Exploring student nurses' intercultural care experiences in clinical practice

SHAO, CHUN,HUA

Abstract

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Chun Hua Shao 邵淳华 (Joy)

This study explores how student nurses experience intercultural nursing care in their everyday clinical practice. It adopts a qualitative social constructionist approach to investigate their perceptions of and responses to positive experiences and the challenges they encountered in their nursing placements and to seek to understand intercultural competencies that are salient in facilitating effective intercultural communication.

Several key findings emerged from the study: 1) Participants socially construct their intercultural care experience in the six domains: intercultural encounters, knowledge, skills, attitudes, engagement and outcomes; and consider intercultural competence is a continual development process. 2) Even though the individual scope of intercultural care encounters (ICEs) varies, the participants all valued the opportunity to be exposed to ICEs, as these allowed them to negotiate and adjust to different cultures, values and worldviews. 3) The participants observed how cultural beliefs and behaviours affect individual patients' interpretations or perceptions of their health condition, how they view its treatment and the efficacy of the medication. Without this essential knowledge, aside from the lack of understanding of a patient's cultural needs, the treatment and care maybe inadequate or inappropriate, which can seriously affect patient's outcomes. However, the data showed the gaps in this aspect of nursing education. 4) One of the biggest challenges the student nurses encountered in ICEs was linguistic barriers, since language affected not only the patients' ability to express their needs and understand the healthcare instructions, but also had nursing implications. 5) Participants reported positive and challenging attitudes in ICEs, which affected their learning, wellbeing, and intercultural communication performance. When workplace adversity persists, some participants even considered leaving the course. It was through personal resilience, accessing support from academics and peers that they decided to stay in their chosen career. 6) The motivations to engage intercultural care were affected by internal and external factors. 7) The participants highlighted that

without considering outcomes for the care recipient (patient) and care provider (the student nurse), competence in intercultural care cannot be validated.

An intercultural care competence ecological framework was developed, which provides a comprehensive view of intercultural care and highlights the dynamic nature of competence development. In these ways, this study complements existing cultural care theories.

The study offers valuable insights for researchers, educationalists, practitioners and policy makers in the areas of intercultural communication and interactions in healthcare services.

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List of Abbreviations

AIE: Autobiography intercultural encounter
BSc (Hons): Bachelor of Science (Honours degree)
CCA: Critical cultural awareness
DH: Department of Health
EM: Ethnic Minority
F: Female
FN： Florence Nightingale
IC: Interculture competence
ICC: Intercultural care competence
ICE: Intercultural encounter
LGBT+: lesbian, gay, bisexual, transgender and others whose gender identity is not based on a traditional gender binary.
M: Male
MSA: Mary Seacole Award
MSc: Master of Science
NCNZ: Nursing Council of New Zealand
NHS: National Health Service
NMC: Nursing & Midwifery Council
ONS: Office of National Statistics
RCN: Royal College of Nursing
RQ: Research question
UK: United Kingdom
WHO: World Health Organisation

Declaration

This EdD thesis is my own work and no part of the material offered in it has been submitted for a degree at this or any other university.

Statement of Copyright

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I am sincerely grateful to my doctoral study supervisor, Professor Prue Holmes, and second supervisor, Dr Sophie Ward, for their inspirational supervision, heartfelt understanding, attention to detail, endless support, and confidence in me throughout this journey. Without their warm and professional approach, I could not have achieved this. So, thank you again for always being there for me over the years.

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Dedication

远在异国他乡用第二语言全时工作的同时还要兼读博士学位和生养三个孩子，的确非常不易，但因为有亲人们的理解，关爱，信任和支持总能让我充满力量，无论多么艰辛我都坚持下来了， 在此特别说声谢谢你们!

首先，我想致谢我敬爱的爸爸(邵善达) 和妈妈（吴红玉），非常幸运在充满爱的家庭出生，成长并且在这漫长的读博之路一直有你们的暖心理解和用心支持。希望你们继续以女儿为荣，安康幸福!

另外，还要感谢我的爱人(徐志强)和三位宝贝儿子(Joshua YiHe Xu 徐懿鹤，Maximus YiJia Xu 徐懿嘉 and Alfred YiXuan Xu 徐懿轩)， 是你们的贴心陪伴，包容，支持和鼓励让我在工作之余还能有精力学习，顺利完成学业，从此全身心回归充满爱和温暖的家庭。 我最亲爱的宝贝们，妈妈回家啦!

I would like to take this opportunity to express my gratitude to my dear family. It was not easy working full-time in a foreign country while studying for a doctorate in a second language, giving birth and raising three children, but your constant understanding, love and support always made me feel empowered with full strength, so I persevered no matter how hard it was.

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Love you all, as always!

Chapter 1

Introduction

> *The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being regardless of race, ethnicity, national origin, religious and philosophical beliefs, gender, sexual orientation, cultural values, age, and other diversities.*
>
> World Health Organization Constitution, 2006

As an internationally recruited nurse in England, I have had a number of first-hand experiences with the National Health Services (NHS) from various perspectives: as a staff nurse, a patient, a carer and a nurse educator. Following a period of adaptation, I have been involved in providing bedside nursing care to patients from various ethnic and cultural backgrounds and have voluntarily helped patients and staff requiring Mandarin Chinese interpreting. As an acutely ill patient, I received emergency treatment and nursing care from a multidisciplinary team. A few episodes of family members' hospitalisation have allowed me to witness hospital healthcare provision for ethnic minority (EM) patients from a carer's perspective. My 11-year-old son, born and raised in the UK, is fluent in English but was surprised by the limited communication with the nursing staff. He wondered why they were not speaking to him in the same way as to other children in the same hospital ward. My father, a consultant surgeon in China, was surprised by the limited information given by the healthcare providers during his hospital stay. As a nurse educator, I also hear emotional stories about student nurses' intercultural encounters in clinical practice.

Both my personal experiences as an overseas nurse (coming from a nursing background in China and working as a nurse in a UK hospital), a nurse educator (supporting and teaching theories and clinical nursing care within an undergraduate nursing degree), and a healthcare service user from an EM community—along with societal, professional and academic gaps in understandings of interculturally competent nursing—inspired me to conduct a qualitative study to explore student nurses' clinical experiences of intercultural nursing care in clinical settings in England.

The findings will provide insights into aspects and issues of intercultural communication encounters from the perspectives of a small group of trainee student nurses during their clinical training in a hospital setting. The outcomes of the study will improve understanding of intercultural encounters between patients and healthcare providers and insights into what culturally competent care might look like. It will also inform the practice of healthcare professionals, education providers and policy makers aiming to improve healthcare services for people from diverse backgrounds.

In this chapter, I present the importance of this thesis (1.1), the research aim and research questions (1.2), and the structure of the thesis (1.3).

1.1 Importance of the Study

The 2001, 2011 and 2021 UK censuses indicate a significant increase in the number of people from diverse religious background (see Figure 1.1a and b) and EM groups (see Figure1.1c) (Office of National Statistics, 2011, 2021a and b). This trend is set to continue. While the increased diversity has enabled a diverse workforce, it is also perceived as a big challenge since each individual carries their unique cultural norms, practices and health beliefs, placing demands on the health service to meet culturally sensitive care needs (Waite & Calamaro, 2010). Albarran et al. (2011) reported that many EM migrants and refugees face health and emotional issues and so require access to healthcare services. Many of these people have different healthcare requirements to those of indigenous people, due to their diverse cultural needs and religious beliefs (Stevenson & Rao, 2014). For example, some chronic conditions (e.g., cancer, diabetes, chronic obstructive pulmonary disease (COPD), hypertension, stroke and ischemic heart disease) are related to cultural lifestyle aspects, such as specific components of the diet. To treat these patients effectively and for them to have a satisfactory patient experience, it is recognised that pure technical proficiency and superficial communication does not suffice. Instead, more specific competences such as a person-centred, culturally sensitive, respectful, compassionate, and holistic therapeutic manner and effective intercultural communication help nurses gain a good understanding of their patients' healthcare needs and to respond to the unique needs of every individual (Leininger, 2002; Hester, 2012).

Figure 1.1 *Percentage of diverse religion arrival in UK (Source: ONS, 2011)*

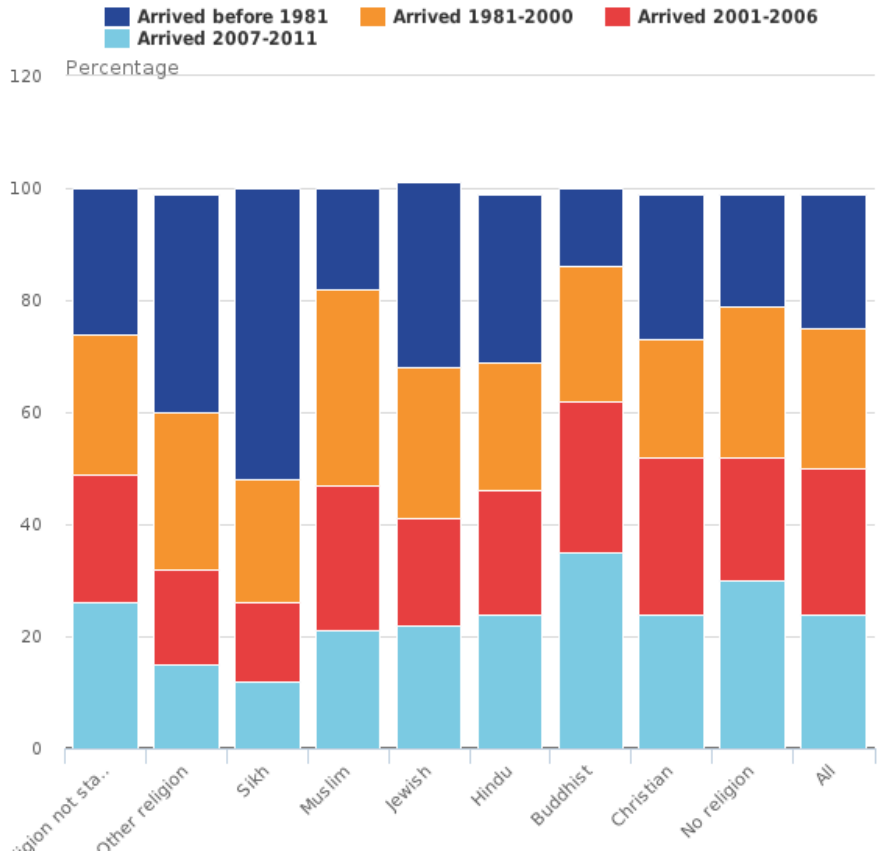


Figure 1.2 *Religious composition, 2011 and 2021 (Source: ONS, 2021a)*

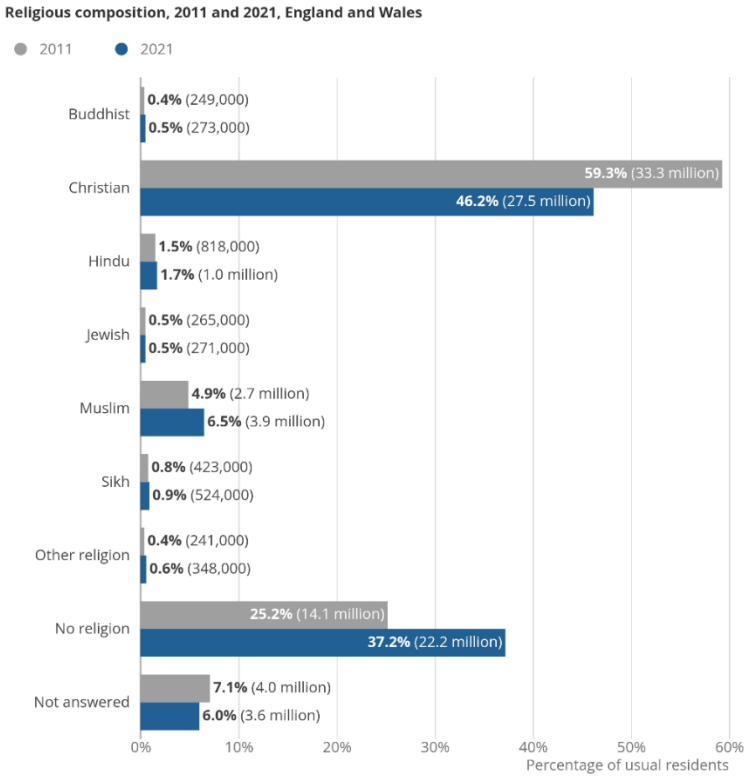
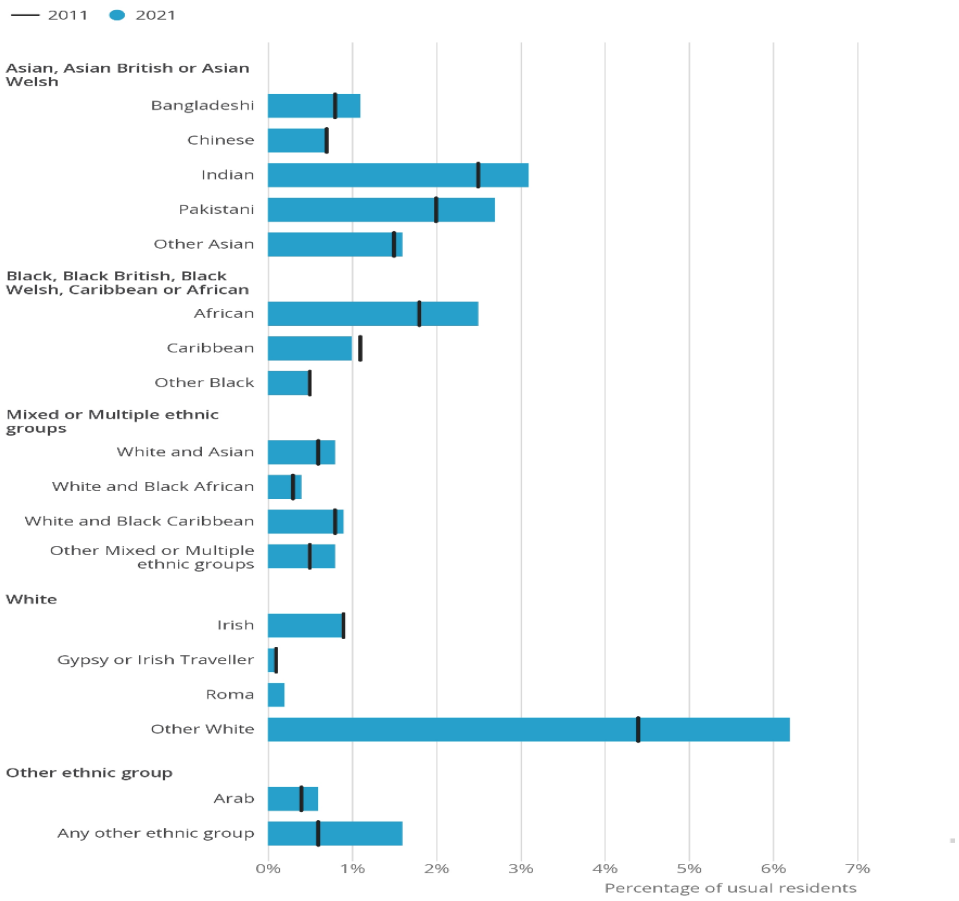


Figure 1.3 *Ethnic minority group, 2011 and 2021 (Source: ONS, 2021a)*



The Department of Health and Social Care (DHSC – the Department of Health (DH) prior to 2018) has developed a series of policies that acknowledge Britain as a multicultural society with diverse needs which requires practitioners to make their care provision in a manner sensitive and responsive to cultural and ethnic diversity. For instance, the Patient's Charter (DH, 1997) sets out patients' expectations of standards of healthcare; Our Healthier Nation (DH, 1999) provides a strategic plan to minimise health inequalities; The Vital Connection (DH, 2000) presents an equalities framework and national targets for the National Health Service (NHS); The NHS Race Equality Scheme (DH, 2005) and NHS Constitution for England (DH, 2015) further promote race equality. However, the health outcomes of EM groups are still much poorer than those of the dominant ethic group, which were considered mainly due to difficulties in accessing healthcare services with appropriate cultural and linguistic provision to meet the needs of people from different cultural backgrounds (Gilbert, 2003; Karlsen, 2007; Stevenson & Rao, 2014). Consequently, EM patients experience higher rates of

morbidity and mortality than the majority ethnic population does because their needs are not addressed by the healthcare system (Desouza, 2008; Domenig, 2004).

Nurses are usually the first point of contact when accessing a healthcare service. If they present negative attitudes such as criticism or blame, consciously or unconsciously, such behaviour can be demeaning to patients, causing them avoid the service in the future (Papps & Ramsden, 1996). Therefore, as an essential healthcare service provider, nurses have a moral obligation and professional duty of care to offer a high-quality service to all patients, including those from EM groups (Nursing and Midwifery Council (NMC), 2015). Originating from deep Christian values of respect, kindness and empathy, a central tenet of British nursing is caring, which entails relieving patient suffering and promoting health and wellbeing (Eriksson, 2002). To increase patients' satisfaction and promote equality in health service provision, culturally competent care has become a paramount component in nursing practice (Leininger, 1998, 2002; Gerrish et al., 2004). However, as Boi (2000) reported, cultural aspects of care have been mostly ignored and nursing staff demonstrate inadequate intercultural competence. This lacuna includes a tendency to treat EM patients as a single ethnic group and to provide ethnocentric *nursing* care, which affects the quality of service provision (Vydelingum, 2006).

Due to collective thoughts and behaviours, including language, religion and health beliefs, that are passed down through generations, it is suggested that people with different cultural backgrounds respond differently to nurses and clinical interactions (Boi, 2000). Therefore, nurses are required to have adequate knowledge and understanding of cross-cultural interactions to provide culturally competent care. Taking a critical cultural perspective, Papps and Ramsden (1996) found that when one group is larger than another or has more power (e.g., nurses in hospital wards), there is a tendency for the more powerful individuals to impose their own values on others (e.g., individual patients). Such behaviour may impact the identity and security of the less powerful group, which could affect their health and wellbeing. Consequently, to ensure an even balance of power in clinical practice, nurses need to be aware of their own cultural sensitivity, attitudes, behaviour and life experiences and the impact these can have on patients (Nursing Council of New Zealand, NCNZ, 2002).

It Is widely believed that the quality of culturally sensitive nursing care and health outcomes can be improved by increasing nurses' cultural competence (Perng & Watson, 2012) through nurse training and continual education that enables qualified staff to acquire the essential cultural knowledge, skills and attitudes. Clinical mentors and academic educators are critical in modelling and fostering the required IC of our next generation of nurses (Donaldson & Carter, 2005; NMC, 2012; Scammell & Olumide, 2012). To understand patients' cultural backgrounds holistically, Leininger (1991) developed 'transcultural nursing theory' and Purnell (2002) highlighted 12 domains to consider when assessing and providing care for an individual, including heritage, communication, family role/structure, work/job/occupation, bio-cultural ecology, high-risk behaviours, nutrition and food/diet, pregnancy and birth practices, death rituals, religion and spirituality, health beliefs and practices and healthcare practitioners. Over the past decade, a number of educational programmes have also been designed and implemented to prepare student nurses for caring for patients from different cultural backgrounds. Many cultural care development models have been implemented worldwide, with research being carried out to evaluate their effectiveness and practitioners' clinical experience. Additionally, various assessment tools have been developed to measure student nurses' culture-related knowledge, skills and attitudes (Capell et al., 2007, Wilson et al., 2010). However, as these are mainly self-assessment tools their validity and accuracy have often been questioned as when self-reporting respondents may succumb to social desirability bias, i.e. our tendency to respond in ways that we feel are more appropriate or socially acceptable to others (Perng & Watson, 2012). Thus, research that aims to explore student nurses' experiences of intercultural encounters through the use of qualitative methods (such as interview) is important as it is useful to collect a richer, more in-depth understanding of students' lived experience of intercultural encounters and thereby to increase knowledge of how their interactions and experience shape students' understanding of the world and their position within it (Bryman, 2012).

Many studies have explored the cultural aspects of nursing care; however, these focus mainly on the experiences of patients and qualified staff nurses (Cioffi, 2003; Gerrish, 2001; Gerrish et al., 2004; Murphy & Clark, 1993; Leishman, 2004; Barnes et al., 1998; Boi, 2000; Boyle, 2000; Chenoweth et al., 2006; Leininger, 2002; Locsin, 2000; Narayanasamy, 2003). There is far less literature on student nurses' clinical

experiences and their training needs. In the UK, scholars such as Gerrish et al. (1996), Leishman (2004) and Koskinen et al. (2008) reported that healthcare programmes were not providing sufficient training for students to handle intercultural communication effectively. For instance, Gerrish et al. (1996) revealed that student nurses did not feel well equipped with the required cultural skills to communicate effectively with people whose cultural background differed from their own. Leishman (2004) reported that British nursing education offered little in the way of cultural diversity and that their knowledge and skills training did not adequately prepare student nurses to apply relevant knowledge to practice. Student nurses also expressed the need for training to improve their intercultural awareness and competence in their clinical practice (Leishman, 2004). In response to these educational needs, the British Royal College of Nursing (RCN) developed its transcultural learning resources (TLR) (Husband & Torry, 2004), which are free to access and available on their website. Intercultural Education of Nurses in Europe (IENE) led by Professor Papadopoulos also created a series of free online toolkits to promote culturally competent compassion, courage and communication in healthcare (Papadopoulos et al., 2016).

Over 20 years have passed since Gerrish et al. (1996) studied English student nurses' lived experiences, and the demographic profile of UK society has changed significantly in that time. In addition, more than a decade has passed since Leishman (2004) and the RCN's transcultural learning resources were published. During this time, pre-registration nursing education has not only moved to being all-degree level but also aims to "underpin the level of practice needed for the future" (NMC, 2010, p. 8). In the light of this change, it is important to conduct a study to discover whether current British nursing students now feel better prepared for providing intercultural care, particularly considering the significant increase in EM communities in recent decades (ONS, 2011, 2021b). The findings from this study will increase knowledge of how their interactions and experience shape students' understanding of the world and their position within it. Furthermore, this information will allow educationalists to evaluate current nursing curricula and develop suitable courses for a more interculturally competent nursing workforce. Clinically, the findings will help staff nurses take proactive actions to support and improve student nurses' competence during their clinical placement period.

1.2 Aim and Research Questions

Dealing with an illness such as cancer can be stressful for patients; they may feel frightened when facing various forms of treatment and nursing care. A patient's stress can be further exacerbated in an unfamiliar hospital ward environment where a number of healthcare providers are from a different cultural background, especially when the patient speaks a different language. Therefore, given the UK's ever-increasing multicultural population, providing culturally competent nursing care is pivotal to reducing cultural disparities in diverse healthcare settings and ensuring patient satisfaction and positive outcomes. Within this context in addition to personal and professional perspectives (discussed in section 1.1), research conducted with the aim to explore student nurses' experiences in intercultural communication with people from diverse cultural backgrounds during their clinical placement in England and to examine the influence of culture on how such students feel, think and act (i.e., their intercultural communication). The experience includes student nurses' own practice, their opinions, their observation of the practice of others, and their own treatment on placements.

The following research questions (RQs) and subquestions were posed:

RQ1: How do student nurses experience intercultural nursing care in their everyday clinical practice?

- Does their own culture affect their approach to others? If so, how?
- What positive experiences do they encounter? How do they perceive these experiences?
- What challenges do they encounter? How do they perceive and manage these challenges?

From this exploration and understanding of student nurses' intercultural communication experiences, I explored the following:

RQ2: What intercultural competences are salient in facilitating effective intercultural nursing care?

- What are the factors and features of effective intercultural encounters in clinical nursing practice?
- What are the relationships among these factors?

1.3 Key Concepts and Themes

Culture is a complicated and evolving concept. Some culture-related terms such as ethnicity and race and cultural competence and sensitivity are commonly used interchangeably, leading to some conceptual ambiguity. Therefore, it is useful to describe and clarify some common terms and themes in relation to cultural care in nursing. Before defining intercultural communication and competence, I unpack terms such as culture, race, ethnicity, competence, and safety to lay the ground on which this thesis rests. In each case, the key term is set in bold. The Preface provides a list of abbreviations used in this thesis.

1.3.1 Culture

Culture can refer to different things by different people in different contexts (Suominen et al., 1997). For example, some anthropologists consider culture in terms of large groups of people who share a history, language and beliefs. The anthropologist, Claude Levi-Strauss (1966), refers to culture as the combination of a symbolic system consisting of symbols of both physical and social reality. Keesing (1974) claims this dimension 'transcends the boundaries of language and custom that divide people' (p. 79.). Risager (2006) argues that 'cultural symbols' are created and recreated, their meaning transferring interaction between people. They are therefore fluid and dynamic rather than fixed entities. Barett et al. (2013) also recognise the dynamic nature of culture and define it as the combination of features of material, social and subject forms. The material aspect of culture is the 'physical artefact commonly used by the members of a cultural group'. The social aspect of culture is 'the social structure of the group'. The subject aspect of culture consists of beliefs, norms, collective memories, attitudes, values, discourses and practices, which members of the group commonly use as frames of reference for thinking about, making sense of and relating to the world. Goodenough (1964) referred to culture as something one has to know or believe in order to perform or behave in a way that is acceptable to as that culture's members. It is clear that Goodenough considers culture as more of a mindset rather than as physical or material entities. Scope wise, the term 'culture' has been viewed narrowly, in terms of ethnicity, or even more narrowly in terms of the Māori in New Zealand (Papps & Ramsden, 1996). More broadly, Raymond Williams (1976) refers to culture as a range of social life processes including ideas, attitudes, language, and practices,

which can be articulated or presented in a variety of formats such as texts, artistic style, architecture and so on.

In nursing, transcultural care theorists Leininger (2002) and Papadopoulos (2006) define ‘culture’ as a set of learned and shared values, beliefs and norms within a group of people. In this way, culture is manifested and understood through people’s shared functional behaviour, patterns (also referred to as symbolic interactions) and understood through interpretation of their motivations, for example, beliefs, religion, language, body image and customs (Jirwe et al., 2006; Gerrish & Papadopoulos, 1999). As both of these are social science approaches, their elements can be searched for and identified quantitatively. However, more critical approaches focus on power relations and their consequences, for example, cultural safety, as explained in section 3.2. Taking a more social constructionist approach (in the interpretive paradigm), Barrett et al. (2013) search for the emergence of these elements through social interaction. Here, **culture** is considered as shared patterns of behaviour and interactions, cognitive understanding and affective constructs that are continuously learned, shaped and reshaped through socialisation. While helpful in recognising the members of the group, these also differentiate people from another group. Instead of considering culture patterns as an automatic process of development, culture can also be viewed as continuous, as being modified and reshaped through interactions and communication (i.e., through intercultural communication) (Dervin, 2016). Therefore, although behaviours and attitudinal and affective patterns may exist within a particular group, the characteristics of the ‘culture’ are distributed differently in individual members. Thus, individuals within the group do not adopt these common features in an identical way, at all times or in all life situations. In this way, the importance of the socialisation process as a means of acquiring the necessary attitude, values, and behaviours to be a member of any group and to understand the different identities and communication among the members of any culture group are acknowledged (Deardoff, 2006; Stanfield, 1993). In clinical nursing care, culture not only affects how nurses engage with their patients in nursing care, but also how the nurses and patients perceive illness and health in relation to their own culture.

In summary, culture is a difficult concept to define; thus, different disciplines refer to it in different ways. As this study takes a social constructionist approach, it considers the

definition outlined by Barrett et al. (2013) to be the most appropriate working concept as that definition of culture can be helpful when it comes to addressing the commonplace issues and differences within and across cultures and challenging cultural stereotypes in clinical practice.

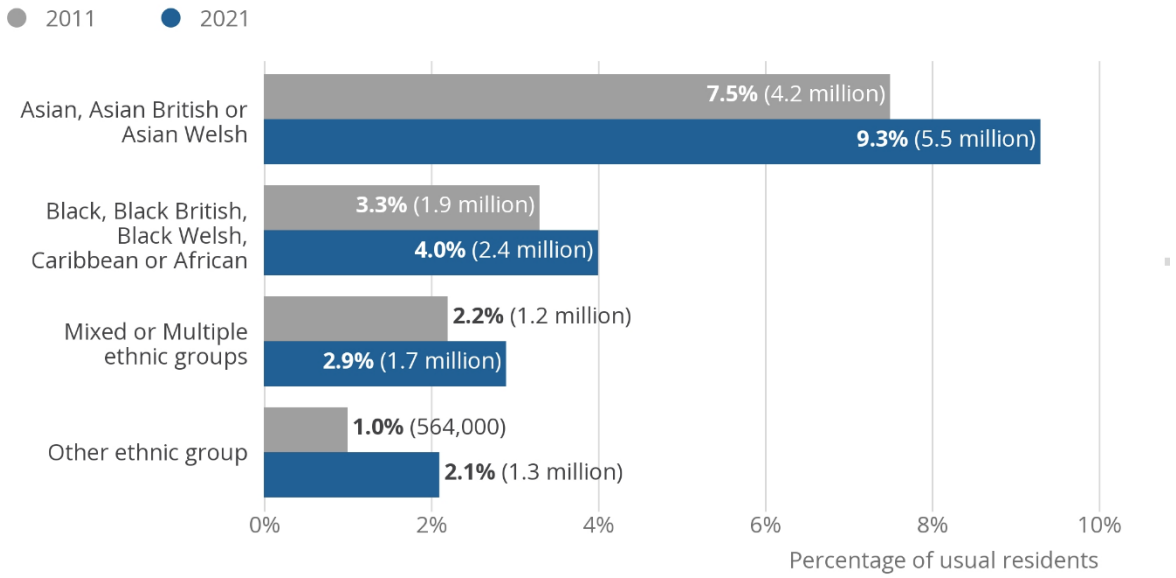
1.3.2 Race and Ethnicity

The terms ‘race’ and ‘ethnicity’ are closely related to culture and are sometimes used interchangeably. **Race** generally refers to a person’s physical characteristics, such as bone structure, facial features, hair texture or skin colour, which are associated with certain geographical regions or populations (Zuckerman, 1990). Race is also a socio-political concept used to symbolise social interest and conflicts. In some societies, a person’s physical characteristics are sometimes linked to social hierarchies and resource distribution, including access to healthcare, educational opportunities, and social interactions (Hester, 2012). Therefore, race is also viewed as a political phenomenon and a socio-historical process. **Racism** is when a person believes members of each race possess characteristics, qualities, or abilities specific to that race, and uses this belief to distinguish one racial group as inferior or superior to the others. To avoid political and historical implications, the word ‘culture’ is commonly used instead of race. However, it is the socio-political factors rather than cultural traditions that determine who is prioritised and has access to which resources in a society. For this reason, multiculturalism, culture and ethnicity are commonly viewed as static objective facts that can be contained, to compare different cultural populations (Hester, 2012).

Ethnicity refers to a particular social group that shares a common anthropological origin and traditions, such as linguistic traits, religion, and nationality. As such, it is considered a broader concept than race (Betancourt et al., 2005) and is often used in the National Census report to demonstrate composition in the UK (see figure 1.3, ONS, 2021b). **Black and Minority Ethnic (BME)** is a term used to describe a collective ethnic minority population. BME has been used widely in government documents, and traditional and social media when referring to people or their previous generation who have migrated to the UK and have solid cultural heritage ties to countries outside of the UK. However, this term has been criticised for not including white ethnic minorities

(for example, Irish Heritage groups). Therefore, **Ethnic Minorities (EM)** is considered more appropriate, so that is the term adopted in this thesis.

Figure 1.3 *Ethnic minority group distribution 2021 and 2022 (ONS, 2021b)*



White is another ethnic classification used in government surveys and social research to classify individuals descended from Europe and North America who have light skin tones. While **British** is a term often used to describe something or someone from or associated with Great Britain, **White British** is a term used in the national census to represent people who identify their ethnic group as indigenous or native English, Scottish, Welsh or Northern Irish – also called the 'indigenous' or 'native' population. The term '**indigenous**' often relates to the original inhabitants or earliest settlers of the land. The British Isles has a history of Celtic, Saxon, Norman, Irish and Polish etc. immigration, all of whom have light skin tones. Considering their significant genetic linkage to the first inhabitants of the island, the term 'indigenous population' was used interchangeably with White British. However, the term 'White' has been criticised for being a socially defined racial group, which has political implications since it is primarily based on skin colour and so fosters a binary racial world view in which 'non-white' is deprioritised. This hegemonic white ethnic classification in Britain has been deemed 'inappropriate', as it implies white 'normality', 'neutrality' or 'universality' (Aspinall, 1998). Therefore, another term, '**native population**', has been developed to encompass people born and raised in any part of the country regardless of their racial

or ethnic background. This term gives more emphasis to an individual's strong links with the country and their British nationality. Even though some people prefer the term 'White British' for its historical continuity and cultural heritage, in consideration of the UK's multiple waves of immigration and cultural exchanges, the broader term of 'native population' better reflects the multicultural nature of the country, so is considered more appropriate in this thesis. British citizens who identify as having a stronger link to ancestry to countries other than the UK can choose the relevant ME subgroups in the national census. According to the Census (ONS, 2001, 2011 and 2021), this group makes up 18.3% of the population in England and Wales, an increase from 14.0% in the 2011 Census and from 12.5% in 2001. This trend shows that Britain has become a more ethnically diverse country over the past two decades.

1.3.3 Cultural Competence and Safety in Nursing

Cultural competence and safety are used to describe standards in cultural aspects of care. Despite benchmarking the quality of nursing care, the terms do mean different things.

Competence usually means the ability to do something well, successfully or efficiently, but the word tends to function differently in different contexts and ranges from the process of developing a set of skills that can be applied in a situation to a list of static abilities and qualities (including attitudes, knowledge, understanding and skills), which can be applied through action in a relevant situation (Feng et al., 2009). In nursing, the International Council of Nurses (2005) refers to competence as an effective level of performance in which nurses apply combinations of knowledge, skills and clinical judgement in practice. Therefore, **cultural competence** could be defined as the combination of knowledge, skills and attitudes nurses require to provide effective cross-cultural care.

Tuohy et al. (2008) argue that in healthcare, nursing students and staff should not only consider cultural competence but also cultural safety when providing care to patients from different cultural backgrounds. **Safety** is related to preventing danger or reducing risks from hazards to health and wellbeing (Zealand, 1992). **Cultural safety** is defined as "the effective nursing of a person/family from another culture by a nurse who has

undertaken a process of reflection on their own cultural identify and recognises the impact of the nurses' culture on their own nursing practice". (Papps & Ramsden, 1996, p. 491). Therefore, cultural safety means having an awareness of cultural groups in a society and how they are perceived and treated by others and providing care that is sensitive to them to ensure their needs are met. Unsafe nursing practices are actions or omissions that endanger wellbeing, demean or disempower the cultural identity of the patient (Zealand, 1992).

Sensitivity is another word frequently used in nursing practice; it refers to the degree to which a device or person responds to change. A nursing professional who has **cultural sensitivity** is not only able to recognise subtle changes in a patient's appearance and behaviour but is also able to respond to those changes (Jirwe et al., 2006). Zander (2007) argues that cultural sensitivity comprises attributes of cultural competence in addition to the domains of cultural awareness, knowledge, and skills. In this study, **culturally sensitive care** means respecting and considering a patient's language, cultural traditions and practices while providing nursing from a different cultural context (Castro & Ruiz, 2009). Cultural sensitivity therefore enables nurses to provide culturally congruent care (Capell et al., 2007). It also opens a space for interculturally competent nursing care in that nurses must be sensitive to the culture and communication of individuals, irrespective of their background or culture.

1.3.4 Transcultural Nursing Care

In nursing, principles around cultural aspects of care come mainly from transcultural care theory. This was developed in the 1950s by Leininger, a nurse, sociologist, and anthropologist. She who refers to **transcultural nursing care** as a formal subject of study and practice in respect to individuals' diverse beliefs, values and ways of living and the application of this knowledge to practice when providing nursing care to patients, their families, and cultural groups (Leininger, 1997a). Therefore, transcultural nursing care is provided in a way that is sensitive and responsive to the needs of individual patients, relatives, and cultural groups within a society. Section 2.2 presents more detailed discussion about transcultural care theory.

Even though transcultural care is widely used in nursing, it has been criticised as a rather a static term and as focusing on comparing two or more cultures. Furthermore, existing transcultural competence and cultural safety theories do not cover the breadth of the intercultural communication experiences of nurses undertaking clinical care. Therefore, the terminology, and its meaning, when understood in relation to student nurses' lived experiences of intercultural care, need deeper exploration. The new, more active term, '**intercultural**' has recently been introduced into education; this term concerns an interactive process among different individuals' positions (Feng et al., 2009). I discuss this concept next.

1.3.5 Intercultural Care Competence

Over the last couple of decades, IC has attracted increasing attention in politics, business, education, and the media. In an internationalisation context, Deardorff (2004) defines **intercultural competence** as the overall capacity to respond successfully to cross-cultural situations and to handle tasks, difficulties, challenges or even opportunities for the individual—either alone or with others (Deardorff, 2009). In this context, IC is not only a set of skills that can be applied in a situation, but also a combination of attitudes, knowledge, understanding, and skills applied through action in any relevant situation. While the term intercultural competence does not appear to have been used in the nursing field (see section 3.2), this study understands intercultural nursing care as an ongoing self-evaluation and development process rather than competence as an end point.

To sum up, it is essential to define terms related to intercultural care competence including culture, competence, safety, transcultural care, and intercultural care competence in nursing practice at the outset, as these terms help to clarify any conceptual ambiguity and set a good foundation for the study, thus helping readers to understand the thesis.

1.4 Organisation of this Study

The first chapter introduces the thesis, describes the importance of the study (section 1.1), its research aim and research questions (section 1.2) and outlines the organisation of the study (section 1.4). The key terms that commonly appear in cultural

aspects of nursing care are explained in section 1.3, so helping to clarify the interchangeability and conceptual ambiguity of some common terminology in the field of intercultural nursing care.

Chapter 2 presents the literature review. Section 2.1, which reviews nurse educational provision of cultural competencies, I then provide a critical review of research literature on IC experiences in clinical settings (section 2.2) and some well-known cultural competence theories in nursing and other field (section 2.3 and 2.4).

Chapter 3 presents the research framework for this study. Philosophical considerations are introduced in section 3.1, along with an explanation of my research paradigm and research strategy. Section 3.2 discuss theoretical aspects of sampling methods, the data collection methods (interview) and the data analysis method (thematic analysis), the rationale for choosing them for this study and a detailed explanation of the process. Section 3.3 describes some fieldwork and lessons learned from the pilot and main study. Sections 3.4 and 3.5 present ethical considerations and research quality issues encountered in this study. This chapter concludes with a discussion of reflexivity (section 3.6).

Chapter 4 presents and discusses the empirical findings in relation to participants' intercultural care experience, including intercultural care-related encounter (section 4.1) , knowledge (section 4.2), skills (section 4.3), attitudes (section 4.4), engagement (section 4.5) and outcomes (section 4.6).

Chapter 5 is the conclusion. Section 5.1 summarises the key findings in relation to the research questions. Section 5.2 addresses the research's contributions and implications for theory, education, practice, and research. Section 5.3 summarises of research's challenges and limitations. Section 5.4 presents directions for future research. The chapter concludes with my final remarks (section 5.5).

Chapter 2

Literature Review

Globalisation and worldwide migration of people have placed increased demands on healthcare professions to provide culturally sensitive care to patients from different cultural contexts. In order to gain a good understanding of existing research on student nurses' intercultural experiences in clinical settings and to identify common constructs of the most frequently cited cultural care competence theories, a comprehensive literature review was conducted. The keywords used were '*cultur* care', 'experience', 'nurs*', 'competenc*', 'cultur* safety' and 'theory or framework or model'. The following databases were used: PuMEdline, CINAHL, PsycINFO, ERIC, Google Scholar, Web of Science, Wiley Online Library, Taylor & Francis online and ScienceDirect. Reference and citation searches were also carried out to include as much relevant literature as possible to develop a good understanding of the context, overview of the theory and research on cross-culture care in nursing practice and identify the research gap and importance for my study.

This chapter first addresses cultural education provision in nursing (2.1); it then reviews key research on the experiences of patients and nurses when interacting with people from different cultural backgrounds and the strategies they used to manage the situation (section 2.2). Sections 2.3 and 2.4 present and critically review widely recognised cultural care theories in nursing and intercultural competence in other fields. The chapter ends with a summary of the reviewed literature and highlights gaps in both knowledge and research in the field of intercultural nursing care.

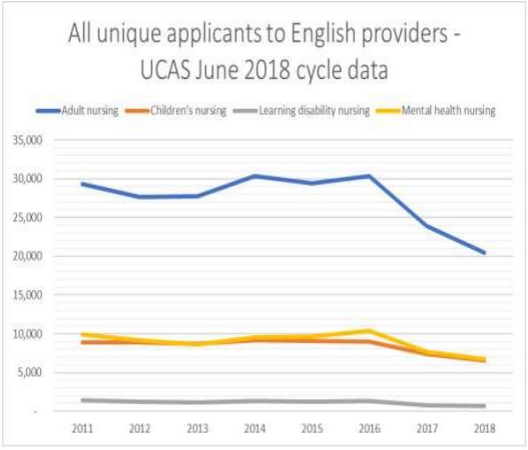
2.1 Cultural Competence Education for Nurses

In the UK, all registered nurse programmes are education-led and sited within higher education institutions. To ensure the right people are recruited to deliver a safe and high-quality service, candidates who wish to enter the nursing profession must go through a rigorous application and selection process. These assess their minimum academic attainment and value-based prior qualifications and experience (Department of Health, 2019). For international applicants, whose English is second language, their minimum of English capacity must also be met (NMC, 2023). In 2012,

nursing education changed to an all-degree level. Prior to that change, most qualified nurses completed at diploma and advanced diploma levels. Currently, the majority of nursing students undergo a 3-year undergraduate programme, with a small number of degree holders from other healthcare professions graduating through a 2-year postgraduate route. On successful completion of the programme, students gain a Registered Nurse qualification.

There are four fields of nursing: adult, child, mental health and learning disability. Trainee adult nurses were chosen for this study, since that programme has the greatest number of students (see Figure 2.1) and the broadest age range of patients. Adult patients have a variety of care needs across a range of conditions (including acute illness, aged care, and the care of patients with long-term conditions) in a range of healthcare settings. Students gain an academic and professional qualification through integrated study of theory (50%) and supervised clinical nursing practice (50%), and have supernumerary status during their clinical placements, which are randomly allocated across the region throughout their training. Placements involve working under the supervision of qualified staff in hospitals, health centres, nursing homes, hospices, and NHS communities. These placements are pivotal in helping students link and apply nursing theory to clinical practice, thus helping them to transfer from education to employment. Towards the end of their second year of study, students are encouraged to participate in overseas immersion programmes, with 6-10-week placements in different parts of the world.

Figure 2.1 *Applicants to nursing courses: English Providers (Source: DH, 2019)*



To serve the multicultural and multi-ethnic composition of British society, the nursing profession has been facing challenges in providing quality care that is responsive and sensitive to individual healthcare needs from minority groups as well as the majority population. Therefore, it is important for nursing educators and clinical managers to consider how to prepare their future workforce and maintain their competences to meet the healthcare needs of diverse clients. Many toolkits and programmes have been developed for improving cultural competence in nursing education, and each offers a special approach to help nurses provide culturally sensitive and competent care (Papadopoulos et al., 2016). However, the extent to which cultural education is being incorporated in educational institutions varies considerably. In addition, researchers have identified several issues when applying these toolkits and programmes to practice due to the lack of one universally agreed, precise definition of culture and the tendency to overly emphasise race and ethnicity (Drevdahl et al., 2008; Stein et al., 2010). Without consideration of other factors such as an individual's biological, psychological and economic status, a patient's cultural care experience may be impacted. In addition, there are no universally agreed, clear guidelines nor standard goals through which staff can measure whether they have met the needs of a diverse culture, a factor which increases difficulties for educators' ability to design a culturally responsive curriculum (Clark et al, 2011; Grant et al., 2013; Thackrah & Thompson, 2013). Despite the domains and subdomains of the construct of cultural competences needing further refinement to achieve the best healthcare outcomes, according to Albarran et al. (2011), staff who rated higher in these domains may achieve better patient outcomes. Horvat et al. (2014) reported that staff behaviours, patient engagement and mutual understanding following cultural competence training improved in comparison to the control group. Therefore, to help professionals learn and develop appropriate cultural competence, incorporating these contents into the pre-registration curriculum and continuing educational programmes is recommended.

To ensure future nurses are prepared to meet diverse cultural needs, a variety of theoretical principles have been adopted to guide the understanding, design and implementation of intercultural nursing education and clinical practice, including cultural relativism, critical pedagogy, social constructivism, human rights, and citizenship. Social constructivism is a widely used approach in nursing education since it recognises the importance of active engagement in social interaction and cultural

contexts in clinical experiential learning. Lev Vygotsky (1978), a prominent social constructivist, proposed the concept of the 'Zone of Proximal Development' (ZPD), which is the gap between what an individual can do independently and the level they can achieve with support and guidance from more experienced staff. Vygotsky considers learning to be an active and collaborative process. Through social interaction (such as dialogue, negotiation, shared experience, discussion, and collaboration), student nurses connect new learning to prior learning experiences, to enable a new and deeper understanding. As a result, they co-construct intercultural meaning and understanding. Teaching and learning methods, such as active learning, collaborative team project work, clinical and experiential learning, and reflection are rooted in social constructivism principles.

The social constructivist approach goes beyond the lecture style of rote memorising for teaching and learning, and instead provides scaffolding for the four domains of clinical competencies set by the nursing regulatory body, NMC, in the UK (NMC, 2015). By fostering critical thinking and collaborative teamwork, students can become equipped with the knowledge, skills and attitudes needed to provide competent and compassionate healthcare (Benko, 2012; Combs, 2018; Epp, et al., 2021). For example, reflection encourages students to think critically about their personal beliefs, biases and stereotypes, strengths and areas for future improvement. This helps them to develop a deeper understanding of their role in providing culturally competent care to patients from diverse backgrounds. In addition, through clinical experiential learning, students actively engage in intercultural encounters whereby they apply knowledge and skills to the real world, which in turn helps them to understand the complexities of nursing care environments and social contexts in healthcare settings.

Bentley et al. (2008) conducted a nationwide survey of cultural diversity training for UK healthcare professionals. Their study which included courses in nursing, medicine, physiotherapy, occupational therapy, speech and language therapy and pharmacy revealed that about one quarter of healthcare educational institutions were not offering cultural diversity educational programmes for their students. Even in universities where intercultural education took place, the survey revealed a significant difference in the content, teaching methods and amount of teaching and learning taking place. The study concluded that inadequate cultural diversity training in major healthcare

programmes may lead to students' lack of IC before they qualify. Bentley et al. (2008) also highlighted that certain parts of England where EM groups have low representation, such as North East and Wales (see Figure 2.2a) provide less intercultural training in comparison to places with higher percentages of minority residents. Bennett (2006) argues that some universities' lack of awareness regarding the ethnic proportions of their local populations may contribute to a neglect in the provision of intercultural training and that the institutions in these regions may therefore feel little imperative to offer specific content to address the needs of minority groups (Bentley et al., 2008). However, these attitudes are found lacking considering that there is still a relatively large absolute number of EM groups in such regions (see table 2.1, and figure 2.2, ONS, 2011 and 2021b). Moreover, large numbers of the EM population migrate across different regions in the UK (ONS, 2013). In addition, some people in ethnic minority groups have a disproportionate tendency to develop certain diseases. For example, South Asian migrants are more likely to develop coronary heart disease than native British people, and some minorities have a higher mortality rate and prevalence of complications (Forouhi et al., 2006).

Figure 2.2 *National identity, England and Wales, 2011 (Source: ONS, 2011)*

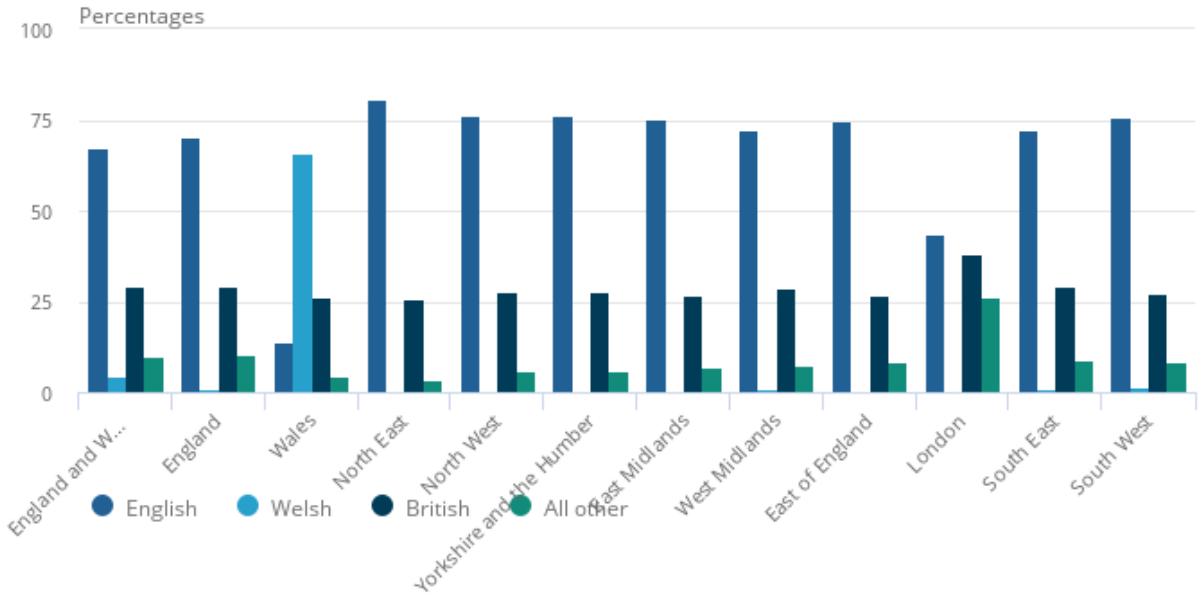


Table 2.1 *Ethnic minority group, 2011 and 2021, England and Wales (Source: ONS, 2021b)*

Ethnic Group	2011 (number)	2021 (number)	2011 (percent)	2021 (percent)
Asian, Asian British or Asian Welsh: Bangladeshi	447,201	644,881	0.8	1.1
Asian, Asian British or Asian Welsh: Chinese	393,141	445,619	0.7	0.7
Asian, Asian British or Asian Welsh: Indian	1,412,958	1,864,318	2.5	3.1
Asian, Asian British or Asian Welsh: Pakistani	1,124,511	1,587,819	2.0	2.7
Asian, Asian British or Asian Welsh: Other Asian	835,720	972,783	1.5	1.6
Black, Black British, Black Welsh, Caribbean or African: African	989,628	1,488,381	1.8	2.5
Black, Black British, Black Welsh, Caribbean or African: Caribbean	594,825	623,119	1.1	1.0
Black, Black British, Black Welsh, Caribbean or African: Other Black	280,437	297,778	0.5	0.5
Mixed or Multiple ethnic groups: White and Asian	341,727	488,225	0.6	0.8
Mixed or Multiple ethnic groups: White and Black African	165,974	249,596	0.3	0.4
Mixed or Multiple ethnic groups: White and Black Caribbean	426,715	513,042	0.8	0.9
Mixed or Multiple ethnic groups: Other Mixed or Multiple ethnic groups	289,984	467,113	0.5	0.8
White: English, Welsh, Scottish, Northern Irish or British	45,134,686	44,355,038	80.5	74.4
White: Irish	531,087	507,465	0.9	0.9
White: Gypsy or Irish Traveller	57,680	67,768	0.1	0.1
White: Roma	-	100,981	-	0.2
White: Other White	2,485,942	3,667,997	4.4	6.2
Other ethnic group: Arab	230,600	331,844	0.4	0.6
Other ethnic group: Any other ethnic group	333,096	923,775	0.6	1.6

Approaches to adding these training modules to nursing curricula vary from integrating cultural aspects of care into theoretical study to be delivered in a classroom setting (Reeves, 2001) to immersing students in this aspect of care through experimental learning. In other words, students gain this competence through their learning in a real multicultural working environment during clinical practice (Frisch, 1990, Ryan et al., 2000). Leishman (2004) found that British nursing education offered little in the way of cultural diversity training and that the knowledge and skills training did not adequately prepare student nurses to apply relevant knowledge to practice. Student nurses also expressed their desire for training to improve their intercultural awareness and competence in their clinical practice. As nearly two decades have passed since Leishman's study; it would be useful to see whether the situation has improved.

2.2 Research in Intercultural Communication (ICC) in Clinical Settings

A number of studies reported cultural aspects of nursing care encounters in American (Leininger, 2002; Locsin, 2000), Canadian (Wuest, 1991), Oceanian (including Australian and New Zealand, Chenowethm et al., 2006) and European multicultural populations (Barnes et al., 1998; Boi, 2000; Boyle, 2000; Narayanasamy, 2003). In the UK, several studies identified issues around transcultural nursing care in the context

of diverse British populations (McGee, 1992; Gerrish et al., 1996; Le Var, 1998; Gerrish & Papadopoulos, 1999; Parfitt, 1988; Narayanasamy, 1999a, 1999b; Price & Cortis, 2000; Holland & Hogg, 2001; Narayanasamy, 2003; Cortis, 2003).

Within the UK context, from the patient's perspective, epidemiological and socioeconomic data shows that the rate of ill health and the subsequent healthcare received differs significantly between ethnic minority groups compared to the majority of their native British counterparts (Gerrish, 1997). Previous research (Cortis, 1991; Henley, 1982; Murphy & Clark, 1993) reported that individual patients' needs are frequently not met due to a lack of cultural knowledge and linguistic barriers on the part of doctors, nurses and other healthcare providers resulting from a lack of understanding, stereotyping, unsatisfactory nurse-patient communication, and 'derogatory' attitudes towards people from cultures other than the dominant native British culture. The Black Report (Townsend & Davidson, 1982) found that ill health and death are not distributed equally among Britain's ethnic groups and argue that these inequalities have widened rather than decreased since the establishment of the NHS in 1948. Ten years later, Balarajan and Raleigh (1993) conducted an epidemiological study highlighting the importance of ethnic and cultural factors to health inequalities in British society. Even more recent studies reveal that the healthcare needs of ethnic minorities are mostly not met, with many migrants and refugees facing health and emotional issues which require them to access healthcare services (Albarran et al., 2011). The health outcomes of ethnic minority groups are still much poorer than those of their native British counterparts which were considered mainly due to difficulties in accessing healthcare services because these organisations have not provided adequate culturally and linguistically appropriate services and information (Gilbert, 2003; Karlsen, 2007; Stevenson & Rao, 2014). Consequently, their morbidity and mortality rates are much higher because their needs were not recognised or considered by the healthcare system (Desouza, 2008; Domenig, 2004).

From the nurses' perspective, language issues were reported most in the literature. For example, in Yakar and Alpar's (2018) study, 94.6% of nurses reported that language barriers affected the quality of their nursing care. A variety of strategies were reported to overcome such barriers when dealing with intercultural care encounters. For instance, Jirwe et al. (2010) and Yakar and Alpar (2018) recommended hiring

professional accredited interpreters to provide culturally congruent care to patients. Tuohy et al. (2008) revealed that nurses identified the importance of using the same interpreter for a patient so that the relationship between all parties could be maintained. However, difficulties were also reported: e.g., interpreters are not always widely used due to financial reasons and staff lack awareness of the process (Cioffi, 2003; Gerrish, 2001; Gerrish et al. 2004, Ozolins & Hjelm, 2003). In Yakar and Alpar's (2018) study, 78% of staff commented that when an interpreter was used, there were concerns about their lack of professional knowledge and it was suggested that they should be offered training. Other studies found that, despite an interpreter's speaking the same language, their communication was not effective in other ways such as a lack of eye contact or frequent use of medical jargon (Douglas et al., 2011). Singleton and Krause (2010) also argue that interpreters should be familiar with the patient's culture and have sufficient medical knowledge. Yakar and Alpar (2018) go further, suggesting that interpreters should come from and/or have lived in the same culture as the patient. In addition, they reported that interpreters should be the same gender as the patient.

Apart from lacking a common language when caring for patients from different cultures, the literature identifies other issues, including lack of knowledge about a patient's culture and perceived negative attitude. In Boi (2000), staff who were trained outside of the EU reported that they had no formal training in caring for patients from different cultural backgrounds and felt they were not fully prepared for this aspect of care. Some staff commented that their ability to provide safe and effective care was affected, while overseas nurses recognised their inadequacy in cultural knowledge and requested additional intercultural training to raise their cultural awareness and understandings. In the same study, nurses trained in England felt they had enough knowledge. This finding contradicts many other self-perception of intercultural knowledge studies suggested that staff could have more input into post-registration education around cultural diversity and health beliefs. Leininger (2002a) highlighted that nurses did not adequately recognise the importance of understanding cultural differences. This lack of understanding may lead to a tendency to view EM patients as a single ethnic group, which may lead to the provision of ethnocentric nursing care and ineffective interaction and affect the quality of service provided (Vydelingum,

2006). Scammell (1991) revealed unprofessional attitudes and even discrimination against patients and colleagues from different cultural backgrounds. Husband (2000) also reported that inequality is still not challenged, since the majority community do not believe that EM people are truly equal or deserve to be treated the same as majority population despite the liberal ethos of tolerance by the more powerful party (Papadopoulos et al., 2008).

To establish a trusting therapeutic relationship, a patient's culture and beliefs need to be taken into consideration and respected. Some staff nurses reported that their knowledge of patients from different cultures and with different health beliefs is learned through direct communication with patients' relatives (Boi, 2000). Others suggest it is learned through formal intercultural education that addresses cultural differences and health beliefs, nurses' awareness, cultural understanding, flexibility, and tolerance towards cultural diversity. Studies on student nurses' cultural care competency reported that they expressed frustration and anxiety when they were not able to communicate with patients effectively, and they expressed a desire for more formal learning opportunities in pre-registration programmes (Gerrish & Husband, 1996; Bradby, 2001; Kai et al., 2007; Jirwe et al., 2010). Jirwe et al. (2010) reported the need for Swedish student nurses to develop aspects of cultural knowledge and revealed how students acquired their cultural knowledge and skills, including minimally through their taught programme and during placements which helped them appreciate more about cultural diversity not only among patients, but also staff and colleagues. The findings from these studies suggest the need for a deeper understanding of what British student nurses think about their own competences in delivering cultural care and the variety of ways to acquire cultural care-related knowledge and skills.

In summary, although there is disparity in health needs across different cultural groups and across cultural aspects of care encounters, studies have focused mainly on the experiences of qualified staff nurses (Cioff, 2003; Gerrish, 2001; Gerrish et al., 2004; Murphy, 1993; Leishman, 2004). Only a small number of studies explore student nurses' clinical experiences. While many studies indicate successful initiatives in nurse education in the USA, Australia, and Canada, fewer explore students' experiences in the UK. Therefore, it cannot be assumed findings in the existing literature are

applicable in the multicultural UK context. Furthermore, much has changed in nursing and UK society in the 20 years since Gerrish's study of English student nurses and nursing educational programmes. It is therefore timely to investigate whether current British nursing students feel better prepared for this aspect of care, particularly given British's diverse population.

2.3 Cultural Care Competence Theories

In order to improve quality of nursing care for people from all backgrounds, nursing researchers and theorists have developed various cultural competence care models. More than 300 articles were initially identified related to cultural competence in nursing. Of these, about 50 articles specifically referred to models of cultural competence in relation to developing nurses' competence when caring for patients from diverse backgrounds. Thirteen cultural care related theories were identified (see table 2.2). All claim to originate from one of two fundamental schools of thought: transcultural care or cultural safety.

Table 2.2 *Theoretical models of Cultural Competence (Arranged by Year of Publication)*

Authors, year	Model name	Components
Leininger, 1991	Sunrise model	Six domains (culture values and lifeways; religious, philosophical, and spiritual beliefs; economic factors; educational factors; technological factors; kinship and social ties; and political and legal factors)
Willis, 1999	Framework for cultural competence	Seven-step progression (knowledge of one's own culture, knowledge of others' culture, cultural interaction, cultural tolerance, cultural inclusion, cultural appreciation/acceptance, cultural competence)
Wells, 2000	Cultural development model	Six stages in two phases: cultural incompetence, cultural knowledge and cultural awareness as the cognitive phase; cultural sensitivity, cultural competence, and cultural proficiency as the affective phase
Burchum, 2002	Model for cultural competence	Six attributes (cultural awareness, knowledge, understanding, sensitivity, interaction and skill)
Campinha-Bacote, 2002	Culturally competent model of care	Five constructs (cultural awareness, knowledge, skills, encounters and desire)
Suh, 2004	Model of cultural competence	Four domains as antecedents: cognitive, affective, skills and environmental encounters; three attributes of cultural competence (ability, openness, flexibility) and three variables

		(receiver-based, provider-based and health outcome)
Wepa, 2005	Cultural safety	Three-step cultural competence progression: 1) cultural awareness, where the healthcare practitioners understand there is a difference between cultures; 2) cultural sensitivity, which involves self-cultural exploration and identification; 3) cultural safety.
Papadopoulos, 2006	Model for developing cultural competence	Four stages: cultural awareness, cultural knowledge, cultural sensitivity and cultural competence
Andrews & Boyle, 2008	Transcultural nursing assessment guide for individuals and families	Twelve categories of cultural knowledge (cultural affiliations, values orientation, communication, health-related beliefs and practices, nutrition, socioeconomic considerations, organisations providing cultural support, education, religion, cultural aspects of disease incidence, biocultural variations and developmental considerations across the life span
Giger & Davidhizar, 2008	Transcultural assessment model	Six cultural phenomena (communication, space, social organisation, time, environmental control and biological variations)
Purnell, 2008	Purnell model for cultural competence	Twelve domains (overview, inhabited localities and topography; communication; family roles and organisation; workforce issues; biocultural ecology; high-risk health behaviours; nutrition; pregnancy and childbearing practices; death rituals; spirituality; healthcare practices; and healthcare practitioners)
Jeffreys, 2010	Cultural competence and confidence model	Transcultural nursing skills in cognitive, practical and affective dimensions, transcultural self-efficacy and culturally congruent care

Historically, cultural aspects of care have been missing from nursing education, research and practice (Lancellotti, 2008). Leininger was the first person developed a concept of **transcultural competence** in the 1950s to raise nurses' awareness and encourage them to understand cultures that are different to their own (Leininger, 1991 and 2002a). In this theory, she depicts and defines the key factors affecting culturally congruent nursing care. This means providing tailored care to patients with diverse values, beliefs and behaviours based on their social, cultural and linguistic needs (Betancourt et al., 2005). On this basis, she considers culturally competent staff to be those healthcare providers who have the necessary knowledge about different cultures and the ability to apply this knowledge to practice. These practitioners are sensitive to cultural differences when they provide care to people from diverse cultural backgrounds (Leininger, 1991).

Cultural safety is another theory found in nursing, which refers to having an awareness of cultural groups in a society and how they are perceived and treated by others

(Papps & Ramsden, 1996). It was introduced in New Zealand in the 1990s as an essential curricular component in nursing educational programmes, which involves providing care that is sensitive groups such as Māori to ensure their needs are met (Spence, 2005). This concept was developed in the context of the country's colonisation history and in response to the poor health status of Māori., so this concept is specific to New Zealand. While transcultural care competency involves understanding the diversity of patients' cultures, cultural safety focuses on the culture of healthcare professionals and the power relationship and tensions that emerge from this that emphasise power inequalities in the wider social structure.

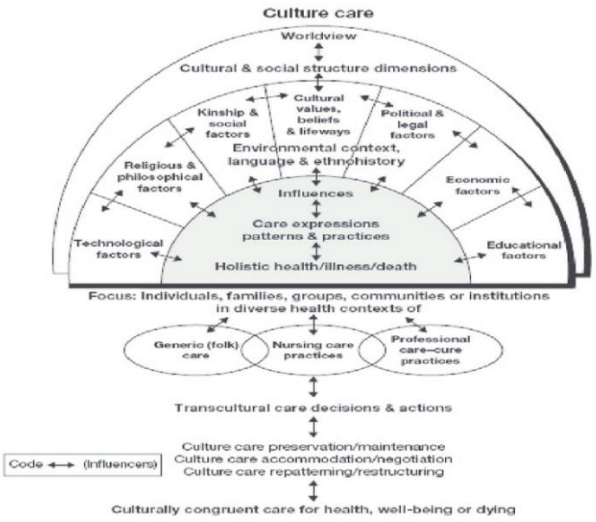
Over the past three decades, many theories of cultural competence-related models have emerged in the nursing field. Thirteen commonly cited models were identified in the literature search (see table 2.2). With the exception of Wepa (2005) which is related to cultural safety, all the other models grew out of the transcultural nursing concept developed in American and global North countries. Whilst some view cultural competence as a dynamic concept and emphasise the development or changing process, (e.g., Wepa, 2005; Campinha-Bacote, 2002; Papadopoulos, 2006) the remainder tend to be compositional. They consider cultural competence to be relatively containable; hence, they focus on components and attributes without specifying the relations among them. Andrews and Boyle (2012) and Jeffreys (2010) take this approach; however, Suh's (2004) model has more multiple dimensions, including four domains of antecedents, three attributes of cultural competence and three variables. Although there are some similarities among cultural care models, they complement each other. For example, Papadopoulos' model which started from cultural awareness and then cultural knowledge, resembles Campinha-Bacote's model in terms of viewing transcultural competence as a growing process and consider the constructs are interrelated. Whereas Papadopoulos puts greater emphasis on cultural compassion, Campinha-Bacote's stresses more on cultural desire at the later stage. Table 2.1 illustrates the differences between these models, alongside their essential components and their year of publication. In view of this thesis' word limit, I have chosen to concentrate on three studies: Leininger's sunrise model because it was the first model developed in the nursing field and the root of other transcultural models; and Campinha-Bacote's process of cultural competence

model due to its popularity and being widely cited in nursing programmes; and Suh's cultural competence framework due to its comprehensiveness. Cultural safety theory is then described.

2.3.1 Leininger's Sunrise Model

Madeleine Leininger, an American nurse, sociologist and anthropologist, identified that individual health values and beliefs could vary significantly between cultures. Based on this principle, in 1991 she developed the sunrise theory which addresses the importance and interrelationships of culture-related factors in an individual's health, wellbeing and death, including their religion, worldview, and social, financial, political, educational, linguistic, gender and environmental factors (see Figure 2.3). She asserts that in order to provide a culturally responsive service to patients from diverse cultural backgrounds, nurses should practise in respect to individual patients' beliefs, values and ways of living. Further, this knowledge should be applied to patients' families and their cultural community, and efforts should be made to develop an in-depth understanding of the values and beliefs of different cultures and apply this knowledge in daily practice (Leininger, 2002a, Leininger, 1991). Even though the sunrise model contains few layers, Leininger comments that it does not matter where one starts when collecting patient information, since what matters most is having an open mind to gain a better understanding of the patient.

Figure 2.3 *The Sunrise Model (Source: Leininger, 1991)*



The central purpose of the sunrise theory is to develop culturally congruent, safe and meaningful care in nursing practice by depicting explicitly cultural differences and common care universalities and explaining the close relationships between culture and care and individuals' health and wellbeing. This approach has helped raise awareness of unrecognised cultural aspects of care in nursing education by revealing ethnocentric ideas in Western healthcare as being the norm in nursing (Gardner, 2005). Therefore, the model has been praised for transforming nursing education. Lancellotti (2008) reported that this transcultural theory helped in recruiting and retaining nursing students from a variety of cultural backgrounds and has helped add a cultural component into nursing care plans as part of routine practice. However, the underlying assumption of Leininger's sunrise theory is that people from the same cultural background share the same values and beliefs. Once identified, these principles may lead to stereotypes of certain cultures, races and faiths and cause harms that are worse than ethnocentric care itself (Rosenbaum, 1991). The theory therefore lacked consideration of the differences not only between cultures but also within a culture and between generations. Stokes (1991) argues that the sunrise model has ignored other factors within a wider social context, including diversity of gender, socioeconomic class, religion and politics which may also affect individuals' health beliefs. This oversight could result in academics' missing from developing their students' critical cultural awareness and reflection (Duffy, 2001). Although the theory seems to ensure that patient care is sensitive to cultural needs, Baxter (2000) expressed concerns around over-simplifying the issues, since some patients may feel offended if they are treated according to their presumed culture. Furthermore, the theory pays too much attention to certain cultures, which could also cause patients and staff to feel like a 'special case' or to feel patronised by such intensive attention (Friedman, 1990).

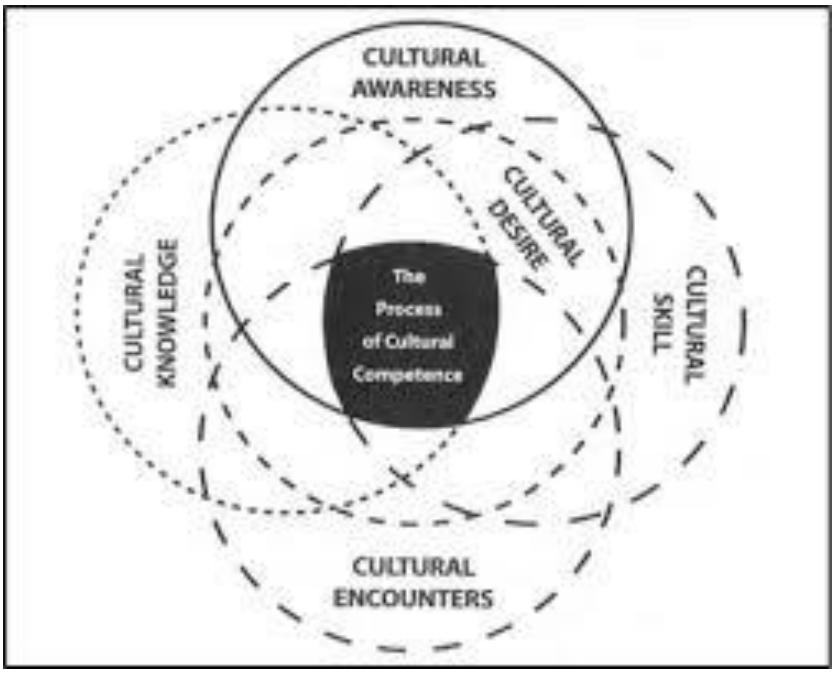
Following her sunrise model, Leininger also announced her 'Transcultural Vision 2020' (Leininger, 2001) whereby all nurses should be prepared to provide competent transcultural care globally by 2020. However, this approach was based on the assumption that all nurses wanted to provide care specifically to meet individual patients' cultural needs (Eisenbruch, 2001). It misses recognising or addressing the fundamental issues of prejudice and racism among some nursing and healthcare workers. Ahmad (1993) also expresses concerns that this transcultural approach may

cause institutional racism, that is when institutional systems and routine practices treat ethnic minority groups differently from their majority counterparts. Therefore, ethnic minority groups will continue to face difficulties in accessing healthcare if barriers, including racial discrimination, prejudice, stereotyping, hostility, and negative attitudes that blame culture as the root of ill health remain (Fletcher, 1997). In addition, the definition and vision of transcultural competence led to people seeing such competence as having an endpoint.

2.3.2 Campinha-Bacote's Process of Cultural Competence Model

Raised in a Cape Verdean community as a second-generation Cape Verdean, Josepha Campinha-Bacote, a clinical psychiatric nurse, realised that she was neither black nor white and was counted as 'other' among minority ethnic groups. This realisation triggered her interest in exploring wider differences between cultural groups. Blending medical anthropology, Pedersen's multicultural counselling framework (1988) and Leininger's transcultural nursing (1978), she developed the process of cultural competence model (Campinha-Bacote, 1998). Instead of considering cultural competence as a fixed and static entity, Campinha-Bacote viewed it as a dynamic process and believed practitioners should view themselves as becoming more culturally competent *practitioners* rather than culturally competent staff. Campinha-Bacote's culturally competent care model consists of five constructs: cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire (see Figure 2.4). Campinha-Bacote asserts that practitioners should seek to address these five aspects whenever they deal with culturally different clients, since the bigger the constructs, the more deeply practitioners internalise them (Campinha-Bacote, 2002). Compared to more linear models, Campinha-Bacote views these five constructs as interrelated and interdependent.

Figure 2.4 *The Process of Cultural Competence in the Delivery of Healthcare Service* (*Source:* Campinha-Bacote, *2002, p. 183)*



Campinha-Bacote's cultural awareness construct was based on her belief that lack of a self-cultural awareness may lead to practitioners' imposing their values and beliefs on to people from other cultures. She recognised that individuals' responses to healthcare needs can vary according to their accumulation of life experience and adaption to other cultures, important factors in avoiding stereotyping people according to their ethnic origin. Therefore, even though practitioners may have obtained fundamental knowledge of health beliefs and values, they are still required to assess patients individually rather than use presumed ethnic information. She also emphasises that practitioners should not consider themselves to be the expert in a particular group based on three or four encounters with specific members of that group, as variations exist within cultural groups. Campinha-Bacote argues that practitioners' superficially stating that they respect a patient's values and beliefs or implementing interventions based on the literature around effective care of a particular cultural group is not adequate. It is more important for practitioners to have the genuine motivation and desire to engage in cultural communication and interaction to provide care that is truly culturally sensitive and responsive. She calls this 'cultural desire'. The added constructs of 'cultural awareness' and 'cultural desire' are more advanced

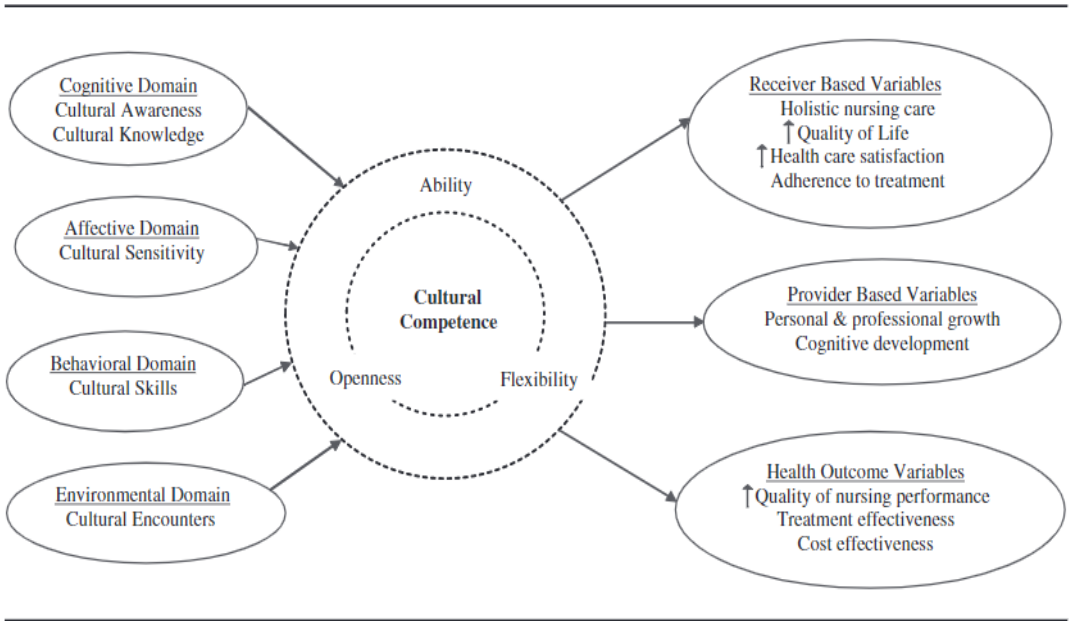
developments from Leininger's sunrise model. Therefore, this model has been well-recognised and is encouraged for use in clinical cultural practice development (Campinha-Bacote, 2001; Campinha-Bacote & Munoz, 2001), administration (Campinha-Bacote, 1996), policy development (Campinha-Bacote, 1997) and healthcare education (Campinha-Bacote, 1998b).

Despite its popularity, the model is criticised for its ethnicity and 'foreignness'-focused approach, which presents a rather narrow and essentialist view of culture rather than a more open-ended and fluid constructionist view of culture (Albarran et al., 2011). Furthermore, even though the core of Campinha-Bacote's model is based on cultural understanding and acceptance, such an ethnicity-based transcultural theory overly emphasises ethnicity and thus could cause some to view ethnic diversity negatively or as being problematic. This also cause traditional way of cultural care practice as 'acceptable' hence could be 'preserved and maintained', and label 'unacceptable' practice needs to be 'negotiated or accommodated' (Leininger, 2002b). Such notions reinforce the privileging of dominant knowledge, skills and attitudes of one culture over another (Albarran et al., 2011).

2.3.3 Suh's Cultural Competence Framework

Rooted in Leninger's transcultural care and Campinha-Bacote's process of cultural competence theory, Eunyoung Eunice Suh (2004) developed her comprehensive cultural competence framework in nursing. For Suh, transcultural competence comprises antecedents (i.e., cultural awareness, cultural knowledge, cultural sensitivity, cultural skills, and cultural encounters), attributes (i.e., ability, openness and flexibility) and outcome variables (i.e., outcomes of care receivers, providers and health) (Figure 2.5).

Figure 2.5 *Suh's Model of Cultural Competence (Source: Suh, 2004, p. 97)*



In addition to Campinha-Bacote's cultural desire, Suh asserts that an individual's ability, openness and flexibility are important factors in determining effective culturally competent care. In comparison to the two previous transcultural care models, Suh's model focuses on both healthcare providers' attributes and outcomes from both the care provider and the receiver's perspective. In other words, to achieve the best outcomes for receivers, providers and health variables, healthcare staff must develop appropriate cultural knowledge, skills, sensitivity and attitudes and sufficient exposure to cultural diversity. Suh's approach is the first-time outcomes have been included in a cultural care model. Omitting outcomes may restrict the effective evaluation of cultural care competence provision (Capell et al., 2007), since patient satisfaction and healthcare outcomes provide the most valid indication of effective care interventions, as they focus on the patient's experience of intercultural care rather than on the nature of the intercultural communication. As this approach requires investigation of how nurses communicate with patients, Suh's model is more theoretically supported than other models.

Despite its frequent adoption by researchers, the model has been criticised for being too abstract and complicated for students and nurses to grasp and therefore it was criticised for hard to implement (Perng & Watson, 2012). As with the other two transcultural nursing theories, Suh's model also ignores the history of exploitation and

colonialism which may result in unequal power relations in care provision. Even though lists of common features of cultural practice and lifestyle provide useful information and raise awareness of culture differences, without deep thinking and understanding the model could potentially be misused and cause stereotyping, in effect reinforcing institutional racism and prejudice (Lancellotti, 2008). Therefore, from a critical theory perspective, this transcultural nursing model is also inadequate to address power issues in nursing practice which, in turn, could undermine nurses' ability to challenge social injustice and recognise racism and health disparities. Farmer (2003) and Gustafson (2005) pointed out the potential risk of structural violence elements of transcultural care whereby racism and oppression can be re-inscribed by the dominant cultural group in professional nursing interactions. The only cultural care model in nursing that currently addresses racial, gender and other inequalities and emphasises cultural diversity is the cultural safety model (Papps & Ramsden, 1996).

2.3.4 Cultural Safety

The term cultural safety is derived from New Zealand's colonial history. New Zealand is a bicultural country consisting of the indigenous Māori people and migrants from mainly European countries. As a result of colonisation, Māori people have experienced significant disadvantages in health care services and consequently have poorer health statuses compared to other New Zealanders (Blakely et al., 2004). Their colonised history includes encountering threats to their self-determination and legal rights to ownership, development, autonomy, and authority which are essential to their health and wellbeing. In addition, stereotyping and the negative attitudes of healthcare professionals about Māori culture and lifestyle have a significant impact. It has also been reported that cost, travel, lack of culturally responsive services, fewer opportunities for referral for diagnostic tests and treatment have caused significant problems for Māori accessing health services (Ellison-Loschmann & Pearce, 2006). Consequently, Māori people have poorer health outcomes, prolonged recovery periods and shorter life expectancies (Health, 2004). In this model, cultural safety follows three steps: 1) cultural awareness, in which healthcare practitioners understand that there is a difference between cultures; 2) cultural sensitivity, which involves self-cultural exploration and identification; and 3) cultural safety, which is the final stage of development. This approach is based on the notion that "unsafe

practitioners diminish, demean and disempower those of other cultures, while safe practitioners recognise, respect and acknowledge the right people" (Cooney, 1994, p. 6). The student nurses' own identity, beliefs and assumptions in practice are formally examined (Nursing Council of New Zealand, NCNZ, 1992). Cultural safety therefore emphasises self-identification and the recognition that attitudes and behaviours impact on practice.

As this model was designed to address health professionals' and institutions' behaviours and attitudes in relation to safe or unsafe practice rather than to focus on diverse healthcare receivers, its focus was to raise awareness of power relationships and patients' rights rather than ethno-specific content (Papps & Ramsden, 1996). It was based on the notion that nurses' own identity, assumptions and attitudes towards others can seriously affect quality of service. However, since the cultural safety model focuses mainly on the needs of the indigenous Māori population, it could reinforce a fixed checklist of Māori people's cultural needs, potentially leading to stereotyping and bias (NCNZ, 2005). Moreover, simply having knowledge of a patient's culture may not account for the fact that a patient might deviate or change from their original culture (Desouza, 2008). It also does not give sufficient focus to the many other ethnic groups in multicultural New Zealand. Another criticism of this model regards the number of hours allocated to it in the nursing curriculum, since it has generated a significant amount of debate and discussion among both professionals and the public. Some complained that too much attention and study time were given to cultural safety in place of more 'traditional' content in nursing education, potentially 'compromising' the quality of pre-registration nurse education (Papps & Ramsden, 1996). Despite such criticisms, cultural safety addresses the unequal power relationship and racism that can exist in practice and which cause an emotional strain on those who experience it (NCNZ, 2005). This element is missing from existing transcultural care theories.

2.3.5. Summary of Cultural Care Theories

While transcultural theories primarily consider cultural encounters between nurses and patients from diverse ethnic backgrounds, i.e. they take a narrow view of culture, the New Zealand model incorporates a wider contextual view of culture thereby including not only Māori, but also other disadvantaged groups such as the homeless, children,

women and people with mental health issues. It therefore considers a broader view of cultural encounters. These transcultural models were developed from an American, European and Australian healthcare staff standpoint. The cultural safety model is the only model based on the patient's viewpoint considering the healthcare providers to be outsiders. In addition, these frameworks were developed based on their unique political and historical contexts. For example, the New Zealand framework addresses racism and other forms of oppression much more than North American, Australian, and Canadian frameworks do. The North American theories focused on Latin Hispanic, African American and ethnic minority immigrants (Leininger, 2002b) but did not include aboriginal people in Australia, while the New Zealand theory focused more on disadvantaged groups such as indigenous Māori, the homeless and people with mental health issues.

Transcultural care is rooted in Leininger's extensive professional nursing experience with people from diverse backgrounds. She also brings anthropological insights, religious view of care and creativity and the biological scientific medical view of human beings through her recognition that a global mindset is missing when caring for patients from diverse backgrounds. The following features were identified as key components relating to the meaning of cultural care competence in transcultural care models: 1) an awareness of cultural diversity among humans; 2) a list of abilities to care for patients from different cultures; 3) positive attitude towards people from other cultures, including open-mindedness, curiosity, and sensitivity. While the models all concur that knowledge, skills and attitudes are essential factors that determine effective culturally competent care, Campinha-Bacote added the notion that cultural encounters as well as cultural desire and cultural awareness are also key foundations in developing cultural care competence. Suh's framework is the most complicated and considers four domains as antecedents (cognitive, affective, skills and encounters). To these, three attributes of cultural competence (ability, openness, flexibility) and three variables (receiver-based, provider-based and health outcome) were added to highlight the importance of outcome variables in evaluating the effects of cultural care competence provision.

Transcultural care theory has helped to add culture into the human element of nursing care (Lancellotti, 2008). However, all of these competences are based on a narrow definition of culture, i.e., ethnic difference, rather than a broad view that incorporates age, gender and disability. Kersey-Matusiak (2012) commented that such an overt emphasis on ethnicity in the cultural aspect of care can lead to an 'us versus them/or the other' atmosphere and reinforce stereotypes and prejudice towards the EM population. This theory was also criticised for sustaining the status quo and neglecting critical social issues, since it addresses mainly the individualised nurse-patient relationship but not wider social inequalities. Research has shown that fundamental elements of a relationship involve recognising, valuing and respecting differences, and that people who support racism tend to hold an opposite view which is neither recognised nor challenged. In order to address social inequalities, it is important to allow voices to be heard, especially those of the vulnerable. This need is addressed in cultural safety, as the purpose of this model is aimed to reduce and eliminate the health disparities suffered by New Zealand Māori related to colonisation and linguistic and cultural barriers (NCNZ, 2005).

2.4 Byram's Intercultural Communicative Competence Theory

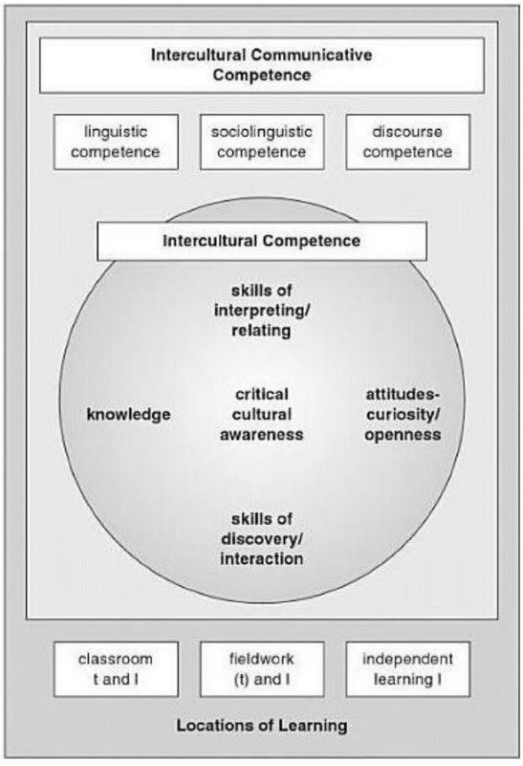
The transcultural nursing care models discussed previously are helpful to some extent in promoting respect for cultural diversity and recognition of cultural differences, including individuals' cultural influences as well as broader social economic and political factors. However, these models mainly focus on one's own position, rather than emphasising the intercultural 'in-between' position (Feng et al., 2009; Kramsch, 1993). This position is characterised by an interactive and exchange process between individuals from different cultural backgrounds and includes negotiating and adapting healthcare practices to accommodate different patients' beliefs and practices, to provide culturally sensitive care. To gain a deeper understanding of intercultural care encounters during clinical practice, it is useful to explore well-developed intercultural theories from other disciplines.

Intercultural competence (IC) theories have been widely recognised and used in education, business, and administration over the recent decades. Some theorists see the intercultural position as a 'third space' or 'negotiation zone' (Crozet et al., 1999),

while Byram (1997) speaks of the 'intercultural speaker'. He asserts that IC enables people to mediate/interpret the values, beliefs and behaviours of themselves and others and to stand on the bridge between people of different cultures (Byram & Zarate, 1997, p. 12). Based on these ideas, several contemporary IC models have been developed over the past two decades.

Byram's intercultural communicative competence model (Figure 2.6) was originally designed for use in foreign language classroom teaching for secondary school students, but it has since been widely recognised and cited across different fields (Corbett, 2003; Deardorff, 2009). Despite being designed for different discipline, the essential features of cultural competence may be useful in understanding nurse-patient intercultural encounters during clinical nursing practice; hence, Byram's intercultural communication competence model is explored here.

Figure 2.6 *Model of Intercultural Communicative Competence*



Source: Byram, 2009

Byram's (2009) model comprises five main components: linguistic, sociolinguistic, discourse competencies, IC and locations of learning. The first three dimensions relate

to language and sit at the top of the model. IC, which is positioned below these, encompasses skills of interpreting/relating, skills of discovery, knowledge, attitude/curiosity/openness, while critical cultural awareness (CCA) sits at the centre of the model. Locations of intercultural competences (which are similar to the *cultural encounter* in transcultural care theory) come at the bottom the model. These are: the classroom (between teacher and learner), fieldwork (teacher and learner or just the learner) and independent learning (just the learner) which would correspond to the ward where nurse-patient communication takes place, and the nurse's communication with his/her patients. Therefore, similar to Campinha-Bacote and Suh's models, cultural-related knowledge, skills, attitudes and encounters are essential components of IC in Byram's model. Byram argues that the individual's attitudes towards the person from a different cultural background with whom she/he is interacting is the foundation of all other four values, since he believes that without this basic competence, the other four cannot truly develop (Byram, 2012).

CCA is positioned at the centre of the IC box (Figure 2.6) to emphasise its importance "the ability to critically evaluate on the grounds of explicit criteria, perspectives, practice and products in one's own and other cultures and countries" (Byram, 1997, p. 64). As with cultural safety in nursing, Byram (1997) believes that linguistic learners should not only gain the 'deep learning' of their own and others' cultures but should also have the ability to analyse and criticise these through cultural study. He considers CCA to be the "rational and explicit standpoint from which to evaluate"; thus, CCA involves responsibilities and ethical and moral actions which directly link to and determine the outcomes of the other four components. Hence, CCA can not only enhance knowledge, skills and attitudes, but can also be used as the foundation for dealing with communication and interactions during cultural care encounters in healthcare settings.

Byram (2008) also added the supplementary element of 'action orientation' in which he highlighted strong 'active', 'interactive' and 'participative' features in IC. This orientation is in line with Barrett et al. (2013) who emphasis on the importance of action or application in intercultural encounters equates to the nursing process in daily practice.

Corbett (2003) notes that Byram's model is the most fully worked out specification in IC and involves the kinds of knowledge and skills required to mediate between cultures in such encounters. However, as Byram's model was designed for the language classroom, it lacks a healthcare context when applied in student nurses' clinical IC practice. Currently, transcultural care and cultural safety are the only theoretical models that guide clinical nursing practice and education. Therefore, fresh thinking is needed to create a framework that covers the essential features of transcultural care, cultural safety, and IC in nursing.

2.5 Summary

This chapter reviewed cultural education provision in nursing as one of the major strategies to tackle health disparities and improve health outcomes for patients from diverse cultural backgrounds. Developing a culturally competent workforce which has not only cultural knowledge but also competence in intercultural care remains the major strategy. However, recent research shows that educational provision around cultural care in healthcare and nursing is still un-unified and inadequate and that approaches to cultural care vary within pre-registration nursing programmes. Consequently, there is a need to conduct research on student nurses' experience when caring for patient from diverse backgrounds. The findings of the study will provide insight on issues in current nursing practice and education from the perspective of trainee nurses.

In order to identify essential components and current ideologies of culturally competent care, I described a number of models from mainly transcultural care and cultural safety theories. Three widely cited transcultural care models were critically reviewed: Leininger's sunrise model, Campinha-Bacote's process of cultural competence model and Suh's cultural competence framework, along with the concept of cultural safety. Table 2.1 highlighted their features, similarities, and differences. Although the concept of intercultural competence is not widely used in nursing, it is gaining traction in other professions. Byram's Intercultural Communicative Competence model was chosen as an appropriate framework to explore student nurse-patient intercultural communication in clinical settings. Despite not having been applied in nursing, this model covers common features of transcultural care (i.e., culture-specific knowledge,

skills, attitudes, and encounters) and addresses the importance of critical engagement through its critical culture awareness component and the supplementary element of application (or action taken), which shows Byram's model has potential to be adopted to the nursing field.

This literature review of cultural education, research studies and transcultural care theories suggests a lack of sufficient provision of culturally congruent care for people from ethnic minority backgrounds due to culture and language barriers. This inadequacy creates ineffective communication and potential misunderstanding of cultural differences by staff and consequently affects patients' satisfaction and health outcomes (Boi, 2000). A number of cultural care educational programmes in healthcare have been developed worldwide. These seem to have three main aims: to help staff and student nurses develop a better understanding of individual cultural differences; to better equip staff to provide culturally sensitive person-centred care; and to promote care that is more humane, dignified, and respectful. However, recent studies have revealed certain issues in relation to difficulties caused by a lack of a shared language, cultural knowledge and awareness which compromise the quality of care delivery and affect patients' satisfaction and health outcomes (Gerrish, 1997; Albarran et al., 2011). To manage the lack of a shared language, professional interpreters and family members are used. Some concerns were raised around both approaches and alternative methods suggested, such as using a remote telephone service. However, there is no evaluation data around using this strategy. Research has revealed that the majority of qualified nurses (especially overseas nurses) acknowledge their lack of cultural knowledge and a need to acquire this knowledge to enhance their intercultural care competence (Cortis, 1991; Henley, 1982; Murphy & Clark, 1993). Furthermore, most studies were carried out in the global North, in the US, Australia, New Zealand and Europe. In the UK, the studies were conducted 20 years ago and much has changed in nursing education since then. This situation suggests the need for deeper investigation into how student nurses might communicate to promote equality in line with the legislation (i.e. Equality Act 2010) to ensure patients from all backgrounds have equal access to high-quality care that is safe and effective. Therefore, as an experienced lecturer for pre-registration nursing programmes who is responsible for ensuring that the future nursing workforce is fit for

purpose (NMC, 2012), it is useful for me to conduct research to see how current student nurses experience intercultural care in clinical practice and to understand their views on culturally competent care.

Chapter 3

Research Methodology Framework

This research investigated student nurses' lived experiences in intercultural encounters (ICEs) during their clinical practice and explored how they engage in intercultural communication with others. In this chapter, I discuss how I answered the research questions by referring to the following three areas: the philosophical underpinnings of the study (3.1), its methodology (3.2) and methods (3.3). The philosophical section addresses what constitutes reality (i.e., the research paradigm, 3.1.1) and how to obtain knowledge (i.e., research strategy, 3.1.2). The methodological section refers to the theoretical explanation of how I, as the researcher, can gain an understanding of reality (Richards, 2015). The focus here is on the theoretical arguments around the data collection approach. It covers rapport and the potential for bias, the interview protocols and questions, the researcher's impact on interview narratives, language, sampling and data analysis approach. The methods section describes how I collected and analysed the data to reveal the participants' lived reality (Maggs-Rapport, 2001). Ethical considerations, research quality, reflexivity and reflection are reported in sections 3.4, 3.5 and 3.6, respectively.

3.1 Philosophical Considerations

The researcher's philosophical standpoint is the set of fundamental beliefs held by that researcher that guide the entire research process. These assumptions help to shape how the research is formulated, the research question/s asked and how the researcher identifies information to answer the research question/s (Creswell, 2013). It is therefore important to address my philosophical position, the research paradigm, and the research strategy.

3.1.1 Research Paradigm: Social Constructionism

Social constructionism was considered the most appropriate paradigm to guide this study as it sees the social world as existing in the context of the human mind (i.e., agents construct reality), so reality can only be accessed when the individual is thinking about it and interacting with others. In other words, a social constructionist's world of variety and fluidity is not something natural or given; instead, it is caused by

humans' moment-to-moment interactions and ongoing revision of concepts such as culture or organisation (Currieet al., 2012). Therefore, the social constructionist view of reality is local and specific and dependent upon the individual. Social constructionist researchers, therefore, emphasise the individual's interactions and relationships with other people. Creswell (2013) also points out that an individual's personal background and specific context shape their interpretation and interaction with others. Consequently, individuals' versions of social reality at specific times depend on their relationship and interaction with the social world and change through a continual process of construction and reconstruction (Creswell, 2013).

From the cultural research perspective, Holliday's (2016) 'grammar of culture' illustrates the dynamic and negotiable feature of culture, echoing the notion of social constructionism. He notes that we are all 'cultural travellers' constantly moving across a cultural environment, and through interaction and communication within our small cultural group (such as in a hospital workplace, in relationships and friendships), individuals' minds travel across social and temporal frames to make sense of their intercultural experience. During interactions, the individual observes and contrasts their values and behaviour to find common ground to negotiate and construct their tolerance of the other cultures encountered. Nugus (2019) illustrates how communication and interaction in healthcare settings such as a hospital are the outcomes of a series of negotiated actions by the individuals involved rather than the prescribed actions of doctors, nurses and other health professionals following a professional code of conduct. This negotiation process includes the constant establishment of interactions, review, forgetting, revision, and termination. Becker (1982) and Nugus (2019) support the notion of social constructionism, arguing that people adapt and form their cultural perspectives constantly in response to their immediate interactions and that there is no perfect set of cultural descriptions and solutions to solve everyday culture-related problems. My 12 years of observation and personal experience as a staff nurse at different hospital departments in China and the UK, and a further 16 years as a senior lecturer providing guidance and support to pre-registration student nurses on theoretical and clinical practice, have indicated that intercultural communication within healthcare settings is a negotiable and adaptable process which one built in and through interaction rather than externally prescribed and fixed set of behaviours. Therefore, given that my study focuses on the interactional,

dynamic and contextual nature of intercultural communication and interaction, a social constructionist approach was chosen for this research.

3.1.2 Research Strategy: Interpretive Qualitative Inquiry

Quantitative and qualitative strategies are two distinct epistemological foundations commonly used in social research (Bryman, 2012). Quantitative researchers follow a positivist epistemology and align more with the natural sciences. Epistemology relates to what and how we can know knowledge (Bloomberg, 2012). Quantitative researchers believe that social reality is an externally independent, stable and objective world which is measurable, so they tend to pay particular interest to quantifiable data in the research process. Quantitative research tests hypotheses through deductive processes (Bryman, 2012) and identifies causality to generalise the findings to a wider population (Harding, 2019). In contrast, qualitative researchers believe social reality is subjective and varied; they are interested in complex views and the experiences of individuals. Simplifying these into a few categories is not their objective. They follow an inductive process and focus on words (verbal or written) that describe an individual's subjective interpretation of the world (Bryman, 2012). Creswell (2013) asserts that the qualitative researcher intends to understand the deep meaning of the social phenomenon through individuals' descriptions of their experience, which is why qualitative research is also called 'interpretive' research. Based on the following three considerations, an interpretive qualitative research strategy was considered appropriate for this study:

The first is an epistemological consideration. Whereas an objectivist's interests would focus on the controllable concerns of the researcher (Denzin & Lincoln, 2005), interpretive qualitative research approaches are rooted in a concept of individual subjectivity, which is used to interpret important personal life events such as student nurses' experiences and perceptions of ICEs. This approach requires sensitive interpretive skills and a strong desire to first gain a good understanding of a social phenomenon through seeing and sensing what the participants perceived and then to derive and address meaning (or something meaningful) from those individuals' perspectives (van Manen, 2006). The original motivation of this study was to gain a deep understanding of the internal meanings of student nurses' lived experiences through their descriptions of 'what' they have experienced, 'how' they perceived it and

'why' they think the way they do. Therefore, a qualitative approach was deemed best suited to achieving my research objectives.

Second, from a cultural anthropologist's perspective (Hall, 1990; Moon, 1996), a quantitative approach identifies cultural determinants and cultural values in intercultural communication and behaviours across different nations and ethnic groups. However, Levine et al. (2007) argue that such quantified comparative approaches are inadequate for social research, which aims to develop an understanding of human interactions and relationships, especially in specific contexts such as in hospitals where the majority of the patients are native populations. It is my intention to avoid ethnocentric error by including participants from a range of ethnic cultural backgrounds to allow all student voices to be heard, expose some taken-for-granted assumptions and develop an insight into some of the deep issues or challenges student nurses' encounter. Therefore, a qualitative approach was considered the most appropriate for this study (Otten & Geppert, 2009).

The social constructivist ontology and qualitative interpretative epistemological standpoint led me to formulate the following research questions (RQs) and subquestions to explore the experience of student nurses when interacting with cultural others during their clinical experience.

RQ1: How do student nurses experience intercultural nursing care in their everyday clinical practice?

- Does their own culture affect their approach to others? If so, how?
- What positive experiences do they encounter? How do they perceive these experiences?
- What challenges do they encounter? How do they perceive and manage these?

From this exploration and understanding of student nurses' intercultural nursing care experiences, I explored the following:

RQ2: What intercultural competences are salient in facilitating effective intercultural nursing care?

- What are the factors and features of effective intercultural encounters in clinical nursing practice?
- What are the relationships among these factors?

3.2. Methodology

Qualitative inquiry requires a particular methodology. To obtain the detailed information required to depict individuals' lived clinical experience when communicating with people from diverse backgrounds as accurately and fully, data collection methods must be able to produce as informed and sophisticated information as possible (King, 2010). To collect such rich data, methods that have minimum structure and maximum depth, such as observation, documentation, focus groups, and interviews, are commonly used.

One-to-one, face-to-face, in-depth interviews are considered the most appropriate qualitative research data collection method. The interview is considered an effective data collection method since it stimulates detailed stories, thoughts, and feelings from the participant (Creswell, 2013). King (2010) asserts that interviews elicit detailed stories, thoughts, and feelings from participants so they can provide a rich, detailed, first-person account of their experience. Harding (2019) also pointed out that interviewing allows the researcher and participant to engage in a dialogue whereby initial questions are modified according to the participant's response, and the researcher can then ask further questions if any other interesting topic areas arise. Thus, the researcher has the opportunity to listen to a participant's narrative of their experience and explore the relevant issues by asking further probing questions over a substantial period of time. In this way, participants' subjective views of their social world can be captured. Despite being time-consuming and requiring some skills to organise and conduct effectively, one-to-one interviewing allows the production of a large amount of data and brings insights into 'what' participants perceive and 'why' and 'how' these thoughts and feelings develop. In addition, the interview allows the researcher to clarify and ask any follow-up questions that are important and relevant to the research topic (Smith et al., 2009).

This study did not adopt other qualitative research methods such as observation and focus group. This is because my research is related to student nurses' personal

experience and views about their ICEs. As these could be sensitive, participants may not feel comfortable sharing their experiences and thoughts with their peers in focus groups. Furthermore, Liamputtong (2012) noted that confidentiality may be an issue in focus groups, as it can only be requested by the researcher but not enforced. As such, focus group was not considered an appropriate data collection method for this study. Due to the changing population, including staff, patients and visitors who access the ward area, gaining informed consent for observation might also have been difficult, and presented ethical issues. If participants are aware of being observed, they may not behave or interact naturally, a factor which would affect the principle of naturalism (Harding, 2019). During observation, my role as the researcher is automatically involved in the activity; consequently, my position as the senior lecturer to nursing students might have altered the natural behaviours of the students. Consequently, observation was not considered a viable data collection method.

3.2.1 Sampling Strategy

This study adopted **purposive sampling**, which refers to selecting respondents who most fit the purpose of the research. In this study, these are student nurses from the adult nursing field who have done their placements. Bryman (2012) commented that most qualitative researchers use purposive sampling since it entails an attempt to establish a good correspondence between research questions and sampling. In other words, the researcher selects participants who have experience relevant to the research questions. As this study relates to the intercultural aspect of nursing education, purposive sampling was conducted to recruit people with experiences in this area (Bryman 2012). I recruited as many participants as possible from various backgrounds, different years of study, genders, ethnicities, and countries of origin (see Table 3.1), whose clinical ICEs had taken place in healthcare settings as part of their Pre-registration Adult Nursing clinical placements. They were recruited via email, classroom announcements and word of mouth (snowball sampling) from other students. I also used snowball sampling to increase my sample. I invited participants identified in my purposive sample to voluntarily spread the word of the research, as they thought their fellow nursing students had some special experience which might contribute to the study and so encouraged them to participate (Harding, 2019).

Table 3.1 *Participants' demographic data*

Year 1				Year 2				Year 3			
Pseudonym	Ethnicity	Gender	Age	Pseudonym	Ethnicity	Gender	Age	Pseudonym	Ethnicity	Gender	Age
Azindoo	Ghana	M	39	Feihong	Chinese	F	43	Aoife	N. Irish	F	**32**
Miremba	Uganda	F	31	Zabe	Zimbabwe	F	36	Dakila	Filipino	M	43
Nesta	Zimbabwe	F	26	Aminsa	Nigeria	F	22	Mourhinda	Guyana	F	38
Tani	Ghana	F	38	Saanvi	Indian	F	36	Mohammad	Iran	M	43
Corazon	Filipino	F	34	Cara	N. Irish	F	27	Eira	Welsh	F	34
Matthew	English	M	24	Emily	English	F	28	Susan	English	F	24
Grace	English	F	21	Tony	English	M	20	Linda	English	F	31
Ruby	English	F	25	Hannah	English	F	43	Margaret	English	F	21
Michelle	English	F	38	Eve	English	F	32	Jessica	English	F	42
Sophie	English	F	20	Angela	English	F	21	Rebecca	English	F	29
Jasmine	English	F	34	Alice	English	F	40	Barbara	English	F	28
James	English	M	22					Laura	English	F	21
Aimee	English	F	29					Amber	English	F	23
Daisy	English	F	42					Emma	English	F	22
								Nancy	English	F	21
								Zoe	English	F	41

Qualitative studies usually have fewer participants than quantitative studies, so within that small sample, the researcher can examine convergence and divergence in some detail based on individual participants' interpretation of their experience. Baker and Edwards (2018, p. 5) note that inexperienced qualitative researchers tend to conduct more interviews based on their assumption that doing so is 'seen as better'. They argue that instead, it is the care, time and quality of the convincing rich and complex narrative analysis that matters, rather than the number of interviews since qualitative researchers are expected to explore participants' minds deeply to understand how and why people perceive what they do and how they interpret and interact with the situation.

Saturation indicators are used widely in qualitative studies. Saturation occurs when the interpretation becomes visible and clear, and no new findings and meanings can be derived from the data (Creswell, 2013). However, O'Reilly and Parker (2013) argue that saturation has multiple meanings when used in different research approaches and is, therefore, questionable if used as a sole indicator of sample adequacy. Smith et al. (2009) recognised that, in reality, data is unlikely to reach saturation since interviews can always yield something new. Harding (2019) asserts that it is usually the amount of time and resources available that determine when to stop collecting data. Bryman (2012) also suggests four other factors determining the sample size. The first is the

breadth of the research question. The second factor is the analytic approach of the study. The third factor is the characteristics of the sample population. The fourth factor concerns the minimal requirement. Baker and Edwards (2018) suggest a median sample size of 30 is sufficient if the interview is complemented with participant observation, and Bryman (2012) suggests a minimum of 20-30 participants for interview-based qualitative research. In order to capture the variability in year 1, year 2 and year 3 student nurses' experiences and world view, 41 participants (table 3.1) were recruited from pre-registration adult nursing students at one university of North East of England who had undertaken their clinical practice in healthcare settings serving a multicultural population, including people with different countries of origin. More detailed information about the research setting, access to the field and recruitment are reported in section 3.3 Fieldwork.

3.2.2 Data collection method – interview

The primary aim of the study's interviews is to facilitate the investigation of student nurses' perceptions and experiences of ICEs. The semi-structured approach was chosen, since it offered both spaces to pursue topics of particular interest to the participants and flexibility in terms of the order or wording of questions, thus enabling good insights from student nurses regarding their clinical ICEs. At the same time, a degree of structure prevents the conversation from straying too far from the context of the study for too long (Smith et al., 2009). Constrained by time and opportunities to obtain in-depth information from the participants, a balance between maintaining focus on the research issues and avoiding excessive control is needed. As a new qualitative researcher using semi-structured interviews, I developed a research protocol in advance with some pre-set interview questions, which will not only relieve nervousness but also make the data analysis easier (Harding, 2019).

Interview Protocol

Creswell (2013) asserts that an interview protocol can be used to guide the interview and to help the researcher think through the interview process, including: potential interview questions; how to ask these; how to respond to participants; and how to predict and manage any potential problems that might occur, such as handling potentially sensitive questions. Even though the interview protocol has a list of the

prompt questions, it is much less specific than a structured interview schedule; having a brief list of prompts for the research areas to be covered still proved flexible when the interviews were conducted.

The interview protocol may include full questions or words or phrases as *aide-mémoires* (Hennink, 2011) as reminders of the key areas to be covered in the interview. Even though the full questions can be viewed as inflexible, as a new researcher with English as my second language, I was able to think about the interview questions' wording and sentences in advance to avoid potential confusion or misunderstanding (King, 2010). Having an interview protocol eased my anxiety as I did not need to worry about forgetting to ask certain questions. In terms of the style of interview questions, Bryman (2012) asserts that open questions help to avoid any assumptions the researcher might have and which may lead participants towards particular answers. Open and expansive prompts also facilitated my interaction with the participants, allowing them to describe and evaluate their detailed experience at length (Smith et al., 2009).

When ordering the sequence of interview questions, moving from relatively descriptive questions to more analytical questions is recommended, so that participants feel comfortable talking early on in the interview before more analytical questions are posed. To ensure the interview flows, questions can be re-ordered; however, doing so requires good listening skills to make sure all the research topics were covered (Roulston, 2010). For instance, when participants only covered part of a topic or provided information that required further information, the interview protocol could be used to ask follow-up questions. My interview protocol incorporated an introduction, prompts and strategies for dealing with difficult situations and was constructed before the interviews (see Appendix 1). I also highlighted keywords in red to make myself quickly eye-catching key questions and ensured they were answered.

Interview Questions: Autobiography of Intercultural Encounters

Good interview questions are pivotal if a phenomenon is to be explored sufficiently. As Braun and Clarke (2006) point out, good data is fundamental to generating good analysis reports; furthermore, the information collected should go beyond surface-level common sense statements and instead must be deep, rich and complex. The

researcher, therefore, needs not only to have effective interview skills but also to prepare a list of useful and relevant questions to ask at the interview to reveal the individual's reality. To achieve this end, the autobiography intercultural encounter (AIE) technique was chosen (Byram, 2009), as it is useful to stimulate individual's personal stories and is commonly suggested for use in qualitative educational and healthcare research (Alkheshnam, 2012; Koyama, 2012).

Byram (2009) commented that the **AIE** is an instrument to explore individuals' intercultural experience by asking a series of questions that prompt them to recall an encounter with people who they perceived as 'the cultural other' no matter how close or far those people were in terms of time or place. Autobiography, also called 'story of personal life' (Méndez García, 2016), encompasses personality, identity and multiple social memberships, including nationality, language, gender, age and class (Thurlow, 2004). **Intercultural encounter** refers to an individual's interaction with people whose language, ethnicity, religion, gender and other features are different to themselves (Méndez García, 2016).

AIE follows a 'looking back' and 'looking forward' structure (Byram, 2009). It includes presenting the background of the encounter and interactions; exploring personal feelings and assumed feelings of others involved; identifying similarities and differences; and summarising what should be done (if anything) as a consequence. In this way, the stories become the bridge between the past and the future, i.e. through the AIE structure, an individual is guided through their interpretation of past experience(s) to identify points for future development. Therefore, AIE helps individuals share insights into their private world (Pavlenko, 2007) and fosters intercultural understanding (Byram, 2009) through constant negotiation and assessment between the self and the other's values, beliefs and assumptions in context.

Byram (2009) comments that individuals can also benefit from this process by making sense of that experience and deciding how to take ownership of their intercultural world. However, Trahar (2009) reported that people tended to feel uncomfortable

exposing their thoughts and were, therefore, reluctant to share their autobiographical perceptions as doing so could make them feel vulnerable and insecure, especially when the topic is related to sensitive issues. Participants, therefore, might not provide an honest view of their intercultural experiences. Nevertheless, Byram (2009) argues that AIE encourages and guides individuals to reflect on experiences that have special meanings or significance; to consider the skills and knowledge they have or should have had at the time—and hence enhances self-awareness. Jackson (2005) reported that such a reflective experience could develop critical cultural awareness and social skills. By allowing personal and deeply hidden ideas to surface, self-knowledge may be enhanced, allowing participants to question their values, beliefs, attitudes and behaviours around ICEs. Given these advantages, the research's topic and its aims, AIE was considered appropriate to be used as the guide to develop an interview protocol.

Different types of interview questions were used to collect factual information such as demographics (age, gender, ethnicity, years of study, previous ICEs). Other types of questions focused on participants' observations and experiences; actions they have taken and feelings at the time; and perceived opinions. A series of AIE questions and prompts were used as the guide to ask the participants about experiences that had been particularly important to them. In this study, the questions regarding knowledge and skills are: *'Did you know these differences before?' 'Where did you get these knowledge/skills from?' 'How did you acquire them?'* Questions about behaviour included: *'How did the patient choose their menu?'* Questions relating to attitude and feelings included both positive and negative aspects: '*How do you think the patient felt at the time?'* The questions regarding actions included: '*What did you do? Do you think you did the right thing? Why?*' *'What will you do differently should a similar situation occur again?'* Interview questions were primarily descriptive to encourage participants to be analytically involved, in order to achieve so, demographic questions were asked first to make interviewees feel comfortable (Harding, 2019). They were then invited to answer more analytical questions (Bryman, 2012). These questions helped participants to reflect on a particular event and think about what they had learned or should learn from an intercultural encounter; what actions they had and had not taken and why; how an individual was perceived, responded and felt at the time; what

aspects of the event had special meaning to them; how they responded; and how they understand ‘others’ and ‘other cultures'.

Researcher’s Impact on Emotional Narratives

Denzin (2007) commented that emotion is the essence of being human. The purpose of qualitative research is to use the researcher as an instrument to reveal the world of the participants, meaning that the researcher engages not only intellectually but also emotionally with participants to reveal their deeply hidden stories (Dickson-Swift, et al., 2009). Thus, research into emotionally sensitive areas may impact everyone involved, including the researcher, participants, or transcriber. Such research requires emotional labour on the part of the researcher, who must not only manage their own emotions but may potentially be expected to help the interviewees manage theirs, since if the emotion is not managed well, the researcher may vicariously experience participants’ negative emotions generated through the research (Dickson-Swift et al., 2009). Some research has revealed that even transcribers, who have no direct contact with the participants, can be affected emotionally when interviews involve a sensitive topic, and they become so deeply immersed in the voices and stories of the research subject (Cameron, 1993; Darlington, 2002; Etherington, 2007; Lalor et al., 2006; Melrose, 2002; Warr, 2004). Such emotional disturbances may manifest as exhaustion, anxiety, disconnection from friends and family or social isolation (Lalor et al., 2006). Therefore, it is important to recognise and acknowledge potential physical and psychological effects in the early stages of research, especially for novice researchers like me, so that preventative measures can be taken, such as encouraging myself to think more about my own well-being at the design stage.

3.2.3 Data Analysis method – thematic analysis

Qualitative data analysis allows the researcher to make sense of the raw data through exploring, interpreting, and generating understanding and meaning (Boeije, 2010). Braun and Clarke (2006) refer to data analysis as a deliberate and self-conscious effort to break down individual data into pieces to put all cases together creatively to produce a report constructed meaningfully and relevant to the research objectives with plausible arguments. However, this process is often messy as such detailed data does not automatically fall into neat categories (Van der Zalm & Bergum, 2000). Therefore, an effective analysis method is crucial to interpret and present the phenomena.

The thematic analysis method, which is recognised as the most fundamental approach in qualitative studies (Vaismoradi et al., 2013), was adopted in this study since it can help the researcher identify what has happened and answer the research questions relating to people's behaviour, attitudes and motivations (Braun & Clarke, 2006). In addition, thematic analysis can offer thick descriptions of the data and its products, e.g., summaries that show the key features of the dataset, enabling wide variety as well as commonalities and differences within the dataset to be identified. Furthermore, thematic analysis is useful to identify, analyse and report patterns and themes within the data, thereby transforming description into interpretation in a continuous process (Braun & Clarke, 2006). Following a strategic analysis process, themes emerge from a series of reflective thoughts and a review of the data from various perspectives (Desantis & Ugarriza, 2000). Braun and Clarke (2006) emphasise that analysis is an active process of identifying codes and themes, selecting interesting ones and reporting to readers rather than a passive process based on the assumption that themes will emerge automatically over time. As a novice qualitative researcher, such a flexible and accessible thematic analysis method seemed the best approach to analyse 45 hours' worth of interview data (see Table 3.2 and Appendix 8) and to answer the research questions.

Table 3.2 *Participants' interview times*

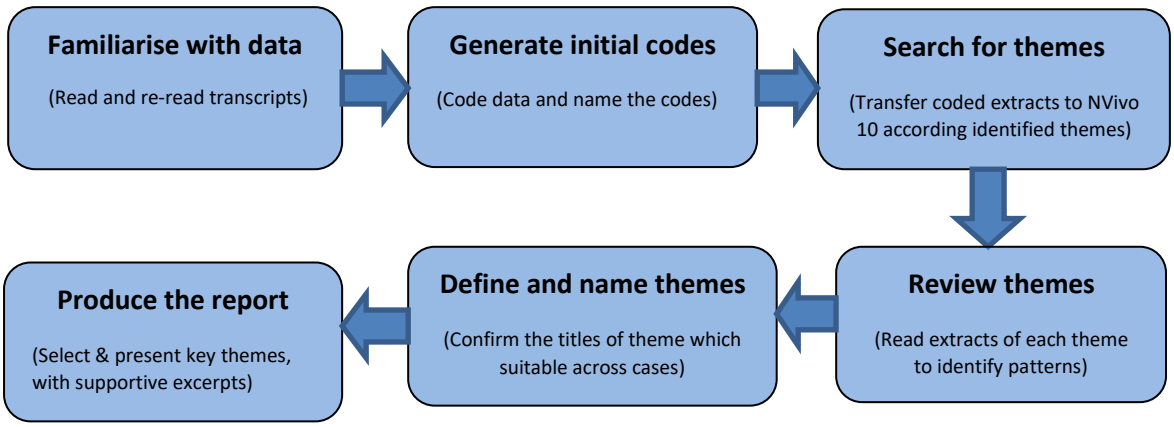
Year 1			Year 2			Year 3		
Pseudonym	**Ethnicity Origin**	**Interview Time**	**Pseudonym**	**Ethnicity Origin**	**Interview Time**	**Pseudonym**	**Ethnicity Origin**	**Interview Time**
Azindoo	Ghana	1hr 56mins	Feihong	Chinese	1hr 30mins	Aoife	Northern Irish	54 mins
Miremba	Uganda	1hr 11mins	Zabe	Zimbabwe	1hr 01mins	Dakila	Filipino	1hr 30mins
Nesta	Zimbabwe	54mins	Amins a	Nigeria	1hr 21mins	Mourhinda	Guyana	1hr 20mins
Tani	Ghana	1hr 33mins	Saanvi	Indian	1hr 15mins	Mohammad	Iran	1hr 42mins
Corazon	Filipino	27mins	Cara	Northern Irish	56mins	Eira	Welsh	1hr 01mins
Matthew	England	47mins	Emily	England	58mins	Susan	England	58 mins
Grace	England	1hr 19mins	Tony	England	20mins	Linda	England	1hr 01mins
Ruby	England	1hr 02mins	Hannah	England	1hr 15mins	Margaret	England	41 mins
Michelle	England	1hr 29mins	Eve	England	1hr 22mins	Jessica	England	57 mins
Sophie	England	35mins	Angela	England	1hr 17mins	Rebecca	England	48 mins
Jasmins e	England	42mins	Alice	England	1hr 21mins	Barbara	England	1hr 04mins
James	England	1hr 13mins				Laura	England	1hr 05mins
Aimee	England	55mins				Amber	England	1hr 24mins
Daisy	England	1hr 05mins				Emma	England	45 mins
						Nancy	England	55 mins
						Zoe	England	1hr 15mins
Total (45hrs 04mins)		15hr 8mins			14hr 36mins			15hr 20mins

Thematic analysis is useful for examining commonalities, differences, and relationships. Examining commonality refers to identifying similarities across the dataset, and this can then be further analysed to understand why and how similarities

occur in a particular group (Braun & Clarke, 2006). Conversely, examining differences means exploring how different parts of the findings are connected and contribute to the overall understanding of themes and phenomena. Thematic analysis is flexible, allowing the researcher to choose the appropriate level of analysis according to the research objectives. It involves searching across the entire dataset to find repeated patterns, themes of meaning and aspects of interest in the data using a variety of levels of interpretation relevant to the research question. Therefore, thematic analysis can be used for describing the entire dataset as well as for a detailed interpretation of one (or a few) aspects of the phenomenon. As such, before the analysis was conducted, I decided on the level and process of analysis to be used within my thematic analysis.

Braun and Clarke (2006) describe six steps in thematic analysis (figure 3.1): to identify themes and categories emerging from the data, including becoming familiar with the data, generating initial codes, searching for themes, reviewing, and refining the theme, defining, and naming themes, and reporting. They also point out that analysis is not a linear process from steps one to six but a more 'recursive' process (Braun & Clarke, 2006, p. 86), where the researcher moves back and forward throughout the process. The detailed analysis process in this study is reported in section 3.3.3, and the key findings are reported in chapter 4.

Figure 3.1 *Thematic analysis process (Braun & Clarke, 2006)*



Become familiar with the data

Becoming familiar with the data requires the researcher to read and re-reread it, summarising it using 'constant comparative' methods (Braun & Clarke, 2006). This step helps the researcher to identify patterns and interesting aspects, understand surface meanings, and summarize key features from individual participants (Harding, 2019). While reading and rereading the transcripts helps to immerse the researcher in the data, Barbour (2007) adds that summarising is an essential part of qualitative data analysis since it helps to identify patterns and allows for insights across the entire dataset, thereby reducing the initial transcribed data to a smaller set, ready for next step of comparison and contrasting between interviews.

Generating initial codes

Walton (2000) comments that a **code** is the most basic segment of raw data, representing an interesting feature that may be analysed in a meaningful way to help answer research questions. Coding is a process of selecting, separating and sorting data (Charmaz, 2014), to achieve the aims of thematic analysis. A code draws attention to a commonality within a dataset (Gibson & Brown, 2009). Even though using constant comparative methods and coding together might speed up the analysis, Harding (2019) suggests that the novice researcher is better at doing these separately since the coding is a rather superficial mechanical process, compared with deeply thinking about the meaning of the data. Coding can be done manually or by using Computer Assisted Qualitative Data Analysis (CAQDA) software, such as NVivo (Bazeley, 2013). NVivo is more efficient than manual data analysis, as it removes time-consuming physical tasks such as writing code on transcripts and cutting/pasting chunks of text (Bryman, 2012). In addition, NVivo allows reflexive annotation to record how codes were created, and how the data were analysed, which is helpful for more in-depth analysis (Harding, 2019). However, Blismas and Dainty (2003) commented that using a hierarchical order may restrict other types of relationship analysis. As a novice researcher, I started with a paper-based coding process to note down the initial codes at the side of the transcripts on the first few interview data and then transferred these codes to NVivo to create electronic codes to analyse the rest of the interview dataset.

Searching for and reviewing themes

Searching for and reviewing themes involves categorising related codes and then checking to see if the categories match the coded extracts across the entire dataset. These processes, together with code generation, are repeated and refined before a conceptual theme is created (Braun & Clarke, 2006). A **theme** is a participant response, repeated across the dataset, that captures something important and relevant to the RQ and is hence worthy of attention (Braun & Clarke, 2006). A **category** is the descriptive name of that group. Therefore, a theme is generated from the 'latent' text, hence is abstractive (Graneheim & Lundman, 2004), whereas a category is created from 'manifest' text content (Desantis & Ugarriza, 2000), hence is descriptive.

Naming and defining themes

Each specific theme in relation to the overall story of the findings is then given a name and descriptive definition by the researcher. Braun and Clarke (2006) suggest that the name of the theme should be precise, to the point, and easy for a reader to grasp and understand its meaning straight away. In addition, the scope of each theme in terms of what is or is not included should be concise, i.e. one to two sentences. In this study, 5 key themes were emerged following thematic analysis, namely intercultural care encounters, knowledge and awareness, skills, attitude, engagement, and outcomes (section 3.3.3 and chapter 4).

Interpreting data and producing the report

The purpose of the deep analysis is to identify conceptual themes and develop a theory by interpreting patterns in the data and understanding the underlying meaning of the stories. Braun and Clarke (2006) suggest that the analysis should go beyond the surface and uncover hidden meanings that explain why and how the respondents feel and act the way they did, linking these to the overall story and wider debates with literature support. In this way, underlying explanations are explored, and potential implications are considered. After analysing the data, I created an innovative Intercultural Care Competence Ecological Framework to illustrate the six essential domains of intercultural competence and their relationship to some internal and external factors that emerged from the data (see Chapter 5.1). At this final stage, the researcher is also expected to identify and select vivid and compelling examples

relevant to the research questions and link these to existing literature to explain the phenomenon. The detailed findings of this study are reported in Chapter 4.

3.3 The Fieldwork

Fieldwork goes beyond data collection and analysis. In order to gather useful information and gain a good understanding of the data collected, I carried out a series of actions. Following the ethical approval, 41 participants were recruited and participated in face-to-face semi-structured interviews lasting 27–120 minutes at the participants' university. The interviews were digitally recorded and transcribed verbatim for thematic analysis. This section reports the research setting, access to the field and recruitment (3.3.1), lessons learned from the pilot study (3.3.2) and a detailed report of the main study process (3.3.3).

3.3.1 Research Setting, Access to the Field and Recruitment

Participants were undertaking their 3-year full-time pre-registration adult nursing course at one university in North East England. This programme is based on an apprentice-type model (similar to teacher training schemes) designed to include periods of clinical experience with associated theory taught in university (see section 2.1). The students' clinical placements took place in healthcare settings serving a multicultural population from different countries with diverse cultural needs. Clinical experience is underpinned by a substantial service contribution, with student nurses providing up to 50% of study times providing clinical nursing care and being integral to service delivery.

After obtaining ethical approval from the University Education Ethics Committees at both the participants' and my doctoral programme university, I commenced participant recruitment in May 2015. Recruiting student participants to the study involved three levels of negotiation: 1) obtaining permission from the head of the department to allow me to conduct research with adult nursing students. 2) accessing the subject head, class teachers and personal tutors for introductions to the relevant students to allow me to explain the project to them. 3) gaining individual students' interest and willingness to participate in the study. The research purpose was explained using a research information pack (Appendix 2), followed by a combination of invitation emails

and in-class recruitment of adult nursing students between June and July 2015 (Appendix 3). One benefit of working in the same department was that I received permission from both levels of gatekeeper relatively quickly. Although Fetterman (2010) suggests asking respected gatekeepers to introduce the project to potential participants, Harding (2019) notes that sensitive topics might raise concerns about confidentiality or about students' being penalised academically if they raise concerns about staff, which may account for the fact that within a month after the subject head had sent the email invitation to students no responses had been received. Another reason for this low response situation was possible that students preferred face-to-face communication, which could reassure them of confidentiality and anonymity and offer them the chance to ask questions to clarify any concerns they might have.

The face-to-face classroom recruitment was challenging initially due to my lack of experience as a researcher and my position as a senior lecturer. Consequently, no students responded to the initial face-to-face classroom recruitment. On reflection, I concluded that my approach may have been too similar to that of my lecturing style, which did not put students at ease in terms of sharing their personal experiences. I, therefore, changed my approach, adjusting my language and tone of voice, and explained the importance of participation and sharing experiences and humbly invited them to participate as valuable knowledge holders. This approach helped to build a relaxed, friendly atmosphere in which students were more motivated to participate and to ask questions. I also emphasised more clearly the confidentiality and anonymity procedures in place. To maintain anonymity at the recruitment stage, I left a box for students who were willing to participate and provided envelopes for all students so that they could return their completed invitation letters to me should they decide to participate. Eventually, forty-seven candidates volunteered to participate in the research. One left the programme unexpectedly; 5 were from the mental health or paediatric fields, which had different training contents and different ways of communication. Forty-one students fit the inclusion criteria (i.e., existing Pre-registration Adult Nursing students with clinical intercultural experience) and were recruited to participate in the study. Of these, 5 were male, and 37 were female (see Table 3.); 12 self-identified had an Asian- or African-based ethnic origin, and 4 were from different parts of the UK. Two were aged under 20; 18 were aged 21–30; 14 were aged 31–40; and 7 were 41 or older. Given my study purpose, study design,

heterogeneity of the population, theoretical approaches and available resources, a sample size of 41 was considered sufficient (Bryman, 2012; O'Reilly & Parker, 2013).

Table 3.3 *Participants demographic information*

		Age group				ME		Other part of UK			Gender	
Year group	Total	18-20	21-30	31-40	41-50	Asia	Africa	Northern Ireland	Welsh	English	Male	Female
Year 1	14	1	6	6	1	Philipino 1	Ghana 2 Uganda 1 Zimbabwe 1	0	0	9	2	12
Year 2	11	1	4	4	2	China 1/Indian 1	Zimbabwe 1 Nigeria 1	1	0	6	0	11
Year 3	16	0	8	4	4	Philipino 1/Iranian 1	Guyana 1	1	1	11	3	13
Total	41	2	18	14	7	5	7	2	1	26	5	36

3.3.2 Pilot Study

Since this was my first time conducting qualitative research interviews with English as a second language, a pilot study with a small number of participants was considered beneficial to test the suitability of the research methods and the interview protocol and to identify any other potential issues during the research process (Harding, 2019). Although the interview protocol was created to shape the interview, Smith et al. (2009) argue that this does not guarantee the quality or content of the interview, so a pilot study can be used to test this. The lessons learned from this experience allowed me to adjust the interview questions accordingly. Following ethical approval from the participants' university (appendix 4) and Durham University, where I currently study (appendix 5), a purposive sample of pre-registration BSc adult nursing students from a university in northeast England who had experienced intercultural care was recruited. Recruitment was carried out in June/July 2015 and involved a combination of invitation emails and classroom recruitment. To gain a range of experiences in interview, four nursing students were invited to participate in this pilot study: two from year one and two from year three; one from each year group was of EM origin; two males and two females from different age ranges (see table 3.4). The interviews were digitally recorded following the consent, and data was transcribed verbatim. Braun and Clarke's (2006) thematic analysis process was used to analyse the data.

Table 3.4 *Pilot Study: participants' demographic data*

Year group	Pseudonym	Gender	Age	Country of origin	Interview length
Year 1	Azindoo	Male	39	Ghana	116 min
	James	Male	22	England	73 min
Year 3	Mourhinda	Female	38	Guyana	80 min
	Laura	Female	21	England	65 mins

Six main lessons were learned from the pilot study, relating to the interview location, questioning preparation and asking skills, and the data analysis process.

The first lesson related to the interview location. Participants were given a choice of interview location beforehand, so they could choose a comfortably familiar setting where they felt safe and free from any distraction that might affect their engagement (Harding, 2019). Following this discussion, a quiet meeting room was pre-booked, and a privacy notice was placed on the door during the interview. However, there was uncontrollable noise outside of the room, so the participants opted instead to be interviewed in my private office, which was much quieter. They also agreed that this gave them more privacy, so they did not worry about being overheard (Bryman, 2012). On one occasion, my office telephone rang. I did not answer the call, but the lesson learned was to set the phone (and my personal mobile phone) to be silent before the interview. I also asked the participants to set their phones to silent, and all happily agreed.

The second lesson related to the interview question preparation. A semi-structured interview protocol was devised, comprising a mixture of closed and open-ended interview questions, along with some prompts. This was amended following post-interview self-reflection and student feedback (Appendix 6). The primary aim was to facilitate the investigation of student nurses' perceptions and experiences in intercultural encounters. Good interview questions are pivotal in allowing such phenomena to be explored sufficiently. AIE was chosen as the most appropriate framework to adapt to the design of interview questions for this study (see 3.2.2). Some candidates arrived with a sheet of paper with bullet points, while others had difficulty recalling events accurately and thoroughly. Following reflection, I chose to email the interview questions to participants one week prior to the interview so they

had time to think about relevant experiences in advance, which proved an effective action (Bott & Tourish, 2016).

The third lesson is regarding interview protocol. Participants' demographic characteristics were collected before the recordings commenced, including their age; the age they were when they moved to the UK; and their ethnic background if they were not originally from the UK. To encourage participants to expand on their answers, I prepared five different types of probes: motivational, amplification, exploratory, explanatory and clarification probes (Harding, 2019, p. page 41). A motivational probe encouraged the participant to say more; amplification probes encouraged participants to give more detailed descriptions, i.e. "Could you tell me a bit more about…?" Or "Could you give me an example of…?" Exploratory questions helped to find out more about a situation, i.e. "Why do you think so?" Explanatory probes were used to prompt participants to explain their opinions, feelings, or behaviours, i.e. "How did that make you feel?" Clarification probes allowed me to clarify my interpretation and understanding of the participant. Even though these pre-devised probes felt artificial, they enabled me to ask follow-up questions and obtain much wider and deeper information. Due to my lack of interviewing experience, I was initially quite nervous and stuck rigidly to the questions and protocol to avoid missing any essential questions. However, I frequently broke the participant's flow by stopping to comment that I would explore an issue they were discussing in a later question. I revised the interview protocol based on this experience following the pilot study. For example, questions were reordered to make them flow better, and keywords were highlighted in red to make them more eye-catching (see Appendix I). Refining the protocol through the pilot study also helped me to develop a 'mental map' of the interview process, which increased my confidence, flexibility, responsiveness, engagement, and active listening.

The fourth lesson related to manage interview process. Having taught nursing students for eight years prior, I was confident in public speaking in my professional field. However, this was the first time I had conducted interviews to collect data and I was nervous about confusing my role as a lecturer and my role as a researcher and the implications these had for power relations if not managed properly. In addition,

having English as my second language, I was worried about my immediate understanding and response to students when they share their personal and professional experiences. The first participant (Azindoo) was particularly open and freely shared his intercultural experiences, commenting that it was the first time he felt his voice was valued. However, he also shared some his on-campus experiences, even though interesting, it was not directly related to the study. This was one of the reasons why his interview lasted particularly long (116 minutes) in comparison to others' (around 65-80 minutes). Whist I was concerned about discourage the participant to share their stories if I tried to stop him and keep the interview on track, Azindoo commented at the end of interview that it would be useful for me to remind him to stick to the research topic and the interview protocol. This experience helped me gain confidence to politely move participants towards more relevant conversations.

The fifth lesson related to the value of post-interview reflection. King (2010) and Gibson and Brown (2009) comment that it is important to note down and capture the highlights of the interview while it is still fresh in the mind so that the information can be recorded as accurately as possible. Immediately after each interview, to facilitate this evaluation process, I used a self-performance reflection form (appendix 6) to record how the interview went (for example, whether the interviewee was talkative, cooperative, nervous, etc.); when and where the interview took place and the conditions (i.e. noisy/quiet); my personal feelings about how the interview went; any striking stories the interviewees shared; and any other observations of the interaction that stuck in my mind. For example, the first participant was emotional when describing how he was treated in comparison to his indigenous peers at the same placement. I recorded how he expressed these feelings and how I responded. Vaismoradi et al. (2013) assert that the emotions captured in these notes help the researcher to be better immersed in the transcribed data and gain a deeper sense of the whole story. As a caring professional and person, it was painful to hear students becoming upset during the interview. From the pilot study, I learned that my counselling skills and years of guidance tutor's experience were useful in calming and settle the participants after each interview.

The final lesson related to the data analysis process. I initially thought that transcribing the data myself would help with familiarisation. However, after a few hours, I learned this was rather time consuming and challenging. In addition, since English is not my first language and potentially words and expressions articulated that I might not have recognised, some meaning might be lost or distorted. Incidental words, such as ‘um’ or ‘er’, were retained to maintain accuracy, which was helpful for data analysis (Hennink, 2011). Still, I did not capture this information when I transcribed the data, but the professional transcriber has the skills to capture this. To ensure the quality and efficiency of the transcription, I employed a reputable professional transcriber, which made a significant difference, considering the massive amount of data that was collected later in the study. I was also conscious that the transcriber would not have picked up non-verbal cues, so as their punctuation that can affect the meaning of the data, as well as any audible cues (such as laughing, sobbing, pauses or changes in intonation), would have been an interpretation (Gubrium and Holstein, 2001). Therefore, I used my recollection of the interviews to annotate the transcriptions afterwards.

When reading the transcripts, I was surprised at how evident my expectations were in the way I asked questions and used probing. Through reflection, I amended my interview and probing style, which was valuable to the main study. After immersing myself in the data, I noted the key themes that emerged and created an initial thematic analysis framework. The pilot study report described key findings under three main themes. Each theme used paraphrasing as well as verbatim quotations, followed by a critical discussion to link the findings to the existing literature as a separate chapter. This approach resulted in repetition and a sense of disconnectedness, so for the main study, I merged the findings and critical discussion, providing these side by side in the thesis. A series of analytical questions was used to produce a more in-depth analysis, which further explored illustrative extracts and analytic narratives supported by more relevant literature. This was reported as part of a Florence Nightingale Research Award project (Shao, 2018) and contributed to the present thesis.

In summary, through the pilot study, I learned that interviewing is demanding and different from everyday conversation or teaching activity. The participants and I underestimated the power of personal issues in the interview. Through this pilot process, I not only set a better physical environment for the interviews but also developed skills in recognising my own bias and leading questions, and dealing with sensitive issues and participants' emotions. These all built up my confidence and competence in data collection. In addition, the initial data transcription and analysis process confirmed that thematic analysis was appropriate to this study and helped me create an initial framework for later stages of analysis.

3.3.3 The Main Study

This section focuses on the process on the data collection and analysis at main study.

3.3.3.1 Data collection

Following the pilot study, revised interview protocols and interview techniques were used to guide further data collection in the main study phases. This section reports digital recording and immediate post-interview reflection, consideration and observation of interview language choice, and rapport and bias prevention in the interview process.

- Digital recording and immediate post-interview reflection

All interviews were digitally recorded so that I could concentrate on sense-making during the conversation without being distracted by writing detailed notes or asking the participant to repeat themselves (Oppenheim, 2001). In addition, audio recordings enabled verbatim quotations to be used in the findings section (Harding, 2019). Lessons learned from the pilot study (3.3.2), I paid particular attention to the recording environment since audio clarity was important to ensure data was transcribed accurately. I also used a backup recorder in case of device failure. Immediately after the interviews, I reflected on the interview process and critically examined my performance in terms of the way how I reassured participants at the beginning of the interview, how effectively I asked the interview questions, and guided participants after the interview should they present any emotional disturbance at the interview. In addition, I also noted my feelings throughout the interview process and summarised

key findings from the interview and any situation worth particular attention or useful for later deeper analysis after transcriptions returned from a professional transcriber.

- Interview language

I was born and raised in China, and Mandarin is my mother tongue. I share the experience of learning English as an additional language with 12 out of my 41 participants. Compared to native English speakers, I (and they) have different accents and ways of expressing myself (and themselves). Cortazzi et al. (2011) revealed that potential misunderstandings were caused by pronunciation, word stress, accent, intonation and speed of expression, grammar, vocabulary and styles of nonverbal presentation. For example, I prefer to provide context before commenting on a topic, a feature which Cortazzi et al. (2011) noted is quite common in speakers of South and East Asian languages. In contrast, English and Western language speakers often comment first, and then provide context later. Canagarajah (1999) noted that English as a second language might be associated with negative perceptions of dominance, impacting power relationships. I felt nervous while interviewing native English-speaking students, as I felt less linguistically proficient and was worried about potential misunderstandings in describing the research context. However, after the first few interviews, I became familiar with the interview process, and my confidence developed as I noticed my usual intercultural communication strategies could keep the conversation going.

Harding (2019) comments that language barriers between the researcher and participants could create significant methodological challenges as well as affect the quality of the study. Language choice is a crucial factor when interviewing multilingual participants, and Durkin (2008) points out that offering the choice of language helps to establish rapport and trust. Cortazzi et al. (2011) reported the advantages of interviewing in a first language. These include having more comfortable, open and expressive communication and so eliciting more accurate information. One of the participants spoke Mandarin Chinese as her first language and English as her second language—the same as me. I offered her the choice of using both languages throughout the research process, allowing for familiarity and comfortableness of context and expression. However, she chose English for the interview since she felt she could discuss the topic in English more easily because her professional training

experience was in an English-speaking environment, and she felt she could be more critical and evaluative. This concords with research by Cortazzi et al. (2011) on Chinese students who gain their professional knowledge in English associated English with authority, criticality and the articulation of freedom. The nature of the interview process of this study, which required participants to provide an authentic critical reflection of the experience, is one of these situations (Canagarajah, 1999). None of the other 11 multilingual participants speaks my mother tongue. Our common language of English was used in the interview; however, using English may potentially have hindered some clarity of expression because of our unique accents and different ways of expressing our thoughts (Cortazzi et al., 2011). Nevertheless, all these students had passed their course entry requirements as ME students, including minimal English proficiency tests and had lived in the UK and experienced more than six years of cultural adaptation, so they all had sufficient English to undertake their studies and interview. Therefore, English was chosen as the study's interview language.

To minimize linguistic barriers, I met participants before the interview to discuss the content and purpose of the research and the interview questions. This also provided opportunities to informally familiarise ourselves with each other's accents, reducing the potential for misunderstanding. To keep the interviewees engaged in the conversation and connected to the story, I drew on my years of experience as a nurse to create and maintain a warm atmosphere and to value and respect their attempts to share their unique 'lifeworld' stories with me. I listened attentively and encouraged participants to talk at length, checking for understanding when appropriate and paraphrasing if I noticed signs that my interview questions might be misunderstood (Harding, 2019). In addition, more time was allowed for interviews in which English was a second language since potentially more time is needed to think during the interview (Cortazzi et al., 2011). These strategies ensured a smooth interview phase.

- Rapport and bias prevention in interview

Interviews allow participants to articulate their thoughts at length. In addition, face-to-face interviews allow both the interviewer and participants to observe visual cues throughout the process, such as emotional expressions or non-verbal signs, so that the researcher can respond appropriately. It is important to develop a rapport with

interviewees, as this can help build a trusting relationship, making it easier for them to share personal or sensitive information with the researcher (Cassell & Symon, 2004). However, it requires special skills to persuade participants to share their personal views, experience and feelings with a researcher whom they do not know well or with their lecturer or assessor. Oppenheim (2001) commented that rapport is the key to an effective working relationship, which is crucial to a successful interview. Therefore, every effort was made to establish a good rapport to gain in-depth information from participants, particularly those whose issues had strong personal meanings (Crist & Tanner, 2003).

I was conscious that interviews were different to everyday conversations, and special skills were required to elicit personal views, experiences, and feelings from participants to me, a sole researcher they have not met before or who might have met me as a lecturer/assessor of their study. Therefore, I made a conscious effort to reassure participants of confidentiality at the beginning of the interview. For example, a comprehensive information pack was given to those students who consented to take part in the study; also, after a consent form (Appendix 7) was signed, each participant was reassured that the interviews were voluntary, and that confidentiality and anonymity would be maintained at all times, and they could withdraw at any time. In addition, to build trust and rapport early on, I also tried to minimise the hierarchical relationship by reassuring the participants that questions could be refused at any time and that the data would only be used for research purposes. However, this may also create a risk of bias (Lewis, 2006), so I made an extra effort to be neutral in my views on issues and instead focussed on observations throughout the interview. I also mitigated potential bias by clarifying my role in eliciting information and views rather than assessing their ability and competencies in intercultural communication. In addition, due to the rapport, I established with participants, I noted they might try to give answers that they felt I was looking for. This is known as a ‘double hermeneutic’ bias (Smith, Flowers, & Larkin, 2009). Therefore, I avoided commenting on personal information in case it caused the participant to digress in that direction because of a misplaced assumption that this was a research aim (Hennink, 2011). I also discussed the interview questions with supervisors to ensure these potential biases could be reduced or avoided. In this way, I maintained a rapport while keeping an appropriate

distance from the participants. A good level of rapport and a sympathetic approach ensured the participants' engagement, influencing the depth of their responses to the interview questions (Smith et al., 2009).

3.3.3.2 Data analysis

Braun and Clarke's (2006) systematic thematic analysis was used to comb through the raw data, simplifying and reducing its volume. I used my intuition to identify the relevant and meaningful patterns and themes that were significant to the research question. Data were analysed using a case-by-case approach and transcribed contemporaneously to prevent accumulation.

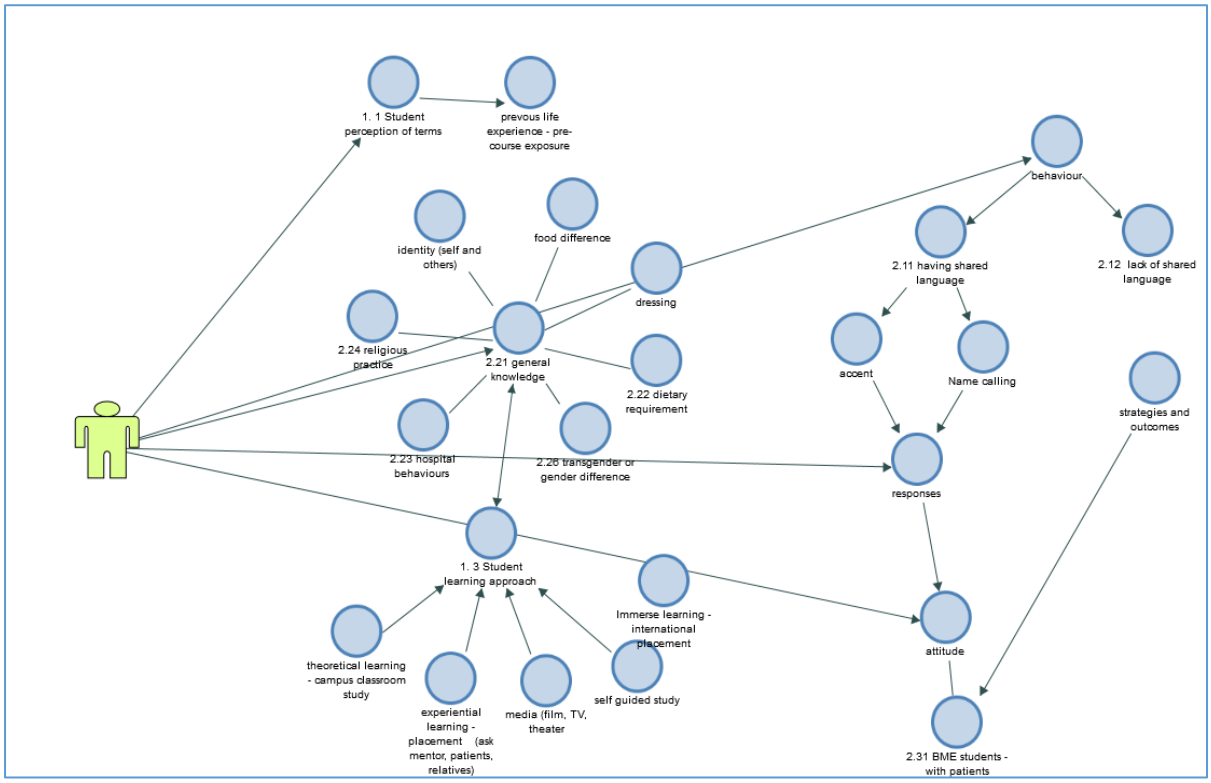
After the interview data were transcribed verbatim by a professional transcriber, I checked the transcripts against the audio recordings to ensure the conversations were captured accurately and to prevent the risk of missing any crucial information. I also appended the transcripts with additional notes taken at the time of the interview and immediately after the interview, including vocal intonations, physical expressions and gestures that might not be audible in the recording. These were then incorporated into the narrative and analysis. Even though multiple readings were time consuming, this was important to validate the accuracy of the transcribed data and to ensure my full grasp of the information. Summarising the data involved focusing on the information relevant to the research questions, including, 1) identify the relevant sections; 2) decide which pieces of information are relevant to which research question; 3) eliminate repeated information; 4) paraphrase the data as an answer to the research question. This process substantially reduced the mass of detailed data to a list of bullet points, making it easier to identify similarities and differences across cases. While comparing and contrasting, I listed the similarities and differences between the first two interview data sets, amending these as other cases were recorded. As the list grew, the similarities list reduced while the differences list became more complex, so broader titles were used for commonalities, in addition to subgroups based on participants' year groups.

Both manual and computer-assisted coding (using NVivo) were used, following four steps: 1) identify categories and put the relevant information into the group; 2) name

codes and write them beside the transcripts; 3) review the list of codes and categories; 4) use appropriate words to report the findings to reflect commonalities and differences within the dataset. I coded the first two transcripts manually, writing the code beside the text and using coloured pens to highlight the relevant extracts. These were then cut out and placed into a labelled section of a file. However, this was time consuming, so I used NVivo to code the remaining transcripts. When a data extract did not match an existing code, a new code was created. Open coding helped to develop the initial codes and categories, which then became a more focused process as the data accumulated and relationships between codes were identified. After reading the transcripts, I grouped the relevant information into categories based on broad similarities, which helped to sort and organise the large volume of data (see appendix 9). Some codes were placed into multiple categories. This preliminary categorisation process was useful in helping me see the overall structure of the dataset and for selecting codes.

I then read the extracts within the codes and categories to see whether they still belonged there and adjusted them if necessary. When the entire dataset had been checked, the NVivo code list was printed to compare the volumes of data within each code and category (and subcategories). An initial NVivo map was also created (Figure 3.2) and printed to show the relationships between codes and categories, which helped me to check whether the thematic map represented the entire dataset. By this point, I was confident that the data was organised in a relevant, coherent, and logical way.

Figure 3.2 *Initial NVivo map*



As the analysis progressed, codes and categories, and connections between these, began to emerge (Boeije, 2010). Therefore, the codes and categories were consistently revised according to patterns and themes, which allowed me to search for connections across the emerging themes. A few codes initially stood out as not belonging to any categories, but as the analysis progressed and more respondents commented, these became new themes. Some codes only appeared occasionally but were nevertheless interesting, despite not appearing under any specific categories or themes. These were reported in the findings to present contrast and a balanced perspective. Some codes were moved to other categories or subcategories, while some new categories or subcategories were established to cover a number of codes that required more conceptual thinking.

I then identified the essence of each theme and joined these together as a 'storyline', selecting the most interesting and relevant subthemes to be analysed in depth and presented in the thesis, supported by data extracts to answer the research questions. Memos were used to note my decision-making processes and rationale. I tried to see through the eyes of participants to make sense of their perceptions, attitudes, beliefs, emotions, experiences, opinions and feelings. Many themes were identified that could

not be reported in the thesis due to the word limit. To ensure comprehensiveness and an appropriate depth of analysis, I followed Kohles et al. (2012, p. 292), who suggested choosing themes that have high analysis value based on 'salience and frequency' criteria, so I selected and prioritised themes, and reported six of them which are considered as having the most significant impact on the individual and organisation, as well as a high occurrence within the dataset in Chapter 4. The Nvivo map was further developed as the base of my innovation Intercultural Care Ecological Framework (section 5.1) to demonstrate the relationship between these themes and categories.

To explain the participants' storylines accurately and effectively, I selected the most vivid and appropriate extracts to answer the research question and to convey the participants' narratives (Braun & Clarke, 2006). Along with a brief commentary, these supported the discussion, highlighted key issues and presented a balanced account of the participants' experiences. To maintain the relationship between the findings of this study and previous studies, contemporary literature was also cited when a clear connection was apparent. This demonstrated how the concepts emerging from this study either extended or challenged existing literature on intercultural encounters and competencies in nursing education, which is my contribution to knowledge in this area.

3.4 Ethical Considerations

As already explained in section 3.3, I obtained ethical approval and participant's consents for this research prior to undertaking my interviews. Throughout the research process, ethical principles of beneficence, autonomy, nonmaleficence, confidentiality and anonymity, as well as power relationship issues, were considered and strictly adhered to.

3.4.1 Beneficence

In order to justify whether a study is worth carrying out, the first principle to be considered is beneficence to ensure the researcher, the participants and society will benefit from the study (Harding, 2019). This research explored student nurses' experience of ICEs during clinical placement. Its benefits lie in the fact that it has helped me and will help other nursing educators to identify perceptions, knowledge

and skills nursing students have and to reveal potential gaps in nursing education and clinical practice. Such knowledge will inform future curriculum development, helping participants and future nursing students on this aspect of care competence and ultimately helping patients no matter their background. The outcomes of this research will inform the development of a framework for delivering cultural competence in healthcare, which will be included in undergraduate and postgraduate curricula to facilitate cultural awareness in teaching, learning and assessment. In addition, the research findings provide a new and unexpected view of student nurses' perceptions of intercultural communication, reflecting the diverse ways nursing students learn and respond to cross-cultural encounters. Nursing students will gain better insights into groups within their cultural environment and their effects on existing healthcare provision. The findings will also help nursing lecturers and practice facilitators understand students' learning on intercultural communication aspects and adjust existing teaching and practice. All personnel involved with teaching nursing students will gain competence in intercultural communication and become aware of their own impact on students. The project will enrich and promote the design of inclusive university curricula by providing insights into the student experience in a highly diverse and internationalised world. Improved healthcare educational programmes will also benefit service users whose needs will be addressed. Further training can be provided for student nurses before they qualify, thus also increasing their employability in the wider healthcare community and international market.

In addition, their participation helped students to understand the research process better and to reflect on things taken for granted during their daily practice and on their intercultural practice. This process enabled them to identify gaps in knowledge and future educational needs to develop their competence. Several participants indicated their appreciation at the end of the interview since they felt it was the first time their stories were listened to, and their voices heard. In addition to the final thesis, a summary of this research will be published in a peer-reviewed journal, thus benefitting staff and students across healthcare institutions.

3.4.2 Autonomy

Participating in this research was a new experience for students, so there was a potential risk of anxiety relating to an unfamiliar process. Prior to obtaining informed

consent, participants were provided with a participant information sheet (Appendix 2) detailing the aims of the research, data collection methods and procedures, rights of autonomy, confidentiality, and anonymity considerations, as well as the contact details of my research supervisor and me in case they had any queries. The students were informed that participation was voluntary and that their statutory rights as student nurses would not be affected if they declined to participate.

The students who expressed willingness to participate were then invited to formally consent to take part in the research by signing the participant consent form (Appendix 7). This detailed the following: participation/withdrawal, anonymity and confidentiality rights, digital audio recording, data collection methods, and rights to use interview extracts for a doctoral thesis, published journal articles, conference presentations and local seminars (BERA, 2012). The consent form listed the ethics committees' and research supervisor's contact details. All participants were informed that they could withdraw from the study at any stage and that, in that case, any information collected relating to that individual would be destroyed, unless the participant explicitly agreed at the point of withdrawal that their data could be used (BERA, 2018).

3.4.3 Nonmaleficence

The study was not expected to cause any physical harm to the participants. However, it was possible that it could trigger emotional disturbance, as participants might not feel comfortable exploring certain issues associated with strong memories and emotions, particularly regarding critical episodes or their interactions with those from other cultures (Speziale et al., 2011). Méndez García (2016) commented that personal stories also bring the opportunity for individuals to reflect on the event and rethink their understanding and perception of intercultural competencies and emotions. This introspective process helps them to understand their experience better, which can have both positive and negative effects. The positive experience usually happens when they relay a cooperative event, or a positive relationship established during personal contact. However, narrating a negative experience may raise some suppressed emotions or thoughts in their consciousness, which could be painful. Kilianska-Przybylo (2012) commented that AIE was beneficial to developing self-knowledge about interculturality, but that disclosing personal stories could reveal emotional conflict, suppressed uncertainty, frustration, vulnerability, and traumatic

experience, which could cause unease or anxiety. In addition, I was aware that a one-to-one hour-long interview carries a risk of causing distress, embarrassment, and tiredness, so participants were informed that they could refuse to answer any questions which might cause discomfort. I drew upon my extensive experience as a senior nurse to identify any signs (verbal and nonverbal) of potential emotional risk and was prepared either to stop the interview to offer support if necessary or refer participants to relevant services if needed (Holloway & Todres, 2003). Moreover, participants were allowed to pause the interview or take a break at any time if they felt tired. After each interview, all participants were offered time to debrief and discuss their feelings regarding AIE and provided emotional support and guidance if needed. Several students showed emotional distress when discussing negative incidents they had experienced; however, none requested pausing the interview or needed to be referred to a university counsellor. In fact, those students expressed gratitude for having their stories listened to and noted that having their experience captured was a relief, so they were keen to support the study in the hope that more attention and awareness would be raised. In section 3.2.5, I specifically discussed my own emotional distress experienced as a researcher and the support I used at the time.

3.4.4 Privacy and Confidentiality

Sharing experiences may reveal some individuals' intimate personal secrets to the researcher. In order to respect and protect privacy, all participants were informed that confidentiality and anonymity would be maintained throughout the study, and all data was treated in accordance with the Data Protection Act (1998) (Swinton, 2009). No real names appear in any paper or electronic document relating to this research. The students involved cannot be identified by other participants, the wider student body or university staff. A codename was used for transcription, and pseudonyms were used in the findings. All paper-based information and digital voice recordings were stored securely in a lockable filing cabinet in my individual locked office at work. That office has a security alarm. All electronic data was stored on my personal computer, which is password protected. Once the study is complete, the digital recordings will be erased, and any electronic files will be deleted (Barbour, 2007).

3.4.5 Power Relationship

One of the key reasons for conducting qualitative research is to empower individuals to disclose their stories, share their perceptions and express their voices (Smith et al. 2009). However, the potential power relationship between a researcher and participant may inhibit openness or make potential recruits feel pressured to participate in the study (BERA, 2018). While the status of being a senior lecturer at the same institution as the participants allowed me access to students, I was aware that this power relationship may impact their responses, thus affecting the quality of the interpreted outcomes. To minimising the effect of the power relationship, I ensured that I was not involved in any direct teaching or marking of the cohort of nursing students I drew from. I made this situation clear to students at the project information provision stage. They were also reassured that their participation would not be revealed to other students or academic staff. After the transcription and initial interpretation had been drafted, I invited respondents to read the report not only to ensure the credibility of the study, but also to diminish my perceived seniority (who, as a lecturer, is conventionally considered to know better than students). By reading the initial report, participants played an active role in validating the data and interpretations. In addition, I continued to be reflexive throughout the study by keeping a research journal and having regular discussions with my research supervisor should any data have an effect on it. Every effort was made to ensure the students felt able to openly discuss their experiences relevant to this study (Creswell, 2012).

3.5 Research Quality: Trustworthiness

While qualitative research is meant to reveal the ‘real world’, the researcher’s involvement and immersion in the participants’ lived experience through discussion and interpretation means the real world will be subject to change. For this reason, qualitative research is often criticised for lacking scientific rigour compared to traditional quantitative research since the latter is assumed to use validated measurements to analyse causal relationships among variables (Bryman, 2012). In order to give readers confidence concerning the rigour of this research, it is important to show that the respondents’ voices were heard, and that the conclusions and theories generated were derived from a good understanding of the research data. To

achieve this end, the researcher should make a special effort to ensure the trustworthiness of the entire research process and findings. Trustworthiness is judged and evaluated according to some essential criteria, each of which has an equivalent in quantitative research, namely credibility (which parallels internal validity); transferability (which parallels external validity); dependability (which parallels reliability) and confirmability (which parallels objectivity) (Lincoln, 1985).

Credibility is the extent to which the findings are valid and believable (Silverman, 2013):In other words, how accurately the findings represent the data from the phenomenon being explored. To ensure the findings did not unintentionally distort the data, I took the following actions:

1) I read and re-read the transcripts thoroughly before the analysis was carried out to ensure good knowledge of the data when selecting and reporting findings. I also checked the findings several times to ensure they accurately reflected respondents' stories (Jupp, 2006).
2) I employed respondent validation, also called 'member checking'; this allowed respondents to check the findings to ensure their views had been accurately expressed Flick et al., 2004). This process was time-consuming, and some participants queried some of the comments they were unfamiliar with. Burnard et al. (2008) noted that it is normal for some participants not to recognise the emerging theories since they each contributed only a small part to the entire interview dataset. Long and Johnson (2000) commented that inconsistency among the participants does not mean the participant's perceptions are not valid but illustrates the variety of feelings and understandings experienced.
3) I used peer review, also called 'inter-rater reliability'. This technique involves inviting colleagues to read through transcripts and findings to check whether the findings can be justified. However, according to Vaismoradi et al. (2013), peer review is not necessarily useful for validating findings since one researcher's coding is not necessarily better or more objective than another's. Furthermore, as my doctoral degree study requires my sole contribution, peer review may breach confidentiality due to a third party's accessing the interview data. However, to ensure their credibility, I discussed some findings with colleagues who also teach pre-registration nursing students and the transcriber who became familiar with the data during the transcription, thus reducing the potential for sole researcher bias.

4) I attempted to avoid bias. Whilst it can be useful to have a nonprofessional read the data and findings to consider whether they match (Harding, 2019), I appreciated the difficulty of asking friends to read through the entire 45 hours' worth of interview transcripts. Therefore, I asked them to read only samples of the transcribed data and related findings and to comment on whether these matched.
5) I also kept a reflective diary of the research journey. Reflexivity is the self-examination of the researcher's understanding of the issue and conscious awareness of how and why decisions are made (Rolfe, 2006), especially around analysing data and how the findings were produced (Jupp, 2006). Through reflexivity, I could capture thoughts and decision making and identify when other factors unduly influenced these processes. In this way, I acknowledged my own role during the data collection and analysis and findings production, so that readers will be able to reach a similar outcome by following the same procedure (Harding, 2019). More detailed information about my reflexivity is included in section 3.6.

Transferability establishes whether the research's conclusions and recommendations can be applicable in different settings (Harding, 2019). Transferability was ensured by describing my research context, data collection and analysis method in great detail, so that the reviewer can assess the appropriateness of the findings and transferability to other situations. Pringle et al. (2011) suggested that having a broader sample (in this study, N=41) helps to make judgements of transferability to other areas easier.

Dependability is concerned with stability over time and place (Maggs-Rapport, 2001), which was attained by following a systematic approach to data collection and analysis consistently (Smith et al., 2009). Golafshani (2003) commented that employing multiple data collection methods such as observation, interviews, and recordings (i.e., triangulation) may lead to a more reliable and diverse construction of realities. However, Long and Johnson (2000) argued that the assumption of triangulation is false, as it can produce evidence in which some data is true while other data is false. As a novice researcher lacking observational and focus group skills (see section 3.2), I sought to avoid creating such issues in the research process which might have affected the data quality (Clark et al., 2011).

Confirmability means the degree of neutrality and avoidance of personal bias throughout the research process (Harding, 2019). To reduce bias based on my previous experience, I rigorously read and re-read the data. Confirmability was ensured through regular critical supervision; consistent documentation of self-reflection and reflexivity throughout the data collection and analysis process (see sections 4 and 5 of this chapter); maintaining transparency in the data analysis process; and extracting direct quotations from the raw data. I also used detailed contextual information from respondents to support the discussion and theoretical concept development. Taking such measures helps the reader to judge whether the data and research process match the conclusion and implications.

3.6 Reflexivity

Enosh and Ben-Ari (2016) described **reflexivity** as the researcher's deliberate consciousness of their own mind while actively engaged in the research process. Consequently, reflexivity involves two distinctive processes: discovery and construction. Only through re-examining preexisting knowledge can the researcher discover discrepancies and contradictions between the things to be explored and previously acquired understanding. This process challenges the researcher's established understanding of the world and stimulates their curiosity to construct more advanced knowledge and theories in the researched field (Enosh & Ben-Ari, 2016, p. 579). In order to make sense of phenomena and to construct new theories in a subjective qualitative study, the researcher must constantly move in and out of the research process and negotiate and challenge taken-for-granted knowledge. To achieve this end, Enosh and Ben-Ari (2016) advise that the researcher adopts reflexivity from the outset of their research.

As an experienced nurse and senior lecturer in nursing education, my pre-research understanding of students' experiences in ICEs was mainly positive. I had assumed that they were excited about having the opportunity to work with people from different cultural backgrounds. This was one of the reasons I decided to work away from my home country. My experience, which felt particularly vulnerable was as an overseas nurse who had a six-month adaption period in an acute hospital before I was fully

recognised as a registered nurse in the UK—similar to student nurse status. Six Filipino colleagues began their adaptation period at the same time as me in the same department. We worked hard and were enthusiastic about learning, making a conscious effort to adapt ourselves to the culture in this country to be recognised and respected by colleagues and patients. We encountered various attitudes from managers and staff nurses; some were empathetic, supportive, admiring of our braveness to leave home, and curious about our ways of working and living in an entirely new country, while others considered us ignorant or lower in qualifications and status. They often deliberately joked and laughed about our accents in front of colleagues and patients; they felt this was normal, commenting that it was us who had chosen to come to their country. Some colleagues did not allow us to make any clinical decisions despite many of us having several years of post-qualified experience in our own countries, sometimes reaching manager and director levels in nursing. It is my belief that all people should be treated the same no matter where they come from or which language they speak. This should also be an essential quality measurement of healthcare services. Before moving into academia 16 years ago, I mentored student nurses, always encouraging them to expose themselves to the diverse learning environment, treating them with respect and supporting their learning whenever possible. As a senior lecturer, I care about the students and the future nursing workforce, and I ensure they are well-equipped to practice and feel they are well supported throughout their learning. After supporting six groups of students to become registered nurses over 15 years as their personal tutors, very few students commented negatively about their ICEs, so I assumed that most of them were well supported by the clinical and academic staff.

From a patient and carer perspective, I have witnessed staff professionalism and seen my family treated with care and respect. I have also witnessed the opposite, which was unforgettable. For example, my 68-year-old father, a highly reputable consultant surgeon in China who does not speak English, suddenly had a stroke while visiting my family in the UK. I witnessed staff nurses who patiently used different gestures to make sure my father understood the intervention, but I also noticed some staff had minimal interaction with my father in comparison to other patients in the same bay. One female nurse frowned when my father refused her offer to bathe him after three days of hospitalisation. However, I understand why my father refused the offer of being bathed,

not because of the lack of personal hygiene but because modesty and privacy are highly valued in Chinese culture, especially for my traditional-minded father when interacting with a different gender. Another stood in the middle of the bay laughing loudly in front of the other patients when she saw that my father's bed had lost control and gone to the highest level when he was trying to adjust the bed sitting position. It was me, a family member, who immediately ran to the bed to ensure my father was safe and not frightened. I was concerned about how my father would have been treated had I not been there. Despite happening ten years ago, these events are still vivid in my mind. I was conscious of my personal experience, so my professional responsibilities and curiosity triggered me to find out more about ICEs from the future nursing workforce's perspective.

To maintain reflexivity in research, Koch and Harrington (1998) comment that the researcher should be simultaneously self-aware and self-apprised throughout the research process to ensure their knowledge and experience do not impact the rigour of the research process and product. This process differs from reflection, which often retrospectively evaluates the event that has happened to develop a plan for future responses should the same event occur again. For example, at the end of each interview, I used the interview performance sheet to reflect on the process, capture any critical issues and significant comments/events the participants mentioned, and observe and reflect on the entire interview process (3.3.3.1). These were then stapled together with the transcripts for analysis of each case. Schluter et al. (2008) commented that this type of consistent, conscious self-reflection could enhance the rigour of the research.

Koch and Harrington (1998) suggested that in order to ensure objectivity is sustained and biases avoided, researchers should use Husserl's phenomenology approach to 'bracket' their experience. Here, 'bracketing' refers to suspending all personal beliefs, knowledge and experience of a phenomenon during the research. However, Gadamer (2004) comments that we cannot entirely bracket our experience and emotions when analysing data since our understanding of a phenomenon comes from personal conceptual and emotional information stored in our memory, which helps to negotiate and interpret research data. In other words, the researcher's existing knowledge plays a vital role in the research process.

It has been a great learning experience at each stage of this research to consciously maintain self-awareness of my position and assumptions around the research question while at the same time remaining open-minded and attentive to the different views and realities shared by participants. To achieve this awareness, I kept a research diary to record and understand my preresearch knowledge, beliefs, and attitudes to the topic and to distinguish new knowledge and learning (Gadamer, 2004). In order to avoid bias, I developed and asked myself a series of questions when reading and analysing every piece of information since I could easily take for granted my years of experience in the field (Schluter et al., 2008). This approach does not mean that I have to bracket or diminish their prior knowledge; instead, preexisting knowledge is valued, and those years of professional knowledge and experience, together with literature, can help support the argument and gain a much better understanding if treated with care. At the data analysis stage, I asked myself the following questions: 1) What did the participant say? Or what has happened? 2) What does it mean? Or what does this imply? 3) Why did they think, see and do that? 4) What are the underlying assumptions here? Where is the evidence? What did the literature say about it? 5) What was the outcome? What and how do current theory and literature explain this? 6) Why did I think the way I did? Was that true, objective and fair? (Schluter et al., 2008). This way, I kept my assumptions from clouding my mind before analysing and interpreting any cases, so no salient information was overlooked or assumed. Asking these questions significantly challenged my taken-for-granted assumptions and understanding of ICEs in healthcare settings.

3.7 Chapter Summary

This chapter presented the methodological framework for this study, underpinned by literature support. Social constructionism and qualitative interpretative approaches were chosen to guide the study, and semi-structured interviews were used for data collection. Purposeful sampling was considered the most appropriate approach to recruiting participants who meet the criteria. Due to the sensitivity of the interview questions, language and the researcher's impact on emotional narratives were discussed. Braun and Clarke's (2006) thematic analysis was chosen to guide data

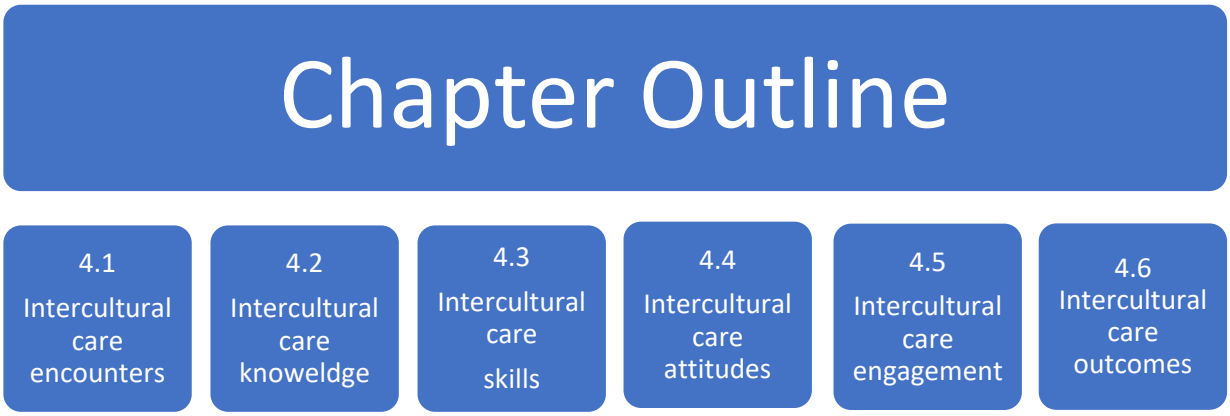
analysis. Following obtaining ethical approvals, a pilot study was (No=4) carried out to testify the research methods and process, which were considered useful to adjust the data collection and analysis process for the main study. Ethical considerations focused on beneficence, autonomy, non-maleficence, privacy and confidentiality, and power relationships. Reflexivity and reflection were discussed at the end of this chapter to explain what issues I encountered during the research process and how I overcame these challenges.

Chapter 4

Findings and Discussion of Intercultural Care Experiences in Healthcare Settings

This study aimed to explore pre-registration student nurses' intercultural care experiences during their clinical placement practice period to gain insight into key features of competencies needed for intercultural encounters when providing nursing care. During the interview, participants shared episodes demonstrating their understanding of intercultural care and the presence, absence, and development of their intercultural care competence. Semi-structured interviews (N=41) were used to collect in-depth descriptive data, which provided an opportunity to capture these perceptions through looking back, articulating, interpreting, and evaluating their intercultural care experiences. **The intercultural care experience** in this thesis refers to the impression student nurses develop during an intercultural situation when providing nursing care. Six themes emerged from the detailed analysing of the 45 hours of interview data; these encompass perceptions and experiences of intercultural encounters, knowledge, skills, attitude, engagement, and outcomes. While they partly intertwine and overlap, they still represent distinct domains.

Figure 4.1 *Chapter outline and key themes*



The findings and discussion presented in the first sections of this chapter address research question 1 and its subquestions:

RQ 1: How do student nurses experience intercultural nursing in their everyday clinical practice?

- Does their own culture affect their approach to others? If so, how?
- What positive experiences do they encounter? How do they perceive these experiences?
- What challenges do they encounter? How do they perceive and manage these challenges?

In each section, I report what the participant experienced or witnessed in practice. The following discussions link these experiences to theories and literature to indicate what these events mean and why the participants think or respond in that particular way. The study's detailed implications and recommendations are presented in the final chapter. When they first appear, key terms are set in bold; definitions are also provided to give contextual information and understanding of the concepts discussed in this thesis.

Section 4.1 presents the participants' perceptions of intercultural care competence (ICC) and intercultural care encounters (ICE). It gives us an understanding of what ICC and ICE entail and means to them. Different types of knowledge that participants consider valuable are reported in section 4.2. The approaches they have used to acquire this knowledge are also included here. Section 4.3 considers the skills participants valued as essential abilities for ICEs and the approaches they considered useful in obtaining these skills. Section 4.4 manifests a variety of attitudes the participants experienced in their placements, how they make sense of their emotions when dealing with these attitudes and how they responded to the negatively perceived attitudes. Different types of intercultural engagement are presented in section 4.5, along with perceived enablers and barriers for sensitive engagement. Section 4.6 reports the participants' perceived outcomes of ICEs from the perspectives of students (as healthcare providers) and patients (as healthcare receivers). These six themes are intertwined and are discussed separately in this report only for explanation purposes.

Following detailed exploration, analysis, and discussion to understand students' intercultural communication experiences in these six domains, section 5.7 concludes this chapter by drawing the essential research findings together and highlighting their relationship in developing an individual's intercultural competence, thus answering research question 2 and its subquestion:

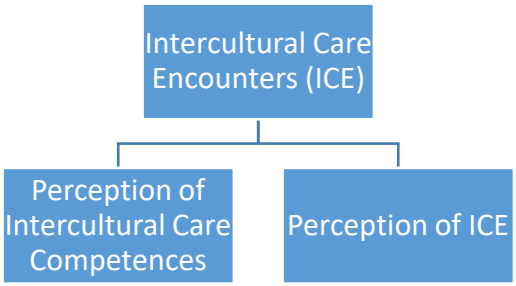
RQ2: What intercultural competencies are salient in facilitating effective intercultural nursing care?

- What are the factors and features of effective intercultural encounters in clinical nursing practice?
- What are the relationships among these factors?

4.1. Intercultural Care Encounters (ICEs)

An **intercultural encounter** is a social situation in which one person meets and interacts with another (or group of people) who have a different cultural background (Barrett et al., 2013). When the interaction is within a caring setting such as a hospital, it is referred to as an **intercultural care encounter** (ICE). This section presents the participants' perceptions of ICCs and impressions of their ICEs (see Figure 4.2).

Figure 4.2 *Intercultural care encounters*



4.1.1 Perception of Intercultural Care Competences (ICCs)

Many participants (such as Nesta) considered that everybody is a cultural individual and saw having the competencies to meet people's needs as an important part of their holistic nursing practice and as essential to helping to understand and meet patients' cultural needs.

> *It* [ICC] *is definitely an important part because it falls under the holistic approach as well, so you'd be supporting the patient in a holistic perspective and meeting their needs. (Nesta, Y1, Zimbabwean student)*

Participants described their understanding of the competencies needed for caring for people from different backgrounds as having knowledge and understanding of other cultures and the ability to recognise the differences, understand and adjust in order to

work with and meet those needs in a respectful way and have a smooth dialogue with cultural others.

> *Intercultural competence is having the knowledge of the other cultures that are around you, knowing how you can adjust to that kind of culture and being able to work with anybody from a different culture… Also, it is the ability to be able to treat everyone as an individual and respect their rights and cultural aspects of their backgrounds. (James, year 1, English student)*
>
> *…just having an understanding of other cultures, so you know about different aspects of care for everyone's needs, in order to meet that. (Amber, Y3, English student)*
>
> *It is being able to meet those people's needs according to their level of understanding, so being able to communicate with them and to have a smooth dialogue with them. (Mourhinda, Y3, Guyanese student)*

This description shows the students' view of competencies in caring for culturally diverse patients as not only having knowledge, understanding and ability but also valuing actions (i.e., '*to communicate*', '*to have smooth dialogue*' etc.) and also thinking purposefully about outcomes (i.e., '*to meet everyone's cultural needs*'). These views show they placed more emphasis on communication and outcome than shown in Leininger's (1997) transcultural care (see 1.3.3 and 2.3.1).

While the above students perceived ICC as a list of containable attributes (i.e., having a compositional view of the term), some participants considered IC a learning process (i.e., a dynamic concept). For example, Aoife thought her ICC would improve with more exposure to ICEs and managing the situation independently.

> *I think competency comes after we qualified. …we're just doing all the theory now; I do not think we really learn competent intercultural skills until we get into the real word and that goes for everything. (Aoife, Y3, Northern Irish student)*

As discussed in section 2.3, people who view ICC as a compositional concept tend to present it as a list of relevant traits, as skills the individual needs in order to perform competently in ICE, whilst people who view ICC as a conceptual term emphasise the time dimension of intercultural communication; therefore, they value the process of progression over time.

When asked what interculturally competent staff look like, participants such as Nesta described a competent person as having effective communication skills, showing care,

commitment and compassion, being able to learn about different cultures, asking appropriate questions and knowing about the availability of relevant resources to accommodate the needs of all patients.

> *Just good communication skills, show your care and commitment, and try your best for your patient, compassion, treat everyone equally and respect patients and be an advocate for your patient no matter what background… and know the relevant resources for when there are problems, such as the phone you can use for translators and interpreters. (Nesta, Y1, Zimbabwean student)*

This response is similar to Leininger's (2002) articulation. She describes competent intercultural care as flexibly providing relevant and appropriate care to clients from diverse ethnic and cultural backgrounds. The students' responses show that they have a good conceptual understanding of competent intercultural care.

4.1.2 Perception of Intercultural Care Encounters (ICEs)

All the participants reported that they had experienced communicating with people from different cultural backgrounds during their clinical placements. Most emphasised their experience with people from a different country of origin and ethnicity. Several participants from ethnic minority backgrounds acknowledged that they frequently encountered native British patients; however, none considered communication with native British patients as ICE. For example, when Mourhinda named patients' countries of origin she did not include native British patients.

> *I have had intercultural encounters with people from various backgrounds, from Poland, Latvia, Malaysia and Africa. I haven't met anybody from other country, such as Caribbean.' (Mourhinda, Y3, Guyanese student)*

Some participants view ICEs during placements as situations that involve interactions with people from an ethnic minority background, possibly due to their narrow understanding of culture (see section 1.3.1). Excluding interactions with native British patients may be because EM participants speak fluent English and do the same job as the native British nurses, so consider looking after native British patients as the norm at work. Patients from ethnic minority backgrounds are different from the norm, so these EM participants perceive their communication with the ethnic minority patients as ICEs, including patients from the EM participant's home country. For

example, Feihong, originally from China, shared her experience of looking after a Chinese patient as one of her ICEs. This finding is consistent with other studies of internationally qualified nurses (Allan & Larsen, 2003; Gerrish & Griffith, 2004). It also explains why participants who had international placements considered their interactions with ethnic minority patients from that country as intercultural encounters rather than simply as 'local' patients, despite the participants being the ethnic minority in a foreign country. For example, Amber described her intercultural experience in Portugal based on her interaction with ethnic minority people:

> *... when I went to Portugal and there have also been ethnic minority patients throughout my time on placement that I've encountered that have different backgrounds. (Amber, Y3, English student)*

In addition to culture of origin, a few participants also included incidences of gender and religion as intercultural experiences. One male participant, James, commented on gender differences linked to religious belief and practice when caring for male patients on a urology ward. The patient, who had a Jewish background, was nervous about having a tumour removed from his prostate and having a urinary catheter after the operation. This patient was unpleasant and sometimes even rude to female staff, even though they were qualified and experienced, but not to the male student, who was only a first-year student nurse. Following discussion and reflection, he realised that "*Jewish men prefer to talk to a male than female staff and man should have more provenance"* despite the fact that James did not agree. Therefore, even though he was only a junior student nurse, due to his gender, he noticed the patient and the relatives treated him more respectfully than qualified female staff.

In addition to commenting on differences relating to the country of origin, ethnicity and gender perspectives, participants also reported intercultural experiences when they interacted with people whose language, age, religion and physical capacity (for example, visual and hearing impairment due to disease or treatment) differed from their own, revealing that some students view intercultural experience more broadly than others, which may depend on their perception of culture and the opportunities for exposure during placements. Rathije (2007) argues that how people perceive

intercultural encounters varies depending on their interpretation of culture since each person is acculturated differently as regards their moral judgement, decision making and expectations and how to interact with others.

All participants valued being exposed to diverse cultures in practice and commented on a variety of benefits to their learning, including making them "*think more ahead in terms of what the other part was wanted, what type of person they are*" (Sophie) and "*be better prepared to compromise own belief if needed'* (Michelle). They commented that these experiences contributed to changing their perception of intercultural care, which helped them "*develop different worldviews",* "*to understand more"* (Alice) and their "*knowledge and skills of other cultures increased consequently*" (Tony). In addition, participants also reported that ICEs helped them to understand and become aware of cultural differences, consequently developing their confidence in dealing with intercultural situations in clinical practice. Despite the opportunity to be exposed to ICEs being highly valued, some recognised that working in a multicultural environment does not mean that nursing students and staff have the IC to provide culturally sensitive and safe care. Each ICE should be evaluated, and only those with positive outcomes indicate effective interaction and should be promoted (Briscoe, 2013).

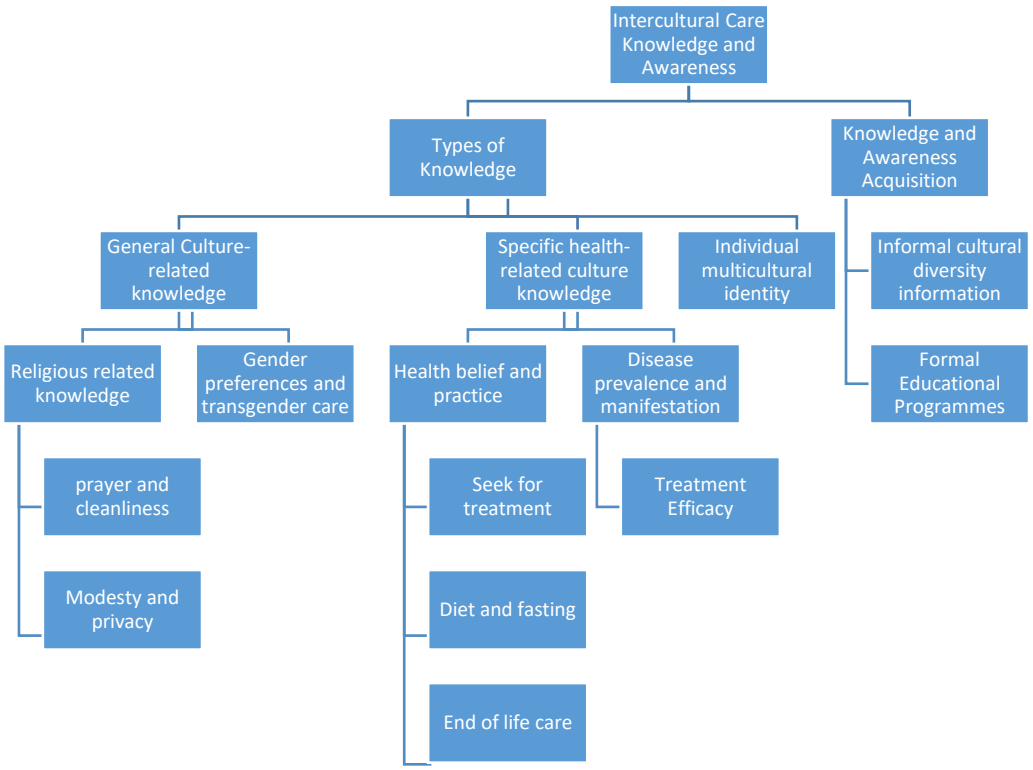
In brief, the data showed that, even though the participants demonstrated their understanding of the concept of ICC through a compositional mix (including perceived intercultural competence as the mix of the knowledge and understanding of diverse cultural needs, the ability to adjust behaviour and attitudes in order to establish a smooth dialogue with patients and having appropriate attitudes to provide equal standards of care to patients from all cultural backgrounds) and dynamic orientations (i.e., emphasis ICC development over time), they all valued the importance to ICC and ICE in nursing practice. Their perceptions encompassed country of origin, ethnicity, religion, language, gender, and physical capacity. However, they all acknowledged that the ICE offers a place for individuals to negotiate and adjust to varous cultures, values and worldviews. At the same, they also recognised the limitation of their intercultural knowledge, an area which is explored in more detail next.

4.2 Intercultural Care Knowledge and Awareness

The next theme to merge from the data was i**ntercultural care knowledge** (ICK). This refers to information such as concepts, facts and perceptions that are fundamental to effective IC and includes beliefs, behaviours, psychological and biological similarities and differences that may affect health (Papadopoulos et al., 1998). Conversely, **intercultural care awareness** means being aware of people's backgrounds, norms and values, which may affect their own behaviour and attitude and the ability to recognise and describe similarities and differences between different cultures (Papadopoulos et al., 1998). When these are related to the individual's (i.e., in this study, a student nurse's) own culture, it is called '**self-cultural awareness**'. An individual's personal experience significantly influences intercultural care knowledge and awareness; this can be developed through formal and informal education (Bohman & Borglin, 2014). Foronda (2008) argues that cultural knowledge and awareness are paramount in nursing practice since they affect quality of communication and patient satisfaction.

This section reports the three types of cultural-related knowledge and understanding that participants consider as important, including general culture-related knowledge (4.2.1.1), specific health-related knowledge (4.2.1.2) and individual multicultural identity (4.2.1.3); and the approaches they have used to acquire intercultural care knowledge and develop cultural awareness (section 4.2.2).

Figure 4.3*: Intercultural care knowledge and awareness*



4.2.1 Types of Knowledge

The data revealed that general culture-related knowledge, specific health-related knowledge and multicultural identity are the essential types of knowledge they consider useful in intercultural practice (see Figure 4.3).

4.2.1.1 General culture-related knowledge

General culture-related knowledge refers to understanding cultural diversity and its key concepts and common practices, including the variety of worldviews, histories, social, political, and economic statuses, languages, religious practices, shared traditions and values of different cultural groups (Bernal, 1998).

Participants reported that they frequently encountered patients and staff from diverse cultural backgrounds, but they felt their knowledge was insufficient to provide competent intercultural care. Some reported that their knowledge was only superficial,

such as knowing country names, religions, and some common dietary requirements, without understanding why people have different dietary needs. Naming differences is not the same as understanding differences, which is the core of cultural care. For this reason, while a few felt they could "*get by*" many encountered difficulties that consequently affected their management of the situation. They used words like "*frustrated*" and "*difficult*" to describe their feelings.

> *I know a little about different cultures, but I don't think I know enough, things that would be significant for a patient that I might not be aware of…For nutrition, what meals people would prefer? What they don't? and why? I would need to know more about them. (Michelle, Y1, English student)*

This section will report participant's clinical experiences relate to religious related knowledge, gender references and transgender care.

1) Religious related knowledge

Members of some religions are obliged to observe and practise their faith. Their faith plays a profound role in their daily living in terms of diet, prayer, modesty, privacy, gender preferences and end of life (Mohammadi, 2007). Trying to adhere to such principles may lead to challenges in a busy Western-value-based healthcare environment. The issue can be exacerbated when healthcare staff lack knowledge and understanding of the significance of meeting these principles. This section reports participants' experiences when EM patients demonstrated cultural needs relevant to religious practices, including prayer, hospital visit, modesty, and privacy.

- ***Prayer and hospital visits***

In some religions, prayer is viewed as the way to have open communication with God and is, therefore a central way to strengthen the relationship with God. Prayer is a principal form of worship and is viewed by many as an essential part of their being (Mohammadi, 2007). As Al-Shari (2002) reported, prayer becomes part of their spiritual healing practice when an individual is ill, especially for medically uncurable conditions such as HIV and cancer. Therefore, healthcare staff respecting a patient's spiritual healing methods can help to foster a good relationship with patients and families. However, participants such as Barbara reported that some staff were unaware of the importance of maintaining a clean and quiet environment for Muslim patients (to show respect to Allah) during prayer. Instead, they interrupted prayer by

offering tea/coffee or food during Ramadan, which caused unnecessary tension in the relationship between healthcare providers and patients. They commented that if nurses were aware of different cultural practices, such tension could be avoided, and better service provided.

> *We had a patient who was Muslim, he had a severe learning difficulty and his dad stayed with them for the duration of the hospital stay in a cubicle, The patient was down for a procedure and his dad was praying on a mat in the cubicle and somebody went in to ask him if he wanted a cup of tea and he was a little bit annoyed about it. To the staff, she was doing a good thing by asking them if they wanted food, but if she had have been aware of what the religion entailed prior to them going in, then she wouldn't have knocked and asked, because you could clearly see that they were praying through the window in the door. (Barbara, Y3, English student)*

Participants observed different ways of praying, which caused some challenges in practice. Some patients did so quietly without disturbing other patients, while others caused conflict with other patients or even broke hospital policy. For example, Alice encountered a situation in which family members frequently occupied the day room to pray, which was not only against the infection control policy (due to exceeding the number of family members being allowed to visit), but also affected other patients on the ward. Several other students reported similar.

> *There was once a tricky situation, there was a patient was in one cubicle and all the family was in there. There were so many relatives that they had to stay in the corridors, but that was encroaching on the critical care unit. So, they had to use the day room of another ward, which was difficult, because they were praying in the day room for the patient that was poorly…then other patients couldn't use that day room, but they needed to pray, because that's all in their culture. It was a very difficult situation to manage. (Alice, Y2, English student)*

Visiting a relative or friend in a hospital to show care and empathy is highly encouraged in Islam, Chinese and many other cultures (Khan 1994) since home, family and friends are viewed as resources for mental and spiritual strength, which may help the healing process. It is common that people from these cultures tend to travel long distances to visit the ill and may stay with patients throughout the visiting time or even longer if they are allowed to. Their presence can occasionally interfere with healthcare delivery and require managers in the ward to offer alternative solutions since these patients must respect rather than dismiss their visitors, which would be viewed as rude and

unacceptable. If the nurses dismissed these visitors, this could cause huge embarrassment to the patients (Al-Shahri, 2002). Thus, Leishman (2004) suggests that hospitals should embrace cultural differences and offer facilities to adapt to the visiting situation rather than ask visitors to modify their practice to suit the hospital visiting policy.

- ***Modesty and privacy***

It is common practice in surgical wards for patients to be visible for routine general observation during the first few hours postoperatively. However, a third-year student reported that one patient consistently drew the curtain to prevent her from being seen by others. Without understanding the female Muslim patient's need for privacy, Emma commented that she was frustrated about why this patient was so private and did not know how to manage this situation to balance the patient's religious needs with the need for clinical observation.

> *The lady was very private and was used to being very covered up for her culture, so we had to always have the curtain around the bed, and that was a bit of a problem because in hospital, you need to see what is going on with your patients. It's not generally the way that it's done, so to try and explain to gain cooperation was quite difficult. (Emma, Y3, English student)*

On an internet search, Emma learned that privacy and modesty concerning male and female appearance and genitalia (Yosef, 2008) are particularly important in certain cultures, especially among females. Therefore, if more than one patient shares a room in a hospital, these ladies tend to pull the curtain to enable privacy from visitors and healthcare professionals from both genders and at any age. Therefore, she suggested offering a single bay for these patients when possible.

When James, a male English student nurse, tried to communicate with a female patient, he noticed that she tended to avoid eye contact and only spoke a little, sometimes even deliberately creating a language barrier by not speaking in English and letting her close male relatives speak on her behalf. He later learned this was because of their belief that a male leads the family and is viewed as the protector, disciplinarian spokesperson and sometimes even the decision maker (Yosef, 2008). Not understanding this practice, James "*was puzzled and thought the patient was*

either not satisfied with him and did not trust him, or was being abused by her family"'

As these two examples show, a lack of cultural knowledge can cause misunderstanding and may cause anxiety for both staff and the patients.

2) Gender preferences and transgender care

Several participants (such as Grace) encountered patients who had preferences related to their religion practice around their health provider's gender.

> *Sometimes they prefer a male and then sometimes, women, especially sometimes husbands of female patients don't want male staff to be caring for them. (Grace, Y1, English student)*

Social touch (including shaking hands), as well as hands-on nursing care between unrelated, opposite genders, is discouraged or even forbidden in some cultures (Schwartz, 1991). These populations are not allowed to expose their body or even discuss their feminine-related condition with the opposite gender (Yosef, 2008). Without knowing this or accommodating these needs, participants felt" frustrated" and observed that Muslim patients showed stress when they had to break the rule to be examined or discuss their health issues with healthcare staff of the opposite gender. Rajaram and Rashidi (1999) revealed that such a culturally insensitive practice would prevent them from openly sharing their health problem with healthcare staff or even accessing healthcare services. Even though some patients may consent to being touched by healthcare staff from the opposite gender, this may only be to avoid embarrassing the authority of healthcare professionals, and they may still feel deeply uncomfortable about it (Schwartz, 1991). Therefore, every effort needs to be made to ensure staff from the same gender are available to interview and provide personal care for patients who have gender preferences on religious grounds. If this is not possible, having a close relative or nurse from the same gender present is recommended because as Pirotta (1994) reported even when being examined by a female healthcare professional, some female patients can still shy away and resist exposing their bodies. The same idea applies when selecting a same gender interpreter.

Participants also reported their anxiety when looking after patients from lesbian, gay, bisexual, transgender and others whose gender identity is not based on a traditional

gender binary (LGBT+) group due to a lack of knowledge of their needs. When asked whether they are aware of any policies and concepts in caring for people from LGBT+ and other diverse backgrounds, participants reported that they were unsure about the relevant policies and feared being labelled as sexist, racist or discriminatory. For example, Matthew reported a patient who had a tumour removed following a male to female transgender operation (although the patient still had male genitalia). Without awareness of the patient's sensitivity, he accidentally misspelled his name, with one letter missing, causing the patient to be severely upset, frustrated and insecure. Matthew found out later that the patient's reaction was because this patient wanted people to view her as female, especially in the urology ward, where all other patients are male, and the staff still assesses her male genitalia to assess for signs of bleeding and postoperative aftercare.

> *I had a transgender patient, male to female, having a tumour removed, but still had male genitalia, but from the start, felt very anxious… I admitted her, and when I was writing her name on the board, I mis-spelled it by one letter–But the minute I started writing on the board, her eyes were on us, a very intense look, as if paranoia. I immediately apologised and changed it and normally you expect people to be all, like just joking, like "Oh, it's fine. It happens", but she looked really upset and frustrated… (Matthew, Y1, English student)*

Matthew was surprised by the patient's reaction initially, which he perceived as only a small name misspelling. He was not able to interpret the underlying reasons behind the behaviour but judged it based on a heteronormative reaction, causing tension or cultural conflict, which affected the therapeutic relationship and compromised the quality of care (Narayanasamy & White, 2005). Following the incident, Matthew stated, "*I tried my best to be sensitive to it, but I did not feel I had the necessary skills nor knowledge to fully treat this patient with confidence".* Matthew's comment shows that without knowledge and understanding of the transgender patient's values and vulnerability, the student nurse could not properly consider their needs and respond sensitively. This incident also shows that gender orientation is one of the aspects of ICEs that require a specific set of relevant competencies that students need to learn and comprehend.

This incident demonstrates a need for training to develop better understanding of LGBT+ patients' needs and awareness of their vulnerabilities when seeking healthcare

services to ensure they can be treated fairly, and everyone involved can feel comfortable and confident. A few other participants also cared for LGBT+ patients and reported a similar lack of knowledge and understanding of the specific needs of these patients. It has been reported that LGBT+ patients encounter significant challenges in receiving compassionate care in hospital settings (Hashemi et al., 2018). LGBT+ people have higher levels of mental health issues than the general population, and about 15% of LGBT+ people avoid accessing healthcare services due to fearing inappropriate staff attitudes and actions (Robinson, 2019). Therefore, there is an urgent training need for student nurses and even qualified nurses to develop competencies and confidence to care for LGBT+ patients.

This finding echoed studies that found LGBT+ patients are particularly vulnerable during hospitalisation (Leininger, 1978; Boi, 2000). Several participants urged the university and the placement area to offer more support and guidance to develop this aspect of knowledge. This request shows they are aware of the importance of knowledge in caring for diverse patients, are conscious about their knowledge deficit and have the desire to acquire cultural knowledge formally from both university and placements.

4.2.1.2 Specific health-related cultural knowledge

In addition to broader cultural-related knowledge, participants also reported the need to have health-related specific information. **Specific health-related cultural knowledge** is the healthcare practitioner's understanding of health-related beliefs and cultural values, disease incidence and prevalence, pathology, commonalities and differences across different cultures, treatment efficacy and physical variations that may affect disease manifestation, such as skin colour, body structure or laboratory differences (Horvat et al., 2014, Taylor, 1998; Campinha-Bacote, 2002, p. 182). This section reports students' experiences concerning health beliefs and practice, disease prevalence and manifestation and treatment efficacy.

1) Health beliefs and practice

Participants reported different health beliefs they have encountered in patients' treatment and nursing care. **Health belief** means a set of ideas that an individual holds

about matters that constitute their health, the reasons for their illness and methods to overcome an illness which significantly impact an individual's health behaviours and outcomes (Yosef, 2008). There are a variety of health beliefs people hold worldwide. For example, while Western medicine emphasises evidence-based treatment, traditional Chinese herbal treatments are based on experience; there is no right or wrong, but they work in some way. The section reports different health beliefs that the participants had experienced, including seek for treatment, diet and fasting and end of life care.

- ***Seek for treatment***

Participants commented that knowing a patient's health beliefs could help them to understand how patients view their health and medical needs when they are ill, such as refusal of blood transfusion for Jehovah's Witnesses. For these patients, options of special medical products or optimisation procedures to minimise the risk factors related to transfusion need to be discussed and consented to before the operation, especially prior to major surgery. Lack of understanding of these beliefs and a lack of awareness of alternative therapeutic options can potentially lead to medico-legal and ethical issues in clinical practice (Chand et al., 2014). Despite its potentially serious implications, Barbara was surprised to observe that even qualified nurses were not fully aware of this issue.

> *We had a lady in a cubicle who had advanced directives for Jehovah's Witnesses which said she didn't want a blood transfusion. I didn't know they were a Jehovah's Witness until a relative come and I found out it was not set up, and I said, "But she's going for an ablation, which is going through the femoral artery. The biggest risk is bleeding; therefore, quite possibly need a blood transfusion. The Trust would be sued massively if they gave her a transfusion, but also not just that, you're breaking her code of belief. (Barbara, Y3, English student)*

Other participants also reported that an individual's health beliefs could affect how they seek and comply with medical treatment and nursing care for long-term conditions, such as type II diabetes mellites (DM). For example, Barbara observed that DM patients from the Muslim tended to be admitted to hospital for treatment at a later stage than others and commented that '*knowing cultural and religious differences (i.e., health beliefs) helped me to understand diverse behaviours around seeking health treatment and to promote self-care more effectively when making care and health promotion plans for patients".* Managing DM effectively requires patients' self-care

(blood sugar testing, regular exercise, medication taken, diet control and food care) daily unless there is a sudden deterioration or uncontrollable complications. Schoenberg et al. (2008) reported that patient-perceived efficacy of the medicine, levels of respect for medical staff's authority and familiarity with conventional therapy are useful indicators for the type II DM patient's long-term self-care. Hjelm et al. (2003) found that European participants had a higher tendency for active self-care behaviour (such as actively searching for information about the management of their illness) and healthier lifestyle (such as change of diet and more exercise) to chronic disease such as DM in comparison to Arab participants, who had a lower tendency for self-care and instead adapted to DM since they considered DM as 'the will of Allah or God'. Yosef (2008) reported that Muslims consider illness to have supernatural (God or evil), social (evil eye or stress), natural (old or dirty environment), or hereditary causes. Because of these perceptions, their compliance with self-care was low for nutrition (Al-Nuaim, 1997) and physical exercise (Al-Shahri, 1996), especially among female Muslims.

- ***Diet and fasting***

Participants commented on the complexity of dietary care for people from different cultures because, in addition to some general food-related requirements, patients may also require halal or kosher meat, or vegetarian or vegan diets, which all have specific requirements for the preparation process and time of consumption. While some participants (such as Alice) commented that they could rely on kitchen staff to provide the appropriate diet for patients based on their request, others (such as Eira) felt '***frustrated***' for the complexity of uncertainty due to not being aware of the reasons why a patient had to have the food which family provided.

> *There are different nationalities, patients who need different sorts of dietary requirements …Even though I don't know much about these types of the diets I've never encountered a problem because the kitchens always provide a dedicated menu and stuff for patients, so they seemed happy. (Alice, Y2, English student)*

> *This patient would not eat anything we made or gave her because her son said she has a strict religious requirement and only likes the food that the family would make, but I don't know why she had to eat certain types of food only and felt **frustrated** when it's the mealtime but the relatives haven't brought the food for her. (Eira, Y3, Welsh student).*

Northeast England has the biggest Jewish community in the UK. This community has strict guidelines for choosing and preparing for their kosher diet. In a hospital, it is

impossible to know where the meat came from or how the food was prepared in the catering department, which could explain why Eira's patient refused to take any food provided by the hospital. Another participant, Aoife, felt '***awful***' when she observed a Jewish patient who was offered non-Kosher food for weeks without anyone noticing.

> *This man had been in our care for several weeks, and then somebody realised that he was Jewish and he shouldn't have been eating any pork products, so that went missing for a long time before that came up… He wasn't communicative because he had dementia, so he wasn't aware, but I felt awful, even though he wouldn't have come to any harm by eating pork. It's just obviously against his religious beliefs. (Aoife, Y3, Northern Irish student)*

Participants observed that different religions have specific ways of processing food and even specific eating times. For example, one participant observed a halal meal brought to the ward in the evening for patients during Ramadan, but they were not sure whether any patients could be exempted from fasting to prevent health deterioration during daytime. Some also expressed anxiety about whether common treatments, such as giving intravenous fluids and feeding through a nasal gastric tube, might go against the patients' beliefs.

> *Prior to them coming in, the chaplaincy service handed out some leaflets regarding Ramadan. I had a look at it because I'm always interested in it and they said: I didn't actually realise: any invasiveness, even just NG feeding or anything like that is classed as breaking their belief, so I questioned a few people about it and said: "Oh, so what happens of someone's in intensive care unit and they're not able to pray and things like that?" 'Cos it's breaking their culture, and you talk about people's well-being and holistic needs, it's not just physical nursing that they need; they need care for all of their needs. (Barbara, Y3, English student)*

Fasting during Ramadan requires Muslims to refrain from eating or drinking from sunrise to sunset for the entire ninth month of the year. However, such lengthy abstinence from food and drink could affect their treatment regime if they are admitted to the hospital, especially if they are physically vulnerable, e.g., after having undergone emergency treatment or major surgery. Barbara's experience also shows a gap in student nurses' knowledge about dietary requirements in relation to patients' treatment during hospitalisation.

- ***End of life care***

Care for the dying is one of the most sensitive parts of nursing care since the end of life can be painful and emotional for patients and those left behind. Participants highlighted a variety of beliefs the patients held on their end-of-life care, with complex needs in planning and managing dying and performing the last offices, that is, the care of the body of the deceased. Participants expressed their lack of confidence around this aspect of care and worried about unintentionally going against the patient's wishes in their final weeks of life. They also recounted different observations and views on the way staff and relatives performed at the last offices. For example, James, a first-year student, compared his belief to the patients' views and commented on how he managed the differences mentally.

> *There were things when people die, some people open the window saying so the spirit could get out. Personally, I don't know. I'm the science kind of brain that you're a body, and when your body stops, you stop. I really don't know because people have spiritual experiences or paranormal or whatever and ghosts and spirits, … you can't just discount it all; you can't say, "Oh no, the whole thing's a lie". So, I really don't know. I'm on the fence about it. (James, Y1, English student)*

Different cultures have different beliefs about death and dying, which may help patients and relatives cope with their emotions. For example, some patients' relatives expressed their preference for opening windows after a patient dies to help release the soul and spirit from the room since they believe that even when the body has ended its biological function, the soul and spirit are everlasting. James commented that even if he did not share this belief, he still concurred because he felt "*it took little effort but gave great comfort to their relatives*". This shows the student nurse's awareness of the importance of respecting patient's and relative's cultural needs at the end of life care and their efforts to ensure this happens when they can. Even so, some participants were worried about unintentionally offending their patients due to a lack of knowledge and understanding and were concerned they would be viewed as discriminatory or racist if they performed inappropriately. Therefore, it will be useful for students and staff to have the required knowledge and to be able to access support from the relevant department to facilitate the ritual procedures when possible.

2) Disease prevalence and manifestation

Tony, a second-year student, observed a high proportion of South Asian patients admitted to the cardio ward. He later commented that having bicultural ecological knowledge helped him make better decisions to collect culturally relevant data and provide appropriate care and health promotion for these patients.

> *When I was in a cardio ward in my first year, I initially felt strange that there were a lot of patients of South Asian ethnicity… I later found out from the internet that it was mainly caused by the type of food they prefer to take, so I asked more focused questions regarding the patient's food habits, and before the patient was discharged, I discussed some healthier food choices with her. (Tony, Y2, English student)*

Disease incidence and prevalence can present differently among different ethnic groups due to genetic differences. Some ethnicities have a higher tendency to develop specific diseases, such as stroke, cancer, sickle cell disease, cardiovascular disease (CVD) and type II diabetes (Leishman, 2004). South Asian groups have a higher rate of diabetes, while people from West African ethnic origins have a higher risk of carrying the sickle cell gene, and Afro-Caribbeans have a higher prevalence of prostate cancer (Knott, 2022). Similarly, it was reported that African patients have a higher chance of developing asthma and requiring hospitalisation, while Asian patients have a higher tendency to develop pneumonia and diabetes mellitus (Knott, 2022). Male patients have higher cancer mortality rates than female patients (Kersey-Matusiak, 2012). These conditions are also associated with diet, lifestyles and culturally directed health behaviours. Participants commented that having knowledge and awareness of these differences could help provide more focused health promotion that has been found to be effective in reducing risk factors and consequently less re-admission to hospital.

Other participants commented that having knowledge about specific genetic elements and cultural issues in response to illness, such as changing skin colour when an ethnic minority patient's conditions changes (e.g., at different stages of pressure ulcer or lip colour with cyanosis), compared with patients whose skin colour of white was needed, since they reported that '*education is often based on white patients, but is not applicable to patients with darker skin colours in practice'*. Leininger (1997, p. 34) said that "Nursing needed to shift from a largely ethnocentric and uni-cultural position to a multicultural knowledge base in order to be relevant and effective in working with people worldwide". Therefore, to ensure competent and appropriate care and

treatment for these patients, participants emphasised the necessity to include more content relating to differences in disease prevalence between ethnic groups in the pre-registration nursing curriculum.

- ***Treatment efficacy***

Saanvi observed that the differences between male and female patients after pain relief medication was a given, but she commented that the current textbook and pharmaceutical reference book guidance was based on age, without mention of gender; therefore, she commented that gender should be taken into consideration.

> *On the BNF, it gives the dose of medication according to the age, but I noticed that the way a man and woman present their pain is different and demands different doses of the medication to relieve pain. For example, for the same operation, females tended to be offered more painkillers than male patient. (Saanvi, Y2, Indian student)*

Physicality and genetic differences may affect medication metabolism. The term '**treatment efficacy**' was used to describe people from different groups who may respond to medical treatment differently due to their biological differences (Seeleman, 2009). Specific cultural knowledge encompasses common biomedical genetic elements and responses to illness and treatment due to ethnic and cultural group pharmacology, which relates to medication metabolism responses according to ethnic and cultural group body structure. This relates to epidemiology (the tendency to develop certain diseases or health conditions), diagnosis (due to different presentations of illness) and ethno-pharmacology (i.e., various effects of different medication treatments in ethnic groups). For example, older patients' metabolism is slower than younger people's; therefore, they have a higher risk of accumulating a toxic dose if routine doses are given to them. Exner et al. (2001) reported that Caucasian patients with a particular heart defect are more responsive to Enapril (a medication used to treat hypertension) than patients of African origin. Seeleman (2009) points out that specific cultural knowledge on treatment efficacy can positively influence the effects of the treatment, impacting patients' recovery and hospital stay. However, most students commented that they hardly know any of this and suggested having the opportunity to learn more through either informal or formal education.

4.2.1.3 Individual multicultural identity–multifaceted individual

Dakila, a Filipino who has lived in the UK for over ten years, holds British citizenship and speaks fluent English, but commented that he still prefers to cook and eat Filipino dishes and speak his home language. Conversely, Feihong, originally from China, has lived here for a similar period but prefers to speak in English because she is married to a British man and has two children who only speak English, and her medical-related terminology and knowledge were all learned in the UK.

> *But our roots, we know, we are so happy when we hear but the Philippines, so it's about our identity. Even though we are British citizens, and we can speak fluent English, go to church at the weekend mix with local people, we still have that Filipino identity in ourselves, like we still prefer to cook and eat our own type of dishes and speak Tagalog when we are with Filipino family and friends. (Dakila, Y3, Filipino student)*

> *I did have one experience looking after a Chinese person in orthopedia who broke his leg, so you have to translate this terminology into Chinese. You need to have a bit of knowledge about it as well. So, in some way, I'd prefer English, much easier, because I know the English term; the medication – what's it called; I have to think twice about what's that called in Chinese? Because I don't have a lot of nursing knowledge in Chinese... I... Because I am learning about nursing in English. If I were a nurse in China, it would probably be no problem at all because I'd have nursing knowledge in Chinese, but for me, it's much easier to tell this patient in English. So, it's not much different for me to look after patients, whether they speak the same language as me or not. (Feihong, Y2, Chinese student)*

The above statements show people not only have a physical illness identity, but also hold multiple racial, religious, professional, and social class backgrounds, which influence the intercultural communication. Other participants also commented that all individuals have different characteristics originating in ethnic origin (such as the colour of skin and hair), cultivated from family living and wider societal interactions (such as languages, beliefs, knowledge, customs, and ways of communicating and behaving acquired from education at work and other social connections). Even those who have the same belief may have diverse microcultures, varying by the country where they were born, language and accent, the degree of their religious conservatism, and preferences for food and drink, which highlight the importance of individualised holistic care (Mohammadi et al., 2007). For example, James observed that '*within Judaism,*

Orthodox Jews tend to be buried, but Reformed Jews tend to accept both burial and cremation after death.'

In summary, even though having general and health-related knowledge is useful to bridge with and increase understanding of different cultures, the participants recognised the multifaceted features of individuals' cultural identities and highlighted that ethnic origin, skin and hair colour, and English language capacity significantly impact how they are perceived and consequently how they communicate with others. Focusing solely on such attributes can lead to mistaken conclusions about cultural identity as being historically based on static characteristics; this knowledge is insufficient to understand a culturally diverse population and can easily lead to stereotyping or even exacerbate problems (Dean, 2001). Even if they speak fluent English, this does not mean that people from ethnic minority groups have entirely adapted to British culture and vice versa. To have effective intercultural care, it is paramount to have general knowledge of cultural diversity while also appreciating the complexity of identity, which is individually and socially constructed, contextual, emergent, and evolving. Papadopoulos et al. (2017) highlight that the patient's characteristics, such as age, religion, or language, should be respected and considered as the centre of culturally compassionate care practice.

4.2.2 Knowledge and Awareness Acquisition

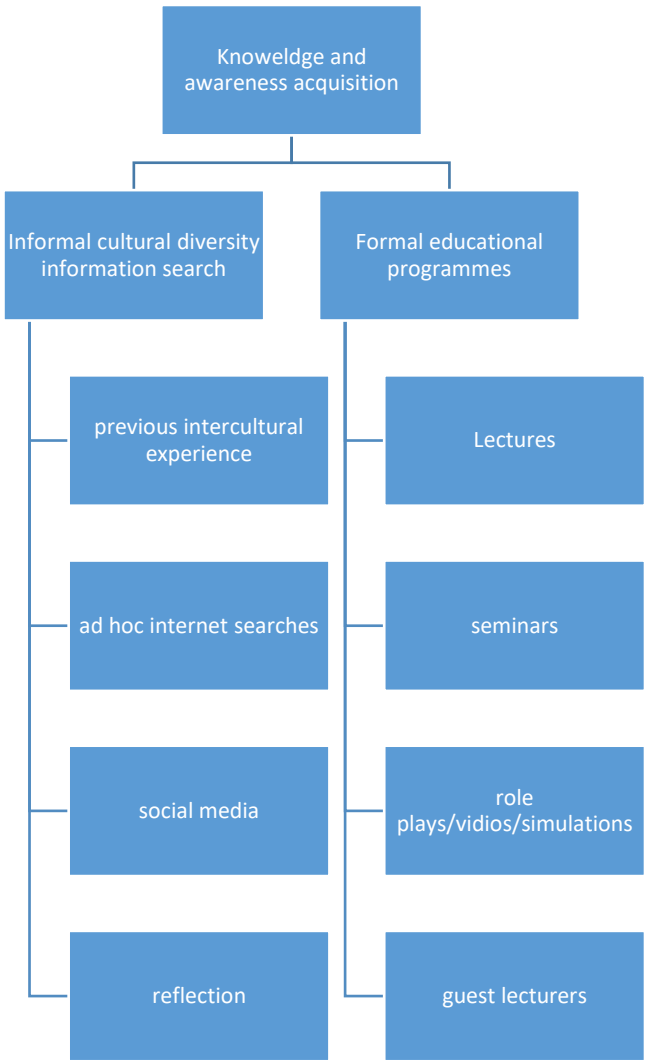
Many participants, such as Barbara, recognised their lack of cultural-related knowledge and valued the competent cultural knowledge in providing quality nursing care.

> *It's regarding Ramadan. I didn't actually realise that any invasiveness, even just nasal - gastric feeding or anything like that is classed as breaking their belief. As a nurse, you need to ensure people's well-being and holistic needs. It's not just physical nursing that they need; they need care for all of their needs, so to have the competence about the culture is important. (Barbara, Y3, English student)*

Historically, culturally sensitive, and congruent care has not been considered an important part of nursing practice. Instead, the focus is on disease management in the medical model (Leininger, 1997). Even when holistic care was addressed, cultural needs were not prioritised. Lim et al. (2004) revealed that nurses who are not

adequately educated in culturally sensitive care find it difficult to function effectively and efficiently with patients from different cultural backgrounds. Participants in this study highlighted the importance of having knowledge and awareness of cultural diversity, and reported ways in which they have acquired their current knowledge (See Figure 4.2.2)., including informal education (such as previous experiential experience from clinical placement and past life events, ad hoc internet searches, social media and critical reflection), and formal education programmes (such as through lecture, seminars, role plays/video/simulations and guest lecturers from patients and experts). More detailed report about their experiential learning from placements, critical reflection and past life experience are presented in section 4.3.6, 4.5.2 and 4.5.2 respectively (see Figure 4.4)

Figure 4.4 *Knowledge and awareness acquisition*



4.2.2.1 Informal cultural diversity information search

Participants reported that their cultural knowledge came mainly from informal approaches, including previous intercultural experiences where knowledge was obtained from patients, their relatives and friends and social media. This is consistent with previous studies (Boi, 2000; Leishman, 2004; Yakar & Alpar, 2018), which revealed that most staff gain intercultural knowledge from their past 'real life' experience when looking after patients from overseas—also called 'learning through doing' (Whiteford & St-Clair, 2002). Senior-year participants also commented that their confidence grew over the years. This shows the importance of having opportunities to be exposed to intercultural encounters and the value of having contact with diverse patient groups since participants commented that each experience brings learning about the new culture and broadens their perspectives. Clinical placement allows students to be exposed to real-life situations, especially patients from diverse cultural backgrounds. This exposure was useful for increasing students' confidence and competence in intercultural encounters (Long, 2012).

Ad hoc internet searches were also used to find relevant information when difficulties were encountered. Even though these informal approaches were recognised as helpful, the participants reported that this information had a '*lack of theoretical support'* (Angela), '*could be not comprehensive'* (Eve) and was '*sometimes not reliable'* (Corazon), which could *'mislead and cause further confusion'* (Michelle). The participants appreciated the complexity of various cultures existing in society and recognised the difficulty of mastering all cultural beliefs and related behaviours. They commented that more formal pre- and post-registration education would help them acquire more detailed, systematic and trustworthy cultural information. This would make them more aware of different values, beliefs and practices, consequently improving their quality of intercultural care (Boi, 2000).

4.2.2.2 Formal educational programmes

According to Leininger (2002b), values and beliefs are essential in cultural aspects of care, and the way to improve knowledge and skills and to avoid thinking in Western-centric terms is best done through formal education. She also suggests academics should add cultural knowledge and skills as a subject in pre- and post-registration

programmes. Participants, such as Azindoo, commented that intercultural communication is an essential part of their daily nursing practice, so it should be an important component of the nursing curriculum. However, they reported that this was either not taught or only '*briefly touched*' upon.

> *The only module which briefly touches on elements of diversity would be on care, communication and compassion. It doesn't [go into] detail, and that was when we were talking about how to react with people with diverse backgrounds. (Azindoo, Y1, Ghanaian student)*

Azindoo's experience supported Yakar and Alpar's study (2018), who found 85% of nursing students reported that they did not receive formal training on intercultural education; even those who had been taught something felt it was only superficially covered. As such, students' knowledge and understanding of different cultures came mainly through ad hoc encounters or influenced by the media. Leishman (2004) also reported nurse education's lack of a focused approach to intercultural education in pre and post-registration courses and commented that the education in this area was too limited to apply the relevant knowledge meaningfully and appropriately.

Participants reported that lack of cultural-related knowledge and inability to obtain it from the patients had caused them anxiety and dissatisfaction. Therefore, to be better prepared for this aspect of care, they suggested that academics place more emphasis on cultural aspects of knowledge and understanding. The findings concur Yakar and Alpar's study (2018) who revealed that 84.5% of staff have not had formal intercultural nursing care education. Plaza Del Pino et al. (2013) also found that cultural knowledge was gained through direct care of patients from different cultures rather than formal cultural training.

Nurses are not expected to become culture experts, but they should have minimal knowledge of cultural-related theories, concepts, and terminology to help them develop cultural acceptance and understanding and treat patients as individuals. This includes exploration and awareness of their own cultural identity to avoid potential ethnocentrism, unconscious bias and stereotypes; understanding cultural issues general and specific to individual health; gaining skills and knowing about facilities available for breaking language barriers, such as interpreter services and alternative methods; and develop awareness of and sensitive approaches to a range of health-

related culture differences and issues (Boi, 2000; Whiteford & St-Clair, 2002). The participants believed that intercultural education should be flexible enough to address the emerging and evolving needs of diverse cultural backgrounds, which Azindoo commented:

> *It might sound too ambitious, but a module tailored towards working in a culturally diverse environment would really help because that module would be solely that and [people] would start to think: my behaviour would have to be a bit acceptable; I would have to do this to this person and that person is quite different and so on and so forth. I know there are a few lecturers who are well shaped with this that when they come to lectures, they are quite interactive regardless of that person's background and after such a person is shaped by the fact that we are culturally diverse and you've got to accommodate other people, you have to give other people the opportunity, if they are culturally diverse, I think it helps shape their orientation. (Azindoo, Y1, Ghanaian student)*

In terms of the types of teaching methods, lectures and seminars were suggested. Lectures were reported to have the advantage of disseminating information to a large group and are the main teaching strategy in nursing education. However, the learning is relatively passive, resulting in lack of engagement, poor knowledge retention and limited behaviour change (Long, 2012). Therefore, participants did not favour lectures for intercultural education. Instead, they suggested the seminar format would help them understand cultural concepts better through group discussion, which allows them to '*exchange ideas*', '*share success stories*' and '*clarify understanding*'. Participants commented that the use of roleplay and simulation to practise and enhance intercultural communication skills in a non-threatening environment in clinical scenarios, and critical incidents drawn from placements, helped lift a *'veil of ignorance'*, helping students '*empathise with cultural minorities*'. Simulated activities also were suggested as valuable tools to help students learn how to accept and tolerate diverse cultures and practices and modify their approaches to nursing care (Ryan, 2000). In addition, viewing videos of intercultural communications and inviting previous patients and expert staff as guest speakers to explore cultural diversities and discuss intercultural issues were also considered appropriate strategies. This concurs with Babyar et al. (1996), who argue that to ensure student nurses value the importance and understand culture-related concepts effectively, and these should be addressed from both cognitive and affective perspectives. However, it is worth noting that in-depth exploration and discussion of some issues might cause distress and discomfort to

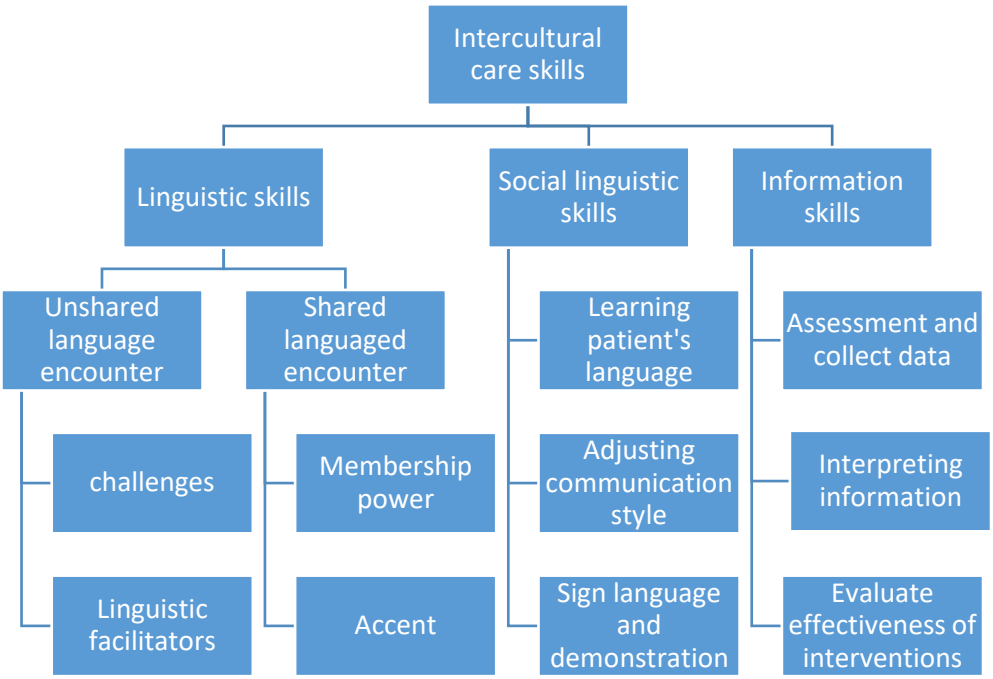
some due to their emotional or political significance (Sargent et al., 2005). These sessions, therefore, need to be appropriately considered and delivered to ensure that the discussion can create opportunities to express strong opinions in a place where trust, respect and safety are fostered and where conflicting opinions can be challenged in a constructive and supportive way. This will eventually help students achieve a positive transformation and appreciation of why and how individual beliefs and assumptions can hinder understanding in ICEs (Iedema et al., 2006; Briscoe, 2013).

In summary, participants identified two types of culturally related knowledge that were particularly useful in daily practice, including general cultural-related knowledge and specific health-related cultural knowledge. They expressed the need for general cultural knowledge about key concepts of care in relation to cultural diversity, such as the proportion of cultural diversity nationally and regionally, concepts of stereotypes, bias, racism, human rights, and worldviews, as they were considered beneficial to help them make conscious choices when interacting with patients. In addition, adhering to faith-related health beliefs and practices, such as modesty, gender preferences, diet/fasting and ideas around causes of illness, could lead to challenging situations. Staff's lack of cultural knowledge could add a further layer of difficulties for both patients and healthcare providers (Yosef, 2008). Participants commented that the knowledge they learned at university was not always applicable. For example, they reported that assessment of acute cyanosis, jaundice and ulceration development were taught based on the colour of the lips, soft tissues, and skin, but that these cannot be used to assess darker-skinned people, and so can potentially lead to delayed treatment and affect their recovery. To provide culturally sensitive services for these populations, it is important for nurses to develop a good knowledge and understanding of cultural diversity and cultural factors that may impact health behaviours and treatment efficiency. In addition, healthcare providers need to acknowledge individuals' multicultural identities since identity is not a stable entity but is socially constructed and may change over time. Therefore, learning about different cultures should be ongoing (Dean, 2001). The participants commented that through informal experiential learning and pragmatic learning strategies via formal educational programmes, student nurses could gain essential knowledge, awareness and understanding of different cultures. This will enable them to respond flexibly, respectfully, and sensitively to patients' needs.

4.3 Intercultural Care Skills

Three essential intercultural care skills emerged from this study, including intercultural information skills, linguistic skills, and social linguistic skills (see Figure 4.5).

Figure 4.5 *Intercultural care skills*



Linguistic and social linguistic skills mean using verbal and nonverbal skills when communicating with cultural others to enable information collection and conveying. They are vital to maintaining an effective therapeutic relationship with patients and collegiality with peers and staff. **Linguistic skills** include paying conscious attention to language and engagement during cross-cultural communication, the ability to speak and understand the other language, as well as the capacity to understand cultural others and make patients understand. Given that some people are speaking a second or third language or that two people may be using English as a common medium even if it is not their mother tongue, the precision of grammar is not essential in intercultural care communication. **Social linguistic skills** refer to using nonverbal and general social means such as body language, appropriate humour, and other adjustments to assist understanding. These are determined by an individual's ability to listen, observe, and assess the patient's condition. This aspect of cultural competence also includes the ability to facilitate the patient's linguistic needs, for example, by altering the tone

of voice and speed of speech or by using body language, sign language and visual aids.

Intercultural information skills are the ability to carry out culturally appropriate physical assessments, interpret information gathered to determine precise needs or make accurate diagnoses and evaluate the effects of interventions according to physical and biological variations. Participants commented that cultural information skills are essential for effective intercultural care; however, they are similar to other information skills in nursing and can be acquired through academic studies and clinical interventions through placement training. These skills are underpinned by intercultural knowledge (see section 4.2), which determines the accuracy of diagnosis and interventions, and consequently affects the treatment and care provided to the individual. Therefore, they consider that if they have sufficient intercultural knowledge and general information skills, linguistic skills and social linguistic skills, they have no concerns in intercultural nursing care. Sheila particularly commented:

> *Except for the language, I don't think there is any problem because if you can communicate with the patient effectively, anything else that would affect the situation you can overcome as the patient could communicate their needs to you, and you can communicate with them, then you can give them the high-quality care that they need (Sheila, Y3, English student).*

Many participants saw linguistic and social linguistic skills as the most important skills they specifically needed during their intercultural encounters and considered that they were the determinants of effective communication and mentioned most in the interview. This is supported by Yakar and Alpar (2018), who revealed that the fundamental competence in ICEs is effective intercultural communication since it is through language (linguistic skills), tone of voice and body language (social linguistic skills) that individuals display their thoughts and emotions, even if subtly. Due to the word

limits in this thesis, this section reports linguistic and social linguistic skills and how participants acquired these skills.

4.3.1 Linguistic skills

Participants commented that effective communication was the most crucial part of effective intercultural practice, with language highlighted as one of the essential factors. For example, Sheila considered language the only barrier to effective ICE since she felt that when the language is shared, there were no difficulties in communicating with and understanding patients, no matter their cultural background since they can always '*get by'* by asking questions directly. Other participants noted that discussion was more effective when people spoke the same language.

> *If there's staff who do speak the same language, then that's a lot easier to discuss things in a more efficient way.' (Nesta, Y1, Zimbabwean student)*

This finding concurs with Yakar and Alpar's study (2018) on qualified staff nurses, in which 94.6% of staff considered language barriers the greatest difficulty encountered in clinical practice. Participants in this study reported that when there was a shared language, it would be easy to accommodate patients' different cultural needs, but when there was a language barrier, only a superficial nurse-patient relationship formed, so it was difficult to identify the patient's specific needs. For example, a second-year student from a native British background, Hannah, reported that when the patient can speak English, communication was '*brilliant*', but when the patient could not speak English, it was '*particularly difficult*'.

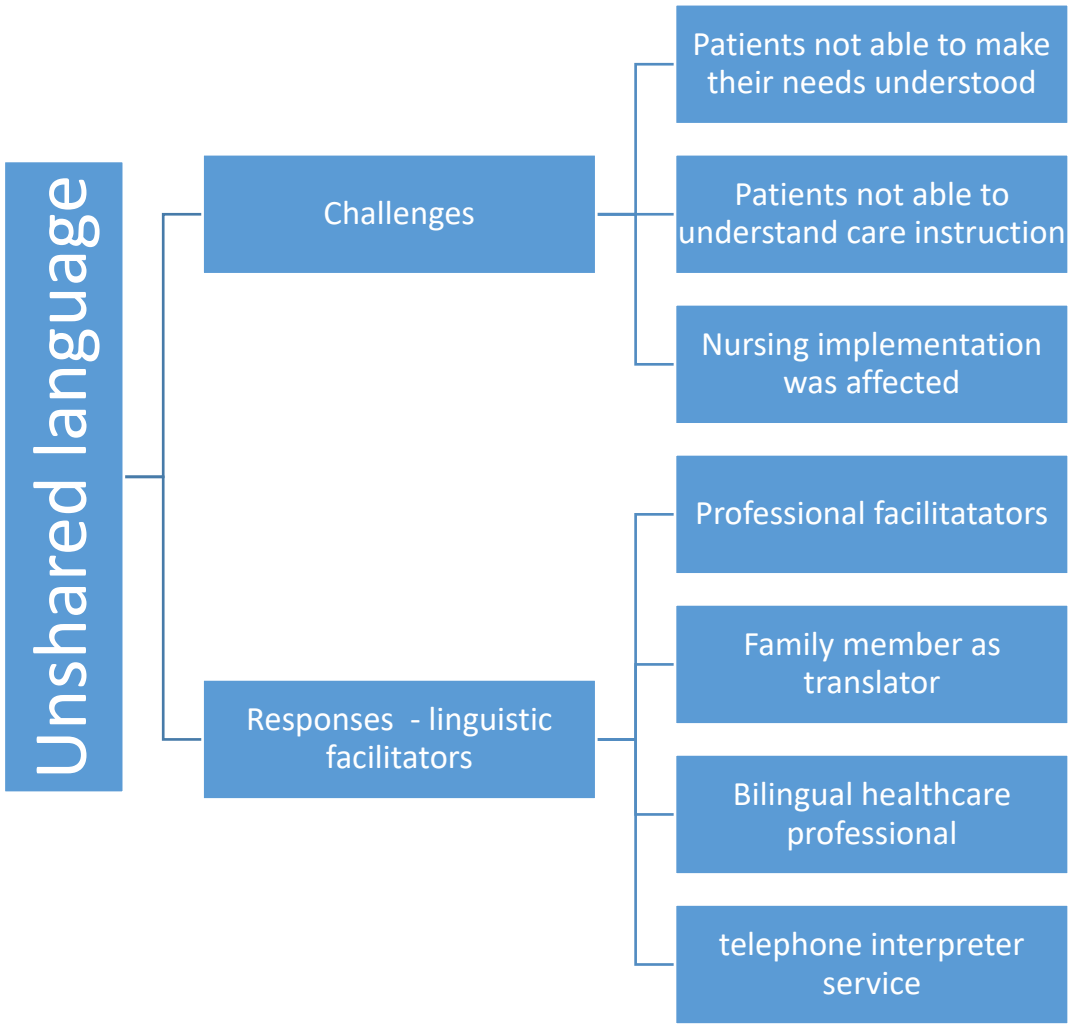
> *We have a big Jewish community, and they're fine because the communication's brilliant. For example, they order kosher meals, and it's fine… but when you've got somebody who doesn't speak English and trying to determine culturally what they can eat. Is it a Halal meal, or do they have a special diet?… It then becomes particularly difficult. (Hannah, Y2, English student)*

Participants reported that they respond to patients' needs differently depending on whether the shared and unshared language is there, as described in sections 4.3.1 and 4.3.2, respectively.

4.3.1.1 Unshared language encounter

When a shared language is missing, the participants reported a number of challenges, which affect both patients and staff care delivery, including patients not being able to make their needs understood, patients not being able to understand care information and instruction, and nursing implementation being affected. In order to break the linguistic barriers, lingustic barriers were used, such as professional interpreters, family members as translator, bilingual health care professionals as translators and tlephone interpreter services (see figure 4.6).

Figure 4.6 *Challenges and responses to unshared language*



1) Challenges

One of the challenges participants commented on most was when a common verbal language was missing. They reported that a lack of shared language caused issues

for both the patient (who found it difficult to convey their needs) and the student nurses (who could explain and carry out procedures to the patients).

- Patients not able to make their needs understood

Without a shared language, participants commented that patients were not able to express their needs to the nursing team. Consequently, it was difficult for the student nurse to assess the patient's need, to understand and provide appropriate care:

> *It's **hard** when you just need to know general things, like how many sugars do they have in their cup of tea? What do they like to eat? What do they normally pick? Are they vegetarian? Can they have fish? … as you need to know these things about a person to make their stay as comfortable as possible; to make them feel like they're not in a hospital as much as you can. (Aimee, Y1, English student*

> *I think she quite often wanted her position adjusted in the bed, or she wanted her pillows fixed, but we just **couldn't understand** what she needed, like she pointing the pillow and you lift the pillow up and she's [tut, tut, tut] and you just didn't know what she wanted… staff were really patient and trying everything they could, but you just didn't know and she was getting frustrated. (Cara, Y2, Northern Irish student)*

Participants also commented that linguistic barriers when describing pain could lead to inadequate pain control. For example, numerical pain assessment tools were commonly used to assess pain, but when asked to rate their pain level numerically, some patients may choose a '*favourite or sacred number*' rather than the number that correctly reflects their level of pain. Also, patients may find it '*hard to describe the type of pain in words'*, or there is '*no equivalent English to translate the meaning of specific types of pain'*. Some may not describe their pain at all '*to disguise their linguistic problem'* and '*avoid embarrassment'*, especially when the nurses show signs of frustration and lack of patience. Consequently, some patients were not given the appropriate amount of pain relief medication (Narayan, 2010). Gorman's (1995) study found that language barriers are one of the key reasons for not meeting the needs of patients from diverse cultural backgrounds.

- Patient is not able to understand care instructions

The lack of a shared language can also cause limited information to be passed on to patients, affecting their understanding of what has happened and potentially causing numerous or even severe adverse effects:

In the practice areas like at Transplant unit, it becomes really complex and very important medications are given, such as Immuno-suppressants. People take them at the same time, but some patients take anti-coagulants at different times of the day for immune-suppressants. If someone's not able to understand and speak English, how are they going to communicate that with you? It's really difficult. It's scary for them. But it's also scary for you. (Barbara, Y3, WB student)

*Certain nursing practice, like doing the **drugs round** with the patients, was a bit difficult because you couldn't tell if she knew what it was. You couldn't have that confidence… but with other patients where you've got a common language, you can discuss what it is, what it's for… It doesn't feel comfortable just handing something over… (Eira, Y3, Welsh student)*

- Nursing implementation was affected

Similarly, when there was a language barrier, student nurses also had difficulty gaining consent to implement nursing care:

*After the operation, we couldn't **assess her pain**, especially in terms of **gaining consent** to look at her dressings and stuff. We couldn't do any of that till ten minutes later when her daughter arrived. So even then, she could have been bleeding, but we wouldn't have been able to ask her for consent to have a look. (Angela, Y2, WB student)*

But it was difficult when I worked the night shift with that lady, but it is just like a language barrier…Well the fact that if she buzzed, we didn't really know what she needed. (Jessica, Y3, English student)

Participants also had difficulties when patients who do not speak English had another physical illness which already affected their therapeutic communication, e.g., patients having eye surgery, suffering hearing loss, are confused or are dying.

*I was on a ward with people who was having **eye surgery**; I had the barrier of them being visually impaired as well as not being able to communicate effectively, so it was quite difficult because you're not going to be able to use visual prompts as much to tell them after the operation. (Ruby, Y1, English student)*

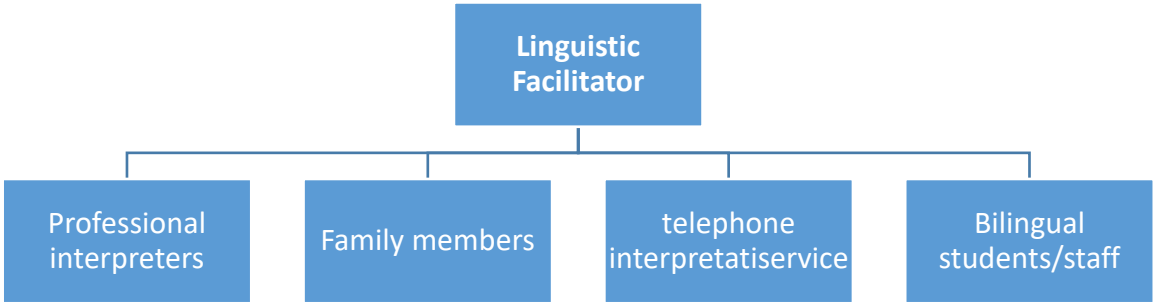
*It was very difficult, because she (the patient) didn't speak English, and she was also **confused**, so there was like a double barrier straight away… She was an insulin dependent diabetic, but don't think she would have ever been able to **give consent**…She couldn't understand the need to get up to the toilet, things like that… They were just saying "toilet" and taking her to the toilet and I don't think she understood what she was supposed to do when she went to the toilet… (Linda, Y3, English student)*

When a shared language is not established, students encountered a variety of situations they found particularly difficult. To manage these situations, different actions were taken (see Figure 4.2), including using linguistic facilitators, the telephone interpreter service, visual/audio aids, personal adjustments and other special measures. This section will focus on the first two, the remaining three measures are described in section 4.5.1.

2)Linguistic facilitators

Some participants turned to linguistic facilitators, including accredited interpreters, family members and bilingual healthcare professionals from ethnic minority backgrounds to deal with language barriers (see Figure 4.7).

Figure 4.7 *Linguistic facilitators*



- Professional interpreter

Professional interpreters are people who have received interpretation training and are accredited by a language translation organisation. Participants reported positive experiences working with professional interpreters when linguistic barriers prevented them from providing effective healthcare. For example, Saanvi and Jessica reported that it was helpful to convey information in both directions and that, consequently, '*the nursing care and treatment plans were able to proceed*. They observed that the patients seemed '*relaxed*', '*reassured*', and '*satisfied*', since they were '*able to express their feelings and also understand the situation'*.

Both student nurses and patients clearly valued having accredited interpreters to facilitate communication. Many studies also revealed the benefits of using interpreters to assist nursing care, facilitate therapeutic relationships and enhance patient satisfaction (Aboul-Enein & Ahmed, 2006). The professional interpreter enhances the patient's understanding, which in turn fosters trust and depth of discussion regarding treatment and care (Zurlinden, 1995). However, participants revealed that most of their

experiences were gained with community nurses and public health staff; they had limited first-hand experience with interpreters in hospitals, since those services were mainly accessed by doctors rather than by nurses. This finding is consistent with other research (Flores, 2005; Gerrish et al., 2004; Gerrish, 2001), suggesting an urgency to raise health professionals' and managers' awareness of the importance of using interpreters when caring for patients with limited English language proficiency. There is also a need to ensure sufficient financial support so staff can access interpreting services, given the challenges and potential serious consequences for these patients.

> *For the Romanian patient, the interpreter used to just come once a day in the morning before the doctor's round. So the doctor can communicate with him… so the interpreter was used for the doctor's ward rounds, not for nursing care. (Saanvi, Y2, Indian student)*

> *There are only two times in 3 years that I've come into contact with interpreters. The first one was to relate to explaining the diagnosis or collecting information with the doctor. The second one was before the operation, so obviously, doctors, surgeons, anaesthetists, they were all involved. (Jessica, Y3, English student)*

When the participants were asked why accredited interpreters were not accessed for nursing practice, the reasons given included" '*complicated procedures'*, '*nonavailability*', '*last minute cancellation*'. Staff members' '*lack of proactivity to access interpreters'* was also reported, with '*financial constraints'* being the most reported reason. However, a second-year student, Cara, stated strongly that cost should not be a factor, considering the importance of having an interpreter to assist in effective patient assessment and treatment.

> *I don't think the cost of an interpreter should matter. If the patient was lacking English that much, especially she was in her 80s and she was quite frail, and I think she's massively vulnerable, it wouldn't have mattered at that point. (Cara, Y2, Northern Irish student)*

The amount of '*time spent waiting for'* the interpreter to arrive was another issue. One participant was disappointed with the interpreter service, reporting that their patient was already discharged by the time the interpreter eventually arrived. This shows the need for more efficient service administration to increase the accessibility and availability of accredited interpreters in practice, either by employing more accredited interpreters or by using alternative interpreting facilities such as telephone or online services (Flores, 2005). In addition, interpretation requires the students to speak more clearly and be prepared to give *much longer time in this three-way conversation*, to

help the interpreter to understand the condition. This implies that it is crucial to raise awareness of the skills required to engage in this type of communication effectively and to ensure students and staff who work with interpreters have sufficient training to communicate effectively and accurately.

Several participants who used a professional interpreter commented that they felt comfortable and confident talking to them. However, some raised concerns about confidentiality, dignity, accuracy, efficiency, professional knowledge and approach and special skills required to carry out this tri-Logue communication. Several concerns were also raised, such as '*lack of accuracy',* possibly because even though they may have passed an English language proficiency test, the interpreter may not have knowledge of the relevant medical terminology (Zimmermann, 1996). Due to the interpreter's '*lack of healthcare knowledge'*, the participant had to spend '*a lot of time*' explaining basic medical procedures and was still concerned about the accuracy of the information translated to the patient. As such, there is a need to develop interpreters' essential healthcare knowledge further.

Some students also addressed the issue of '*breach of confidentiality'* since patients might not want interpreters to be around, especially when personal issues are disclosed. This indicates the importance of professional training for accredited interpreters to gain confidence and trust from staff, students, and patients. In addition, '*concerns about dignity*' were raised since interpretation might involve a patient's physical assessment, and the patient may not want their body or wound to be viewed by a stranger. Similarly, the student commented that there was no choice around the interpreter's gender, which patients from some religions are particularly strict about; they suggested that it would be ideal if staff could choose the most suitable interpreters based on their gender and/or previous customers' (patients and relatives) reviews (Timmins, 2002).

One student was concerned about the interpreter's '*lack of professionalism'* based on his experience when the interpreter raised a discussion on health and safety practices rather than performing her role as a translator, which the participant did not think was appropriate. The student commented that further training is needed to ensure interpreters are competent and consider data protection, confidentiality, and

professional boundaries to be essential. Interpreters' health knowledge, professional approach, timing and availability were also highlighted as important:

> *[Interpreters should] go through like a **training process**, like with **confidentiality** and **data protection** and things like that, generally just to go through a process when you go for a job… I think that **health knowledge** would help immensely, because if the patient asks, "what does that mean?" Explaining what needs to be done to a certain part of the body, and if the patient obviously doesn't understand what that is, the translator, instead of asking us if she has a bit of knowledge, then she could say. I do think it would help… Also, **timing and availability**. 'Cos in case of an emergency, you need a translator there and then. If the patient needs to sign a consent form, you can't do anything unless the patient understands and has signed… (Daisy, Y1, English student)*

In summary, even though professional interpreters can help patients with linguistic barriers, some unsatisfactory experiences were reported. In this study, no students mentioned being involved in customer reviews after they had accessed interpreting services. It might therefore be useful to ask patients or their families and staff who have accessed the interpreter service to complete a survey to share their experience. Further training should then be provided according to this feedback. Students also commented that it would be ideal if staff could choose the most suitable interpreter based on their gender and/or previous customer reviews. Similarly, Tuohy et al. (2008) found that nurses identified the importance of using the same interpreter for patients, so that the relationship could be maintained across all parties.

- Family member as translator

All participants reported that they had used a patient's family member as a translator to assist communication, and they felt this was a *much more convenient and helpful* way to identify the patient's needs than accessing professional interpreters.

> *It's only when there are doctors around, then they use [interpreters] for, like when they have meetings. But then, mostly, from what I've seen, they just use families. (Dakila, Y3, Filipino student)*

> *When his daughter was there, it was a lot easier… it was very helpful that the daughter was there, but when she did go, it was hard because there was a huge language barrier. (Matthew, Y1, English student)*

However, participants also expressed concerns about using family members as interpreters, including a lack of accuracy in translation (due to bias and limited health

knowledge), patient confidentiality, availability issues and lack of interest in translation. Several students had concerns about '*bias'* because family translators may not want patients to know things, which may affect whether the '*information [is] accurately or completely passed on to the patients or translated to staff*'. This idea was also reported by Murphy & Clark (1993), who explained the reason for filtering information was because it was considered sensitive or personal. Participants were also concerned that family members do not usually have a medical background, so they may have '*limited healthcare knowledge'*, which could complicate the translation process as well as the quality of the translation. Participants also raised concerns around the '*risk of breach of patient confidentiality'* since a few patients seemed to not want their relatives to be aware of certain personal matters. Even though participants reported that they had used family members to translate, some family members had *limited availability* to provide this assistance due to work or home commitments. While most relatives are supportive and willing to help, a few students witnessed some relatives showing *a lack of interest* in assisting with the translation process.

Some students preferred to use a family member rather than a professional interpreter (Nesta), while some presented the opposite view (Daisy). A couple of students commented that the combination of both a professional interpreter and family members is a better way (Aimee).

> *Compared to professional interpreters, I think relatives can interpret more accurately because they know that person more than the interpreter does… It's their relatives, so they know so much about the patients… They know about their preferences, what they prefer, and just in general, their likes and dislikes. So yeah, they'll be able to tell you more. (Nesta, Y1, Zimbabwean student)*

> *I feel interpreters are better than family members. 'Cos with the interpreter, you can actually say more, even though it's still confidential. But you can actually go into greater depth, especially if the patient doesn't want the family to know too much, and then the translator is the only option. (Daisy, Y1, English student)*

> *I think for little things like asking what they like to eat and how they normally transfer or are they normally self-caring, you can ask the family. I think you need an interpreter for important things to do with their will or different things like that. I don't think you should be asking the family things like that because you don't know what their interior motives could be… You can't always trust what people's motives are, can you? (Aimee, Y1, English student)*

However, the patient wanted both (family and the interpreter). So, they would have the translator at one stage and then obviously have their family there all the time with them. So, they've got the best of both worlds. For me, I also like the combinations of both because I think both would work better than just like the family. (Daisy, Y1, English student)

The findings revealed that family members had been used as an alternative measure for patients who require language support. This concurs with Anderson's (2003) study, which reported that only 12% of translation was done by interpreters in contrast to 88% of linguistic facilitators being family members or ad hoc hospital staff. It is reported that patients in certain cultures may prefer to have relatives close by to translate for them (Gerrish et al., 2001). While this may be a convenient way of dealing with communication obstacles, participants expressed several concerns about this approach. For example, perceived biases in interpreting information were reported, since relatives selectively chose which content to translate to avoid embarrassment or cause their relatives to stress or worry (Bradby, 2001). Despite relatives' being able to make social conversations in English, they lacked knowledge of medical terminology and subsequently may not be able to translate complex medical concepts and procedures (Flores, 2005). Participants were concerned about the relative's lack of professional training, which may lead to mistakes in information exchange, inaccurate medical histories being taken, and consequently to the risk of inappropriate interpretation and intervention. In this circumstance, nursing staff need to be aware of the limitation of using a family member as a translator and balance this against the quality of the interpretation service and the patient's wishes. Also, the UK government and NHS face more and more financial stress, so it is hard to budget the cost for face-to-face 24-hour interpreter services for medical and nursing care.

Participants were also worried about ethical issues around confidentiality since some patients may not want their relatives to be aware of their illness. Furthermore, some family members may have work or other commitments which impact their availability (Jirwe et al., 2010). Participants reported that while some relatives were quite supportive and willing to help, others had shown a lack of interest in being involved in translation. It is therefore important that student nurses and qualified staff are aware of these potential problems when using family members as interpreters, and they should offer patients and their relatives the choice.

- Bilingual healthcare professional as a translator

Apart from using relatives as interpreters, several students witnessed members of staff and students from EM backgrounds being accessed to assist communication, with positive outcomes.

> *We had a **Czech** lady who couldn't speak any English, and she needed consent for a procedure, so we tried to get an interpreter for that, but luckily, there's also a lady in the cath labs that spoke Czech, so we managed to get her up and explain everything immediately. (3M1203, third-year English student)*

Participants observed different approaches being used to access bilingual staff, such as a *staff notice board* on the *hospital intranet* and *speculative telephone calls* to other wards to find staff who may speak the same language as patients. Students who have bilingual and multilingual capacities also offered this service and commented positively about their experience '*because [you] can do something different for that person and make a difference in somebody's life'.* Students who did not speak a second language commented positively about having staff and student colleagues who could speak a second language. They suggested recruiting more bilingual staff and having a record of bilingual staff and their proficiency to help overcome language barriers.

> *Sometimes people who work in the hospital have second languages, and that can help… It would be quite handy if you had a list of who worked for the hospital and had second languages and how fluent they were, and you could just access them if you wanted to. (Eve, Y2, English student)*

In this study, staff from the same ethnic minority background and with the same language as the patient were reported as successfully interpreting healthcare interventions. This is consistent with other research that found staff who can speak second or more languages (such as overseas recruited staff and students) were evaluated positively in facilitating communication (Cioffi, 2003; Bradby, 2001; Robinson, 1998). The participant noted above also showed high satisfaction with intercultural communication and suggested that it would be beneficial to have more bilingual staff. This finding also echoes Flores' (2005) study, which reported the value of bilingual healthcare providers to EM patients in terms of job satisfaction, quality of care, optimal intercultural communication and healthcare delivery. The participants also suggested that '*recruiting more bilingual staff and having a record of staff*

members' language proficiencies during the recruitment process, with their preference of whether they would like to help in situations when an urgent interpreting service is needed, would be helpful'. To increase student nurses' bilingual capacity, universities may also consider providing language lessons for student nurses interested in learning a new language.

- Telephone interpreter services

When linguistic facilitators are unavailable, the telephone interpreter service, also called the 'linguistic helpline', was used. A telephone interpreter service functions in the same way as the face-to--face interpreting service translating information to the patients in their language and then translating the patient's information in English to staff. This service enables access to professional interpreters over the phone rather than having them physically attend hospital settings. Even though participants reported that they were aware of the telephone interpreter service, many commented that they had never heard of this service before. Therefore, there is a need to raise student and staff awareness of the variety of language facilities available and to allow them to choose these according to their needs. To do this, it may be beneficial if universities invite former patients and staff who can speak different languages and accredited interpreters, to talk about their intercultural care experience and facilitate nursing students' exchanging experiences of ICEs during placement. In this way, students who have accessed telephone interpreting services will be able to share their experience with those who have not encountered it.

> *The only interpreter service I've personally accessed is the translator over the phone, where you ring the line, and you ask what language they need to speak, and you say what you want to get across to the patient and then they obviously translate it into their language. (Margaret, Y3, English student)*

Participants who accessed the telephone service reported benefits such as '*quick and easy access'* and '*cost effectiveness'* compared the face-to-face interpreter service. In comparison to having family members translate, students found the telephone service to be '*more factual'* and able to '*provide more accurate'* information. However, some participants commented that they still '*prefer to have face-to-face communication'*, as this allows '*facial expressions and relationship building'*, which are useful to assist judgement in interactions. Nevertheless, some students raised concerns about this

service, including '*added patient anxiety'* due to a lack of trust in the telephone interpreting service, '*variation in local dialects'* and '*poor quality of translation'*. This suggests the quality of interpreting services needs to be improved by employing only competent linguistic staff with adequate healthcare knowledge and communication skills.

In summary, from their experiences with linguistic facilitators, participants reported a variety of benefits and limitations of these services and suggested that the NHS should have a better system to ensure more interpreting services are available for patients whenever needed. Even when translated materials are provided to the patients, interpreters should still be available if they have any questions (Yakar & Alpar, 2018). The telephone interpreting service was reported to have the advantages of easy and quick access and cost-effectiveness compared to face-to-face interpreting services, but it seems that students are not fully aware that this service exists. Some students preferred face-to-face interpreters '*because facial expressions helped judgement in interactions*.' Students also raised concerns such as additional patient anxiety caused by a lack of trust, variation in local dialects and poor quality of translation. This means that service managers not only need to make sure a variety of linguistic facilitators are available but also raise staff awareness of their existence and the strengths and weaknesses of different types of facilitators so that they can select appropriately.

> *I've found that they generally get more distressed 'cos they don't understand what's going on. If we can't get interpreters out, then at least someone who can let us explain to the person on the phone what's going on, any new changes or anything that's important that they need to know, and they spend two or three minutes, it would probably settle the patient a lot more than not knowing anything. (Laura, Y3, English student)*

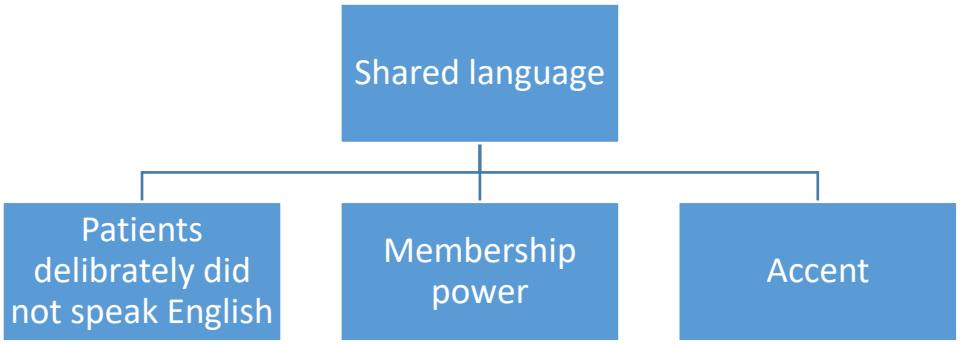
Although the importance of using professionally accredited interpreters to facilitate cross-cultural communication is widely recognised, many studies revealed that they were not used sufficiently in the UK (Gerrish, 2001), Sweden (Jirwe et al. 2010; Lundberg et al., 2005) or Australia (Cioffi, 2003) due to perceived financial constraints. For this reason, relatives of patients were commonly used as translators in the information exchange process. Even though using relatives may be convenient, doing so raises several concerns. For example, they are not always available when needed and relatives may lack professional training, which could lead to mistakes in

information exchange (Jirwe et al., 2010). Bradby (2001) found that patients and relatives selectively chose which information to translate, particularly when the exchange involved personal information, which might cause embarrassment or cause relatives stress or worry. Gerrish et al. (1996) highlighted that even though relatives may be able to convey daily social messages, they might not know enough medical terminology to help them understand their relative's illness and its related care and treatment. This situation may lead to misunderstandings and the wrong information being passed on, with severe consequences. From an ethical perspective, Robinson (1998) asserted that using family members as linguistic facilitators can breach confidentiality since patients may not want to share their medical condition and related information with their relatives. Resolving these issues is not easy. While alternative arrangements such as using telephone interpretation services, have been reported, there is no literature evaluating the effects of these services.

4.3.1.2 Shared language encounter

Despite the language being reported as the main challenge encountered during intercultural communication, some participants commented that they experienced difficulties in communication. This includes when patients deliberately not speaking in English, membership power issues and accent (see Figure 4.8).

Figure 4.8 *Challenges in shared language*



1) Patient deliberately did not speak English

that even when people were able to speak English, they experienced communication difficulties for different reasons, including '*the other part chose not to communicate by deliberately not speaking English'*, '*personal preferences of language choice'* and *'illnesses*. For example, Zoe reported her experience when the patient chose not to

communicate her needs by creating a linguistic barrier for religious reasons, which she felt was '*the hardest obstacles*' in delivery care to this patient. When this occurred, Zoe approached her clinical mentor for help, which she was advised to leave the patient alone until her relatives arrived.

> *She was an older lady. She did have some parts of English that she would use, but other times, she didn't really want to communicate, so she would just talk in her language, and it was quite a struggle. So, she would perhaps create this language barrier. I feel myself useless because I couldn't help her. She couldn't tell me she needed to help her. It was one of* ***the hardest obstacles*** *I've probably ever come across….it was not because of language barriers, but it was a lot of barriers, I think. From a religion perspective, she didn't want to speak to a male student or staff even in hospital, especially in front of her relatives. (Zoe, Y3, English student)*

2) Membership Power

The participants also reported experiences working with staff from different ethnic minority backgrounds. Most commented positively that working with multicultural staff brings an '*opportunity to view culture differently*' and praised their '*hard work*'; however, one English student experienced difficulties when a group of ethnic minority staff spoke their own language at work and during break time. She said it made her '*feel excluded from the conversation*', so she felt '*isolated, scared, and worried*'. This shows the membership power of the 'shared known' (such as language) in intercultural communication.

> *On occasions in the staff room, I was working with three or four Filipino nurses, everyone would come in and speak a different language, and I would be sitting in the tearoom, but I wouldn't understand anything that they were saying and wondered whether they were talking about me or not… I feel not intimidated but a bit isolated, scared, and worried, especially being a student and not knowing people very well. (Margaret, Y1, English)*

Membership power is an important influence in intercultural communication. When communicating with others, the group members within the organisation tends to be noticed, which is associated with power. In clinical placement, individual statuses (such as student nurse, staff nurse, ward manager) hold different levels of power in IC, which can affect the way interlocutors communicate between members of different groups. As a first-year student, Michelle became the minority in that group despite

being in her own country; she felt disempowered compared with qualified nurses from ethnic minority backgrounds, which explains why she felt isolated and worried. This potentially affected her quality of clinical performance and learning (see section 4.4).

3) Accent

The **Accent** is also highlighted in this study. Edwards (1999) argues that accent carries an important part of the individual's social identity. Residents who were originally born and have lived in North East England may develop a 'Geordie' accent, which has significantly different intonations to those of people who come from other parts of the UK or other English-speaking countries. Some students experienced difficulties understanding the strong Geordie accent. For example, Emily, who is from the Midlands in England, struggled to understand people with a strong local accent, which she commented could potentially cause misinterpretation. Even students who have already lived in North East England for three years still have difficulties understanding patients who have a strong Geordie accent.

> *I think some patients who might be hard of hearing might struggle with various accents if they've lived in the Northeast all their life and all they've heard is a Northeast accent..., if you have someone with a very strong accent who is a patient, like Glaswegian and a very Geordie accent can be difficult, there are people I even struggle to understand, even though I'm from this country. (Emily, Y2, English student)*

> *When I first started, I thought everyone's culture was different to mine because someone said there's a North and South divide. But I really did notice that. Not in just a massive way, just I could not understand Northern people's strong Geordie accent...I still struggle even though better than before. (Zoe, Y3, English student)*

Even though all participants spoke English fluently, some from ethnic minority groups had their accents addressed in practice. Miremba, a first student from Uganda, started to learn and speak English when she was at nursery school and had no problems socialising with English-speaking friends; she commented that she was asked to repeat again and again during placement when she tried to make comments. This was possibly due to a stigma associated with her accent (Gluszek & Dovidio, 2010). Lindemann (2002) revealed that prejudiced listeners spend less effort and patience understanding accented speech. This may lead to lowered comprehension and negative perceptions of problems in communication and social acceptance (Ryan,

1983), which might contribute to the speaker's loss of sense of belonging, an important part of human social needs (see section 4.4) (Baumeister & Leary, 1995). This explains why Miremba commented that her biggest fear in practice was answering the telephone since she was worried about whether people would be able to understand her, hinting towards worries around social acceptance in the placement context.

> *Luganda is my first language, and English is my second language which I learned from when I started nursery school…I've said something, and then I was asked to repeat it again and again, because they said they don't understand the word. And the word I said was English, but I think it's because the accent is different from Northeast to Africans … It's the same word, but the way they pronounce it may be different from the way I pronounce it. (Miremba, Y1, Ugandan student)*

> *The biggest fear in communicating with the culture of others is: will I understand them? Will they understand me? Even though I know people can understand me when I'm outside, in different settings like in practice, fear I've got inside me and question myself will they understand me? Will I understand them? I used to have this [fear] of answering phones… because I've got this, I fear I'm not going to understand what they're saying because of their accent. It's different to face to face communication because you're looking at them and you're reading their lips. But on the phone, you can get somebody, whose accent is really strong… or they're so fast that I can't understand…Somebody just listens to your accent and they just know it's an African… (Miremba, Y1, Ugandan student)*

Apart from interacting with patients, one participant witnessed staff nurses frequently mimicking and laughing at her. This caused a qualified Filipino nurse to struggle to be part of the team, mainly because her accent signals her difference from the majority staff team. She felt weaker as a foreign worker from a developing country, especially when her native colleagues overtly expressed stigmatised behaviour in front of her (Gluszek & Dovidio, 2010).

> *There was one Filipino nurse who was really good at what she was doing, but just because of the way she pronounced the words, as soon as she wasn't around, they were abusing the words the way she says. "Oh, I asked, he and she said…" But they didn't mention it in a nice way; they were mimicking the way she mentioned the words, behind her back. And I saw that over and over, sometimes giggling, sometimes talking… She felt that. She knew that because when we were in the break, she was normally alone in the break, or one or two from different backgrounds… Not because they wanted to go*

with her, but because they had to go at that time…. And she says, "I'm used to it". You could see she was struggling to be part of the team. (Mohammad, Y3, Iranian student).

Students and staff from ethnic minorities reported negative experiences due to their accents. This indicates a need to help them develop positive social identities and raise native speakers' awareness of their ethnic minority colleagues to foster a welcoming atmosphere and bolster their confidence and sense of belonging. For example, Laura, a third-year native British student, shared her strategies when encountering difficulties with ethnic minority accents and commented that it was mainly '*through talking and getting used to the accent'* by chatting about general things such as where they are from. Another student, Margaret, said asking them to '*speak slower'* and *'repeat politely'* also helped.

This is one of the strategies used when encounter people from different cultural backgrounds, I start to talk first and then work out what accent, how strong… And then figure out in what way to talk as I don't think you're going to know unless you actually talk to them, so I just had a general conversation, like where they're from, where did they train, how long have they been on this ward? How did they find it? …just through the experience of talking, they're very interested in talking about where they've come from, so they're quite willing to chat to you about how they've got here, then within about 30 seconds, you know whether you're going to be fine, or whether you're going to have to sort of change tactics and think about how you're going to chat to them, … Most of them, there isn't an issue at all. (Laura, Y3, English student)

Some of them [staff from the Philippine] do talk very fast during the handover time, and you can't get what they were saying… On a few occasions, we've had other staff members asking them to stop…They then stop and explain that helped. (Margaret, Y3, English student)

Compared to ethnic minority students, English students from other regions in the UK did not report discomfort with their accents, possibly because they had a shared British national identity, so they did not need to worry about being accepted (Adank et al., 2009). Therefore, their worries about communication problems were significantly lower. Some even viewed the variety of accents as an opportunity to experience differences, open conversation and build a rapport with others. For example, a second-year Northern Irish student, Cara, noticed that some staff hold stereotypical views of the Northern Irish, such as liking alcohol. They were interested to find out whether this

was true and to hear Cara's view, something which she did not mind sharing. Her positive approach also helped her to be introduced to other Irish staff, which made her feel welcomed in the placement area.

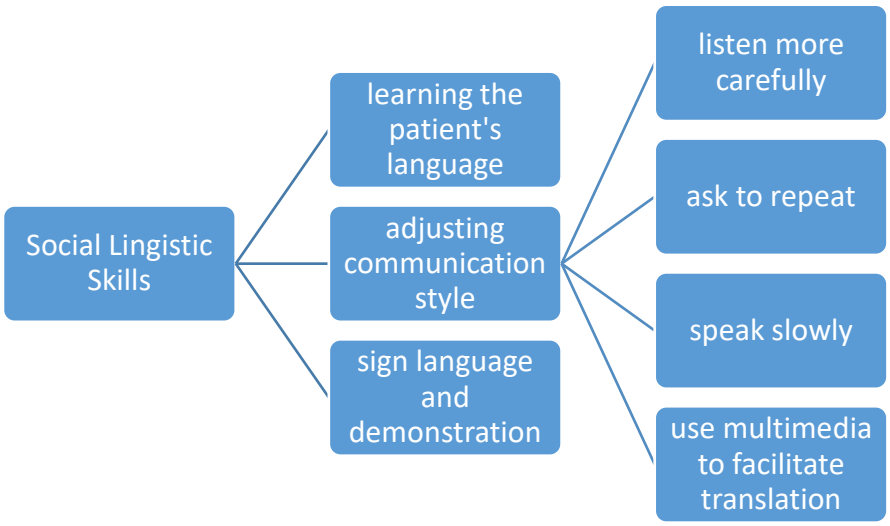
> *They stereotype Irish as being drinkers and liking alcohol stuff, so they were more interested in learning about my background and what we did… I don't mind sharing this as I found that it was lovely. And there was an Irish doctor and an Irish physio on the ward, so they quickly introduced me to them. So, it was lovely that they made me feel really welcome. (Cara, Y2, Northern Ireland student)*

In summary, despite participants' initially commenting that the lack of a shared language was the most challenging part of intercultural communication, they later commented on difficult situations even when the shared language was established. These controversial observations and statements hinted that a shared language is not sufficient to accommodate different cultural needs and that other aspects are required to manage intercultural situations in clinical practice, such as adequate intercultural care knowledge and appropriate attitudes. Membership power and accent-related issues were revealed in this section. Although native British students from different regions encountered accent differences during the placement, students from ethnic minority backgrounds reported negative perceptions of being stigmatised and discriminated against, which caused anxiety and a sense of not being part of a team. The reasons behind such attitudes and ways to deal with these will be discussed in section 4.4.

4.3.2 Social Linguistic Skills

When language facilitators are not available, students reported that they used various social linguistic skills to keep the communication going and establish relationships, including '*using body language'* (or gestures), '*physical demonstration'* (or mime), '*using sign language'*, '*handwriting'*, '*learning the patients' language'*, '*teaching patients how to speak English'*, '*giving more time'*, '*changing voice/tone/speed of speech'*, '*asking to repeat'* and '*asking for help'* from their mentor and other qualified staff, with some positive effects (see Figure 4.9). These will be discussed in more detail in section 4.5.1, attentative cultural engagement to gain understanding and sensitive cultural actions to accommodate.

Figure 4.9 *Social linguistic skills*



Some participants changed their communication style to ease the communication, using, for instance less clinical language, slang and jokes, which were commonly used in daily practice. Aboul-Enein and Ahmed (2006) suggest that simple, daily words instead of complicated or medical jargon should be used when a language difficulty is encountered.

> *I was caring for a lady from Bangladesh who had very recently moved to the UK to meet her family and spoke quite broken English, so I tried to use less clinical language and also use **less terminologies and British slang** that I would usually use, so I tried to use a more formal English and **cue cards**, **hand signals that are universal**, that actually helps quite a lot, and I felt she could understand what I was trying to so we kind form a kind of simple basis for that level of communication. (James, Y1, English student)*

> *Just to try to come down to her level a little bit and explain in a simple way. The patient felt happy about being answered and knew what's going to happen. (Feihong, Y2, Chinese student)*

1) Learning the patient's language

Some student nurses even made attempts *to learn the patients' language* from friends or the patient's families, demonstrating their care and compassion towards their patients (NMC, 2015). Consequently, those participants reported that patients became more cooperative and satisfied with the care provided. Students who participated in international placement also commented on their experiences of learning the patient's

language in providing daily nursing care to establish communication with local patients and understand their needs.

> *I asked his son to teach me: how do I say "hello", her name and what she would like us to call her while she's here, so that I could introduce myself, and then she was thrilled with that when I very badly pronounced what he told me to say…she smiled and big beaming smile. (Eira, Y3, Welsh student)*

> *I actually rang my best friend, who's fluent in German, and asked her keywords like 'toilet', 'pain', 'sitting', 'standing'… I wrote them all down and photocopied them for the people who were in that bay to try to figure out what she wanted…we managed to get her to and from the toilet and give her painkillers when she wanted. (Laura, Y3, English student)*

> *I only started learning Portuguese the year before I went, but [when I got there], I realised how little I'd learned… so it was a team effort between the patient and me to try and help each other understand what we're talking…I think it helped to understand the patient's needs more and to try and facilitate them to be able to communicate. (3S1206, third year English student, had international placement in Portugal)*

2) <u>Adjusting communication style</u>

When they encountered linguistic difficulties, participants used various strategies to help people understand, including *listening more carefully*, and *asking them to repeat*, with positive results. In addition, some participants also made efforts to change the speed ('*speak slower*') and tone of voice ('*soft tone*'), to help patients understand and, at the same time, make them feel respected. They have also *used multimedia to help the patient translate* between their home language and English. Participants provided extra checks and were more attentive to helping when there was a linguistic barrier to ensure that the patients did not feel neglected.

3) <u>Sign language and demonstration</u>

Sign language was used with some effect'; however, they admitted to having only limited skills since they had not had any formal courses in this skill. Some participants commented that sign language differs across countries. In general, however, they expressed their wishes to learn more and suggested the hospital or university could offer such a course for people who wanted to learn.

> *Sign language is a cross-cultural thing because different countries have different sign languages; there's the British Sign Language and American one… I don't know if they're similar and to what extent they're different….there was lots of different families which have their own versions of sign language and to make it a standard thing across the*

country, so that if somebody from London moved to Edinburgh, they would still be able to communicate, so it's not a different…. (Eira, Y3, Welsh student)

To include the patients in social conversations with the staff, participants used '*demonstration'*, and all found it useful. Students *used a variety of body language*, which was valued highly. Nonverbal skills such as hand gestures and facial expressions are useful methods that help patients to gain some understanding (Aboul-Enein & Ahmed, 2006). However, the students also noticed the limitations of using body language, indicating a combination of different linguistic and social linguistic skills offers a better solution.

*We tried different ways to keep the communication going, like **nodding**, **smiling**, **gestures** and **staying lower** when communicating with him, I would either be at eye level or obviously down at the level where I would be helping him with his slipper, and that would be opportunities for me to look up and see: is this okay for you? Are you happy? And then he'd tend to nod. (Michelle, Y1, English student)*

A lot of body language is used in situations, and is quite effective as well, but there are limitations since you can't find the degree of pain… What type it is… Is there anything else? You can't investigate it or assess it as thoroughly. (Alice, Y2, English student)

This section reported and discussed different social linguistic skills student nurses have used to facilitate effective intercultural communication. These include altering the speed and tone of voice, using simple plain words, and avoiding jargon and using demonstration and body language. The participants highly valued these skills and recognised that the linguistic and social linguistic skills they demonstrated could either make others feel part of the team or make them feel excluded, which can affect their wellbeing and sense of belonging (see sections 4.4.1). With purposeful, sensitive efforts, they reported some positive effects, which revealed that artful intercultural care skills when assessing, interpreting and performing nursing procedures are particularly useful for building a positive therapeutic relationship with people from diverse backgrounds (Giger & Davidhizar, 2008).

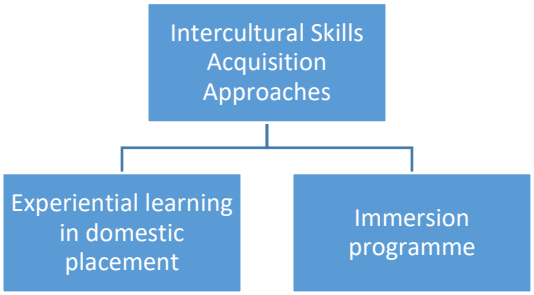
*I think **body language** was useful, like the gesture…used alongside the **picture cards** was really good. Everybody knows that [gesture], 'drink'. But what drink do they want? we used a milk bottle and a picture of a cow and then a milk bottle with milk in…So we used a mixture of different cards… **It's how you build up that relationship with the patient**…So, it's a combination of a lot of things. Pictures, body language and your own*

observation of your patient's facial expressions to assess the pain. (Zoe, Y3, English student)

4.3.3 Intercultural Skills Acquisition Approaches

Even though the language is important in intercultural communication, some students realised that linguistic competence is not the only criterion for IC; many other skills are equally important, so they should not be complacent when their interlocutors speak the same language. They commented that most of their intercultural skills come from experiential learning from local clinical placements and immersion programmes (see Figure 4.10).

Figure 4.10 *Intercultural skills acquisition approaches*



Experiential learning in domestic placement

Students' intercultural knowledge and skills are gained mainly from direct nursing care during placement, which they labelled as '*learning by doing*' or '*trial by error*'. This included observation of the different ways patients present their illness and personal needs; different expectations of, and responses to, nursing care; access to interpreter services and other linguistic facilitators; and different approaches to breaking down communication barriers. For example, Zabe asked the patient's relatives to interpret to help the doctor to identify the issue and clarify the surgical procedure based on his previous experience with this patient.

I was struggling to call the patient's name, but the son-in-law, when he came to talk to me, I found it quite useful because I was going to have [communication] problems. Normally when the doctor finishes doing his examination, they will tell you: "You've got to explain to the patient that he needs the surgery; that right now he needs to go to this place…" So the reason I involved relatives to be the interpreter was based on my previous experience because I felt it would be useful to help the patient and also to help the doctor to identify issues and diagnose. (Zabe, Y2, Zimbabwean student)

Students also reported that their communication skills with people from different cultures developed over time. More senior students had more confidence. Consistent with other studies (Gol & Erkin, 2019; Kilic & Sevinc, 2018), student nurses should be exposed to more ICEs to develop their ICC.

> *My confidence developed over time, and I am more aware of different cultures and see different sorts of services that can cater for different cultures in comparison to my first-year study. (Alice, Y2, English student)*

When asked how she developed her knowledge in practice, Michelle commented that asking patients was useful, although she also expressed the need for more formal education.

> *I have some general understanding of the cultural difference, but in terms of providing care to those patients, I still think there's more you need to learn to be able to handle the situation more competently. I would need more backup from the education side and also more effective ways to maybe ask patients how they would like their care to be delivered and different aspects of it, like hygiene needs and obviously the nutritional side. (Michelle, Y1, English student)*

While 'trial by error' experiential learning is a good way of learning, it was reported that onsite guidance was also particularly helpful. Clinical educators and mentors may guide students to evaluate the effects of strategies available to deal with intercultural nursing care issues and discuss things like '*personal technical and emotional responses to the situation'*, which contribute to enhancing the students' learning and developing their confidence in managing intercultural communication. Participants commented that discussing their experience can act as a '*sounding board'* to help students become aware of their own values and biases.

Participants recognised that ad hoc intercultural experiences with one particular patient might not represent the entire culture of that group. They commented that '*academic supports'* for students' learning during placement through '*guidance and skills training'* (such as simulation or role play, see 4.2.2) was also useful to help link theoretical knowledge about intercultural communication. In this way, the students can be encouraged to recognise their own values and beliefs and be open-minded regarding cultural differences. Consequently, students gain a better understanding of the patient's perceptions of health and their behaviour and are therefore able to assess

and address the patient's health problems more effectively. This training also requires academics to have sufficient knowledge and skills in intercultural nursing practice and education, as inappropriate approaches and attitudes can have detrimental effects on students' intercultural learning (Jeffery, 2000).

Immersion programme

Four participants had international placements during the second year of their pre-registration nursing programme and reported positive learning outcomes from personal and professional perspectives (see section 4.1.2.). An **immersion experience** means putting an individual into a new environment or culture, which demands effective socialisation by using a limited shared language to communicate between individuals and groups. Kearney et al. (2014) and Powell and Biederman (2017) commented that cultural knowledge is gained mainly through intensive cultural immersion and exploration. The international placement participants from this study reported benefits including '*learn[ing] to think differently*', '*gain[ing] better understanding of differences of other cultures*', '*develop[ing] more communication skills*' and '*confidence growth*'.

> *It's really beneficial. I saw nursing, which in my opinion, was backdated to what we practice in England, but when I went to a different country, I saw the complete opposite. I think it depends on where you go. You might see yourselves as being behind and them as being more advanced… But it's worth doing either way, even if I came back and thought I don't want to be like the nurse, I don't want to do it that way, which is something I learned and grateful for what we have got here. (Emma, Year 3, English student)*

These experiences show that international placements bring benefits and challenges to students when they move out of their comfort zone and encounter difficulties living in another culture; these include different languages, educational expectations, and clinical practices. A process of negotiation and adaptation to a new culture is required while also making efforts to meet basic needs for daily living and professional learning outcomes. Duffy (2001) suggests that academics should foster students' learning of cultural differences beyond a superficial level by not focusing on differences but instead paying attention to commonalities and encouraging critical reflection on their attitudes and responses to perceived cultural differences and similarities. Doing so not only helps to develop a deeper understanding and connection to the host culture but

also broadens perspectives on inclusive practice and reduces unconscious bias regarding the other culture. Many studies report that immersion helps to develop students' cultural self-awareness, promotes sensitivity, increases flexibility and reduces stereotyping (Levine, 2009).

Despite the benefits of the immersion programme, difficulties were also experienced (see section 4.1.2). To ensure a satisfactory learning experience, the participants noted three strategies: sufficient preparation, support from peers and mentors and self-reliance.

The importance of preparation for culturally sensitive care in the targeted immersion learning area was highlighted. Participants found '*case study analysis'*, '*reviewing the literature relating to the immersion site'* and '*developing a project for future research'* helped them develop essential adaptation strategies. However, some participants commented that without a systematic approach and support, such ad hoc preparation sometimes mismatched with the actual situation. Ryan et al. (2000) also found this. Due to the communication barriers, participants were at risk of isolation in their new environment and culture. Therefore, before departure, these students were informed about different communication styles, such as daily language, body language, listening and other nonverbal responses, in the host culture and cultural tradition.

> *I only started learning Portuguese the year before I went, but [when I got there], I realised how little I'd learned… so it was a team effort between the patient and me to try and help each other understand what we're talking…I think it helped to understand the patient's needs more and to try and facilitate them to be able to communicate.(Amber, Y3, English student)*

Participants reported additional coping strategies such as '*avoiding performing tasks without your mentor's presence'*, '*laughter when you don't understand'*, '*problem-solving for things unexpected'*, '*critical reflection on the incident'* (both clinical and living situations), '*learning to communicate differently by using body language and cultural language'* and '*learning to live differently to adapt to unique individual's condition'*. These they called 'self-reliance coping' or 'situational coping'. In addition, participants recognised the importance of '*having peer supports'* as well as support and guidance provided by the '*onsite clinical mentor'* and '*academics remotely from*

the university', as echoed in other studies (Ryan et al., 2000). This means there is a need for the university to develop partnerships with the host placement provider to address perceived barriers and offer support proactively. Some also formed a new supporting relationship in the host area, which they found useful in developing a sense of belonging and safety. These are considered important for self-efficacy and intercultural care engagement (see section 4.5.2). In addition to experiential learning at local Trust hospitals and the immersion programme, some students commented on the benefits of developing their linguistic skills through free or affordable language classes to help them become familiar with a variety of everyday words and learning about a different culture, which in turn helped them to provide more culturally sensitive and competent care. Other studies (e.g., Aboul-Enein & Ahmed, 2006) reflected this idea.

The international placement had a positive impact on students' professional nursing practice by providing opportunities in intercultural communication. However, due to demographic constraints and contextual issues, not all students can afford to participate in international placements; therefore, alternative solutions such as '*simulation'*, '*role play*', '*case studies*' and '*inviting previous patients to share their experience*' were suggested as useful ways to develop cultural diversity and modify approaches when providing care for culturally different clients and working with staff from different backgrounds.

In summary, the findings showed that intercultural communication requires the interlocutors to reconstruct and renegotiate their daily accepted or automatic behaviours and thinking, sometimes they might need to question these patterns. The participants reported challenges they encountered when linguistic barriers were not resolved and emphasised the importance of linguistic facilitators in supporting effective intercultural communication and quality nursing care. This support includes professional interpreters, family members as translators, telephone translation services and bilingual/multilingual staff. Limitations of these linguistic facilitators were also reported, suggesting further training for professional interpreters was needed and that hospital managers should provide more financial support to allow staff, especially nursing staff, to use appropriate services in facilitating intercultural care. When the linguistic facilitators were not established, students used their own social linguistic

skills with various effects. The reasons for their active engagement and innovations will be discussed in section 4.5.

All participants valued '*learning by doing*' to develop their intercultural care skills on both local and international placements by using observation, taking initiatives, reflecting, and asking patients and their relatives. Additionally, support from clinical educators and mentors could provide a 'sounding board' for sharing technical and emotional responses to a situation. Participants also recognised that academic support during placement and campus studies (such as simulation and role play) was crucial to help them link theory to practice, especially for those students who did not have the opportunity to attend an international placement. Participants who had international placements valued their experience highly. A variety of strategies were reported to help students on international placements adapt to the context of a new culture, including preparation, establishing social support from fellow students, academics and clinical mentors, and self-reliance helped students to think, adapt and communicate differently.

4.4 Intercultural Care Attitudes

The third section concerns the affective component of ICC**,** i.e., **intercultural care attitude**. It encompasses how an individual thinks and their feelings towards people from a different cultural background. Though manifested in different forms, it reveals an individual's inner thoughts and feelings towards cultural others.

This section reports a variety of attitudes the participants experienced and witnessed during ICE (section 4.4.1), sense making of these perceived socialisations (4.4.2) and strategies they used to cope with adverse intercultural socialisations (section 4.4.3).

4.4.1 Manifestation of Attitudes

Although intercultural knowledge and linguistic skills are important in intercultural encounters (ICE), many participants (such as Zabe) observed that having a caring

attitude and interpersonal skills also have significant impact to effective intercultural communication.

> *[Being] culturally competent is not just about the abilities and the knowledge, but attitude to the patient and interpersonal with colleagues as well, including no discrimination, have tolerance since people have got rights and choices as even if they are different, you need to respect them anyway. (Zabe, Y2, Zimbabwean student).*

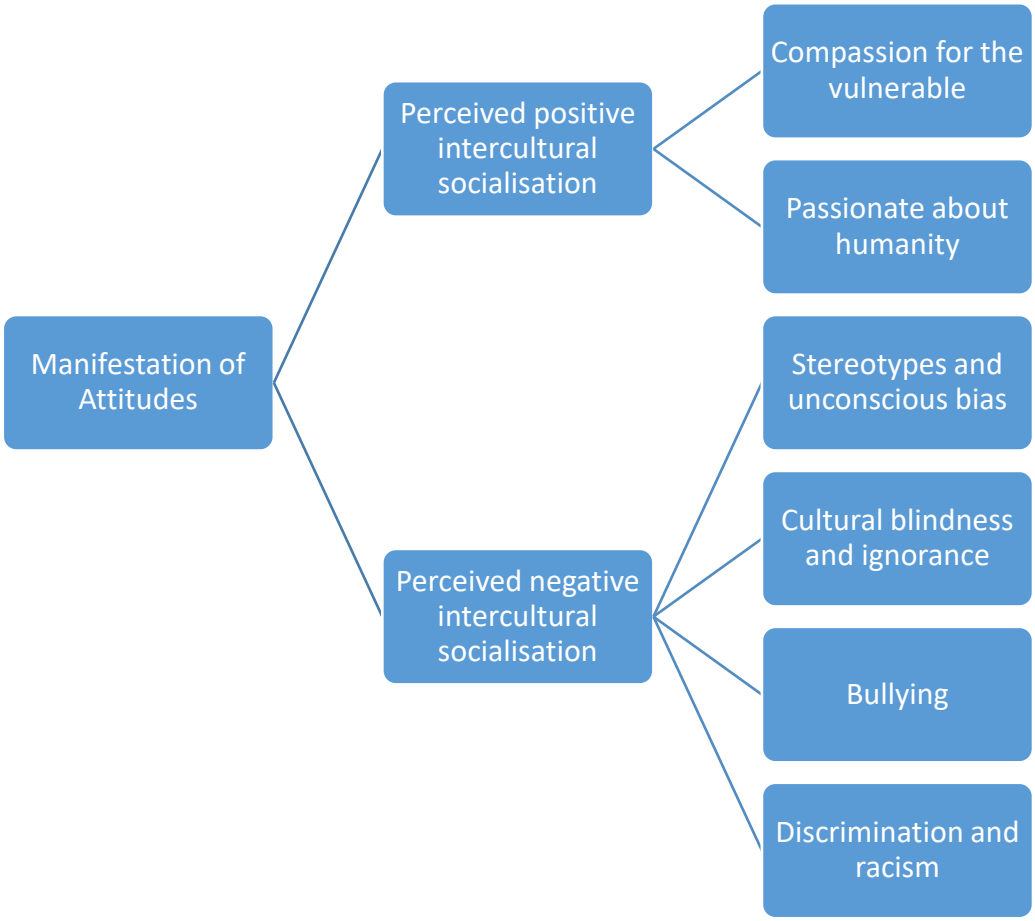
This extract echoes Jeffery and Smodlaka (1996) who assert that attitudes exemplify an individual's professional value and can affect internal motivation to interact with cultural others. This point is further supported by Campinha-Bacote (1999) who commented that people do not care how much you know until they first know how much you care.

Many participants commented that they observed attitudes being presented in two distinct formats: verbal (i.e., by using spoken language) and nonverbal (i.e., by use of tone, eye contact, personal space, gesture, facial expression, therapeutic touch, and conversational silence) (see Figure 4.4). In comparison to consciously expressing one's opinion verbally, people tend to use nonverbal behaviours at subconscious or even unconscious levels, and the message presented can either reinforce or contradict the verbal information. Participants (such as Hannah) commented that even though nonverbal expressions are more subtle, they do exist and could negatively affect the counterpart's emotions if they perceive the interaction to be unfriendly and insensitive.

> *You can tell from their facial expression, like grimacing at… "I've tried" … the patient could sense that. For all he couldn't understand 'til his son came in and told him "you have to stay here", so their face looked so annoyed… Instead of saying "just wait five minutes" or something like that but shouting after him "stay here! Don't go!" (Hannah, second year English student).*

Through these verbal and nonverbal expressions, participants experienced two distinctive intercultural socialisations: perceived positive and negative intercultural socialisation (see Figure 4.11).

Figure 4.11 *Manifestation of attitudes*



Perceived positive intercultural socialisation

The participants consider positive intercultural socialisations are those with appropriate verbal expressions and nonverbal behaviours, showing genuine interest to others (i.e., curiosity), willingness to learn from different culture (i.e., openness) and making others feel comfortable, respected, and welcomed. For example, Amina demonstrates her positive attitude through respecting cultural differences and making an effort to learn about them and others' cultures to gain an understanding of things they like and dislike.

> *It is obviously respecting it... I have to understand is that this person has a different background, a different upbringing from the way I am, so I make sure that I understand them through try to know what they like, what they dislike; try to know more about their culture; try to know more about them when I have a patent who has a different cultural background. (Amina, Y2, Nigerian student).*

Similarly, Aoife sees an interculturally competent person as someone who has a positive interpersonal attitude, is willing to communicate with people from diverse backgrounds, and is mindful of being sensitive to cultural differences so as to make the other feel comfortable rather than offended.

> *Staff who has positive attitude are those willingly to talk to people that are different in some way from you, so it could be race, religion, colour, live in a different country in the past, so they brought up in a different system of beliefs and maybe things that different to you, but need to be sensitive about, … Certain ways in which are done differently in different cultures that you need to be mindful of, making people comfortable, not offending them in those terms. (Aoife, Y3, WB)*

When asked about possible reasons for these positive attitudes, participants considered compassion about vulnerability and passion for humanity to be key.

- Compassion for the vulnerable

When the shared language was missing, some also expressed their sympathy and sadness for these patients and their relatives, which showed their compassion for the vulnerable. For example, Emily and Rebecca said they felt '*quite upset*' and '*really sad*' when they saw a patient was suffering from their illness and could not express themselves or understand what was happening to them.

> *He was very poorly and very vulnerable and it was **quite upsetting** to see how ill he was, yet he couldn't communicate in English to tell how ill he was… (Emily, Y2, English student)*

> *She had bone marrow cancer and it was all within the diagnosis period as well, so you wanted to be able to provide her with support… She also had a tiny baby in the bed with her but she didn't know what's going on… It was **really sad**. (Rebecca, Y3, English student)*

Some students blamed themselves. They felt useless (Zoe) or regret (Dakila) for not being able to speak an additional language, and felt they were not being professional because the patient's needs were not recognised and consequently, as nurses, they are not able to provide the same standard other patients received.

> *I feel myself **useless**. I wish I could understand why she was being like that, but she obviously wasn't going to tell us why. (Zoe, Y3, English student)*

> *I felt **regret** not studying more Chinese when I was in the Philippines, 'cos I felt that I could have used it more… …? (Dakila, Y3, Filipino student)*

These student nurses' compassion may relate to their duty to provide holistic care, so when they noticed that they could not achieve this standard, they felt inadequate, stressed and frustrated (Forrest, 1989). Kai et al. (2007) highlight that these emotions might lead to professional uncertainty or perceived disempowerment and suggest that it may be beneficial to use a support network to discuss and share difficulties with mentors and academics.

Conversely, other participants reported '*a great deal of job satisfaction*'when their efforts had made a positive difference to patients. For example, Mourhinda felt she crossed over into the patient's world after she learned few words of a patient's language because she believed language should not be a barrier preventing the patient's receiving the same standard of care.

> *After I learned a few words of the patient's language, I felt really good. It's like I've **crossed over into his world**… I think this gentleman, he deserves the same as well, and language shouldn't be something to prevent him from experiencing what the other patients had received… (Mourhinda, Y3, Guyanese student)*

Compassion is at the core of Confucian, Buddhist and Christian philosophies, i.e., being sensitive to the other's pain and suffering and having a strong desire to take action to alleviate that pain (Goetz et al., 2010). In culturally competent nursing, Papadopoulos and Pezzella (2015, p. 2) defined compassion as '*a human quality of understanding the suffering of others and wanting to do something about it using culturally appropriate and acceptable nursing interventions, which take into consideration both the patients' and the carers' cultural backgrounds as well as the context in which care is given*.'

So, when the student nurses perceived a meaningful accomplishment of high quality patient care delivery, they gain a sense of achievement and satisfaction with their role performance (Celik & Hisar, 2012; Kalisch et al., 2011).

Some participants (such as Feihong) explicitly highlight the value of care and compassion in nursing and commented that this was also why they chose nursing as their career.

> *Patients are in pain or illness, they need care and compassion… attitudes go hand in hand with the knowledge base, that's my belief and where my passion is, hence I come to nursing. (Feihong, Y2, Chinese student).*

Other participants reported the benefits of compassionate cultural care They made comments like '*more cooperative'*,'*effective in their treatment'*, '*fostered a trusting relationship'*, '*patient's suffering is reduced'*. In turn, these student nurses felt '*rewarded'* and a '*sense of achievement'* (section 4.5). Conversely, a lack of compassion leads to negative outcomes, including patient and staff/student dissatisfaction and health disparities.

> *You don't have to speak the same language, you can smile and that's a language that every human being shares… if somebody's upset and they're crying, we understand that they are upset and they are crying, but we don't have to know the different languages. There are certain body language that we can exhibit that we can relate to the person, you know "is everything fine?. (Mourhinda, Y3, Guyanese student).*

However, participants observed that due to time and finance restraints some qualified nurses were not able to have enough time with patients to provide good quality care, despite expressing their wishes to be compassionate. This concurs with Dixon-Woods et al. (2014) which found that high levels of desire for compassionate care mismatched with clinical observation, often caused by time constraints. McKivergin and Daubenmire (1994) report that spending time on meaningful therapeutic communication, such as attentive listening and sensitively meeting the patient's needs, was overtaken by increased demands to complete tasks, bureaucracy, and target-driven management systems (Curtis, 2013). Also, financial restraints around employing professional interpreters were said to affect the provision of compassionate care for patients with linguist difficulties (see section 4.2). These suggest that policymakers and organisation leaders should be aware of the significant impact of staffing issues and cost-cutting strategies, should set more strict legislation and provide financial support to shift priorities from cost efficiency to compassionate care provision (Papadopoulos et al., 2017).

- Passionate about humanity

Many participants expressed their passion for humanity by viewing all of the people in the world as equal and believing the human race should include everyone on earth. Having this worldview, they see the similarities between human beings (such our need to eat, having emotions) rather than focusing on physical differences (such as our skin colour). For example, Zoe and Miremba commented that, as human beings, people are the same even though they may differ in physical appearance. Having this view, they offer patients with same standard of care, love, and ability no matter their background.

> *I've got needs and preferences and it's the same for people from different cultures and beliefs and if you can accommodate them to the best you can. (Zoe, Y3, English student)*

> *We are not different; we are all human beings. The main difference is a physical difference, which is the colour. In other things, it's the same and so nothing has changed my perception about looking after a white person. I give them the same love, the same level of care, to my best ability. I don't hold back; I react as quick as possible if anyone wants help, regardless, whatever, the cultural background of the person is. (Miremba, Y1, Ugandan student).*

Similarly, Mourhinda commented that her positive world view is the key to her positive intercultural socialisation. She thinks all human lives are of equal value and that people should not discriminate based on skin colour, language, religion or beliefs or social status. Having such a passion for humanity, she sees the person before the illness, which makes it easy for her to empathise and be compassionate to the disadvantaged and vulnerable.

> *I have grown to think of people as people, regardless of if they may have a disability, whether they come from a different background, different culture. My understanding is that once we look like each other, is that we are people, and we deserve to be treated like people. So anybody coming through the hospital door on admission is a person to me…I see the person first, before I see the illness. (Mourhinda, Y3, Guyanese student).*

Several participants found having a passion for humanity and compassion for the vulnerable were helpful for establishing and sustaining positive interpersonal relationships and providing satisfactory patient care. They also observed that people who had the opposite attitude have a tendency towards negative socialisations. The next section deals with this idea.

Perceived negative intercultural socialisation (interpersonal difficulties)

According to the data, participants experience and witnessed a variety of perceived interpersonal insensitivity and negativity—also called work-based interpersonal adversity—including stereotypes, unconscious bias, bullying, discrimination and racism related to ethnocentrism.

Ethnocentrism refers to the idea that an individual views their own culture's values and beliefs as superior to those of others (Andrews & Boyle, 1995); hence, they limit their ability to see or experience beliefs and values of other cultures. As a result, their interlocutor's values and spiritual beliefs are less considered and respected, and minimal effort is made to promote trusting relationships since ethnocentric individuals tend to expect the minority groups to adapt to the dominant culture (such as being white, using English language in the UK) with silence (Leininger, 1990; Taylor, 1998). Ethnocentricity is manifested as feeling superior to other cultures, and ethnocentric people have a higher tendence to have negative attitudes such as discrimination and racism towards culture others. In this study, four manifestations of negative intercultural attitudes which the participants considered were rooted from an ethnocentric worldview emerged: stereotypes, unconscious bias, cultural blindness and ignorance, bully, discrimination and racism.

- Stereotypes and unconscious bias

Stereotypes are over-generalised and fixed beliefs about a group of people; they can negatively influence the way we perceive others, leading to assumptions and judgements. For example, when the patients saw an Irish student (Cara) in the ward, they asked whether she was drunk often, which was based on their stereotype of Irish people's social habits (section 4.2). Cara commented that '*the problem with stereotypes is not that they are all wrong, but that they are incomplete'*. This makes one story become the only story and leads to unconscious bias.

Because of stereotypes, the participants noted that it was sometimes easy to judge different cultures unconsciously and generate assumptions about what a patient is like, i.e., **unconscious bias**. Even though unconscious bias is common, it can lead individuals to make assumption and unsound judgements which can cause negative

effects like unfair treatment and unintentional discrimination towards others. For example, in Amina experience, people have unconscious bias and believe that '*black people are not intelligent or don't know what they are doing*', so when she made comments or contributions to the discussion they were not noticed or responded to, even though her peer was praised for saying the same thing.

> *Some time, some people are unconscious about the way how they treat you. They don't really mean it, but because that's how the brain functions or something; maybe that's how they were brought up… Some people just believe that* ***black people are not intelligent****, or they* ***don't know what they are doing****. (Amina, Y2, Nigerian student)*

Similarly, Azindoo also experienced staff who stereotypically viewed individual's superiority based on their skin colour or the country they come from.

> *For example, they think white man is cleverer than the black man, or the British are better than the Germans or the French or the Chinese, or whatever. These kinds of stereotypes… (Zaindoo, Y1, Ghanaian student)*

Duffy (2001) commented that stereotyping is categorising people into groups based on some unique characteristics, transcultural 'cookbook' type of textbooks and articles organise chapters on Asian, African American, and other groups, which may contribute to stereotypical portraits of cultural diversity. Current global travel and communication have significantly blurred geographical boundaries, so stereotyped approaches and assumptions lead to increased risks of making a wrong judgement. In nursing, while the fast nature of unconscious thinking may be useful to help individuals make quick decisions in emergencies, sometimes such thinking can be too fast to interpret the situation or people accurately (Kahneman, 2011).This implies that, when learning about a new culture, to prevent stereotyping others, individuals should expect cultural complexity and learn from interactions with patients and their families rather than solely relying on secondary information, such as the internet or books.

In order to let people get to know him and build connections to staff from the dominant cultural group, Azindoo made extra effort but he noticed that staff deliberately backed off and ignored engaging in eye contact and conversation with him, which made him feel sad.

From my personal experience, they don't give you the opportunity to get close to them, to know them or let them to know you. And even if you do, they try to back off. But I don't know whether they realise it or not, but I think they really know for sure that they are not giving you substance, so I gave you an example of, you know, even saying hello to somebody and the person does not necessarily even look at your face and say hello back to you. Or sometimes, ignore you saying hello. Or the person doesn't actually never say hello to you; you can say hello ten times, the person doesn't. I feel horribly bad. (Azindoo, Y1, Ghanaian student)

Here Azindoo echoes Sutherland (2013) who found that stereotyping is closely related to ethnocentrism and those who were stereotyped were not offered the chance to explain their cultural beliefs, personal preferences, values, and knowledge. Consequently, their unconscious bias persists and is used as the base to judge people from different cultures, leading to making wrong assumption and affecting relationship.

- Cultural blindness and ignorance

Participants also observed that some healthcare staff believed that all the patients should be treated the same regardless their race or cultural orientation, meaning they interacted with culturally different people without addressing their cultural needs. This attitude is called **cultural blindness** (Lindsey et al.,1999); cultural blindness leads to culturally insensitive care.

For example, Mourhinda mentioned a patient who did not speak nor understand English; nevertheless, he was spoken to in English, and a treatment decision was made without his true understanding of the situation. When reflecting on this incidence, Mourhinda exhibited strong emotion, and commented that she was pained to see a member of an ethnic minority group treated like that i.e., as if he did not exist; she also felt ashamed as part of the healthcare team since she thought the way the patient was treated was disrespectful and unprofessional, i.e., breached the patient's right in decision making and went against the standard of 'no decision about me without me'.

*For the gentleman from Latvia, the consultant and his team came around and they actually stood at his bed and they spoke what they had to say in English. He didn't understand a word and then a decision was actually made at his bedside, and I was thinking: well, what part does he have to play in there? It's just **like he's not there at all**. And the standards say "no decision about me without me". So, he was practically left out. (Mourhinda, Y3, Guyanese student).*

Leininger (1996) commented that treating all patients as if they are culturally alike can cause harm. The underlying reason for culture blindness is that some people think that cultural differences do not exist or matter, or they perceive difference as a threat among inefficacious individuals, so they tend to be less motivated or avoid taking cultural needs into consideration when they plan and implement care (Jeffreys, 1999). For this reason, there is an urgent need for cultural diversity education for all healthcare staff to raise their awareness and understanding of the essential concepts and to focus on the similarities and differences between cultures and their impact on health delivery. In this way, confidence and competence in intercultural interaction can be increased and healthcare staff may be more willing to provide individual holistic care based on physical needs as values and beliefs.

- Bullying

Bullying is when individual(s) abuse power to harm, offend, insult, undermine or intimidate those whom they perceive as vulnerable. It presents as ridiculing or demeaning someone, belittling colleagues, insulting comments, excessive teasing, spreading gossip or rumours, persistent criticism, blocking training opportunities (deliberately setting someone up to fail), lack of consideration for others or inappropriate jokes that are unwarranted and unwelcomed (Cortine & Magley, 2003).

Several students reported that they were bullied during placement. For example, Emily, a second-year English student, experienced staff who had qualified 15 years ago consistently commenting negatively about younger generations in front of her and peer students. She reported that, despite these senior nurses' treating patients with respect and care, they perceive student nurses as not as good as they were at the time when they qualified, which made these young students feel belittled and stressed. Such experiences even made them doubt whether they had chosen the right profession, since such negative attitudes were different to what they were taught at university.

> *The old nurses who trained during Project 2000 and after presented different ways in which they communicate with each other, with patients and other members of staff… some nurses are nice, but some still hold hierarchical beliefs and commented the younger generations are inadequate, which was quite sad… It made me doubted whether I have chosen the right profession… so there's loads of different micro cultures within the ward and between different areas as well. (Emily, Y2, English student).*

Griffin (2004) reported that the people who are most vulnerable to bullying are students who are on a temporary contract, with learning outcomes to achieve which are assessed by the senior permanent staff. During clinical placement, qualified nurses, including nurses who are diploma holders and have been in the profession for many years, are the dominant group and hold power, knowledge, and experience (Camerino et al., 2008).

Emily overheard comments like: '*if [we] treat them hard when they are new to the profession, they could develop more competence and become stronger/tougher; therefore, they push the student nurses to work harder, since that is how they were trained in the old days*.' However, Emily did not agree with these tactics and commented that such a training approach created a negative experience, i.e., '*has made me feel so little, and significantly reduced my confidence, that has affected my performance and competence*'.

Curricula have changed significantly over the past two to three decades, although the broad aim of pre-registration remains the same: to prepare a future workforce that is fit for purpose. With the fast changes of modern technology in society and healthcare, older nurses may worry about their knowledge and skills being outdated and view energetic youngsters, who have a modern education and will gain higher degree as a threat to their profession or job security. Therefore, to maintain power and status, they oppress the vulnerable group (such as minority staff and students) when they can (Parfitt, 1998). Reporting such oppressive behaviour is difficult because it tends to be well hidden and only visible through carefully curated comments that make the older staff appear good.

Emily commented that when she was working with these senior staff, she was '*so stressed that the quality of care was comprised*', because the stress affected her cognitive performance, e.g., her attention span and information interpretation. This means the nurse-to-nurse bullying culture not only affects individual negatively in the workplace but also impacts on quality of patient care. This bullying even made Emily consider leaving the course. This echoes Hutchinson et al.'s (2006) finding that some attrition is caused by a 'bully eats young' experience, which leads students to doubt themselves and significantly affects their wellbeing.

- Discrimination and racism

Discrimination refers to an individual or a group of people's being treated less favourably based on actual or perceived characteristics such as race, colour, ethnicity, national origin, religion, disability, age group, etc. (Boi, 2000). **Racism** means one racially defined group is superior or inferior to another (Scammell & Olumide, 2012, p. 545). The participants picked up such attitudes from verbal expressions and nonverbal behaviour during intercultural communication and interaction. Participants reported that they experienced and witnessed discrimination and racism towards patients, staff and student nurses who were mainly from ethnic minority backgrounds.

Some participants, such as James, witnessed racism between patients. A patient who was from the local area deliberately kept physically distant from another patient from an ethnic minority community, and verbally made a 'racial slur' against him.

> *I've dealt with a few patients who were very uncomfortable about being in the same bay as people from other religions, so between patients themselves… There are six-bedded bays, an 80-85-year old gentleman who had come in from the northeast, he actually lived in the same house that we was brought up in, so very Geordie. And he was located next to a gentleman from India. I noticed that the Geordie gentleman was a little bit uncomfortable straight away and actually moved and sat somewhere else, which was quite strange, so I asked him but he made a racial slur to the gentleman, like "I'm not sitting next to this so-and-so", so that was very thrown back. It was so abrupt that I wasn't quite sure what to say. (James, Y1, English student)*

In addition to patients to patient racism, participants witnessed staff 'shy away', 'give up' even being abrupt when the patients' shared language was not established. For example, Ruby observed that staff deliberately avoided allocating themselves to these patients.

> *Some staff are ignorant of it and taking a step back; not coming forward and saying "Oh, I'll have this person", but not being proactive, knowing that it's going to have something extra to organise… Like if they're splitting the bays, people would avoid have somebody who they think they might have a communication barrier with… Not because of the culture, but they think it takes more effort and cause more work because they know that there's going to be interpreters to organise, or it's going to take longer to do the paperwork. And if it's going to make more work for people, I don't think they like it and therefore shy away from it sometimes… (Ruby, Y1, WB student)*

Similarly, Linda and Mohammad also observed that staff avoid helping student nurses deal with these patients or even overtly ignore their requests, even when the help buzzer has gone off.

> *Some people make extra time, 'cos that's the kind of person that they are and then other people won't try as hard and have got that extra time for her. There's not that much time, but you have to try things… they would go straight into the room and go straight for a different patient, curtains round. Off they go and leave other people to deal with this particular lady…so that kind of hindered your message: leaving students to do… (Linda, Y3, English student)*

> *There is a buzzer at the end of each bed. If they don't like the patient, especially their ethnicity, they ignore it, like "I never heard it". And you can't say "You heard it". They make themselves busy, like "Oh, was it buzzing?" That was just in front of them and they know it. But they ignore it. (Mohammad, Y3, Iranian student)*

The reason why these staff avoided interacting with the patient from an ethnic minority was due to lack of knowledge (4.1). They also thought helping these patients required more effort and took more work, e.g., organising interpreters and taking longer to document nursing care notes for them (Ruby). In addition to nonverbal discriminatory behaviour, Hannah even observed some qualified staff using abrupt language to demonstrate their negative attitude towards patients from ethnic minority backgrounds who have difficulties in understanding English. Hannah considered them rude and unhelpful.

> *But you do see people get a little bit abrupt and frustrated as if they **can't be bothered**. But it's their patient… I have seen their facial expression, very noticeable, like grimacing at the patient… (Hannah, Y2, English student)*

Boi (2000) claims that the individual's ethnocentric beliefs are mainly rooted in a lack of knowledge of other cultures. Ruiz (1981) also found that staff who are 'closed minded' tend to feel threatened by patients from culturally different backgrounds and consequently develop negative attitudes to them, which can significantly affect their relationship with these patients. This was echoed in Vydelingum's (2006) finding that nurses who lack cultural competence tended to use avoidance and ethnocentric practices when dealing with ethnic minority patients. Such discrimination poses a question for nursing education, as observing, and learning these incompetent behaviours sets up bad sample for students. Gerrish and Papadopoulos (1999)

suggest that using videos where students can watch both good and bad elements of intercultural care may be useful in counteracting this negative effect.

Apart from patients, some participants thought they were discriminated against because of their accents, ethnicity, and national origin, which caused their emotional distress. For example, Mourhinda, a third-year student from Guyana recounted a negative experience where her peer was invited to a social farewell meeting at the end of the placement as a way to enable her to keep her a job there, but Mourhinda was deliberately not invited, which made her feel isolated and less valued.

> *There are myself and another student from year three on this placement, but on the last day of placement, a social farewell meeting, gathering was kept for her, but I wasn't included in it… (Mourhinda, Y3, Guyanese student)*

Similarly, Azindoo experienced different treatment. In comparison to his classmate from the same cohort at placement he was not well supported and nurtured in learning and interpersonal relationships. Some staff even ignored his greetings and questions when he approached them. On consideration, he thought it was mainly due to his skin colour since both were studying the same course at the same placement with the same attendance records, competence in English language speaking and intellectual capacity.

> *We are all first year, doing the same programme, all at the same placement, the only difference between me and those other students is the colour. There wasn't anything that suggested I was late on coming on placement; it wasn't an issue of intelligence; I had exhibited strong personality and yet, I never got the same support that the other white British had… the interaction was brilliant with them. If I go to speak the same way, yet their facial expression alone suggested they are not interested. Even if you tried to speak to them, they don't even have time to answer you. Even if they do, they tried to walk away whilst trying to answer you, but if white British students go to ask about anything, they'll be glad and smile and even talk about things that are not even relating to work. If you go to do the same, you're not given the opportunity. They are supported and always assisted to know and when you try to put in so much effort to know, they even say you're overambitious and that you are learning to walk before you crawl. (Azindoo, Y1, Ghanaian student)*

These findings support Scammell's (1991) finding that ethnic minority groups tend to receive less consideration and respect than their native British peers. This lack of

support includes less opportunity to practise, and consequently ethnic minority students had a higher failure rate than their peers; and more importantly, they felt disrespected and not valued during their placement. This shows that there is a need to raise staff awareness and develop intercultural competence with students from minority groups and for placement mentors and academics to provide sensitive and responsive support (Griffin, 2004).

Dakila observed that it was not just students who were treated worse. Filipino recruited nurses were less respected at work and considered perhaps because professional British trained staff think the other countries' education is inferior or less adequate than British nursing education.

> *Like professional superiority… They question the competence of Filipino nurses, and they think Filipino nurses not better than us because they studied in the Philippines, then you can just come here work at the same level… and they think our educational system is better here in England, so I saw them sometime treated as less qualified or even laughed at because of their accent. (Dakila, Y3, Filipino student)*

This observation is consistent with DiAngelo and Allen's (2006) study which revealed overseas recruited nurses and students were discriminated against because of native British privilege and through behaving negatively behave to exert their power. The fact that these people from diverse backgrounds faced racial discrimination which came not just from individual staff but reflected a collective attitude indicates that institutionalised racism exists in placements. **Institutionalised racism** refers to certain behaviours, beliefs and attitudes which are viewed as an accepted social norms or systems of an organisation which support the perception of cultural inferiority (Callender, 2006). According to the Macpherson Report (1999, p. 9), institutional racism is '*the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance thoughtlessness and racist stereotyping which disadvantage minority ethnic people*'.

Institutional racism was reported in many disciplines including social work, politics, education and became the cultural norm for the society; it is rooted in attitudes, power

and many structures (Sawley, 2001). The participants' interviews showed that institutional racism also exists in healthcare, including nursing. This possibly explains why, despite a series of negative reports' being published over the decades, culturally sensitive and responsive care have not been achieved, and minority groups continue to face limited access and poor quality of healthcare service in comparison to the dominant group. Also, difficulties in attrition and staff retention from ethnic minority groups remain. These issues can negatively affect the quality of care delivery (Tullman, 1992), which has been labelled as 'the dark side of nursing' (Jameton, 1992; Corley & Goren, 1998; Stevens, 1998).

Over the years, many hospitals have published policies, as these were considered useful in avoiding adverse work conditions. However, Feihong commented that it is up to the individual staff to take notice of and implement these policies.

> *We have a lot of policies for equality and diversity in place, but whether you want to implement..., I don't really think policy at this stage has much influence. It's all to do with the individual. I don't think the placement I've just been; they know things like this. Even they know, they may not take much notice as everyone else does the same, so they can continue like that. (Feihong, Y2, Chinese student)*

Obviously, some of the current policies have not effectively eradicate discrimination and racism. As in the case of workplace bullying discussed at the previous subsection, the placement manager should make more radical changes to tackle institutional racism, make sure all workers (including students) are respected and valued, enforce a 'zero tolerance policy', treat incident reports seriously and truly strive to foster a working environment which has constructive conflict resolution.

Many studies revealed that persistently experiencing these negative socialisations in the healthcare system contributes to attrition for student nurses and retaining the nursing workforce, especially nurses from ethnic minorities (Jackson et al., 2002;

Strachota et al., 2003). The next section deals with participants' sense making of their experiences and perceived negative socialisation.

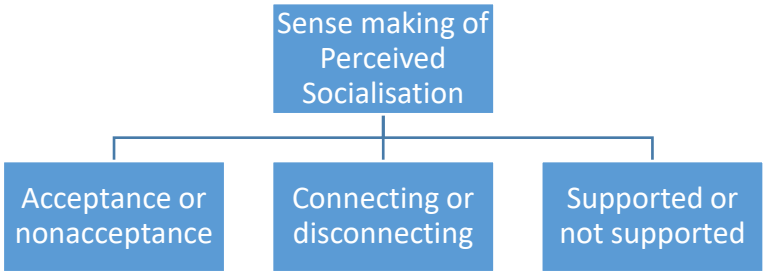
4.4.2 Sense Making of Perceived Socialisation

When participants encountered work-based adversity, they felt '*isolated*', '*ashamed*', '*embarrassed*', '*pain*' and some (such as Mourhinda and Emily) wept with tears and low voice and questioned whether they had chosen the wrong profession.

> *Particularly on my first year, when I was really feeling isolated, and also my confidence to speak up was so low, I was thinking: have I chosen the wrong profession?... So many times. (Mourhinda, Y3, Guyanese)*

When sense making why these perceived negative socialisations led to their deep emotions, three key themes emerged; they relate to acceptance, connectedness, and support (See Figure 4.12).

Figure 4.12 *Sense making of perceived socialisation*



Acceptance or nonacceptance (not being valued)

Many participants commented that to be accepted by the team was important for students in placement, especially for those from ethnic minority background. Therefore, when nonacceptance was perceived, they experienced self-doubt and anxiety. When participants observed that they were treated less favourably than their peers and not accepted by the team, they felt 'really sad' and 'deeply hurt'. For example, when final-year student Mourhinda was not included in the farewell gathering organised by the staff for the final year students, she felt scared that she was not good enough and had to work extra hard alone to achieve her learning and to be accepted.

I wasn't included in it and it makes me wonder would I have to work extra hard to achieve my competencies on this ward… And would it be just up to me alone to make that effort for inclusion in this working environment…it is really, really scary. (Mourhinda, Y3, Guyanese student)

Mourhinda further expressed her sorrow and explained her avoidance of look backing and exploring in great depth the journey she had gone through in case her mind and the person who she was could be 'destroyed', because what she encountered was different to her humanistic approach to others. This shows her desire to be accepted and to be treated fairly and feeling deeply hurt when this did not occur.

I've learned a lot since I've been in this country really, to not look at things too much in depth, because they can really destroy your mind, destroy the person you are, because for me, I'm thinking of everybody as an individual, as a person and for somebody to think of me totally different, I don't want to dwell on that. It's a ***really sad*** *thing that we don't see people as people. We see people as having differences because of colour, because of where they come from, because of who they are, you know, if they've got some disability… In my mind, I should not be. (Mourhinda, Y3, Guyanese student)*

Similarly, other ethnic minority students consider not being accepted as one of the key challenges they encountered in ICE. For instance, Azindoo felt isolated, very uncomfortable and frustrated because she could not fraternise with others in case they misinterpreted him and worsened the situation even though he was conscious of the importance of having communication with the team and its impact to their nursing. He did not feel accepted; was viewed as a nobody who did not deserve to there or deserve to be helped.

As an African working in a white dominated environment. It's such a big challenge to get accepted. In a way that you can't interact… You eventually become uncomfortable and isolated. They think you are probably nobody, or you don't deserve to be there; you don't deserve to be helped. (Azindoo, Y1, Ghanaian student)

Mourhinda commented that not feeling accepted automatically in the same way other indigenous students were made her feel hurt, something which had a long-lasting effect because it '*means a lot*' to her.

It's one of those things that play on the back of my mind a lot… being accepted means a lot, but up to even now, in my third year, I still don't feel comfortable in that field at

all because you don't feel like you can be automatically accepted the same as another student, that make you feel hurt sometimes. (Mourhinda, Y3, Guyanese student)

Mourhinda's experience supports Birks et al.'s (2014) and Cortine and Magley's (2003) studies which reveal that repeatedly encountering adverse interpersonal relationships in the workplace over a period of time can cause students nurses to feel intimidated and offended, encouraging self-doubt, lowered moral and even causing short- or long-term mental health problems such as anxiety, depression, mood swing, irritability and posttraumatic disorder.

A variety of reasons for not being accepted were explored; the consensus was that the differences from the dominant group. For example, Azindoo commented that his physical skin colour was the only reason he was not 'their kind'.

I'm not of the same physical colour, so I'm not accepted in that group. I think that is the problem, because if it is work ethics, probably we work better than them. If it is respect, we give more respect than them. If it is any kind of thing that can be assessed, we do well. So, I don't see where the problem is other than the fact that physically looking, the fact that you are different, you are not accepted. (Azindoo, Y1, Ghana student)

Zabe, from Zimbabwe, reported that staff view people from Nigeria and South Africa as *bossy* because they express themselves and behave differently.

Nigeria and South Africa are viewed as strong people in the way they talk, the way they behave; and the staff always take them wrongly and think they are bossy. Their accent is different, their communication is different and the way they act is a little bit different, but it's not because they are bossy; it's the way they are. That's the way of the culture they were brought up in. But when they come to work in this hospital setting, the staff think they are bossy and feel like they are above them, so they tend be treated negatively and felt unwelcomed. (Zabe, Y2, Zimbabwean student)

Other participants commented that it was due to preconceptions about lack of English language capacity, previous bad experiences with ethnic minorities or different work ethic. For example, Dakila commented that the ethnic students tended to focus only on work during placement, which the staff may not like and may even lead them to question their competence.

it might be personal, it might be their preconception about Filipinos not speaking in English, it might be that they've had a bad experience with Filipinos that they didn't get along with… You know what I mean? Maybe they're… 'Cos work-wise, maybe… Obviously, we have a different work ethic. We work, work, work, work, work. Maybe they don't like that; (Dakila, Y3, Filipino student)

These students sensed the team did not value them and even did not want them to be there since the more they tried to interact with the staff, they more they encountered rejections, so eventually they decided to hide away. However, Azindoo said that if he did not to pay much attention to the learning opportunities, his interest was questioned. This made him feel he was in a no-win situation, i.e., there was nothing he could do to be accepted, respected, and valued.

They really don't value you. It's you're not listened to, probably because they think whatever you say, it's not good or it's not right. Even if it's good; it's just the fact that they just don't want to accept you. That's the point. And even if it's a group work and you want to become the leader, it's like "who is he? Who is he to become…?" They just get so pissed off with the fact that you [as a] black person or whatever. You can't fraternise, because the more you try to fraternise with them, the more they go back for whatever reason, so I learned to be quiet……. (Azindoo, Y1, Ghanaian student)

This is consistent with Levett-Jones and Lathlean (2008). Their respondents' feelings of rejection overshadowed them, creating a barrier that made them reject others, further deteriorating the relationship and even diminishing their motivation to learn. These participants commented that they then had to face a further issue, which was reported as a lack of interest in learning and failure of the placement. Those who responded the other way, i.e., wanting to be accepted, focused their energy mainly on trying to fit in. When their efforts were rejected, their confidence to involve themselves in learning opportunities was reduced, which compromised their learning progress. Some participants also commented that they even sacrificed their learning by acting as a 'spare pair of hands' to be liked and accepted by the team, negatively affecting their opportunity for meaningful learning (Levett-Jones et al., 2007).

Azindoo compared the different ways his native British peer was interacted to in the same placement. People smiled at her, were responsive, helpful, and talked freely, whereas his experience was of one of deliberate avoidance that made him feel demeaned because of his cultural background. To be accepted and treated fairly, he

described his wish to be able to paint his skin colour white, which hinted at how deeply he wished to be accepted by even changing something which is part of his physical self and identity.

> *I have peers or colleagues who have studied the same programme at the same cohort as me, at the same department. She is white British, and she was treated different… Was smiled and responsive, being helped and standing and talking and freely talking, then you ask yourself: why is it you that is different in terms of like the way they interact with you? Even if you want to talk to somebody and by asking questions, the person is trying to answer you by still walking away. I feel would demean you. You don't understand what is going on, but it's at the end of the day because culturally we are different. If I* ***could change my colour***, ***paint my colour white*** *and then go to a different ward on a different placement, my experience would be different. I wish I could do that and I can come back to tell you how different my experience would have been. (Azindoo, Y1, Ghanaian student)*

Conversely, the participants used words like *'feeling safe'*, *'comfortable'*, *'happy'*, '*motivated'* to describe their feeling when they were accepted by the team and commented that they were essential qualities that motivated them to commit themselves to engaging in intercultural encounters rather than being preoccupied with interpersonal relationship issues. This difference is probably because when they perceived they were accepted and valued by the team, they felt more empowered and enabled to take part in learning opportunities and more confident about negotiation in difficult situations and more able to question and ask for support from others during placement (Levett-Jones and Lathlean, 2008).

> *As a student, sometimes you feel like a burden on your mentors and when you feel like that, they don't particularly want you to be there… It's a bit of a burden for them to have you. It feels horrible; that 8 week feels like a year. But when you've got somebody who's accept you and wants you to learn and encouraging, and they want you to do well. It's nice, you feel happy, and it flies over… (Rebecca, Y3, English student)*

Also, these students commented that positive feedback then made them feel more interested and enthusiastic about trying more in that placement in comparison to the place where they were less accepted. This means experiencing a sense of belonging may be the precondition of the student's learning, which suggest that the placement mentors and managers should foster and sustain a welcoming and supportive

atmosphere throughout these placements to enhance student nurses' confidence and motivation in their learning in ICEs.

> *One of the staff from Filipino [sic] I worked with, she was great to me. I learned so much from her, got more than enough time for you. Anything you wanted to ask; she would let you do. She let us try a lot of things, she gave us feedback and explained things to detail, went through a lot of the paperwork side of things with us, got us to do a lot of the writing up with her, because she says "you need to know now, because otherwise, when you go into year two, it's going to be a foreign language. I loved working with her. Great experience with her, thoroughly enjoyed. (Aimee, Y1, English student)*

Other participants reported that when they were in an accepting atmosphere their motivations were strengthened because they felt they were valued as a member of the team, hence they could more easily to build close relationship with staff in the placement and the confidence to participate more in learning activities. However, these positive socialisations were reported mainly by native British students who interacted with ethnic minority staff. For those participants from an ethnic minority, their positive intercultural interactions were mainly from patients. For example, Miremba received love and affection from patients following the outstanding care she provided to patients; and Mourhinda shared her positive feelings when her care was appreciated by the patients, which she felt reinforced her career choice.

> *And that's the result… The patients give me so much love and affection, because the way I deal with them makes me stand out, because they know that I give them so much attention, love and care to the extent that they themselves know their own kind doesn't; give them that level of care and attention and so they are really appreciative, and they like me. (Miremba, Y1, Ugandan student)*

> *Every patient that I've approached on my placement, it was a pleasant experience. They appreciate your effort to look after them…They've always been lovely, which makes me think this is a working environment I want to contribute to. (Mourhinda, Y3, Guyanese student)*

Azindoo also gained some comfort from acceptance and appreciation of patients in his placement. He considered this as possibility due to their position as patients who do not have a choice.

> *At the placement, patients are fantastic because they know they are in a disadvantaged position and somebody's looking after them. So, they accept whoever is on front of them, because they need somebody to look after them. Don't*

forget they're in pain; they're in distress. They want comfort, they want care, they want compassion, so that are not in a position to choose and so they do accept…But when it comes to the nurses, colleagues; that is where the problem is. (Azindoo, Y1, Ghanaian student)

The data shows that the student nurses from ethnic minority backgrounds value acceptance highly and presented deep, sad emotion when this was not achieved, especially when they were treated less favorably in comparison to their domestic peers. This means the clinical mentors and placement managers need to raise the awareness of this need from student nurses and work together to foster a welcoming learning environment.

Connecting or disconnecting (loneliness and isolated)

The participants commented that feeling connected to the team is also important since it helps them to gain a sense of belonging, which in turn helps to develop a close relationship with the members of the team and vice versa. This is another theme which come across strongly from participants from ethnic minority background.

Mourhinda experienced a situation where she was excluded during a break time conversation where everyone took turns to contribute When it came to her turn, she got missed and then the conversation continued as if she did not exist; this made her feel really sad and worried about difficulties around getting connected and feeling part of the team. She considered the reason she was excluded from the conversation was because she was from a different cultural background even though physically, she was sitting in the same room as her native British staff nurses. Even though the staff did not abuse her verbally, she could tell from their body language and excluding behaviours that she was less valued in comparison to her native British peer who was in the same placement. This treatment made her feel extremely hurt and embarrassed.

There wasn't really a sense of inclusion in that ward, because I'm from a different background, different culture and my experience is that on the break time, we would all sit in this room in a circular formation and the conversation would go from one person to another, but in terms of eye contact, when it came to the person next to me, whether it's on my right or my left, I got missed and the conversation continued. That was really sad and embarrassed, and it makes me think: how well am I going to fit into the working environment if this sort of attitude is there? (Mourhinda, Y3, Guyanese student)

When they were not included in the team, the participants felt they were not considered as part of the team; hence, they experienced no sense of belong and had difficulty building a connection to the team. Under these circumstances, they felt isolated and alienated, making Mourhinda '*want to run away'.* Azindoo described it '*like a baby sheep get lost somewhere that starts to cry*' (see Figure 4.13).

> *It's a horrible feeling to be isolated. It's like: who do you talk to? Do I have the courage to go and talk to somebody about it? It's like you just want to run away. It's like you just want to just leave this place and don't come back. Erm, that's how it feels…it's like you're better by yourself than to be in this situation. It's like you're forced to be in this situation and to actually put up with being isolated. (Mourhinda, Y3, Guyanese student)*

> *My better phrase would be 'like a lost sheep. You see a flock of sheep and the baby sheep gets lost somewhere and starts to cry. The only difference is that I can't cry, but I felt like a lost sheep, just walking or wandering along the corridor (Azindoo, Y1, Ghanaian student)*

Figure 4.13 *Lost sheep (Azindoo's Pictorial Description of Experience)*

Azindoo observed that staff disconnected themselves from him rather than offered him opportunities to become connected, or they even purposefully ignored social conversations like greetings.

> *They don't give you the opportunity to get close to them, to know them. And even if you do, they try to back off. I don't know whether they realise it or not, but I think they really know for sure that they are not giving you substance, so I gave you an example of, even saying hello to somebody and the person does not necessarily even look at your face and say hello back to you. Or sometimes, ignore you saying hello. They never ever say hello to you; you can say hello ten times, the person doesn't (Azindoo, Y1, Ghanaian student)*

Feelings of disconnection not only made the participants feel isolated, but also were also considered as impacting on their quality of learning and patient care. For example, Azindoo commented that his feelings of alienation made him feel like working alone when providing care. However, without proper supervision and demonstration, his nursing care may not have been appropriate. In addition, his sadness may have Azindoo's leaked out on his face, which could be misinterpreted as his negative attitude to patients and cause negative feeling to the patients. In addition, being such a lonely worker reduced his concentration, which affected his ability to absorb knowledge and skills at placement.

> *People are not interacting with you that make me look not part of the team. You are like alone working when you go to care for a patient, consciously or nonconsciously, you probably wouldn't know you put up like a gloomy face whilst dealing with the patient and so it might not even look well in your care delivery and so that is one area that I think if one is not careful, you would probably be doing it without you necessarily knowing that is going on. Then, to some extent, it would affect your ability to learn because how can you concentrate? Even if you get help from someone who is trying to explain to you what is going on, your mind will probably be going somewhere else and the fact that you are concentrate, you can't absorb and if you can't absorb, the quality of your training suffers. (Azindoo, Y1, Ghanaian student)*

Mourhinda experienced a similar exclusion experience but commented that when she worked with a team of supportive staff that gave her a feel sense of belonging to the team and her learning was enhanced in comparison to the placement she was not valued.

> *The cath lab, we had a mixture of people from the many ethnic group, Filipino, Egyptian, Pakistani, and it was such a lovely environment. I would go back there because it's so nice and there were no barriers, feel part of the team, I really did enjoy that place and learned a lot. (Mourhinda, Y3, Guyanese student)*

Buchanan (1999) commented that loneliness and alienation were related to feelings of disconnectedness with one's surroundings. They suggested the way to overcome these feeling was to feel in connection with others. However, some participants from ethnic minorities commented that connecting is very difficult when the staff were not interested in building a connection with the students. Lack of connection is detrimental to the sense of belonging, which is a term used to describe positive feelings individuals experience in response to the context, including" feeling secure, accepted, included,

valued and respected by a specific group; feeling connected to the group; their personal and professional values and beliefs are in harmony with those in the group" (Levett-Jones & Lathlean, 2008, p 104). Having a sense of belonging was recognised as the key to socialising people in clinical placements since it was associated with individual's self-esteem and confidence, consequently, belonging enhances students' learning and performance (Newton et al., 2009). The participants valued feeling connected highly and commented it contributed to their positive learning experience in ways such as confidence, job satisfaction and learning outcomes; it even helped to conform their future speciality direction after they qualified.

Supported or not supported

Support is the third theme to emerge in this study. Support is defined as opportunities offered to the student that make it easier for them to participate and progress in their nursing programme and able to interact pleasantly with the team, talk openly about their feelings, share their frustrations and ask questions in the team. In contrast, not feeling supported is related to feeling excluded from these learning opportunities and a lack of trust and close relationship with members in the team; the team does not seem a place for students to share and discuss their feelings or even ask questions (Kosowski et al., 2001).

According to the data, some ethnic minority participants not only perceived themselves as socially excluded, but also as experiencing lack of support for their learning. In Azindoo's eyes, what he experienced was very different to his native British peer, who was offered different levels of support ranging from social greetings to interactions and access to learning opportunities at placement. Azindoo commented that lack of support caused him to lose confidence with his engagement in learning and clinical socialisation, which are vital for nursing students to acquire professional competence.

> *There is no support for my learning. Me, as an African student and you've got your colleagues who are white British, so you are there to be mentored by mentors and these mentors are not supporting you for whatever reason and you look at the other side, the other colleagues are being supported well; are being given responsibilities and the more responsibility you get, the more you get to know. That made me lose confidence in the first place. (Azindoo, Y1, Ghanaian student)*

Similarly, Amina' experienced unsupportive staff who presented as not being interested to answer her question and pretended not to hear it.

> *… if I said something, they would all go as if they had not heard what I said. I asked them one day; I said, "why do I say something and everybody goes quiet as if they didn't hear me?" And then one said "Oh, we do actually hear you" So I said "well why people go quiet?" She had no explanation…I then realised that most of them don't even want to answer the question (Amina, Y2, Nigerian student)*

Feeling unsupported, participants started to feel they had to work alone even though they were aware that they were expected to have active interactions and communication with the staff team and patients throughout placement. Following several efforts without any positive outcome, Azindoo commented if he actively engaged in his learning he was seen as overambitious; however, when he became quiet concerns were raised about his lack of interest.

> *You begin to see yourself as working alone in an environment where you're supposed to have loads of interaction, especially when it comes to nursing, communication is key and so when you are not communicating that much, that obviously would affect your ability to know and your progression, your confidence and so on and so forth, so basically, these are the challenges that people from ethnic minorities normally would face when they are in an environment where it's dominated by another culture, especially the whites. (Azindoo, Y1, Ghanaian student)*

Due to lack of trust, participants' learning opportunities were restrained; not being valued and respected made these minority ethnic students feel vulnerable. The problems became worse when they held back on their learning, as they were then perceived as not motivated to learn (i.e., uninterested), so they had to consistently prove they could achieve the higher standard to gain recognition and acknowledgement from staff and patients who discriminated against them, an observation echoed in Mattila et al, (2010).

In addition, lack of support in placement also caused participants concerns about their assessment placement outcomes, since without a mentor's support and opportunities to engage in clinical practice, they do not learn the essential skills. Azindoo commented became less confident because he was concerned that he would not know

how to practise properly without qualified staff demonstrating or teaching him how to do things.

> *If a mentor doesn't show you what you have to know, how can you do it? You can be an intelligent person anyhow; you can have a master's degree, you can have whatever it is that qualification you've got; if you're not shown how a telemetry for example operates, how do you go and operate a telemetry when you qualified. You would be scared to go and touch it. To the extent that something will probably go wrong. so, then you get confused, you lose confidence, (Azindoo, Y1, Ghanaian student)*

Azindoo further explained that if such a situation had continued throughout his training, his quality of learning would be diminished and directly affect his ability to look after patients in in the nursing profession; even his confidence in himself as a person would be lost in the long run.

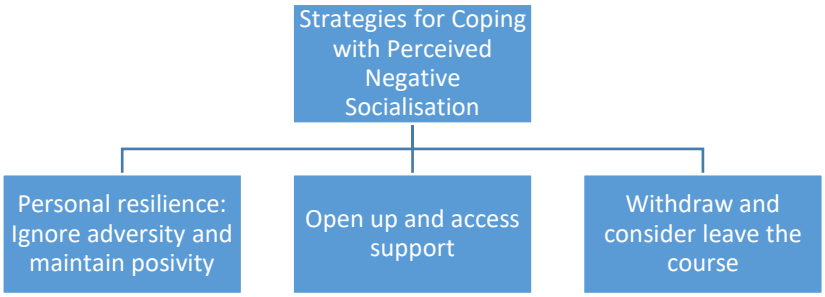
> *If this happens throughout your 3-year programme and you finish, the quality will be diminished. Your confidence will not be there. Confidence as a person, confidence in terms of looking after patients, will not even be there. General confidence will not be there in whatever you do within that environment; it wouldn't be there. (Azindoo, Y1, Ghanaian student)*

Students work with their placement mentors on a day-to-day basis; therefore, mentors play a significant part in fostering a student's sense of belonging and supporting their professional learning. Contextual conditions, such as working in a supportive environment, could have significant influence on students' positive or negative response to this experience. Narayanasamy and White (2005) suggest that nursing education should emphasise fair opportunities for training, increase tolerance promote appreciation of cultural diversity, reduce and eradicate racism, agism, sexism and a privileged mindset.

4.4.3 Strategies for Coping with Perceived Negative Socialisation

The previous subsections explored and discussed the participants' perceived socialisation and how they make sense of these experiences. This subsection deals with responses and strategies the participants use to cope with negative intercultural socialisation (See Figure 4.14).

Figure 4.14 *Strategies for coping with perceived negative socialisation*



Personal resilience: Ignore adversity and maintain positivity

When encountering adverse working environments, most participants said they were emotionally hurtful, pained and sad. For participants who remained on the programme, the common strategy was to ignore adversity when they could tolerate it and to use personal resilience to rebuild personal strength and continue their placement and study. For example, Azindoo decided not to become too emotionally involved; otherwise, he would be burnt out; therefore, he ignored negativity and only took action when it crossed the line.

> *So not make yourself too emotionally involved. Some of the things, it doesn't need you to react, you just have to let it go over your head. It's only when it crosses the boundary or the line, that's when you have to report it... if it's little things that, you just have to ignore it ... (Azindoo, Y1, Ghanaian student)*

Azindoo explained how he adjusted his behavior to ignore adverse feelings and adapt to the environment, for instance presenting a smiling face rather than looking too offensive or defensive.

> *this pressure coming to you initially, you tend to let go and found your way to cope initially, but after a while, you start to readjust yourself and to present, like a smile way and... Rather than looking quite offensive or defensive...(Azindoo, Y1, Ghanaian student)*

However, not everyone felt they could ignore emotional suffering with ease. For example, Tani described how she used personal resilience to repress her emotion in order to ignore an adverse situation by turning a deaf ear and considering it a trivial issue, even though she had heard wrong comments about her, and her heart was pounding.

> *Ignoring by, you turn a deaf ear. You pretend not to hear, but you've heard it, you know what they say.... when you hear wrong information being said to you, you feel like your heart is pounding more than necessary and then you say: come on, this is just a trivial issue. Just ignore it. Go and make your point later. (Tani, Y1, Ghanaian student)*

Similarly, the third-year student Mourhinda commented '*it took a lot of strong willpower and resilience to accept the fact and ignore the feeling to be discriminated'*. Both Mourhinda's and Tani's experience shows they consider resilience as a useful strategy to help them adjust their emotions to deal with adversity and retain a sense of control to the situation. This echoes Coleman and Ganong (2002) who defined resilience as a dynamic process regulating individual's adverse experience where normal functioning is expected to a positive direction, so that the individual can adjust to adversity, maintain equilibrium, retain sense of control, and reduce vulnerability. Other studies also revealed that resilience is viewed as an ability which can be developed through reducing the individual's vulnerability; resilience-building may help with attrition and retention in nursing (Hodges et al., 2005). Accordingly, it is useful to develop student nurses' resilience, so that they are better able to cope with negative socialisation and to protect them from negative impacts of workplace adversity which may encourage them to leave the profession.

Mourhinda shared her pictorial narrative of a dog in the middle of a pack of wolves and explained despite of potential physical and psychological destruction due to cultural differences, getting on with it, making friends with the wolves and getting through were what mattered. She further shared the image and commented that it was particular powerful in strengthening her resilience when she encountered negative socialisations.

> *So, I had a picture a while ago with a set of a pack of wolves and there was a dog in the middle, so my understanding of that picture is that even though the culture might not be right, you might find yourself as the only person in a culture that seemed totally wrong. That can cause human, physical, psychological destruction, you just get on with it. Stay put and get on with it and you will get through this, even if you need to change the mind, the behaviour, or whatever of one of the wolves, you'll make friends and you'll get through this. Such a willpower is a strong tool for me. (Mourhinda, Y3, Guyana)*

Mourhinda further explained the reason why she did not in over 3 years confront nor report negativity was because she did not think it could change anything; this view was based on previous experience when she asked for support but was told not to worry about it, despite the fact she suffered from discrimination badly.

But I try my best not to play on it, because I know is that if I play on it, I can have different perspectives on something and I might just be told, it's not something to worry about, but the presentation of it, if two of you from the same group, same class or same year is on this ward, working towards the very competencies and there's a better appreciation for one than the other. Humanly you would think, but then it's like don't say anything and just get on with life... It does take a lot of resilience to accept the fact... (Mourhinda, Y3, Guyanese student)

Mourhinda's and Tani's experience imply that they see institutional racism and discrimination as a norm. Recognizing the fact that as a student nurse, they did not have the support from their mentor nor had the power to defend or make the organisational cultural change, to survive in this system, they had to ignore the situation rather than challenge it and make change for the long run. Also, a few of other ethnic minority participants reported that they were told they could be in bigger trouble if they reported, since racism was a sensitive topic in NHS service. Reporting could have serious consequences for the staff who they accused. Thus, through threatening and use the students' kindness, the acts of institutional racism were then covered, embedded into day-to-day practice, accepted, and sustained as 'normal'. The participants commented that the reason why they accepted this situation was because they knew they would only stay in their placement for few weeks, then leave; therefore, it was not worth reporting the issue disturbing themselves further in case they were retaliated against or labelled as a '*troublemaker*'. Therefore, they tended to tolerate the unfair treatment by thinking '*finish the placement and pass the assessment then leave and forget about the negative side of this place*'. McKenna et al. (2003) also revealed that students face high rates of negative attitudes during placement and voiced a concern that it may lead them to assimilate these behaviours and treat others the same way even after they qualified. This concern shows the potential further damage in this approach as it reinforces the negative attitude within the organisation (Lachinger et al., 2009).

Mourhinda reported that it took a significant amount of willpower and resilience to keep her focused on study and staying on the programme. She described how her resilience was developed and strengthened during difficult interpersonal relationships throughout her 3-year placements, including asking why she was entering the nursing profession and believing in her own ability.

It took a lot of willpower and resilience to keep focused as to ask myself why I want to do this that actually kept me here in nursing… There are many times when I considered leaving. So even though it's difficult, you believe yourself can do the job, it's just the organizational culture that you can't change. (Mourhinda, Y3, Guyana)

Similarly, Azindoo also demonstrated strong motivations to develop resilience as his coping mechanism, since he believed the adverse work condition would continue even after he qualified.

I am sure that these challenges I am facing will not be the end. It's going to be there for years after I have qualified, I would have to have some kind of coping mechanism because I'm going to face the same situation wherever I go, where it is dominated by, for *example, white people. (Azindoo, Y1, Ghana student)*

Other participants also reported that their personal resilience was strengthened when they considered positive meaning in adverse situations, such as that their motivations to study nursing were mainly related to their personal interests of caring for others who are less fortunate than themselves and viewing nursing as profession which has the potential to build a better life in the future, i.e., as a qualified nurse. In this way, they turned their adverse experience into a powerful to motivation to work harder and achieve higher.

In addition, Azindoo thought self-appraisal was a useful way to strength his resilience. When he was rejected by the staff, he initially experienced self-doubt and felt lonely working at placement. Although this had affected his confidence and performance, then he viewed this experience as toughening him and making him more resilient, which in turn helped him to absorb any condition more competently.

initially, it took me aback, I felt I was alone working there and so it affected my behaviour. I wasn't interactive; I was quieter than usual…the experience has made me tough and resilient more. …That had made me much more competent and I'm sure those that I have worked with at the end of the day would see that I have been able to absorb whatever was thrown at me and I did not go ballistic, or I did not in a way become aggressive. I go always with a smiling face, even with somebody that I know who is trying to defend me, I still give the person a good smile; I still work with the person…I've been able to absorb that and that is because, in terms of the competency, I've been able to make myself more competent to absorb all. (Azindoo, Y1, Ghanaian student)

Azindoo's self-appraisal helped him to maintain psychological balance and positive emotion; these increase ideas and broaden potential actions that come to mind to generate self-enhancement needs and outlook and he used these when he encountered an adverse situation (Jackson et al., 2007). Consequently, when the participants encountered adverse experience at placement, instead of continuously being negative or cynical, adjusting their mindset through drawing a range of positive perspectives was useful to strength their resilience, even when they were in the middle of stressful situations during placement.

Open up and access support

When encountering perceived negative interpersonal relationships, a few ethnic minority students accessed help from their mentors. They shared their positive feelings about the support, e.g., being made to feel special and being motivated to learn (Azindoo).

> *For those who* experienced supportive support, they felt the experience made them feel special and motivated them to continue pursuit study and achieve high. (Azindoo, *Y1, Ghana student)*

After reporting his situation, Mohammad commented that, even though it did not eradicate the situation completely, at least those involved were aware of the impact of their behaviour on students; and they might make some improvement because they were then made aware of their negative attitudes or behaviours.

> *Open up and seek help and then discuss it, because sometimes, when you discuss it, then they know what they are doing and so it changes the situation a bit. It will not eradicate it completely, but it changes it a bit. It makes them accept you a bit more because they know you know, and you've made other people aware that this is what is going on. So, it's more or less like make them change their behavior. (Mohammad, Y3, Iran student)*

Even though many ethnic minority students expressed their desire to access support from professionals, only a few had positive experiences. Mohammad commented it was important to set realistic expectations, since it was not possible to change their habitual behaviour overnight, so individual students still need to make the effort to adjust their expectation and adapt to the environment.

Then again, you've got to accept the fact that you can't change people's behavior overnight…these are the people you're going to work with, so you have to find a way of coping with them and seeing how you can work around it. (Mohammad, Y3, Iran student)

Azindoo also shared his experience of how to gain positive support from staff: 1) to make sure not to be too emotionally involved, otherwise will be burnt out by these negative feelings, so only report when a boundary is crossed i.e., victimised, dehumanised, or your image is tarnished, which hinted he considered a certain level of discrimination was the norm, and he was powerless to tackle it. He therefore accepted and tolerated it; 2) only seek help from staff who have supportive qualities, such as being approachable, patient, kind and caring and show compassion and personal interest in student's experience; 3) when reporting, make sure to explain the intention clearly.

unless it's crossed a boundary and if they are just trying to victimise you, dehumanising you or trying to tarnish your image, then you need to act upon it like report it and then to be discussed…. speak out to those qualified staff who are supportive are approachable, patient, kind and caring, show compassion and personal interests to student's experience… explaining to them what your intentions are. And that has been the coping mechanism that I have been using. (Azindoo, Y1, Ghanaian student)

Nevertheless, some participants also encountered unapproachable and uncaring staff, including both academics and clinical mentors, who asked them to keep quiet rather than raise issues to avoid getting the relevant staff into trouble. For example, Tani commented that the qualified staff and academics told her to get on with it and ignore the situation. They explained that it was the working culture and that she needed to learn it; therefore, it was not worth reporting it. She then learned that she needed to learn tolerance and develop resilience in order to cope with others' discrimination and consequently to become a stronger person.

Annoying to see it happen, but I always got told to get on with it, and ignore, otherwise I will get involved in investigations and policies. I'm not interested in their politics, so try not to get involved in reporting. (Tani, Y1, Ghanaian student)

These participants' experiences echo Rew (1996) who reported that academics who are aware of cultural factors are more sensitive to students from diverse backgrounds

and provide support accordingly and treat them as individuals who have unique needs, aspirations and difficulties and encourage them to succeed. Those who do not have this attitude, especially those who hold an ethnocentric worldview and consider their way is the only way and the best way, believe their ways of thinking and doing are right and superior to others. They believe ethnic minority groups have to adapt to their way; attitudes lead to biases and create barriers to effective communication and support for student nurses in intercultural encounters. Yoder (1997) revealed that most academics missed recognise that being from an ethnic minority background may be a factor which may impact a student's study. Therefore, except for noticeable linguistic issues, they lacked the ability to identify barriers that ethnic minorities encounter; consequently, they tended to provide a low level of attention when these students expressed their desire for support. This suggests that academics need intercultural education to develop competence in fostering positive nurturing relationships with students from diverse backgrounds. In this way, students will have more confidence to actively seek support from them and do their part to maintain mutually beneficial supportive and nurturing relationships (Daly & Palomares., 2004).

A clinical mentor is a role model and essential support to students during their placement; therefore, the mentorship of ethnic minority students needs to be established at the early stage and sustained throughout the placement. However, this study indicated that ethnic minority students' asking for help from academics and mentors depends on their trust in those educators who are either willing to help or have the ability to help them and to prevent students' from causing themselves trouble, since these same people have the power to assess their overall performance and determine their pass or fail on this particular placement. The participants mentioned qualities, such as being approachable, sensitive, and nonthreatening, which are important to enabling these ethnic minority students to feel confident to access them for help. This finding suggests that clinical mentors may require further training in intercultural communication and developing understanding of students' diverse cultural needs. At the same time, ethnic minority students should be encouraged to report discrimination incidents and express their concerns and access support from academics and mentors.

Without success in accessing formal support from nursing professionals, some participants, such as Nesta, reported that getting informal minority social support from

peers and friends was useful in helping them articulate their feelings in a supportive environment; Consequently, they gain a sense of belonging and comfort. For example, the first-year student, Nesta shared her positive experience of receiving guidance from a senior student from the same background.

> *One of my ethnic minority friends was telling me how she suffers a lot at placement, and suggested me: "you have to make sure you know why you are there because everywhere we go, we're going to find people, who treat you like that.' (Nesta, Y1, Zimbabwe student)*

Social support through sharing their experience was considered helpful. Myhre (2011) too found that peer support is useful in reducing anxieties and bringing insight from different perspectives. In addition, some participants found the strong relationship established with other ethnic minority students offered them a sense of the belonging/connectedness within the professional context (Tusaie & Dryer (2004); Tugade & Fedrickson, 2004). In order to eliminate barriers to ethnic minority students' graduate success, Gardner (2005) suggests that academics could be encouraged to join in this group to gain understanding of these students' needs and, at the same time, to provide support and suggestions to these students on how to set up realistic expectations when living in a multicultural society without compromising their own minority culture. Otherwise, the attrition rate in ethnic minority nurses will change radically, further contributing to the unbalanced ethnic minority workforce in nursing.

Withdrawn and consider leave the course

When treated negatively for a period of time, some students questioned their ability and said they did not see themselves as capable of studying the course, since they felt they did not fit into this profession or could cope with the emotional challenges they were facing, because they did not know what to say and what to do to please the staff and get support from them. For this reason, Azindoo commented that he eventually withdrew his attempts to interact with the staff and became quiet.

> *You've got to always evaluate yourself and where you're at, what you can do, who you can do things with, and then things that you can say or cannot say. That might provoke somebody because there are so many things that it's not an issue, but they tend to be an issue and it's quite difficult for you to even [see it well], because one of the reasons why I became quiet was that I didn't know what to say or do that will not be picked on.*

And that's why you became quiet or even withdrawn. I wouldn't know what to say or do that wouldn't be picked on, because you are in a no-win, no-win situation. Whatever you do, whatever you say, if they want to really pick it up, they will pick it up. That is the point. (Azindoo, Y1, Ghana student)

Despite trying to use resilience to ignore the perceived negative socialisation at placement, Mourhinda admitted that sometimes when she encountered the staff who did not build connection with her due to cultural difference, the fact that she felt that she could never change the situation made her hopeless and she requested to be moved from that placement.

Some of them never really worked. While I don't drink, I don't smoke, I don't swear, it would be sometimes difficult to foster a communication relationship with people who tend to like do those things. My beliefs and my values that I don't do these things. So, if you don't share the same, then there's not much to go on. So I asked to be moved to a different area. (Mourhinda, Y3, Guyana student)

Similarly, when the participants experienced clinical placement challenges that exceeded their level of tolerance, the increased stress, fear, confusion, and anxiety led them to question whether they had chosen the right profession. For instance, Azindoo commented that he did not want to return to the placement; Mourhinda even considered leaving the course, especially in her first year when she was most vulnerable.

And it looks so bad that at the end of the day, if you don't take care, you even get stressed as a result and you don't feel like coming back my placement the next day… I even wanted to end the first placement. (Azindoo, Y1, Ghanaian student)

Looking back on first year, when I felt I was isolated in a way, and lack of confidence to speak up as well, there were many times I was question whether I have chosen the wrong profession. so many times I thought of leaving the course. (Mourhinda, Y3, Guyanese student)

Azindoo commented that when he was repeatedly rejected and not supported, he was worried that he would not know what to do to achieve the learning outcomes required for this placement; he was concerned about the possibilty of progressing in the programme; hence, he too even considered leaving.

When you get isolated, you look dejected, rejected, not acceptable and you wouldn't know what you are doing. I got to a point where I couldn't take any more and I was contemplating not continuing the programme after the placement as I wasn't getting support in terms of meeting those competencies, and the weeks were ticking by. I didn't want to waste my time doing basic stuff like hand washing, changing bed and serving meals every day and eventually it ends up being told I have not completed the competences for this year, so I was so much fed up that I decided that I was not going to come back and do the course again. (Azindoo, Y1, Ghanaian student)

There is a growing ethnic and racial population in the United Kingdom; however, the nursing staff and students recruited from this background are underrepresented (Gardner, 2005). One of the reasons is that attrition rates of ethnic minority nursing students are much higher than those from the dominant group. This finding suggests that in order to increase graduation rates from ethnic minority groups and develop a diverse workforce in nursing, it is important to offer the support needed to ensure students from ethnic minority background are retained.

4.4.4. Conclusion

Student nurses entering a department on a temporary placement are especially vulnerable because they tend to be younger, less experienced and have less knowledge about the specialty and the local norms, as well as having their performance assessed by the staff (Lewis, 2006). Thus, their self-esteem and morale are easily undermined if they perceive negative treatment and lack of support. Therefore, as this study show, they highly appreciated positive interpersonal relationships with staff and patients during placement and thought these positive attitudes were rooted in compassion for the vulnerable and being passionate about humanity. Many participants also openly shared their adverse experiences and felt they were bullied by senior staff and discriminated against simply due to their different physical skin colour, the way they talk and behave, despite their making extra effort to work harder than their native British counterpart peers. This treatment led to loneliness, self-doubt, alienation and isolation; a few even wept tears and used a sad voice when interviewed. Some of the participants also witnessed other healthcare staff treating all the patients the same without any consideration for the ethnic minority patient's needs

(i.e., cultural blindness). The participants attributed these negative attitudes to an ethnocentric mindset, since they observed that holding ethnocentric views led to discriminatory behaviours and racism on the part of such individuals. Actively seeking to improve one's self-awareness of personal values and beliefs is the first step towards tackling ethnocentrism. Through introspection interaction with cultural others whose values and needs are disregarded will be recognised and thus bias and prejudice can be reduced (Sutherland, 2013; Campinha-Bacote, 1999). To confront others' ethnocentrism and develop awareness and tolerance to other beliefs and values, student nurses need to have consistent guidance and support from those experts and nursing role models who have already overcome this challenge themselves (Sutherland, 2013).

The data shows that entering a placement atmosphere where the students feel accepted, connected and supported was particularly important, as these were the bridge to their sense of belonging and which was the first step to building their confidence to engage in active learning in the placement. Discrimination made them feel socially and professionally excluded; offensive comments and rejecting behaviour from patients and staff made them feel frustrated and intimidated, that their dignity was not respected. They felt isolated, lonely; some even felt so hurt that they even wished they could paint their skin white to gain the same level of acceptance and respect as their native British peers. Gerberich et al. (2004) argue that these psychological issues may present immediately after the event and may stay for months or even years. As they can have a detrimental effect on professional identity and value, it is important to provide sufficient support to students, especially those from ethnic minorities who experience challenges in socialisation. Ethnic minority students simply look different. Their lack of 'whiteness' does not mean that they are not inferior, deficit, inadequate. Like their native British counterparts, they simply have an inward desire to maintain order in a fair society and to work hard to look after patients and to protect the economic and political benefit of all cultures.

The participants said that encountering intercultural insensitivity, negativity and adverse interpersonal relationships in placement impacted the development of their intercultural knowledge, skills, dignity, and wellbeing. Some responded by ignoring these issues, since they that 'was how things were'. Some thought that it was not

worth reporting such treatment; some thought that reporting it might cause more problems and make them more vulnerable; some even considered withdrawing from study altogether. However, some participants did access support from academics, clinical mentors and peer friends who can be called on to assuage their emotions, offer guidance and support, act as a 'sounding board' and offer validation of their emotions, in particular when emotions were deeply affected in the workplace and when accessing support may lead to unnecessary vulnerability.

It seems individual's capacity to see different forms future possibilities, positive aspects of the event and potential benefits help them maintain positive outlooks, which seems helpful for them to ignore and adjust their perspectives when encounter adverse interpersonal relationship at placement. Participants showed appreciation of uniqueness of self, repressive coping, self-enhancement are helpful to strength personal resilience to reduce the level of adversity related stress and lessen negative emotions (Tusaie & Fredrickson, 2004). In this way, their vulnerability at placement can be minimised and resilience promoted when intercultural adversity is encountered. This study shows that building the individual's resilience has the potential to help student nurses to deal with interpersonal difficulties and consequently attrition and staff retention. Therefore, academics and mentors need to work together to nurture, support and develop this skillset to help ethnic minority students to cope with workplace adversities (Giordano, 1997); at the same time, placement managers and policy makers should take more radical action to tackle institutional racism, so that the student nurses can be better protected and consequently focus more on their learning rather than wasting time and energy on dealing with unnecessary emotional suffering.

4.5 Intercultural Engagement

Edward Hall's (1976) cultural iceberg model shows that we cannot judge people based only on what we see or truly learn the culture of others purely based on overt behaviors. Instead, we must spend time getting to know the individuals and interact with them through intercultural engagement. This emphasis on engagement is in line with what caring in nursing means, i.e., the will to care (such as having passion to humanity and compassion for vulnerability), the intent to care (mental fight/flight battle,

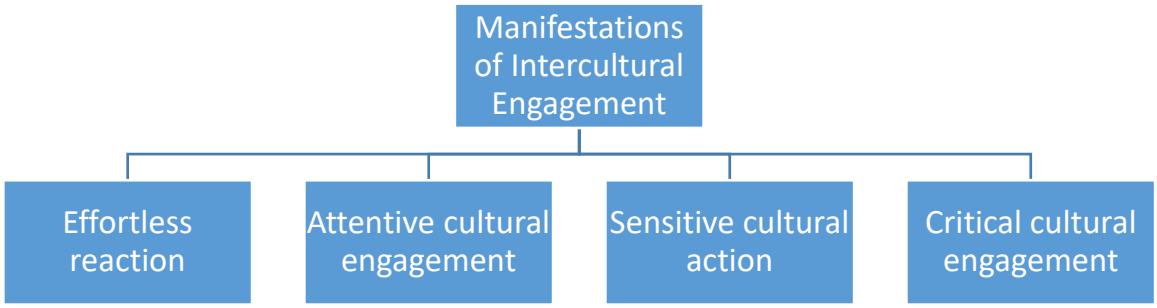
(re)negotiation or (re)adjustment of thoughts/beliefs), and caring actions (i.e., sensitive engagement) (Watson, 1988). Consequently, only through sensitive and purposeful interaction with culturally diverse populations can true intercultural communication care happen, because in this way, individual's internal values, beliefs and thoughts can be revealed and understood.

This section reports the participants' experiences of intercultural care engagement to bring insight into how participants interact mentally and physically during interculture encounters (4.5.1), and participants' perceived enablers and barriers to active intercultural engagement (4.5.2).

4.5.1 Manifestations of Intercultural Engagement

Participants commented that they communicate differently depending on the context; the way they respond during ICE is neither static nor objective, but dynamic and multilayered and created and influenced by the physical and social characteristics of when the communication occurs. In this subsection, I report different types of participant actions, from the least involvement (e.g., effortless reaction), to deep involvement (e.g., gaining understanding, accommodating, adapting and critical interaction) (see Figure 4.15).

Figure 4.15 *Manifestations of intercultural engagement*



Effortless reaction

Participants reported that they observed qualified nurses deliberately avoiding patients from ethnic minority groups by assigning students to communicate with the patients with language barriers, because it would take extra time to get points across (Linda); some even were abrupt and frustrated if the patient could not understand (Hannah). In comparison, student nurses (such as Linda and Hannah) felt more willing to interact with these patients, even though doing so sometimes took some time and they needed

try different ways to reach understanding on both sides. Participants considered one of the reasons why they were more willing to interact with these patients than qualified nurses was because they had fewer responsibilities than these qualified nurses, hence more time to engage. The placement manager should therefore make sure that enough staff are on duty to ensure time is available for effective intercultural communication.

> *If you keep saying it over and over again and trying to demonstrate, eventually she would do it like for standing up and things like that; if you demonstrate and show her what you want to do and she would do it eventually, but it would take a long time… And some staff* ***make extra time*** *and then other people* ***won't try as hard****…It tended to be students that would go and do this lady… So that kind of hindered the message. (Linda, Y3, English student)*

> *I have seen staff get really frustrated if patients can't understand. But sometimes I don't think they give them enough time that they should do… I know the staff are busy, but you've got to look after your patient and not spending a great deal of time with them 'cos they can't understand… I do see people* ***get a little bit abrupt and frustrated*** *that "I can't understand. What am I supposed to do?" And you think: well, we'll just have to try another way to try to get across. You cannot just give up. (Hannah, Y2, English student)*

Participants observed that some nurses view patients from different backgrounds as anxiety-provoking and threatening for forcing them change. Thus, it is important to recognise that it is not in everyone's nature to communicate interculturally; further support and intercultural education are needed to ensure effective intercultural engagement. Other participants (such as James) considered that this disinclination to deal with patients from ethnic minorities might be due to these qualified staff's perceived lack of knowledge of cultural beliefs: fear of being misunderstood or insulting people from other cultures: or embarrassed due to lack of effective communication skills, so they avoid the situation. This view was echoed in Leishman (2004) study, which reported that a nurse may avoid interacting if she/he does not feel comfortable about their own knowledge and understanding of cultural beliefs. This finding indicates an urgent need for intercultural competence education and workload support for qualified staff to help them develop essential intercultural knowledge and skills in ICEs.

> *I've witnessed that some staff are a lot* ***less likely to form a conversation*** *with people from other cultures. They won't try and form a dialogue or relationship. They'll still give the same amount of care and they'll still give all the information that is necessary, but*

> *they won't necessarily try and form like a friendship… I think this possibly because these staff nurses and healthcare assistants may have a lack of understanding of that culture, so they didn't know how to approach them, so there's that kind of* ***fear of the unknown****. (James, Y1, English student)*

If staff consider ethnic minority patients to be difficult to care for, they may develop negative feelings and distance themselves from these patients, or even limit their direct physical or routine care. Participants (such as Mourhinda) commented that doing so can seriously affect the care for the patient. Mourhinda said she found it shocking to see a patient who was silently excluded, and she felt it painful to witness this happening in practice.

> *What I've learned over the past 3 years is that people can be excluded on different levels and it's quite* ***shocking*** *to me how people can be excluded silently… For example, this gentleman from Latvia, because he couldn't speak English and he couldn't express his needs and wants whenever he wanted to, he kept quiet. He didn't know where he was. From patient's perspective, really* ***painful,*** *to be in a place where nobody understands what you're actually going through. (Mourhinda, Y3, Guyanese student)*

Participants also observed that some qualified staff take an approach of asking people from cultural minority groups to cooperate rather than making efforts to find out what is appropriate care for their individual culture. This shows that some staff still have ethnocentric or Anglocentric attitudes to these patients, believing that Western culture is superior to those of ethnic minorities (Murphy & Clark, 1993). Despite participants' observation that most families accepted and followed nurses' instructions to cooperate, they possibly do so because they think it is polite and will please staff rather than because they agree with the course of action (McKinley & Blackford, 2001). Therefore, some participants saw staff nurses attempting to guess possible meanings based on facial expressions to try to '*get by*'. Such practice carries a risk of '*making wrong assumptions*' and can potentially '*lead to misdiagnosis and inappropriate treatment*'. This behaviour may possibly be because these staff did not consider communication with these patients as important, so did not make an effort to improve communication (Murphy & Clark, 1993), as discussed in section 4.4.

Attentive cultural engagement to gain understanding

Participants commented that even though knowledge and skills are important, they have observed that these need to be applied to the intercultural encounter to help

develop continuous understanding. Mourhinda described it is like a bridge that allows you to cross over into the interlocutor's world.

> *After I learned a few words of the patient's language, I felt really good. It's like I've crossed over into his world… I think this gentleman deserves the same, and language shouldn't be something to prevent him from experiencing what the other patients had received… (Mourhinda, Y3, Guyanese student)*

Participants found attentive actions, such as *'respectful questioning', 'attentive listening', 'genuine interests in others and showing a caring attitude'* were useful strategies to help them gain understanding of cultural similarities and differences. When the i extra effort these individuals made did not work, some even tried to approach qualified staff for help. Below Linda explains that using a different approach might help to create better understanding.

> *I am willingly to give the time to sit and talk to her and try and explain everything bit by bit and… If it doesn't work, I'll ask help from others because sometimes you feel like you're not getting through, and it might take another person just to explain it maybe in a slightly different way and she might understand better. (Linda, Y3, English student)*

Other participants also highlighted the importance of making extra effort in communication to gain understanding in intercultural communication and reported ways to do this through giving more time to communication with patients (James), more frequent visits (Ruby), and tactically demonstrating to help identify patient's needs (Sophie).

> *It was just **give a bit more time and effort**, like usually spend about ten fifteen minutes on the paperwork but I think I spent about forty five minutes just trying to convey in different ways and try to find out if she understood, so if I say she is nodding her head that doesn't necessarily means she understand, I would try and get her to relay the information back to me just to know that she understood it. (James, Y1, English student)*

> *I would say checking on them **more frequently** and physically showing them the drink of water if they want a drink, or prompting them with food. (Ruby, Y1, English student)*

> *I tried my best to explain things if the patient didn't understand, like pointing to things, showing things, just doing things like that, I found that has helped. (Sophie, Y1, English student)*

In addition to these in-site demonstrations, some participants value the power of knowledge and made consciously effort to use their existing knowledge and skills to overcome the linguistic barrier (Ruby) and look up other resources in order to gain more knowledge about religion and language (Linda).

> *I think it makes you feel you need to **make more of a conscious effort** and think about what you've learned about communication barriers and things. I think you think about it more because you try to think of ways that you can communicate with that person, other than speaking to them, really. (Ruby, Y1, English student)*

> *I took a little bit of time to **look up about their religion and language**…learn a couple of phrases, or spending a little bit of time with her to do a bit of demonstration of what you want her to do. (Linda, Y3, English student)*

Jasmine also commented that when encountering intercultural communication difficulties, she made extra attempts to see whether the patient needed anything rather than running away.

> *When there's somebody in that situation, you pop your head round to see if there's anything like if he needs any water, then pour some out, or get some…you make a bit of an **extra attempt** to see whether he needs anything or not, rather than trying to be away. (Jasmine, Y1, English student)*

Bensing (2000) argues such active seeking of versatile solutions is a patient-centred approach, something which is highly advocated in modern nursing practice. Participants (such as Cara) revealed that patients are grateful when healthcare staff are willing to listen and step out of their usual practice to meet their diverse needs. This in turn helps establish trust and sustains positive therapeutic relationships, which concurs with Seeleman et al.'s (2005) and Napoles-Springer's (2005) studies.

When asked why they made these extra efforts, Sophie said she did so because she felt the patients needed help, so when something is resolved she felt good inside.

> *It makes you feel good inside, as she really wanted that cup of tea. That extra time is really worthwhile. (Sophie, Y1, English student)*

This point was also echoed by Cara who believed nurses should try different things and seek advice in order to overcome any barrier. She believes it is nurses' duty of care; therefore, it is important not to give up and run away.

> *Even if there is the barrier, you don't just run away, you try and overcome it… you can try different things… seek advice or try and have help…just because there's a barrier, you can't just stop. You have to look after them, don't you? Because it's important. Well, it's important to me … You need to be able to communicate effectively with someone … Like overall, she was happy with her care, because we did try and if you're seen to be making an effort, then at least they know you're not just brushing them off, so I think it is important. (Cara, Y2, Northern Irish student)*

Other participants commented that understanding is the first step in building a trusting relationship. Understanding helps to dissolve biases and stereotypes which commonly causes problems rather than culture differences themselves. This echoes Leininger (2001)'s finding that actively making efforts to understand and integrate the patient's values, beliefs and gender needs in all stages of the nursing process makes patients feel safe with the services they receive. Such a mutual and intertwined ongoing process of understanding and relationship building is considered the heart of effective intercultural communication. Because culture is diverse, continually changing and context-based efforts towards seeking ongoing understandings are the key to maintaining a good relationship.

Sensitive cultural actions to accommodate, adapt and negotiate

After recognising the cultural differences and gaining a good understanding of patients' cultural needs, the next step is to consider strategies to sensitively incorporate these differences into the care provided. Castro & Ruiz (2009) refer to **culturally sensitive care** as respecting and considering patients' language, cultural tradition and practice, whilst providing real time nursing care to people from different cultural contexts. Participants reported that culturally sensitive action is an essential part of nurses' roles and directly affects quality of care. Their way to demonstrate it is through accommodating, adaptation, and negotiation.

Participants reported that sometimes they could not use usual ways to manage unfamiliar situations, so to avoid conflicts or frustration or compromising therapeutic

relationships, some reported new solutions through accommodation and adaptation, which required flexibility and creativity. For example, to maintain quality of care and provide continued linguistic support wherever possible, Daisy said extra support was offered to these patients, for example, extended visiting time which is against usual hospital policy if the patient's relatives were not allowed to stay longer than two hours. To avoid other patients' and relatives' questioning this special treatment, Daisy's team placed this patient in a side room. In this way, family members were allowed to facilitate translation when needed, without affecting other patients.

> *'cos the family were worried about them being there but not knowing what was going on, so you encounter difficulties where the family wanted to stay, but because of the ward environment, you couldn't really offer them to stay as it wasn't appropriate with other patients, so they would extend visiting for them, like **stay a bit later** on a night time; or be there when the doctor sort of came round, so they could be involved then and hear for themselves what the doctor had to say and then relate to the patient. …We put the patient **in a side room**, so that the family member stayed with this particular patient, in order to help with the translation…It was very helpful. (Daisy, Y1, English student)*

Participants recognised there were times their own culture and practice beliefs may not agree with those of patients and reported that under these circumstances they made conscious efforts not to upset or offend people from culturally different groups during the caring process. They adopted this approach because they consider understanding does not mean they have to fully agree with a patient's cultural belief and practice, but means learning and appreciating where their thoughts and behaviours come from, how they developed these and what to do to make sure their needs are met sensitively. For example, James had strong opinions about Jehovah's witnesses not accepting blood transfusions, which he felt was against his life-saving practice; however, when he communicated with the patient and explored the rationales and reason behind this religious practice, he adjusted his approach and thought he should respect the patient's right to believe it and follow the patient's wishes and help to prepare for the operation.

> *Jehovah's witnesses refuse transplants, that's against our life-saving practice. I had looked upon it and discussed with patient to find out why, I still don't necessarily believe in it, but I respect somebody else's right to believe it. (James, Y1, English student)*

Holmes and O'Neill (2012) suggest effective cultural discussions require trust and open-mindedness on both sides. Even when language is not a barrier, such open-mindedness and self-disclosure do not always come easily, especially when one party feels communication is uncomfortable and even painful, even though reconstructing and renegotiating intercultural values and beliefs, and adjusting behaviours are useful strategies in intercultural competence development (Atkins & Murphy, 1993; Lyons, 1999). Hence, actively engaging with people from different cultural backgrounds requires healthcare practitioners not only to examine their views of others and recognise the differences, but also to be able to reconstruct and renegotiate with some part of their thoughts and to adjust their communication style to accommodate the patient's needs.

Through his empathetic and respectful approach, James noticed that '*trust was facilitated, patient smiled and looked more relaxed, as a result, became more participative'*. Through nurturing positive relationships with cultural others, his intercultural confidence developed, and he became willing to engage more with these patients. This is possibly because his individual nursing professional identities were perceived through his relationships with others (Nwosu, 2009).

> *Through this experience, my confidence grew, and I learned that it was not as difficult as I initially thought, so I'd like to do more. (James, Y1, English student)*

Participants found that at times there were not enough resources to accommodate patients' needs. For example, when faced with a patient's refusal to accept treatment due to gender differences, some students (e.g., Tony and Grace) commented that they had to discuss the resourcing issues with the patient to highlight the limited choices available and negotiate with the patient to accept the situation.

> *If they don't want a male nurse to look after them, then I explain that I'm a nurse and reassure them I've been in this situation lots of time. (Tony, Y2, English student)*

> *But if someone doesn't want a female staff, you've got to do your best to try and have only male staff, but sometimes, you've got to say "Look, I know you don't want any female staff, but this is all we've got at the minute, so you've got to, otherwise… I don't like having to say it to some people. But under such circumstances, you either have the option of doing it or not have it at all. (Grace, Y1, English student)*

Tony and Grace commented that even though not ideal, working through negotiations presented in a respectful way helped both patients and their relatives to understand the situation and consequently increase cooperation. This suggests that the managers in the hospitals should make effort to ensure more staff are available and that having a mix of genders on each shift is a way forward in order to meet the patients' cultural needs.

Critical cultural engagement

Even though the participants were aware of accommodating the patient's wishes, some felt doing so does not mean they need to accommodate all a patient's wishes especially when it affects other people's rights such as discrimination and racist. Under these circumstances, they commented that they even had to challenge behaviours to protect other patients and staff. Byram (2012) describes this quality as **critical cultural awareness**, which he defines as the ability to critically evaluate an individual's perspectives, routine cultural practice as well as to others whose culture background is considered as different.

The first-year student nurse, James encountered a patient who was originally a local (Geordie from Northeast). He not only kept physically distant from another ethnic minority patient who was newly admitted to the hospital, but suddenly verbally abused this patient. This made James speechless and felt very uncomfortable. Not knowing how to handle the situation, James sought help from his mentor, who went to the Geordie patient, asked him to go back to his bay and used the Trust Zero Toleration policy to warn him that any form of racism towards others in the hospital settings was not acceptable. James observed that this approach helped the situation, as the Geordie patient went quiet and did not behave badly to the Indian patient again.

> *…I didn't know what to say, felt very uncomfortable, so actually left and went straight to my mentor: "… there's this gentleman, he's being very loudly racist to this other gentleman who actually heard as well. How do I deal with it?" My mentor went in and asked the gentleman to sit where he was and explained to the Geordie patient quietly why he should be a bit more respectful of other people, not only for like their benefit, but also for his own benefit and a light threat, like if you treat anyone like that again, you'll be removed from the hospital grounds according the Trust Zero tolerance policy… the*

gentleman was unhappy, he was then went very quiet, which I think was probably better in that situation. (James, Y1, English student)

This shows that effective intercultural communication is not only about applying a set of skills but also consciously thinking about cultural realities in multiple ways and critically justifying and managing the adverse work situation. This is in line with Byram's (2011) critical cultural awareness, which includes analysing tone's own communities and societies as well as people from other cultural backgrounds, since he believes learning a foreign language inevitably takes other countries, communities, and societies where the language which is spoken into consideration. This is similar as the essence of cultural safety in New Zealand, with its conscious awareness of affects cultural others (see 3.3). This is an important quality in intercultural communication, since the healthcare practitioner not only needs to be able to recognise their own cultural background (i.e., cultural awareness), but should also be able to actively link it to the culture of the intercultural speakers they encounter and able to recognise the cultural commonalities and differences, analyse how their own culture may influence their approach and to prevent imposing their own cultural values and attitudes on cultural backgrounds that differ from their own (i.e., cultural imposition Leininger, 1978).

A *'Zero Tolerance policy*' was mentioned as a useful tool for managing challenging intercultural situations effectively. However, not all student nurses felt comfortable using it to confront the racism they experienced. For example, third-year student, Rebecca, commented that she witnessed a patient making a racist speech to a qualified nurse who was from the Philippines. Although she was aware of the Trust Zero Tolerance policy, she admitted that she did not feel comfortable using it to confront the patient until after she qualified and felt she had more authority.

There is a Zero Tolerance policy on the ward, obviously this patient did need to be warned because that kind of behaviour is not acceptable. when the patient behaved inappropriately, would you do anything about it? But I don't feel comfortable to say it to the patient, I suppose when I've got my blue uniform [qualified], it might be different. (Rebecca, Y3, English student)

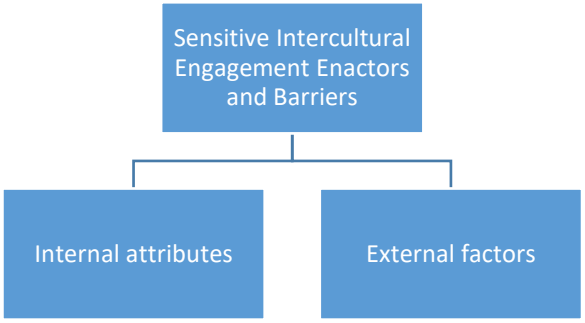
Rebecca's case indicates that even though some participants were aware of this policy in placement, not everyone felt comfortable and confident about confronting a racist

situation since critical cultural engagement did not come easily. According to the data, most participants' views of culture reflect the historical United States of America (USA)'s melting pot notion of culture, also called 'multiculturalism', which often focuses on geographical and historical differences in arts, festivals, dance, music, food and language (Duffy, 2001). Even though this view of cultural diversity is nonthreatening, it is criticised for being superficial, as it requires minimal levels of understanding and engagement with other cultures and avoids the challenges of confronting different attitudes and views, and so can mislead and cause stereotyping. Such a superficial view of culture has the potential to avoid addressing underlying unequal healthcare service provision (Schulman et al., 1999) and issues of cultural tolerance (Iyer, 2000), so the policy makers and managers need to make sure that support is available for junior nurses and student nurses when they practice cultural-related policies.

4.5.2 Sensitive Interculture Engagement Enactors and Barriers

According to the participants, intercultural engagement and levels of sensitivity change over time in different contexts. This shows the importance of **situational competence**, which means the individual can read and analysis the situation, (re)negotiate their inner thoughts and apply the most appropriate knowledge, skills and attitude to the counterpart. The data shows that when having effective intercultural engagement, both individuals' internal attributes and external contextual factors must be taken into consideration (See Figure 4.16).

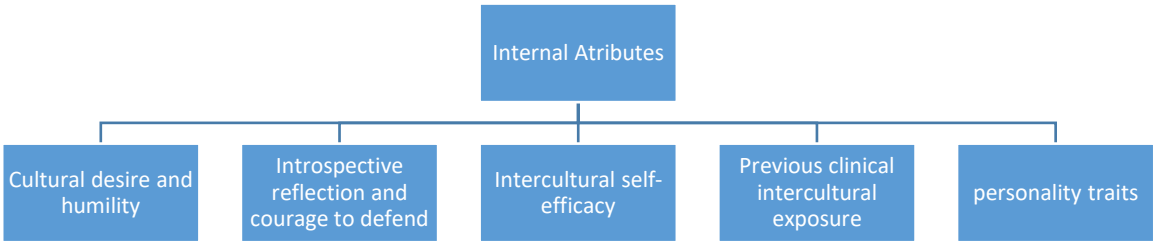
Figure 4.16 *Sensitive intercultural engagement enactors and barriers*



Internal attributes

Internal attributes, also called intrinsic motivators, are the inner drivers that propel an individual to pursue an action (Suzanne et al., 2021). The participants commented that cultural desire and humility, courage to defend, critical cultural awareness and intercultural self-efficacy are the key reasons for them to engage in intercultural encounters actively and sensitively (see Figure 4.17).

Figure 4.17 Internal attributes



- Cultural desire and humility

Cultural desire is a genuine interest in others and having an inner motivation to engage in intercultural competence development (Hultsjo et al, 2019). Love, sacrifice, social justice and humility are how cultural desire is demonstrated clinically (Campinha-Bacote, 2008a), as these are the foundational values for healthcare practitioners. Section 5.1 revealed that participants recognised their knowledge and skills deficits in intercultural encounters. To be able to communicate with people from different cultural background effectively, they expressed a desire for more education, so that their diverse cultural knowledge could be developed to equip them to understand cultural differences and interpret the situation properly; they wanted to acquire skills on how to manage difficult situations, such as when interlocutors have conflict or clashes in perceptions. Barbara also commented that she studied materials offered to the ward to gain some understanding of Ramadan.

> *Prior to them coming in, the chaplaincy service handed out some leaflets regarding Ramadan. I had a look at it because I'm always interested in it and they said: I didn't actually realise: any invasiveness, even just NG feeding or anything like that is classed as breaking their belief, so I questioned a few people about it and said "Oh, so what happens of someone's in intensive care unit and they're not able to pray and things like that?" 'Cos it's breaking their culture and you talk about people's wellbeing and holistic needs, it's not just physical nursing that they need; they need care for all of their needs, so, I was interested in it anyway (Barbara, Y3, English student)*

Participants commented that the way to fulfil their culture desire is to keep an open mind (Michelle) to learning, and they highlighted the importance of lifelong learning for nurses to keep their knowledge and skills up to date (Feihong).

> *'being open to learning about a different culture from the patients themselves, asking the questions appropriately. (Michelle, Y1, English student)*

> *It's care and compassion go hand in hand with the knowledge base as well, apart from I've learned at uni, another important part is that you have to like continue become like a lifelong learner I do think that's an important part, because again to nursing, things do change, policies change and you need to keep up to date with things … (Feihong, Y2, Chinese student)*

Campinha-Bacote (1999) asserts that 'patients don't care how much you know until they first know how much you care' and argues that to be solely able to superficially state that they respect patient's value and beliefs or implement care interventions based on the literature report as effective method to a particular cultural group is not adequate. More importantly, practitioners should have the genuine motivation and desire to engage in cultural communication and interaction to provide care which is truly culturally sensitive and responsive. Based on this idea, she described a practitioner who has 'culturally desire' presents as being passion about cultural others, accepting of cultural difference, willing to be open and flexible to learning from cultural others as cultural informants. Willingness to learn is illustrated when an individual has an open attitude and actively wants to (rather than passively feels they 'have to') learn from another as cultural informant (Campinha-Bacote, 2002). Because practitioners who wish to practise in a culturally competent way are motivated individuals, they are willing to make the effort to learn and improve their cultural knowledge and skill. Therefore, cultural desire is placed at the centre of Campinha-Bacote's cultural competence model and argue that without the desire to provide culturally congruent care, any cultural competence training is not effective (Isaacs et al., 2016).

Participants saw the central motivator of cultural desire as 'cultural humility. This refers to a commitment to address different power imbalances and paternal practice through practitioners' taking a humble position of wishing to learn about another culture from the community as cultural experts on their own culture Tervalon and Murray-Garcia (1998). For example, Zoe recognises culture differences and her knowledge limitations,

views patients and their families as cultural experts; hence, she considers humbly seeking for understanding from them directly is a good way.

> *I've got needs and preferences and it's the same for people from different cultures and beliefs, but I don't know theirs, they are the experts to their own culture, so I tend to ask patients and their families to find out more about them. (Zoe, Y3, English student)*

Similarly, Michelle admitted her limitations in culture knowledge and commented that patients were well educated and lived with their cultural and religious practice; hence, when caring for these patients, she believes that she should ask what they need rather than making judgements on their cultural background or assuming what they needed.

> *Obviously, their needs may feel strange to you, but these patients are very educated about their own cultural and religious practice, so it's just a case of ask them what they wanted, nonjudgementally, not to assume what they might need. (Michelle, Y1, English student)*

Cultural humility is different to cultural sensitivity that the latter practitioner has a hidden superiority to trying to understand the culture other who is at the vulnerable position. Henderson et al. (2016) argues that student nurses who have cultural humility are prepared to actively make an effort to perform compassionate care and to try to understand differences across diverse cultures and help others, which is fundamental to establishing a trust relationship and building a rapport with others.

- Introspective reflection and courage to defend

Not everyone feels at ease interacting with strangers, especially those from different cultural backgrounds with different worldviews and values. This unease can present as reluctance or even fear during interactions. Courage is another quality recognised by the participants; it is defined as being able to speak up when there are concerns and doing the right things for people under their care (NHS England, 2013). From participants' perspectives, courage is described as '*ability to control individuals fear'* and '*willing to do the right thing'* or '*speak up when they have any concerns*', which they consider essential qualities an interculturally competent nurse must have. For example, James considered his position differently and viewed his role as an 'advocate for patients', saying, '*I would not shy away to address the issue and defend for the patient no matter which year I am on the course*'.

Papadopoulos et al. (2017) claim that a perceived protective role in nursing or advocating for people in need is the centre of compassionate care. Without courage, critical cultural awareness cannot be transferred into an active action. However, most participants felt they lacked courage because of their lower learner status when they saw misconduct. Some commented, *'who am I? I am only a student', 'they may not let me pass the placement if I speak up.'* This shows training is needed to empower students to develop courage to advocate for vulnerable patients and defend themselves (see section 5.3). One useful way is through developing students' critical cultural awareness, which is the ability to comprehensively analyse, interpret, evaluate, adjust, and negotiate according to the context (Byram, 1997). Several participants shared their experience of critical cultural awareness and commented that critical reflection on their cultural similarities and differences helped develop their critical cultural awareness and readiness to accept new ideas and perspectives. For example, to foster intercultural competence, the individual is required to reflect at the time of interaction. Zoe consciously questioned her accepted taken-for-granted ways of being, doing and thinking whilst communicating with cultural others. This also requires her to have the ability to know herself and others by constantly using introspection, internal thoughts and feelings whilst observing and interacting in a specific ICE context.

> *I've came across a lot of people from different cultures and backgrounds and it doesn't really affect me. I think you just need to know what their needs and preferences are, which is like for everybody. I've got needs and preferences and it's the same for people from different cultures and beliefs and if you can accommodate them to the best you can. (Zoe, Y3, English student)*

Introspection means examination of one's inner thoughts and feelings about a situation one has encountered. Self-examination facilitates the individual's ability to develop empathy which is important to help sense making of communication behaviours for both self and interlocutor (Patton, 1990). This tends to be a complex, chaotic, interaction and sometimes physically and emotionally hazardous process. Through such a detailed self-reflection process, participants commented that they can think and write freely about their inner thoughts, emotions and that doing so helps them discover their strength and limitations, examine their intercultural competence development process and what they did and how to perform differently next time. This determined

the consequential process of intercultural communication, i.e., how they are going to interact with cultural others.

- Intercultural Self-efficacy

Participants highlighted **cultural self-efficacy,** which is an individual's belief about their ability to learn skills or manage particular intercultural encounters (Jefferys & Smodlaka, 1996). Participants reported that intercultural knowledge and skills, previous experience and personality traits were considered helpful in contributing to their perceived intercultural self-efficacy.

- Previous clinical intercultural exposure

Sophie, a first-year student who had multiple intercultural encounters, commented on her improved level of perceived self-efficacy in identifying, accepting and seeking alternative ways of dealing with patients who have different values and beliefs. This means more opportunities to handle different cultural situations can enhance social linguistic skills and levels of cultural sensitivity and self-efficacy (Meydanlioglu et al., 2015).

> *I have noticed my own confidence has grown massively in looking after patients from other cultural backgrounds. I'm a lot **more confident** in seeking alternatives. At the start, I was very shy and didn't want to talk to anyone; I was very cautious and nervous because I wasn't sure how to talk to them in a way that they understood. But now, I've definitely opened up and I've become a lot more confident, **completely less nervous**. (Sophie, Y1, English student)*

A second-year student, Alice, stated that her confidence improved in her second year in comparison to her first year, possibly because of her increased exposure to and awareness of different cultures and witnessing and experiencing different services that were available to cater for the diverse needs of the patients. In addition, her knowledge developed through communicating with patients and relatives, which increased her understanding and tolerance of diverse cultures (Change et al., 2013), giving her more confidence in dealing with challenging intercultural situations.

> *My confidence developed over time and I am more awareness of different cultures and see different sort of services that can cater for different cultures in comparison to my first year study. (Alice, Y2, English student)*

Nancy, who participated in the immersion programme, commented that her level of perceived self-efficacy was linked with her previous positive intercultural care experiences. Nancy also reported that the qualified staff gave her more trust in dealing with intercultural communication, which further increased her self-efficacy.

> *The staff tend to put me to look after those patients who have language issues now because they felt I have had the international placement and so more competent to deal with situation like this. (Nancy, Y3, English student)*

This may be related to her sense of confidence building when acquiring new knowledge and skills and the ability to apply these in intercultural encounters, which helped her feel adequately prepared and 'safe' to engage in future intercultural interaction (Gol & Erkin, 2019; Kilic & Sevinc, 2018). This also means, for those students who had negative experiences, both academics and clinical mentors provide instant support to re-build their confidence in intercultural encounters, sustaining and even increasing their perceived self-efficacy.

Other participants who had international placements reported that they became more willing to put themselves forward in intercultural encounters compared to before their international placement, possibly because the more exposure they had to intercultural encounters, the more knowledge they developed. Also, their confidence and empathy with people who had linguistic barriers increased; hence, they are more willing to take sensitive actions to break down communication barriers (see 5.3.3). This finding was consistent with Jeffery and Smodlaka's (1999) study, which revealed that intercultural education can positively influence self-efficacy.

- Life experience in intercultural encounters

Participants commented their **intercultural encounters in social contexts** helped their intercultural communication. For example, through direct contact with family members and friends from different cultural backgrounds, Barbara learned how to address people appropriately and how they wished to express themselves to help with relationship building, which in turn helped her intercultural self-efficacy in clinical situations.

> *My mother-in-law, she's African so I can't address her by her first name. I'm not allowed to because it would be rude. I think it's just knowing how to address people from different backgrounds, I mean, by law, I'm allowed to. But, It's not liked, it's a rule…it's just knowing how other people want to express themselves within their culture. (Barbara, Y3, English student)*

Participants' life experiences helped their intercultural communication, especially for students from ethnic minority backgrounds, such as Feihong, who considered she had a high level of intercultural self-efficacy to adjust and adapt communication skills which were based on her life experience. As English is her second language, she learned that self-awareness, strength and limitations are important in effective communication.

> *I think self-awareness, knowing your own strengths and limitations is very important, especially for me because I come from a different culture and English is not my first language. So, I always have to pay attention who I'm talking to and then using different communication skills because communication is one way you can give people the impression about who you are, so you have to adapt your communication skills to that level. (Feihong, Y2, Chinese student)*

Other participants from ethnic minorities also commented that experience as a foreigner brings maturity and adaptability because being surrounded by a new culture created numerous puzzles due to differences in languages, habits and behaviours. Being a minority helps with intercultural comparison and critical examination of one's own culture, which helps to raise awareness of personal stereotypes and prejudices, change ways of thinking, improve sensitivity to another person's situation (i.e., recognising how minority groups feel), being more willing to respect and accept differences and engage in intercultural communication and interactions (Koskinen et al., 2004). This finding is supported by Gol and Erkin (2019) and Lim et al. (2004), who claim that staff who were able to comprehend or speak a second language or more had higher levels of self-efficacy compared to those who only speak one language. This experience is especially helpful in dealing with linguistic barriers, probably because experience of living in a foreign country helped students to empathise more with those from minority groups (Roh, 2014). This implies that more students from ethnic minority groups should be recruited, and international placements should be encouraged.

Some participants, such as Azindoo, commented that maturity (in terms of age) also helped self-efficacy and reduced frustration around intercultural difficulties. They explained that their life experience might bring better understandings of the importance of cultural diversity, a higher sense of cultural awareness, cultural desire, and readiness to cope with communication and interaction during challenging situations.

> *I suppose maturity, as you always say: age is wisdom, or as you grow, you become wider and I am also thinking that my academic background also helps, because I'm highly educated, so that makes me well informed; I've lived in this country for so many years and so I know for example, how people are. I am by religion a Muslim, so I know Muslims the way they are and even if I don't, at the university, I studied the study of religions as a minor and one of the modules was on the bible and on Christianity, to be informed about the Christian religion. I also read books about other religions. I'm well informed; I listen to news, and I get all this information… All this informs me how people are; about cultures that I have never been to the country, but I know the way these people are and what they like and what they don't like and so that is what has informed me. So I'm well informed about cultural differences and that is what is helping me to adjust to this kind of like situation. (Azindoo, Y1, Ghanaian student)*

Such experience might make their ICE experiences richer and more meaningful, bringing short- and long-term impacts to their personal and professional development (Zorn, 1996). However, Lim et al. (2004) reported that age is not a determinant of self-efficacy, possibly because the quality of intercultural experience is more critical to an individual's maturity than age itself.

- Personality traits

Some participants commented that their personality helped their confidence in intercultural engagement. For example, Aimee commented that her easy-going personality attributes help relationship building, especially when there is a sensitive intercultural situation, since she could talk openly, easily agree and handle things sensitively.

> *I am easy going, that helps. I think it's down to the personality of the person and what they're like as people… If there's any issue they openly talk about, easily agreed or sensitivity towards. (Aimee, Y1, English student)*

Personality refers to the patterns of responses an individual exhibits, such as openness to experience, conscientiousness, extraversion, natural reactions and agreeableness. Agreeableness was found to have the highest positive correlation with cultural self-efficacy (Wilson et al., 2013). Aimee commented that her easy-going

personality enhanced her self-efficacy, possibly because she values the importance of getting along with others and is motivated to establish a good relationship with interlocutors to make them feel respected and cared for. This in turn allowed students to receive more health and lifestyle-related information, which is useful for understanding and applying culturally sensitive care to gain patient cooperation and compliance. Tams (2008) revealed that agreeable students obtain more support and encouragement through their communication and interactions, which motivate them to engage more. Such positive engagement processes and outcomes consequently enhance agreeable students' confidence and increase their self-efficacy. Therefore, a higher level of agreeableness is considered a sign of greater readiness for intercultural communication (Baldacchino & Galea, 2012).

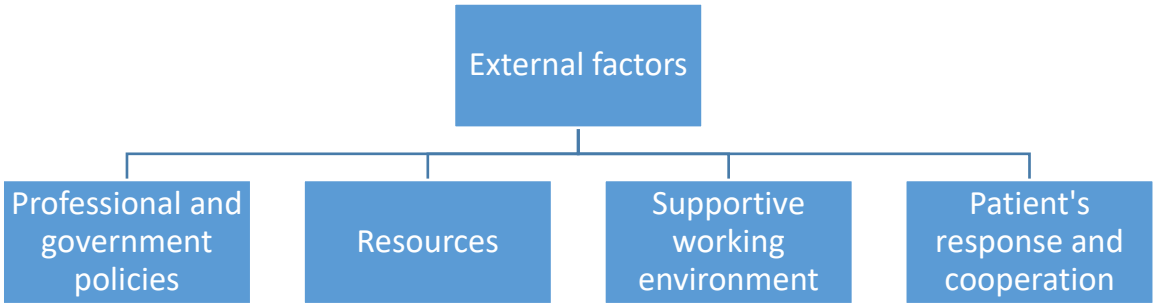
Chan and Sy (2016) suggested identifying and recruiting students with highly agreeable traits. However, this is not the only personality trait that can help develop self-efficacy; personality can be context-dependent and is changeable through education, maturity and life experience. Excluding people who do not have agreeable traits at the recruitment stage may lose many potential nurses with high efficacy in other aspects of intercultural communication. Nevertheless, it may be useful to raise students' awareness of the benefits of having agreeable qualities in intercultural encounters and to purposefully develop their acceptance through intercultural education.

To sum up, this section shows that self-efficacy is a dynamic construct, which changes according to new clinical intercultural experiences and new theories and information the students encounter during the training period (Jeffery, 2000). This also means developing students' self-efficacy in intercultural interactions. Extensive exposure to ICE both clinically and socially is a useful way to enhance student nurses' self-efficacy. The role of academics is critical to encourage students to seek opportunities in intercultural encounters and to make sure the curriculum integrates intercultural theory and practice from an early stage. Having open and agreeable personality traits were considered as having positive impact on student nurses' intercultural engagement.

External factors

Participants reported that contextual factors also affect their level and intensity of intercultural engagement. These include: the professional code of conduct and intercultural policy, which require all nurses to perform professionally in practice with all patients; supportive mentorship and a friendly institutional atmosphere, including staff and patients who are cooperative in intercultural communication; and a willingness to participate in intercultural interactions (see Figure 4.18).

Figure 4.18 *External factors*



- Professional and government policies

Participants showed their understanding of what is essential for a healthcare professional's code of conduct, which is primarily to meet the needs of the patients. While Mohammad witnessed that most staff '*do everything by heart*' and were willing to accept cultural difference, he also saw that a few '*do it just because that's the law*', otherwise they would lose their job. For example, Mohammad's observation shows when individuals engaged in ICE because they have to, their intercultural engagement became minimal or was even perceived as negative, consequently affecting patient satisfaction.

> *If there is a conflict about cultural issues, instead of accepting the culture of the ethnic minority patient have, actually the staff might not make an effort to accept. Or do it because there was a policy in there. Some people are really nice. They accept it and they* ***do everything by heart****. Some people, they* ***do it just because that's the law****. They can't go against the law, otherwise they lose the job. Some people, they don't care; they just can't accept it, if it's the law. But luckily, those are in a very minority, but unfortunately, they exist in the system. Yes, I have seen. They do the job, but they don't do it pleasantly. (Mohammad, Y3, Iranian student)*

The nursing professional code of conduct (NMC, 2012) requires practitioners to demonstrate their competencies when providing holistic nursing care which should be ethically, morally, and legally appropriate. All individual nurses and nursing students have a duty of care to provide culturally sensitive and safe care delivery. However, Rebecca confesses that even though policies such as zero tolerance were available, she would not necessarily use it to challenge a person who was racist at work.

> *Because there is a policy, like a zero-tolerance policy on the ward, but obviously it sounds like this patient didn't need to be warned; that kind of behaviour is not acceptable. At moment, I can say about the policy I suppose, but I suppose when I've got my blue uniform, I will be more confident to use it to confront the patient as I'll be strong enough to challenge this kind of thing, if I needed it. (Rebecca, Y3, English student)*

From moral and legal perspectives, healthcare staff, including nurses and student nurses, are obliged to provide high-quality person-centred care, including culturally appropriate care (DoH, 2019). Many studies also highlighted culturally sensitive care as being the prerequisite to reducing health inequalities and commented that universities have a social responsibility: to prepare the future nursing workforce to gain a good understanding of cultural difference (Berlin et al., 2010); to increase their culture awareness; and to improve overall competencies for intercultural encounters (Kiviharju & Koivumaki, 2012; Berlin et al., 2010). West (2015) revealed that such policies and their associated diversity training helped raise awareness among individuals of a multicultural society but yielded no significant change beyond that and sometimes even presented negative consequences, especially around language barriers (Boi, 2000; Cortis & Law, 2005; Cioffi, 2003; Gerrish, 2000; Murphy, 2011; Stevenson & Rao, 2014).

Participants commented that managers in placements need to be aware of the individual as well as the impact of collective power in fostering a caring environment and to protect those who apply these policies when critical engagement is needed. Leishman (2004, p. 34) agreed and commented that healthcare services should not pay 'lip service' to cultural awareness. Instead, they should make efforts to understand individual cultural backgrounds and their impact on a person's healthcare needs, to provide care accordingly, demonstrating sensitivity (Spitzberg & Changnon, 2009).

Seeleman et al. (2009) revealed that intercultural engagement magnifies competence issues that already exist. Therefore, government and local hospital policymakers should take more radical approaches to providing guidance to assure culturally congruent and safe practice and develop an interculturally competent staff and working environment, if they wish to embrace real cultural diversity to meet the organisational requirements set by the Department of Health (Briscoe, 2013).

- Resources

Participants, such as Margaret, commented that several visual-audio aids were provided by the placement, including printed picture cards and linguistic booklets, handwritten information, and language apps. She said these had a positive impact on intercultural engagement when assessing and providing nursing care to patients with language difficulties, especially when interpreter services were not available.

> *It's a picture chart, got their language underneath and then our language, so we could understand what was going on, so the **picture chart** was quite helpful. Just pointing to things like 'toilet', 'cup', 'plate', 'food'. Just the basics that you would need, and 'Yes', 'no'. (Margaret, Y3, English student)*

Participants highly valued the picture cards with different languages in their engagement in ICE and suggested that every ward should have these. Health-related booklets were also used, but participants reported that some of these provided information in English only, and Matthew suggested it would be better to have multiple language versions to allow patients who have limited English proficiency to be able to read and understand, especially regarding the dose, effects, and side effects of medication, which would help with noncompliance due to language barriers.

> *We provided the leaflet and all the information, but it was difficult to fully educate the patient on it as it hadn't that in the Czech Republic language, but just the English, so I gave that leaflet to his daughter to translate for him. I think they should have different languages.(Matthew, Y1, English student)*

While some students found the printed material useful, others (including third-year students, Linda, Jessica and Laura) reported that they had not often seen these or that the leaflet contained insufficient information, so they had to create one for the

patient. Therefore, they suggested that hospital wards should have some printed language materials readily available to assist language communication for ethnic minority patients.

> *That material was not available on the ward, otherwise, if it is available, we would usually give to the patient, so that's possibly something that can be added in to help communication. (Linda, Y3, English student)*

> *They've got different language leaflets, but only on a certain few thing, but it tends to be like Indian and things like that. (Jessica, Y3, English student)*

> *[The language material] wasn't readily available on the ward, so we had to download them; we had to go through basic pictures, and print off pictures then we had a picture of a toilet, a picture of a knife and fork and a plate… And then we had like a selection of faces, like a happy face, a sad face a crying face, an angry face… and a picture that looked like lots of little tablets and things. When you face language barriers, there should be something on the ward, like a pack of pictures, but I didn't see that on ours. (Laura, Y3, English student)*

When linguistic materials are not available, participants witnessed ad hoc handwritten materials that were produced to assist communication and interaction, with some good effects.

> *It was a Chinese woman who had had a stroke. Her family wasn't in to translate for her; one of the student physios was Chinese, so the **student physio** wrote out a sheet for her… It was things like 'do you need the toilet'? Or 'toilet', 'drink', 'food'… with the English translation underneath, so we took it across to the woman showed her it and she pointed at whatever symbol… It was really useful. (Angela, Y2, English student)*

On the other hand, Saanvi recognised limitations in using printed material, since some words are not easily represented visually, e.g., the intensity and quality of pain, which affected effective intercultural engagement, compromising patients' assessment and treatment.

> *When the family are not there, the only tool we used is the card. Sometimes the words are quite difficult to have a picture, for example on pain assessment, just from their facial expression is not enough… Also, it's difficult to differentiate the severity; they will go with the basic medicine and see if it works and then go for the higher one. So really there's no specific assessment that's been carried out for that patient, although sometimes when the patient's family comes, they will explain. (Saanvi, Y2, Indian student)*

Even though visual materials (printed and handwritten) are useful in helping staff understand patients' needs, Dakila recognised their limitations in conveying instructions. Therefore, several students (such as Jasmine) observed that staff took the initiative to access language apps to break down language barriers to allow visually impaired patients to listen and have an opportunity to type their needs and then translate into English.

> *When the **family** came, we ask for a list of the basic questions in Chinese. Like what does he want for breakfast? How does he have his breakfast? How does he take his tea? Does he want washing…?. So he was just pointing what he wants… But again, you cannot have a conversation, because it's not on the card, he cannot understand us. (Dakila, Y3, Filipino student)*

> *This gentleman not only couldn't understand English but also he was partially sighted, he was registered blind, so he couldn't see that much. So, the Google Translate apps to **make the sound out** so the patient can hear…It helped a lot, because it made his needs known. (Jasmine, Y1, English student)*

Several students also expressed their concerns and commented on the limitations of language apps in clinical practice, including being time-consuming, patients' and staff's capacity to use modern technology, accents and the potential risk of being against hospital policy. However, most participants believe the benefits of language apps in assisting their intercultural engagement outweigh the limitations.

> *At the moment, I don't think our Trust allow app usage in practice. But to be honest, if your patient couldn't communicate, had an app and was sat there, wrote it out, I would have no problem looking at the interpretation of it, because surely that's better than not being able to communicate. (Barbara, Y3, Northern Irish student)*

To sum up, students employed printed materials such as picture cards and health-related brochures with good effect, as also reported by Cioffi (2003), Bradby (2001) and Pergert et al. (2008). When these were not available on the ward, a few commented that they had downloaded pictures from the internet and made cue cards by themselves or asked patients' relatives to translate. This finding indicates that the hospital should provide these materials and make them readily available to help students to actively engage in intercultural communication when language barriers are

present. In comparison to visual materials, participants recognised the advantages of modern technology, such as language apps. However, it seems that Trust policy on language app use varies across different hospitals. It is therefore suggested that service managers should make it clear to staff whether such software or apps could be used in practice to facilitate effective therapeutic communication and, if so, which software should be used. In addition, participants suggested information leaflets regarding medical diagnoses, dosage, effects and side effects of medication should be bilingual, so that students and staff can read the English part while the patient can read the same information in their home language (Aboul-Enein & Ahmed, 2006).

- Supportive working environment

Participants reported that they perform differently in different clinical settings and different students perform differently in the same clinical placement area, depending on the organisational culture. They commented that when the environment is supportive, they were more willing to participate flexibly and creatively. For example, Daisy approached qualified staff for help to assist patients, but while waiting for a translator, she was concerned the patient's condition would deteriorate.

> *I would discuss it [the language barrier] with my mentor and then we would go through that and see what was the best approach, so we decided to wait 'til the family member came back, or we could wait 'til the translator came in, but obviously if there was something abnormal, then I would just keep checking and keep an eye on the patient's vital obs. (Daisy, Y1, English student)*

When students feel accepted and included in the team, i.e., had a sense of belonging, they commented that they can be more 'themselves' in the workplace and became more motivated to learn and engage in nursing practice (5.3); they also had higher creativity and productivity (see section 5.1.2.). When the students were not supported by their mentor and qualified staff, they stated they felt hurt and could not do their best. For example, Azindoo felt vulnerable and discriminated against and felt powerless to confront the situation, so he simply had to accept how he was treated. It is therefore important to ensure a supportive environment to cultivate learning.

> *It's like a no-win, no-win situation for an ethnic minority person who probably finds him or herself in that kind of situation, because if you try to report such a person, don't forget your mentor is there to sign you off; to write good things for you, for you to*

progress and so you are more or less like stuck to accept the situation, but to try to find a way of progressing. (Azindoo, Y1, Ghana student)

Participants reported the importance of supportive relationships in terms of their engagement. They felt supportive mentors not only helped them to learn essential nursing knowledge and skills, but also to develop more meaningful interactions in intercultural encounters, enabling them to think critically and confidently, to make decisions and engage in intercultural interactions (Andrews & Boyle, 2012). This finding shows the importance of a supportive climate for students' development of intercultural competence. Organisational managers and clinical educators need to ensure these supportive mentorships throughout students' placement period.

- Patient's response and cooperation in intercultural interaction

Participants commented that the interlocutor's participation and response to intercultural communication also affected their intercultural engagement. This includes patients, their relatives and staff. For example, when Zoe made an effort at communicating with a patient, that patient did not participate her efforts for a variety of reasons, which affected her future engagements.

She was an older lady, did have some parts of English that she would use, but other times, she didn't really want to communicate, so she would talk in her language and it was quite a struggle. She used to talk in her own language. So, she would perhaps create this barrier, this language barrier? I feel myself useless because I couldn't help her. She couldn't tell me her needs to help her. It was one of the hardest obstacles I've probably ever come across. (Zoe, Y3, English student)

This finding shows participants recognised that communication is a two-way exchange process, and the ideal situation is for both parties to work in the same direction, which can help to achieve the best results. However, when one does not take part, the effects could be negative. This was also relevant to staff, with Michelle commenting that engagement came down to individual staff personality mainly rather than their country of origin.

I feel quite confident with it and beyond anything else, it comes down to whether the nurse is open and friendly and wants to communicate with you, as long as that's open, you could communicate with anyone I should think, there's no particular differences between communicating with people from Britain and also people from other

countries… So, it would always be down to how actively that person wants to engage with you and if they don't, they could be from anywhere in the world. You're not really going to get very far if someone is just you know, the barriers, they're closed down. (Michelle, Y1, English student)

In addition, the participants commented on the importance of mutual respect in intercultural encounters. Corazon (first-year Filipino student nurse) encountered patients who deliberately refused her care and even told her to go back to her home country. Another student, Miremba from Uganda, was refused by a patient, because of the colour of her skin. Both students felt '*embarrassed*' and '*pain*' when they heard these negative comments, and '*fear*' of getting close and looking after these patients who had been racist towards them. These negative experiences decreased their confidence in ICE. Section 5.3 revealed that when mentors and other members of team persistently presented negative attitudes to students, such as bullying, racism and discrimination, they gradually withdrew from communication and interaction with these staff.

Similarly, Miremba found that negative comments from relatives also caused distance and superficial relationships with ethnic minority staff, which she 'shied away' from.

The patient didn't want me to do even just to remove the cannula. she wanted the white lady that I was working with. It hurt me a bit, because of the colour of your skin that they don't want you to touch them…I shied away from this patient from then on. (Miremba, Y1, Ugandan student)

Conversely, other ethnic minority students, such as Azindoo, felt comfortable with their patients and relatives, developed positive relationships and gained a sense of achievement during their placement. He described these patients as '*fantastic*', warm and appreciative of his efforts to care, so he felt more willing to spend time and effort interacting with these patients.

At the placement, patients are fantastic because they know they are in a disadvantaged position and somebody's looking after them. So, it's fantastic. They accept whoever is on front of them, because they need somebody to look after them. Don't forget they're in pain; they're in distress. They want comfort, they want care, they want compassion, so that are not in a position to choose and so they do accept…But when it comes to the nurses, colleagues; that is where the problem is. (Azindoo, Y1, Ghanaian student)

These experience shows that an interlocutor's responses and cooperation have an impact on student nurses' intercultural engagement. This means in order to motivate students' intercultural engagement, especially critical engagement, mentors and clinical managers should work together to foster a positive response from staff, patients and their relatives.

In summary, participants commented that one essential way to maximise intercultural communication is through active engagement in dialogue with people from diverse cultural backgrounds. Such interaction requires the following: the individual's motivation and willingness to understand; negotiating the confusions and contradictions, and sometimes even frustrations; finding ways to adapt to other cultures; and applying knowledge and skills to provide culturally sensitive care to others. The participants consider this is even more important than having cultural knowledge and awareness alone. This means actively gaining an understanding of others in intercultural encounters and shows that mutual respect is the foundation of establishing a trusting therapeutic relationship and hence successful intercultural communication. Participants commented that they demonstrated their sensitivity through empathy, respect and then adapting their practice to accommodate the patient's needs, even if they sometimes did not entirely agree.

Student nurses in the current study perceived that staff (including qualified staff and support workers) were anxious about interacting with people from other cultures and feared making mistakes due to a lack of knowledge and confidence in communicating with these patients. Other studies (Bradby, 2001; Kai et al., 2007; Jirwe et al., 2010) reported that staff and students expressed anxiety about potentially causing offence and being viewed as discriminatory or racist. Those who reluctant to interact with cultural others may think that such people require extra assistance, patience and effort, while others may think different cultures are forcing them to change and feel threatened, which not only increases staff stress, but can lead to patients' receiving inadequate information and poor-quality care (Henderson et al., 2016). Arakelian (2009) also points out that this could result in accusations of insensitivity towards patients from different cultural backgrounds. This indicates a lack in understanding of diverse cultural situations and a requirement for intercultural skills development to

facilitate interacting with cultural 'others' effectively. To develop awareness, sensitivity and competence in intercultural care, Kai et al. (2001) suggests including more culture-related contents in pre and post-registration nursing curricula, such information on cultural beliefs, religious practices and epidemiology of various diseases in different populations.

Participants' levels of engagement were influenced by a number of internal attributes (such as passion about humanity; compassion for the vulnerable; courage to defend and advocate; and self-efficacy) and external factors (such as professional and government policies; placement resources and working environment; and interlocutors' participation and cooperation). Several participants in this study shared their approaches, including giving more time and effort, accommodating, and adapting and even asking for help from colleagues, staff and friends when encountering difficult situations. Actively seeking help to gain understanding and identify effective solutions was considered beneficial to positive therapeutic relationships and intercultural outcomes (chapter 1.1.3).

The interview data revealed the importance of internal attributes, such as an individual's culture desire and humility, courage to defend and advocate and intercultural self-efficacy. In order to develop cultural desire, the individual should have genuine passion to others, be open and flexible to others, recognise similarities and be willing to accept differences and learn from others (Tervalon & Murray-Garcia, 1998). It is recognised that having cultural knowledge and skills in education programmes does not immediately raise learners' cultural desire because it takes a long time to establish or change people, since these are significantly impacted by the individual's worldview, pervious intercultural experience, political climate and media influences (Isaacs et al., 2016). Therefore, the mentors and academics should be tactical in cultivating and supporting students cultural desire development, especially when student nurses encounter difficult situations during placement.

External factors were also revealed in this study. Participants highlighted the importance of the hospital's providing facilities to support intercultural communication for people who have linguistic difficulties. A variety of things such as picture cards,

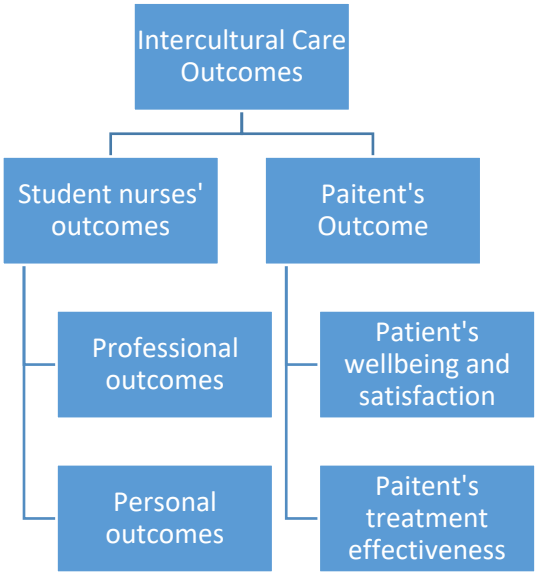
charts and folders (with or without languages) were shown to be useful in helping intercultural engagement and interaction. Participants commented that bilingual printed materials should be made available to assist intercultural communication and enhance intercultural engagement. Students also reported the value of supportive mentorship and cooperative therapeutic relationships with patients and their relatives, as these helped them gain more knowledge and understanding in intercultural communication and to develop their confidence in intercultural interaction.

4.6. Intercultural Care Outcomes

Intercultural care outcome is defined as the perceived results of ICE. It is the final theme that emerged from this study. Capell et al. (2007) assert that missing outcomes may restrict the effective evaluation of cultural care competence provision, since patient and staff outcomes provide the most valid indication of effective care interventions. Therefore, this section answers RQ1: How do student nurses experience intercultural communication in their everyday clinical practice?

This section starts by reporting outcomes participants (as the healthcare provider) experienced at ICE (section 4.6.1) from a professional and personal perspective. The patients (as the healthcare receivers) the participants witnessed are discussed in section 4.6.2, including patient's wellbeing and treatment effectiveness. These experiences were particularly difficult when shared language was not established; therefore, the examples they presented were mainly in this context. (See Figure 4.19)

Figure 4.19 *Intercultural care outcomes*



4.6.1 Student Nurses' Outcomes

Participants reported that when caring for patients who have linguistic difficulties, they achieved positive and negative outcomes relevant to their personal and professional. These are presented in section 4.6.1.1 and 4.6.1.2 respectively.

4.6.1.1 Professional Outcomes

The participants reported three different outcomes which are relevant to their satisfaction with their daily work, longer term effects and cognitive development.

When interacting with patients with linguistic barriers, some participants felt stressed and used words such as '*hard*', '*difficult*', '*struggle*', '*stressed*' or '*frustrated*' to articulate their feelings, which made them feel '*nervous*' about looking after these patients, For example, Jessica felt upset when she observed that a Chinese patient who did not speak nor understand English was not aware what was going to happen to her.

> *It was the Chinese lady in Endoscopy, which was really **upsetting** because as nurses, we are supposed to offer patients exactly the same service; it's supposed to be individualised care, but I didn't feel like we could give that lady that level of care, because we couldn't really explain to her what was going on; she didn't understand what was going on. (Jessica, Y3, English student)*

Jessica further explained that this emotional outcome was in conflict with her nursing ethic to offer the same service to all patients in terms of informed consent and individual-based personal care for the service they were receiving. Therefore, she was not satisfied with the outcome. Similarly, other participants also considered that effective communication with patients was one of the essential criteria for a satisfactory intercultural care outcome, so when basic communication was not established, participants expressed dissatisfaction and doubt over the nursing care they provided. This finding was illustrated most strongly by Mourhinda, who felt she was not fulfil her duty of care because she was not able to meet the patient's needs.

> *I **feel disconnected** from the care … Not being able to meet that need is like really not fulfilling the need of the person. It's like seeing somebody hurting, but there's nothing much you can do for them because there's nobody else here who can help me [to understand the situation]. (Mourhinda, Y3, Guyanese student)*

On the other hand, some participants shared positive experiences when they used other languages to help break the linguistic barriers. When they achieved these positive outcomes, they used the words such as '*satisfied*' (Alice) and '*feel good*' (Feihong) to describe their emotional achievement. For example, even though Alison was consciously aware her Spanish was not fluent, since she has not lived there for long time, she managed to use her second language to help translate a patient's condition in an urgent situation when an interpreter was not available. This positive outcome made her feel satisfied and reinforced her commitment to using her additional language more in the future. This episode showed this satisfactory intercultural outcome had a positive influence on her intercultural engagement.

> *There's a patient at Chest Clinic who don't speak English. He's having chest pain; he keeps grabbing his chest, it's quite urgent but nobody understood the patient's Spanish at the time. That's where my Spanish came in handy… I felt **very satisfied** as well, because I actually helped the patient based on my other skills… I started to refresh my Spanish every now and then just in case it's become needed again. (Alice, Y2, English student)*

Similarly, even though Feihong encountered challenges in using her mother tongue, Chinese, to translate medical terminology since she obtained all her medical knowledge in English, she used initiatives (i.e., metaphors) to help a patient to understand the rehabilitation process and be more willing to comply with the instructions at home. Through this extra effort, she felt she had achieved a positive

outcome and *'felt good'* because she considered this person as 'close to her heart' (since they share the same ethnicity and talk the same language); also she helped to resolve the problem with her initiatives for this patient who was frustrated and fearful because he did not know what would happen next to him in a foreign country.

> *I did look after a Chinese people in orthopaedic ward, who broke his leg, so I helped to translate this terminology into Chinese. I feel easier when talk about social aspect, but in terms of medical terminologies, I don't know about the Chinese version because I learned the knowledge from practice in UK and by reading books or writing assignments, so I used metaphors to explain and help him understand the rehabilitation process and instruction for post injury recovery at home…. It* ***was good****, because on one hand, you feel like you helped somebody close to your heart because we speak the same language, and on the other hand, you do appreciate patients he couldn't speak a lot of English who is frustrated and frightened. (Feihong, Y2, Chinese student)*

These perceived professional positive and negative outcomes at work resonate with Deardorff (2009) who describes successful intercultural outcomes as mutually positive feelings about the intercultural relationship, task achievement and stress minimisation and vice versa. Participants highlighted the importance of effective communication between nurse and patient when a lack of shared language caused issues for both the patient (who found it difficult to convey their needs) and the student nurses (who were not able to explain procedures to the patients), which drove them to take actions to achieve a positive outcome, which in turn helped their job satisfaction. This is because they believe that if effective communication is not established, nurses felt unsatisfied with their job and thus felt incompetent in communication since they were worried about being misunderstood, compromising the patient's quality of care. So, participants expressed frustration and anxiety when they were not able to communicate with patients effectively. This finding is echoed in many studies (Gerrish et al , 1996; Bradby, 2001; Jirwe et al, 2010) and it might link to the conflict between their professional uncertainty, disempowerment perceived due to their limited knowledge and skills and their perceived professionalism and duty of care (Kai et al., 2007). Conversely, participants felt job satisfaction increased when made efforts to re-establish communication with patients, which increased their confidence in ICE and motivated them to engage more.

Secondly, the participants also found long-term effects on their role as a nurse in ICE. For example, Laura felt there were more opportunities for job security; Nancy noticed that staff had more confidence in her because of her international placement experience; Sean increased his understand and knowledge; and Sheila commented that ICE made her more proactive and considerate.

> *I start to think the doors are open once you've finished your training. You can work all over the world now, if you like, really. (Laura, Y3, English student)*
>
> *The staff tend to put me to look after those patients who have language issues now because they felt I have had the international placement and so more competent to deal with situation like this. (Nancy, Y3, English student)*
>
> *My perception of intercultural care changed so much… I understand it more and my knowledge of other cultures has increased. (Sean, Y1, WB)*
>
> *It makes me think a lot more… trying to think ahead what they would want, what type of person they are, and trying to compromise that way. (Sheila, Y3, English student)*

Thirdly, the participants commented that critical reflection within and after the ICE helped them to reflect on their inner thoughts and feelings about the interaction, which helped raise their awareness of their own culture in relation to other cultures. This manifests as increased self-efficacy in recognition of diverse cultural needs, heightened tolerance to culture differences, being more skilful and sensitive to other people's cultural needs and willingness to be more flexible and creative in nursing interventions when encountering communication barriers and cultural clashes (see detailed discussion and excerpts in section 5.4), which were considered useful to help their sensitive intercultural engagement and job satisfaction (Jeffreys & Smodlaka, 1996).

4.6.1.2 Personal outcomes

From a personal perspective, some ethnic minority students experienced negative intercultural outcomes and used words, such as pain, difficulty, isolated, alienated and hurtful to describe their personal emotional suffering due to adversity at work like discriminations and racism, which made them felt not accepted, disconnected and unsupported. These perceived negativities not only affected their sense of belonging but also negatively affected their wellbeing. **Wellbeing** means an individual feels

happy, has a sense of belonging, feels respected and accepted by others, which is an important part of an individual's holistic health (Hamilton & Essat, 2008). So, when their wellbeing suffers, exceed their tolerance or goes beyond their resilience to be able to ignore the adversity, they even consider leaving the course. These were analysed and discussed in section 4.4.3.

On the other hand, participants commented that effective ICE produced personal benefits by enhancing personal maturity and enriching their life experiences. For example, Aimee shared her learning of not making judgements too quick based on superficial observation.

> *When I left that Romanian family's house, I said to the health visitor "I feel bad that I judged her so quickly …. they did want to know a lot about the benefits system and there was something not right about their set up here. But as a person, she was nice and it made us to think: don't judge a book by its cover. Definitely not. That's a big lesson I've learned from that. (Aimee, Y1, English student)*

Participants who had international placement commented that their cognitive improvement as well as their values and worldview changed due to their cross-cultural experience. For example, Emma commented on the enjoyment she gained from immersing herself in different cultures, overcoming challenges and gaining insights which brought a new ways to view the world.

> *I love to be involved in different cultures and totally immerse myself in it, so I enjoyed that anyway, regardless of the nursing…the chance to have three months in a different culture has to overcome lots of challenges but also bring lots of insight… It's good in that sense. (Emma, Y3, English student)*

Through their cultural immersion, other participants also reported that they saw different values and ways of living and mentally evaluate their experience. As a result, they could recognise their knowledge deficit and change their views of the different culture and expectations of others. They commented that such different thinking processes created an opportunity for open-mindedness. This was possibly associated with the international placement forcing the student nurse to adapt to a new culture and socialise with people whose shared meanings were the dominant base of the communication. For example, Amber shared her international learning experience of shying away from working independently to feeling more comfortable about adjusting

her care accordingly as she understood more different ways of living in Portugal.

> *It was a bit too complicated for me to understand with at the beginning. There were times when my mentor would be busy elsewhere and then I'd maybe just go around doing the blood pressure or the obs, or whatever. And so then one patient would ask for something and you know when they all start asking for different things you don't know what they're saying, so I started to learn some simple language and by the end of placement, I felt more comfortable on providing the care which were different to what we were taught in the UK and understand more the different way they live. (Amber, Y3, English students)*

This means being outside of their familiar culture and comfort zone and experiencing cultural variation (such as in values, beliefs, religions and customs), helped them adapt to a different form of nursing practice as well as socialise with people with people from a different culture. Through this process, they learned how to communicate and think differently; consequently, expanding their personal perspectives was an outcome.

Having explored perceived positive and negative outcomes from professional and personal life, I next explore different outcomes the participants witnessed.

4.6.2 Patient's Outcomes

The participants viewed patients' wellbeing and health improvement as paramount in quality healthcare provision; this was recognised as the key driver for students to work hard to achieve positive results. This section reports on patient's wellbeing and satisfaction in section 4.6.2.1 and patients' treatment effectiveness is presented in 4.6.2.2.

4.6.2.1 Patient's Wellbeing and Satisfaction

Participants reported some disrespectful behaviours which may have affected patient's wellbeing. In particular, Mourhinda expressed her sadness when she witnessed a patient's condition being discussed and a decision made by the medical team without the patient's involvement, resulting in the patient's being transferred to another city without the patient's knowledge.

> *Like the gentleman from Latvia, he didn't know that he was going to be transferred to another hospital. The ambulance team, **everybody knew, he didn't know**. As the ambulance team showed up and he was just taken off the ward and transferred to*

another hospital. I feel really sad… because he was basically left out of most of the decisions that are made about him. (Mourhinda, Y3, Guyanese student)

Other participants (such as Lisa) observed that patients who could not speak English were isolated from the other patients in the same hospital ward, which she thought meant the patient might felt 'bored' and 'quite isolated'.

*I thought she'd be really **bored**, because she couldn't speak to people, and she was in a shared bay. There were six people in the bay with her and they used to all talk across each other, but she was **quite isolated**, because she couldn't join in. So, from her side, in terms of socialisation in the hospital, it was limited. (Lisa, Y3, Welsh student)*

Similarly, Tony felt patients who have linguistic barriers might be scared about having an acute disease, which could add to their emotions when they were in an alien environment with unfamiliar staff, equipment and treatments.

*It's got to be **scary** going in somewhere where you don't really have much clue what's going on because the doctors and staff don't speak your language … It's scary having a stroke but going into like an alien environment as well. It must be **hard**. (Tony, Y2, English student)*

Nevertheless, when Alice used her Spanish to help the patients, she observed that patient and the relative were grateful possibly because she helped to break the language barrier to help them so their needs could be met. At the same time, the extra effort she made to help them to be understood made them feel respected and that their needs were valued. This effort also helped with rapport as well and helped them feel connected to the settings and feel ensured they could be cared for, elements which are all essential to an individual's wellbeing.

they were just grateful that they could be understood and that I could help them. It was quite satisfying as well, because I built that rapport up with them, so we would meet their needs. (Alice, Y2, English student)

This excerpt demonstrates that when communication was re-established through accessing language facilities (e.g., by bilingual staff), positive outcomes were reported. Similarly, Jessica also observed how a patient' became '*more relaxed*'

when the interpreter came and explained the procedure to her, because she could connect to the environment and people around her.

> *Before the interpreter arrived, her body language and everything was uptight, and she just sat and she didn't move… But when the interpreter was there, she just sat smiling all the time…that's kind of a sign showing she feels **more relaxed**… so the treatment could go ahead. (Jessica, Y3, English student)*

Participants were concerned that patients can be nervous and anxious about being left in an unfamiliar environment while receiving medical treatment and nursing care to relieve symptoms and illness, especially if they are transferred to a new environment. Their sense of belonging and environmental connectedness can decrease significantly; more importantly, this may be due to their perceived lack of social acceptance from ward staff and not always being able to articulate this verbally (Hamilton & Essat, 2008). This is particularly acute for those seeking political asylum, who may have suffered multiple negative experiences, such as loss of identity, separation from family members and homeland, bereavement, posttraumatic stress disorder, racism and other discriminations (Bentham, 2003; Maddern, 2004). When those patients were helped to understand and their needs were respected and met, the participants noticed they looked more relaxed and grateful for the effort the student made, which was related to their sense of belonging because this respect was assured and their wellbeing enhanced. Therefore, it is crucial to help them form a sense of belonging and connection throughout their hospital stay.

In addition to the linguistic issues, section 4.2, 4.4 and 4.5 also reported that patient satisfaction was affected due to a lack of cultural knowledge (such as religious practice, gender-related matters, as well as health-related knowledge), adverse attitude (such as discrimination and racism) and insensitive engagement, which highlighted the importance of developing competence in ICE for nurses and other healthcare providers.

4.6.2.2 Patient's Treatment Effectiveness

Participants commented that insufficient information exchange situations cause difficulty for patients' cooperation and adherence to treatment, which sometimes led to poor-quality care and inaccurate diagnoses. For example, due to linguist issues,

Eve found that an ethnic minority patient had received pain relief 4 and half hour late; Zoe even observed a patient who could not have an operation. These incidents all impacted the quality of care and effective of treatment.

> *When the patient's family were in during visiting time in the afternoon, they told us he was in **pain**. After the visit, we were trying to get more information from him before you give any more analgesia, but it didn't work… in the end, they just upped the dose of what he'd previously had. …He still needed more, but it was just that we didn't get any more information from him until his family came back, so it was about **4 and half hour later**.' (Eve, Y2, English student)*

> *She knew "thank you" and "yes and no", but that was it. In terms of an operation, which involved a lot of different anaesthetics, a case of if it's keyhole and if they need to open her up, she has to sign for that she understands that any operation could lead to death, and complications, blood transfusions… but she didn't understand nothing of that, so she **couldn't have the operation** until she knew what she was signing for…' (Zoe, Y3, English student)*

Conversely, even though not everyone could speak a second language, some participants took initiatives to learn languages to help patients establish communication. Cara reported that the staff made particular efforts to teach patients some simple English; Mourhinda made an effort to learn some language from a patient whilst helping his daily living needs; patient cooperation was then achieved, and effective treatment could be enhanced.

> *Cos we would have written words in English and in Polish, so she would try to learn and read it out loud… So, when we went in, she would try and pronounce them…like, if she wanted to say 'shower' or 'toilet', we would keep saying it and saying it until she learned the English for it, so she would say "toi-let", so we would be able to assist her to toilet. (Cara, Y2, Northern Irish student)*

> *A gentleman from Latvia, who has limited ability to speak English. We don't understand a thing each other is saying. But, on taking him to the toilet, he always mentioned a word and then I realised that that's thank you, so I would say it back to him and it made the nurse patient relationship a little bit smoother…, he was very cooperative after I've learned to say that word in his language .(Mourhinda, Y3, Guyanese student)*

These views were echoed by Halabi and De Beer (2018) who revealed that lack of a shared language could put patients at risk of inappropriate diagnosis, delays in treatment or even death, because without mutual understanding, there is a high

tendency to cause noncompliance or misunderstanding, so treatment might either be unnecessary or wrong, which can significantly affect its effectiveness (Waite & Calamaro, 2010).

To sum up, this section discussed student nurses perceived intercultural outcomes at ICE from both student and patient perspectives. From the students' perspectives, the participants experienced some challenges which affected their job satisfaction; in contrast, when they overcome these difficulties, they gained job satisfaction. In addition, they also noticed long-term effects of ICE, such as becoming more proactive and understandable to patients who have linguistic barriers and more confident that they can look after culturally diverse patients. Thirdly, through introspective reflection, the participants also developed their awareness of their own culture in relation to other cultures and increased their self-efficacy in engaging in sensitive ICE. Although some ethnic minority students reported negative outcomes in ICE due to adversity at work, which affected their personal wellbeing, positive personal outcomes were also reported, such as their knowledge of cultural diversity, changing their view of the world and developing effective communication skills.

A number of challenging situations were reported around communicating with patients who have language barriers and how this issue affected successful ICE outcomes. Through active engagement, participants helped to re-establish communication and build rapport with patients, which enhanced student nurses' job satisfaction. While most participants reported their patients were satisfied with the care they received, some noted that some patients seemed isolated, suffered delayed treatment and that their health deteriorated due to lack of understanding and cooperation. To achieve utmost patient intercultural outcomes, participants recognised the importance of re-establishing communication through a variety of linguistic facilitators (e.g., professional interpreters, family members), creative commitments from the nursing team (e.g., learning a patient's language), increasing their knowledge in general and health-related cultural knowledge, and practising culturally sensitive attitudes in ICE.

4.7 Chapter Summary

This findings and discussion chapter aimed to answer the research questions: 1) How do student nurses experience intercultural communication in their everyday clinical practice? and 2) What intercultural competences are salient in facilitating effective intercultural communication? The data analysis shows the students construct their intercultural care experience from six domains: intercultural encounters (section 4.1), intercultural knowledge (section 4.2), intercultural skills (section 4.3), intercultural attitude (section 4.4), intercultural engagement (section 4.5) and intercultural outcomes (section 4.6). Despite representing specific perspectives, all six intertwine and overlap.

According to the data, three different types of cultural knowledge and awareness were recognised as important to effective intercultural care; they are general culture-related knowledge (such as religious, gender and transgender knowledge), specific health-related cultural knowledge (such as health belief and practice; disease prevalence and manifestations and treatment efficacy); and individual multicultural identity. The way students acquire their current intercultural care knowledge comes mainly through informal cultural diversity information (i.e., social media, previous travel experience, internet and talking to patients and their relatives). Minimal cultural knowledge was included in the nursing curriculum. However, students valued this formal approach highly and they wanted the university to provide more formal training to develop their cultural knowledge and understanding.

The participants openly shared the linguistic and social linguistic skills they used in ICE. When they encountered linguistic barriers, the participants reported that patients were not able to express their needs and understand care instructions; in addition, nursing care implementations could be affected. Different types of linguistic facilitators were explored, including professional interpreters, family members and bilingual health professionals as translators and telephone interpreter. These services were valued highly as a mean of assisting intercultural communication. When these linguistic facilitators were not available, the students reported a variety of social linguistic skills they employed to re-establish communication, including learning the patient's language, adjusting their communication style and using sign language and demonstration, with some positive effects.

The participants shared their thoughts and feelings when they perceived positive and negative attitudes during placement, in particular students from ethnic minority backgrounds, who believed they often encountered different forms of stereotypes, unconscious bias, bullying, discrimination, and racism. They were conscious of being different to the indigenous staff and peers in terms of their cultural heritage, and they strove for acceptance from them, since they considered feeling accepted, connected, and supported by them were important to their wellbeing and professional recognition. Otherwise, they felt they were rejected and unsupported, which made them feel hurt and isolated. Despite admitting it was hard, they tended to use personal resilience to rebalance their emotional equilibrium. Even though some EM students commented that opening up about their emotional suffering and accessing support from academics, mentor, peers and friends were helpful to re-establish their sense of belonging, very few received positive support from academics, which showed that further training is needed to develop academics' intercultural awareness and their understanding of the challenges EM students encounter at placement.

Different forms of intercultural care engagement were revealed in this study, from effortless reaction, attentive and sensitive cultural engagement, to critical cultural engagement. Internal and external attributes were explored in detail in section 5.5.2, and these proved useful to answer research question 2: What intercultural competences are salient in facilitating effective intercultural communication? From an internal perspective, cultural desire and humility, introspective reflection, and courage to defend and intercultural self-efficacy were considered the keys to motivate their active engagement. External factors such as professional and government policies, resources (including both staff, time, and intercultural care-related materials), supportive working environment and patient response and cooperation in intercultural interaction were valued as having a strong impact on effective intercultural engagement.

The participants reported that the healthcare provider (i.e., student nurses and qualified staff) and healthcare receiver (i.e., patient) positive outcomes are the key indicators for effective intercultural communication. The data shows that successful ICE outcomes were related to mutually positive feelings about the intercultural relationship, task achievement and a sense of belonging. From the student nurses' perspective, these affect their profession (e.g., job satisfaction, long-term effects, and

awareness to their own culture in relation to the interlocuter's culture) and personal life (e.g., broaden open-mindedness and effective communication skills). From the patients' perspective, effective ICE outcomes impact their satisfaction, wellbeing, and treatment effectiveness. In addition, the participants view these outcomes as one of the key motivators for their intercultural engagement. These findings show that outcomes are not only related to their experience (to answer to RQ1), but also have a strong influence on other domains of their intercultural communication (relevant to answering RQ2: What are the factors facilitate effective intercultural communication?).

Chapter 5

Conclusion

The final chapter provides the conclusion to this study. I start by providing a summary of the main study and demonstrating how the research questions have been answered (5.1). Section 5.2 deals with the research contributions and implications for intercultural nursing theories, education, practice, service users and research. Research challenges and limitations and directions for future research are discussed in sections 5.3. and 5.4. The chapter ends with final remarks (5.5).

5.1 Summary of the Main Study

The study focused on exploring student nurses' experience in clinical practice when they encounter people from diverse backgrounds. Interviews were employed to transform their experience to the conscious level and consequently to understand the underlying meaning of these experiences. This study adopted a social constructionism position and used interpretative qualitative inquiry methodology. Following ethic approvals from both researcher's and the participants' universities' ethical committees, a pilot study was conducted prior to the main study. A total of 41 pre-registration nursing students from diverse backgrounds were recruited and participated in in-depth semi-structured interviews. The participants came from different year groups at a university in the Northeast of England. The interviews ranged from 27 to 116 minutes in length. They were audio recorded and the data was transcribed verbatim. The participants were encouraged to openly articulate their feelings and experiences and the meaning they ascribed to these experiences. In this way, I was able to collect rich descriptive data to answer the research questions. Braun and Clarke's (2006) thematic analysis process was used to guide the data analysis. After reading and re-reading the data, codes and themes were identified and defined. The interview data was then inputted into Nvivo to help organise and choose examples which are more significant and compelling. These were reported in chapter 4. The key findings related to research questions are summarised below.

Answers to RQ 1: How do student nurses experience intercultural nursing care in their everyday clinical practice?

- Does their own culture affect their approach to others? If so, how?
- What positive experience do they encounter? How do they perceive these experiences?
- What challenges do they encounter? How do they perceive and manage these challenges?

The findings from this study show that the participants socially construct their intercultural care experience in the six domains. These include intercultural encounters; knowledge; skills; attitudes; engagement; and outcomes. According to their different perceptions of culture, the scope of participants' intercultural encounter ranged from their geographical and ethnical origin, belief, religions, and language and those who are different from themselves to broad perspectives of including different sexual orientation, gender, and age groups. Even though the scope and experience of ICE varied, they all valued the opportunity to be exposed to ICE as it allowed them to negotiate and adjust to different cultures, values and worldviews.

Participants recognised the importance of having sufficient intercultural knowledge, including general culture-related knowledge (such as religious knowledge, gender preference and transgender care), specific health-related cultural knowledge (such as health beliefs and practices, disease prevalence and manifestation and treatment efficacy) and individual multicultural identity, because they learned that culture plays a vital role in an individual's health perception (i.e., health belief), behaviour (i.e., health practice) and their response to medical treatment, which in turn impacts treatment efficacy. The participants observed that culture beliefs and behaviours affect an individual patient's interpretation or perception of their health condition, views of treatment and efficacy to medication. Without these essential knowledges, aside from the lack of understanding of a patient's cultural needs, the treatment dose or methods may also be inadequate or inappropriate, something which can seriously affect patient outcomes. However, the data generated from this study shows the gaps in nursing education when delivering nursing care to a culturally diverse population and its effects on current healthcare provision. They reported that their knowledge is rather

superficial, which sometimes causes them anxiety, frustration and even fear when looking after patients from diverse backgrounds in case they are perceived as ignorant, racist or discriminatory. Sometimes, the patients' cultural needs were not met due to lack of knowledge, understanding and skills. Therefore, the student nurses asked for more culturally related contents to be added to the nursing curriculum. This shows their awareness of their cultural knowledge inadequacy and a desire to seek opportunities to develop cultural competence.

The participants reported that one of the biggest challenges they encountered in ICE was the linguistic barriers, since these not only affect the patients' ability to express their needs and understand the healthcare instructions, but also have nursing implementations. A variety of verbal and nonverbal approaches were employed to overcome these challenges, with some positive outcomes. These includeed employing professional interpretators, approaching relatives or bilingual/multilingual staff and using a telephone interpreter service. Even though all the participants appreciated the importance of accessing accredited interpreter services, the findings revealed that the service gatekeepers (qualified nurses) did not seem to use the interpreters sufficiently due to financial constraints, long waiting times and also a lack of interest. Therefore, the relatives of patients were the most popular facilitators for communication with patients with language barriers. However, concerns were raised about using family members as interpreters on the grounds that they lacked clinical understanding, thereby creating potentially inaccurate translation, compromised patient confidentiality and difficulties in their availability. Bilingual health professionals were praised for enabling temporary resolutions for patients when neither accredited interpreters nor family interpreters were available. When no one available to translate, some students used initiatives to esatblish communication channels to help mutual understanding, such as learning a patient's language, adjusting communication styles and using sign language and demonstration, with good effects. Even when shared language was there, some participants experienced difficulties due to membership power and accent, which made them felt marginialised and lonely, particularly for those from EM backgrounds who perceived themselve vulnerable to being steretyped and discriminated against due to their cultural heritage differing from that of the majority indigenous staff.

The data showed that the student nurses gained their intercultural knowledge and skills mainly through learning informally in the real world, i.e., trial by error or searching for information on the internet. Despite being fast and convenient, they were concerned about the lack of a systematic approach, and some feared some information might not be reliable and possibly misleading. These concerns do not match with the notion of student and qualified nurses having the awareness and sensitivity to provide culturally congruent and competent care to patients from different cultural backgrounds. Therefore, the study suggests that incorporating intercultural contents throughout the nursing curricula is paramount to patient-centred holistic care practice and education.

Participants reported that they received positive and challenging attitudes in ICE. Some of them enjoyed their placement and were motivated to learn when they perceived they were respected, valued, and accepted in their placement. This is because being accepted, connected, and supported are particularly important as they were the bridge to their sense of belong, which was the first step to build their confidence to engage in active learning in the placement. Some reported that they were treated negatively by colleagues and qualified staff in their group. Students from EM backgrounds suffered more intensely from negativity and perceived the adverse experience was mainly due to their different physical skin colour and country of origin. Such negative experiences (such as discrimination and racism) made them feel unvalued, rejected, doubted, emotional, and they created high levels of stress. A few students even wept and spoke sadly, since the perceived negativity had an impact to students' and patients' dignity and wellbeing. Some participants admitted that they had considered withdrawing from the placement or leaving the course entirely. They used personal resilience to bring about emotional equilibrium and to keep them on the programme. The data showed peer friends were useful in acting as a 'sounding board', allowing them to exile emotions. They offered validation of their friends' emotions, provided guidance and support and helped them to gain a sense of belonging.

Participants consider that one the most important part of intercultural care is through intercultural engagement. They experienced and witnessed different forms of intercultural engagement from least (i.e., effortless reaction) to more active engagement (such as attentive and sensitive engagement to critical cultural

engagement). Whilst students reported that they used a variety of initiatives to demonstrate their sensitive engagement at ICE (such as extending visiting times in order to accommodate translation needs), they also observed that the staff who were anxious about interacting with patients who have linguistic barrier due to lack of knowledge and confidence avoided communicating with these patients and considered looking after them was time-consuming. This shows that further staff training is needed to raise these nurses' awareness and develop their confidence in ICE.

Even though the attributes of knowledge, skills and attitudes are important indicators of cultural competence, participants highlighted that without considering outcomes for the care recipient (patient) and care provider (the student nurse), competence in intercultural care cannot be validated. From student nurses' perspective, their personal and professional perspectives were affected. When they encounter challenges, such as linguistic barrier, they used words like 'hard', 'frustrated', 'nervous' etc. to describe their professional negative outcome. When they overcome the challenges, they felt satisfied and felt good. Some also observed long-term outcomes (such as job security) and increased self-efficacy. At a personal level, whilst some ethnic minority students' wellbeing suffered because of adverse relationships, others received support and acceptance, which motivated them to learn and engage more. In addition, their personal intercultural outcomes also presented as improved cognition (i.e., thinking differently) and communication. According to the data, positive outcomes for patients presented as patients' wellbeing and satisfaction and better cooperation and treatment effectiveness. Conversely, if the linguistic and social barriers persisted, patients' treatment and recovery could be affected due to lack of understanding and compliance. Participants observed that their creative commitment and increased intercultural knowledge had a positive impact on patient outcomes, such as shorter hospital stays and increased cooperation.

The key findings related to the second research question are summarised below:
Answers to RQ 2: What intercultural competences are salient in facilitating effective intercultural nursing care?

- What are the factors and features of effective intercultural encounters in clinical nursing practice?

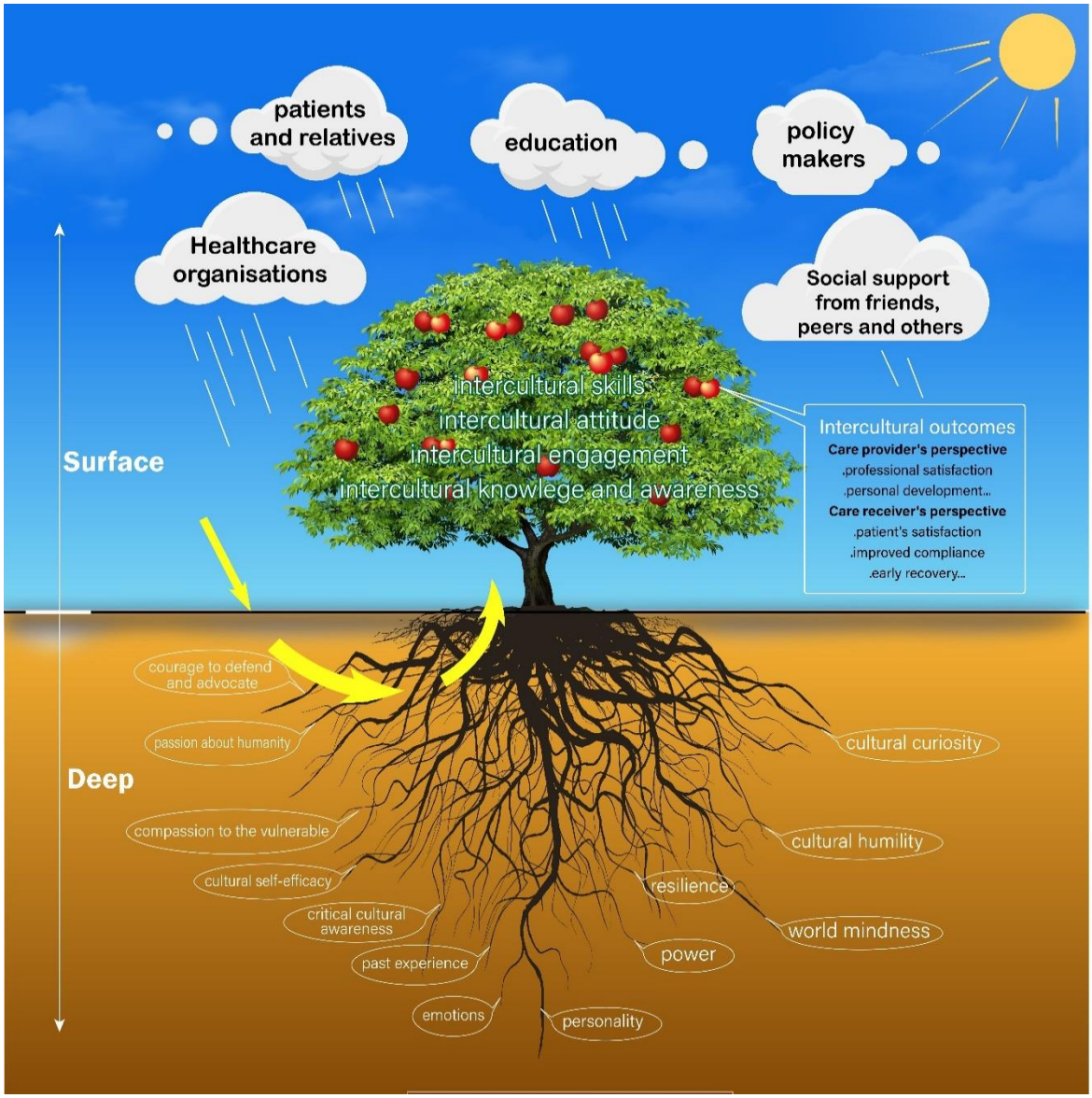
- What are the relationships among these factors?

This study revealed the complicated experiences nursing students encountered in this multicultural professional context during their clinical placement. They consider ed interculturally competent nurses to be those who have adequate intercultural knowledge, ability to work effectively and the ability to take appropriate actions to assess and respond to diverse needs and achieve desired outcomes with people from different culture background. This means when providing nursing care for people from different cultural backgrounds, the individual should acknowledge the culture differences, making efforts to explore and respect the differences and respond to diverse cultural needs sensitively and appropriately. No matter whether a shared language is present or not, culturally competent individuals have not only the ability to communicate and interact with people from different cultural backgrounda, but are also able to evaluate the differences, tolerate and accept these different values and perspectives. They are also need to actively engage in the intercultural actions before the effects are measured and evaluated.

The study revealed that six domains intertwine and overlap. In addition, the data showed that individual's knowledge and skills do not automatically ensure active engagement since they are impacted by some internal and external factors. The data shows that internal attributes (such as passion about humanity; compassion for the vulnerable; courage to defend and advocate; and cultural self-efficacy and outcome mindedness) have the positive influence to motivate individuals to actively involved in ICE. Professional and government policies (such as the NHS' Zero Tolerance policy); placement resources (such as bilingual leaflets and sufficient numbers of staff to provide a gender mix), a supportive working environment (such as welcoming atmosphere and positive mentorship); and interlocutors' participation and cooperation are the helpful external factors to motivate and ensure effective intercultural care provision.

The data also revealed that intercultural care competence is not only a list of knowledge, the ability to have intercultural skills, appropriate attitude, and sensitive engagement, but also a dynamic process that starts in early life and continues to grow through (re)negotiation of and (re)adaptation to ICE events. Individual (internal) and environmental (external) factors significantly affect an individual's ICE performance and level of engagement. Based on this notion, a tree-shaped intercultural care ecological framework was created to demonstrate the relationship between the six essential domains and their internal and external factors (see Figure 5.1).

Figure 5.1 *Shao's Intercultural Care Competence Ecological Framework*



In this framework, factors relating to the individual cultural care competence are presented using a tree metaphor. It encompasses visible (above the soil, such as branches, leaves and fruit elements) and nonvisible parts (under the soil, the roots). The visible parts include things that are measurable or noticeable, including intercultural knowledge and awareness, skills, attitudes, engagement, and outcomes, which are key themes that emerged in this study.

Nonvisible factors are those characteristics that are not often measured or noticed, but which have significant influence to an individual's intercultural care performance. These include cultural humility, cultural curiosity and self-efficacy, compassion for the vulnerable, courage to defend and advocate, personality and resilience and critical cultural awareness. These are discussed in sections 5.4 and 5.5. Using the tree metaphor, it can be seen that these are critical, because they absorb water and nutrients from the soil and transport these substances to the visible part of the tree to support its life processes and function (growth and fruit production). They also anchor the tree so that it can stand upright and firm in the ground.

Tree growth and development are also greatly affected by environmental factors (also called external factors), such as humidity, temperature and light. For nurses, these external factors might include healthcare organisations, the education system, government and policy makers, patients, relatives and peers. These are reported primarily in section 5.5, in an analysis of participants' motivations to engage in intercultural care. However, such factors are also discussed throughout the thesis.

5.2 Contribution and Implications

This study has brought insight into how the nursing students construct their reality in everyday clinical practice. Thus, the study has the potential to contribute to existing knowledge in different ways. This section discusses how this research can contribute and its implications for existing intercultural theory, research, education, and practice.

5.2.1. Theoretical Contributions and Implications

The intercultural care competence ecological framework generated from this study brings new insight and complements existing transcultural competence theories in different ways.

First, the new model encompasses a more comprehensive list of internal factors. Further developed from Leininger's Sunrise transcultural care model, Campinha-Bacote (2002) placed cultural desire as one of the five constructs (see 2.3.2), and considers it is through an individual's genuine motivation and desire to engage in cultural communication and interaction that care can be truly culturally sensitive and responsive. Papadopoulos' (2014) model for developing culturally competent and compassionate healthcare professionals was the first model to highlight courage and compassion in providing culture care, and so she positioned compassion at the centre of the red heart (see Figure 5.2). This means compassion is required if healthcare providers are to be sensitive to the pain or suffering of another in combination of a deep desire to relieve the suffering (Papadopoulos, et al., 2016). These models foreground the findings revealed in my own study, and these qualities were considered as the invisible factors in intercultural engagement (i.e., the roots of the tree), which are critical to support the tree's life processes and function. In addition to these qualities, my ecological framework also explicitly brings other invisible attributes into the intercultural care practice. These include passion about humanity and cultural humility, which further enable individuals to be more mindful of valuing and respecting different cultures in ICE.

In addition, the framework includes the qualities of introspective reflection and critical cultural awareness, to remind people be more alert and responsive to workplace adversity. According to the literature, current cultural competence modes in the global North tend to present a list of common features of cultural practice and lifestyle without explicit emphasis on critical thinking and understanding. This approach has the potential to cause stereotypes and to reinforce institutional racism and prejudice (Lancellotti, 2008). Through data analysis, introspective reflection and critical cultural awareness are emphasised in competent intercultural nursing care, and so they were added to the ecological model, which again complements the existing transcultural nursing care model.

Secondly, the new model embraces ecological system as the base to inform thinking which may be easier to comprehend and implement than previous models. Suh's (2004) model was the first model to include outcome variables and provided the most comprehensive constructs, including the static containable domains (i.e., cognitive, affective, behavioural and environmental) and outcome variables (from receivers and providers-based variables and health outcome variables) (see section 2.3.3). However, the model was often criticised as being too abstract for students and healthcare providers to understand and implement (Perng and Watson, 2012). The patients' (as the healthcare receivers) and students' (as the healthcare providers) outcomes were recognised as one of the key constructs in my ICC ecological framework, and placed as the 'fruit' to represent and emphasis the product of effective ICE. Furthermore, my study revealed the importance of environmental factors such as healthcare organisations and the education system and it used the metaphor of environment, light, temperature, humidity, and clouds to illustrate how important they are in greatly affecting the tree's (individual's ICC) growth and development. Hence, they are much easier for students and staff to understand.

The final contribution is the terminology evolution. One key feature of the emergent findings is the emphasis on the interactions among different individuals, i.e. intercultural, which is different from the meaning of transcultural which has the emphasis on healthcare provider. The study is the first to place active action (i.e. intercultural engagement) explicitly in a model of intercultural nursing care. Participants commented that intercultural engagement, both mentally (such as understanding) and physically (such as sensitive action) does not sufficiently demonstrate their effective intercultural care, but it is through transfer of knowledge and skills in the nursing care process (i.e. planning, diagnosis, implementing and evaluating) that culturally congruent care truly takes place. Therefore, my ecological framework—'intercultural care competence'—is more appropriate as its simple metaphorical illustration style may be easier for students and qualified staff to implement in practice. This new theoretical model, combining essential features from both cultural safety and transcultural care, has the potential to further improve quality nursing care in a multicultural society.

5.2.2. Educational Contributions and Implications

The research findings uncovered student nurses' experience and reported their knowledge inadequacy in both general cultural knowledge and biomedical specific knowledge in cultural care. This deficit can cause misunderstanding and may cause anxiety for both staff and the patients. Consequently, the student nurses could not provide safe and effective care service. This shows there is an urgent training needed for student nurses and even qualified nurses to develop the competences and confidence to care for patients from diverse backgrounds. To achieve that outcome, this study suggests changes to teaching contents, methods and academic preparation.

5.2.2.1 Teaching contents

The study has revealed that the students do not feel prepared for intercultural care in placement, which led some of them to feel neither confident nor comfortable communicating with people from different backgrounds. They hardly had opportunity to examine and understand the essential concepts of race, racism and characteristics of disadvantaged people in relation to their health, even though evidence shows that these concepts underly most care inequalities. They observed both clinical mentors and academics trying to avoid discussing these issues openly, possibly because they were not sure about these either and were concerned that the sensitivity of these behaviours' being reported by students could damage their professional image and reputation and could lead to an individual's losing their job. Therefore, it suggests there is a need to integrate this aspect of care into pre and post-registration nursing educational programmes to improve student and qualified nurses' intercultural awareness, sensitivities, knowledge and skills, so that culturally competent care can be truly delivered.

General cultural knowledge is the foundation of one's wider understanding of a different culture. Therefore, to understand how patients' cultures, affect their behaviour, perceptions and attitudes to nursing care and medical treatment, it would be useful to have knowledge of general rules of communication and interaction within different cultural groups, including specific communication patterns, language and vocabulary choices, customs and religious and spiritual practice. In this way, the students would understand why patients have such specific requirements. Such

knowledge would enable them to feel more convinced that they were doing the right thing and also more comfortable when they deal with other patients in the same unit who had to the adhere to things like the visiting policy and the use of the day room for socialisation.

Specific cultural knowledge, such as treatment efficacy, determines the effects of the treatment and impacts a patient's recovery and hospital stay; however, most students commented that they hardly know any of these things and suggested the benefits for having the opportunity to learn more through either informal or formal education. To ensure the provision of culturally sensitive services for minority populations, it is important for nurses to develop good knowledge and understanding to cultural diversity and cultural factors which may impact on their patients' health behaviour and treatment efficiency. It may require a different approach to acquire knowledge and become more aware of different cultural traditions, customs and health related facts and figures. Boi (2000) also supports the idea that increasing nurses' awareness, knowledge and understanding of cultural diversity, different health beliefs and related disease prevalence and treatment efficacy can increase quality of care provision.
The study showed that building an individual's resilience has the potential to help student nurses to deal with interpersonal difficulties and consequently to address attrition and staff retention. Therefore, it is suggested that academics and mentors need to work together to nurture, support and develop skills to help ethnic minorities to cope with workplace adversities (Giordano, 1997); however, at the same time, the placement manager and policy makers should take more radical action to tackle institutional racism, so that the students can be more protected and consequently focus more on their learning rather than wasting time and energy on dealing with unnecessary emotional suffering.

The study has identified that intercultural communication needs to be improved through formal university courses and continuing workplace education, so that cultural differences can better recognised, tolerated, respected, and sensitively responded to and so that effective communication and trusting therapeutic relationships can be established and safe care ensured (Chan & Sy, 2016; Henderson et al. 2016). As a result, the patients can receive truly holistic and high-quality care, and with their intercultural knowledge and skills improvement, students can feel better prepared for

their nursing registration. Stress levels can also be reduced whilst job satisfaction is increased, which in turn helps attrition and job retention.

5.2.2.2 Teaching Methods

In terms of teaching methods, the participants reported they only have had scarcely lectures and suggested some practical methods to help student nurses develop intercultural competences. They thought teaching methods that went beyond lectures could contribute to the learning process meaningfully. The methods they mentioned included case studies, simulation and role play and inviting previous patients from ethnic minority, transgender and elderly background to share their experiences. International placement has been proved to have a positive impact on individuals' professional nursing practice by providing opportunities in intercultural communication for students; however, due to demographic constraints and contextual issues not all students can afford to participate in international placements. Therefore, alternative solutions, such as simulation, case studies and inviting previous patients to share their experiences were suggested as useful ways to develop cultural diversity and modify their cultural approaches when providing care for culturally different clients and working with staff from different cultural backgrounds.

Participants reported their existing learning came mainly from experiential learning during placement, especially the immersion programme, where intercultural encounters were valued highly, and they were encouraged to take the opportunity to communicate with those from culturally diverse backgrounds. Critical reflection was also valued highly in developing students' understanding of people from different cultural backgrounds. Reflection involved writing down their selected encounter episodes to challenge their perceptions of cultural differences and critically reflecting on their engagement and nonengagement with intercultural communication and interaction. Reflection can stimulate the students to interpret and explore how they (re)constructure and (re)negotiate those daily taken-for-granted ways of thinking, behaviours, attitudes and assumptions, and they were considered useful tools to help students to make sense of their ICEs (Holmes & O'Neill, 2012). Such reflection requires students to have appropriate critical skills to ensure the deep inward exploration of stereotypes, unconscious bias and racism, which in turn enhance their

levels of self-awareness and intercultural care competence and enable them to evaluate and develop effectiveness in ICE. These suggested active learning methods are rooted in social constructivist approaches, which were discussed in the literature review chapter (see section 2.1). In order to achieve culturally competent care provided by nursing professionals, deepened intercultural education should be integrated into nurse education as a priority; otherwise, the empty exercise will continue the status quo (Barbee & Gibson, 2001).

5.2.2.3 Academics

The study revealed some students encountered repeated bullying, discrimination, and racism during, which caused cognitive problems (such as lack of concentration) and mental health issues (such as feeling distressed, lonely) during placement. The problems led to negative outcomes for both students and patients; as a result, some participants even considered leaving the course. Therefore, academics should be aware of the severity of these issues and provide appropriate education and support before students enter their first placement. These measures include providing information to help them understand negative workplace attitudes and incident reporting procedures. In addition, academic should work together with the placement to ensure students have the confidence that any report they make will be handled properly and that support is provided after they report an incident Such support includes access to counselling services and debriefing after the investigation. This suggests that it will also be useful for nursing lecturers to understand students; and to adjust existing teaching and support methods accordingly. Furthermore, all personnel involved with teaching nursing students need to be adequately prepared in terms of the intercultural communication competences that they need to have to deal with students and become aware of their own impact on students.

Academics are in a good position to facilitate students' in-depth discussion and learning. However, this study revealed that there is lack of consensus on the guidelines and approaches to intercultural education in the nursing curriculum, which means the quality of the teaching will be largely dependent on the expertise of the academics and their experience and attitudes to intercultural care. Having intercultural education in the curriculum is particularly important for academics who are culturally

blind and who consider care should be delivered equally regardless the patient's cultural background. Therefore, there is a need for academics to thoughtfully design a culturally integrated nursing curriculum and develop educational guidelines to support academics' delivery of intercultural care-related subjects.

5.2.3. Practice Contributions and Implications

Clinical placement offers repeated intercultural encounters for students to learn and try interactions with culturally diverse populations. Thus, these placements have as significant impact on improving students' intercultural competences and effective care. Several important issues emerged from the study which contribute to clinical practice for policy makers and managers and clinical staff.

5.2.3.1 Policy makers and managers

Clinical placement is the effective setting for experiential learning and developing nursing students' intercultural and other nursing-related knowledge and skills. This study revealed that being passionate about humanity, compassionate about the vulnerable and an ethno-relative worldview are key to students' generating positive intercultural attitudes to patients. On the other hand, the study also showed that placement might also be places for 'breeding negativity and disturbing team dynamics', which cause some vulnerable group to feel alienated, sad and potential produce poor outcomes for both students and patients as a result of emotional suffering and stress; if persistent over a period of time, such stresses can affect their clinical performance or even make students consider leaving the course. This implies that organisational factors such as a hierarchical management system have the potential to increase the negative attitudes and behaviours such as bullying the vulnerable. This showed there is a need to continue educating senior nurses to keep their knowledge up to date in healthcare modernisation and develop their skills and attitudes in mentoring younger generations appropriately through cultural awareness education which may help to change their negative mindset of viewing youngsters as a threat.

When these negative attitudes were not stopped by the team and the manager, they become normalised or institutionalised (Stevens, 2002), which suggests policy makers

and placement managers should make efforts to have an explicit 'zero tolerance' bullying policy and enforce this, since for many organisations, this remains a paper exercise, implying permission to continue (Einarsen, 2011; Narayanasamy & White, 2005). In addition, victims who reported such behaviours must be protected and reassured that if they were bullied, they were the victim, and it is not their fault. Culley (2001) argues that legislation cannot tackle values and racist attitudes which persist in the hearts and minds of individuals. The better way is through education to raise their cultural awareness and increase their knowledge and skills.

In consideration of the large proportion of patients from culturally diverse community, it is crucial for hospital managers to have awareness of issues in intercultural encounters and to make sure facilities are designed and made available and suitable for patients' cultural needs. Given that Muslims need to pray five times a day (dawn, noon, afternoon, sunset and evening) and observant Jews pray three times a day (morning, afternoon, and evening), it is useful to have a suitable space as well as additional support for when patients need to pray. Therefore, the ward manager should make sure this workload is taken into consideration when allocating staff and support workers to their duties and to ensure adequate facilities are available to assist patients' needs for prayer during hospitalisation. In addition, the participants suggested hospitals should embrace cultural differences and offer facilities that adapt to the visiting situation rather than asking visitors to modify their practice to suit the hospital's visiting policy (Leishman, 2004). Due to religious practice, patients may have strict gender requirements in receiving nursing care, which suggests every effort needs to be made to ensure that staff from the same gender interview and provide personal care for patients to meet gender preferences.

This study also revealed that language barriers are still the main challenges students encounter when caring for culturally different patients. Despite interpreter services' being available, it seems these were not adequately used nor encouraged for nursing practice for a variety of reasons. Although most of the student nurses appreciated the help they can provide, they also made suggestions for service improvements, such as offering further medical knowledge and effective communication skills training to interpreters and better matching to patient's cultural structure and gender needs (i.e., from those of the same sex as the patient). The participants reported that lack of

accessing interpreting services could significantly affect quality communication engagement, and vice versa (see section 4.3.1). Materials such as visual, audio aids and language apps are helpful to establish some basic understanding, which enabled students to engage more in intercultural communication. In addition, dietary resources provided at the hospital canteen were also useful to ensure patients' religious needs are met, which also contributes to their physical and mental recovery in healthcare settings (section 4.5.2).

5.2.3.2 Clinical staff and mentors

The study revealed that the clinical staff and mentors are in the paramount position to offer opportunities to nurture student to communicate and interact with diverse cultural backgrounds, which will not only raise their awareness of the cultural similarities and differences and develop their intercultural knowledge and skills, but also enhance their intercultural self-efficacy, which in turn improves their confidence and commitment to engage in intercultural encounters (Gol & Erkin, 2018).

In addition, role modelling from interculturally competent staff, either through placement observation and coaching or prerecorded videos was commented on as a powerful way to develop cultural knowledge and skills (Gerrish & Papadopoulos, 1999). Ranzijin et al. (2009) argue that inviting guest lecturers with extensive expertise in intercultural education and minority group patients and members of diverse communities is also helpful to bring lived experience and insight from different perspectives. These approaches were reported as a useful way to share knowledge and skills and capture a rich variety of cultural perspectives which will motivate students to be more willing to learn about different cultures and to work with people from diverse backgrounds (Halabi & De Beer, 2018).

In addition, students are expected to achieve many learning outcomes during placement, which also require additional support and guidance to manage challenging situations and demands (Tee et al., 2016). However, the study revealed that some students, especially those from ethnic minority backgrounds, encountered repeated bullying, discrimination, and racism during placement. When experienced such adversity, student nurses felt sad, isolated and even feared accessing support, which

they considered was related to not being accepted as part of the team, disconnected and unsupported. In addition, without opportunity to learn and to be supported, these competences can not be achieved and can seriously affect their assessment and course completion. As a result, adversity can cause participants considered to change their placement: some even to leave the course.

5.2.4. Research Contributions and Implications

This study contributes to research in two ways, i.e., the methodological confirmation and researcher's involvement and emotion.

5.2.4.1 The Methodological Shift

Many studies have used quantitative approaches to measure communication competence through self-reporting performance measures, questionnaires or psychometric tools (Byram, 1997). However, such tools decontextualise the participant when considering appropriate and effective communicative behaviours and attitudes. Similarly, Spitzberg and Changnon (2009) reported that conceptualising intercultural competence as a category of skills or knowledge set did not sufficiently explain why individual behaviour differs in different contexts. In contrast, through the interview process, the participants bring their own intercultural-related practice, observations, attitudes, thoughts, and reasons for their way of thinking and actions during clinical placement. Interviews also encourage them to look more deeply and even more critically through a continued question and answering process, sometimes even involving emotions. Therefore, social constructive-based qualitative research approaches are considered more useful for yielding rich answers to the proposed research questions.

Based on this understanding, this study was grounded in a social constructionist paradigm to explore student nurses experience when serving patients and working with people from diverse cultural backgrounds in the Northeast of England. This approach allowed me to take the role as researcher to conduct an interpretive enquiry, which is very different to my previous approach of positivism to viewing the world. Due to the way I was taught in nursing, my initial intercultural communication knowledge was heavily influenced by essentialist theories such as Leininger's sunrise model

(2002), through constant introspective reflection and reflexivity that I shifted my epistemological stance from an essentialist approach to interpretive perspectives to view the world. This shift allowed me to see a variety of views the participants shared and to report the findings from different perspectives.

5.2.4.2 The Research Process: Researcher Involvement and Emotion

Ellis and Bochner (1999) and Game (1997) assert that emotion is an essential part of the research process, which involves both 'feelings' and 'thinking'. However, Dickson-Swift et al. (2009) reported that researchers' emotions tend to be ignored and remain unacknowledged, which was true to this study at the beginning stage of research. Despite predicting that students might become emotional when disclosing personal stories of intercultural encounters, I underestimated the level of emotional trauma they had experienced in placements until the first interview in the pilot study. To become deeply immersed in participants' private experiences of difficult times, it is required that the researcher must draw on empathetic skills in order to build rapport with the participants and to help them to feel secure and comfortable (Yin, 2016). As a result, the participants can 'open up' and be willing to self-disclose their personal stories, helping the researcher to 'see through their' eyes and understand their work (Harding, 2019). It can be challenging for the researcher to do this while also remaining objective. When emotional subjects arose, instead of stopping the interview, participants preferred to continue and were grateful for having their story heard and their experiences witnessed. However, on occasions, I would burst into tears a few hours after settling the participants at the end of the interview using my years of counselling skills.

One reason for this strong emotional reaction came from the significant difference between reality and expectation. My impression of nursing staff at healthcare settings had been of kind and caring individuals who respect everybody. However, the stories I heard from few EM student participants showed that they were treated with disrespect, discrimination, and racist attitudes, which caused deep emotional pain to them. I and my lecturing colleagues have always placed students at the centre of our work, so it was sad to hear that student had been treated so badly off campus. In particular, they were told not to complain, since the procedure could cause

‘complications’ for them. The detailed discussion, ‘nurses eats their young’ (Bartholomew, 2006) was explored and analysed in chapter 4.4.

Dickson-Swift et al. (2009) note that some research encounters might trigger the researcher to recall their own experiences, which can cause an emotional response. It was the case that some of the stories reminded me of how I was treated when I first came to the UK during my adaptation period. I initially thought that nursing practice would have changed significantly over the last 15 years, as during that time nursing education has changed from Diploma to Advanced Diploma, then to an all-degree course in 2012. However, when I heard some of the negative experiences of EM students, I recalled vivid pictures of the people who had treated me negatively, which caused me to burst into tears. In addition, I was also emotionally touched by some stories and imagined how hurt the students felt when other staff were ignorant or displayed negative words or behaviours. This also made me worried about how my children would be treated in their healthcare professional education.

Emotion management refers to a conscious or unconscious effort to alter the status of feelings and emotion, both internally and externally (Dickson-Swift et al., 2009). Even though the professional transcriber informed me that much of the transcription work did not affect him due to the amount of transcription he has completed over the years, he did admit that he did feel ‘*sad and found it emotionally taxing when hearing the interviewee becoming upset*’, but then he reasoned that the research was intended to improve the service and he was contributing to this in his own way through transcribing the interview. Nevertheless, I always maintained an open conversation with the transcriber about his emotional experience during the work (Dickson-Swift et al., 2009).

To manage my own emotion, I used the following strategies:
I established a boundary around my role at the interview as the researcher not a counsellor nor personal tutor and referring interviewees to occupational health or the university counselling service when appropriate.

To prevent emotional and physical exhaustion in response to the data, I interviewed a maximum of two cases per day and allowed sufficient time for debriefing after the interview as well as a recovery period.

I recognised and admitted my emotional tiredness, exhaustion, and burnout when this happened and accessed informal support from empathetic colleagues, friends and family members throughout the research process, maintaining confidentiality at all times.

As I learned lessons the pilot study, I was then prepared for some emotional disturbance when interviewing students from a ME background since Dickson-Swift et al. (2009) commented that there is a high chance that the researcher will experience this disturbance if the research topic has some similarity to their own life experience.
I found that regular supervision was valuable, not only academically but also for wellbeing support. My supervisor could recognise early signs of emotional distress and provided support and guidance on emotional management strategies, including self-care throughout research process.

Inspired and influenced by the transcriber's resilience strategy, I transferred my emotion and energy into making sure the project revealed the reality of students' experience and fulfilled their wishes to make their voice heard by wider professional and society through publication and public speech. Winning of prestigious a Mary Seacole award to support the pilot study phase and a Florence Nightingale Scholarship to support the main study phase and a bursary to present and attend the British Educational Research Association, as well as number of international and national conference presentations, were evidence of my contribution to make the project recognised by wider academia, healthcare professional, and societies. More benefits were reported in section 3.6.1 as my personal motivators to continue the project. Even though I did not access counselling services, I was aware of these and could self-refer or refer interviewees if needed.

At the end of the interview, interviewees who became upset were given debriefing time and directed to the university counselling service; however, all declined this service, saying that they felt it was a relief to have somebody listen to their stories so that their

voice could be heard by the wider profession and society. When hearing some negative experiences and worrying issues from the participants, I felt sad and tried hard not to show my extreme emotion in front of these students. In addition, during the first interview, I was concerned that opening up emotionally would compromise my research rigour by sending the message that I was too subjective. Dickson-Swift et al. (2009) revealed that female researchers tend to report more emotion than male researchers, possibly due to emotional presentation across genders; females tend to talk more openly about emotions than males (Hochschild, 2012). Nevertheless, it is important to make sure both male and female researchers can talk about their emotions and feel supported, since the consequences of being unsupported can be damaging to psychological health wellbeing. In this way, I ensured my duty of care to the participants, the transcriber and myself.

5.3 Research Challenges and Limitations

This section will report key challenges encountered and discuss the limitations of this study.

5.3.1 Challenges

We conduct qualitative research when we want to empower individuals to share their stories, hear their voices, and minimise the power relationships that often exist between a researcher and the participant. The study was ethically sensitive in that I was the senior lecturer at the same institution as the students. This relationship may have impacted students' responses and thus potentially increased the subjectivity of the interpreted outcomes. Therefore, I made it clear to them that I would not be involved in their assessment nor teaching, so they felt more willing to share their experience at the interview.

Potential risks related to participation include loss of confidentiality, discomfort and/or embarrassment and fatigue during interview. To avoid loss of confidentiality, a code name rather than real names was used in transcription. Audio tapes and any paper-based data were locked in a lockable file cabinet in my single person office. Furthermore, participants were instructed to let me know at once if there was a

problem that needed to be addressed. In this way, I reassured the participants so they could continue to be involved in the study.

Regarding interviews, as a novice researcher and as English was my second language, I was particularly nervous before the interviews. In order to overcome this nervousness, I devised an interview protocol and used virtual maps for the interview which could be drawn upon if, during the interview itself, things became difficult. As a consequence, I was able to be a more engaged and attentive listener and a more flexible and responsive interviewer. Therefore, a large number of new skills were needed quickly. I found constructing a schedule a very useful way to conduct interviews, particularly because it could be refined and rehearsed with my supervisor and peers; so, after a few interviews, I became more confident.

5.3.2 Limitations of the Research

Having participants from only one higher educational institution indicates that caution needs to be taken with the conclusions drawn from this study. The student nurses who participated in this research may have different intercultural experiences to students from other ethnic backgrounds due to their country of origin, age, years of living experience in the UK and level of English language proficiency. Furthermore, participants' placement experience and intercultural care education programmes may differ from those in healthcare settings and universities elsewhere in the country where ethnic minority populations are different.

Although the study was conducted in the UK and the data comes from student nurses' experiences rather than those of patients and staff nurses, many of the findings are consistent with those of the similar studies undertaken in other countries: for example, the difficulties nurses encountered when a shared language is missing, the range of strategies used to break the language barriers, staff attitudes towards interpreter services and the desired interpersonal attributes of interculturally competent staff (Flores, 2005; Gerrish et al., 2004; Jirwe et al., 2010). This means the implications arising from this study have relevance beyond the UK. However, I am also consciously aware that many intercultural competence models in nursing have been developed by Global North countries; therefore, the construct may reflect only the worldview of these

Western developed countries and may limit the healthcare system's provision of culturally competent care in other countries. Therefore, it is useful to research in other parts of the world to understand their views of culturally competent care. So, as the model was developed as an intercultural care competence tool, it would be worth looking at cross-cultural studies in different countries to test the domains and attributes and refine what intercultural care competence is.

5.4 Directions for Future Research

Currently, there is no agreement regarding who is the group to define and set the criteria of intercultural care competence. Is it the healthcare professional or the patient and their relatives? Therefore, even though the framework emerging from this study has included association with patients and their outcomes from student nurses' perspectives, further research is needed to examine the relationship between these constructs and refine the domain of cultural competence in healthcare. For example, there is a need for further study to examine and refine the domains of cultural care competence.

Further research could consider a study with student nurses and university academics on what exactly is being taught concerning intercultural care competence, and how the student nurses believe the formal contents impact on their clinical placement and cultural competences. Further research could also focus on interviewing lecturers about how they select intercultural educational models and the contents and methods they to deliver their intercultural programmes in order to develop student nurses' intercultural competences. There could also be a follow-up study with students who participated in the new curriculum on how they use the theory in clinical practice. The findings can help to identify whether the students have developed more intercultural competences after participating in the intercultural education programme.

The students revealed a number of internal attributes (such cultural humility and self-efficacy) strongly associated with the student's motivation on intercultural engagement and patients' clinical outcomes and satisfaction; therefore, further educational research could be conducted to testify the effective ways of teaching and learning these attributes to healthcare professionals and student nurses.

The literature review shows that the current literature on diverse patients' needs and their cultural clash in the Western values-based healthcare system in the UK is rather limited, which means this aspect of care still has not been fully explored. As a result, the effective strategies to manage the situation may have not developed, including maintaining modesty and privacy for Muslim women, facilities for prayer and family visits. Therefore, further research could be conducted to identify intercultural experience from patients' perspectives.

Accent was identified as one of the negatives experienced by the ethnic minority students. There is no literature that explores how nonnative and native accents were perceived by staff and patients in clinical areas, and how these perceptions impact on their relationship and communication with the speakers. So, it would be useful to conduct research to explore how accent affects interpersonal relationships at work.
The data revealed that ethnic minority students were perceived negatively in placement and disappointment that their expectations were not met. It would be useful for future research to explore if the findings are transferable to nursing students in the wider population (such as a different cohort, different EM student groups and different nursing branches) and in other healthcare programmes at different universities and healthcare settings. In addition, it would be interesting to interview qualified staff, academics and patients about their views of working with EM students and their views on interpreter services for patients who require linguistic support.

5.5 Final Remarks

Through exploring student nurses' intercultural experience, this thesis has identified the key knowledge, skills, appropriate attitudes and sensitive engagement needed for effective communication and care outcomes for patients, students and other healthcare staff. In addition, healthcare providers' and receivers' outcomes are considered important constructs in effective ICE.

The findings suggest that institutional racism as well as individuals' ethnocentric worldviews still adversely affect care quality and the experience of people from diverse

backgrounds. It seems that a combination of intercultural education and legislation to influence the intercultural care implementation may be a way forward.

Through this study, I also had the opportunity to hear open-hearted stories from student nurses about their intercultural care experiences. All participants, especially those from ethnic minority groups, expressed their appreciation of my desire to listen to their voice, learn from their experience and make their voice heard to a wider professional population, including nursing academics, practitioners, and leaders. Mourhinda commented that she hoped that this study would make a real difference to the experience of people from diverse backgrounds, including patients and student nurses.

> *I'm happy to be part of this research and I hope that the outcomes will make a big difference for people from a different cultural background, because not a lot has been done for people of different cultural backgrounds and nurses come in from different places. How can we forget the babes that we are moulding? These are precious minds and whatever is being fed into the minds of students, whether theoretically or practically, that's how we're going to mould the next generation of nurses. (Mourhinda, Y3, Guyanese student)*

As a senior lecturer for pre- and post-registration nursing programmes, I am in the right position to be the role model to ethnic minority nursing students who wish to serve people's health and succeed in the nursing profession. Also, this position affords me the power to influence the future curriculum and its effective delivery to ensure intercultural care is effectively embedded in the educational system and is led and delivered by culturally competent academics and administrators. As a link tutor to a local NHS trust, I have the unique opportunity to work in partnership with the policy makers and managers to enforce intercultural-related policies (such as the Zero Tolerance policy) and to ensure that they are seriously implemented and evaluated and people who report incidences of racism etc. are protected and supported. In addition, I can work together with the trust educational team to set up continuing education programmes to continue to raise staff awareness and competences to care for patients from diverse backgrounds and to cultivate a welcoming environment to support students from all background to learn and flourish.

I believe all people are equal; the purpose of intercultural education is to help people recognise and bring human value into real life. My mission as a registered nurse, nurse

educator, mother of the fifth generation of a family which has continuously provided healthcare service enables me to continue promoting the WHO's constitution motto (2006) of providing highest attainable standard of health to every human no matter what background they are from.

> *The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being regardless of race, ethnicity, national origin, religious and philosophical beliefs, gender, sexual orientation, cultural values, age, and other diversities.*
>
> World Health Organization Constitution, 2006

Appendix 1: Interview Protocol

STUDY TITLE: An Exploratory Study of Student Nurses' Intercultural Encounters in Clinical Practice

NAME OF RESEARCHER: Mrs Chun Hua Shao (Joy)

PARTICIPANT IDENTIFICATION NUMBER: _____

1. **Welcome & Introduction:**
   - Introduce self.
   - Brief overall aim and purpose of the project
   - Take consent to audio recording and participation of the study.
   - Reassure confidentiality and anonymity to research.

2. **Informal Introduction: Social & Cultural Background:**

   Questions:
   - *Could you tell me where were you originally come from, please?*
   - *Have you lived in other country before? If so, what did you do, and for how long?*
   - *Would you like to tell me about any experience you had with people whose cultural background was different to you before you entered the course?*

3. **Main Questions: Student's Intercultural Experience in Practice:**

   a. **To explore the perception of IC encounters**

   Questions:
   - *Can you tell me your understanding of intercultural encounter, please?*
   - *What does culturally competent care mean to you? What skills and knowledge are required? Anything else?*
   - *How confident are you in delivering culturally competent care?*
   - *How did you acquire your knowledge and skills in cultural encounters?*

   b. **To explore experience of IC communications in practice**

   Questions:
   - *Generally, is it more easy/difficult for you to talk to culture others, compare to people from your own origin? Why?*

   - *Can you tell me about any positive experience of IC encounters during your clinical placement?*

     Probe:
     What happened? What did the two sides say and behave? What strategies were employed? How effective was it? How did the communication end up?

   - *Can you tell me about any challenges you encountered/witnessed during your clinical placement?*

     Probe:
     What's happened? What did the two sides say and do? How did you feel about that? Why? What communication strategies were employed? How effective were they? How did the communication end up? Will you do differently should the similar situation occur again? Why and how?

c. To explore factors influence interviewee's experience in IC encounter.

Questions:

- *What factors/conditions might help or prohibit your communication with culture others?*

  Probe:

  What do you think is required to support you and staff in providing culturally competent care in practice? Why? Are there any topics which you think should be addressed in student's training? Why?

4. Closing Comments & Thanks:

Questions:

- *During the nursing course, you might have written a reflection on an IC encounter in practice. If so, would you like to share that with me?*
- *Is there anything else you'd like to tell me?*
- *Do you have any questions?*

Express thanks for their participation, give information should any follow-up support needed, and ask if they would like to receive a summary of the results when available (if so, how? e.g. email/post).

Appendix 2: Participant Information Sheet

Study title: An Exploratory Study of Nursing Students' Lived Experience of Intercultural Encounters in Clinical Practice

Dear student

I am a doctoral student at Durham University undertaking the study of exploring Pre-registration nursing students' experience in working with people whose culture backgrounds are different to themselves during their clinical placement periods. You are warmly invited to take part in this study. Please take time to read the following information carefully and discuss it with others if you wish. Also, please feel free to ask me if there is anything that is not clear or if you would like more information before agreeing to be in the study. Thank you.

What is the background and purpose of the study?

The UK 2011 Censuses indicates a significant increase in the figures of people from Black, Asian and Minority Ethic (BAME) groups. There are those amongst this group who have different healthcare delivery needs from those of the indigenous people due to their diverse cultural needs and religious beliefs. Promoting equality and equity has been at the heart of NHS England's values to ensure that the organization exercises (including staff recruitment and service provision) fairness in all that it does, and that no community or group is left behind in the improvements that will be made to health outcomes across the country. The purpose of the study is to explore Pre-registration nursing students' experiences in intercultural communication and interactions during clinical placement periods.

Why have I been invited?

You have been invited to take part in this study because you are recognised as one of the Pre-registration nursing students who is likely to encounter intercultural communication and interactions during your study at Northumbria University.

Your views are important for the study because your experience of this topic can help educators have a better understanding in nursing students' intercultural experience, and consequently help them tailor experiences to promote and further enhance student nurses' intercultural competence in clinical practice.

Do I have to take part?

Taking part in this study is voluntary. It is up to you to decide whether to take part. You can ask me any questions you want to understand what is involved in the study and what this would mean for you. If you would prefer not to take part, you do not have to give any reason, and no one will mind.

If you agree to take part, you will be asked to sign the consent form to say that you are taking part voluntarily and that you understand what is being asked of you. Even if you sign a consent form, you are free to withdraw from the study at any time.

What will happen if I take part?

I will invite you to talk about your views of working with people whose cultural background are different to yours during your placement periods and its impact on your clinical experience. This one-to-one face to face interview will be held in a private room at Coach Lane Campus or a public place at the choice of you, and at a time which is convenient to you. With your permission, I will record the interview with a small digital audio recorder. The interview will last about 60-90 minutes.

What are the possible benefits of taking part?

Taking part in this research project will give you opportunity to see how qualitative research is undertaken. You will also be able to record in your Personal and Professional Development Portfolio (PPDF) that you have participated in a research project as part of your on-going development. As a result of participating in this study, you may also develop a more heightened awareness of intercultural communication with other staff and patients in healthcare settings. Also, the research outcomes will also inform intercultural education for the pre-registration nursing curriculum in the future. If you wish, you may receive a copy of the summary report of the study.

Will my taking part in this study be kept confidential?

All information collected during the study will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be identified from it.

The data for this study will be collected using a digital audio recorder during the interview. Once the interview has ended, the recorder will be kept in a lockable briefcase and transported from the interview venue to my locked office at Coach Lane Campus. The recording will then be transcribed, and a written record of your discussions will be created. These documents will be anonymised and marked by a unique identified codes allocated to you by me. This will not be seen by anyone else.

The research data generated from the interviews will be kept securely on a password protected computer and in a locked cabinet, accessible only to me. There is onsite security and alarms are fitted to the building. All digital recordings will be deleted, and any paper-based information will be shredded seven years after the study is completed according the university Data Protection policy, which is based on Data Protection Act 1998 and Freedom of Information Act 2000.

If I take part, can I withdraw from the study at a later date?

You can withdraw from the study at any time. Simply contact me that you would like to withdraw. All data collected from you will be destroyed as confidential waste unless you agreed to use the data up until the date and point of withdrawal. My contact details are at the end of this information sheet.

Who has reviewed this study?

The proposed study has received ethical approval from the School of Education Ethics Sub-Committee at Durham University where I registered for doctoral studies, and the Faculty Research Ethics Committee at Northumbria University where the research is to take place.

Who is organising and funding for the study?

The study will be conducted by me as part of my Doctor in Education (EdD) studies at Durham University. This research project is supervised by Dr Prue Holmes ([redacted]@durham.ac.uk) from the School of Education at Durham University.

The study was awarded a national Mary Seacole Award which is funded by the Department of Health, Health Education England and NHS employers, in association with the Royal College of Nursing, the Royal College of Midwives, Unison and Unite Community Practitioners & Health Visitors Association. The study is also supported by Northumbria University as part of staff development activity.

What will happen to the results of the research study?

The findings from the initial phase of the study will be reported to the Mary Seacole Award Committee and disseminated at Mary Seacole Award Ceremony at Headquarter of Royal College of Nursing in October 2015. A further detailed research report will be written as part of my doctoral thesis and will be shared with the Pre-registration Nursing programs at Faculty of Health and Life Sciences, Northumbria University. The results will also be published in education and health care journals and conferences. With your permission, anonymous quotes may be used to illustrate the study's findings. You will not be identified in any report or publication arising from the study. If you wish, you may receive a copy of the summary report of the study.

What if I have questions or concerns after reading this sheet?

In case of any further questions about any aspect of this study, please do not hesitate to contact me in the first instance, and I will do my best to clarify or address these. If you have any concerns about this study, please contact my supervisor, Dr Prue Holmes at Durham University on 0191[redacted] or email [redacted]@durham.ac.uk.

What should I do now?

If you think that you would like to take part in the study, please sign and return the attached invitation sheet to my office at [redacted] Campus (Allendale House, room 003, Coach Lane Campus west) or send through your [redacted] University email to [redacted]. On [redacted] of the return sheet/email, I will contact you to arrange

the interview at mutually convenient time at Coach Lane Campus or a public place at the choice of yours.

Thank you very much for taking the time to consider taking part in the study.

Joy

Chun Hua Shao
Senior Lecturer
[redacted]

Email: j.shao@[redacted]

Appendix 3: Participant Invitation Letter

Dear <<Nursing student name>>

Re: Research study to explore pre-registration nursing students' lived experience in intercultural encounters in clinical practice

We are helping the researcher, Mrs. Joy Shao, who is based at Faculty of Health and Life Sciences, Northumbria University with a research study, and are writing to you to ask if you would be willing to take part.

The project aims to find out your views and learning experiences on intercultural communication and interactions in clinical practice. We hope that the study will further enhance our understanding and supporting students at the pre-registration nursing programs in teaching intercultural communication and globalization.

Please take time to read the enclosed "Participant Information Sheet" carefully. If you decide you would like to take part, please read and complete the enclosed 'Participant Invitation Sheet' and return this form to the researcher's office at Allendale House (room 003), Coach Lane Campus (West) using. Alternatively, you can send the completed form to the researcher via your Northumbria University email to j.shao@northumbria.ac.uk.

If you have any questions regarding this research, please contact Mrs. Joy Shao by telephone 0191 215[redacted], or by e-mail at j.shao@northumbria.ac.uk . She will try her best to answer your queries.

Thank you for considering taking part in this study. The researcher is look forward to hearing from you.

Yours sincerely

Director of the Programme

Appendix 4: Ethical Approval from Participant's University

Professor [redacted] ***CBE FRCN***

This matter is being dealt with by:

Professor Pauline Pearson

Ethics Lead

Department of Healthcare

Faculty of Health and Life Sciences

[redacted]

Tel: 0191 [redacted]

Email: [redacted]@[redacted]

Joy Shao

Department of Healthcare

22 May 2015

Dear Joy

Faculty of Health and Life Sciences Research Ethics Review DHCShao190315

Title: An Exploratory Study of Pre-Registration Nursing Students' Lived Experience of Intercultural Encounters in Clinical Practice

Following independent peer review of the above proposal, I am pleased to inform you that University approval has been granted on the basis of this proposal and subject to compliance with the University policies on ethics and consent and any other policies applicable to your individual research. You should also have recent Disclosure & Barring Service (DBS) and occupational health clearance if your research involves working with children and/or vulnerable adults.

The University's Policies and Procedures are available from the following web link:
http://www.[redacted]/researchandconsultancy/sa/ethgov/policies/?view=Standard

All researchers must also notify this office of the following:

- Commencement of the study;
- Actual completion date of the study;

- Any significant changes to the study design;
- Any incidents which have an adverse effect on participants, researchers or study outcomes;
- Any suspension or abandonment of the study;
- All funding, awards and grants pertaining to this study, whether commercial or non-commercial;
- All publications and/or conference presentations of the findings of the study.

We wish you well in your research endeavours.

Yours sincerely

Professor [redacted]

Ethics Lead for Healthcare, on behalf of the Faculty Research Ethics Review Panel

Appendix 5: Ethical Confirmation Letter – Durham University

Durham University, School of Education

30 March 2015

Chun Hua Shao
EdD student

c.h.shao@durham.com

Dear Joy

I am pleased to inform you that your application for ethical approval in respect of 'An exploratory study of pre-registration nursing students' lived experience of intercultural encounters in clinical practice' has been approved by the School of Education Ethics Committee

May we take this opportunity to wish you good luck with your research?

Appendix 6: Self-Performance Assessment of Pilot Interview

Date: **Time:** **Venue:**

Interview Code:

General feeling:

Overall Score:

Aspects	Score	What's happened		What'll do differently next time
		Positive	Negative	
Contents				
Process				
Venue				
Rapport				
Equipment				
English Language				
Questioning technique				
Demographic profile				
Follow up				
Interview Protocol				
Post-interview Reflection				

Appendix 7: Participant Consent Form

Participant identification number ☐☐☐☐

STUDY TITLE: An Exploratory Study of Pre-registration Nursing Students' Lived Experience of Intercultural Encounters in Clinical Practice

NAME OF RESEARCHER: Ms Chun Hua Shao (Joy)

Please read carefully the "Participant Information Sheet" before completing this consent form. Please indicate whether or not you agree to take part by initialing the appropriate box, and signing the form at the bottom.

	Please initial the boxes	
	YES	**NO**
1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. I have been informed that the investigator can be contacted via email j.shao@[redacted] or telephone 0191 [redacted].	☐	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my rights of being as a student in Northumbria University or legal rights being affected. I understand that all data will be destroyed if I withdraw.	☐	☐
3. I understand that any data collected from me will be anonymised, and my personal details will be kept confidential.	☐	☐
4. I am willing to participate in an interview. I agree to be contacted by the researcher and therefore provide my contact details on the invitation sheet.	☐	☐
5. I agree to audio record the interview the study in which I take part for the purposes of the research. I understand that I may ask for the recording to be stopped at any time. I understand that the recordings will be kept safely and then discarded seven years after the study is completed.	☐	☐
6. I agree to the use of extracts and results from the study in the researcher's doctoral thesis, publication of journal articles, conference presentations and local seminars.	☐	☐
7. I would like to take part in the above study.	☐	☐

Any concerns about this study, please addressed to:
Sheena Smith, the Ethics Sub-Committee of the School of Education, Durham University, on 0191 334 8403 or e-mail: Sheena.Smith@Durham.ac.uk; Professor [redacted], Ethics Coordinator of Depart of Healthcare, [redacted] University, on 0191 [redacted] or email [redacted]@[redacted]; and Research Supervisor Dr Prue Holmes on 0191 [redacted] or email: [redacted]@durham.ac.uk.

Name of Participant _____ Date_____Signature _____

I certify that I have presented the above information to the participant and secured his or her consent.

Name of the Researcher_____ Date_____Signature_____

Appendix 8: Participants Interview Records

Year group	Pseudonym	Gender	Age	Ethnicity Origin	Interview Periods	Total Interview Hours
Year 1 (N=14)	Azindoo	M	39	Ghana	1hr 56mins	15hr 8 mins
	Miremba	F	31	Uganda	1hr 11mins	
	Nesta	F	26	Zimbabwe	54minss	
	Tani	F	38	Ghana	1hr 33 mins	
	Corazon	F	34	Filipino	27mins	
	Matthew	M	24	English	47mins	
	Grace	F	21	English	1hr 19mins	
	Ruby	F	25	English	1hr 02mins	
	Michelle	F	38	English	1hr 29mins	
	Sophie	F	20	English	35mins	
	Jasminse	F	34	English	42mins	
	James	M	22	English	1hr 13mins	
	Aimee	F	29	English	55mins	
	Daisy	F	42	English	1hr 05mins	

Year group	Pseudonym	Gender	Age	Ethnicity Origin	Interview Periods	Total Interview Hours
Year 2 (N=11)	Feihong	F	43	Chinese	1hr 30mins	14hr 36mins
	Zabe	F	36	Zimbabwe	1hr 01mins	
	Aminsa	F	22	Nigeria	1hr 21mins	
	Saanvi	F	36	Indian	1hr 15mins	
	Cara	F	27	N. Irilish	56mins	
	Emily	F	28	English	58mins	
	Tony	M	20	English	20mins	
	Hannah	F	43	English	1hr 15mins	
	Eve	F	32	English	1hr 22mins	
	Angela	F	21	English	1hr 17mins	
	Alice	F	40	English	1hr 21mins	

Year group	Pseudonym	Gender	Age	Ethnicity Origin	Interview Periods	Total Interview Hours
Year 3 (N=16)	Aoife	F	**32**	N. Irish	54mins	15hr 20mins
	Dakila	M	43	Filipino	1hr 30mins	
	Mourhinda	F	38	Guyana	1hr 20mins	
	Mohammad	M	43	Iran	1hr 42mins	
	Eira	F	34	Welsh	1hr 01mins	
	Susan	F	24	English	58mins	
	Linda	F	31	English	1hr 01mins	
	Margaret	F	21	English	41mins	
	Jessica	F	42	English	57mins	
	Rebecca	F	29	English	48mins	
	Barbara	F	28	English	1hr 04mins	
	Laura	F	21	English	1hr 05 mins	
	Amber	F	23	English	1hr 24mins	
	Emma	F	22	English	45mins	
	Nancy	F	21	English	55mins	
	Zoe	F	41	English	1hr 15mins	

Appendix 9: Codes and Categories

Nodes

Name	Modified On	Modified By
a exposure to IC communication prior course	19/08/2015 19:37	JSHAO
a Understanding of IC competence	19/08/2015 19:44	JSHAO
culture	19/08/2015 19:43	JSHAO
interculture competence	19/08/2015 19:44	JSHAO
challenges	19/08/2015 19:37	JSHAO
Challenges communciation	19/08/2015 19:21	JSHAO
care difference	19/08/2015 19:28	JSHAO
faith difference	19/08/2015 19:28	JSHAO
language difference	19/08/2015 19:28	JSHAO
challenges in socialisation	19/08/2015 19:28	JSHAO
Strategies	19/08/2015 19:37	JSHAO
body language	19/08/2015 19:40	JSHAO
interpretor	19/08/2015 19:38	JSHAO
family member translate	19/08/2015 19:38	JSHAO
professional interpretor	19/08/2015 19:39	JSHAO
learning patient language	19/08/2015 19:39	JSHAO
other	19/08/2015 19:40	JSHAO
Outcomes	19/08/2015 19:49	JSHAO
visual aid	19/08/2015 19:41	JSHAO
suggestions for future	19/08/2015 19:37	JSHAO
placement	19/08/2015 19:30	JSHAO
policy maker	19/08/2015 19:30	JSHAO
university	19/08/2015 19:31	JSHAO
things helper and prohibiter	19/08/2015 19:37	JSHAO
previous exposure and experience	19/08/2015 19:43	JSHAO
staff and peers	19/08/2015 19:42	JSHAO
relationship	19/08/2015 19:46	JSHAO
supportive attitude from other staff	19/08/2015 19:46	JSHAO
student nurses	19/08/2015 19:33	JSHAO
attitude of students	19/08/2015 19:34	JSHAO
knowledge of culture differences	19/08/2015 19:34	JSHAO
skills of intercultural communication	19/08/2015 19:34	JSHAO
time	19/08/2015 19:43	JSHAO

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