire conversation.*
5. I think about what points of view the other person might have.
6. I approach the conversation using several different points of view.

POSITIONING

1. As I talk to the other person, I am aware of that person's personal characteristics (e.g., race, gender, socioeconomic status, cultural practices, physical abilities).
2. When talking to other people, I am aware of my personal characteristics (e.g., race, gender, socioeconomic status, cultural practices, physical abilities).
3. I feel like there are power differences in the conversation between me and the other person because of my personal characteristics (e.g., race, gender, physical abilities, job title, income, or social status).
4. I notice that how much people listen to me at work is affected—either positively *or* negatively—by my personal characteristics (e.g., race, gender, physical abilities, job title, education, or work experience).

DIALOGUE

1. I work collaboratively with the other person to solve problems.
2. My primary goal in the conversation is to express my agreement or disagreement with the other person.*
3. I am open to learning new things.
4. I think the conversation produces new ideas.
5. I feel creative during the conversation.
6. My primary goal in a conversation is to reach agreement with the other person.*
7. When a conversation does not produce agreement I feel like that conversation was a waste of time.*

8. I leave a conversation feeling empathy for the other person.
9. If someone disagrees with me, I examine my position to see if I should change.

REFLECTION

1. I reflect on a conversation after it has happened.
2. I learn new things about myself by thinking back to past conversations.
3. I forget the details of conversations almost immediately after they happen.*
4. I think back about what worked and what didn't work in a particular conversation.
5. I adjust my current behavior after thinking back on conversations.
6. Following a conversation, I think about how my beliefs may have been different from the other person's beliefs.
7. Reflecting on conversations with other people helps me notice the established norms at work.

ACTION

1. I notice things about the other person that don't fit the stereotypes of people with his/her differences.
2. I find that my views of the other person's differences are reaffirmed.*
3. Conversations with others lead me to consider alternatives I hadn't thought of before.
4. Talking to other people changes the way I think about other people who are different from me.
5. I challenge other people on their stereotypes and prejudices.
6. I feel compassion for people who are different from me.
7. I look for ways to show respect for others' differences when I interact with them.
8. I do not let the other person's differences influence the way I interact with him or her.*

* = Oppositely worded statement used for measuring scalar reliability of the instrument

Appendix III

CIT Instrument

Think about a conversation you have had with someone who is culturally different from you. Choose *ONE* particular conversation, incident, or interaction that stands out in your memory, and answer the following questions about it. Answer all questions using the SAME conversation, incident or interaction. Please give detailed responses.

The purpose of this questionnaire is to provide you with an opportunity to describe your experiences as they relate to interactions you have at work with people who are culturally different from you. This can include interactions you have had with patients or coworkers.

1. Who was involved? What was that person's job or role? What was your job or role? You do not need to use real names.

2. What made this person culturally different from you? How did you (or do you now) know there were cultural differences?

3. Please tell a detailed story about what happened in your interaction with this person. As you think back on the interaction, try to include

- any relevant background information
- what you and the other person said and did (include direct quotations as you remember them)
- what motivated you to say or do certain things
- how you felt at the time
- how you feel about the interaction now

4. What was the outcome or result of this interaction? Was it the outcome you wanted? Why or why not?
If not, what would you do differently next time to change the outcome?

5. Why do you think this particular interaction stands out in your memory?

6. Since this interaction, what, if anything, have you reflected on, learned, or changed about the way you interact with people who are culturally different from you?

7. Have you taken the Diversity & Intercultural Competence I course offered by UNMH? (Yes/No)

Appendix IV

Recruitment and Reminder Email Texts

Praxis Recruitment Email (sent Monday, April 7, 2014):

Dear _____,

The Office of Diversity, Equity & Inclusion is working with a doctoral student in Communication & Journalism to determine the impact of the basic diversity training program at UNMH. As UNMH works toward improving health outcomes in our community, studies like this one provide valuable information, and your help is needed. Even if you have not taken diversity training, your responses are critical to the success of this study.

Please click on the link below to participate in a brief, 10-minute survey. Your participation is completely voluntary, and your responses will remain anonymous.

https://www.surveymonkey.com/s/unmh_dei_survey1

Please complete the survey by **Wednesday, April 16**. Thank you for your participation!

Sincerely,

[STH informant name and title]

Praxis Reminder Email 1 (not sent):

Dear _____,

Don't forget to help the Office of Diversity, Equity & Inclusion by completing the following online survey! Your responses will provide valuable information that will help determine the impact of the basic diversity training program at UNMH. Even if you have not taken diversity training, your responses are critical to the success of this study.

Please click on the link below to participate in the survey. Your participation is completely voluntary, and your responses will remain anonymous.

https://www.surveymonkey.com/s/unmh_dei_survey1

Please complete the survey by **Wednesday, April 16**. Thank you for your participation!

Sincerely,

[STH informant name and title]

Praxis Reminder Email 2 (sent Tuesday, April 15, 2014):

Dear _____,

Tomorrow is the last day to help the Office of Diversity, Equity & Inclusion by completing the following online survey. Your responses will provide valuable information that will help determine the impact of the basic diversity training program at UNMH. Even if you have not taken diversity training, your responses are critical to the success of this study.

Please click on the link below to participate in the survey. Your participation is completely voluntary, and your responses will remain anonymous.

https://www.surveymonkey.com/s/unmh_dei_survey1

Please complete the survey by **Wednesday, April 16**. Thank you for your participation!

Sincerely,

[STH informant name and title]

CIT Recruitment Email (sent Monday, April 21, 2014):

Dear _____,

The Office of Diversity, Equity & Inclusion is working with a doctoral student in Communication & Journalism to determine the impact of the basic diversity training program at UNMH. As UNMH works toward improving health outcomes in our community, studies like this one provide valuable information, and your help is needed. Even if you have not taken diversity training, your responses are critical to the success of this study.

Please click on the link below to participate in a survey where you will be asked to write about a time when you interacted at work with someone who you consider culturally different than you. The survey should take you under 30 minutes. Your participation is completely voluntary, and your responses will remain anonymous.

https://www.surveymonkey.com/s/unmh_dei_survey2

There are multiple surveys in this study, and if you have already been asked to participate, we encourage you to consider completing this survey as well. Your time is greatly appreciated.

Please complete the survey by **Wednesday, April 30**. Thank you for your participation!

Sincerely,

[STH informant name and title]

CIT Reminder Email 1 (sent Thursday, April 24, 2014):

Dear _____,

Don't forget to help the Office of Diversity, Equity & Inclusion by completing the following online survey! Your responses will provide valuable information that will help determine the impact of the basic diversity training program at UNMH. Even if you have not taken diversity training, your responses are critical to the success of this study.

Please click on the link below to participate in the survey. Your participation is completely voluntary, and your responses will remain anonymous.

https://www.surveymonkey.com/s/unmh_dei_survey2

Please complete the survey by **Wednesday, April 30**. Thank you for your participation!

Sincerely,

[STH informant name and title]

CIT Reminder Email 2 (sent Tuesday, April 29, 2014):

Dear _____,

Tomorrow is the last day to help the Office of Diversity, Equity & Inclusion by completing the following online survey. Your responses will provide valuable information that will help determine the impact of the basic diversity training program at UNMH. Even if you have not taken diversity training, your responses are critical to the success of this study.

Please click on the link below to participate in the survey. Your participation is completely voluntary, and your responses will remain anonymous.

https://www.surveymonkey.com/s/unmh_dei_survey2

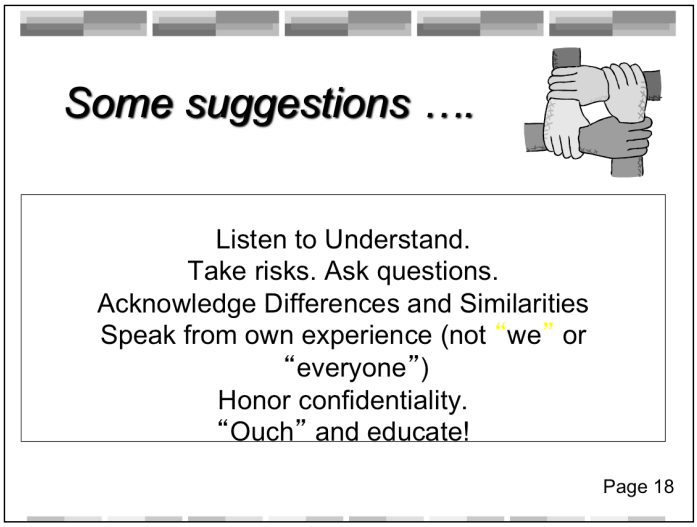
Please complete the survey by **Wednesday, April 30**. Thank you for your participation!

Sincerely,

[STH informant name and title]

Appendix V

Sample Slide and Presenter's Notes from Basic Diversity Training



Seek to understand before seeking to be understood

People are different AND similar at the same time (remember Jack Condon's definition of culture)

Saying "we" is unfair – no one represents an entire group… "everyone" is oppressive, because not every agrees or thinks alike – saying either is often an attempt (sometimes unconscious) to bolster our own position by making it sound like we have a group to back us up…

"Ouch" and educate – when someone says something that hurts your feelings, say "ouch"! It's a quick, non-threatening way to signal the hurt or the line being crossed. You can then also choose to explain in a non-violent way (educate, or enlighten) the source of the "ouch"

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Appendix VI

Sample Narrative from Critical Incident Survey

Respondent V

Q1: Who was involved? What was that person's job or role? What was your job or role? You do not need to use real names.

My patient had delivered her baby the previous day and I was caring for her and her baby.

Q2: What made this person culturally different from you? How did you (or do you now) know there were cultural differences?

My patient was originally from China, Mandarin Chinese was her primary language even though she did speak fluent English. Her mother was with her and only spoke Mandarin.

Q3: Please tell a detailed story about what happened in your interaction with this person. As you think back on the interaction, try to include
• any relevant background information
• what you and the other person said and did (include direct quotations as you remember them)
• what motivated you to say or do certain things
• how you felt at the time
• how you feel about the interaction now

My patient wanted to learn how to breastfeed her baby and I was in her room to help her with this. She did not hold her baby so as I was helping her, I held her baby to her breast while the baby was feeding. The baby was sleepy so I undressed him to keep him awake while feeding and the patient's mom seemed upset. Once the baby was feeding, she placed a blanket over the baby even with my hands still holding the baby to his mom's breast. This is when I remembered that their culture has a strong belief that the mom and baby need to be only warm for a length of time after having a baby. I told the mom I was sorry I uncovered the baby for so long and thanked her for covering her grandson with a blanket since my hands were busy. The patient translated this and both the patient and her mom seemed happy about this interaction. I was also able to show the patient's mom how to hold the baby to the breast because it is also part of their culture that the new mother does not do anything to care for herself or her baby. I was glad that I had learned a little about their cultural expectations before I took care of this family. It felt good to be able to give this family the care they needed in a way that was appropriate for them. Other nurses on the unit didn't want to care for this family because they didn't understand why the patient didn't take care of her baby or even feed herself. I wish more healthcare providers were more interested in learning the cultural aspect of their patients so that we can all make their stay with us a good experience (as good as can be expected in a hospital setting).

Q4: What was the outcome or result of this interaction? Was it the outcome you wanted? Why or why not? If not, what would you do differently next time to change the outcome?

This patient asked for me to be her nurse the following day. When she went home that day, she and her mother thanked me for my care. They filled out the patient survey and had wonderful things to say about our unit and our hospital. It is the outcome I wanted because I always want my patients to know that I (and because of me, the hospital as a whole) cares about them as a whole person, not just the diagnosis for why they are in the hospital.

Q5: Why do you think this particular interaction stands out in your memory?

This family was so grateful for everything I did. It seems wierd to me that someone would not even hold their baby to feed them after they are born, much less to not even lift their hand to take a drink of water (hot water in this instance).

Q6: Since this interaction, what, if anything, have you reflected on, learned, or changed about the way you interact with people who are culturally different from you?

I was surprised at how little it seemed to take to take care of her differently than I care for my other patients. I had thought that it was too much extra in my busy day before I took care of this family, now I know that it isn't as hard as I had prevously thought.

Q7: Have you taken the Diversity & Intercultural Competence I course offered by UNMH?

No